Babu v. County of Alameda
Consent Decree
Case No. 5:18-CV-07677

Seventh Status Report

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Miami, Florida

November 7, 2025

This document addresses the provisions of the Consent Decree (CD) assigned to Dr. E. Carolina Montoya for monitoring. The specific provision language is presented followed by this Joint Expert's findings and recommendations. Connected provisions have been combined for this status report. However, several will likely be separated in future reports as the County increases compliance. Additional recommendations may also be added in subsequent reports as information is obtained during implementation. The rating period for this report covers information received and reviewed for the period January 1st through June 30th, 2025. The chart below shows an overview of the specific provisions, utilizing the following codes:

SC **Substantial Compliance**
PC **Partial Compliance**
NC **Non-Compliance**

Summary of Ratings

Provision	Rating
200. Sufficient Mental Health Staff to Comply with Consent Decree	PC
204. Hiring of Additional Mental Health (MH) Staff	PC
205. Training of Third-Party MH Providers	SC
206. Telehealth MH Services	SC
304. Development/implementation of Formal Processes for Administrative Housing	SC
312. Develop Therapeutic Housing Committee	PC
313. Referrals, Placement and Removal from THUs	PC
317. Development/implementation of Step-down Protocols for Therapeutic Housing Units	PC
404. Restrictive Housing Step 1 Population Evaluated Within 14 & 30 Days; SMI Cases Reviewed	PC
406. Assessment of SMI Persons in Step 1 Within 24 Hours of Noted Deterioration	SC
700. Develop and Implement Policies/Procedures with Expert for Provisions	PC
701. Implement Revised Policies/Procedures for Therapeutic and Behavioral Health Services	PC

Provision	Rating
702. Develop a Plan to Implement Therapeutic Housing Units	SC
703. Individuals with SMI to Receive Therapeutic Services	PC
704. MH Staff Communication with Custody Staff	PC
705. Mental Healthcare at Intake	SC
706. “Emergent” MH Condition at Intake	PC
707. “Urgent” MH Condition at Intake	PC
708. “Routine” MH Condition at Intake	PC
709. Requests and Referrals for MH Services Following Intake	PC
710. Initial MH Screening by Qualified Mental Health Professional (QMHP)	PC
711. Intake Database Requirement to Flag Self-Harm Incidents from Prior Incarcerations	SC
713. Timely Verification of Medications for Newly Arriving Inmates	PC
714. MH Intake Interviews and Assessments in Private and Confidential Spaces	PC
715. Pre-booking Screening	SC
716. Implement Quality Assurance Policies and Procedures of Intake	PC
717. Conduct MH Encounters in Confidential Setting, with Consistent Providers of Appropriate Duration	PC
718. Implement Electronic Tracking System for Referrals	PC
719. Develop and Implement Policy Addressing Timeliness of Routine and Emergency MH Referrals	PC
720. Provide Appropriate Training Regarding Psychiatric Referrals	PC
721. Develop and Implement Quality Assurance Policies and Procedures for Periodic Audits	PC
722. Develop and Implement MH Levels of Care	SC
723. Provide that MH Clinicians Offer Clinically Appropriate Encounters	PC
724. Identify Clinically Appropriate Spaces	PC
725. Provide Out-of-Cell Programming for Inmates in Restrictive Housing Units and Therapeutic Housing Units	PC
726. Provide Regular, Consistent Therapy and Counseling	PC
727. Provide In-Cell Activities to Decrease Boredom and Mitigate Isolation	PC
728. Develop Formal Clinical Treatment Teams	PC
729. Develop and Implement Policies/Procedures to Establish Treatment Teams	PC
730. Individualized MH Treatment Plans	PC
731. Develop and Implement Policies/Procedures for Treatment Teams	PC
732. Provide Information in Treatment Teams to Medical Providers	PC
733. Provide Calming and Restorative Instruction	PC
734. Provide Substance Abuse Programs for Co-occurring Disorders	PC
735. Provide Daily MH Rounds	PC

Provision	Rating
736. Offer Weekly Face-to-Face Clinical Contacts	PC
737. Provide Additional Clinical Contacts	PC
738. Ensure Individuals Expressing Suicidal Ideation are Provided MH Evaluation and Care	PC
739. Ensure Psychiatric Medications are Ordered in Timely Manner	PC
740. Maintain an Anti-Psychotic Medication Registry	SC
741. Ensure Health Care Staff Document Medication Refusals	PC
742. Conduct Audits of Patients Receiving Psychotropic Medications	PC
743. Develop a New Suicide Prevention Policy	PC
744. Use of Safety Cell as Last Resort for Suicidal Ideation/Phasing Out of Use	SC
745. Severely Curtail Use of Safety Cells	SC
746. Safety Cells Only Used in Exigent Circumstances	SC
747. Individuals in Safety Cells for Maximum of Eight Hours	SC
748. Adopt Graduated Suicide Precautions	PC
752. Develop Policies/Procedures and Training Regarding Suicide Procedures	PC
753. Continue Ongoing Training Regarding Safety Plans	PC
755. Initiating Suicide Precautions	PC
756. Individuals on Suicide Watch Placed on Close Observation	PC
757. Individuals on Suicide Precautions Continue to Receive Therapeutic Interventions	PC
758. QMHP Shall See Inmates on Suicide Precautions on an Individualized Schedule	NC
759. QMHP Complete and Document Suicide Risk Assessment	PC
762. MH Shall Receive Additional Training on Suicide Risk Assessment	PC
764. Develop and Implement Updated Policies and Practices Regarding Suicide Reviews	PC
766. Develop and Implement Standards for Emergency Referrals and Handling of 5150 Holds	PC
767. Assess and Review Quality of Care Provided to Persons Sent to John George	PC
769. Re-orient How Units, Including the Therapeutic Housing Units, are Managed	PC
770. MH Programming for Women	PC
771. Meet and Confer Within Three Months Regarding the Therapeutic Housing Units	SC
772. Therapeutic Housing Units Sufficiently Staffed	PC
900. Implement Systems to Facilitate Community-Based Services During and After Incarceration	PC
901. Develop a Written Re-entry Plan Prior to Inmate Release	PC
902. Evaluating an Individual's Eligibility for Benefits and Linking to Benefits	PC
903. Cooperate with Providers et al. to Support Individuals Post-Release	PC

Provision	Rating
904. Provide 30-Day Supply of Medications at Release	PC
905. Inform County's Full Service Partnerships of Mutual Clients	PC

Ratings → / Report Date ↓	Non-Compliance (NC)	Partial Compliance (PC)	Substantial Compliance (SC)	Implementation Not Yet Required (INYR)	Total
#1 – July 2022	15	40	0	18	73
#2 –March 2023	11	63	0	0	74
#3 – September 2023	7	65	2	0	74
#4 – April 2024	7	68	3	0	78
#5 – October 2024	4	65	9	0	78
#6 – April 2025	2	64	12	0	78
#7 – November 2025	1	63	15	0	79

The following documents were reviewed and utilized in the preparation of this report and determination of the Provision ratings:

Policies:

- AFBH Bridge Medications
- AFBH Disciplinary Incident Response
- AFBH Effective Communication
- AFBH Identifying and Diagnosing "Severe Mental Illness"
- AFBH Intake Psychiatric Non-Verified Medications Pilot
- AFBH and John George Psychiatric Hospital Client Care Coordination
- AFBH Levels of Care
- AFBH Polypharmacy Antipsychotic Medication Registry and Monitoring
- AFBH Preventing Suicide and Self-Harming Behavior
- AFBH Re-Entry Services for Clients with a Serious Mental Illness
- AFBH Release Psychiatric Medication
- Draft – AFBH Psychiatric Referrals and Appropriate Training
- Draft – Refusals of Prescribed Psychiatric Medications and Compliance Audit Requirements
- AFBH Response to Grievances
- AFBH Santa Rita Jail Intake
- AFBH Santa Rita Jail Referral
- AFBH Telehealth Provider Services
- AFBH Therapeutic Housing Units Protocol
- ACSO Access to Care #13.02
- ACSO Behavioral Health Access Team Post Order #10.30
- ACSO Behavioral Health Clients and Therapeutic Housing Inmates #9.04
- ACSO Crisis Communications for Corrections Training
- ACSO Disciplinary Procedures Policy and Procedure #16.01

- ACSO Inmate Death Policy and Procedure #8.18
- ACSO Inmate Observation and Direct Visual Supervision Policy and Procedure #8.12
- ACSO Intake Deputy Post Orders, Policy and Procedure #10.04
- ACSO Intake Procedures ACSO Policy and Procedure #11.02
- ACSO Safety Cells, Temporary Holding Cells, and Multipurpose Rooms Policy and Procedure #8.1
- ACSO Scope of Intake, Classification and Medical Screening Procedures Policy and Procedure #11.4
- ACSO Suicide Prevention and Suicide Reviews #13.06

Reports:

- AFBH Antipsychotic Polypharmacy Report
- AFBH BIA QA Monthly Review
- AFBH Bi-weekly Level of Care Reports
- AFBH Bridge Medications Audits
- AFBH Bridge Medications Log
- AFBH Clients Served by Month, Ethnic Group, and Sex Report
- AFBH Continuity of Care Psychiatric Medications Audits
- AFBH Discharge Medications Report
- AFBH Emergent, Urgent Times Report
- AFBH ITR Call Logs
- AFBH Intakes by Month
- AFBH Intake Times Report
- AFBH Medication Refusal Audit
- AFBH SMI Report
- AFBH Structured Activities Report
- ACSO BHAT Deputy Running Log
- ACSO BHAT Groups
- ACSO SRJ ATIMS Medical-Notes Report
- ACSO SRJ Population 2024
- Lifelong Groups
- Telecare Groups

Other:

- AFBH Brief Initial Assessment (BIA) Tool
- AFBH Case Record Reviews of Current Caseload (N=75) AFBH case records from Clinician's Gateway (CG), AFBH's electronic health record (EHR), were reviewed for the period January 1st through June 30th, 2025. The case records included persons with Levels of Care (LOC) 1 through 4. The records were reviewed for content and quality of information. Records include: intake assessments (BIA), LOC documents, clinical casenotes, psychiatric medication assessments and casenotes, and discharge/re-entry casenotes.
- AFBH Client Re-Entry Plan
- AFBH Comprehensive Behavioral Health Assessment
- AFBH ITR Training Checklist
- AFBH ITR Activity Log
- AFBH Leadership Structure-SRJ (Table of Organization)
- AFBH Post-Release Instructions Form

- AFBH Restrictive Housing Committee Meeting Documentation
- AFBH Restrictive Housing Suitability Review Forms
- AFBH SRJ Staff Assignments (Schedule)
- AFBH SRJ Suicide Prevention Meeting Documentation
- AFBH Suicide Prevention Safety Plan
- AFBH Therapeutic Housing Committee Meeting Documentation
- AFBH Telehealth Psychiatrist Daily Activity Log- Dr. Yun
- AFBH THU Master Schedule
- AFBH Treatment Plan
- ACSO Intake/Receiving Medical Review Form (Wellpath)
- ACSO Restraint Chair Logs
- ACBH/SRJ Staffing Updates
- ACSO SRJ Construction Projects Update

FINDINGS

200. Defendants shall maintain sufficient mental health and custody staff to meet the requirements of this Consent Decree, including maintaining sufficient mental health clinical staffing to provide for adequate 24-hour coverage, seven days a week, and sufficient custodial staff to ensure that programing, recreation, transportation and movement, out-of-cell and outdoor time and all other jail functions can proceed safely. To the extent possible, Custody staff assigned to positions where mental health training is required, including staff assigned to the Therapeutic Housing Units, shall be strongly encouraged to serve in these roles for at least three years to provide for consistency and to maximize the benefit of the training and expertise of the staff assigned to these areas.

204. The Parties agree that staffing for mental health services must be increased. The Board of Supervisors has authorized AFBH to hire an additional one hundred seven (107) employees for the Jail over three (3) fiscal years. Pursuant to this authorization, AFBH intends to hire an additional twenty-seven (27) positions for fiscal year (FY) 2020-2021, an additional forty-two (42) positions for FY 2021-2022, and an additional thirty-eight (38) AFBH positions for a total number of one hundred sixty-one (161) authorized positions by FY 2022-2023. AFBH has also created a new Forensic and Diversion Services Director (Forensic Director) position. The Forensic Director position is a system level director position overseeing all services in detention centers and forensic outpatient programs. In this role, the Forensic Director shall be the overall leader of AFBH incarcerated personnel and mental health contractors at the Jail. Defendants shall ensure that any third-party mental health providers are trained in all aspects of pertinent AFBH policies and procedures including those outlined by this Consent Decree and shall oversee and monitor third-party vendor services. Third-party vendors shall provide clinically appropriate services and shall maximize confidentiality.

Finding: Partial Compliance

Policies: N/A

Training: N/A

Metrics: Interviews with Staff, AFBH Leadership Structure-SRJ (Table of Organization), AFBH SRJ Staff Assignments (Schedule), ACBH/SRJ Staffing Updates, ACSO BHAT Groups Report, ACSO BHAT Deputy Running Log

Assessment: The one vacant supervisor position has been filled during this reporting period and the Table of Organization slightly adjusted to increase oversight of clinical services. The vacancy rate in direct clinical positions is 46%, a slight improvement from the last report, reflecting the addition of three clinicians. Prior reports have stated that hiring suitable candidates and onboarding staff, given the national shortage of clinicians and the County's complicated and extensive hiring process, have limited AFBH in meeting this provision. To streamline the hiring process, the County has established an "open" application process for clinical positions that allows interested persons to apply at any time. AFBH has noted that many applicants, while apparently otherwise qualified, are unlicensed. AFBH has decided to add two supervisory positions to increase the supervisory "span of control" and allow the hiring of unlicensed clinicians.

Prior reports have outlined Alameda County Behavioral Health Department's (ACBHD) efforts to attract and retain staff. These efforts have included monetary incentives for new and existing staff and developing new classifications with higher salaries, e.g., the Forensic Mental Health Specialist classification which includes a higher salary for the specialized work environment. Proactive efforts to recruit staff have also continued during this reporting period with outreach efforts at association conferences and meetings with area educational facilities. AFBH has also entered an arrangement with St. Mary's College to support a Masters-level internship program which will place students at the Santa Rita Jail (SRJ). In addition to providing clinical services (under AFBH supervision). It is anticipated that students will continue working at SRJ upon completion of their training.

Additional staffing over the past several reporting periods has resulted in improved availability of clinicians, greater supervisory oversight of services, and the development of a clinical services structure, i.e., the creation of unit Treatment Teams and service teams such as the Re-Entry Team. However, there are still staffing deficits that inhibit AFBH's ability to provide the treatment services required by the Consent Decree (CD) and the required 24 hour/7 day per week presence of clinical staff necessary for adequate mental health assessment and treatment.

As the overall AFBH system of care and the Therapeutic Housing Units (THUs) continue to be established, the total number and type of clinical/direct service positions will need to be regularly reevaluated. The total AFBH caseload and the average number of persons in the various Levels of Care (LOC) require continuous monitoring to determine the number and type of mental health clinical and supervisory personnel necessary to ensure service delivery according to the CD. During this reporting period, it was noted that the monthly AFBH caseload has increased on the average by 100 clients. As such, since the service system is still being developed (e.g., the total number of necessary THUs and deployment of Treatment Teams remains uncertain), the required clinical staffing pattern remains unclear.

Based on the efforts to comply with the CD, AFBH has also identified possible additional staffing requirements (e.g., increased clinical support for incarcerated persons (IPs) with Intellectual and Developmental Disabilities (IDD) and Psychiatric Disabilities, a Quality Assurance Unit, and expanded Re-Entry staffing). AFBH will be reviewing their developing staffing needs in the next reporting period.

A lack of office space for AFBH staff was reported to be a serious concern cited in prior reports. However, during this reporting period, ACSO identified and converted half of Housing Unit (HU) 31 as workspace for AFBH. At the time of the tour, this workspace was nearly completed and will be available for use in July 2025.

ACBHD's contract with Telecare to increase clinical staffing continues and, during this reporting period, Telecare has provided intake assessment services on the overnight shifts. However, AFBH has determined that, in the near future, additional Telecare staff will be shifted to increase clinical services on the Therapeutic Housing Units (THUs) instead of Intake Transfer and Release (ITR) functions, but will continue to provide overnight coverage in ITR.

AFBH continues to rely heavily upon agency, "locum tenens," medical personnel for staff positions that have been difficult to recruit and fill. Ten (10) of the 21 Psychiatric Provider positions are agency personnel. Five (5) of the 21 Psychiatric Provider positions are currently vacant. The locum tenens employees perform at the same level as AFBH staff.

In August 2024, ACSO significantly expanded the Behavioral Health Access Team (BHAT) from four to eight Deputies. BHAT Deputies are assigned to assist AFBH and the behavioral health population. A brief review of the schedules and HU assignments indicate that an average of four BHAT deputies are assigned on weekdays. The BHAT Deputies continue to escort and monitor group activities provided by AFBH as well as those provided by Telecare and Lifelong. While the increase in BHAT Deputies is certainly a significant enhancement, the recommendation that additional BHAT Deputies may be required to support AFBH clinical services as the system of care evolves, remains the same.

The chart below compares BHAT activity between this and the prior report period. While the available reports of BHAT activities (BHAT Groups and BHAT Deputy Running Log) have some notable discrepancies, there appears to be a slight increase in BHAT escorts although lower than expected given the addition of four BHAT Deputies. During this reporting period, BHAT Deputies have also assumed the responsibility of supporting the activities of the AFBH's Early Access to Stabilization Services Program (EASS) and those needed for IDD assessment functions, but data regarding these escorts is incomplete. Support for the additional services may explain the lower than expected number of BHAT escorts shown in available reports.

