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# ACHIEVING AND SUSTAINING A CONSTITUTIONALLY ADEQUATE MENTAL HEALTH CARE SYSTEM

# RECEIVER'S ACTION PLAN FOR THE MENTAL HEALTH SERVICE DELIVERY SYSTEM OF THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

**August 1, 2025**

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## 1. Executive Summary

The California Department of Corrections and Rehabilitation (CDCR)[1] faces a critical juncture in its effort to resolve long-standing constitutional deficiencies in the delivery of mental health care. Our vision is to strategically frame and drive forward a bold, solutions-oriented plan that targets the root causes impeding meaningful progress—most notably, fragmentation, misaligned reporting structures, and persistent staffing shortages that disproportionately impact the largest and most vulnerable segment of the population.

Resolution is achievable. While trust among institutional stakeholders remains limited, there is a demonstrated willingness to cooperate with our team. The framework we propose capitalizes on this cooperation while establishing systems of accountability and oversight that do not rely on interpersonal trust to function. This pragmatic approach allows for rapid identification of barriers, targeted problem-solving, and swift implementation of durable solutions.

Our aggressive plan is designed to comply with the legal remedies by building a sustainable system of care that improves outcomes at every level—from crisis stabilization to enhanced outpatient care. It prioritizes those currently receiving the least support due to structural and staffing constraints.

Our Action Plan will provide:

- Streamlined oversight and leadership clarity to empower decision-making at institutional and system levels.
- Targeted resource allocation that addresses workforce shortages where patient need is greatest.
- Implementation readiness with a strong focus on actionable, time-bound solutions rather than prolonged analysis or delays.
- Data-informed accountability mechanisms to monitor progress and course-correct in real time.

While there are real costs associated with this transformation, the costs of inaction—both human and fiscal—are far greater. This plan is both necessary and feasible, and it provides a credible pathway to achieving durable compliance and lasting reform in CDCR's mental health system.

[1] Throughout this document, we refer to CDCR generally rather than differentiating between CDCR and CCHCS.

**2. Overview of *Coleman***

*Coleman v. Newsom* is a 35-year-old civil suit involving Eighth Amendment violations with respect to delivery of mental health care to individuals incarcerated by CDCR.[2] Ralph Coleman, a person incarcerated at a CDCR institution, filed this *pro se* lawsuit in 1990. In November 1991, the *Coleman* court certified a plaintiff class of "all inmates with serious mental disorders who are now or who will in the future be confined within [CDCR]." 912 F.Supp. 1282, 1293 (E.D.Cal. 1995). In September 1995, the court adopted a series of findings and recommendations issued by Chief Magistrate Judge Moulds. *See* ECF 547. The court upheld Judge Moulds' finding that "the delivery of necessary care to the mentally ill inmates who comprise the plaintiff class was so deficient that it constituted a substantial violation of the federal Constitution." 912 F.Supp. at 1299. The court further adopted 12 recommendations aimed at correcting Eighth Amendment violations and approved the appointment of a Special Master. *See id.*

The constitutional deficiencies identified in the 1995 order were:

1. Lack of a systematic program for screening and evaluating inmates for mental illness.
2. Significant and chronic understaffing in mental health care services.
3. No quality assurance program to ensure competence of staff.
4. Significant delays in access to mental health care throughout the system.
5. Inadequate supervision of the use of medication.
6. Several deficiencies in the availability and utilization of involuntary medication.
7. Absence of any adequate systemwide procedures for use of mechanical restraints on seriously mentally disordered inmates.
8. An "extremely deficient" medical records system.
9. Inadequate implementation of defendants' suicide prevention program.
10. Inadequate training of custodial staff "in the identification of signs and symptoms of mental illness."
11. Placement of seriously mentally ill inmates in administrative segregation and segregated housing units "without any evaluation of their mental status" and without access to necessary mental health care while housed in such units.

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[2] In 2015, *Hecker v. California Department of Corrections and Rehabilitation* was consolidated with *Coleman*. *Hecker* was brought by incarcerated individuals with psychiatric disabilities who alleged that they were excluded from programs, jobs, services, and activities on the basis of their disability and in violation of the Americans with Disabilities Act and the Rehabilitation Act. ECF 5284 at 2.

12. Use of tasers and 37mm guns against class members without considering whether the behavior leading to use of the weapon was caused by mental illness, or the impact of such weapon's use on that illness.

*Id.* at 1305-1323.

In December 1995, the court appointed a Special Master "to provide expert advice to defendants … and to advise the court regarding assessment of defendants' compliance with their constitutional obligations." ECF 640 at 2. The court later directed the Special Master to conduct monitoring rounds and report to the court on compliance with the remedy. *See id.* The Special Master has now completed 31 monitoring rounds.

Since the inception of the case, the court has approved a series of remedies to address the constitutional deficiencies identified in the 1995 order. The principal documents memorializing the court-approved remedies are:

- Mental Health Services Delivery System (MHSDS) Program Guide (Program Guide)
- Compendium of Custody-Related Remedial Measures
- Semi-annual mental health population projection plans
- Short-, intermediate-, and long-term bed plans
- 2009 and Psychiatric In-Patient (PIP) Staffing Plans
- Department of State Hospitals (DSH) Inpatient Staffing Plan

In 2011, as part of his 22nd Monitoring Round Report, the Special Master identified seven priorities that defendants needed to complete to support full implementation of the *Coleman* remedies. *See* ECF 3990.

- Reevaluate and update suicide prevention policies and practices.
- Make sure that seriously mentally ill inmates are properly identified, referred, and transferred to higher levels of mental health care that [were] only available from DSH.
- Review and comply with all elements of Administrative Segregation Unit Enhanced Outpatient Program Treatment Improvement Plan.
- Complete construction of mental health treatment space and beds.
- Fully implement the 2009 mental health staffing plan.
- Train staff for greater collaboration between custody and mental health.
- Refine and implement MHTS.net to its fullest extent and benefit.

*See id.* at 461-462. The court ordered defendants to complete the projects. *See* ECF 6486.

*Coleman* has a complex and contentious history. In 2009, a three judge court ordered California to reduce the size of its prison population to 137.5% of design capacity. *See Coleman v.*

*Schwarzenegger*, 922 F.Supp.2nd 882 (2009). The Supreme Court affirmed the ruling of the three judge court. *See Brown v. Plata,* 563 US 493 (2011).

In 2013, defendants moved to terminate *Coleman* on the grounds that they had remediated the core constitutional deficiencies identified in 1995. *See* ECF 4275. The court denied the motion based on evidence of ongoing constitutional violations. *See* ECF 4539. Later in 2013, the court expanded the scope of the remedy to include access to inpatient mental health care, segregated housing, and disciplinary procedures. *See* ECF 5131 at 72-74. Before and after the motion to terminate, CDCR and the Special Master worked to develop the Continuous Quality Improvement Tool (CQIT), piloting it at several institutions in 2016 and 2018. In late 2018, a whistleblower alleged misconduct by CDCR with regard to data reporting from CQIT. In 2019, following an investigation and hearing into the whistleblower's allegations, the court determined that defendants had "knowingly presented misleading information to the court." ECF 6427 at 40-41. The court ordered the Special Master to oversee a data remediation process. *See* ECF 8697.

By 2023, defendants had not achieved the staffing levels required by the 2009 Staffing Plan. In late 2023, following an evidentiary hearing, the court found defendants in contempt for failing to maintain at least a 90% fill rate in all mental health classifications. *See* ECF 8291 at 38. Consequently, the court imposed an initial sanction of $111,939,244, which included a doubling of fines for civil coercive purposes. *See* ECF 8291 at 70. The Ninth Circuit upheld the district court's decision to hold the State in civil contempt. *See* ECF 8602 at 5-6. However, it vacated the fines to the extent that they exceeded the State's monthly salary savings and remanded to the district court. *See id.* at 5-6.

In July 2024, the court issued an order to show cause why it should not initiate formal proceedings to appoint a temporary receiver to complete implementation of the *Coleman* remedies. *See* ECF 8330 at 15. The court explained that "defendants have not succeeded in remedying unconstitutionally low mental health staffing levels in most programs in their MHSDS." *Id.* at 3. It further explained that contempt proceedings could begin soon on PIP staffing levels and suicide prevention. *See* ECF 8330 at 2. The court "tentatively conclude[d] that compared to the current pace of remediation a receiver would provide a more prompt and efficient complete remedy." *Id.* at 14.

In explaining its decisions regarding contempt and the proposed appointment of a receiver, the court highlighted several issues that we summarize here because they are important to understanding our proposed Action Plan.

- The *Coleman* class is "approximately 34,079 California state prisoners with serious mental disorders [and] . . . has more than doubled since the start of this action." ECF 8291 at 4.

- The *Coleman* class members "[have] been waiting for nearly three decades for the state to meet its constitutional obligations when it comes to the delivery of mental health care." *Id.* at 4.
- The "vacancy rate in authorized mental health care positions was twenty-five percent" when *Coleman* was filed, and it is now higher. *Id.* at 7. (As discussed below, CDCR has made progress on staffing since the court issued this order.)
- Implementation of the *Coleman* remedies requires a *"sense of urgency." Id.* at 65.
- The court "expects the appointment to be *temporary* in that it expects the receiver will oversee full implementation of the remedy in this action *as promptly as possible, sooner rather than later*." ECF 8574 at FN 1 (emphasis added).
- "Professional, neutral leadership, external to the named defendants and their institutions, will be necessary" to implement the *Coleman* remedy. ECF 8330 at 14.

In April 2025, the court appointed a Receiver-nominee for a four-month period to develop a comprehensive Action Plan to effectuate full and durable compliance with the court-approved and court-ordered remedies in this action. *See* ECF 8589 at 2.

### 3. Development of the Action Plan

The court specified that the Action Plan must: 1) be developed in consultation with the parties and in coordination with the Special Master; 2) be designed to effectuate full compliance with the court-approved remedy in this case; and 3) include a timeline for implementation and metrics to assess progress.

