UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

No. 2:90-cv-0520 TLN SCR

RECEIVER'S SECOND QUARTERLY REPORT

Pursuant to the Court's order setting forth the powers and duties of the Receiver, the Receiver files quarterly reports regarding ongoing monitoring and implementation of the court-approved and court-ordered remedies to expediently provide constitutionally adequate mental health services to all class members in this case. Court's Further Amended Order Setting Out Powers and Duties of the Receiver, ECF No. 8843, § I.D., at 3. These quarterly reports address key accomplishments during the past quarter, ongoing progress toward the goals and milestones in the Receiver's Action Plan (ECF No. 8722) and other actions directed by the court, challenges faced by the Receiver, the Receiver's quarterly expenditures, and all other matters appropriate for judicial review. *Id.* The reports provide overviews of important activities and accomplishments, but do not describe every action that the Receiver has taken. This is the second quarterly report filed by the Receiver, addressing activities from February through April 2026.

I. Key Accomplishments During the Past Quarter

The Receiver and her team had several accomplishments this quarter, including:

Hired Senior Advisors for Mental Health and Quality Assurance. The Receiver hired and onboarded her Mental Health Senior Advisor and her Senior Advisor for Quality Assurance

during the quarter. Dr. Darci Delgado, the Mental Health Senior Advisor, is a clinical psychologist with extensive subject matter expertise in behavioral healthcare and California State governmental leadership as well as first-hand experience providing clinical care to Coleman class members. Gary Ninman, the Senior Advisor for Quality Assurance, is a senior corrections oversight executive with more than twenty-five years of experience in criminal justice, including conducting criminal and administrative investigations, internal audits, and correctional health care oversight as an inspector general. With the addition of these two positions, the Receiver is well-positioned to implement all aspects of her Action Plan. Attachment A includes short biographies of each team member hired by Receiver Peters since September 2025. In order to provide the Court with additional insight on the work of the Office of the Coleman Receiver (OCR), key team members who work on specific issues are identified throughout this report. Each OCR team member has a very broad portfolio, and this report provides a limited snapshot of each person's work.

Launched CQIT+ Audits. After six years on hiatus due to litigation and data remediation, the Receiver began the critical and complex task of testing the Continuous Quality Improvement Tool (CQIT) and evaluating the performance of the remediated Key Performance Indicators (KPIs). The CQIT+ process makes several improvements from past mental health audits and monitoring, including: 1) consolidating several audits into a single process designed to provide comprehensive feedback to each institution; 2) clarifying audit requirements and compliance expectations through regular communication with institutions and a transparent set of remediated KPIs; 3) creating pre- and post-audit expectations for institutional participation in and response to audit recommendations; 4) decreasing the document production requirements for institutions because automated data is now available; 5) taking a collaborative approach to auditing, through the creation of the Receiver's Compliance Team (RCT) and the pairing of

internal and external experts during key audit activities; and, 6) prioritizing issuance of timely and actionable reports.

As discussed in more detail below, the process is off to a very strong start with six audits complete and the third report to be issued within the week. Feedback from both parties is positive, particularly as to the Receiver's approach to auditing and the production of timely, specific, and actionable reports. Moreover, each audit is yielding new, valuable insights that the Receiver's team is using to improve the CQIT audit tool and the operation of the KPIs. Finally, and perhaps most importantly, the OCR's 's constructive, collaborative approach to implementing the Coleman remedies is fostering more open and productive interactions between and among CDCR staff, external experts, counsel for the parties, and other stakeholders. In a case that has been centered on litigation and mistrust for decades, this is an extremely positive development that reinforces our optimism that "the dynamics in Coleman can change to a forward-looking focus on fully implementing the remedy." Action Plan at 16.

Receiver's Role in Approving Mission Changes Impacting MHSDS. On behalf of the Receiver, Deputy Receiver Bill Lothrop and Senior Advisor Jason Williams now participate in CDCR's semi-annual bed planning process to ensure that Mental Health Services Delivery System (MHSDS) needs and interests are fully represented. In addition, OCR and California Correctional Health Care Services (CCHCS) now hold monthly bed planning meetings to prepare for any conversions of units, discuss concerns about the ability to staff proposed units, and prevent mission changes that are not feasible. The OCR shares information about approved mission changes with the Parties once decisions are final.

Improving Institution Staffing Levels. During the quarter, the Receiver issued guidance to employees regarding the importance of adequately staffing all institutions. Throughout the quarter, Deputy Receiver Kathy Toomey and Senior Advisor Laura Harvick met with institutional

and regional leaders, professional organizations, and CalHR to discuss staffing issues and strategies for resolving common issues that impact the recruitment, hiring, upward mobility and retention of mental health clinicians.

Ongoing Presence at CDCR Institutions. Between February and April, the Receiver's team has visited 15 CDCR prisons, conducting full CQIT+ audits at six prisons and separate suicide prevention audits at two additional prisons.[1] OCR employees visited some institutions multiple times within the reporting period.

Incorporating Program Guide Into HCDOM. The Receiver is working with a dedicated team to begin incorporating 2009 Program Guide and compendium materials, along with policies that have been finalized since 2021, into a format that is compatible with the Health Care Department Operations Manual (HCDOM). This is a complex initiative that will have significant benefits when complete. Chief of Staff Alyssa Challenger takes the lead for the OCR on this project.

Improved Advocacy Letter Response Process. The Receiver revised the processes used to respond to patient-specific and systemic advocacy letters from plaintiffs' counsel. This new process helps ensure prompt attention to plaintiffs' patient-specific treatment concerns and also facilitates dialogue with the parties on systemic issues that the Receiver is engaged in addressing through the Action Plan.

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[1] The Receiver's compliance team conducted Continuous Quality Improvement Tool (CQIT) audits at the Correctional Training Facility on March 3-5, Kern Valley State Prison on March 16-20, Folsom State Prison on March 24-26, Central California Women's Facility on April 6-9, Sierra Conservation Center on April 15-16, and Pleasant Valley State Prison on April 20-23. The Receiver's team also participated in suicide prevention audits at the Substance Abuse Treatment Facility on April 15 and at the California Correctional Institution on April 28-29. Other prisons the Receiver's team visited between February and April include the Richard J. Donovan Correctional Facility, California State Prison/Los Angeles County, California State Prison/Sacramento, Solano State Prison, California Medical Facility, the California Men's Colony, and Valley State Prison.

Aligned Mental Health Policy Process to CCHCS Policy Process. To improve the quality and efficiency of the policy development process, the Receiver aligned the mental health policy development process with that used by CCHCS for the medical and dental programs. This will ensure that all stakeholders are able to provide input on mental health policies before they are finalized and that new policies can be readily operationalized by institutions.

Made Reports and Updates Available to the Public and CDCR Staff. The Receiver posts all court ordered reports and CQIT+ audit reports to the CCHCS website. This quarter, the Receiver began using the Statewide Mental Health Program pages on Lifeline, a CCHCS intranet site, to share information with staff, including quarterly reports and the Receiver's written and video messages to employees and patients.

Prioritized Implementation of Suicide Prevention Recommendations. During the quarter, Attorney Advisor Laura Cowall worked with the Receiver's suicide prevention expert and MHSDS leadership to finalize the first draft of a prioritized implementation plan to resolve remaining suicide prevention recommendations. Ms. Cowall also worked with the Parties to reach agreement on a proposal to the court for annual suicide prevention reporting, including a provision to address statewide suicide prevention issues through an annual performance improvement plan process.

OCR Testified Before the Legislature. In April, Receiver Peters testified before the Assembly and Chief of Staff Challenger testified before the Senate budget hearings in support of the Receiver's Fiscal Year 2026-2027 Budget Change Proposal that will fund the Office of the Receiver's activities and provide funding to make employee bonuses permanent. The Budget Change Proposal is necessary to support recruitment and retention of clinical staff, which will improve employee satisfaction and increase the availability of patient care. Legislative members expressed interest in the Receiver's Action Plan and in receiving regular updates. The Receiver

anticipates continued collaboration with Legislative partners and the California Legislative Analyst's Office (LAO).