BHAT Activity/Support for the months of January through June 2025

Month	Completed Escorts	Completed Groups
January	566	168
February	572	176
March	501	158
April	467	125
May	422	119
June	377	117
Current Totals/Averages	2,905/484	863/144
Prior Report Averages	474	126
Increases	**+2%**	**+14%**

Recommendation(s):

1. It is recommended that additional contractual opportunities for clinical services, beyond Telecare and Lifelong, be considered and established to temporarily offset the staff vacancy rate. While contracted services are not preferred to County staff, they will serve to address the ability of the agency to comply with the CD.
2. The AFBH Table of Organization should be updated monthly to closely monitor the position vacancies and review possible changes in structure and position allocation.
3. An ongoing monthly review of the mental health caseload report will permit accurate determination of the type and number of clinical and supervisory staff necessary for the operation of the THUs in accordance with the CD.
4. ACSO should continue to review the current role and deployment of BHAT Deputies as it relates to coverage in THUs and consider whether additional positions need to be established to ensure adequate support for the delivery of mental health services as mental health related services (EASS, IDD assessments) expand.
5. ACSO reports of BHAT activities should be reviewed for accuracy and consistency.
6. AFBH to review their staffing needs based on CD requirements.

205. Defendants shall ensure that any third-party mental health providers are trained in all aspects of pertinent AFBH policies and procedures including those outlined by this Consent Decree and shall oversee and monitor third-party vendor services. Third-party vendors shall provide clinically appropriate services and shall maximize confidentiality.

Finding: Substantial Compliance

Policies: N/A

Training: ITR Training Checklist-AFBH ITR Booth Training-5 Week Milestones, AFBH ITR Runner Training-7 Week Milestones; Ongoing, in accordance with AFBH training

Metrics: Interviews with Staff

Assessment: Substantial Compliance with this provision has been achieved during this rating period. The ACBHD/AFBH contract with Telecare expects that agency clinicians will function equivalent to AFBH clinicians. Reportedly, Telecare staff receive the same onboarding training as AFBH personnel. They are trained to use and enter information (e.g., assessments, casenotes) into the AFBH EHR, the Clinician's Gateway (CG). As modifications have been made to forms such as the Brief Initial Assessment (BIA) Tool and the Level of Care (LOC) documents, Telecare staff have participated in training. Telecare staff also "shadow" AFBH clinicians as new procedures are put in place. New Telecare employees related to the expansion of the Telecare contract are involved in an eight-week "onboarding" training of ITR processes. In addition to the initial training, Telecare employees attend other AFBH training courses when available, and Telecare "Leads" regularly participate in AFBH staff meetings.

Supervision of Telecare staff is a partnership between AFBH and Telecare. While on duty, Telecare clinicians principally report to available Telecare supervisors. However, depending on supervisory coverage, Telecare staff may consult with AFBH supervisors. AFBH Clinical Managers have weekly meetings with Telecare's on-site manager and program manager to discuss operational and staffing issues.

Recommendations:
1. AFBH to continue weekly meetings with Telecare administration.

206. To the extent that Defendants provide telehealth mental health services, meaning the use of electronic information and telecommunications technologies to support long distance clinical health care, including telepsychiatry, Defendants shall ensure effective communication. Defendants shall also ensure that incarcerated persons are provided maximum confidentiality in interactions with telepsychiatry providers, but it is understood that custody staff may need to observe the interaction to ensure safety and security. In such circumstances, custody staff will stand at the greatest distance possible while ensuring safety and security. Defendants shall continue to provide Behavioral Health Clients with access to on-site, in-person clinically appropriate services and any use of telehealth services shall be overseen and supported by on-site AFBH staff.

Finding: Substantial Compliance

Policies: AFBH Telehealth Psychiatric Provider Policy, ACSO Policy and Procedure 10.30 Behavioral Health Access Team (BHAT) Post Order

Training: Completed for relevant staff and ongoing as necessary

Metrics: Observations, Interviews with Staff, Interviews with Incarcerated Persons, AFBH Telehealth Psychiatrist Daily Activity Log-Dr. Yun

Assessment: Substantial Compliance with this provision was achieved during the last reporting period. The AFBH policy regarding telehealth services, approved by ACBHD administration during the last reporting period, describes the straightforward process in detail. AFBH staff persons involved in providing the services have been trained.

Telehealth services are only provided to AFBH LOC 1 and LOC X clients by one (1) Psychiatrist. Telehealth continues to be provided in the AFBH Clinic, in a small, private office. IPs are brought by custody staff to the office at the designated appointment time. Confidentiality is safeguarded to the extent that deputies remain outside the office while the consultations occur. However, an AFBH Medical Assistant (MA) is in the room to facilitate the sessions with the telehealth provider.

In the last report, the utilization of the telehealth services was brought into question. Despite ten IPs scheduled per day of telehealth services (typically a minimum of ten days per month), 42% of appointments were not conducted because the clients refused to meet with the clinician. The recommendation was made that AFBH supervisors/leadership should investigate the reasons for the significant “no show” appointment rate and institute procedural changes as warranted.

For this reporting period, this Joint Expert was provided with the Telehealth Psychiatrist’s Daily Activity Logs for the period January through June 2025. A total of 67 dates of service were reviewed. The Activity Log lists the telehealth appointment schedule for each day and the psychiatrist enters the outcome of the activity. Review of the Logs supports that virtually all clients are LOC 1 (with a few LOC X clients). For this reporting period, 44% (291) of the 648 appointments were not conducted because the clients refused to meet with the clinician. Although Substantial Compliance with this provision is not diminished by this limited utilization, nor the termination of this provision, it does beg to repeat the recommendation that the reasons for refusal be explored in conjunction with the Joint Expert’s monitoring of other provisions. In response to the prior report’s recommendation to assess the significant “no show” rate for telehealth services, AFBH is

considering procedural modifications when IPs fail to keep appointments to determine whether services are no longer desired or warranted.

Where appropriate, clinical documentation of telehealth services was evident in individual IP case records in CG.

Recommendation(s):

1. AFBH Forensic Behavioral Health Clinical Managers should regularly review the Telehealth Daily Activity Logs to ensure compliance with policy.
2. AFBH supervisors/leadership should continue efforts to reduce the significant "no show" appointment rate and institute procedural changes as warranted.

304. Development and implementation of a formal process for the admission, review and release of individuals to and from Administrative Housing, including sufficient due process and transparency to provide the incarcerated person with a written basis for the admission within seventy-two (72) hours, explanation of the process for appealing placement in the unit, conditions of confinement in the unit, an ongoing 30-day review process, and the basis for release to the general population.

Finding: Substantial Compliance

Policies: AFBH Therapeutic Housing Units Protocol, AFBH Levels of Care Policy, AFBH Vetting Restricted Housing Committee Referrals

Training: N/A

Metrics: Observations, Interviews with Staff and Joint Experts, Case Record Reviews, AFBH Restrictive Housing Unit Suitability Review Forms, ACSO Restrictive Housing Committee Decision Forms

Assessment: Substantial Compliance with this provision was achieved during the last reporting period. As explained in prior reports, while the THUs are a form of Specialized Housing, Provision 304's requirement that IPs in THUs be provided with "a written basis for the placement" and a "process of appealing placement" is not appropriate for persons requiring placement in a THU as they are very often unable to participate in these processes due to their decompensated thought processes, volatile emotional state, and risk of harm to themselves or others. The THUs are not administrative segregation and should not be treated as such and the issuance of written notice is more aligned with restrictive housing placements than a clinical setting.

For all IPs on the AFBH caseload being considered for placement in Restrictive Housing, the process as described in the AFBH Vetting Restricted Housing Committee Referrals policy is being implemented. This Joint Expert has attended RH Committee Meetings during four tours and has reviewed minutes of RH Committee Meetings within the report period. Case record reviews have supported that assessments of AFBH clients (placed in the RH Referral Pod of HU 1) pending determination of RH placement are being conducted as required by policy. The AFBH clinical Treatment Team assigned to the RH unit has been trained and are conducting all suitability assessments. The findings of AFBH clinicians and assessment of suitability for placement in RH are being supported in the RH Committee Meetings.

Recommendation(s):

1. AFBH should continue assessing IPs on the AFBH caseload for suitability for placement in RH prior to the scheduled RH Committee meeting and provide their assessment findings.
2. ACSO RH Committee should continue incorporating the clinical findings of AFBH when making RH placement decisions.

312. Development and implementation of a formal process for the admission, review and release of individuals to and from the Therapeutic Housing Units shall include the development of a Therapeutic Housing Committee ("THC"). The THC shall be chaired by an AFBH representative at the supervisory level or higher, and further include a sergeant from the Classification Unit and an ACSO representative from outside the Classification Unit at the sergeant level or higher.

313. Any Staff member may refer an individual to the THC for placement in a Therapeutic Housing Unit. All referrals shall clearly document the reason for referral in writing. After receiving a referral, the THC shall conduct a review to assess the individual's treatment needs and determine the appropriate therapeutic interventions and placement. This review shall include a face-to-face interview with the incarcerated individual and a review of relevant documents. This review shall occur within seven (7) days of referral. Individuals in crisis may be placed in an appropriate Therapeutic Housing Unit pending the outcome of the review. Only the THC may admit or discharge individuals to and from the Therapeutic Housing Units and shall do so based on clearly articulated, written criteria. The presumption shall be that individuals are to be released as quickly as possible back to General Population, consistent with their mental health needs. The THC has the authority to release any individual at any time to a General Population setting.