The court provided the Receiver-nominee with four months to develop an Action Plan to resolve multiple outstanding issues in a 35-year-old case. On its own, this would have been challenging. However, the specific context of *Coleman* made it particularly daunting. *Coleman* has a docket of nearly 9,000 entries and more than two dozen appeals. It intersects with two other Federal class actions - *Plata v. Newsome* and *Armstrong v. Newsom*. And, it involves the provision of mental health care to more than 35,000 individuals.

We worked closely with the Special Master, the parties, and other stakeholders to create a focused, realistic plan that will achieve full implementation of the *Coleman* remedies and bring CDCR into compliance with the Eighth Amendment. The Action Plan is based on observations we made during our four-month review, the current status of the *Coleman* remedies, and several considerations that reflect the unusual complexity of this case.

Given the contentious nature of *Coleman,* we prioritized learning about issues from all sides and avoided relying on any single viewpoint to support the Action Plan. We synthesized information, ideas, and suggestions into recommendations that reflect our own ideas informed by our professional expertise and experience. *See* Appendix A.

Moreover, recognizing the fraught history of this case as well as the urgency required to address the needs of the *Coleman* class, we designed the Action Plan on a timeline that is aggressive, flexible, and realistic. The Action Plan assumes a very optimistic five- to seven-year period to complete implementation and demonstrate durability for most, if not all, remedies. As discussed below, our ability to meet this timeline is dependent on certain conditions, one of the most significant of which is the parties' willingness to turn toward constructive, forward-looking implementation and away from litigation.

The Action Plan also includes milestones and target timeframes designed to track progress and provide regular, transparent reports to the court. The milestones and target timeframes are based on available information and will be refined as necessary to account for new information.

Between April 2 and July 31, 2025, we participated in regular calls and meetings with the Special Master and his experts, plaintiff's counsel, the Office of the Governor, CDCR leadership, the *Plata* Receiver and his team, and the *Armstrong* Court Expert. We also communicated with subject matter experts, unions representing CDCR employees, academics, and criminal justice reform advocates. To encourage honest feedback in all discussions, we told interviewees that we would not attribute ideas to specific individuals or groups in the Action Plan. This proved effective in encouraging open dialogue.

We also visited North Kern State Prison (NKSP), California Institution for Men (CIM), California Health Care Facility (CHCF), Salinas Valley State Prison (SVSP), California State Prison – Sacramento (SAC), Department of State Hospitals, Atascadero (ASH), and California Institution for Women (CIW). Some of these visits were in conjunction with CDCR leadership, the Special Master's team, DSH leadership, plaintiffs' counsel, and/or local institution leadership. During visits, we met employees, observed programs and clinical encounters, toured facilities, learned about concerns, challenges, and accomplishments, and spoke with *Coleman* class members, including at least one class representative.

Finally, we reviewed thousands of pages of written materials, including court orders, briefs, and transcript, and information from the Special Master, parties, the *Plata* Receiver, the *Armstrong* Court Expert, individual CDCR employees, unions, and public sources.

### a. Research Observations

The Action Plan incorporates several observations developed from the interviews, visits, and document review described above.[3]

**MHSDS Structure, Communication, and Information Sharing.** The Action Plan will create an effective organizational structure for MHSDS, and promote communication and information sharing.

[3] Factual information from court filings and other documents is cited below. For reasons explained above, we do not identify the source of information conveyed during interviews or discussions.

MHSDS operates under a complex organizational structure that makes it difficult to understand who is ultimately responsible for delivery of constitutionally adequate mental health services. Mental, medical, and dental health services are all part of the California Correctional Healthcare System (CCHCS), which is led by an undersecretary and is one of three statutorily created components of CDCR. *See* CA Gov't Sec. 12838. A court-appointed receiver in *Plata* oversees the CCHCS medical care program. The CCHCS organizational chart show both the Undersecretary and the *Plata* Receiver with responsibility for the entire organization, including mental health. *See* Appendix B. Moreover, there is no single mental health clinician who exercises supervisory control over MHSDS. The Deputy Director, Statewide Mental Health Program sets mental health policy and supervises clinicians who work at headquarters. Mental health clinicians in institutions report to a chief executive officer (CEO) who reports to the Deputy Director, Institution Operations at headquarters. Both positions report to the Director, Health Care Services who is responsible for the medical, mental, and dental health programs.

The MHSDS structure is also complex because there are multiple intersections between *Coleman, Plata,* and *Armstrong*. Specifically, a series of court-approved coordination agreements make the *Plata* Receiver responsible for providing certain shared services (e.g., IT and facilities) for all three cases. These agreements, which were entered more than a decade ago, were important for deconfliction between the cases and to promote efficiency in CCHCS operations. We have discussed the coordination agreements with the *Plata* Receiver and the *Armstrong* Court Expert. They agree that circumstances have changed since those agreements were entered and the agreements should be revisited if the court approves a *Coleman* Receiver.

Further, poor communication and lack of information appear to be slowing implementation of *Coleman* remedies. Clinicians are frustrated at a lack of clear, easy-to-understand, and regular communication about issues that impact their daily work. Moreover, it can be difficult for employees to find and use policies comprising the *Coleman* remedies because they are not memorialized in the Department Operations Manual (DOM). In contrast, custody, medical and dental policies are in the DOM. Finally, there is no uniform MHSDS mechanism for sharing best practices and lessons learned across institutions. Increased information sharing would provide opportunities for clinicians to learn from CDCR peers as well as experts with experience in other corrections and healthcare systems.

**Staffing Shortages.** Staffing shortages impact every level of care in MHSDS, making it very difficult for CDCR to comply with *Coleman* remedies, particularly timely delivery of care. Therefore, the Action Plan places significant emphasis on building and retaining a mental health workforce because it is a foundational element to providing constitutionally adequate mental health care.

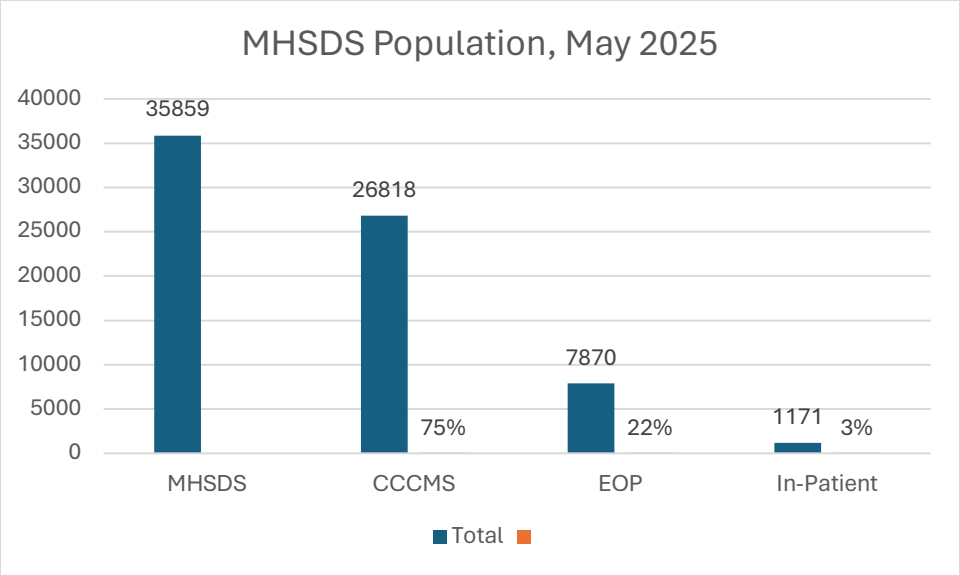
CDCR has struggled to achieve and maintain adequate mental health staffing levels since *Coleman* was filed. There are several reasons for this. First, the 2009 Staffing Plan, which covers most clinical positions, links staffing levels to patients. As explained below, the *Coleman* population has grown significantly. Therefore, the number of required clinicians rises in proportion to the population.[4] In addition, CDCR struggles to hire in remote locations and to compete with employers that offer better pay, flexible schedules, and traditional work environments (e.g., offices and clinics). Moreover, morale among mental health clinicians is low. Clinicians cite poor compensation, inadequate work and treatment space, extensive caseloads, and excessive documentation requirements. This results in clinicians feeling that they cannot provide the care that patients need, making full implementation of the *Coleman* remedies beyond reach.

In order to increase clinician compensation and address concerns about working conditions, the court approved CDCR to use civil contempt fines to pay bonuses, buy supplies, and upgrade work and treatment space. *See* ECF 8381. However, the use of fines to pay bonuses and improve environments is a source of stress for clinicians who worry that fines are temporary.

Over the last 18 months, CDCR has made progress filling mental health vacancies. For example, the fill rates for psychiatrists is at or near 90% at most institutions. In addition, CDCR has taken several steps to increase staffing levels, including realigning human resources staff to streamline processes, reducing the time to hire, increasing use of telepsychiatry, and expanding the types of clinicians who can provide primary care. It is also expanding its use of technology and data analytics to address mental health staffing needs. It recently launched a new system to improve tracking and interaction with applicants during the hiring process. Moreover, it is working to improve how it manages and uses data. Finally, it is expanding its recruitment efforts to include use of a sophisticated talent acquisition system. This is promising progress. The Action Plan will leverage these changes to ensure that CDCR can sustain the mental health staff levels necessary to provide constitutionally adequate care.

**Provision of Care.** The *Coleman* population is about 40% of the overall CDCR population. *See* MIS Report, 5/27/2025. Most patients are treated in the Correctional Clinical Case Management System (CCCMS), the lowest level of care offered in MHSDS. The second largest group is treated in Enhanced Out-Patient (EOP) units. Patients with more significant needs are treated in Mental Health Crisis Bed (MHCB) units or PIP units. A small number of patients are transferred to the DSH for treatment every year.

[4] In contrast, PIP staffing levels are based on the number of beds.




