SOLANO STATE PRISON

Review Period: Oct 2025 – Mar 2026

Onsite: May 12 – 14, 2026

Receiver's Compliance Team

2026

Statewide Mental Health Program
Continuous Quality Improvement

CSP-SOLANO

UNITED STATES

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Background

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

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

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

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

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

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

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

Goals

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

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

Approach to Assessing Compliance

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

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

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

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

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

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

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

Methodology

Data Foundation

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

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

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

Data Collection

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

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

Indicators Excluded from This Report

Part of the 2026 field-testing phase is designed to identify indicators that are not yet functioning as intended so they can be corrected before the Receiver recommends a final set of indicators to the court. During the initial audits, several indicators were identified as producing unreliable results and the quality management team is working on resolving the issues with these indicators. These indicators have been excluded from this report. A list of the specific indicators excluded from this report can be found in Appendix C.

Compliance Color Coding

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

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

Recommendations

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

Certain deficiencies are driven by structural conditions that exceed the institution's capacity to remedy independently. These include statewide shortages of designated RHU EOP beds, insufficient physical infrastructure for group treatment, and systemwide challenges in recruiting and retaining onsite clinical staff in remote locations. Where the report identifies a structural barrier, the Receiver will take the lead in developing and implementing a resolution, whether through infrastructure investment, population management, policy revision, or coordination with CDCR and DSH leadership. Institutional leadership is not expected to solve problems it does not control, but it is expected to maximize compliance within existing constraints and to document and escalate structural barriers through the channels the Receiver's office establishes.

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

Executive Summary

California State Prison, Solano (SOL) is a Level III, 270-degree design institution located in Solano County. It operates 18 housing units across two Level III Mainline facilities (A and B Yard), one Level II Mainline facility (D Yard), a GP Restricted Housing Unit (RHU), and a nine-bed Mental Health Crisis Bed (MHCB) unit. SOL provides treatment to approximately 430 ML CCCMS patients across three separate clinic locations of the institution. RHU patients are housed on Facility B, Unit 10. The MHCB is centrally located within the institution's Correctional Treatment Center (CTC). The institution does not operate an Enhanced Outpatient (EOP), nor Psychiatric Inpatient Program (PIP); patients requiring these levels of care are transferred to other institutions. SOL was not initially built to service an incarcerated mental health population and is one of few remaining General Population (GP) institutions. There have been recent shifts within its incarcerated demographics involving an increased Security Threat Group (STG) population and an increase in incarcerated people with points at a higher custody level with an override to allow them placement at Solano. Secondary events related to the change in demographics included increased violence on some yards, higher refusal rates of offered mental health treatment services, and increased substance abuse resulting in accidental overdoses and acute psychiatric incidents. These factors necessitated frequent mental health intervention and occasional modified programming. C Yard was deactivated within the first quarter of 2026, resulting in a population reduction of 23%. The institution's overall population decreased from approximately 3,817 residents to 2,960. The population of CCCMS patients also decreased from approximately 635 to 480 within the reporting period.

SOL's staffing fill-rate is a foundational strength. For most of the reporting period, SOL was at 100% or above staffing for all allocated mental health staff clinical positions, including psychiatrists, primary clinicians, and recreation therapists. The single supervisor vacancy reflected on reports was due to the current senior promoting into the chief position after the prior chief's retirement. That vacancy has since been filled, with a start date of June 1, 2026.

Institutional strengths are concentrated in custody operations, emergency preparedness, access to mental health care, mental health staffing, and the MHCB treatment planning and length of stays. Nearly all custody staff completed Use of Force training (99%), and all completed Suicide Prevention training (100%). CPR mouth shields were carried by all officers observed. Cut-down kits were complete and standardized across all housing units. Custody staff demonstrated awareness of mental health referral procedures across all yards, and 128-MH5 referral forms were available in all housing units. All transfers to MHCB, ICF, and Acute programs were completed on time throughout the reporting period.

Excellent teamwork between disciplines was described by staff members. Mental health staff expressed high job satisfaction. Clinical strengths were observed throughout the program. Various clinical groups are offered for the CCCMS population including insight-oriented psychotherapy for non-MHSDS individuals, support related to Board of Parole Hearing concerns, and psychotherapy groups. Patients knew their treatment plans and reported attending treatment regularly. IDTTs, particularly those in the MHCB, included an interactive process with engagement by all team members, clinical case discussion, and discussion of level of care.

The deficiencies documented in this report are driven by a combination of structural, operational, and clinical-quality factors. The structural barriers, including a lack of sufficient treatment space and the statewide RHU CCCMS bed shortage cannot be resolved through institutional corrective action alone, as this is a systemwide issue. The operational barriers (CMHPP rounding attendance and tracking) can be addressed with local institutional leadership and adequate resource allocation. The clinical-quality deficits, including safety plan individualization, are supervision and training problems that do not require additional resources to fix.

This three-part framework matters because the solution path differs for each. Systemwide problems require infrastructure, funding, or population adjustment. Local operational problems require protocol revision and custody-mental health coordination. Local clinical-quality problems require supervisory oversight, training, and

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

Priority Recommendations

1. **Provide Refresher Safety Planning Training and Initiate Monthly Supervisory Review**: Safety plan quality is a significant clinical deficit identified in this review. Of five discharge safety plans reviewed onsite, three were not individualized to the patient's specific risk factors and relied on stock phrasing, and the SPRFIT report (Appendix B) review found similar results for rescission cases. Safety plans were signed timely 59% of the time, and supervisory review of discharge safety plans was completed in approximately one-third of required cases. An HQ SPRFIT corrective action plan addressing safety plan quality has been open since July 2025. Safety plans at crisis transitions are the primary clinical instrument protecting patients moving from crisis-level to lower-level care.

   Provide refresher training on individualized safety planning to all clinical staff, with mandatory participation for clinicians routinely assigned to emergent referrals and MHCB 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 supervisory review of a random sample of ten safety plans for rescinded MHCB referrals and patients discharged from mental health inpatient beds who require safety plans, with individual mentoring for plans that do not meet standards.

2. **Improve Sound/Visual Confidentiality in Identified Treatment Spaces**: Onsite assessment found 60%† of group treatment spaces, 38%† of individual treatment spaces, and 20%† of IDTT spaces met all audit criteria. The deficits are concentrated in remediable confidentiality features: windows facing common corridors in ML CCCMS treatment and IDTT spaces, and RHU treatment modules located on the dayroom floor without sound or sight separation. Because SOL was not built for a mental health mission and has had no significant treatment-space construction since opening, near-term gains depend on remediating existing spaces.

   Identify all treatment spaces where confidentiality issues have been documented or reported and implement remedial measures such as placing sound muffling devices, frosting windows where consistent with safety requirements, and scheduling treatment to enable confidentiality in shared spaces. Continue to work with plant operations and the regional team to identify/request additional treatment space if local remedial efforts do not fully resolve the issue.

   Reconfiguration of individual treatment spaces: Most ML CCCMS individual treatment offices are configured with the patient seated between the clinician and the exit. This configuration may impede a clinician's ability to safely access the exit during an emergency or incident of workplace violence. Reconfigure individual treatment space so there is safe egress for treatment providers in the event of an emergency or workplace violence. Treatment providers should not be required to go by or around patients to exit an office as this can compromise their safety.

3. **Maintain Recent Improvements in CMHPP Compliance**: CMHPP compliance was a significant operational deficit of the review period: monthly executive leadership joint rounding occurred 38% of the time, no quarterly partnership round table trainings or IAC meetings were completed, and huddle documentation of required attendees was 49%. As of April 2026, SOL began conducting all required CMHPP elements and provided proof of practice; the remaining task is demonstrating that the correction is durable.

   To ensure durability, identify the specific barriers resulting in reporting period non-compliance with CMHPP monthly, quarterly, and IAC meetings. Implement monthly supervisor audits of the areas of CMHPP that were previously noncompliant to ensure recent improvements are maintained.

4. **Improve Mental Health Documentation Quality and Timelines for Uses of Force**: The single audited controlled use-of-force case did not meet mental health documentation requirements. During the review period, 47 of the 78 use-of-force incidents (60%) involved MHSDS patients, despite MHSDS patients representing only approximately 16% of the institution's population. The volume of MH-involved incidents makes complete and timely mental health assessment documentation a patient-safety priority.

   Review Controlled Use of Force audit data and establish a plan to address deficiencies in mental health documentation, including training and target completion dates.

Institutional Operational Perspective

SOL is a multi-level institution located in Vacaville, California. It operates 19 housing units across two Level III Mainline facilities (A and B Yard), one Level II Mainline facility (D Yard), a RHU in Building B10, and a nine-bed Mental Health Crisis Bed (MHCB) that is centrally located within the institution's CTC. When a licensed medical bed in the CTC is not available, the next preferred location for Alternative Housing (AHU) is the Intake Cells of the RHU (cells 123-131). A and B Yard each contain six 270-degree design cell housing units. D Yard is comprised of six 270-degree design dormitories. C Yard was deactivated within the first quarter of 2026.