II. Receiver's Priorities for the Third Quarter

During the next quarter, the Receiver plans to:

Continue CQIT+ Auditing and Data Testing. The Receiver plans to conduct nine additional CQIT+ audits in the coming quarter. The OCR will also issue the first Tips for the Field document, which will highlight strategies to address common challenges that impede compliance at CDCR institutions. In addition, the Receiver expects to begin sharing selected mental health key performance indicators on existing dashboards that currently display only medical indicators. This project will provide institutional staff and leadership with data on their medical and mental health care compliance in a single dashboard.

Begin an Evaluation of the Patient Populations at all Levels of MHSDS. The Receiver will be conducting a focused clinical review to assess whether patients are being treated at the right level of care and to inform planning for sufficient beds to meet the needs at each level. This evaluation, which will be led by Dr. Delgado, will use multiple modalities including chart reviews, semi-structured interviews with staff and patients, CDCR and MHSDS population trend analyses, and a literature review. Once complete, the review will inform interventions that may be needed to ensure patients are served at the appropriate level of care and to align beds to the identified needs.

Publicize Plan for Making Bonuses Permanent. In early May, the Receiver expects to issue written guidance to all MHSDS employees that explains how bonuses will be paid to current and new employees in 2026/2027.

Prioritize Resolution of Certain Staffing Concerns. During the quarter, the Receiver will prioritize resolution of issues that institution and regional staff and leadership have identified

as particularly problematic. Specifically, she will seek to address some of the concerns related to eligibility requirements for certain pay differentials and simplify the elevation process for mental health hiring decisions.

III. Status of Action Plan Implementation and Execution of Court-Ordered Responsibilities

A. Action Plan Implementation

1. Communications Plan

As noted in the First Quarterly Report, the Receiver committed to "develop and implement a communications strategy to educate employees and stakeholders about the Receiver's vision, role, goals, objectives, and expectations." Action Plan, Action 1.1.1, ECF No. 8722 at 20. After developing an initial plan, the Receiver determined she will need near-term support from an external communications professional. Therefore, the Receiver will contract with an external expert who can refine the existing communications plan and develop an effective implementation strategy that will serve the Receivership for the next several years.

Since her appointment, the Receiver has prioritized communications with CDCR leadership and staff on critical issues. During the last quarter she released video messages to staff and to patients introducing herself and identifying her priorities. She also finalized updated posters that provide patients with information about the Receivership and contact information for the OCR and counsel for both Parties. These posters are now displayed in all facilities. As discussed below, the Receiver has also issued Agency-wide messages regarding staffing and auditing processes. Moreover, she and several members of the OCR have convened or participated in meetings to discuss the Receiver's priorities and Action Plan implementation. For example, the Receiver provided opening remarks at the first meeting of the RCT and the CDCR Annual Suicide Prevention Symposium.

This quarter, the OCR will release the first Tips for the Field document, which will highlight strategies to address common challenges that impede compliance at CDCR institutions. This will be in furtherance of the Receiver's commitment to "identify and share best practices that support implementation of remedies and increased adherence to the Program Guide." Action Plan, Action 1.1.3, ECF No. 8722 at 20. During site visits and through engagement with facility and regional leadership over the last three months, the OCR has identified a number of items for inclusion in the first installment. Examples include tips for routinely removing window coverings to ensure visibility into cells without the need for force or cell extractions and tips to support scheduling mental health appointments to avoid conflicts with incarcerated patients' other activities.

The OCR has made publicly available all court ordered reports on Reports & Court Orders - CCHCS and is working to create a public OCR website. The OCR will post reports from each CQIT+ audit on the CCHCS website, consistent with the value the Receiver places on transparency.

2. Assessment of Mental Health Policy Review and Approval Process

The Action Plan calls for the Receiver to "[m]ove Program Guide requirements into the DOM to ensure that it is easily available to employees." This is to be completed within twelve months.[2] Action Plan, Action 1.1.2, ECF No. 8722 at 20. Chief of Staff Challenger has begun this process by working with a dedicated team to create a mockup that incorporates the 2009 Program Guide text, all the compendium materials currently appended to the Program Guide, and the approved policies that have been finalized since 2021 into a format that is compatible with the HCDOM. This process will be completed chapter by chapter, with the opportunity for the Parties to review the redlined text before it is finalized and moved into the HCDOM. Currently, CDCR

[2] All timelines in the Action Plan run from November 1, 2025. See ECF 8753 at 7.

staff have to consult multiple separate sources to determine the operative policy regarding key elements of mental health service provision. By creating a clear policy resource that incorporates all of the updates that are now held in separate documents, we will make it easier for staff to understand and meet expectations for service provision. This is an essential step to increasing compliance with court-ordered and court-approved Coleman remedies.

The Receiver's office has also aligned the process for new MHSDS policy development with that of the CCHCS medical and dental programs. The new structure tracks all proposed policies while in process and ensures that all agency stakeholders have early opportunity to provide feedback. This change will facilitate the policy development process, helping to ensure that we have buy-in from all necessary stakeholders before rolling out new and revised policies. That way, the policies can be readily operationalized by staff in institutions, promoting the provision of quality mental health care to patients.

The OCR is also working with MHSDS leadership to finalize and implement several policies that were in the final stages of review when the Receiver was appointed. These policies address critical issues such as clozapine use, suicide watch staffing, and psychiatric inpatient (PIP) bed utilization management processes. With input from the Receiver's advisors and the Parties, the policies are being refined and rolled out. The Receiver expects that the backlog of policies will be resolved within the coming quarter and that all the newer policies will proceed through the process described above.

3. Streamline and Clarify the MHSDS Management Structure

In the Action Plan, the Receiver committed to identify an effective structure to supervise MHSDS and implement that structure. Action Plan, Action 1.2.1, ECF No. 8722 at 21. During this quarter, the Receiver and her deputies engaged in a series of discussions with CCHCS leadership about the structure of MHSDS and its relationship to medical and field operations.

These discussions have revealed a number of areas in which greater role clarity is needed between mental health and other programs at the institution and regional levels. The Receiver and her deputies are working closely with CCHCS leadership to clarify roles and foster collaboration in a manner that promotes a "whole patient" approach to healthcare.

4. Establish Hiring as a Leadership Priority

The Action Plan states that the Receiver will establish hiring as a leadership priority and issue a guidance memo explaining her expectations regarding identifying and filling vacancies. Action Plan, Action 2.1.1, ECF No. 8722 at 21. In early February, the Receiver issued a message to all employees in which she emphasized that "[a]chieving and maintaining appropriate clinical staffing levels is essential to providing Constitutionally-adequate care and resolving the *Coleman* case." Deputy Receiver Toomey subsequently met with institutional, regional leadership, and CCHCS leadership to discuss these expectations and ensure that all health care leadership are invested in working toward reducing mental health care vacancies.

Deputy Receiver Toomey, Senior Advisor Laura Harvick, and CCHCS HR leadership also met with CalHR in an effort to resolve common issues directly impacting the recruitment, hiring, upward mobility and retention of mental health clinicians. Institutions in remote locations or locations with especially high costs of living and competing employers face particular hiring challenges, as do institutions with the most volatile and highest level of security patients. Those institutions will likely need additional assistance in order to hire clinicians and rely less on expensive contracted mental health clinicians to meet immediate patient care needs. The Receiver has also strategized about how to better on-board and train new staff, particularly given the significant numbers of interns and unlicensed clinicians who require additional clinical supervision until they become licensed.

5. Require that New Mental Health Units Be Appropriately Staffed When They Open

The Receiver committed to "develop a procedure to ensure that all new units (e.g., EOP, MHCB, PIP) are staffed appropriately when they open." Action Plan, Action 2.1.2, ECF No. 8722 at 21. To facilitate this, Deputy Receiver Lothrop and Senior Advisor Williams are now participating in bi-annual agency level planning regarding facility mission changes. In addition, Deputy Receiver Lothrop and Senior Advisors Williams and Harvick now hold monthly bed planning meetings with CCHCS to collaboratively prepare for any conversions of units. This regular engagement enables the Receiver to raise concerns about the ability to staff proposed units early in the process and delay or prevent mission changes that will not be feasible to staff appropriately. For example, one recently proposed mission change was delayed to provide more time for the institution to staff the units adequately.