In order to achieve and sustain a constitutionally adequate mental health care program, CDCR must be able to provide patients with the right level of care in an appropriate environment based on the patient's individual need. The large size of the *Coleman* population already makes this challenging. In addition, other dynamics contribute to the challenge and help explain the deficiencies identified in the Special Master's recent monitoring reports.

First, there are differences between CDCR's medical and mental health care programs that contribute to poor clinician morale and reduced patient care in MHSDS. With regard to clinicians, the most concerning difference is fear. Some mental health clinicians fear their patients, while medical clinicians who treat the same patients do not share those fears. According to CDCR data, mental health clinicians experience fewer incidents of assault, battery, and other violence when compared to medical colleagues. However, mental health clinicians perceive that they are at greater risk in the workplace. Mental health clinicians also describe fear of providing inadequate care to patients due to staffing shortages and lack of resources, while others fear that inadequate supervision will put their licenses at risk.

In terms of patient care, there are also differences between the medical and mental health programs that impact the provision of care. Perhaps most important is that institutions use "triage plans" to limit mental health care, but not medical care, in response to staffing shortages. The "triage plans" prioritize care for patients at higher-levels at the expense of patients at lower levels of care. For example, CCCMS patients, for whom mandated care hours are already lowest, receive even less care under "triage plans." CDCR has started making changes to align the mental health and medical programs. However, more needs to be done. The Action Plan includes steps to align these programs with the goal of accelerating implementation of *Coleman* remedies.

Second, both patients and clinicians may be reluctant for patients to move between levels of care. Over the last four months, we heard numerous concerns related to patients experiencing trauma as a result of transfers. We also learned of concerns about patients moving from EOP to CCCMS beds. Specifically, both patients and clinicians express concerns that patients' mental health will deteriorate due to lack of programming in CCCMS beds. The Action Plan is designed to increase staffing at all care levels and provide additional resources to support patients moving between care levels in a manner that is consistent with their clinical needs. We believe that these are essential steps to providing constitutionally adequate care in an already overburdened system.

Third, some policies and practices such as use of segregation or force may be justified and also contribute to psychological deterioration in individuals with serious mental health conditions. The *Coleman* remedies already include policies that are designed to balance security concerns and delivery of quality health care. The Action Plan emphasizes increasing compliance with those policies to promote normalization and improve outcomes for patients and employees. For example, increased use of de-escalation techniques can decrease the number of patients who go to administrative segregation and lower the associated risk of their mental health deteriorating. It can also lower uses of force and improve the work environment for clinicians.

Finally, as part of providing timely and constitutionally adequate mental health care, CDCR is required to provide mental health programming to patients. While CDCR does provide some programming, it lacks a centralized approach to developing and using evidence-based programming across institutions. This would promote consistency in programming, centralize development of curricula and materials, and strengthen delivery of constitutionally adequate mental health care.

**Suicide Prevention.** The lack of an effective suicide prevention program was one of the original *Coleman* findings. CDCR remains out of compliance with this recommendation and suicides are higher per 100,000 adults in custody than they were when the case was filed in 1995. See 2023 Annual Suicide Report, Figure 2.

In 2011, the court approved several suicide prevention recommendations made by the Special Master. CDCR has not completed implementation of 13 of those recommendations. Presently, it lacks a comprehensive plan designed to complete implementation of all recommendations as quickly as possible.

As part of achieving sustainable change to its suicide prevention program, CDCR needs to be able to take a headquarters-driven approach to improving how it responds to patient suicides. This involves two issues. First, CDCR has developed a Quality Improvement Process (QIP) to identify patterns and trends in patient suicides and implement effective responses. Presently, the parties disagree about the effectiveness of QIPs, including whether they are sufficiently robust to support continual improvement. Second, the court has provisionally approved CDCR to take over the annual suicide report that has been handled by the Special Master. If appointed, a *Coleman* Receiver will be responsible for assessing CDCR's 2024 suicide report and

recommending whether the court should grant full approval for CDCR to assume responsibility for the annual suicide report.

The Action Plan is designed to fully implement an effective suicide prevention program as soon as possible.

**Quality Assurance/Quality Improvement.** The court has stressed in multiple orders that adoption of a quality assurance/improvement program, including full implementation of CQIT, is essential to allowing CDCR to self-monitor. *See e.g.,* ECF No. 6996 at 7-8 (CQIT's function in facilitating "defendants' assumption of responsibility for self-monitoring the adequacy of mental health care" is "as essential to the constitutional remedy as are individual components measured by CQIT.") CQIT is intended to enable CDCR to move from a focus on institution performance to a headquarters-driven quality improvement process that detects and addresses systemic issues related to quality of care. *See* ECF No. 4232 at 5; ECF 4205 at 63, 66-67.

On July 11, 2025, the Special Master reported that data remediation of all provisionally approved key indicators is complete. *See* ECF 8697 at 6. That paves the way for finalization of CQIT.

If appointed, there are several critical steps that the Receiver will take to implement CQIT, including testing the system, verifying the accuracy of data, developing a data governance structure, and recommending final indicators and compliance levels to the court.

With regard to recommending final indicators and identifying compliance thresholds, the Receiver will focus on the following:

- Does each metric provide valuable information about the provision and quality of mental health care being provided to patients?
- Does each metric provide clinicians with valuable information that helps identify trends and system-wide areas of concern?
- Does each compliance threshold reflect the importance of the issue being measured?
- Should any indicators be measure using compliance ranges rather than fixed percentages or numbers?

In addition, the Receiver will develop a revised monitoring process that utilizes both CQIT and field visits to assess compliance with remedies. The revised field monitoring process will establish new requirements for how institutions prepare for, participate in, and respond to monitoring visits. The revised process will provide timely, concise feedback and clear expectations for resolution of findings.

**Availability and Use of Data.** The Action Plan incorporates strategies for using technology and data analysis to achieve full and durable implementation of remedies. Both CQIT and CDCR's new human resources systems (discussed above) will be valuable tools for monitoring compliance with *Coleman* remedies. Moreover, completion of these systems will provide opportunities to use sophisticated data analysis to identify trends, anticipate challenges and

needs, and measure the impact of change. For example, once detailed data related to staffing and the provision of care are available, those data can be used to assess how, and to what extent, staffing levels relate to the quality of mental health care being provided to the *Coleman* class. That analysis could support institution-specific staffing adjustments taking into account information such as mission, security level, location, and competing local employers. Strengthening CDCR's ability to use data to inform staffing levels and the provision of care will be a critical step in demonstrating sustainability.

**b. Status and Prioritization of Remedies**

The Action Plan recognizes that CDCR has made progress in *Coleman* and prioritizes those remedies that need the most significant support to achieve full implementation. By prioritizing our approach, we intend to make as much progress as possible in the least amount of time. The Action Plan does not propose specific actions to address every remedy. Regardless, the Action Plan is designed to achieve full and durable implementation of all remedies. If appointed, we will adjust our approach as needed to address all remedies.

For the reasons explained above, the Action Plan explicitly prioritizes staffing, suicide prevention, and quality assurance. It also prioritizes increased compliance with existing remedies including policies related to use of administrative segregation, Custody and Mental Health Partnership Plans (CMHPP), and use of force. In many cases, the actions described in the Action Plan are designed to address more than one remedy. Therefore, the Action Plan is designed around themes rather than individual remedies. *See* Appendix C.

The Action Plan also reflects our view that CDCR is nearing full implementation of two remedies. First, it has adopted an electronic health records system (EHRS) that is used by the mental, medical, and dental health programs. The EHRS is the primary source of data for CQIT. Therefore, EHRS will need to be able to provide the specific data fields required for the final, court-approved CQIT indicators. If appointed, the Receiver will move forward with completion of CQIT and recommendation of final indicators. Once those steps are complete, we anticipate recommending that the court find that CDCR has fully remediated its medical records system. Second, CDCR has nearly finished the construction projects recommended in the Special Master's 22nd Round Monitoring Report. The last project at CIM is scheduled for completion in spring 2026. Once CDCR activates that facility, we anticipate recommending that the court find that CDCR has fully complied with the construction initiative identified by the Special Master.

c. **Unique Considerations for *Coleman***

When developing the Action Plan, we considered many complex dynamics that are unique to *Coleman*, including the need to:

- **Plan for a seamless transition back to CDCR at the end of the Receivership.** The court has been clear that a Receivership is intended to be temporary. The Receiver will control

MHSDS for the duration of the Receivership. To prepare to resume control when the Receivership ends, it is essential that CDCR leadership play an active role in implementing the Action Plan.

- **Balance urgency and intentionality**. The long-standing denial of relief to the *Coleman* class highlights the need for near-term, meaningful change that delivers constitutionally adequate and sustainable mental health care. The Action Plan balances the potential effectiveness of certain courses of action with the time and resources needed to implement them. Consequently, the Action Plan prioritizes the use of existing systems, authorities, and procedures provided that we have sufficient information to conclude that they can be effective.
- **Employ the powers of the Receivership to make more profound changes at CDCR if the existing tools do not work.** A Receivership is a powerful remedy. We believe that we can make significant progress in *Coleman* using existing tools. However, if we are unable to fully implement the court-ordered remedies in a timely manner, we will seek the court's assistance to waive provisions of State law or take other necessary steps.
- **Create an independent vision for *Coleman* while recognizing how it intersects with *Plata* and *Armstrong*.** The Action Plan balances close collaboration with *Plata* and *Armstrong* with prioritizing implementation of the *Coleman* remedies.
- **Achieve constitutionally adequate mental health care by increasing focus on existing remedial requirements to normalize environments.** The Action Plan seeks to normalize environments which will promote the provision of quality mental health care and accelerate adherence to the Eighth Amendment. In this sense, the Action Plan is philosophically consistent with The California Model, which the State is already pursuing of its own accord.[5] CDCR is implementing the California Model which draws on international best practices to change culture with the goal of improving working and living conditions for people in custody, employees, and visitors. *See* https://www.cdcr.ca.gov/the-california-model/.
- **Create an Office of the Receiver that can start work immediately while successfully integrating the Office of the Special Master.** The Special Master has significant expertise and institutional knowledge that a new Receiver must leverage to begin work quickly. Our Action Plan is designed to create near-term role clarity as to the Receiver and Special Master, while timely integrating key personnel/experts and functions of the Office of Special Master into a single, consolidated office supervised by the Receiver.