317. Development and implementation of step-down protocols for the Restrictive Housing Units and Therapeutic Housing Units that begin integration and increase programming opportunities with the goal to safely transition incarcerated individuals to the least restrictive environment as quickly as possible.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol, AFBH Levels of Care Policy, AFBH Vetting Restricted Housing Committee Referrals

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff and Joint Experts, Case Record Reviews, Therapeutic Housing Committee Meeting documentation, Therapeutic Housing Committee Referral Forms

Assessment: AFBH continues to implement the approved THU Protocol which establishes the THUs as mental health service delivery areas within the SRJ. The staff responsible for the admission and "release" (removal) of individuals from the THUs are the mental health clinicians and psychiatrists, i.e., AFBH staff. Observations during the recent tour and conversations with staff support that AFBH is responsible for the placement and movement from THUs with the assistance and support of ACSO Classification.

As required by Provisions 312 and 313, the AFBH Therapeutic Housing Unit Protocol describes the clinical criteria for IPs to be placed in a THU. Based on the person's assessed LOC, the protocol explains the services to be provided to assist in their stabilization, improvement in their LOC, and removal from the THU when improvement has been achieved.

Also, regarding compliance with Provisions 312 and 313, weekly Therapeutic Housing Committee (THC) Meetings are required to discuss clients from the male THUs who may be better served in a different THU or in general population housing. As a client's mental health symptoms improve, the THC works with ACSO Classification to move clients to a less restrictive environment whenever possible. The THC must consider the client's ability to function in a less restrictive living environment, their current classification "points," and their history in SRJ HUs. Because a "less restrictive environment" can often involve movement to another THU, the THC necessitates representation from all male THUs to best evaluate appropriate "relocation," if that is the committee's decision.

Regarding the female THU population, a formal THC meeting is not conducted. Instead, IPs are discussed at the weekly "extended huddles." Because the female THU is small, the movement of these clients is resolved at a local team level and rarely necessitates the involvement of Classification.

Proof-of-practice documentation of weekly THC meetings for the months of January through June 2025 has been reviewed by this Joint Expert. Documentation includes an agenda, sign-in sheet, and an individual Therapeutic Housing Committee Referral Form for each client formally discussed. Review of the proof-of-practice finds the meetings to be comprehensive, involve clinical discussion and assessment, and are well attended by AFBH clinical staff. However, as mentioned in the previous report, the meetings are primarily about HU 9 (currently in HU 2) clients. These meetings must address all male THUs and, in the absence of a separate meeting, any females housed in a THU. During this period, it was noted that all meetings were attended by ACSO Deputies and by a Sergeant and/or Lieutenant, as required by procedure. A goal for the next reporting period is for each THU to implement their own individual meeting or additional general meetings. To ensure that these committee meetings function effectively, it is essential that, when possible, meetings be attended by AFBH Psychiatrists and Wellpath nurses, conducted by the unit's Treatment Team, and that ACSO Security and Classification representatives, as required by the provision, participate in the meetings.

Review of this period's THC documentation also shows greater emphasis being placed on clinical presentation and decisions reflect clinical need rather than merely security concerns. This shift in the approach to the meetings will support AFBH's efforts to step-down IPs when appropriate to less restrictive settings. It is critical for the improvement of mental health that IPs be permitted to move to a unit that offers them greater opportunity for less restrictions and more privileges when they are clinically considered to be able to handle the environment.

Another notable improvement in the THC documentation is the addition of a review of IPs which have been at LOC 4 for more than ten days. This review is essential for the treatment teams and all relevant staff members to openly and collaboratively discuss IPs that are not progressing in the continuum of care.

Regarding Provision 317 and the requirement for "step-down protocols," AFBH staff assigned to these units work together as members of the unit's Treatment Team. While each clinician individually assesses and works with the IPs, team members confer in huddles, treatment team meetings, and rounds to jointly assess the person's condition and improvement/progress or lack

thereof. Step-down from the more restrictive levels of care, dependent upon the acuity of the person's danger to self and others, and removal from the unit is based on these reviews and a determination of when the person can be placed in a less restrictive, albeit more (for the stability of their mental health) challenging environment. From discussions with AFBH and ACSO, it seems that in certain situations an appropriate "step-down" placement may not be available given the security level of the AFBH clients. ACSO and AFBH are encouraged to consider all placement options for IPs whose mental health status permits them to function in a less restrictive environment.

Recommendation(s):

1. In the absence of THC meetings on each unit, AFBH should continue to review clients from all the THUs as necessary on a set date and time.
2. Continue proof-of-practice documentation of the THC meetings.
3. Decisions regarding whether a person can "step-down" to a less restrictive unit should be based on clinical presentation and assessment.
4. While not required by the Consent Decree, it is good practice to continue review/discussion of IPs on LOC 4 for more than ten days during the THC meetings.

404. This population (persons in Restrictive Housing Step 1) shall be evaluated within fourteen (14) days of placement in Step 1 for ability to return to general population or to transition to Step 2. Inmates retained in Step 1 following initial review will be evaluated no less than every thirty (30) days thereafter. Incarcerated persons with SMI placed in Step 1 for longer than thirty (30) days shall have their cases reviewed by the Classification Lieutenant and Assistant Director of AFBH, or their designee, weekly following the initial thirty (30) days. If continued placement on Step 1 is approved by the Classification Lieutenant and Assistant Director of AFBH the reasons for doing so must be documented.

Finding: Partial Compliance

Policies: AFBH Vetting Restricted Housing Committee Referrals Policy, AFBH Diagnosing Severe Mental Illness (SMI) Policy, ACSO Policy and Procedure 9.02 Restrictive Housing

Training: Needs Development

Metrics: Observation, Sampling of AFBH Restrictive Housing Suitability Review Forms, Sampling of ACSO Restrictive Housing Committee Decision Forms

Assessment: Compliance with this provision was "bifurcated" in 2024 between this Joint Expert and the Classification Joint Expert, Dr. James Austin. Dr. Austin found ACSO to be conducting formal reviews of IPs placed in Restrictive Housing (RH) within the specified timeframes (within 14 days of being placed in Step 1 and every 30 days while in Step 1), as required by the CD and in Substantial Compliance with the provision. This portion of the provision has been terminated in the CD.

However, as previously noted, the provision also requires that IPs with SMI diagnoses in RH for 30 days or longer be reviewed on a weekly basis. A proof-of-practice confirming that persons are being identified when meeting the 30-day mark and discussed on a weekly basis needs to be provided to this Joint Expert. This Joint Expert has been advised that these persons will be

identified by ACSO and that the review be noted on the formal RH Committee documentation. This documentation will be reviewed in the next monitoring report.

All IPs on the AFBH caseload that are pending placement in RH are assessed by AFBH prior to the next weekly RH Committee meeting. AFBH clinicians complete a Restrictive Housing Unit Suitability Form indicating whether placement in the RH unit is contraindicated by the person's mental health issues, primarily concerning the presence of psychosis and/or suicidality. If a person has a SMI and is contraindicated by AFBH for placement in RH Step 1, they are being placed in an appropriate THU.

Recommendation(s):

1. AFBH and ACSO to continue conducting and documenting the weekly RH assessments, as required.
2. ACSO to continue ensuring that IPs are assessed for retention and/or release from RH according to the assessment schedule and discussed at the RH Committee meetings on a weekly basis. Proof-of-practice to be provided to this Joint Expert.
3. ACSO and AFBH to continue to review the options for placement of persons contraindicated for RH based on their mental health condition.
4. AFBH to modify policy to include all Provision requirements.

406. If an incarcerated person with SMI placed in Step 2 suffers a deterioration in their mental health, engages in self-harm or develops a heightened risk of suicide, or if the individual develops signs and symptoms of SMI that had not previously been identified, the individual will be referred for appropriate assessment from a Qualified Mental Health Professional, within twenty-four (24) hours, who shall recommend appropriate housing and treatment and shall provide the recommended treatment.

Finding: Substantial Compliance

Policies: AFBH Diagnosing Severe Mental Illness (SMI) Policy, ACSO Policy and Procedure 9.02 Restrictive Housing

Training: Completed for relevant staff and ongoing as necessary

Metrics: Case Record Reviews, ITR Call Logs

Assessment: Substantial Compliance with this provision has been achieved during this rating period. This provision addresses the need for a referral process should a person's mental health deteriorate while in RH. AFBH continues to manage this provision by assigning a dedicated clinical Treatment Team to the RH Unit five (5) days per week. This clinical oversight provides an opportunity to identify and address any notable changes in a person's behavior or mental state. Observations of the HUs and interviews with RH staff confirm the presence of AFBH clinicians on the units to help ensure such situations are quickly detected.