6. Limit Use of Triage Plans

The Receiver's goal is to eliminate the use of triage plans. Action Plan, Action 2.1.3, ECF No. 8722 at 21. Presently, there are three (3) institutions with active triage plans in place and these are the same plans that were in place as of the last quarterly report. Senior Advisor Harvick is assessing the existing triage plans, which includes reviewing staffing data, meeting with institution leadership, and looking at the root cause of staffing challenges at each institution. She is also working with institutions to resolve challenges to both filling specific positions and, more importantly, retaining staff at each institution. Moreover, Ms. Harvick is working with CCHCS leadership to ensure that ongoing recruitment activities and hiring are a priority and provide support to institutions with the greatest staffing challenges, including those still using triage plans.

7. Assess Need for Additional Resources to Support Recruitment, Hiring, and Retention

As part of her efforts to address the workforce shortages, the Receiver committed to "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." Action Plan, Action 2.1.5, ECF No. 8722 at 22.

Based on input from CCHCS, the Receiver has identified the need for additional HR staff to focus on providing support to institutions on hiring and retention issues. The Receiver is working with CCHCS and CDCR leadership to assess and request the resources needed to support this request.

OCR employees are also working with CCHCS Human Resources to continue expanding the pool of applicants to mental health positions. In February, Deputy Receiver Toomey accompanied the CCHCS HR hiring team at an outreach event at San Diego State University that was conducted to make students aware of career opportunities with the agency. Along with weekly hiring interviews being conducted in person or via teams for mental health clinicians applying for positions at the institutions, CCHCS HR also completed three Mental Health focused hiring events. These events were held in San Diego on February 5th, Stockton on March 5th and Crescent City on March 18th and three more are scheduled for later in the year. At the Receiver's request, CCHCS HR has begun focusing these regional Hiring Events on institutions using triage plans.

8. Evaluate Compensation Concerns

Consistent with the court's direction when it approved the Action Plan, the Receiver is finalizing her plan for making employee bonuses permanent. In early May, the Receiver expects

to issue written guidance to all MHSDS employees that explains how bonuses will be paid to current and new employees in 2026/2027.

In addition to making bonuses permanent, the Receiver planned to "assess the need for additional increases in compensation to address hardest-to-fill locations or positions." Action Plan, Action 2.3.2, ECF No. 8722 at 23. The Receiver has identified some categories of positions as particularly difficult to fill, including clinical positions serving patients in the highest security units and institutions and supervisory positions that typically do not come with increased compensation and which may require clinicians to forego the most rewarding elements of their work. Having identified these categories of roles as hard to fill, the Receiver is now assessing what mechanisms are available to support hiring and retention into these positions.

9. Expand Use of Hybrid and Flexible Work Options for Mental Health

The Receiver recommended that the court approve a hybrid work policy that was negotiated by the parties prior to her appointment in the Action Plan. Action Plan, Action 2.3.4, ECF No. 8722 at 23. The OCR is working with CCHCS leadership and Labor Relations Deputy Director to approve and implement the hybrid work policy. There are some actions needed, including union notifications, before fully implementing the policy.

10. Enter Agreement with Amend

To support patient care, build social skills and capacity to live in less restrictive environments, and promote meaningful work for custody personnel in inpatient units, the Receiver committed to deploying Resource Teams in inpatient units within CDCR. Action Plan, Action 3.1.1, ECF No. 8722 at 24. Resource Teams have been deployed with positive results in other correctional systems. Resource Team members receive special training in de-escalation and interpersonal skills and can help minimize unnecessary physical interventions and patient decompensation. This results in a safer environment for both patients and staff. When patients

are stabilized and have developed skills for engaging with custody staff, it helps avoid unnecessary cycling through crisis and inpatient beds. Patients who received support from both Resource Teams and clinicians can return to lower levels of care and remain successful there, decreasing staffing pressures in inpatient settings. Pursuant to her Action Plan commitments, the Receiver has negotiated a contract with the Amend program at UCSF to deploy these teams and currently awaits final review and signatures. Once effective, OCR will work with Amend and CDCR to begin planning for the deployment of the Resource Teams in the second half of 2026.

Resource Teams are a new effort that the Receiver will test to determine whether they assist with improving the delivery of mental health care in CDCR PIPs. Throughout the process, the Receiver will evaluate the efficacy of the teams to determine whether they could be more broadly deployed as another available tool to promote positive outcomes for patients receiving mental health services.

11. Establish Implementation Goals and Plans to Resolve Outstanding Suicide Recommendations

As the Receiver's Action Plan emphasizes, full implementation of CDCR's suicide prevention program is of the utmost importance. To that end, the Receiver has committed to developing a prioritized implementation plan for all outstanding suicide prevention recommendations. Action Plan, Action 4.1.1, ECF No. 8722 at 25. Deputy Director Lothrop, Attorney Advisor Cowall, and the Receiver's suicide prevention expert have met with leadership from CDCR's statewide suicide prevention program to identify which recommendations are already approaching compliance and which recommendations require focused action steps. For this year, a high priority outstanding recommendation that requires new strategies to achieve compliance relates to safety planning, the quality of which continues to be a challenge across institutions. The OCR is working with CDCR to examine the safety planning policy, forms, and

training to determine whether they should be modified to improve the individualization and effectiveness of the plans.

In addition to targeting difficult issues such as safety planning, the Receiver's implementation plan also prioritizes a number of recommendations that have the potential to be in compliance in the near term. Action steps for these recommendations include (1) maintaining posters reminding staff conducting intake evaluations to close the door for confidentiality; (2) maintaining a recently increased pool of trainers to conduct suicide risk evaluation mentoring training; (3) designing and installing placards designating restrictive housing intake cells; (4) fully implementing a new electronic system to track 30-minute custody checks after crisis bed or alternative housing discharges; and (5) revising the policy on institutional Suicide Prevention and Response Focused Improvement Teams (SPRFIT) to clarify required membership.

As noted, the Receiver and RCT are currently completing field auditing of all CDCR institutions to assess compliance with the recommendations.[3] Given that, the implementation plan will be a living document that is modified as compliance status at each institution is updated. The Receiver will also continue to refine the implementation plan as CDCR builds out a new statewide performance improvement plan system that will focus on difficult issues that have persisted across institutions. With this new system, SPRFIT will review and prioritize problems revealed by prior years' suicide case reviews. The prioritized problems will then be addressed, as appropriate, through statewide performance improvement projects to be monitored by the headquarters SPRFIT team. OCR representatives and the Receiver's suicide prevention expert continue to participate in the headquarters SPRFIT meetings and will provide input into the statewide performance improvement projects, as they will also serve to address the remaining

[3] For 2026, most SPRFIT audits are conducted in conjunction with CQIT+ audits. For 2027, the Receiver's goal is to conduct all SPRFIT audits in conjunction with CQIT+ audits.

court-ordered suicide prevention recommendations.

12. Complete Transition of Annual Suicide Reporting to CDCR

The OCR has completed a series of productive meetings with the Parties to resolve the remaining issues needed to transition responsibility for annual suicide reporting to CDCR. The Receiver is submitting a revised annual report proposal and proposed reporting schedule to the Court by May 1, pursuant to the October 25, 2025 Order (ECF No. 8801) and March 26, 2026 Order (ECF No. 8874).

13. Test CQIT Data and Functionality and Implement a Revised Field Monitoring Process

Recognizing the critical role that a functioning quality assurance system will have on enabling the Defendants to come into and maintain compliance, the Receiver committed to conduct CQIT testing this year in conjunction with her ongoing field monitoring efforts. Action Plan, Action 5.1.1, ECF No. 8722 at 25; Action Plan, Action 5.2.1, ECF No. 8722 at 26. A comprehensive quality measurement framework was developed over the course of several years with input from the parties, the Special Master, and the court. It comprises over 250 provisional 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 CQIT, including direct observation of treatment delivery, assessment of treatment environments, and interviews with clinical and custody staff and patients.