Facility	Function	MH Population
A, B (Level III ML)	General Population (GP); six housing units each (270-degree design)	ML CCCMS
RHU (B10)	Restricted Housing Unit for GP; also houses CCCMS patients temporarily (two tiers; nine intake cells).	CCCMS Awaiting Transfer
C (Level II ML)	Deactivated.	N/A
D Yard (Level II ML)	General Population; Six dormitories (270-degree design)	ML CCCMS
CTC	Correctional Treatment Center; contains nine-bed MHCB. RHU intake cells utilized as AHU for residents awaiting licensed medical bed space.	MHCB

Mental Health Program Scope: SOL provides treatment to approximately 430 ML CCCMS patients across three separate clinic locations of the institution: Two Level III Mainline facilities (A and B Yard) and one Level II Mainline facility (D Yard). RHU in Building B10 can temporarily accommodate CCCMS patients awaiting transfer. MHCB is centrally located within the institution's CTC and contains nine licensed medical beds. RHU intake cells (123-131) are utilized as Alternative Housing Units when space in the licensed medical beds is unavailable for alternative housing use.

Staffing and Recruitment: During the review period, staffing levels were at or above 100% for most clinical positions, based on the allocated positions. During the onsite review, supervisors explained that there is low staff turnover and recruitment is relatively easy. Staff psychiatry and mental health primary clinician (MHPC) fill rates remain at or above 100%.

Operational Environment: SOL is a Level III, 270-degree design General Population institution that houses incarcerated persons across 18 housing units divided among three yards based on custody level and demographic factors. SOL provides mental health services to patients at the CCCMS level of care and operates up to nine MHCBs within the institution's Correctional Treatment Center (CTC).

During the review period, SOL experienced demographic shifts that included an increased Security Threat Group (STG) population and custody overrides that resulted in incarcerated people with level IV points being placed at SOL's level III yards. Related impacts included increased violence on certain yards, higher refusal rates for mental health treatment, and increased substance abuse resulting in accidental overdoses and acute psychiatric incidents. These conditions required frequent mental health intervention and periodic modifications to programming.

C Yard was deactivated during the first quarter of 2026, reducing the institution's population by approximately 23%. The overall population decreased from approximately 3,817 to 2,960 residents, while the CCCMS population decreased from approximately 635 to 430 patients during the reporting period.

Clinical Programs and Initiatives: SOL leadership has fostered a professional and collaborative work environment that supports staff morale and job satisfaction. Strong working relationships were reported among clinical staff, custody staff, and management. Collaboration was also evident among most custody staff.

In addition to required Mental Health Services Delivery System services, SOL Mental Health provides enhanced programming, including insight-oriented psychotherapy for non-MHSDS individuals.

Infrastructure: Treatment space is the most significant infrastructure constraint. Because SOL was not initially built to serve an incarcerated mental health population, nor has it had any significant physical plant projects to address mental health treatment space needs since opening, clinical treatment areas are dispersed throughout the institution. The Main Line (ML) CCCMS treatment space is spread across 3 areas of the institution. Some areas have individual offices while other spaces have clinicians working in cubicles. The RHU treatment space consists of three therapeutic modules on the RHU day room floor with partitions between them, and a separate room where IDTTs occur (although that is primarily used as an administrative work area). The MHCB, located within the CTC, has one room assigned for clinical operations (individual contacts, IDTTs, recreation therapy, etc.) another therapeutic module on the CTC Day Room floor for additional recreation therapy contacts, as well as two outdoor yards for exercise or recreation therapy. The therapeutic module is utilized for nonmaximum custody patient encounters because available office space is insufficient to accommodate all clinical interactions. The door remains open during these encounters.

Access to Care

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

Confidential and Effective Communication

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

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Timely Access

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
IRU Reviews Completed Timely	100%†	57%†	70%†	100%†	25%†	100%†	74%	
RHU GP Screens	100%	100%†	100%	100%	96%	94%	98%	
RHU Pre-Screen	89%	95%	98%	100%	84%	89%	93%	
Timely IDTTs (v2.0)	79%	80%	85%	87%	88%	94%	85%	
Timely MH Referrals (v2.0)	84%	87%	87%	93%	91%	90%	89%	
Timely MHMD Contacts (v2.0)	72%	87%	86%	83%	91%	84%	83%	
Timely PC Contacts (v2.0)	91%	88%	92%	93%	94%	95%	92%	
Custody MH Referrals								100%
Housing Units Where 128-MH-5s Are Available and Accessible to Housing Unit Staff								100%†

Timely Transfers

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Timeliness of Acute/ICF Referral Submission to IRU	100%†	83%†	100%†	100%†	100%†	80%†	94%
Timely Transfers to EOP (v2.0).		100%†				100%†	100%†
Timely Transfers to PIP	75%†	100%†	71%†	71%†	67%†	80%†	77%
Timely Transfers to RHU CCCMS	100%†	100%†	56%†	46%†	44%†	60%†	62%

Appointments

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
Appointments Cancelled Due to Custody [i]	5%	0%	0%	0%	0%	3%	2%

Treatment Environment

Indicator	Onsite Audits
Adequate Group Treatment Spaces	60%†
Adequate IDTT Spaces	20%†
Adequate Individual Treatment Spaces	38%†

Space-by-Space Assessment

Space / Location	Type	Assessed	Compliant	Primary Deficiencies
ML CCCMS	IDTT	3	Partial	Non-compliance due to window compromising confidentiality, and no conference table in room used during observations on B yard.
	Group	4	Partial	Room is sound confidential however there is a large window facing the hallway compromising confidentiality.
	Individual	12	Partial	Some space is not confidential due to cubicle dividers; this space is not currently used by multiple clinicians but would not be confidential if returned to use for more than one clinician.
RHU	IDTT	1	No	Space is not confidential, free from noise or well ventilated.
	Group	1	No	Space is not confidential or well ventilated.
	Individual	3	No	Space not confidential or well ventilated.
CTC/MHCB	IDTT	1	Yes	
	Individual	1	Yes	

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

✓ **Strengths**

Confidentiality indicators stable and high: Performance data obtained from electronic healthcare record entries shows stable, high compliance across all three indicators over the six-month period (~98%), with no month falling below 93%. SOL staff attempt to maintain confidentiality with their limited treatment space. Because space is limited and treatment spaces are close to one another, staff utilize white noise and sound machines in some spaces to help keep communication private.

Custody referral infrastructure: Custody-mental health referral infrastructure is functioning well. CDCR 128-MH5 Mental Health Referral Chronos were available and accessible across all housing units (100%), and all custody staff interviewed demonstrated awareness of their responsibility to initiate mental health referrals (100%).

Screening and contact timeliness: RHU GP screens, pre-screen, timely MH referrals and PC contacts were all at or above 83% during the reporting period, with dips in performance being temporary. Patient responses regarding access to care were consistent with the data; patients interviewed reported they can get to, and attend their mental health appointments, with patients on B yard in particular stating they go to all of their mental health appointments.

Patient-reported satisfaction: During interviews, patients generally expressed satisfaction with the mental health treatment provided at CSP SOL, and the institution was noted to deliver services above minimum standards. During the onsite visit, the Delancey Street restaurant program was toured, which offers employment opportunities for the incarcerated population.

Custody-driven cancellations averaged 2%: There were two months with custody driven cancellations; October 2025 (5%) and March 2026 (3%). After further investigation, about half (8 of 19) of custody-driven cancellations were actually data entry errors.[1] .

Treatment Offered: SOL does not currently have an EOP program or a designated CCCMS RHU. SOL offers seven groups on B Yard and one group on D Yard, open to CCCMS and GP patients. During patient interviews, it was reported that there are no barriers to attending group, and that mental health services are accessible to those who are not in MHSDS.

CTC treatment environments fully compliant: The IDTT room and individual treatment rooms in the CTC were fully compliant treatment environments, as they were appropriately sized, had sufficient seating, adequate ventilation, controlled temperature, and no distracting noises. The IDTT room and the group room for ML CCCMS on A yard were partially compliant. This room was used for ML CCCMS IDTT and group treatment.

⚠ Concerns

Data–observation divergence on confidentiality: While data reflect high compliance, onsite observation revealed physical conditions in several treatment areas that compromise confidentiality in practice. The indicator captures whether the clinician documented the encounter as confidential, but observations indicate that further improvements to space are necessary to ensure that the physical environment meets confidentiality requirements. Clinician understanding of the standard that contacts must meet to qualify as confidential also requires improvement.

Individual treatment spaces: Both ML CCCMS level II, education A and level III education B, consist of an office suite where one office is not confidential, as the office has a window where other staff and incarcerated individuals walking by in the main corridor can see in. The other offices in the suites (both in A and B) are confidential. Besides the office suite, A yard CCCMS features a large office divided into cubicles. Currently, a single psychologist uses the space, which ensures confidentiality. If the institution changes how it uses the room (e.g.,multiple clinicians to see patients), it would no longer be considered confidential.

Group treatment spaces/IDTT spaces: In ML CCCMS there is a large window facing the hallway, compromising confidentiality as others walk down the hallway to access other programs such as education or individual programs. This group space is also utilized for IDTTs. RHU B10 is not confidential, it uses TTMS in a day room separated only by partial walls or tall dividers without a ceiling. This setup limits sound privacy and allows visibility from the unit's top tier. Group treatment space for RHU is also used for IDTT and individual sessions.

IRU review timeliness: Timely completion of IRU reviews had a low compliance rate. Further review of this performance revealed this delay is due to additional information requests from IRU to the institution inpatient coordinator in eight of the referrals.