As discussed above, the Action Plan is intended to be aggressive, flexible, and realistic with a very optimistic five- to seven-year timeline. The following conditions are necessary to meet this aggressive timeline, and the absence of these conditions will delay final resolution of this case. If the necessary conditions are present, we are optimistic about making significant progress toward resolution within the five- to seven-year timeframe.

[5] The California Model is a custody-focused initiative and is not in dispute in *Coleman.*

First, the parties must be willing to continue to engage in constructive dialogue and collaboration with a goal of achieving forward-looking change. For decades, *Coleman* has been marked by litigation and mistrust. In the past four months alone there have been multiple motions and one appeal. In contrast, the *Plata* and *Armstrong* cases, which are closely related to *Coleman,* operate in a much more constructive way. During development of the Action Plan, the party representatives with whom we met were collaborative and cooperative. Moreover, the Special Master and his experts, acting in their capacity as an arm of the court, provided timely and detailed feedback about *Coleman.*

Based on our experience over the last four months, we are optimistic that the dynamics in *Coleman* can change to a forward-looking focus on fully implementing the remedy. The Action Plan explains how the Receiver will work to resolve disagreements and foster collaboration and trust between the parties. However, the parties must be willing to engage in those processes. If every action of the Receiver is litigated, there is little promise that the Action Plan or the Receivership will be effective in the least time possible.

Second, the parties must be willing to focus on implementing existing remedies and ensuring they are durable. Full implementation of the *Coleman* remedies is long overdue. Therefore, the Action Plan identifies and prioritizes implementation of the existing court-ordered and approved remedies. At this point in the case, we believe that efforts to narrow or expand the remedies will draw attention and resources away the urgent task of achieving full implementation of the existing remedies.

Finally, the Receiver has the resources necessary to implement the *Coleman* remedies. We recognize that the State's current budget situation is difficult. However, constitutional compliance is required regardless of finances. ECF 8291 at 56. Moreover, the human and financial costs of not implementing the *Coleman* remedies are significant. While we will seek efficiencies and maximization of resources, the Action Plan will require additional resources to implement. *See* Appendix D.

## Vision, Mission, and Strategic Goals

**Vision Statement**. The Office of the Receiver will enhance the delivery of mental health care by building a durable, constitutionally adequate, patient-centered correctional mental health care system that promotes dignity, accountability, and health equity, laying the foundation for the successful return of control to the State of California.

**Mission Statement.** In coordination with CDCR leadership, we will deliver a correctional mental health care system where every person with a serious mental health diagnosis receives timely, humane, and evidence-based care, supported by professional integrity, operational transparency, and continuous improvement. While embracing CDCR's principles of normalcy and humanity, we will enhance existing working and living environments to provide a constitutionally adequate level of mental health care along with work environments that provide meaningful and rewarding careers for clinicians.

We have identified six strategic goals in the Action Plan, each of which is designed to achieve constitutionally adequate and durable mental health care delivery by MHSDS.

**Goal 1**: Improve Mental Health Care Delivery Through Culture Change and Effective Management

**Goal 2**: Achieve and Retain a Qualified Mental Health Workforce

**Goal 3**: Provide Adequate Care at Every MHSDS Level and Treat Each Patient at the Appropriate Level of Care

**Goal 4**: Fully Implement a Suicide Prevention Program

**Goal 5**: Complete Development and Implementation of a Quality Assurance Program

**Goal 6**: Create Mechanisms to Demonstrate of Remedies

Below, we discuss each goal along with its associated objectives and the actions that the Receiver will take to achieve the goals and objectives. We also identify target timeframes for completion of each action. Appendix F summarizes the goals, objectives, actions, and target timeframes.

## Overview of the Office of the Receiver

If appointed, the Receiver will lead implementation of the Action Plan. In order to make demonstrable progress in the anticipated timeframe, the Receiver will need a small staff and the ability to retain subject matter experts in mental health, human resources, custody, data analytics, and other areas. A draft organizational chart is attached. *See* Appendix E.

The Receiver will prioritize building trust and collaborative working relationships with and between the parties. This is essential to accelerating implementation of remedies and resolving *Coleman.* The Receiver will play a critical role in informally resolving disputes between the parties. The Receiver's approach will be based on clear, consistent, and frequent communication, openness to ideas, pragmatism, and timely decision making. When addressing disagreements between the parties, the Receiver will consider:

- What is needed to provide adequate mental health care?
- Does the resolution make good use of available resources?
- What is the best solution that provides quality care and timely resolution?

The Receiver will recommend use of an informal dispute resolution process before either party raises an issue with the court**.** The Receiver will hold a standing monthly meeting with both parties. Before the meeting, the parties will identify areas of concern or disagreement and come prepared to discuss resolution. If possible, the Receiver will resolve issues during the meeting. If necessary, the Receiver will convene one or more follow up meetings to try to resolve the issue. If informal resolution cannot be reached between monthly meetings, the Receiver will place the issue on the agenda for the next meeting. After discussing the issue with the parties, the Receiver will decide whether further discussion is likely to be productive. If so, the Receiver will continue to meet with the parties. If not, the Receiver will inform the parties that the informal resolution process has ended. The Receiver will decide the issue and notify the parties provided the decision is within the scope of authority delegated by the court. If the Receiver concludes that the issue requires court involvement, the Receiver will notify the court as quickly as possible and propose a resolution.

If appointed, the Receiver will work with the Special Master to facilitate a seamless integration of his office with the new Office of the Receiver. The offices will merge and the Special Master will report to the Receiver for all purposes. To achieve this transition, the Receiver will work with the Special Master to:

- Review current duties/projects of the Special Master and determine which should continue. Within 90 days of appointment, transition most Office of Special Master activities to the Office of the Receiver.
- Pause regularly scheduled field audits while visiting all institutions and assessing the best way for the Receiver to use field monitoring to achieve full compliance with all remedies.

- Assume responsibility for finalizing CQIT. This will be done in close collaboration with the *Plata* Receiver.
- Achieve full integration of the offices within 12 months.

Finally, the Receiver will continue to work closely with the *Plata* Receiver and *Armstrong* Court Expert to promote efficient coordination on issues of mutual interest and concern. The Receiver-nominee engaged regularly with the *Plata* Receiver and *Armstrong* Court Expert while developing this Action Plan, including attending the *Plata* Receiver's weekly executive team meeting and the monthly Court Coordination meetings. Therefore, the Receiver-nominee is well-positioned to work closely with them to ensure effective coordination.

## Goals, Objectives & Actions

**Goal 1: Improve Mental Health Care Delivery Through Culture Change and Effective Management.** CDCR has many dedicated employees who strive to provide constitutionally adequate mental health care. However, the culture and management structures of the MHSDS do not provide sufficient support for employees or implementation of the *Coleman* remedies. The Receiver will need to change the culture and mindset at CDCR with regard to *Coleman* and address the MHSDS management structure to provide clear lines of authority, accountability, and role clarity, all of which are necessary to create durable change.

**Objective 1.1 Use communication, transparency, and accountability to drive change.** It is essential that employees believe that implementation of the *Coleman* remedies is achievable and that the Receiver, and CDCR and CCHCS leadership consistently communicate that message. The Receiver will prioritize communication, transparency, and accountability to create a shared vision around the implementation of the *Coleman* remedies. This will include seeking opportunities to increase accessibility of information and encourage information sharing.

**Action 1.1.1 Implement a comprehensive communications strategy.** The Receiver will develop and implement a communications strategy to educate employees and stakeholders about the Receiver's vision, role, goals, objectives, and expectations. Once the initial strategy is in place, the Receiver will create opportunities for employees to provide feedback and track Action Plan progress. Initial strategy developed and implemented in 90 days.[6]

**Action 1.1.2 Assess options for aligning the MHSDS policy process with that used by the medical and dental health programs.** Move Program Guide requirements into the DOM to ensure that it is easily available to employees. Assess the mental health policy development and publication process and decide whether to adopt some or all of the processes used by medical and dental. Finally, assess whether certain mental health information should be promulgated in regulations. Complete movement of Program Guide to DOM within 12 months. Complete assessments of policy process and regulations within 18 months.

**Action 1.1.3 Share best practices across CDCR institutions**. Develop a strategy to identify and share best practices that support implementation of remedies and increased adherence to the Program Guide. Complete strategy development within nine months.

[6] If appointed, the Receiver will create an interim communications plan to cover the first 90 days. That will include meetings and calls with CDCR and CCHCS leadership, visits to institutions, and communications to employees.

**Objective 1.2 Streamline and clarify the MHSDS management structure.** The current MHSDS structure is not providing the level of mental health coordination and oversight needed to complete implementation of the *Coleman* remedies.

**Action 1.2.1 Centralize and streamline mental health reporting structure under a *Coleman* receiver.** Determine the most effective organizational structure to supervise MHSDS. Implement the new structure. Update all organizational charts and documents to ensure that supervisory structure is clear. Communicate changes to employees. Complete changes within 180 days.

**Goal 2: Achieve and Retain a Well-Qualified Mental Health Workforce.** Achieving and maintaining a well-qualified mental health workforce is critical to resolving *Coleman.* In order to accomplish this, leadership at all levels must prioritize hiring, onboarding, and retention of mental health employees. Moreover, CDCR must use sophisticated recruitment practices, research and data analytics to assess staffing challenges, identify trends, project needs, and set goals. It also needs user-friendly tools (e.g., dashboards and reports) that leaders at all levels of the organization can use to monitor recruitment, hiring, and retention.

The Receiver will hire a senior advisor to provide dedicated, daily attention to staffing issues. The senior advisor will work closely with human resources and program offices on recruitment, hiring, and retention.