To enable CQIT testing, the Receiver established the Receiver's Compliance Team, which is composed of independent subject-matter experts, regional clinical experts, and employees from the Office of the Receiver. This blended team reports to Senior Advisor Gary Ninman. Attorney

Advisor Deena Fox works closely with Mr. Ninman and the RCT. 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. Though external and internal members of the RCT had not worked jointly in the past, the RCT has made an impressive and quick transition to a collaborative model, often working in pairs when on-site and consulting with one another as they are assessing compliance and providing technical assistance.

The RCT was trained to use CQIT for gathering on site data in February and auditing began in March. By the end of April, the RCT will have completed six of 25 planned audits for 2026. This aggressive schedule is both producing actionable feedback to the facilities and enabling the Receiver and the staff managing the quality assurance tools to identify and resolve bugs, challenges with the indicators, and technical issues with the tool.

During onsite visits, the RCT takes a collaborative, multi-method approach to assessing compliance and identifying strengths and areas for improvement. In addition to collecting data for the CQIT indicators, the team cross-references automated data that has been collected over time against direct onsite observations. The RCT also examines staff workflows to verify that the operational processes generating automated data are functioning as intended. To gain a fuller picture of institutional performance, the team conducts interviews with both clinical staff and patients. Throughout the visit, the RCT members work diligently to understand why an institution may not be in compliance on a specific issue. This information gathering and analysis of underlying causes allows the team to draft a meaningful report after the visit 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.

The audit report uses a framework developed under the direction of Mr. Ninman and Ms. Fox. 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.

Reports are prepared on a quick timeline and issued about four weeks after site visits. This timeline ensures that the feedback is timely and that facilities have an opportunity to immediately address identified issues. The reports include an executive summary that highlights strengths of the institution's mental health program and lists priority recommendations requiring attention from the facility's leadership. Reports for two audits have been distributed to the audited facilities. Each of these reports as well as the ones that are to come will be posted to Reports & Court Orders - CCHCS as soon as we have confirmed their compliance with Americans with Disabilities Act requirements.

Emerging Themes[4]: Though we are at the beginning of the auditing year, themes are already emerging. Among the strengths we are observing are increased staffing at the facilities, training compliance, compliance with key custodial obligations including consistent availability of cutdown kits for suicide prevention and knowledge of the processes for referral to mental

[4] The Executive Summaries of the completed reports are attached at Attachment B.

health services, complete nursing screenings for people coming into a facility, and meaningful engagement of participants in group mental health treatment. At the same time, we are identifying common challenges across facilities including failure to provide the required number of timely, confidential mental health treatment hours even when staffing is strong, interdisciplinary treatment team meetings that fail to cover key aspects of required treatment planning content, treatment space availability challenges, some treatment being conducted in settings that are not confidential, and lack of safety plan individualization. Because we have identified these themes, we are beginning to tackle the issues at a systemic level, in addition to making recommendations to institutions to develop responsive actions.

Issues Identified Through CQIT Testing: As is typical with the rollout of a complex new system, we identified a number of problems in the first few months of CQIT testing and the capable and hardworking team managing the CQIT tool has been resolving issues quickly to support future audits. For example, in the first few rounds of testing, the team learned that items with a "not applicable" response were coded in a way that resulted in errors, so the back-end coding needed to be updated. In a few instances, the questions in the CQIT tool had not been updated to align with the remediated questions for the indicators, so they needed to be corrected to reflect the current standards. Some indicators call for quarterly or annual data and the Guidebook instructions needed to be revised to clarify how to enter the data to cover the full required audit period. We have also identified questions about the reliability of data for a few indicators and have removed some indicators from early reports as we seek to better understand and address the source of the issues. Through rapid updates to the tool, auditing instructions, and process, the full CQIT team has shown flexibility, grace, and a positive, problem-solving approach to the work. Ms. Fox is the OCR lead for addressing issues that emerge related to CQIT implementation and the KPIs.

14. Complete Development of User-Friendly CQIT Dashboards to Monitor Compliance

Now that so much of the data used to assess institution compliance is automated, information is available to facilities about their performance year-round. Currently, the information is available to facilities through an intranet site and staff can access that site and review compliance with each automated indicator at any time. The Receiver is committed to making this data highly visible and easy-to-use to promote regular, data informed decision-making by institutional leadership and staff at the facilities. Action Plan, Action 5.1.3, ECF No. 8722 at 25. ("In order to ensure that the quality assurance/improvement program is durable, clinicians, the parties, and the Receiver need easy-to-use data dashboards."). Because the institutional CEOs and staff are familiar with dashboards that are already in place to track compliance with medical care metrics, the Receiver is working with CCHCS to build reporting on 25 key mental health compliance metrics into those dashboards. This project will provide institutional staff and leadership with data on their medical and mental health care compliance in a single dashboard. We anticipate that this is a first step toward showing mental health and medical data on the same dashboards to enable institutions to adopt a "whole patient" approach to healthcare. We expect the initial mental health indicators to be added to the medical dashboards during the coming quarter.

15. Implement a New Process to Guide Institutions Through the Pre- and Post-Field Monitoring Process

Before the availability of automated data related to the indicators and the deployment of CQIT, institutions invested significant time and resources into preparing for monitoring visits. After the visits, reports typically were not available to document the findings for a number of months and there was not clear set of expectations for responding to report findings when the

reports were ultimately released. The Receiver committed to develop new processes for preparing for audits and responding to the findings that result. Action Plan, Action 5.2.2, ECF No. 8722 at 26.

The availability of automated data that is pulled for the RCT by central office staff has significantly reduced the burden on facilities in the lead up to audits. There is now a small set of documents that the institution is required to upload into a SharePoint folder for the RCT to review in advance of the visit. No paper documents or binders are produced in advance. The remaining information is compiled by central office staff using the automated data. Feedback from the institutions about this change has been positive, as one would expect.

The Receiver has also set clear expectations for responding to audit findings after the release of the report. Institutional leadership is now 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. Facility leadership is then responsible for implementing their responsive plans and certifying their completion. Throughout this process, the OCR is actively involved in reviewing plans and tracking implementation and are developing a process to confirm that recommendations have been implemented in a way that achieves compliance and that institutions maintain compliance in those areas. All of these actions are designed to ensure that these reviews drive measurable changes, rather than producing reports that go unread.

Not only is the OCR involved in assessing institutional actions to come into compliance in response to the audits, but OCR staff are regularly engaging with facility leadership and visiting institutions to help develop solutions to challenges throughout the year. For example, Mr.Williams, Senior Advisor for Custody, regularly tours institutions and meets with leadership

to identify challenges impacting MHSDS and recommend potential solutions to the Receiver and her deputies.

B. Execution of Court-Ordered Responsibilities

1. Assessment of Inpatient (PIP) bed licenses

The Court directed the Receiver to make a recommendation regarding the potential suspension of licenses for inpatient beds at two facilities. ECF No. 8752 at 24. The Receiver's Mental Health Senior Advisor is now leading a review of bed utilization and referrals. Dr. Delgado is developing a program evaluation with the goal of assessing whether patients are being treated at the correct level of care and identifying interventions to address any systemic issues that are identified.[5] This multi-modal, evidence-based approach will include chart reviews, semi-structured interviews with staff and patients, CDCR and MHSDS population trend analyses, and a literature review. This assessment will inform the Receiver's ultimate recommendation regarding whether to suspend any further PIP bed licenses, as Defendants had proposed, in light of projected bed need.

2. Coordination with and Auditing of DSH

The Receiver and her team are engaged in ongoing discussions with DSH about updates to the memorandum of agreement and related policies that facilitate admission and treatment of patients at DSH. ECF No. 8829 at 15-16. Several members of the OCR, including Ms. Fox, Dr. Delgado, and Mr. Williams are working on this project with the goal of finalizing the documents in the coming months.