Timely MHMD contacts: Timely MHMD contacts have hovered in the 80% range, with October 2025 at 72%. Although the Executive Summary and Staffing table show Staff Psychiatrist positions at 3.5 filled on a 3.0 allocation (0% vacancy), SOL has experienced a functional psychiatrist vacancy that is not reflected in the

[1] Office technicians at sending institutions incorrectly entering the cancellation reason on the appointments, which accounted for all the MHCB custody-driven cancellations. The correct cancellation reason would have been that the patient moved out of the institution. The cancellations were on the SOL dashboard due to the patients being admitted to SOL's MHCB from other facilities, resulting in the need for the sending facility to cancel the patient's pending appointments; because the mental health reports reflect performance based on where the patient resides, not who cancelled, these show on SOL's report.

formal counts, resulting from an additional position allocated for the upcoming CCCMS RHU. A SAR has been approved, and SOL leadership is actively working to fill the position.

Transfers to EOP were completed within policy timelines consistently throughout the reporting period. Acute and ICF referrals were also submitted to IRU timely in most months.[2]

Timely Transfers to RHU CCCMS: Fifty-two patients required transfer to a CCCMS RHU during the reporting period. Of those, 62% were transferred to a designated CCCMS RHU within policy timeframes. The difficulty with meeting transfer timelines is due to a statewide shortage of CCCMS RHU designated beds. To help address this need, SOL has been designated to open a CCCMS RHU on July 1, 2026.

During this audit, a report anomaly was identified for at least one patient, who reflected a 159 day stay at SOL's RHU; the C&PR confirmed the longest this patient had ever stayed in the RHU at SOL was for five days. Further research is occurring to determine the cause of this anomaly.

Timely Transfers to PIP: There were 37 referrals to ICF or Acute level of care during the reporting period, five of which were endorsed and admitted to Department of State Hospitals (DSH) ICF program. The 77% six-month average for this indicator reflects the timeline for transfers to PIPs (excludes DSH) completed within 72 hours of acceptance to the program. Delays in PIP transfers are due to the SOL team waiting for the receiving institution team to confirm they are ready to receive the patients; this is not consistent with policy, which requires patients to be transferred within 72 hours of acceptance but not additional confirmation regarding readiness for patient arrival. Although physical transfer after acceptance is not consistently occurring within 72 hours of acceptance, overall timelines from referral to admission have been met 100% of the time.

Documentation is not consistent regarding custody-driven cancellations: The custody-driven cancellations attributable to SOL operations all occurred on 10/02/2025. There were eleven patient contact appointments that were canceled by the MHPC due to custody modified program on 10/02/2025. There were two active PSRs on that date, but the PSR directives allowed attendance at priority ducats with a 10 to 1 escort in place. Cancellation for the appointments is recorded in two separate systems and the reasons for cancellation recorded by custody and the MHPC in their two documentation tools were inconsistent. The healthcare lieutenant entered information citing clinician cancellation or patient no show as the reason for cancellation on that date, and the MHPC entered custody modified program as the cancellation reason.

Recommendations

1. Improve Sound/Visual Confidentiality in Identified Treatment Spaces: Identify all treatment spaces where confidentiality issues have been documented or reported and implement remedial measures such as placing sound muffling devices, frosting windows where consistent with safety requirements, and scheduling treatment to enable confidentiality in shared spaces. Continue to work with plant operations and the regional team to identify/request additional treatment space if local remedial efforts do not fully resolve the issue.

2. Reconfigure Individual Treatment Spaces: Reconfigure individual treatment space so there is safe egress for treatment providers in the event of an emergency or workplace violence. Treatment providers should not be required to go by or around patients to exit an office as this can compromise their safety.

[2] In November there were six referrals and in March there were five reflected on reports from electronic health record and SOMS data; one of the patients listed on the report as late in March is a data error, as the patient's level of care was changed to ICF on February 24 and he was admitted to an ICF program on February 27.

3. Identify and Address the Barriers to Timely RHU CCCMS Transfers: Ensure each patient retained in an RHU beyond the approved transfer timeline is there for a justifiable reason. Any patient who has been approved to return to the General Population should be moved the same day they are eligible for transfer. Continue working with the regional mental health administrator to request expedited clinical transfers for any patient in an overflow setting who is demonstrating clinical decompensation. RHU transfer delays are driven by the statewide shortage of designated beds, which is outside institutional control. However, the institution is responsible for ensuring that patients awaiting transfer receive treatment services available in their current setting, that pending transfers are tracked and prioritized by clinical acuity, and that cases involving clinical deterioration are escalated immediately through the regional mental health administrator. The institution should also track how many MHSDS patients in RHU/awaiting RHU placement are there because of safety concerns and seek to identify strategies to resolve those issues quickly in order to limit RHU placement for non-disciplinary reasons. The Receiver recognizes that the systemwide shortage of designated beds at the required levels of care is a structural barrier affecting multiple institutions and will address it as part of her broader remedial planning, including evaluation of bed capacity, population distribution, and institution resources.
4. Increase Consistency of Documentation and Communication Between Custody and Mental Health: Convene a meeting of mental health and custody leadership to review communication and documentation regarding appointment cancellations due to custody. Develop a protocol to address decision-making regarding limited circumstances in which clinical appointments could be cancelled and ensure clear communication among disciplines when a PSR is in place. Implement the protocol with line staff.

Custody and Mental Health Partnership Plan

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

Indicator	Onsite Audits
CMHPP MH Daily Huddles	98%
CMHPP MH Huddle Documentation of Required Attendees	49%
CMHPP MH Huddle Documentation of Supervisor Attendees	100%†
CMHPP Monthly Executive Leadership Joint Rounding	38%
CMHPP Monthly Executive Leadership Joint Rounding Attended by Required Executives	38%
CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH Program	100%†
Healthcare Staff with CMHPP Annual Training	99%
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours	
ML CCCMS and RC CCCMS CMHPP Monthly Joint Supervisory Program Tours with Required Attendees	
ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees	100%
ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings	0%†
Quarterly Partnership Round Table Training Completed as Required	
Required Staff Attendance of Quarterly Partnership Round Table Training	0%†

✓ Strengths

Huddles, weekly meetings, and training compliance: The CMHPP MH Huddle Documentation of Supervisor Attendees, ML CCCMS and RC CCCMS CMHPP Weekly Supervisory Meetings with Required Attendees, and the CMHPP Monthly Executive Leadership Joint Rounds Conducted in MH program were rated at 100% compliance. The CMHPP MH Daily Huddles occurred 98% of the time. The compliance rate for CMHPP Annual training was 99% during this review period. During the onsite interviews, staff reported that relationships between clinical staff, custody, and management were mostly positive and resulted in good morale.

⚠ Concerns

Executive engagement inconsistent: Although executive rounds occurred within the housing units when conducted, executive leadership engagement within the CMHPP is inconsistent at SOL. The CMHPP MH Huddle Documentation of Required Attendees was 49% for this review period; there were 0 entries in the huddle monitoring tool for 3rd watch huddles. The huddle review periods that were audited were 10/6/25-10/26/25 and 1/5/26 – 1/24/26. Three of the 21 huddles reviewed did not have mental health staff present. Compliance with monthly executive leadership joint rounding requirements, including required executive attendance, was 38%. During the six-month time frame, a total of one patient participated in the patient interview portion of the CMHPP. The process is designed to include patient interviews during the Executive Rounding each month. There were zero ML CCCMS CMHPP Monthly Incarcerated Person Advisory Council Meetings, and the compliance rate for Required Staff Attendance of Quarterly Partnership Round Table Training was 0%.

Required CMHPP meetings not completed: During the review period, no quarterly partnership round table training courses or monthly IAC meetings were completed in any area. There were no ML-CCCMS Joint Supervisory Tours completed during the review period. Nonetheless, staff reported good relationships across disciplines and patients reported satisfaction with care provided at SOL.

Recommendations

1. Maintain Recent Improvements in CMHPP Compliance: Identify the specific barriers resulting in reporting period non-compliance with CMHPP monthly, quarterly, and IAC meetings. As of April 2026, SOL began conducting all required elements of the CMHPP according to policy; proof of practice was provided. Implement monthly supervisor audits of the areas of CMHPP that were previously noncompliant to ensure recent improvements are maintained. If noncompliance recurs, convene a joint meeting between mental health and custody leadership to review barriers and implement a formalized action plan, including a review of the CMHPP requirements.

Psychiatry

There are required timelines for psychiatric response to medication non-adherence notifications, appropriate use of involuntary medication procedures under Penal Code §2602, and systematic monitoring of medication safety and continuity through the Medication Administration Process Improvement Program (MAPIP). MAPIP tracks the percentage of 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. MAPIP also tracks the percentage of patients prescribed categories of medications who received appropriate diagnostic monitoring consistent with clinical guidelines, combining these indicators into a single composite measure. These indicators assess whether patients received timely access to prescribed medications and appropriate safety monitoring.