ACSO RH staff also make necessary requests for immediate/emergency AFBH assistance by phone to the ITR staff. These requests are documented on the ITR Call Log. A review of the Logs for the six months in this reporting period show 107 calls from RH to AFBH (during all shifts) which were responded to by the AFBH Crisis Response Team, informally known as the "Runners" in a clinically appropriate manner from a total of 2,535 call in the period. The number of calls from RH for emergency assistance has significantly reduced over the past two reporting periods from an

average of 27 per month to 18 per month in the current period. It is important to note that numerous calls are information exchanges and requests from RH staff to AFBH, not issues directly related to IPs. As previously requested, the ITR Call Log has been modified with columns added for additional information regarding the outcome of the call requests.

Additionally, AFBH clinicians who are assigned to the RH unit as well as the Clinical Supervisor participate in the weekly RH Committee. In situations when clients deteriorate, they are assessed for the appropriateness of being moved to another housing location.

Recommendation(s):

1. AFBH to continue review of the ITR Call-Request Log to serve as proof-of-practice of compliance with this referral process. The "Outcome" of the requests should include the time of the response, whenever possible, to assist with ongoing internal monitoring, if not otherwise documented in the Log.

700. Defendants shall work with the agreed-upon joint subject matter expert, as discussed in Section IV(A), to develop and implement policies, procedures, and forms required to implement the provisions contained herein. All Staff shall be trained on the topics, as discussed in Section IV(A), including any modifications to policies and procedures described herein.

701. Consistent with the preceding paragraph Defendants shall implement revised policies and procedures to ensure appropriate access to therapeutic and behavioral health services throughout the Jail. These policies and procedures shall include the staffing, establishing admission and re-entry criteria, levels of care, and treatment plans and services for all therapeutic housing unit(s) within six (6) months of the Effective Date, including the current Behavioral Health Unit and any other unit's housing Behavioral Health Clients designated as SMI, to ensure increased coordination between mental health and custody staff.

Finding: Partial Compliance

Policies: N/A

Training: N/A

Metrics: N/A

Assessment: The last report indicated that AFBH had obtained approval of 17 policies and procedures from ACBHD leadership. Training and formal implementation of these policies is currently ongoing. No other new policies have been completed during this reporting period. However, work has continued on AFBH draft policies related to medication refusal, re-entry services, and referrals to psychiatrists.

It is critical that AFBH review these policies and procedures as needed or, at a minimum, every six months to ensure that they reflect operations and continue to meet the mandates of the CD and other current operational requirements and to make updates as necessary,

Recommendation(s):

1. AFBH to continue developing necessary policies and submitting for review towards approval.
2. Formal training for all approved policies to be provided. All training must include detailed lesson plans, related forms/documentation, and include an interactive component. Proof of training must be produced and obtained and is subject to Joint Expert review.
3. All policies should be reviewed at least every six months for accuracy with actual/current processes and revised, if necessary. Accurate and complete policies are essential as they will be used to prepare auditing tools to measure progress towards the CD provisions and measure maintenance of the changes.

702. Within three (3) months of the Effective Date, Defendants shall develop a plan to implement Therapeutic Housing Unit(s) at the Jail, as set forth in Section III(G)(6). Final implementation of the Therapeutic Housing Unit(s) shall be dependent upon completion of reconfiguration of the units; however, Defendants shall implement the Therapeutic Housing Unit(s) within one (1) year of the Effective Date.

Finding: Substantial Compliance – Consider Discontinuation of Monitoring

Policies: AFBH Therapeutic Housing Units Protocol

Training: N/A

Metrics: N/A

Assessment: This provision has been met, i.e., a plan for the THUs has been developed and THUs have been implemented. This provision has been reinforced by the ACBHD approval of the Therapeutic Housing Unit Protocol. HUs 9 (currently in HU 2), 24 (currently in HU 21) and 35 have been identified as THUs and operate in accordance with the Protocol to the extent possible with staffing limitations. Training has been provided to all appropriate staff and will continue as necessary. THUs have dedicated clinical Treatment Teams providing clinical services on each unit and conduct huddles to discuss clients and rounds for LOC 4 clients and weekly THC meetings.

Both AFBH and ACSO have continued their efforts to establish and operate the THUs as designed and described in the THU Protocol. Full implementation of the THU Protocol has not yet been achieved and is dependent upon additional staffing and provision of a complement of treatment services.

A clinical Treatment Team has also been assigned to RH (HU 1) to assist with IPs on the AFBH caseload and to address any notable changes in mental health functioning of anyone on the unit. Huddles are occurring on the RH Unit Monday through Friday.

Recommendation(s): This Joint Expert finds that the County has been in Substantial Compliance with this provision for the last four rating periods (in excess of 12 months). Accordingly, this Joint Expert recommends the parties consider requesting this provision be terminated from the Consent Decree. In the meantime, the Expert will reduce monitoring of this provision in future reports.

703. During the interim period, individuals with SMI shall receive the therapeutic services described in Sections III(F)(2), (3), and (4) as deemed clinically necessary for their individual needs. Defendants shall also develop policies and procedures to provide incarcerated persons appropriate access to therapeutic and behavioral health services throughout the Jail. Defendants shall develop appropriate training to all custody staff including staff assigned to any units where Behavioral Health Clients may be housed regarding the needs of Behavioral Health Clients, mental health resources available at the Jail, and how to assist Behavioral Health Clients in accessing such resources within six (6) months of the Effective Date. Thereafter, Defendants shall implement the policies and procedures, including providing appropriate training to all staff, consistent with Section IV(A).

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol, AFBH Diagnosing Severe Mental Illness (SMI) Policy and Procedure, ACSO Crisis Communications for Corrections Training,

Training: ACSO Crisis Communications for Corrections Training

Metrics: Interviews with Staff and IPs, Observations, Case Record Reviews, AFBH Structured Activities Reports, THU Master Schedule, AFBH SMI Report, AFBH Training Logs

Assessment: Over the past year, AFBH has continued to refine and improve their efforts to assess and identify persons with SMI at SRJ. These enhancements include finalizing the policy and conducting a pilot program regarding the assessment and identification of SMI, the "flagging" of SMI in CG, and ensuring that persons with SMI being released from custody have a documented Re-entry Plan. The average number of persons identified as SMI per month during this reporting period (February through June) was 113, a significant increase when compared to 48 in the last report period. This attests to the greater sensitivity of the diagnostic process being utilized by clinical staff. At this point, the average number of IPs with SMI designation is 113 or 11% of the total AFBH caseload thus the majority of the AFBH caseload is non-SMI. However, care record reviews indicate that not all persons meeting criteria for SMI are being identified as such. While this may be an oversight at intake due to limited information, as clinical services are rendered and the person's mental health condition understood, the SMI designation should be added to the case record in CG.

IPs Designated as SMI & Participation in Structured Activities

Month	Persons with SMI Designation/All LOC	%age of SMI in Structured Activities
February 2025	108	94
March 2025	126	95
April 2025	118	79
May 2025	91	92
June 2025	120	94
Monthly Average	113	91
Average Last Reporting Period (9-12/2024)	48	N/A

AFBH has been compiling a monthly Structured Activities Report which details the type of clinical (individual and group) activities attended by IPs designated as SMI. These reports indicate that persons designated as SMI are receiving/participating in clinical contacts with AFBH counselors and psychiatrists and participating in AFBH groups. As indicated in the chart above, on the average, 91% of persons identified as SMI are receiving/participating in mental health treatment services to some extent. This report, available for five months in this reporting period, is essential in the assessment of what and how services are being provided to SMI-designated IPs. This report, which also provides the amount of time for services rendered, will be of great value in determining compliance with this provision

Furthermore, a "drill down" into those IPs that did not receive clinical services found that, for the most part, only two particular IPs remained on the "no participation" list for more than two months; the remainder of the IPs received some services over the report period.

The ongoing operation of the THUs, where persons with SMI are most likely to be housed, allows for the placement of severely disturbed persons in an environment that offers specific clinical services supported by more consistent observation and interaction. HUs 9 (currently in HU 2) and 35 are entirely committed as THUs for males. Given the housing arrangements in these units, THU 9 (single/double cells) should be used for the more severely disordered males (LOC 3 and 4) and THU 35 (dorm-like setting) for the LOC 2 male inmates. This would ensure that, as a person's mental health stabilizes, they would be "rehoused" to a unit that offers greater freedom of movement and activities. However, it has been challenging for ACSO to house according to a person's LOC given that custody classifications (minimum, medium, maximum) must generally be separated. During this last reporting period, portions of HU 8 were also designated for use as a THU.

The THU for women (HU 24) consists of pods C and D currently in HU 21. However, these pods are also used to house women that do not require THU placement, i.e., not LOC 2-4 or even on the AFBH caseload. Although this does not necessarily conflict with AFBH's provision of individual counseling or groups, it will impact the creation of a "therapeutic milieu" as the units are further developed if not all inmates are part of the AFBH caseload.

It is essential that ACSO continue to place LOC 2-4, males and females in the identified THUs and that IPs be moved out of the THUs when AFBH determines it is appropriate to do so.