The court also authorized the Receiver to "audit all aspects of treatment of Coleman class members in DSH, including their admission, mental health treatment, discharge, and transfer

[5] This review will also inform the Receiver about the appropriateness of placements in EOP, an issue that the Parties discussed at the recent status conference.

monitoring of DSH" in the Further Amended Order Setting Out Powers and Duties of the Receiver. ECF No. 8843 § II.A. In order to help develop the auditing plan, members of the OCR visited one DSH facility this quarter and will visit another in June. To inform the plan, the OCR also reviewed recent DSH quality improvement reports and intends to build on the data that DSH gathers for its internal quality assurance work to support an efficient auditing process. The Receiver expects to finalize her DSH auditing plan in the coming quarter.

3. Coordination with Institutions to Spend Fines Money

In August 2024, the Court approved the Parties' plan for the expenditure of staff contempt fines and ordered Defendants to implement the plan. ECF No. 8831 at 7. In addition to staff bonuses, this plan allocates budgets for all prisons providing mental health treatment to purchase supplies (e.g., materials for group and recreational therapy) and items to improve working conditions (e.g., furniture, improvements to treatment and office spaces). *Id.* at 8-16. During this quarter, representatives of OCR and CCHCS worked with institutional leadership to communicate the amounts of unexpended funds for each institution (overall, about half of the fine money remains) and to provide guidance on the types of items that would be approved. A February memo notified each institution of their remaining funds and listed approved items, such as office furniture and supplies, soundproofing devices, group room presentation equipment, and various recreational therapy supplies. During site visits, the Receiver and her team have heard positive feedback about how fines expenditures are benefitting patient programs and staff morale. The Receiver will continue to provide oversight of this process so that the issues identified in the staffing contempt proceedings can continue to be addressed.

4. Submission of Annual Budget for 2026/2027

Consistent with the Order setting out the powers and duties of the Receiver, which requires that the Receiver "establish a budget for the Office of Receiver for each subsequent year

of operation, with each such budget due ninety days in advance of each budget year and included in the quarterly report" ECF 8765 at 7, the Receiver submits her proposed budget for the Office of the Receiver for FY 2026-2027 as Attachment C.

The proposed budget assumes the following:

OCR Employees. The Receiver will hire up to two new employees to provide research and analysis to support Action Plan implementation, assist with a range of projects currently underway, and work with Amend to oversee the implementation of the Resource Teams once they are funded.

The Receiver also plans to increase the duties and salary for our executive assistant. Since her appointment, the OCR has assumed responsibility for all aspects of field auditing/monitoring, including scheduling and coordinating logistics for three to four field audits per month. This, as well as the natural progression of the Receivership, has led to an increased demand for executive assistance.

The Receiver does not anticipate any other changes to the OCR team during fiscal year 2026/2027. All salaries for OCR employees will remain at the level approved by the court, and are at or below levels proposed in the Action Plan.

External Experts for RCT. The Receiver plans to retain four additional mental health subject matter experts to participate in field audits and provide input and advice on clinical and operational issues. Given the number of field audits required in 2026 as well as the accelerated pace for issuing reports, the Receiver needs to ensure that OCR has sufficient experts in psychiatry and psychology to cover the audits and other oversight activities. These mental health experts will be compensated at the $380 hourly rate previously approved by the court for subject matter experts and will work on a part-time, as needed, basis.

Consultants. The Receiver will retain consultants to provide advice on communications

strategy and analyze the amount of time that mental health clinicians spend on non-clinical activities. These will be time-limited contracts with specific deliverables that will support Action Plan implementation. The hourly rates for these consultants will be at or below those approved by the court in the Action Plan. The proposed budget also includes the estimated cost of the Amend contract, which will be needed for Resource Teams.

Travel. All projected travel expenses for OCR employees and external RCT members are included in the proposed budget. Travel for RCT experts is in addition to the amounts included in the Action Plan because OCR has taken over all duties previously assigned to OSM.

Legal and Financial Services. The proposed budget includes costs for legal and financial services, including payroll processing, auditing, compliance with legal requirements pertaining to California public benefit corporations, and employment issues.

The Receiver requests that the court approve the 2026/2027 budget and issue an order clarifying that she be allowed to operate without the need for Court approval as to specific hiring and salary decisions so long as the operation remains within the scope of the Court-approved annual budget. While this would represent a change from past practices in this case, it will support the Receiver's ability to move as quickly as possible to address outstanding issues and implement the Action Plan.

IV. Challenges to the Receiver's Execution of Powers and Duties

At this time, the Receiver does not have specific challenges to raise with the Court but will identify challenges in future quarterly reports as they emerge.

V. Expenditures

On March 16, 2026, the Court authorized the Receiver to use accumulated fines in the Special Deposit Fund to fund the Office of the Receiver through January 2027. The Court approved expenditures that include, but are not limited to, salaries, consulting fees, the costs of

supplies, equipment, office space, transportation, and travel.

1. Revenues

For the months of January and February 2026, monthly salaries were paid directly to the Receiver and her staff. Following the court order directing the State of California to transfer from the Mental Health Special Deposit Fund to the Receiver's Office Fund, the Receiver requested $2,000,000 be deposited for ongoing office expenses. Total year-to-date revenue since the September 2025 appointment of the Receiver from the State of California is $3,744,040.

2. Expenses

The expenditure summary for the second quarterly report covers January through March 2026. April expenses will not be fully realized until after the submission of this report, so will be included in the next Quarterly Report. The total operating expenses of the Office of the Receiver for this period were $1,708,511, detailed in Attachment D.

Attachment A

Overview of Office of the Coleman Receiver

Since September 2025, Receiver Colette Peters has hired the following individuals to work with her and Deputy Receivers Bill Lothrop and Kathy Toomey to implement the court-ordered and court-approved remedies in the Coleman case.

Alyssa Challenger, Chief of Staff

Alyssa Challenger was appointed as a Special Advisor/Chief of Staff on September 30, 2025. Prior to joining the team, she served as a Senior Advisor in the Office of the Director at the Federal Bureau of Prisons, where she oversaw the agency-wide policy development and approval process, Congressional appropriations, and the expansion of programming.

Deena Fox, Attorney Advisor

Deena Fox was appointed as an Attorney Advisor on December 8, 2025. Prior to joining the team, she served as a Deputy Chief in the Civil Rights Division of the U.S. Department of Justice, where she led statewide investigations, litigation, and implementation of remedies involving corrections, juvenile justice, and behavioral-health systems.

Laura Cowall, Attorney Advisor

Laura Cowall was appointed as an Attorney Advisor on December 8, 2025. Prior to joining the team, she served as a Deputy Chief in the Civil Rights Division of the U.S. Department of Justice, where she supervised investigations, litigation, and implementation of remedies in complex cases involving prisons, jails, juvenile justice facilities, and police departments.

Jason Williams, Senior Advisor, Custody

Jason Williams was appointed as a Senior Advisor for Custody and Operations on December 19, 2025. Prior to joining the team, he had recently retired from his position as the Director of Corrections Services within California Correctional Health Care Services, where he oversaw Health Care Placement Oversight Program (population and bed management),Compliance and Reporting Unit, Health Care Facility Support, Accreditation and Licensing Compliance Unit, and Field Operations.

Gary Ninman, Senior Advisor, Quality Assurance

Gary Ninman was appointed as a Senior Advisor for Quality Assurance on January 22, 2026. Prior to joining the team, he served as the Inspector General for the Oregon Department of Corrections, where he led statewide oversight, internal audits, investigations, intelligence operations, and correctional health care accountability.

Laura Harvick, Senior Advisor, Staffing

Laura Harvick was appointed as a Senior Advisor for staffing on January 22, 2026. Prior to joining the team, she had recently retired from her position as an Assistant Deputy Director of

Human Resources with the California Correctional Health Care Services, where she oversaw recruitment, hiring, policy, and activation support within the three HR regions.

Darci Delgado, Senior Advisor, Mental Health

Darci Delgado was appointed as a Senior Advisor for Mental Health on March 18, 2026. Prior to joining the team, she served as an Assistant Secretary with the California Health and Human Services Agency, and prior to that as a Psychologist with the Department of State Hospitals, where she provided clinical care to *Coleman* class members.