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Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Timely Response to Critical Non Adherence Notification (v2.0)		0%†	0%†	100%†	100%†		60%†	
Timely Response to Non-Critical Med Non-Adherence Notification(v2.0)	73%	41%	53%	79%	65%	88%	64%	
Controlled Use of Force Incidents Required to Administer PC2602 Medication								50%†

✓ **Strengths**

MAPIP diagnostic monitoring compliant: The overall diagnostic monitoring portion of MAPIP averaged 96% for the reporting period. Diagnostic monitoring for antipsychotics averaged 97%. There was adequate oversight and support to effectively monitor the diagnostic monitoring metrics for the reporting period.

⚠ **Concerns**

Medication non-adherence response rates are low: Timely response to critical medication non-adherence notifications averaged 60% over the six-month reporting period. Response to critical medication non-adherence had an inconsistent trajectory, ranging from 0% for some months to 100% in other months indicating variability in timely follow up for patients identified as non-adherent with critical medications. Response to non-critical non-adherence averaged 64%. While this metric dipped as low as 41% in the month of November 2025, the metric had trended up to 88% for the month of March.

Timely Medication Administration: Timely prescribing psychiatry medications occurred 88% of the time during the reporting period. Rates were somewhat lower for patients who transferred within the institution or from other institutions with intra-system administrations at 83% for GP and 87% for Mental Health inpatient; and 66% for inter-system administrations for GP and 89% for inter-system administrations for Mental Health inpatient. The full MAPIP medication administration breakdown is provided in Appendix C.

Recommendations

1. Conduct a Medication Non-Adherence Notification Response Workflow Review: Map the current workflow for how non-adherence notifications for both critical and non-critical medications are received, triaged, scheduled, and addressed, identify where notifications may be lost, delayed, or not acted upon. Provide clarification and training to staff on workflows to ensure clarity on required processes. Track monthly compliance with a target of sustained improvement toward the compliance threshold.

2. Resolve Nursing and Custody Barriers to Timely Medication Administration: Conduct a multidisciplinary analysis on the process of medication administration for all patients receiving psychiatrist prescribed medications in the institution. Identify barriers and areas for improvement; implement the changes necessary to administer psychiatrist prescribed medications in a timely manner; and monitor, evaluate, and sustain these changes.

Patient Safety

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

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

Indicator	Onsite Audits
Heat Related Illness Incidents for MHSDS Patients Prescribed Heat Alert Medications	0
Number Restraint Incidents	0
Number of Seclusion Incidents	0

✓ **Strengths**

No Incidents: No heat-related illness incidents occurred among MHSDS patients prescribed heat alert medications during the reporting period. No Stage II or Stage III heat events required precautionary activation. There was no seclusion or restraint use during the reporting period.

Quality of Care: Care Access

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
IDTT Patient Attendance	70%	80%	80%	75%	67%	84%	76%	
IDTT Required Staffing	53%	44%	67%	81%	62%	48%	60%	
IDTTs with Observed Interactive Process								100%†

✓ **Strengths**

100% of observed IDTTs met the interactive process standard: The review included observation of multiple CCCMS IDTTs across RHU, D-Yard, and B-Yard. CCCMS patient interviews conducted on A-Yard also supported this finding. Overall, several core audit criteria were met, including timely starts, patient attendance, staff introductions, explanation of the IDTT purpose, review of clinical history and diagnosis, and justification of level of care.

Patient attendance and engagement: Team introductions and explanations of the IDTT purpose were consistently provided. The observed MHCB IDTT was particularly thorough when describing the patient's clinical history, functional impairments, diagnosis, strengths and weaknesses. Based on the performance report, during the review period an average of 76% of patients attended their IDTT. Patient attendance at IDTTs was not identified as a barrier and based on IDTT onsite observations, patients were generally engaged and provided opportunities to ask questions. During interviews, 85% of patients reported knowing their treatment plan and denied any barriers to treatment as it related to mental health staff. However, some patients reported that custody staff do not appear knowledgeable when responding to mental health crisis.

Psychiatrist engagement was a strength throughout the IDTTs during onsite observations. Psychiatrists appropriately reviewed psychiatric history, medication considerations, and, when applicable, discharge planning, across programs.

Level-of-care justification: During onsite observations, auditors found that discharge planning and level of care determinations were consistently supported by, and appropriately justified through review of the patient's diagnosis and level of care history.

⚠ Concerns

IDTT required staffing averaged 60% with no sustained improvement trend: Required staffing averaged 60% during the reporting period, with attendance rates ranging from 44% to 81%. Compliance improved to 81% in January 2026; however, staffing attendance during the remaining months ranged from 44% to 67%, SOL maintained a 100% fill rate for allocated mental health clinical positions throughout most of the reporting period, despite with a small clinical team. The IDTT staffing measure credits attendance only for the patient's assigned primary clinician and psychiatrist; attendance by alternate clinicians is not reflected in the measure.

Treatment planning was inconsistent across observed IDTTs. Minimal treatment planning was observed in the RHU IDTT, and several IDTTs across programs lacked measurable treatment goals. Safety planning was also not observed during the RHU IDTT.

Clinical jargon limited engagement: Although most patients attended IDTTs, patient engagement was limited due to the use of advanced clinical terminology and jargon. Although relevant clinical information was shared in the ML CCCMS D-Yard IDTT, the lack of simple language may have limited patient understanding and participation.

Discussion of custody factors and RVRs can go into more depth. In the RHU IDTT, neither RVR history nor custodial factors were discussed. In another example, during a B-Yard discharge IDTT, review of custody factors was limited, and there was no discussion of specific RVRs or related implications regarding risk level.

Intake completion and computer access: One of two D-Yard primary clinician initial intakes had not been completed prior to the IDTT. Additionally, the D-Yard primary clinician did not have computer access during the IDTTs.

Recommendations

1. Implement an IDTT Quality Improvement Process: Implement routine supervisory observation of IDTTs using a standardized checklist, followed by direct feedback to treatment team members after each observation. The quality improvement process should focus on strengthening treatment planning, ensuring measurable treatment goals are developed and linked to diagnoses and functional impairments, and improving overall consistency across IDTTs.

Quality of Care: Documentation

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

Indicator	Onsite Audits
Cases with documentation of appropriateness of LOC discussed for patients identified by 7388B as potentially requiring Higher Level of Care.	80%†
IDTTs in which PC Intake Evaluations were Completed Prior to Initial IDTT	75%†
IDTTs in which Psychiatry Intake Evaluations were Completed Prior to Initial IDTT	100%†

During onsite observations, five Higher Levels of Care forms were reviewed as part of the IDTT process for patients potentially requiring a higher level of care. The reviews included three cases in ML CCCMS, one case in MHCB, and one case in RHU. Of the five cases reviewed, one IDTT discussion in RHU did not adequately address the appropriateness of the patient's level of care leading to 80% compliance.

✓ **Strengths**

Psychiatry intakes timely: Primary psychiatry intake evaluations were completed prior to the initial IDTT in 100% of the cases reviewed. This indicates that the current workflow requiring a psychiatry evaluation before the initial treatment planning meeting is functioning effectively in the cases assessed.

⚠ **Concerns**

MHPC intake evaluations incomplete: Twenty-five percent of the IDTTs reviewed on site did not have a completed MHPC intake evaluation documented in the chart prior to the initial treatment planning meeting.

Recommendations

1. Reinforce expectations that MHPC intake evaluations be completed in the healthcare record prior to the initial IDTT meeting. Establish a quality improvement initiative to accomplish this recommendation. Workplans should include clear assignments and audit of treatment plans to measure improvement progress.

Rules Violation Reports

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
RVR MH Assessments Conducted in a Private Setting	83%†	63%†	80%†	75%†	89%†	60%†	74%	
RVR MH Assessments where Documentation Requirements were met	50%†	75%†	38%†				57%	
RVR MH Assessments where the Patient was Informed of the Limits of Confidentiality	100%†	100%†	100%†				100%	

Timely RVR MH Assessment Request	30%†	12%†	25%†	57%†	29%†	10%†	24%	
Timely Submission of MH RVR MH Assessment Results (v3.0)	71%†	58%	79%†	50%†	71%†	73%†	66%	

RVRs Issued	3,009
RVRs Issued to Non-MHSDS Participants	79%
michRVRs Issued to Patients at the Acute Level of Care	0%
RVRs Issued to Patients at the CCCMS Level of Care	21%
RVRs Issued to Patients at the EOP Level of Care	0%
RVRs Issued to Patients at the ICF Level of Care	0%
RVRs Issued to Patients at the MHCB Level of Care	0%

The RVR Analytics report (SOMS, run 5/13/2026) identified 3,009 RVRs issued during the full audit period: 622 to CCCMS patients, two to EOP patients, fifteen to MHCB patients, 1 to an ICF patient, six to APP patients, and 2,363 to non-MHSDS individuals.

⚠ Concerns

Timely RVR MH Assessment Request (24%): Only 24% of MH RVR Assessment Requests were initiated within the two-day time frame during the reporting period. Monthly compliance ranged from 10% in March to 57% in January.

Private Setting for RVR-MHA (74%): RVR-MHA assessments were conducted in a private setting 74% of the time, with monthly rates ranging from 60% in March to 89%† in February. In approximately one of four assessments, the patient was assessed in a setting that did not meet the confidentiality standard. Raw data indicate patients who transfer before a confidential assessment can be completed or decline a confidential assessment at SOL or after transfer appear to contribute to this measure.