**Objective 2.1 Adopt a focused, leadership-driven approach to hiring, onboarding, and retention.** Addressing CDCR's mental health staffing shortage will require continuous leadership support to build and sustain adequate staffing levels.

**Action 2.1.1 Make it a leadership priority to timely identify and fill all mental health vacancies.** Communicate Receiver's expectation that vacancies be identified and filled as quickly as possible. The Receiver will issue a guidance memo explaining her expectations and will make this a central theme of her communications plan. Guidance memo issued within 30 days.

**Action 2.1.2 Require that new mental health units be appropriately staffed when they open (or reopen).** Develop a procedure to ensure that all new units (e.g., EOP, MHCB, PIP) are staffed appropriately when they open. Implement new procedures within 12 months.

**Action 2.1.3. Limit use of triage plans.** The Receiver's goal will be to eliminate the use of triage plans to the greatest extent possible. Until that time, the Receiver will review and approve the use of any triage plans. If appointed, the Receiver will require institutions to submit all active triage plans within 30 days. The Receiver will determine whether and to what extent each institution may continue to use a triage plan. In addition, the Receiver will institute a new procedure to evaluate, approve, and monitor triage plans. New procedures implemented within 120 days.

**Action 2.1.4 Ensure that new employees get off to a strong start.** It is essential that new employees have a positive experience even before they start work. Leadership can and should play a critical role in onboarding new employees in a manner that starts them on a positive path to a productive career. The Receiver will establish a consistent onboarding program for all mental health clinicians. The new program will require local leadership involvement in onboarding to ensure that new mental health employees have a positive experience. Once the plan is implemented, the Receiver will assess its use through surveys and field visits. Onboarding program developed and implemented within 12 months.

**Action 2.1.5 Assess need for additional resources to support mental health recruitment, hiring, and retention.** Addressing CDCR's mental health staffing needs requires a significant investment of time and resources. The Receiver will assess the number of employees currently focused on mental health staffing and evaluate whether additional resources are needed, on a short- or long-term basis, to achieve the required 90% mental health staffing level at every institution. Complete assessment within 90 days. If additional resources are needed, submit plan to court within 120 days.

**Objective 2.2 Use Sophisticated Recruitment Strategies to Increase Clinician Staffing Levels.** CDCR is expanding its use of technology and data to strengthen recruitment. Objective 2.4 addresses use of data for recruitment. In addition to supporting the use of technology and data to enhance recruitment efforts, the Receiver will centralize and expand the use of clinical internship programs in MHSDS. Robust clinical internship programs can be highly effective tools for attracting new clinicians. While MHSDS does use clinical internship programs, they are not centrally managed or standardized across institutions.

**Action 2.2.1 Enhance recruitment of clinicians by expanding use of mental health internship programs.** The Receiver will hire a coordinator who will develop a plan to centralize and expand use of clinical internship programs. The plan will establish goals and targets for annual internship program expansion, strategies for achieving expansion, and proposed metrics for assessing the impact of expanded programs on clinician fill rates and retention. Complete internship centralization and expansion plan within 12 months.

**Objective 2.3: Increase Retention by Addressing Clinician Concerns Regarding Working Environments and Compensation.** In order to address staffing needs in a meaningful and sustainable way, CDCR must be able to retain clinicians once it hires them. Therefore, it is insufficient to focus only on hiring. Retention is equally important.

**Action 2.3.1 Assess factors contributing to clinician fear and identify strategies for addressing them.** Clinician fear, especially of patients, is a serious concern that needs to be addressed to improve morale and create better outcomes for patients and clinicians. The Receiver will partner with an outside expert to assess this issue and identify strategies designed to address it. Complete assessment within 12 months.

**Action 2.3.2 Evaluate compensation concerns.** The Receiver will propose that the monthly bonuses currently paid from fines be made permanent. In addition, the Receiver will assess the need for additional increases in compensation to address hardest-to-fill locations or positions. Within 60 days, provide the court with results of assessment and recommendations.

**Action 2.3.3 Develop a comprehensive plan to ensure that all institutions provide adequate work and treatment space for mental health clinicians and programs.** Survey all institutions to assess office and treatment space needs and options (e.g., renovation of existing space, hoteling, use of trailers, etc.). Following the assessment, the Receiver will develop a plan and timeline for phased implementation of prioritized needs. Complete plan within 18 months.

**Action 2.3.4 Expand use of hybrid and flexible work options for mental health clinicians.** We recommend that the court approve the hybrid work policy negotiated by the parties and pending with the court. In addition, the Receiver will assess other options for increasing workplace flexibility for clinicians. Complete assessment within 12 months.

**Action 2.3.5 Decrease clinician time spent on non-clinical tasks.** The Receiver will evaluate clinician hours spent on non-clinical tasks and identify options for reducing that time. This will include consider options for increasing administrative support, changing policies and procedures, simplifying documentation requirements, and deploying new technologies. Complete assessment within one year.

**Objective 2.4 Increase the Use of Data Analytics to Achieve and Sustain Adequate Mental Health Staffing Levels.** As discussed above, CDCR is developing several tools that will allow it to collect and use data to analyze issues related to recruitment, hiring, retention, and morale. This data will be a critical resource to achieving sustainable mental health staffing levels. The following are steps that the Receiver will take as the new systems are being developed. Once reliable data is available, the Receiver will develop a more comprehensive plan to use of data analytics to support mental health staffing.

**Action 2.4.1 Work with CCHCS leadership to complete development and expansion of planned systems.** The Receiver will champion ongoing efforts to develop the applicant tracking system, centralize and standardize data, and adopt new technologies for talent acquisition. For this action, the timeframe is dependent on status of each project at the time of appointment.

**Action 2.4.2 Use data to assess recruitment and hiring processes.** As data becomes available from the applicant tracking and other systems, the Receiver will begin using it to assess issues such as how applicants enter the CDCR hiring process, how long it takes to hire, and what types of recruitment strategies work best for specific professions. Timeframe is as soon as possible once data becomes available.

**Goal 3: Provide Adequate Care at Every MHSDS Level and Treat Each Patient at the Appropriate Level of Care.** The MHSDS population has increased substantially since 1990. Therefore, it is essential that CDCR treat patients at the correct level of care, including allowing them to step down when it is clinically appropriate. Moreover, increasing compliance with existing remedies can decrease interactions that contribute to a patient's psychological deterioration and help avoid the need to move patients to higher levels of care.

**Objective 3.1 Expand policies and procedures that encourage patients to step down.** It can be difficult for patients to step down between care levels. There are many reasons for this, including fewer treatment requirements and resources for CCCMS as well as CDCR policies and procedures that can disincentive stepping down.

**Action 3.1.1 Evaluate the use of Resource Teams to enhance patients' ability and willingness to step down.** Work with the Amend program at UCSF to deploy trained Resource Teams at each PIP. The five Teams will work to ensure that each patient living in a PIP receives consistent engagement in out-of-cell activities designed to improve their social skills and capacity to live in a less restrictive and specialized environment. The goal of the Resource Teams is to train custody staff to have more meaningful work, help PIP patients avoid stagnation, and optimize their ability to advance under psychiatric care. The ultimate aim is to support each patient's clinical advancement toward being assessed as ready to step down to EOP level care. If Resources Teams are successful in the PIP units, the Receiver will explore the possibility of expanding the teams to other units. Enter agreement with Amend within 90 days.

**Objective 3.2 Reduce interactions that can contribute to psychological deterioration in patients.** As discussed above, the size of the *Coleman* class makes it essential for CDCR to increase adherence to existing policies relating to use of administrative segregation and force. This can help decrease the likelihood that patients need to move to higher levels of care.

**Action 3.2.1 Increase compliance with existing remedies regarding use of Administrative Segregation Units**. Develop a plan to increase compliance with existing policies regarding use of administrative segregation. Plan developed within 18 months.

**Action 3.2.2. Increase compliance with existing policies regarding use of force.** Develop a plan for increasing compliance with existing use of force policies, including training requirements and Custody and Mental Health Partnership Plans. Plan developed within 18 months.

**Objective 3.3 Expand use of evidence-based mental health treatment programs.** CDCR can improve patient outcomes by increasing its use of evidence-based programs. By offering more programming in CCCMS, CDCR can support patients' ability to step down when it is clinically appropriate for them to do so.

**Action 3.3.1 Develop a transparent and replicable process for assessing programming needs and expanding use of evidence-based programs to meet those needs.** Partner

with outside expert to develop a plan for CDCR to expand use of programming, particularly in CCCMS. Assessment to be completed within 24 months.

**Goal 4: Fully Implement Suicide Prevention Program.** The lack of an effective suicide prevention program was one of the original *Coleman* findings. Moreover, CDCR's suicide rates have increased significantly over the last several years. It is past time to fully implement the suicide prevention program.

**Objective 4.1 Complete implementation of 13 recommendations from the Special Master's 22nd Round Monitoring Report.**

**Action 4.1.1 Establish implementation goals and plans to resolve outstanding suicide recommendations.** Develop goals and implementation plan to resolve all outstanding suicide recommendations. Plan will be based on root cause analysis to determine why CDCR has not implemented each recommendation. Plan will include prioritization of recommendations and/or institutions to guide implementation. Goals and plan developed within 180 days.

**Action 4.1.2 Complete transition of annual suicide reporting to CDCR.** Work with CDCR and parties to evaluate 2025 draft suicide report, resolve disagreements, and provide a recommendation to the court. Timeframe is dependent on when draft plan is ready for review.

**Action 4.1.3 Evaluate QIPs to ensure that they support continuous quality improvement.** Within 18 months, identify and implement any changes needed to strengthen QIPs.

**Goal 5: Complete Development and Implementation of a Quality Assurance Program.** CDCR must complete implementation of an effective quality assurance/improvement program to resolve *Coleman.*

**Objective 5.1 Recommend final CQIT indicators and thresholds to court.** Since CQIT is intended to facilitate self-monitoring by CDCR, it must provide accurate, reliable information that identifies areas of concern at an agency-wide level.