AFBH staffing limitations due to vacancies however continue to hinder the ability to provide true therapeutic services for all identified persons, especially those with SMI. Case record reviews for the period appear to reflect a greater continuity in treatment interventions both clinical and psychiatric. Case record reviews have noted BIAs followed by more extensive assessments and casenotes by both Clinicians and Psychiatrists for Medication Support. IPs with SMI are receiving more frequent follow-up visits from psychiatrists and clinicians. Daily huddles for those identified as LOC 4 and frequent IOL/intensive observation assessments also provide a consistent opportunity for clinical contact and review of the person's status.

Since the last tour, ACSO followed through on its plans to renovate the C pods and multi-purpose rooms in HUs 1, 2 and 9 and multi-purpose rooms in HUs 24 and 35 to create confidential treatment space. The renovation plans, which were reviewed with the Joint Experts, have been completed although each unit has different issues related to additional work. These areas will certainly provide an opportunity for greater therapeutic services within the THUs. It is recommended that, in addition to the increase in available space, the County should endeavor to

create a more therapeutic environment using art, wall colors, and other decorative features to reduce the institutional "feel" of the units. The County must also ensure that adequate space is available in the THUs for confidential interviews and group activities.

Recommendation(s):

1. Emphasis should continue on identifying persons that meet criteria for SMI and flagging them as necessary. Clinical staff (psychiatrists and clinicians) should be involved in this process. SMI identification should be made, as appropriate, beyond the intake process.
2. Emphasis on providing clinical services to IPs designated as SMI should continue to be an AFBH staffing priority.
3. Whenever possible, ACSO Classification to continue to place LOC 2-4 IPs in the identified male and female THUs.
4. AFBH needs to provide ACSO with the additional number/type of housing assignments needed for the size of the mental health caseload.
5. ACSO needs to convert additional HUs or pods within HUs to become THUs based on the average size of the AFBH caseload.
6. Housing assignments in the pods within HU 21 which currently serve as the female THU should reflect LOCs whenever possible.
7. AFBH should continue refining policies and procedures with related forms and training regarding therapeutic services provided both in the THUs and wherever IPs on the mental health caseload are housed.
8. Determine the type and number of clinical staff required to serve the mental health caseload; modify staffing plan and hiring of staff as necessary.
9. AFBH to increase the provision of treatment services as availability of staff increases.
10. Treatment Team rounds in the THU for LOC 4 persons are to be conducted daily (seven days per week).
11. ACSO should complete any additional renovations to C pods in HU 1, 2 and 9 to create confidential treatment areas.

704. Mental health staff shall communicate with custody staff regarding the mental health needs of Behavioral Health Clients on their housing unit where necessary to coordinate care. Defendants shall develop and implement policies and procedures governing coordination and sharing of information between mental health staff and custody staff in a manner that respects the confidentiality rights of Behavioral Health Clients to include standards and protocols to assure compliance with such policies.

Finding: Partial Compliance

Policies: ACSO Policy and Procedure 10.30 Behavioral Health Access Team (BHAT) Post Order, ACSO Policy and Procedure 13.02 Access to Care, ACSO Policy and Procedure 9.04 Behavioral Health Clients and Therapeutic Housing Inmates, AFBH Therapeutic Housing Protocol, AFBH Vetting Restricted Housing Committee Referrals

Training: ACSO Crisis Communications for Corrections Training

Metrics: Observations, Interviews with Staff, AFBH THU Master Schedule, AFBH Therapeutic Housing Committee Meeting documentation, AFBH Restrictive Housing Suitability Review Forms, ACSO Restrictive Housing Committee Decision

Forms, Case Record Reviews, ACSO 2024 BHAT Deputy Running Log, ACSO 2024 BHAT Groups

Assessment: In keeping with the last report and as observed during the tour, formal opportunities for communication between mental health and custody staff have been established and are ongoing. Huddles in the THUs reportedly take place five days per week and five days per week in RH (HU 1). Involvement and participation by both custody and clinical personnel was significant at the few huddles which were observed by this Joint Expert during the most recent and past tours. Custody staff engaged in the dialogue regarding the status of persons in the THUs and offered their perspectives and thoughts. Huddle participants sign in to the huddle and outcomes of huddle discussions are entered in the clinical case records. During this reporting period, AFBH leadership determined and implemented a weekly "Expanded Huddle" at each THU during which more detailed review of clients can be conducted.

Therapeutic Housing Committee meetings to discuss AFBH clients in all THUs, except HU 24, are being conducted on a weekly basis as discussed in the Assessment section of CD provision 317 of this report. These meetings include both AFBH and ACSO representatives and are intended to address clients of concern from all THUs. Ideally, individual committee meetings should be held by each THU and require representation from ACSO, as indicated in the provision. It is critical that ACSO and AFBH staff continue to participate in these committee meetings as they are intended to develop strategies to help the mentally disordered persons on the unit stabilize and be ultimately housed in a less restrictive environment.

AFBH is also present at the facility's weekly RH Committee meetings to discuss individuals on the AFBH caseload and participate in the decisions made by the committee. AFBH has identified its Forensic Behavioral Health Clinical Manager and Forensic Behavioral Health Clinical Supervisor (as designee for Assistant Director) to be dedicated representatives at these meetings along with other AFBH staff including clinicians and psychiatric providers.

ACSO requests for AFBH assistance are documented on the ITR Call Log. These include requests for immediate/emergency assistance (emergent and urgent referrals), non-emergency assistance and informational notifications. ACSO RH staff also make necessary requests for immediate/emergency AFBH assistance by phone to the ITR staff. A qualitative, random review of 120 Log entries in the six-month period found an extensive variety of requests for assistance at varying levels of necessity, some of which expressed concerns about possible suicidal/self-injurious behaviors. Based on the decrease in the number of calls and the breadth of issues for which assistance is being requested, ACSO staff appear to be utilizing AFBH/contractual mental health staff. Information on the Logs indicates that calls are being handled in a clinically appropriate manner.

Recommendation(s):

1. Both ACSO and AFBH need to continue to consistently assign staff to units servicing IPs with mental health designations to increase the "team" concept in staff.
2. Both agencies need to continue developing and revising policies that address formal communication.
3. ACSO to continue reviewing and assessing the number of BHAT deputies necessary to support mental health treatment functions.

705. Defendants shall take the following actions regarding mental healthcare at intake: a. Implement an appropriate standardized initial assessment tool to screen clients at intake

for mental health concerns. This assessment shall include specific screening for suicidality and potential for self-harm. At a minimum, the screening for suicidality and potential self-harm shall include: (a) Review of suicide risk notifications in relevant medical, mental health, and custody records, including as to prior suicide attempts, self-harm, and/or mental health needs; (b) Any prior suicidal ideation or attempts, self-harm, mental health treatment including medication, and/or hospitalization; (c) Current suicidal ideation, threat, or plan, or feelings of helplessness and/or hopelessness; (d) Other relevant suicide risk factors, such as: (i) Recent significant loss (job, relationship, death of family member/close friend); (ii) History of suicidal behavior by family member/close friend; (iii) Upcoming court appearances; and (e) Transporting officer's impressions about risk. The screening shall also include the specific questions targeted towards individuals with co-occurring mental health and substance abuse disorders, including: (1) substance(s) or medication(s) used, including the amount, time of last use, and history of use; (2) any physical observations, such as shaking, seizing, or hallucinating; (3) history of drug withdrawal symptoms, such as agitation, tremors, seizures, hallucinations, or delirium tremens; and (4) any history or serious risk of delirium, depression, mania, or psychosis.

Finding Substantial Compliance

Policies: AFBH Santa Rita Jail Intake Policy, ACSO Policy and Procedure 11.02 Intake Procedures, ACSO Policy and Procedure 10.04 Intake Deputy Post Orders, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: Observations, Interviews with Staff, AFBH BIA Tool, AFBH Suicide Risk Assessment Tool, Case Record Reviews, AFBH Monthly QA BIA Review-ITR, AFBH Intakes Completed by Month

Assessment: Since the last tour, the AFBH Brief Initial Assessment (BIA) has been further modified to obtain more detailed information regarding substance use and ensure effective communication and early identification of intellectual and developmental disabilities. AFBH Intake staff and contracted staff working in ITR use this tool for virtually every individual booked into SRJ. The form meets all requirements of the CD and includes inquiry into relevant areas of mental health history, current functioning, and includes a suicide risk screening. The form also includes a place to enter the LOC designation which identifies the person's level of mental health service need and is critical for placement in THUs. The BIA Tool is completed electronically and becomes a part of the client's AFBH Electronic Health Record (EHR) with a paper version available as a "backup" should systems be unavailable. Case record reviews found completed BIAs in 100% of the records. The suicide risk portion of the BIA is being completed, and LOC designations are consistent with the results of the suicide screening portion of the tool. Training on the BIA and related procedural changes has occurred and continues as necessary.

The chart below presents the number of intakes completed, by month for this reporting period, by either AFBH or contracted ITR staff. The chart indicates that there is relative consistency in the number of intakes conducted by AFBH each month. The average number of intakes per month for the last reporting period was 1,492 These figures allow AFBH leadership to better establish staffing requirements for the ITR functions.