Documentation Requirements (57%): RVR mental health assessments audited by the institution team reflected 57% met chart audit documentation requirements. Ensuring RVR mental health assessments are conducted appropriately is critical to identifying symptoms and functional impairments that may have contributed to the behavior and to providing the custody officer with sufficient clinical information to determine whether remediation of the RVR is appropriate.

Timely Submission of MH Assessment Results (66%): RVR-MHA assessment results were submitted over six months at a rate of 66%. Small variability was found from 58% to 73% during the reporting period.

Recommendations

1. Improve RVR-MHA Documentation and Timeliness: Identify and address the barrier to assessments meeting documentation requirements and timely assessment results. Establish a quality improvement initiative to accomplish this recommendation. Workplans should include clear assignments for corrective actions and audit of RVR-MHA assessments to measure improvement progress.

RHU: Timeliness

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

Indicator	Oct 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
ICC Review of Max Custody PIP Patients Within 10 Calendar Days of Arrival	0%†					0%†	
Timely Transfers to RHU EOP		100%†	100%†	100%†	50%†	89%†	
ICCs with Mental Health Clinicians Present and Relevant Information Provided							100%†
Initial ICCs Reviewed that were Held within 10 Calendar Days of Arrival to Restricted Housing Placement							100%†

✓ Strengths

NDRH tracking compliant: Non-Disciplinary Restricted Housing (NDRH) tracking procedures met compliance standards during the onsite review. Property issuance logs and NDRH tracking logs were current and accurate. Patients identified as NDRH-designated had current documentation supporting their housing status. These custodial monitoring processes provide the administrative foundation for ensuring NDRH patients are identified and tracked for timely transfer.

Mental Health Clinician Participation at ICCs (100%†): The clinician was present for all of the four observed ICCs. Two of the observed ICCs were for MHSDS patients. In all observed cases the clinician knew the patient's mental health information, inquired regarding thoughts of self-harm, and provided information regarding the patient's level of care and other factors related to their mental health condition.

⚠ Concerns

Decline in Timely Transfers to RHU EOP: The monthly data shows a decline over the past two months. The primary driver is the statewide RHU EOP bed shortage. At this time, SOL does not have a designated RHU EOP program and must transfer patients to hub institutions. Transfer timeliness depends on bed availability at receiving facilities, which is outside SOL's institutional control.

While awaiting transfer, these patients remain in settings that have already been determined to be clinically inadequate for their level of care. The transfer delay directly affects patient access to the treatment program determined to be clinically appropriate for the patient.

Recommendations:

See the recommendation addressing RHU CCCMS transfer timelines in Access to Care.

RHU: Documentation

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

Indicator	Nov 2025	6-Month Avg	Onsite Audits
Controlled Use of Force MH Assessments Meeting Documentation Requirements	0%†	0%†	
IDTTs Observed in which Pt Electronic Health Records and SOMS are Available			60%†
Observation of Psych Tech Rounds Where EC, Interaction, and Referrals Met All Audit Criteria			100%†
Psychiatric Technician Rounds Documentation Audited Meeting All Audit Criteria			100%†
PT Rounds Completed in Restricted Housing Units			100%†

✓ Strengths

Nursing Functions: PT rounds were observed. Staff demonstrated a commitment to patient engagement, documenting encounters at cell front as required. During the observed post RHU placement screening questions, staff asked the required mental health screening questions as written, provided clarification when needed, and interacted directly with the patient. A confidential assessment was offered and declined; the patient requested to be seen at the cell front.

Intake cell use: Three patients were housed in RHU in the identified intake cells (123-131). All patients housed in the intake cells were appropriately housed for less than 72 hours and were in possession of an entertainment appliance. All cells were suicide resistant and clean.

Security welfare checks: A security/welfare check was observed in the RHU. The officer conducted a thorough physical observation of living breathing individuals. Five cells had sheets/towels hanging in front of the bunks which blocked the view of the individual residing in the cell. In each case, the officer directed the individuals to remove the items. The Guard 1 report was reviewed for the previous 24-hour period. The report was printed and signed by the RHU sergeant. Two memos were attached outlining the minor deficiencies noted and addressed by the sergeant.

⚠ Concerns

Controlled Use of Force Mental Health Assessments Meeting Documentation Requirements (0%): Only one controlled use of force mental health assessment was audited during the reporting period. That assessment did not meet documentation requirements because documentation of consultation with custody and nursing staff was missing.

Recommendations

1. Controlled UOF Audit: Review controlled use of force mental health audits for next quarter to ensure there are not systemic issues related to use of force mental health assessments. If further audits reveal ongoing errors, initiate a quality improvement initiative to ensure staff completing assessments complete all requirements.

RHU: Out-of-Cell Activities/Care

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

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

Indicator	Onsite Audits
Custody Staff who can Identify all NDRH Patients	100%†
NDRH Patients Provided Personal Property	100%†
Peace Officers Observed to Carry Their CPR Mouth Shield	100%

✓ **Strengths**

Custodial care functions compliant: Custodial care functions in designated RHU programs are largely compliant. ARHR data for designated RHU CCCMS patients confirmed that out-of-cell time, shower access, and phone access met requirements. All patients observed in the RHU were in possession of working entertainment appliances. NDRH patients had been provided with personal property in 100% of the cases. All peace officers observed in all housing units, including RHU, were carrying CPR mouth shields. Custody staff could identify all NDRH patients (100%). Staff demonstrated awareness of their responsibilities for patient property, appliance access, and emergency preparedness.

Sentinel Events and Specialized Custody

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

Indicator	On-site Audits
Custody Staff Attendance at UOF Training	99%
Days Alternative Out-of-Cell Activities were Offered to Patients on Heat Alert Medications when Indicated	N/A
MHCB Patients Placed in TTM According to Policy	N/A
Thermometer Checks completed and accurate	100%
Use of Force Involving MH Patients	60%

✓ **Strengths**

UOF and CMHPP Training Completion: Of 733 custody staff, 732 completed Use of Force (UOF) training at the rate of 99%, and 732 attended the annual Custody Mental Health Partnership Plan (CMHPP) training at the rate of 99%. Healthcare staff attendance of both UOF and CMHPP training completion was also in compliance. Of 112 nursing staff, 111 completed UOF training at the rate of 99%. One hundred and ten nursing staff attended

the annual CMHPP training at the rate of 99%. All 22 mental health staff completed both the UOF and CMHPP training.

Heat Plan Infrastructure: Thermometer checks were completed and accurate in all housing units reviewed (100%). Temperature logs were maintained and thermometers were visible on each post at the highest tier where residents are housed. There was an incident when the digital heat log system had temporarily gone down. However, staff appropriately utilized a paper process to document temperature readings until the system returned online.

Heat Plan readiness: The Heat Plan was never activated during the review period (no Stage II or III heat events), thus no heat related illness incidents occurred among MHSDS patients. Correctional officers were able to articulate an adequate knowledge of the Heat Plan, as well as their responsibilities during a heat alert. Heat Plan reference materials were available and heat risk medication lists were readily available across each post.

Mechanical Restraint Use and Documentation: 128B Mechanical Restraint Reviews (MRR) in the Mental Health Crisis Bed were compliant. There was one non-MAX patient in the unit at the time of the review who was appropriately reviewed and approved for movement without restraints. These findings indicate that the MHCB maintains appropriate restraint documentation and that mechanical restraints are not being applied to patients whose custody classification does not warrant use.

⚠ Concerns

UOF Involving MH Patients: There were two controlled use of force incidents and 76 immediate use of force incidents within the reporting period. One MHSDS patient was involved in a controlled use of force incident and 46 MHSDS patients were involved in immediate use of force incidents. Of the two controlled uses of force, one required administration of PC2602 medication. Forty-seven of the 78 use of force incidents during the review period (60%) involved at least one MHSDS patient. Comparatively, the MHSDS population share at SOL is approximately 16%.

Recommendations:

1. Evaluate Use of De-Escalation: Review procedures and ensure custody staff engage in de-escalation including accessing support from mental health staff for MHSDS participants, where possible to prevent unnecessary uses of force.

Suicide Prevention

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

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Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg	Onsite Audits
Discharges from MHCB with clinician review of discharge summary	100%†	100%†	100%†				100%†	
Documentation of Acute/ICF Discharges with Clinician to Clinician Contact within 5 days				100%†			100%†	
Emergent and Urgent MH Referrals That Result in SREs	50%†	67%†	50%†	50%†	67%†	100%†	71%†	
MHCB Daily Provider Contacts (v2.0)	84%	80%	90%	87%	88%	87%	86%	
MHCB/PIP Supervisory Reviews of Discharge Safety Plans	25%†	50%†		25%†	50%†	25%†	32%	
Required MH Clinical Staff with Completed SRE Mentoring and Biennial Training	100%	4%	70%	91%	96%	96%	76%	
Safety Plans Signed Timely	88%†	50%†	33%†	33%†	50%†	67%†	59%	
Timely Clinical Follow-Ups (V2.0)	0%†	50%†	0%†		100%†	100%†	50%†	
Custody Follow Ups, Page 1								50%†
Custody Follow Ups, Page 2								0%†
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								17%†
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								100%†
MHCB Out of Cell Activities								100%†
Nursing Staff Current with CPR Training								100%
Observed Initial Health Screenings								100%†
Onsite Review of Patient Orders for Issue and Observation								100%†
Patients in Alternative Housing with a Bed								100%†
Referrals That Received a SRE When DTS or Suspected Intentional OD was not Marked on the MH Referral								100%†
RHU Intake Incarcerated Persons Appropriately Housed								100%†
Suicide Resistant Cells								100%†

✓ **Strengths**

Suicide Prevention: All required suicide prevention training courses were completed within designated timelines. As of March 2026, training compliance was at or above 96% for all required courses; SRE Mentoring and Biennial Training averaged 76% across the period after a November decline to 4%, recovering to 96% by

February. Custody suicide prevention training was at 100%, and mental health and healthcare staff suicide prevention training were both 99%. Nursing and custody CPR training was at 100%.