**Action 5.1.1 Test CQIT data and functionality.** Develop and implement a plan to test CQIT. Complete testing within 12 months.

**Action 5.1.2 Recommend final indicators and compliance thresholds to the court.** Within 18 months, recommend final indicators and compliance thresholds.

**Action 5.1.3 Complete development of user-friendly CQIT dashboards to monitor compliance.** In order to ensure that the quality assurance/improvement program is durable, clinicians, the parties, and the Receiver need easy-to-use data dashboards. Within one year

following court approval of final indicators, develop, test, and deploy user-friendly CQIT dashboards.

**Objective 5.2 Develop new processes for field monitoring and for recommending to the court that CDCR has fully implemented a remedy.** With the completion of data remediation and the expectation that CQIT can soon be used as part of monitoring, the Receiver will adopt a revised approach to field monitoring and develop a process for recommending that CDCR has fully implemented a remedy.

**Action 5.2.1 Implement a revised field monitoring process.** Implement a revised field monitoring process that uses both CQIT and institution visits to assess compliance with remedies. New process will include timeframes for feedback and parameters for report content and recommendations. New process implemented within 180 days.

**Action 5.2.2 Implement a new process to guide institutions through the pre- and post-field monitoring process.** Implement new processes that establish Receiver's expectations for how institutions will participate in field monitoring. This includes timelines and requirements for institutional: 1) self-assessments using CQIT data; 2) action plans to address deficiencies; and, 3) implementation of all recommendations. Within 12 months, implement new processes.

**Action 5.2.3 Seek court approval for a process to recommend that CDCR has fully implemented a remedy.** Develop a process for recommending to the court that CDCR has fully implemented a remedy. Proposed process will detail the steps that the Receiver will take to evaluate whether the remedy is fully implemented and identify the types of information that the Receiver will use to support its recommendation. Within 12 months, submit proposal to court for approval.

**Goal 6: Create Mechanism to Demonstrate Sustainability of Remedies.** Many of the actions described above are designed to promote sustainability. For example, revising the MHSDS management structure, improving communications, increasing the use of evidence-based programming, and making it easier for patients to accept care, are all designed to provide long-term changes that support the provision of constitutionally adequate mental health care. In addition to these ideas, we will explore other ideas to improve sustainability.

**Objective 6.1 Assess feasibility of MHSDS seeking outside accreditation.** One way to demonstrate the durability of the care provided by MHSDS is to seek outside accreditation to shows how that care aligns with community standards.

**Action 6.1 Partner with outside expert to assess feasibility of MHSDS seeking outside accreditation.** Assessment complete within 36 months.

# Appendix A

# Qualifications and Accomplishments of Receiver-Nominee & Deputy Receiver-Nominees

**Receiver- Nominee Colette S. Peters**

Leveraging more than 34 years of public safety experience, she served as Director of the Oregon Department of Corrections for over a decade and, up until recently, led the Federal Bureau of Prisons (FBOP). Prior to her departure from the FBOP, she was the longest-tenured active corrections director in the country, totaling 16 years of service as a director.

She has earned an international reputation for advancing the principles of normalcy and humanity for those who work and live in prisons, promoting employee wellness, increasing agency efficiency and effectiveness, and using data to improve outcomes for people in custody. Over the past 22 years, she has held executive-level roles including Director of the Oregon Youth Authority and Oregon's Inspector General.

**Receiver-Nominee William Lothrop**

An accomplished correctional executive with over 32 years of progressive leadership within the Federal Bureau of Prisons (FBOP), including tenure as Acting Director and Deputy Director, he brings demonstrated expertise in high-level corrections administration, public safety policy, crisis response, and institutional reform. Adept at managing large-scale operations, he has led diverse, multidisciplinary teams across the country—including oversight of 122 facilities across six regions, as well as medical services, mental health services, and reentry initiatives.

He prioritized accountability in addressing sexual misconduct and ensured that facilities received improved access to suicide prevention care through appropriate mental health treatment and accurate, up-to-date mental health information related to suicide risk. He worked to reduce the opportunity for—and lethality of—self-directed violence by tracking and reporting the use of restrictive housing, lockdowns, and the presence of illicit substances and contraband. He used data and research to refine suicide prevention policies, developing data-driven recommendations for assessing suicide risk and mandating institutional reviews following the death or suicide attempt of an incarcerated individual—efforts aimed at fostering transparency, accountability, and continuous improvement in correctional health care.

**Receiver-Nominee Kathleen Toomey**

Drawing on more than 24 years at the U.S. Department of Justice (DOJ), she is a skilled executive and legal professional who excels at using innovation, creativity, research, and data analysis to solve complex organizational challenges. With over a decade of experience managing high-level operations in legal and law enforcement agencies, she has addressed chronic

operational issues in organizations subject to extensive oversight from Congress, the DOJ Office of the Inspector General, and the Government Accountability Office. At FBOP she led efforts to tackle a severe staffing shortage—increasing staffing levels at the FBOP from 89% to 93% within 12 months— and a $3 billion modernization and repair backlog.

She has overseen some of the most complex components of large organizations, including Human Resources, Administration and Finance, the Office of Congressional and Public Affairs, and Information & Technology. Notably, she developed an Urgent Action Team approach to solving chronic institution-specific issues and led the first rapid-response team at Metropolitan Detention Center Brooklyn, a facility long challenged by cultural, staffing, and infrastructure issues. Under her leadership, the team swiftly addressed urgent needs related to staffing, health services, and operations. In less than nine months, custody staff levels increased from 55% to 70% through targeted pay increases and the development of new tools that streamlined and accelerated the hiring process. She also advanced patient care by expanding the use of telehealth while partnering with a local hospital (See Attached *Brooklyn Urgent Action Team Fact Sheet as of September 19, 2024*).

**Together at the Federal Bureau of Prisons (See Attached *Reforming and Strengthening the Federal Bureau of Prisons 2021-2025***
https://www.justice.gov/archives/media/1385321/dl?inline )

As the Director, Deputy Director, and Associate Deputy Director of the Federal Bureau of Prisons (FBOP), they inherited the agency during a time of significant turmoil, including allegations of inhumane and criminal activity. They led one of the largest law enforcement agencies within the U.S. Department of Justice and the nation's largest correctional system, overseeing complex national operations and nearly 40,000 employees across six regions—all while managing an $8 billion budget.

Together, they upheld constitutional principles while advancing the Bureau's dual-purpose mission: to foster a humane and secure environment and to ensure public safety by preparing individuals for successful reentry into their communities.

They were responsible for the care and custody of nearly 155,000 adults housed in 122 federal prisons, 178 community-based facilities, and on home confinement. This included oversight of their education, programmatic needs, and their physical, medical, mental and behavioral health. Through FBOPs National Gang Unit, Counter-Terrorism Unit, and Intelligence Office, they collaborated with federal and local law enforcement partners to gather intelligence and maintain the safety and security of our institutions and communities around the globe.

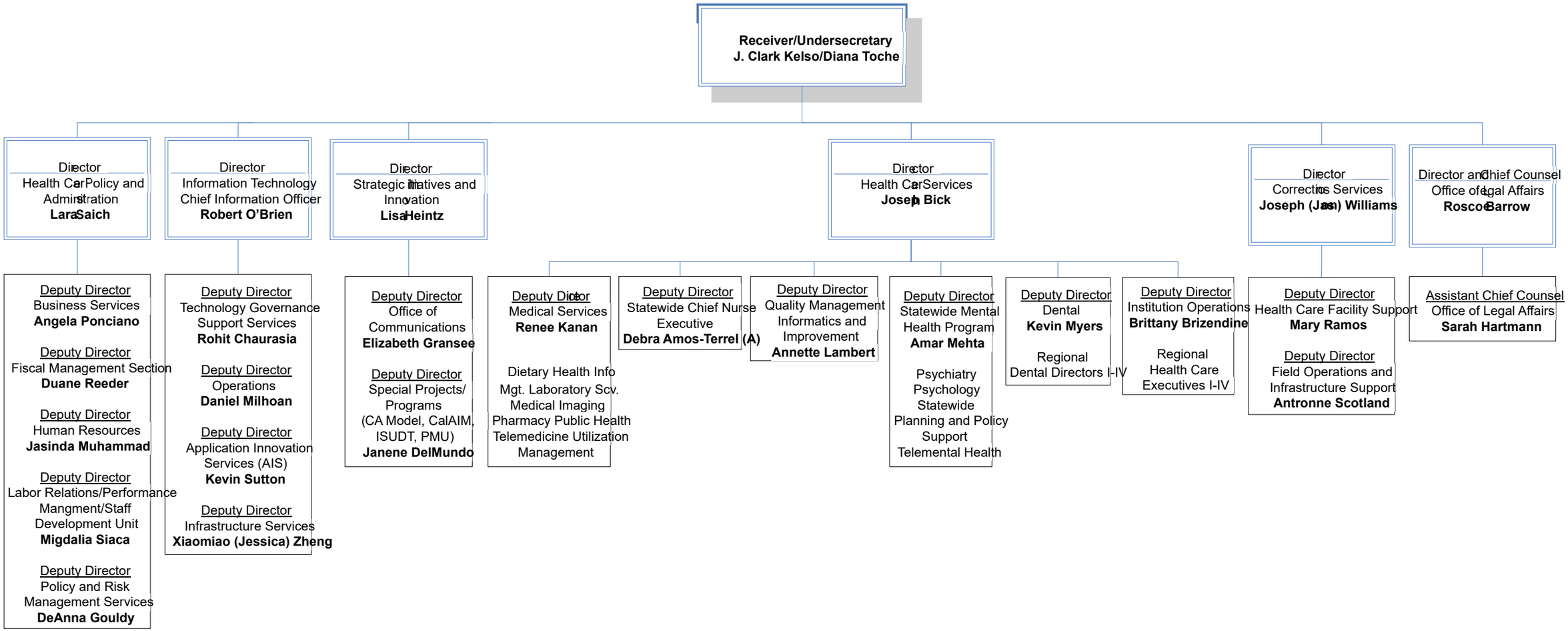
They worked closely with FBOPs national union leadership to ensure that employees received resources and support. They regularly engaged with Congress to communicate the Bureau's longstanding challenges and successfully garnered public policy support and additional funding. They also collaborated with the Office of the Inspector General and the Government Accountability Office to promote accountability and root out misconduct.