Month/Year	# of Intakes Completed
January 2025	1,584
February 2025	1,401
March 2025	1,533
April 2025	1,503
May 2025	1,692
June 2025	1,514
Total/Average per Month	9,227/1,538
Prior Report Average per Month	1,492

AFBH has conducted a monthly quality assurance (QA) review of completed BIAs. ITR Clinical Supervisors and the ITR Clinical Manager review approximately 20 cases per month. QA reviews for the months of January through June 2025 were reviewed by this Joint Expert and demonstrate a thorough review of the BIA documentation that provides meaningful recommendations to staff for improvement. According to AFBH leadership, findings of the reviews are discussed in weekly ITR leadership meetings, with corrective actions identified and taken.

Recommendation(s):

1. AFBH needs to continue monthly QA reviews of BIAs and provide proof of practice to this Joint Expert.
2. AFBH to modify policy as necessary to include the QA review and process.

706. b. An "Emergent" mental health condition requires immediate assessment and treatment by a Qualified Mental Health Professional in a safe therapeutic setting to avoid serious harm. Individuals requiring "Emergent" mental health treatment include: individuals who report any suicidal ideation or intent, or who attempt to harm themselves; individuals about whom the transporting officer reports a threat or attempt to harm themselves; or individuals who are at imminent risk of harming themselves or others; individuals who have severely decompensated; or individuals who appear disorientated or confused and who are unable to respond to basic requests or give basic information. Individuals identified as in crisis or otherwise having Emergent mental health concerns shall be seen as soon as possible by a Qualified Mental Health Professional, but no longer than within four (4) hours of referral.

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707. c. An "Urgent" mental health condition requires assessment and treatment by a Qualified Mental Health Provider in a safe therapeutic setting. Individuals requiring "Urgent" mental health treatment include: individuals displaying signs and symptoms of acute mental illness; individuals who are so psychotic that they are at imminent risk of severe decompensation; or individuals who have attempted suicide or report suicidal ideation or plan within the past thirty (30) days. Individuals identified as having Urgent concerns shall be seen by a Qualified Mental Health Professional within twenty-four (24) hours of referral.

708. d. A "Routine" mental health condition requires assessment and treatment by a Qualified Mental Health Professional in a safe therapeutic setting. Individuals requiring "Routine" mental health treatment include individuals who do not meet criteria for Urgent

or Emergent referral. Individuals identified as having Routine concerns shall be seen by a Qualified Mental Health Professional within five (5) business days or seven (7) calendar days of referral.

Finding: Partial Compliance

Policies: AFBH Santa Rita Jail Referral Policy, AFBH Santa Rita Jail Intake Policy, ACSO Policy and Procedure 8.12 Inmate Observation and Direct Visual Supervision, ACSO Policy and Procedure 11.4 Scope of Intake, Classification and Medical Screening Procedures, AFBH Levels of Care Policy and Procedure, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews, ITR Call Log, Emergent, Urgent Times Report

Assessment: The AFBH referral policy needs extensive revision as it lacks important components related to this provision.

As of January 1, 2025, the AFBH Crisis Response Team began tracking Emergent and Urgent referrals on the ITR Call Log, including the time each client was evaluated. As shown in the chart below, the average response time for Emergent referrals is well within the four (4) hour requirement (the maximum average response time in the month of January was 1 hour, 54 minutes). Similarly, the average response time for the Urgent referrals was also well within the 24-hour requirement (the maximum average response time in the month of March was 5 hours, 47 minutes). Tracking of Routine referrals to determine whether they are being evaluated within the required timeframes has not yet been implemented.

Month	Referral Type	Total # by Referral	Seen < 4 hours	Seen > 4 hours	Seen < 24 hours	Seen > 24 hours	Average Response Time
January	Emergent	241	222	15	-	-	1 hr, 54 mins.
	Urgent	150	-		144	6	3 hrs, 44 mins
February	Emergent	211	197	14	-	-	1 hr, 15 mins
	Urgent	99	-	-	97	2	4 hrs, 25 mins
March	Emergent	283	252	31	-	-	1 hr, 31 mins
	Urgent	92	-	-	88	3	5 hrs, 47 mins
April	Emergent	278	270	8	-	-	1 hr, 22 mins
	Urgent	130	-	-	125	5	4 hrs, 57 mins
May	Emergent	275	266	9			1 hr, 6 mins
	Urgent	123	-	-	120	3	4 hrs, 23 mins
June	Emergent	244	232	12	-	-	1 hr, 16 mins
	Urgent	93	-	-	93	0	3 hrs, 10 mins

Recommendation(s):

1. The AFBH Referral Policy needs to be revised.

2. AFBH needs to continue developing the capacity to have "emergent" referrals consistently seen for a clinically relevant assessment within four (4) hours of referral.
3. AFBH needs to continue developing capacity to consistently address referral appointments within 24 hours of "urgent" referrals for mental health services.
4. AFBH needs to develop capacity to consistently address "routine" referral appointments within five business days/seven calendar days of referral.
5. AFBH to continue tracking the response time for the different types of referrals; initiate tracking of "routine" referrals.

709. e. Following intake, individuals who request mental health services or who are otherwise referred by Staff for mental health services whose concerns are not Emergent or Urgent shall be seen by a Qualified Mental Health Professional within fourteen (14) days of the request or referral. Individuals who present with Emergent or Urgent concerns post-intake shall be assessed and seen in accordance with the timelines set forth above.

Finding: Partial Compliance

Policies: AFBH Santa Rita Jail Referral Policy, Draft – AFBH Psychiatric Referrals and Appropriate Training Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, AFBH Half-Sheet Referral Form, ITR Call Logs, SRJ ATIMS Medical-Notes Report Samples, Case Record Reviews

Assessment: The general policy regarding referrals, which is essential to compliance with this provision, needs to be revised. AFBH plans to streamline the referral process to ensure that referrals are correctly made, received and responded to within the required timeframes. To this end, a new referral form has been developed, reviewed and approved, but has yet to be implemented pending completion of the policy and procedure related to the referral for services process. While an electronic tracking system for referrals is not available, a dedicated email has been established to receive referrals. During this reporting period, a policy specific to psychiatric referrals has been developed and is in draft form.

AFBH receives referrals and requests for assistance with mental health services and related issues in various ways. IPs can request services through paper or electronic medical request forms, ACSO and Wellpath refer persons for assessment and intervention via the AFBH Half-Sheet Referral Form, by phone, in person, email, and on ATIMS (the ACSO Jail Management System). AFBH also receives referrals from attorneys, the courts, family members of IPs, and community-based providers by phone or email.

On a daily basis, AFBH staff receive a Medical-Notes report from ATIMS, which lists all referrals made via ATIMS. The report provides the incarcerated person's information and the reasons for the referral, which may be medication refusals. Samples of the Medical-Notes for the reporting period were reviewed. Information on the Medical-Notes documents is detailed and informative. Case record reviews indicate that referrals via the Medical Notes report are being identified and addressed.

Non-emergency referrals that come through via ATIMS (either from ACSO or Wellpath) are scheduled for a follow-up appointment with a clinician or psychiatric provider, as needed. These

appointments are typically scheduled within 14 days, depending on the type of referral and when the individual was last seen. However, reliable data to support this is not yet available for review.

Beyond ITR, most referrals for AFBH assistance by ACSO are calls made to a dedicated AFBH line in the ITR area. Calls are documented on the ITR Call Log. These include requests for immediate/emergency assistance (emergent and urgent referrals), non-emergency assistance and informational notifications. A total of 2,535 entries were made on the Log over the six months of this reporting period. As such, AFBH received an average of 14 requests per day or 423 notifications per month. This is a 15% decrease in the number of calls received during the last reporting period. The decrease in calls may reflect the increase in AFBH services in the THUs and availability of staff on the units to address issues. The ITR Call Logs will continue to be monitored over the next reporting periods to gather further information.

A qualitative, random review of 120 Log entries in the six-month period found an extensive variety of requests for assistance at varying levels of necessity, some of which expressed concerns about possible suicidal/self-injurious behaviors. Based on the decrease in the number of calls and the breadth of issues for which assistance is being requested, ACSO staff is utilizing AFBH/contractual mental health staff. Information on the Logs indicates that calls are being handled in a clinically appropriate manner.

The CD also requires that agencies within the SRJ (ACSO, AFBH and Wellpath) monitor the welfare of all IPs and act when persons are isolating themselves, refusing to come out of their cells, refusing medications and/or food. When these issues are noted, the agencies must refer the incarcerated person to the appropriate party or immediately contact the appropriate party. AFBH and ACSO need to ensure that these requirements are incorporated into their policies and procedures and that the processes are adhered to.

Case record reviews show that referrals from all of these sources are being received and responded to.

Recommendation(s):

1. AFBH needs to continue its plan to fully develop an efficient and effective referral process.
2. AFBH needs to revise its policy regarding the process for mental health referrals with related forms and training.
3. While the ITR Call Log has been modified for additional “outcome” information regarding requests for assistance, the Log should require entry of the time of the response to the request for auditing purposes.