Emergency preparedness infrastructure is compliant: All housing units reviewed had compliant cut-down kits with standardized inventory sheets. All MHCB cells and RHU intake cells met suicide-resistant criteria. SREs upon rescission of MHCB referrals were completed 100% of the time. Suicide precaution rounds were timely at 98% with 99% staggered observation compliance. R&R initial health screenings met all audit requirements.

Alternative housing and TTM compliance: No patients were placed in alternative housing during the onsite review. No occurrences of patients being held in a TTM over the four-hour maximum allotted time were found during the review period.

Urgent and Emergent Referrals: Review of a sample of 39 urgent and emergent referrals that were not placed for DTS were reviewed. Results of the 39 cases reviewed revealed that only one emergent referral required an SRE. The SRE was completed within the appropriate timeframes. All other referrals were appropriately classified and did not warrant an SRE.

MHCB Issue and Observation Order Documentation: A review of ten MHCB patients who were placed on suicide watch or suicide precaution status during the review period revealed that in all cases patients had adequate clinical justification documented for all required days.

MHCB IDTT observation: One initial MHCB IDTT was observed in the MHCB during the review. All IDTT criteria were met. All IDTT team members contributed to the discussion and provided relevant information. Safety planning, issue and observation status, and privileges were discussed. The patient was given an opportunity to provide input regarding his treatment while in the MHCB.

⚠ Concerns

SRE Quality and Documentation: Overall compliance with completion of SREs within required timelines declined from 87% in October to 82% in March, as indicated in the On Demand Performance Report. Compliance for SREs upon MHCB referral for Danger to Self (DTS) remained at 50% over the audit period, and compliance for emergent consults for danger-to-self increased from 50 to 100% in March for an overall compliance rate of 71%.

SRE Compliance by Type	Compliance	N
Emergent consults for DTS	71%	17
Upon rescission of MHCB referral	100%	2
Upon MHCB referral for DTS	50%	20
30-day post-MHCB SRE	100%	3

The 50% rate for SREs upon MHCB referral for DTS is attributed to after hour referrals to the MHCB where the patients are seen by on call psychiatry, however SREs are not completed at the time of the referral.

Safety Planning Quality: Five safety plans were reviewed; of those, three were not individualized to the patient's specific risk factors, failed to identify clinical interventions and relied on stock phrasing rather than individualized content. SOL currently has an open HQ SPRFIT corrective action plan.

Supervisory review of discharge safety plans were completed on time for 32% of the time in the safety plans that were reviewed (N=19).

Timely Clinical Follow-Ups[3]: Timely clinical follow-ups averaged 50% across October through December before improving to 100% during February and March. The low rates of timely follow ups in October–December (50%) were a result of signing the documentation late in two of the four cases.

Custody Inpatient Discharge Follow-Ups (7497s): Two custody follow-ups were completed on paper during the audit period, and two using the digital system.[4] October had one incarcerated person on a custody follow-up resulting in 89% compliance due to deficiencies in the 30-minute checks. November had one patient who required follow up but did not have a 7497 initiated or completed. SOL currently has an open HQ SPRFIT CAP to address this issue.

SPRFIT Committee: Review of October - March SPRFIT meeting minutes found that SPRFIT meetings met quorum in all months except October. Compliance data, improvement projects, previously assigned corrective actions based upon SPRFIT audits, brief review of self-harm incidents and patients in the SRMP were noted. There were no serious suicide attempts with a medical severity rating of "3" that necessitated a clinical review or root cause analysis during the review period. Low compliance in this area is a result of omitted documentation of the discussions during the IFC and IAC meetings.

Recommendations

1. Provide refresher training on individualized safety planning to all clinical staff, with mandatory participation for clinicians routinely assigned to emergent referrals and MHCB 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 supervisory review of a random sample of ten safety plans for rescinded MHCB referrals and patients discharged from mental health inpatient beds who require safety plans, with individual mentoring for plans that do not meet standards.

Sustainable Process and Utilization Review

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

Indicator	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	6-Month Avg
MHCB clinical stays within timeframes	93%†	100%†	100%†	85%†	100%†	100%†	96%
Timely Transfer to MHCB (v2.0)	100%†	100%†	100%†	100%†	100%†	100%†	100%

✓ **Strengths**

Timely MHCB transfers: Transfer to MHCBs occurred within the 24-hour policy required timeframe in 100% of the cases throughout the reporting period.

[3] Percentage of clinical follow-up sequences completed on time after physical discharge from an Acute program, ICF program, or DSH location, or physical discharge from a MHCB program for patients referred for suicidality, or after a rescinded MHCB referral for suicidality.

[4] A transition from paper forms to a digital system to track follow up activities that were previously recorded on the 7497 forms is underway. Only paper forms can be audited using the existing audit tool. Once the transition is complete, a new audit assessing completion of the digital record will replace the current indicator.

Staffing

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

Classification	Allocated Positions	Filled Positions	Functional Vacancy Rate
Chief Psychologist	2	1	50%*
Chief Psychiatrist	1	1	0%
Senior Psychiatrist (Supervisor)	0	0	0%
Senior Psychologist (Supervisor)	1	0	100%
Supervising Psychiatric Social Worker I	1	1	0%
Senior Psychologist (Specialist)	2	2	0%
Recreation Therapist	1	1	0%
Staff Psychiatrist	3	3.5	0%
Psychologist – Clinical	3.5	3.5	0%
Clinical Social Worker	1	1	0%
MHPCs	8.5	9.75	0%
PC: Psychologist		4.75	
PC: Clinical Social Worker		4	
PC: Marriage and Family Therapist		1	
PC: Professional Clinical Counselor		0	

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

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**

Full Staffing Across Clinical Line Classifications: All allocated clinical social worker, psychologist and MHPC positions are filled, with MHPC positions filled above allocation (9.75 on an 8.5 allocation). Staff psychiatrist positions are filled above allocation (3.5 on a 3 allocation).

Staff Engagement and Clinical Culture: Clinical staff consistently reported a positive work environment with a professional clinical culture.

Receiver's Signature Page

Date: 7/6/26

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 Prison
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 Program
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 Clinical Case Management System
RHU EOP	Restricted Housing Unit Enhanced Outpatient Program
RHU GP	Restricted Housing Unit General Population
RJD	Richard J. Donovan Correctional Facility
RT	Recreation Therapist
RVR	Rules Violation Report
RVR-MHA	Rules Violation Report – Mental Health Assessment

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

Appendix B: Suicide Prevention Report

During May 12-14, 2026, the Receiver's Compliance Team conducted a review at the California State Prison, Solano. Various team members contributed to the documentation within the Suicide Prevention and Response report.

Restricted Housing Unit (RHU)

***Second Watch Partnership Huddle**:* The sergeant, mental health staff, senior psych technician, custody officers and the sergeant were present during the huddle. The huddle included discussion regarding new arrivals and any patients in the SRMP.

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

Intake Cells: SOL has nine retrofitted intake cells (123-131). All nine retrofitted intake cells were clearly labeled with "intake" signage. Please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

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

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

Section II: Inpatient Units

Suicide-resistant cells: SOL has one licensed MHCB consisting of 9 beds. The census was two during the review. All cells were found to be suicide resistant.

Interdisciplinary Treatment Teams (IDTT): One initial MHCB IDTT was observed during the visit. The patient was admitted for danger-to-others; however, he also reported thoughts of wanting to hurt himself. The IDTT had all required members present. The patient was on max custody status and was placed in the therapeutic module. The primary clinician initiated the introductions and stated the purpose of the IDTT. The patient was on suicide watch observation and was issued a safety smock. Appropriateness of issue and observation status was discussed. The clinician provided relevant historical and clinical summary that included current symptomatology, diagnosis, reason for admission, previous hospitalizations, and strengths and weaknesses. Measurable treatment goals were identified and discussed. Discussion about the patient's recent RVRs also occurred. Diagnosis, medication and side effects were thoroughly discussed by the psychiatrist. The CCI was engaged and contributed relevant information for the patient along with providing encouragement. Nursing staff provided a thorough summary of the patient's status and medical history. The recreational therapist discussed information about out of cell time and offered activities.

Overall, the team was interactive, and all members participated in the discussion. Although it was the patient's initial IDTT, safety planning was discussed. Higher level of care and appropriateness of level of care was also discussed. The patient was given an opportunity to provide input regarding his treatment while in the MHCB. Discharge planning was briefly discussed during the IDTT.