Michelle Ryan, Executive Assistant

Michelle Ryan was appointed as an Executive Assistant in the Office of the Receiver on October 24, 2025. Prior to joining the team, she served as an Executive Assistant in the Office of the Director in the Federal Bureau of Prisons, where she oversaw operations and led administrative support staff.

Attachment B

Executive Summary

Correctional Training Facility (CTF) is a large, medium-security institution that provides Correctional Clinical Case Management System (CCCMS) level of care to a growing mental health population, 836 patients at the start of the review period, 937 at the time of the site visit. Within CTF there are two operational units, Central and North. CTF does not operate an onsite Mental Health Crisis Bed (MHCB) unit.

CTF's institutional strengths are notable. Clinical staffing is among the strongest in the state, psychiatry is at 96% capacity, non-supervisory clinical positions are at or above 90%, and the entire mental health program is staffed with onsite personnel; the facility does not rely on telemental health for daytime operations. The Mental Health Referral Chronos (CDCR 128-MH5) were available across all housing units and custody staff demonstrated consistent awareness of referral responsibilities. Appointment completion rates are at 100%, custody-driven cancellations are near zero, and timely MHCB transfers averaged 95% despite the logistical complexity of external transport. Emergency response infrastructure is strong, all housing units had compliant cut-down kits, all officers carried CPR mouth shields, and all RHU intake cells were suicide-resistant. The RHU consistently emerged as an area of operational strength across multiple audit domains. Treatment team members were observed to be empathic, patient-focused, and responsive to patient concerns, and patients who attended IDTTs reported feeling listened to by their providers. CTF's emphasis on continuity of care through team-based assignments when primary clinicians are unavailable reflects thoughtful program design.

The deficiencies documented are not driven by resource scarcity. With adequate staffing, strong custody cooperation, and an institutional culture that values patient engagement, the barriers to compliance are primarily procedural, clinical-quality, and environmental. The six priority recommendations below target the areas where the gap between institutional capacity and actual performance is widest and where patient safety, constitutional adequacy, or both are at stake.

Priority Recommendations

1. **Conduct Immediate Retrospective Review of Mood Stabilizer and Antipsychotic Diagnostic Monitoring and Implement Prospective Safety Tracking**. These medications have narrow therapeutic indices where missed monitoring can result in toxicity, organ damage, or subtherapeutic dosing. Depakote therapeutic level monitoring was at 0% for three consecutive months; lithium level and EKG monitoring showed similar gaps. The Chief Psychiatrist should conduct a retrospective review of all patients prescribed mood stabilizers during the reporting period to confirm required labs have been completed or are now scheduled, identify the root cause of the monitoring gap (ordering failure, lab completion failure, or documentation error), and implement a prospective tracking system (whether through standing lab order review, automated Electronic Health Records System (EHRS) reminders, or a manual monitoring calendar) to prevent recurrence. Extend this review to the antipsychotic metabolic monitoring measures showing significant variability (blood sugar 60–100%, lipids 33–100%, thyroid as low as 33%). Demonstrate sustained compliance at or above 90% across all diagnostic monitoring measures within six months.
2. **Improve RVR-MHA Clinical Quality and Documentation**. Of 228 Rules Violation Report-Mental Health Assessments (RVR-MHA) completed for MHSDS patients during the reporting period, only one recommended alternative discipline or mitigation, a rate below 1%. Documentation met requirements 0% of the time. Onsite leadership should conduct a retrospective clinical review of a representative sample (minimum 20 cases) to determine whether clinicians are conducting individualized assessments or completing the form by rote, interview clinicians to identify barriers to recommending mitigation, and provide written clinical guidance with case examples (after removing all identifying information).

3. **Address Suicide Prevention Clinical Process Deficits: Safety Planning Quality, Timely Clinical Follow-Up, and SRE Mentoring Completion**. Two HQ Suicide Prevention and Response Focus Improvement Team (SPRFIT) corrective action plans have been assigned for safety planning deficiencies. Timely clinical follow-ups after MHCB discharge declined to 0% in the final two months of the reporting period. These findings converge on the clinical processes most directly responsible for preventing suicide in a population with established risk, and they are failing at the moments of highest risk (post-crisis discharge, transition from acute to routine care). The CMH or designee should respond to both CAPs within the 45-day deadline, implement the required random sample audits and monthly SPRFIT committee reporting, and ensure all current safety plans are individualized to the patient's specific risk factors. Clinical supervisors should identify and resolve the specific barrier causing the 0% follow-up compliance trend. Reconcile the Suicide Risk Evaluation (SRE) mentoring data discrepancy and achieve mentoring completion at or above 90%.
4. **Implement a Structured IDTT Quality Improvement Initiative**. Interdisciplinary Treatment Team (IDTT) required staffing averaged 31% over six months with no improvement trend. None of the eight IDTTs observed across three settings met all quality criteria. The most frequent deficiencies (absent case formulation, no measurable treatment goals, no level-of-care discussion, no RVR review, and limited MHMD engagement) are not staffing problems; they are clinical practice and supervision problems. Clinical supervisors should develop and distribute a standardized IDTT checklist aligned with the audit criteria, conduct regular supervisory observations of IDTTs using the checklist, and provide direct feedback to treatment teams. Address the specific barrier preventing MHMD attendance at IDTTs (which is a scheduling or expectations issue given 96% psychiatry staffing). Pre-release planning documentation (3% six-month average) should be integrated into this initiative through a prospective tracking mechanism that identifies patients approaching release. Achieve IDTT required staffing at or above 75% and demonstrate measurable improvement in observed IDTT quality within six months.
5. **Establish Facility-Wide Language Access Compliance for All Mental Health Contacts**. The audit identified a systemic pattern of inadequate language access across IDTTs, ICC hearings, and PT rounds. Certified interpreters were not utilized for Spanish-speaking patients in clinical encounters where staff served as informal interpreters, resulting in incomplete translation of both patient statements and team discussions. This is not an isolated finding in one program area, it is a facility-wide pattern that affects the constitutional adequacy of treatment delivery, the validity of clinical assessments, and patients' ability to participate meaningfully in decisions about their care, housing, and discipline. Institutional leadership should identify all limited-English-proficient (LEP) patients in the current MHSDS population, confirm certified interpreter services (telephonic or in-person) are available and accessible for all clinical contact types, and issue clear written guidance that staff interpretation without certification does not satisfy the effective communication requirement. Include language access compliance as a standing element in supervisory observations of IDTTs, ICCs, and PT rounds.
6. **Develop and Begin Executing a Treatment Space Remediation Plan**. Treatment space adequacy is the most significant environmental deficiency. Auditors found that few spaces met audit criteria, with 0% for group spaces, 33% for IDTT spaces, and 38% for individual treatment spaces. The primary driver for these low ratings is a ventilation-confidentiality tradeoff created by physical plant limitations, staff must choose between adequate airflow and treatment privacy. Institutional leadership, in coordination with Plant Operations, should conduct a systematic assessment of all mental health treatment spaces, identify which can be remediated through HVAC modification or reconfiguration versus those requiring capital improvement, and submit a Mental Health Expenditure Request for spaces requiring infrastructure work. Implement interim measures for the highest-volume treatment spaces (sealed-window ventilation, relocation to compliant spaces) and complete remediation of at least the most frequently used individual treatment spaces and both IDTT rooms within six months.

Executive Summary

Kern Valley State Prison (KVSP) is a Level IV, 180-degree design institution located in Kern County. It operates four Level IV Mainline (ML) facilities, a Minimum Support Facility, two freestanding Restricted Housing Units, and a 12-bed Mental Health Crisis Bed (MHCB) unit. KVSP provides treatment to approximately 1,757 MHSDS patients across a Non-Designated Mainline Enhanced Outpatient Program (EOP) with 288 beds, a designated Restrictive Housing Unit (RHU) CCCMS with capacity for 128 patients, and approximately 1,300 ML CCCMS patients. KVSP does not operate a designated RHU EOP program; patients requiring this level of care must be transferred to hub institutions.