**Key accomplishments include:**

- **Strengthened efforts to prevent deaths in custody.** Identified and implemented more than 50 actions to reduce suicide risk among individuals in custody, including:
    - Ensuring employees received current and accurate mental health information.
    - Improving access to and the delivery of suicide prevention care through appropriate treatment.
    - Reducing opportunities for, and lethality of, self-directed violence by tracking and reporting the use of restrictive housing, lockdowns, single-cell placement, and illicit substances and contraband.
    - Using data and research to refine suicide prevention policies by developing data-driven recommendations and encouraging institutional reviews following suicides or suicide attempts.
- **Improved recruitment and retention.** After decades of stagnant and declining employment levels, increased overall staffing from 85% to 93% in just 2.5 years.
- **Prioritized employee wellness.** Recognizing the toll corrections work takes on staff—with an average lifespan of 58 years after 20 years of service, high rates of PTSD, and widespread health issues—expanded the role of Crisis Support Teams to include ongoing and proactive wellness efforts. Enhanced Employee Assistance Program (EAP) services to include retirees and mandated counselor certification. Created the Chief Employee Wellness Administrator role to oversee wellness initiatives nationwide.
- **Addressed the $3 billion maintenance and repair backlog.** Developed 5-, 10-, and 15-year strategic plans to manage infrastructure deficiencies that have left employees and individuals in custody working and living in dilapidated conditions.
- **Closed or turned around underperforming units and entire facilities.** Closed or restructured institutions that failed to meet standards of correctional excellence—some of which were plagued by criminal and inhumane conduct.
- **Promoted accountability and transparency.** Held individuals accountable and worked to create safer, more humane environments across the agency in partnership with DOJ's Office of Inspector General. Established the position of National Chief Inspector to internally mirror the oversight functions of the Office of the Inspector General, using data to proactively address cultural decline, contraband, and criminal misconduct.
- **Implemented the First Step Act (FSA).** In less than 5 years, facilitated 175,000 individuals to complete more than 600,000 evidence-based programs and productive activities. Released nearly 40,000 individuals to supervision through earned FSA time credits within 2 years, resulting in substantially lower recidivism rates (12.4%) compared to the national average return rate to federal, state, or local custody (49%).

CALIFORNIA CORRECTIONS
HEALTH CARE SERVICES

May 1, 2025



Appendix C

## STATUS AND PRIORITIZATION OF COLEMAN REMEDIES

| Remedies | Status and Prioritization |
|---|---|
| **Staffing Shortages** (1995 Order and Special Master's 22nd Monitoring Round Report) | CDCR continues to have difficulty hiring and retaining mental health clinicians. Because staffing shortages negatively impact many other remedies, they are a significant focus of the Action Plan. *See* Goal 2. |
| **Suicide Prevention** (1995 Order and Special Master's 22nd Monitoring Round Report) | Suicide rates among are higher now than they were in 1995. Since CDCR has not fully implemented its suicide prevention program, it is prioritized in the Action Plan. *See* Goal 4. |
| **Quality Assurance** (1995 Order and Special Master's 22nd Monitoring Round Report) | The Court has identified development of a quality assurance program as the key to ending court oversight in *Coleman*. The Action Plan prioritizes full implementation of a quality assurance program. *See* Goal 5. |
| **Administrative Segregation** (1995 Order and Special Master's 22nd Monitoring Round Report) | CDCR has implemented changes to its administrative segregation policies and practices. However, it continues to struggle with some aspects of providing adequate levels of mental health care to those in administrative segregation. The Action Plan emphasized increased adherence to existing policies. *See* Goal 3. |
| **Significant delays in access to mental health care throughout the system.** (1995 Order and Special Master's 22nd Monitoring Round Report) | CDCR has implemented changes to improve access to mental health care. However, patients continue to experience delays in receiving treatment, often due to staffing shortages. The Action Plan will address delays in care through a focus on staffing and quality assurance. *See* Goals 2 and 5. |
| **Lack of systemic program for screening and evaluating inmates for mental illness** (1995 Order) | CDCR has implemented changes to improve screening and evaluation of inmates for mental illness. However, staffing shortages at some institutions result in patients not seeing clinicians in a timely manner. The Action Plan addresses this through a focus on staffing and quality assurance. *See* Goals 2 and 5. |

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| **Inadequate supervision of the use of medication** (1995 Order) | CDCR has implemented changes to improve supervision of the use of medication. Monitoring of these issues will be through the quality assurance program. *See* Goal 5. |
| **Several deficiencies in the availability and utilization of involuntary medication** (1995 Order) | CDCR has implemented changes to address deficiencies in the availability and utilization of involuntary medication. Monitoring of these issues will be through the quality assurance process. *See* Goal 5. |
| **Absence of any adequate systemwide procedures for use of mechanical restraints on seriously mentally disordered inmates.** (1995 Order) | CDCR has implemented systemwide changes to its use of mechanical restraints. Monitoring of these issues will be through the quality assurance process. *See* Goal 5. |
| **Inadequate training of custodial staff "in the identification of signs and symptoms of mental illness"** (1995 Order and Special Master's 22nd Monitoring Round Report) | CDCR has made changes to address this deficiency, including adopting Custody and Mental Health Partnership Plans. Full implementation of of those policies is uneven. *See* Goal 3. |
| **Use of tasers and 37mm guns against class members without considering whether the behavior leading to use of the weapon was caused by mental illness, or the impact of such weapon's use on that illness.** (1995 Order) | CDCR has made changes to address use of force. Full implementation is uneven. The Action Plan emphasized increased adherence to existing policies. *See* Goal 3. |
| **An "'extremely deficient'" medical records system.** (1995 Order and Special Master's 22nd Monitoring Round Report) | CDCR adopted an electronic health records system (EHRS). As explained on pages 14-15, once the court approves the final CQIT indicators (that rely on data from EHRS), we anticipate recommending that the court find that CDCR has fully remediated its medical records system. *See* pages 14-15 and Goal 5. |
| **Complete construction of mental health treatment space and beds.** (Special Master's 22nd Monitoring Round Report) | CDCR has nearly completed this construction initiative. As explained on pages 14-15, once the last construction project is complete in spring 2026, we anticipate recommending that the court find that |

Appendix C

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|---|---|
| | CDCR has fully implemented this remedy. *See* pages 14-15 and Goal 5. |

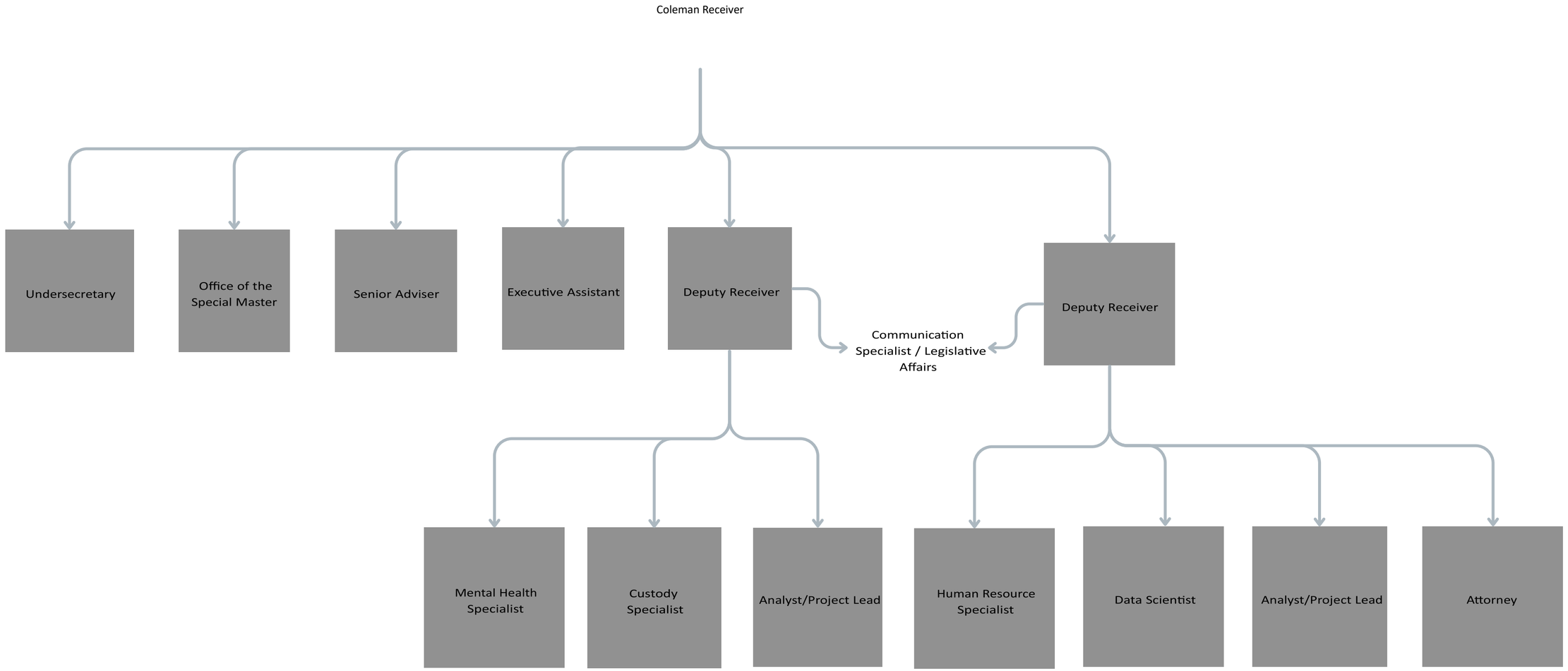
**Appendix D Estimated Costs for Implementation of Action Plan**