Quality of Safety Planning: Reviews of MHCB rescission data found that one of two cases had an adequate safety plan containing specific interventions to reduce suicide risk. Safety plans were also reviewed for five patients who were discharged from the MHCB and remained at SOL. The results revealed that two of the five were found to be adequate. Most safety plans did not include clinical interventions to reduce suicide risk, were not patient specific, and included the same language across multiple safety plans and sections.

Areas for improvement continue to be found in documentation of identifying each patient's specific risk factors, documentation of specific interventions to reduce risk and refraining from using cut and pasted information in multiple sections. This issue was first identified during the July 2025 HQ SPRFIT review. The CAP regarding this concern will remain open.

Suicide Watch and Suicide Precaution: There were two patients housed in the MHCB at the time of the on-site review, one patient was on a suicide watch observation and one on a Q30 watch. For timeliness of suicide precaution and suicide watch rounds during the audit period, please refer to the Continuous Quality Improvement Report (CQIR) for a summary of the findings.

Observation and Issue Orders: All issue and observation orders posted on the patients' cell doors were current and accurately matched the provider orders documented in EHRS. Clothing and personal items issued to each patient were consistent with these orders.

Documentation for 10 patients on suicide watch or suicide precaution orders during their stay at the MHCB was reviewed. The results revealed that all 10 patients' daily documentation included justification for limited issue and observation status.

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

MHCB Supervisor Review of Discharging Safety Plans:
A review of the On Demand Performance Report during the audit period indicated that the MHCB Supervisor or Chief of Mental Health reviewed 35% of the required safety plans. The On Demand report also indicated 59% of safety plans were completed timely (n=19).

Clinical Discharge Follow-Ups:
During the audit period, SOL had 71 total admissions to the MHCB. Twenty patients were from SOL, with the remaining 51 admitted from other institutions Two MHCB referrals resulted in recissions. The On Demand Performance Indicator noted SOL's Timely Clinical Follow Up compliance during the audit period as 50% (n=6). Two of the three clinical follow ups after physical discharge were completed timely. In one of the three cases, the patient returned to the MHCB leaving two clinical follow-ups required. A psychiatrist signed the follow up documentation late in the delinquent case. One of three follow ups for rescinded patients was completed timely. It appears that one of the rescinded patients was sent to an outside hospital and did not return to the institution and the other delinquent case was a result of the documentation signed late, however the follow up contact was completed timely.

As of March 2025, the business rule indicates that day 1 of the clinical follow up must occur within 24 hours of discharge or recission from the MHCB. Additionally, follow up compliance is now calculated as compliant or not compliant for the entire follow up series, whereas it was previously calculated daily. Currently if one day of the follow up is out of compliance, the entire follow up is now deemed out of compliance. Changes to these business rules have significantly impacted compliance for this indicator statewide and are currently in the process of being updated to reflect the intent of the statewide policy, which mandates daily follow-ups beginning the day following physical discharge, rather than within 24 hours.

A review of the two patients rescinded from MHCB LOC and three patients discharged from the MHCB who stayed at SOL during the 5 day follow up process was conducted to ensure safety plans are completed/updated, if warranted, during the 5 day follow up process. Results revealed that in one rescinded case, the SRE was completed by a psychiatrist, and a safety plan was not completed. Subsequent follow-ups during the next five days for this patient did not result in updated safety plan information despite indicating that the safety plan was reviewed with the patient.

Alternative Housing

Licensed medical beds in the CTC are utilized for alternative housing; however, when not available, retrofitted intake cells in the RHU are used. There were no patients in alternative housing at the time of the review. During the previous review, Lindsay Hayes found that in four of 71 cases reviewed, patients were held in the TTM a few hours over the four maximum time allotted. Lindsay Hayes also found that in nine of 71 cases, patients were placed on 15-minute observations while placed in alternative housing. During this review, no patients were held in the TTM over the four-hour maximum allotted time, and there were no instances of patients on 15-minute observations while placed in alternative housing. The SPRFIT Coordinator conducts monthly audits on both areas to ensure compliance.

During the audit period, OnDemand Performance Report data revealed SOL was 100 percent compliant with timely transfers to the MHCB. Justification documentation for two MHCB rescinded patients was reviewed, and findings revealed that both SREs included a clinical rationale for rescinding the patients from MHCB level of care.

Suicide Risk Management Program (SRMP)

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

SOL maintains an internal SRMP list which as of April 1, 2026, does not include any patients. Previous SRMP patients and status are listed on the log.

Discharge Custody Checks

Data from October 2025 through March 31, 2026, found that 63 percent of page one of the Discharge Custody Check Sheet (CDCR MH-7497) form was completed correctly by mental health clinicians and 60 percent of page 2 of the Discharge Custody Check Sheet forms were completed correctly by custody staff. As of February 16, 2026, SOL began utilizing the digital custody check application process.

These audit results are based on an institutional audit of paper 7497 forms. Audit results are compiled monthly, shared with the SPRFIT Committee, and sent to the Statewide Suicide Prevention Unit and incorporated into this CQI report.

Local SPRFIT Committee

Review of six monthly SPRFIT meeting minutes for the reporting period found that SPRFIT meetings met quorum in all months except October. The Health Care AW or Captain designee was absent that month. Compliance data, improvement projects, previously assigned corrective actions based upon prior SPRFIT audits, brief review of self-harm incidents and patients in the SRMP were noted. There were no serious suicide attempts with a medical severity rating of "3" that necessitated a clinical review or root cause analysis during the review period. Current SPRFIT local operating procedures (LOPs) were consistent with policy.

SOL's SPRFIT Coordinator last attended a Patient Family Council (PFC) meeting in December 2025 and the Patient Advisory Council (PAC) on December 16, 2025.

Urgent and Emergent Referrals for Danger to Self

A review of the OnDemand Performance Report for Urgent/Emergent referrals found that SREs for emergent consults were completed in 71 percent of cases (n=17) for DTS.

	Measurements	Hour Overdue	Compliance
Emergent and Urgent MH Referrals That Result in SREs	17	26.3	71%
SRE after Emergent MH Consult for Self-harm/Suicidal Behavior or ideation/DTS	15	29.9	73%
SRE after Emergent MH Consult for suspected intentional drug overdose	2	0.0	50%

In addition, a review of 39 urgent and emergent referrals not classified as danger to self during the audit period were reviewed. In one emergent referral, the patient expressed passive suicidal ideation and a SRE was completed. All other referrals were appropriately classified and did not warrant SRE completion.

Suicide Risk Evaluations

A review of the Suicide Risk Evaluation indicator in On Demand for the period of October 1, 2025, through March 31, 2026, resulted in an overall compliance of 84 percent for SREs completed timely.

	Measurements	Time Overdue (Days)	Compliance
Suicide Risk Evaluation	61	0.2	84%
SRE at MHCB referral for DTS	20	0.5	50%
SRE at rescission of MHCB referral for DTS	2	0.0	100%
SRE following MHCB Discharge (CCCMS and Non-MHSDS) - 1st	3	0.0	100%
SRE following MHCB Discharge (CCCMS and Non-MHSDS) - 2nd	2	0.0	100%
SRE prior to discharge IDTT (MHCB)	34	0.0	100%

There were 20 patients referred to the MHCB for DTS during the review period. On Demand Performance Report data indicated 50 percent (10/20) had the required SRE completed. Low compliance is attributed to after-hour referrals to the MHCB where the patients are placed in alternative housing by the on-call psychiatrist, however SREs are not completed at the time of the referral, however, are completed by a MHPC the next day. There were thirty-four clinical discharges from MHCB. SREs were completed in 100 percent of cases.

The business rules for the MHCB referral indicator have changed in recent months to accurately reflect current statewide policy. Concerns regarding meeting timelines for after-hours referrals were identified, which negatively impacted compliance during this audit timeframe. HQ is actively reviewing options to address this concern to better align with the intent of the indicator. Additionally, the Current Due Dates report was recently revised, to better assist with timely scheduling.

Emergency Response

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

Suicide Case Review Quality Improvement Plan (QIP) Follow Up
There were no suicides in 2025. There are no open QIPs.

Training and Mentoring Compliance

Review of the Coleman Court Mandated Trainings SharePoint for March 2026, indicated the following compliance rates:

- Understanding and Assessing the Presence, Severity and Risk of Suicidality: 96%
- Safety Planning Intervention: 100%
- SRE Mentoring: 100%
- Suicide Risk Management Program: 100%
- Annual IST Suicide Prevention 2025):
  - Custody: 100%
  - Mental Health: 99%

    - Nursing: 99%
- CPR Certification
    - Custody: 100%
    - Nursing: 100%

Receiving and Release (R&R) Screening

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

Crisis Intervention Team (CIT)

SOL does not have a CIT.

Assignment of Corrective Action Plans as a Result of this Review

As a result of this review, no additional CAPs have been generated. Two previously assigned CAPs will be closed out. Focus should remain on the two open CAPs (compliance with 7497 and adequate documentation in the safety plans) and the newly identified recommendation.