Institutional strengths are concentrated in custody operations, emergency preparedness, and the MHCB admission process. All custody staff completed Use of Force training (100%) and suicide prevention training (100%). CPR mouth shields were carried by all officers observed. Cut-down kits were complete and standardized across all housing units. Heat Plan compliance has improved since the last quarterly custody review. Custody staff demonstrated awareness of mental health referral procedures across all yards, and 128-MH5 referral forms were available in all housing units. Timely Transfer to MHCB averaged 90%, with the Suicide Prevention and Response Focus Improvement Team (SPRFIT) Review independently confirming 99% admission within 24 hours (N=195). Custody and Mental Health Partnership Plan (CMHPP) executive leadership rounding was completed at 100% and supervisory program tours met all requirements.

Clinical strengths were observed in specific program areas. Psychiatric Technician rounds in the RHU were described as excellent by the audit team, with real-time documentation, patient engagement, and confidentiality. The RHU CCCMS group treatment program demonstrated skilled facilitation and active patient participation. The START NOW[1] group in the ML EOP featured robust therapeutic process work. The MHCB admission process functions efficiently despite high referral volume. Chapel spaces on B, C, and D yards provide confidential, adequate group treatment environments for the ML CCCMS population.

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 group treatment space in the ML EOP, the statewide RHU EOP bed shortage, and onsite clinician vacancies, cannot be resolved through institutional corrective action alone, these are systemwide. The operational barriers (an average of ten daily lockup orders halting programming in affected yards, a 22% custody-driven cancellation rate for mental health appointments, a jumpsuit shortage in the RHU, and medical assistant redirection from telehealth support are within institutional control and can be addressed with local institutional leadership and adequate resources allocation. The clinical-quality deficits, including safety plan individualization, Suicide Risk Evaluation (SRE) documentation accuracy, Interdisciplinary Treatment Team (IDTT) case formulation, and Higher Level of Care (HLOC) non-referral documentation, 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 six priority recommendations below are organized by urgency and target the areas where patient safety, treatment adequacy, or both are at stake.

[1] START NOW is a structured, skills-based group psychotherapy program developed for use in correctional settings. Drawing on CBT and DBT principles, it was designed to address the high prevalence of personality disorders, impulse dysregulation, and co-occurring mental health conditions among incarcerated individuals.

Priority Recommendations

1. **Address Suicide Prevention Clinical Process Deficits: Safety Plan Quality, Suicide Risk Evaluation (SRE) Documentation, and MHCB Issue-and-Observation Order Justification.** Of fifteen safety plans reviewed for rescinded MHCB referrals, fourteen were not individualized and relied on stock phrasing. None included patient participation. Of eight MHCB patients reviewed for daily justification of issue and observation orders, only one had adequate documentation for all days on suicide precaution status. Two onsite SRE assessments observed by auditors were inconsistent with the subsequent completed documentation: the clinician did not ask about current suicidal ideation, but denial of ideation was documented. Overall SRE compliance declined from 95% to 73%. Supervisory review of discharge safety plans was completed timely for only 42% of discharges. One HQ SPRFIT corrective action plan remains open for safety planning quality; one new CAP has been assigned for MHCB issue-and-observation order documentation.

   Provide refresher safety planning training to all clinical staff, with mandatory participation for clinicians assigned to emergent referrals. Direct the MHCB program supervisor to review daily justifications for all patients' Issue and Observation Orders prior to discharge and provide real-time training as needed. Initiate monthly supervisory review of ten safety plans for rescinded MHCB referrals, with individual mentoring for inadequate plans. Respond to the two open HQ SPRFIT CAPs within established deadlines.

2. **Conduct a Comprehensive Treatment Space Assessment and Maximize Available Treatment Hours Across All Levels of Care.** KVSP's treatment space limitations affect multiple program areas documented throughout this report: the ML EOP cannot schedule the required minimum of ten hours per week of structured treatment (see Treatment Offered); individual treatment spaces in ML CCCMS and RHU CCCMS have confidentiality and safety deficiencies (see Confidential and Effective Communication; Facility and Environment of Care); and overflow populations in B1 and GP RHU have no access to structured treatment programming (see RHU: Out-of-Cell Activities/Care).

   These findings originate in different sections but share a common root: the institution does not have a current, documented accounting of what its existing physical plant can support. Without that accounting, neither the institution nor the Receiver can distinguish between deficiencies that are remediable through better utilization of existing space and deficiencies that require infrastructure the institution does not have.

   Accordingly, KVSP needs to conduct a facility-wide treatment space assessment covering every space used or potentially usable for individual contacts, IDTT meetings, and group treatment across all levels of care and housing designations, including ML EOP, ML CCCMS, RHU CCCMS, RHU GP, B1 overflow, and the MHCB. For each space, document its current use, usable hours for mental health activities per week, compliance status against each CQIT audit criterion (confidentiality, safety, size, ventilation, temperature), shared-use conflicts, and remediable deficiencies. The Receiver's Compliance Team collected detailed space-by-space data during the March 2026 onsite audit; the institution should request this data from the Regional Mental Health Administrator and use it as the foundation for the assessment rather than duplicating the work.

   Upon completion of the assessment, calculate the maximum schedulable treatment hours per week for each program at full utilization of all qualifying spaces. Compare the result against the current patient population and the applicable Program Guide treatment hour minimums. Immediately implement any changes that increase or improve treatment capacity without capital investment (including resolving scheduling conflicts between group sessions and yard time, ensuring groups run for their full scheduled duration, reconfiguring furniture in offices with egress safety concerns, and applying sound-masking or visual barrier modifications to spaces with remediable confidentiality deficiencies). Track average weekly treatment hours offered per patient monthly and demonstrate upward movement.

Structural Issue: If the completed assessment confirms that KVSP's existing physical plant cannot support the required treatment volume for its current population even at maximum utilization (which preliminary data suggests may be the case for some programs) the Receiver will evaluate options including capital investment, population adjustment, program redesign, or other remedies that are outside institutional control. The institution's completed space assessment, with supporting data, is a prerequisite for this evaluation.

3. **Resolve Barriers to Timely MHMD and MHPC Contacts.** Timely MHMD contacts averaged 63% despite 91% psychiatrist staffing, indicating a scheduling workflow problem. Timely MHPC contacts averaged 73% against a 75% fill rate that includes telehealth providers with functional limitations. Critical medication non-adherence response was at 14% and non-critical at 26%, with the non-critical rate declining from 34% to 10% over the reporting period.

   Conduct a scheduling workflow assessment to identify root causes of below-threshold contact rates. Implement revised scheduling protocols, including clarified procedures for appointment resolution and elimination of scheduling backlogs.

4. **Improve IDTT Quality & Required Staffing.** IDTTs had required attendees present 44% of the time. Only 29% of observed IDTTs demonstrated an interactive process. HQ sustainable process review showed 27% compliance with HLOC non-referral documentation, declining for five consecutive quarters. Staff demonstrated limited foundational clinical skills in case formulation, with treatment planning lacking clear linkage between mental health symptoms, functional impairments, and diagnosis.

   Develop and implement a structured IDTT quality improvement plan including a standardized checklist, supervisory observation, direct feedback, and training on case formulation, treatment goal development, and level-of-care decision-making. Integrate HLOC documentation improvement into this initiative. Address barriers to primary clinician attendance in IDTT by reviewing provider assignment and scheduling practices.

5. **Address Security Welfare Check Deficiencies in Restricted Housing.** Onsite observation identified staff completing welfare checks through partially covered windows and blacked-out cells and accepting verbal confirmations in lieu of visual observation of living, breathing individuals. B1 overflow welfare check intervals were not staggered as required. Guard One electronic logs in RHU 1 and 2 showed 91% and 88% compliance on timing, but timing compliance without observational quality does not fulfill the clinical safety purpose of the check.

   Retrain all RHU staff on welfare check requirements, emphasizing that each check requires direct visual confirmation of a living, breathing individual free from obvious injury. Initiate weekly supervisory audits of welfare check quality across all RHU settings, including B1 overflow.