| | FTE | Rate | Total | Notes |
|---|---|---|---|---|
| **Receiver's Office Employees (Estimated)** | | | | |
| Receiver | 1 | $ 390.76 | $ 812,784 | |
| Deputy Receiver (WWL) | 1 | $ 336.80 | $ 700,552 | |
| Deputy Receiver (KTT) | 1 | $ 330.71 | $ 687,883 | |
| Senior Advisor (MH) | 1 | 330 | $ 686,400 | |
| Senior Advisor | 1 | 300 | $ 624,000 | |
| Attorney | 1 | 300 | $ 624,000 | |
| Analyst/Paralegal | 1 | 195 | $ 405,600 | |
| Analyst/Paralegal | 1 | 195 | $ 405,600 | |
| Analyst/Paralegal | 1 | 195 | $ 405,600 | |
| Admin support | 1 | 150 | $ 312,000 | |
| **Subtotal** | | | **$ 5,664,419** | |
| | | | | |
| **Subject Matter Experts/Consultants (Estimated)** | | | | |
| HR | 1 | 380 | $ 790,400 | |
| Custody | 0.5 | 380 | $ 395,200 | |
| Data scientist | 0.5 | 380 | $ 395,200 | |
| MH | 1 | 380 | $ 790,400 | |
| Communications | 0.05 | 380 | $ 39,520 | |
| Employee engagement/wellness expert | 0.25 | 380 | $ 197,600 | |
| Programming | 0.25 | 380 | $ 197,600 | |
| Consultant | 0.05 | 375 | $ 39,000 | |
| **Subtotal** | | | **$ 2,844,920** | |
| | | | | |
| **Other Receviers Office Costs (Estimated)** | | | | |
| Outside counsel - partner | 0.05 | 495 | $ 51,480 | |
| Outside counsel - associate | 0.1 | 345 | $ 71,760 | |
| Travel | | | $ 216,000 | |
| Office space | | | $ 100,000 | |
| Supplies, etc. | | | $ 25,000 | |

| | | | | |
|---|---|---|---|---|
| **Subtotal** | | | **$** | **464,240** |
| TOTAL RECEIVER'S OFFICE COSTS | | | **$** | **8,973,579** |
| | | | | |
| **IMPLEMENTATION COSTS (ESTIMATED)** | | | | |
| | | | | |
| **Resource Teams** | | | | |
| 1 team per PIP (currently 5 PIPs). | | | **$** | **5,750,000** |
| Amend project manager (team trainer) | 0.75 | | $ | 200,000 |
| Amend senior leadership for oversight | 0.4 | | $ | 125,000 |
| Travel | | | $ | 15,000 |
| Amend admin time classroom organizing and materials | | | $ | 50,000 |
| Subcontract for external evaluators | | | $ | 325,000 |
| | | | $ | 715,000 |
| UC indirect rate (on all but team salary costs (line 39)) | 0.3 | | $ | 214,500 |
| Amend Subtotal | | | **$** | **929,500** |
| **Total Resource Team Cost** | | | **$** | **6,679,500** |
| | | | | |
| **Making Bonuses Permanent** | | | **$** | **25,300,000** |
| | | | | |
| **Staffing Challenges Assessment** | | | | |
| Consultant (30 institutions @ 10 hours @ 2ppl) | 0.30 | 380 | **$** | **237,120** |
| | | | | |
| **Clinician Fear** | | | | |
| Consultant | 0.05 | 380 | **$** | **39,520** |
| | | | | |
| **Programming** | | | | |
| Consultant to recommend plan to expand and centralize evidence-based programming | 0.05 | 380 | **$** | **39,520** |
| | | | | |
| **Suicide Prevention** | | | | |
| Expert advice (OSM) | 0.05 | 380 | **$** | **39,520** |

| | | | | |
|---|---|---|---|---|
| **CQIT** | | | | |
| Expert advise (OSM) | 0.05 | 380 | **$** | **39,520** |
| | | | | |
| **Accreditation** | | | | |
| Consultant | 0.05 | 380 | **$** | **39,520** |
| | | | | |
| **TOTAL IMPLEMENTATION COSTS** | | | **$** | **32,414,220** |

# APPENDIX E - OFFICE OF THE RECEIVER - COLEMAN
# ORGANIZATION CHART



# RECEIVER-NOMINEE ACTION PLAN

| | **NOTES**: Unless otherwise described, target timeframes are to days/months/years following appointment. Metrics in this chart are based on available data and information. If the court approves the Action Plan and appoints a Receiver, additional metrics will be developed as information and data becomes available. | **Immediate (First 6 months after appointment)** | | | | **Short-Term (6 months to 2 years)** | | | **Medium-Term (3 to 4 years)** | | **Long-Term (5 to 7 years)** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Goal 1** | **Improve Mental Health Care Delivery Through Culture and Effective Management** | Establish baseline measure for employee views/knowledge about Coleman | | | | Employees views improve by X per year | | | Demonstrable improvement in employee views and understanding of Coleman | | Increased adherence to Program Guide and other remedies | | |
| **Objective 1.1** | **Communication, transparency, and accountability** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 1.1.1** | Communications strategy | | | | | | | | | | | | |
| **Action 1.1.2** | MHSDS Policy Process/Program Guide | | | | | | | | | | | | |
| **Action 1.1.3** | Share best practices | | | | | | | | | | | | |
| **Objective 1.2** | **Streamline and clarify the MHSDS management structure.** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 1.2.2** | Centralize and steamline mental health reporting structure | | | | | | | | | | | | |
| **Goal 2** | **Achieve and Retain a Well-Qualified Mental Health Workforce.** | Plans are developed and critical positions are filled | | | | 90% of positions are filled | | | 95-100% positions filled | | Demonstrate durability by maintaining fill rates of at least 90% | | |
| **Objective 2.1** | **Adopt a focused, leadership-driven approach to hiring and retention of mental health employees.** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 2.1.1** | Timely identify and fill all mental health vacancies. | | | | | | | | | | | | |
| **Action 2.1.2** | Staffing levels for new units | | | | | | | | | | | | |
| **Action 2.1.3** | Triage plans | | | | | | | | | | | | |
| **Action 2.1.4** | Onboarding | | | | | | | | | | | | |
| **Action 2.1.5** | Resources to support recruitment, hiring, and retention | | | | | | | | | | | | |
| **Objective 2.3** | **Use sophisticated recruitment strategies to increase staffing** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 2.2.1** | Clinical internship programs | | | | | | | | | | | | |
| **Objective 2.3** | **Increase retention by addressing working environments and compensation** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 2.3.1** | Assess factors of fear and identify strategies for addressing | | | | | | | | | | | | |
| **Action 2.3.2** | Assess compensation concerns | | | | | | | | | | | | |
| **Action 2.3.3** | Adequate work and treatment space | | | | | | | | | | | | |
| **Action 2.3.4** | Expand hybrid and flexible work options | | | | | | | | | | | | |
| **Action 2.3.5** | Time spent on non-clinical tasks | | | | | | | | | | | | |
| **Objective 2.4** | **Increase use of data analytics** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 2.4.1** | Develop and expand systems | Dependent on status of each project | | | | | | | | | | | |
| **Action 2.4.2** | Use data to assess recruitment and hiring | | | | | | | | | | | | |
| **Goal 3** | **Provide Adequate Care** | Plans developed; baseline measure of employee satisfaction | | | | Employee engagement scores | | | Mental health providers | | Attrition decreases and | | |
| **Objective 3.1** | **Expand policies and procedure** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 3.1.1** | Resource Teams | | | | | | | | | | | | |
| **Objective 3.2** | **Reduce interactions contributing to deterioration** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 3.2.1** | Increase compliance with existing remedies regarding AD SEG | | | | | | | | | | | | |
| **Action 3.2.2** | Increase compliance with existing policies regarding use of force | | | | | | | | | | | | |
| **Objective 3.3** | **Expand use of evidence-based programs** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 3.3.1** | Develop process for assessing programs | | | | | | | | | | | | |
| **Goal 4** | **Fully implement suicide prevention program** | Plan and goals developed | | | | Increase compliance each year. | | | Achieve minimal compliance at all institutions. | | Demonstrate durability | | |
| **Objective 4.1** | **Special Master's Recommendations** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 4.1.1** | Address outstanding suicide recommendations. | | | | | | | | | | | | |
| **Action 4.1.2** | Complete transition of annual suicide reporting to CDCR. | | | | | | | | | | | | |
| **Action 4.1.3** | Evaluate the QIP process. | | | | | | | | | | | | |
| **Goal 5** | **Quality Assurance Program** | Test CQIT | | | | Final measures and thresholds approved | | | ?? | | CDCR begins self-monitoring | | |
| **Objective 5.1** | **Recommend final CQIT indicators and thresholds to Court** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 5.1.1** | Test CQIT data and functionality. | | | | | | | | | | | | |
| **Action 5.1.2** | Recommend final indicators and compliance thresholds to Court. | | | | | | | | | | | | |
| **Action 5.1.3** | CQIT dashboards | | | | | | | | | | | | |
| **Objective 5.2** | **Field monitoring and recommending that CDCR has fully implemented a remedy.** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 5.2.1** | Implement a revised field monitoring process. | | | | | | | | | | | | |
| **Action 5.2.2** | Pre- and post-field monitoring process. | | | | | | | | | | | | |
| **Action 5.2.3** | Process to recommend that CDCR has fully implemented a remedy. | | | | | | | | | | | | |
| **Goal 6** | **Ensure Sustainability and Durability of Remedies** | | | | | | | | | | | | |
| **Objective 6.1** | **Seek outside accreditation for MHSDS** | **Up to 30 days** | **31-60 days** | **61-90 days** | **90-180 days** | **6 - 12 months** | **12-18 months** | **18 - 24 months** | **25-36 months** | **37-48 months** | **48 - 84 months** | | |
| **Action 6.1.1** | Partner with outside expert to assess feasibility | | | | | | | | | | | | |