Problem	Corrective Action Plan	Current Status
1. Lindsay Hayes reported 9/71 patients in alternative housing were placed on 15 minute observations.	**The CMH (or designee)** shall review this concern and identify an intervention to correct this deficiency and a plan to ensure sustainability once corrected, which may include initiating a project and/or reviewing this concern monthly in the SPRFIT committee until sustainability is achieved.	During this audit, there were no instances of this occuring. The SPRFIT Coordinator reviews each patient in alternative housing to ensure compliance with observation levels. This information is reported each month in the SPRFIT meeting and minutes. **Due to ongoing compliance, this CAP can be closed.**
2. Lindsay Hayes reported in 4/71 cases, patients were held in TTMs over the four hour maximum time awaiting transfer to the MHCB.	**The AW of Healthcare (or designee)** shall review this concern and identify an intervention to correct this deficiency and a plan to ensure sustainability once corrected, which may include initiating a project and/or reviewing this concern monthly in the SPRFIT committee until sustainability is achieved.	During this audit, Region 1 MHCT Lts nor this reviewer found any instances of patients being placed over four hours. The SPRFIT Coordinator reveiws each patient to ensure no patient is held in a TTM over 4 hours. This information is reported each month in the SPRFIT meeting and minutes. **Due to the ongoing compliance, this CAP can be closed.**
3. Lindsay Hayes reported 73% with Page 1 and 82% compliance with Page 2 of the 7497 form.	As this issue is currently a CAP listed on SOL's Project Pipeline, **the CMH (or designee) and the AW of Healthcare (or designee)** shall review this concern and determine if the current plan to address this deficiency remains appropriate or if it should be brought back to the SPRFIT committee for review.	During the audit period, there were two custody follow ups completed on paper during and two using the electronic system. For the purposes of the CQI audit, only the paper version is included in the audit. October had one incarcerated person on a custody follow up resulting in 89% compliance with deficiencies in the 30 minute checks. November had one incarcerated person who did not have a 7497 initiated or completed. The CAP will remain open.
4. Lindsay Hayes noted concerns with the adequacy of safety plans. Specifically for rescinded patients he reported 5/9 (56%) had adequate safety plans completed and he reported 16/20 (80%) of patients discharged from the MHCB had adequate safety plans.	**The CMH (or designee)** shall review this concern and identify an intervention to correct this deficiency and a plan to ensure sustainability once corrected, which may include initiating a project and/or reviewing this concern monthly in the SPRFIT committee until sustainability is achieved.	Audit results revealed that 2/5 safety plans were found to be adequate. The majority of safety plans did not include clinical interventions to reduce suicide risk, were not patient specific, and included the same language across multiple safety plans and sections. It is recommended that a refresher training be provided to all MH staff. The CAP will remain open.

As a result of this review, the following action is recommended:

1. <u>Provide Refresher Safety Planning Training</u>: Provide refresher training on individualized safety planning to all clinical staff, with mandatory participation for clinicians routinely assigned to MHCB rescissions and MHCB 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 review of safety plans for rescinded MHCB referrals and patients discharged from mental health inpatient beds who require safety plans, with individual mentoring for plans that do not meet standards.

Appendix C: MAPIP

INSTITUTION 6 MONTH TREND

California State Prison, Solano

Population Health Management	6 Months	Trend	OCT	NOV	DEC	JAN	FEB	MAR
Diagnostic Monitoring (All)	**96%**		**96%**	**95%**	**94%**	**95%**	**98%**	**99%**
QT Prolongation EKG 12 Months	-		-	-	-	-	-	-
Antipsychotics (All)	97%		97%	100%	88%	97%	100%	100%
Lipid Monitoring	96%		100%	100%	50%	100%	100%	100%
Blood Sugar	93%		100%	100%	71%	90%	100%	100%
EKG	100%		-	-	100%	-	-	-
AIMS	100%		100%	100%	100%	100%	100%	100%
Med Consent	100%		100%	100%	100%	100%	100%	100%
CBC with Platelets	100%		100%	100%	100%	100%	100%	100%
CMP	100%		100%	100%	100%	100%	100%	100%
Thyroid Monitoring	89%		75%	100%	-	83%	100%	100%
Blood Pressure	100%		100%	100%	100%	100%	100%	100%
Height	96%		83%	100%	100%	100%	100%	100%
Weight	100%		100%	100%	100%	100%	100%	100%
Pregnancy	-		-	-	-	-	-	-
Clozapine (All)	-		-	-	-	-	-	-
Blood Sugar	-		-	-	-	-	-	-
Lipid Monitoring	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
EKG	-		-	-	-	-	-	-
AIMS	-		-	-	-	-	-	-
Thyroid Monitoring	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Blood Pressure	-		-	-	-	-	-	-
Height	-		-	-	-	-	-	-
Weight	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-

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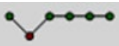
Mood Stabilizers (All)	91%		100%	67%	100%	100%	100%	100%
Carbamazepine (All)	-		-	-	-	-	-	-
Carbamazepine Level	-		-	-	-	-	-	-
CBC	-		-	-	-	-	-	-
CMP	-		-	-	-	-	-	-
Med Consent	-		-	-	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Valproic Acid (All)	77%		-	40%	100%	100%	100%	100%
Med Consent	100%		-	-	100%	-	-	-
Blood Pressure	100%		-	-	100%	-	100%	-
Height	100%		-	100%	-	100%	-	100%
Valproic Acid Level	0%		-	0%	-	-	-	-
CBC with Platelets	50%		-	0%	-	100%	-	-
CMP	50%		-	0%	-	100%	-	-
Weight	100%		-	100%	-	-	100%	-
Pregnancy	-		-	-	-	-	-	-
Lithium (All)	100%		100%	100%	100%	100%	-	100%
Lithium Level	100%		100%	-	-	-	-	-
Thyroid Monitoring	100%		-	-	100%	-	-	100%
CMP	100%		-	-	100%	-	-	100%
CBC	100%		-	-	-	-	-	100%
EKG	100%		100%	-	-	100%	-	-
Med Consent	100%		100%	100%	-	-	-	-
Height	100%		100%	100%	-	-	-	-
Weight	100%		100%	100%	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Oxcarbazepine (All)	100%		100%	100%	-	-	-	100%
CBC	100%		-	-	-	-	-	100%
CMP	100%		100%	-	-	-	-	100%
Med Consent	100%		100%	100%	-	-	-	-
Pregnancy	-		-	-	-	-	-	-
Lamotrigine - Med Consent	-		-	-	-	-	-	-
Antidepressants (All)	94%		91%	92%	97%	93%	95%	97%
EKG (Tricyclics)	-		-	-	-	-	-	-
Med Consent	99%		100%	100%	97%	100%	100%	100%
Thyroid Monitoring	80%		60%	63%	100%	79%	80%	88%
Pregnancy	-		-	-	-	-	-	-
Venla Blood Pressure	100%		100%	100%	100%	100%	100%	-

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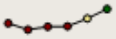
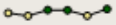
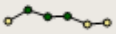
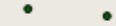
Medication Management	6 Months	Trend	OCT	NOV	DEC	JAN	FEB	MAR
Medications Received Timely (All)	**81%**		**81%**	**81%**	**80%**	**80%**	**81%**	**83%**
By Transfer Type								
New Arrival to CDCR (RC) – RC	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – RHU	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – MHCB	-		-	-	-	-	-	-
New Arrival to CDCR (RC) – CTC	-		-	-	-	-	-	-
Intra-System (Within Institutions) – GP	83%		86%	88%	50%	-	-	-
Intra-System (Within Institutions) – RHU	-		-	-	-	-	-	-
Intra-System (Within Institutions) – MH Inpatient	87%		93%	73%	100%	48%	79%	91%
Intra-System (Within Institutions) – Specialized Medical	99%		98%	-	100%	-	-	-
Inter-System (Between Institutions) – GP	66%		67%	57%	62%	63%	75%	90%
Inter-System (Between Institutions) – RHU	90%		89%	86%	92%	92%	86%	94%
Inter-System (Between Institutions) – MH Inpatient	89%		89%	89%	88%	88%	95%	87%
Inter-System (Between Institutions) – Specialized Medical	85%		84%	100%	90%	91%	79%	81%
Return to CDCR – GP	78%		85%	75%	87%	58%	25%	78%
Return to CDCR – RHU	95%		-	100%	-	-	-	91%
Return to CDCR – MH Inpatient	-		-	-	-	-	-	-
Return to CDCR – Specialized Medical	83%		70%	88%	-	90%	100%	-
Stable Housing	81%		82%	82%	80%	80%	81%	83%
Leaving CDCR	98%		91%	100%	98%	100%	95%	100%
By Provider Type								
Psychiatry	88%		87%	88%	88%	87%	88%	88%
By Provider Type								
Psychiatry - Refused	1%		1%	1%	2%	1%	1%	1%
Non-Formulary by Psychiatrists	**4.9%**		**5.5%**	**5.5%**	**4.8%**	**4.9%**	**3.7%**	**4.5%**

Appendix C: Excluded Indicators

- Documentation of Clinical Barriers to Patients LRH Placement are Documented in the MTP
- Documentation of Correctional Counselor Review of LRH during IDTT with an Appropriate Response
- Scheduled MH Appointments Completed or Refused
- Mental Health Primary Clinician Continuity of Care
- Mental Health Psychiatrist Continuity of Care
- Monthly Review of EOP Modified Treatment
- MHSDS Patients Released from CDCR with Pre-Release Planning Forms Signed
- RHU Incarcerated Persons Who Received an RHU Orientation Guide
- Quality of Safety Planning to Reduce Suicide Risk
- Quality of Selected SRE Documentation