6. **Conduct a Retrospective Review of Mood Stabilizer and Antipsychotic Diagnostic Monitoring and Implement Prospective Safety Tracking.** Valproic acid therapeutic level monitoring averaged 46%. CBC and CMP monitoring for valproic acid averaged 53% and 51% respectively. Lithium CMP monitoring averaged 64%. These medications have narrow therapeutic indices where missed monitoring can result in toxicity, organ damage, or subtherapeutic dosing. Antipsychotic metabolic monitoring showed sustained deficits: lipid monitoring 62%, blood sugar 73%, thyroid 73%. Ensure staff are aware of MPAIP monitoring timelines.

   Conduct a retrospective review of all patients prescribed mood stabilizers (valproic acid, lithium, carbamazepine, oxcarbazepine) during the reporting period to confirm that required laboratory monitoring has been completed or is now scheduled. Identify and address the root cause of the monitoring gap. Implement a prospective tracking system for mood stabilizer lab monitoring. Extend the review to antipsychotic metabolic monitoring measures showing sustained deficits. Provide MAPIP training on updated monitoring timelines for all prescribing staff.

Attachment C

CALIFORNIA CORRECTIONAL MENTAL HEALTHCARE RECEIVER CORPORATION
Unaudited Statement of Revenues and Expenditures
January 2026 - March 2026

	Budget	Actuals	Difference Between Budget and Actuals
Revenues			
Mental Healthcare Special Deposit Fund	2,929,798	2,929,798	-
Investment Earnings	-	-	-
Miscellaneous Income	-	-	-
Total Revenues	2,929,798	2,929,798	-
Expenditures			
Prison mental healthcare administration and oversight:			
Salaries	1,277,065	1,277,065	-
Legal and professional services	-	-	-
Reimbursable costs	68,270	68,270	-
Office expenses	33,880	33,880	-
Contractor Costs	329,296	329,296	-
Other	-	-	-
Capital outlay	-	-	-
Total Expenditures	1,708,511	1,708,511	-
Available Balance	1,221,288	1,221,288	

CALIFORNIA CORRECTIONAL MENTAL HEALTHCARE RECEIVER CORPORATION
Unaudited Statement of Revenues and Expenditures
January 2026

	Budget	Actuals	Difference Between Budget and Actuals
Revenues			
Mental Healthcare Special Deposit Fund	360,134	360,134	-
General Fund	-	-	-
Investment Earnings	-	-	-
Miscellaneous Income	-	-	-
Total Revenues	360,134	360,134	-
Expenditures			
Prison mental healthcare administration and oversight:			
Salaries	341,054	341,054	-
Legal and professional services	-	-	-
Reimburseable costs	16,838	16,838	-
Office expenses	-	-	-
Insurance	-	-	-
Contractor Cost	2,242	2,242	-
Other	-	-	-
Capital outlay	-	-	-
Total Expenditures	360,134	360,134	-
Available Balance	-	-	-

CALIFORNIA CORRECTIONAL MENTAL HEALTHCARE RECEIVER CORPORATION
Unaudited Statement of Revenues and Expenditures
February 2026

	Budget	Actuals	Difference Between Budget and Actuals
Revenues			
Mental Healthcare Special Deposit Fund	569,664	569,664	-
General Fund	-	-	-
Investment Earnings	-	-	-
Miscellaneous Income	-	-	-
Total Revenues	569,664	569,664	-
Expenditures			
Prison mental healthcare administration and oversight:			
Salaries	441,817	441,817	-
Legal and professional services	-	-	-
Reimburseable costs	28,668	28,668	-
Office expenses	-	-	-
Insurance	-	-	-
Contractor Costs	99,179	99,179	-
Other	-	-	-
Capital outlay	-	-	-
Total Expenditures	569,664	569,664	-
Available Balance	-	-	-

CALIFORNIA CORRECTIONAL MENTAL HEALTHCARE RECEIVER CORPORATION
Unaudited Statement of Revenues and Expenditures
March 2026

	Budget	Actuals	Difference Between Budget and Actuals
Revenues			
Mental Healthcare Special Deposit Fund	2,000,000	2,000,000	-
General Fund	-	-	-
Investment Earnings	-	-	-
Miscellaneous Income	-	-	-
Total Revenues	2,000,000	2,000,000	-
Expenditures			
Prison mental healthcare administration and oversight:			
Salaries	494,194	494,194	-
Legal and professional services	-	-	-
Reimbursable Costs	22,763	22,763	-
Office expenses	33,880	33,880	-
Insurance	-	-	-
Contractor Costs	227,875	227,875	-
Other	-	-	-
Capital outlay	-	-	-
Total Expenditures	778,712	778,712	-
Available Balance	1,221,288	1,221,288	-

Attachment D

California Correctional Mental Health Care Receiver Corporation
Actual[1] and Planned Expenses Incurred
July 2026 - June 2027

Employee costs	Jul (estimate)	Aug (estimate)	Sep (estimate)	Oct (estimate)	Nov (estimate)	Dec (estimate)	Jan (estimate)	Feb (estimate)	Mar (estimate)	Apr (estimate)	May (estimate)	Jun (estimate)	YEAR
Salaries	$556,269	$556,269	$556,269	$556,269	$556,269	$556,269	$556,269	$556,269	$556,269	$556,269	$556,269	$556,269	$6,675,225
Reimbursable Costs	$38,541	$38,541	$38,541	$38,541	$38,541	$38,541	$38,541	$38,541	$38,541	$38,541	$38,541	$38,541	$462,491
Subtotal	$594,810	$594,810	$594,810	$594,810	$594,810	$594,810	$594,810	$594,810	$594,810	$594,810	$594,810	$594,810	$7,137,716

Contractor costs	Jul (estimate)	Aug (estimate)	Sep (estimate)	Oct (estimate)	Nov (estimate)	Dec (estimate)	Jan (estimate)	Feb (estimate)	Mar (estimate)	Apr (estimate)	May (estimate)	Jun (estimate)	YEAR
Professional Services	$263,409	$263,409	$263,409	$263,409	$263,409	$263,409	$263,409	$263,409	$263,409	$263,409	$263,409	$263,409	$3,160,903
Reimbursable Costs	$55,614	$55,614	$55,614	$55,614	$55,614	$55,614	$55,614	$55,614	$55,614	$55,614	$55,614	$55,614	$667,368
Subtotal	$319,023	$319,023	$319,023	$319,023	$319,023	$319,023	$319,023	$319,023	$319,023	$319,023	$319,023	$319,023	$3,828,271

Office costs	Jul (estimate)	Aug (estimate)	Sep (estimate)	Oct (estimate)	Nov (estimate)	Dec (estimate)	Jan (estimate)	Feb (estimate)	Mar (estimate)	Apr (estimate)	May (estimate)	Jun (estimate)	YEAR
Operational Costs	$46,069	$46,069	$46,069	$46,069	$46,069	$46,069	$46,069	$46,069	$46,069	$46,069	$46,069	$46,069	$552,828
Legal Services	$0	$0	$0	$0	$10,000	$0	$0	$0	$0	$0	$0	$0	$10,000
Insurance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$60,000	$0	$60,000
Contracted Services	$76,113	$76,113	$76,113	$76,113	$76,113	$76,113	$76,113	$76,113	$76,113	$76,113	$76,113	$76,113	$913,356
Subtotal	$122,182	$122,182	$122,182	$122,182	$132,182	$122,182	$122,182	$122,182	$122,182	$122,182	$182,182	$122,182	$1,536,184

Totals	Jul (estimate)	Aug (estimate)	Sep (estimate)	Oct (estimate)	Nov (estimate)	Dec (estimate)	Jan (estimate)	Feb (estimate)	Mar (estimate)	Apr (estimate)	May (estimate)	Jun (estimate)	YEAR
Monthly planned expenses	$1,036,014	$1,036,014	$1,036,014	$1,036,014	$1,046,014	$1,036,014	$1,036,014	$1,036,014	$1,036,014	$1,036,014	$1,096,014	$1,036,014	$12,502,171
Estimated Cumulative Total	$1,036,014	$2,072,029	$3,108,043	$4,144,057	$5,190,071	$6,226,086	$7,262,100	$8,298,114	$9,334,129	$10,370,143	$11,466,157	$12,502,171	$12,502,171

[1]Acutal expenses based on receipts and invoices submitted as of the date of report submission