710. f. This initial mental health screening shall be conducted by a Qualified Mental Health Professional in a confidential setting. The Jail shall ensure that the initial mental health screening is completed within four (4) hours of admission, or as soon as practicable if there are a large number of incarcerated persons being processed through intake or if there is a serious disturbance or other emergency within the Jail that prevents AFBH from fulfilling this task. The screening shall be documented and entered into AFBH’s electronic mental health records system. AFBH shall promptly obtain copies of records from community-based care provided through ACBH and request copies of records from other county contractors immediately following the individual’s admission to the Jail.

Finding: Partial Compliance

Policies: AFBH Santa Rita Jail Intake Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: Observations, Interviews with Staff, Case Record Reviews

Assessment: The AFBH SRJ Intake policy is approved. Every new intake at the SRJ is seen by an AFBH or contracted QMHP and an initial mental health assessment, typically the BIA, is completed. AFBH currently operates two booths in the ITR area for confidential intake assessments. (A third interview area is also available but is not deemed by this Joint Expert to be confidential.) As AFBH strives to complete intake assessments within the four-hour period required by the CD, AFBH and ACSO agree that additional confidential interview space is necessary. During this tour, ACSO reviewed possible plans to convert an area in the ITR area for additional interview booths. However, at the time of this report, there is no final decision regarding the creation of additional space in ITR for AFBH.

The chart below presents the number of intakes completed, by month for this reporting period, by either AFBH or contracted ITR staff.

Month/Year	# of Intakes Completed
January 2025	1,584
February 2025	1,401
March 2025	1,533
April 2025	1,503
May 2025	1,692
June 2025	1,514
Total/Average per Month	9,227/1,538
Prior Report Average per Month	1,492

The chart above indicates that there is relative consistency in the number of intakes conducted by AFBH each month. These figures allow AFBH leadership to better establish staffing requirements for the ITR functions.

During this reporting period, ITR began to determine the length of time it takes to complete the BIA. At this time, they are obtaining this information manually using date/time stamp information provided by ACSO booking staff. A report to determine whether assessments were completed within the required four-hour timeframe has been developed and indicates that of the 9,227 intakes, 4,759 or 51% were initiated within four hours of booking. AFBH has been advised however that, for the next reporting period, the calculation must be altered to include the time it takes to complete the BIA, not just to begin the BIA process.

Recommendation(s):

1. Further, ongoing review of facility mental health service needs and staff assignments should be conducted to ensure AFBH/contracted presence in the ITR area to complete the BIA within the four-hour timeframe.
2. ACSO and AFBH to continue consideration of additional intake space needs, identify areas for use and initiate plans for construction.

3. AFBH needs to alter their compliance audit of the BIA tracking efforts that attest to the completion of the BIA within the four-hour timeframe required by the provision.

711. g. Develop and implement an intake database requirement to flag self-harm incidents from prior incarcerations. This flag shall be entered by AFBH into ACSO's Jail Management System (ATIMS) and AFBH's Clinician's Gateway System (or equivalents). This flag shall be used to identify patients who are "high moderate or high risk" based upon an appropriate scoring protocol. Individuals who engage in self-directed harm, either during arrest or while in custody at SRJ, including in prior incarcerations at SRJ, shall be referred by either ACSO, AFBH, or Wellpath, for evaluation and scoring. The flag shall incorporate a modifier to indicate the level of risk which shall only be visible within the Clinician's Gateway System. The flag shall be used to ensure that AFBH, ACSO, and Wellpath are all aware of the occurrence of higher risk behaviors so appropriate interventions can be made. The flag shall also be historical so that when an individual leaves and returns to custody, the flag shall auto-populate in all relevant systems to ensure the patient is evaluated as soon as possible and to mitigate risk for additional self-harm. Once the flag is implemented, ACSO and AFBH shall work together to conduct appropriate training for relevant staff members.

Finding: Substantial Compliance – Consider Discontinuation of Monitoring

Policies: AFBH Santa Rita Jail Intake Policy, AFBH Diagnosing Severe Mental Illness (SMI) Policy, ACSO Policy and Procedure 11.40 Scope of Intake, Classification and Medical Screening Procedures

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews, ITR Training Checklist

Assessment: This provision is in Substantial Compliance. Suicide and self-harm flags have been placed in ATIMS. The approved SRJ Jail Intake policy describes how suicide and self-harm flags are to be determined. The BIA currently in use includes designations for SMI and Suicide Risk flags. AFBH staff enter the Suicide and Self-Harm flags into ATIMS. Suicide flags are being entered into ATIMS when noted on the BIA or when a person is placed on IOL. AFBH will continue its efforts to ensure that all flags and LOC designations are provided for all IPs. Appropriate staff have been trained and additional staff will be trained as necessary.

Case record reviews support the presence of suicide and self-harm flags when appropriate.

Recommendation(s): This Joint Expert finds that the County has been in Substantial Compliance with this provision for the last three rating periods (in excess of 12 months). Accordingly, this Joint Expert recommends the parties consider requesting this provision be terminated from the Consent Decree. In the meantime, the Expert will reduce monitoring of this provision in future reports.

713. i. Develop and implement policies and procedures to provide for the timely verification of medications within twenty-four (24) hours for newly arriving inmates to prevent delays in medication continuity upon arrival to the facility.

Finding: Partial Compliance

Policies: AFBH Bridge Medications Policy, AFBH Santa Rita Jail Intake Policy

Training: Completed

Metrics: Interviews with Staff**,** AFBH Consent to Obtain Medication Verification form, Wellpath policy review, Case Record Reviews, AFBH Bridge Medications Log, AFBH Bridge Medications Audits

Assessment: The process for the verification of current medications for newly arriving inmates to maintain continuity of medications are discussed in two AFBH policies that have been approved and implemented. The AFBH Bridge Medications policy details the actions of the ITR clinicians and psychiatric providers in verifying and prescribing the medications and the audit process for the functions. In policy, current medications are to be verified within 24 hours of a person's intake into the SRJ by the on-site psychiatric provider or on-call Telecare psychiatrist and entered in CorEMR (the Wellpath EMR). Efforts to comply with this procedure, including the use of the non-verified medication request form, are made and documented in the person's case record. If medications cannot be verified according to timelines established in policy, the person will be placed on the scheduled psychiatrist's Immediate Care Clinic (ICC) schedule for the following day. Case record reviews for this reporting period indicate when medication verifications are initiated and completed.

AFBH clerical compiles a Bridge Medications Log tracking report monthly. The Log is available for review. The Log lists each person for whom a verification request was made and the outcome of the verification (e.g., person referred to ICC, medications ordered, verification received). Although a valuable tool, it has been determined that the Bridge Medications Log has duplicated and inconsistent information. It Is recommended that AFBH address the reliability of the information in the Bridge Medications Log.

To further assess the process of providing bridge medications, AFBH is expected to conduct a quarterly audit utilizing the Continuity of Care Psychiatric Medications Audit Tool. This audit reviews the actions of the psychiatrists and nursing staff in the process of rendering bridge medications. One audit was prepared during this reporting period in April 2025 and reviewed for the purposes of this provision. The audit indicates compliance rates between 92% and 100% on the audit tool items which assessed if medications were verified within 24 hours, ordered within 24 hours by psychiatric providers, and if medications were delivered within 48 hours by Wellpath nurses. It is encouraging that AFBH is now conducting audits of their processes. Future monitoring by this Joint Expert will focus on the quality of these audits.

As compliance is also dependent upon the delivery of medications, the appropriate Wellpath policy has also been reviewed and found to be consistent with the CD provision. According to their policy, once initial doses of psychiatric medications are ordered, the medications are immediately placed for the next available medication administration line. Specifically, daily and evening (HS) medication will be provided within 24 hours, twice a day (BID) medication within 12 hours, and three times a day (TID) medication within 12 hours.

Recommendation(s):

1. AFBH to continue compiling the monthly Bridge Medications Log. It is recommended that totals for the various outcomes of the process be added to the Log report. Issues with the reliability and duplication of information in the Log should be addressed.

2. The Continuity of Care Psychiatric Medications audits need to be continued on a quarterly basis and provided to this Joint Expert as proof-of-practice.

714. j. Ensure that all mental health intake interviews and assessments conducted in ITR shall occur in private and confidential spaces. Staff shall inform newly arriving individuals how to request mental health services. Upon completion of the intake screening form staff shall refer individuals identified as having mental health concerns for a follow-up assessment.

Finding: Partial Compliance

Policies: AFBH Santa Rita Jail Intake Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: Observations, Interviews with Staff, Case Record Reviews

Assessment: AFBH has access to two dedicated booths in the ITR area for intake assessments that offer a confidential interview process.

During the BIA process, IPs are advised of how they can request mental health services during their incarceration. This action is documented in the person's clinical records (CG).

The BIA process requires the clinician to identify the person's LOC which determines whether they will be placed in a THU and identifies when their next clinical encounter will take place. Case record reviews showed 100% compliance with determining/entering a LOC based on the results of a completed BIA at intake.

Recommendation(s):

1. AFBH and ACSO to continue dialogue and planning for additional confidential interview space in the ITR area.

715. k. Prior to accepting custody of any arrestee, Jail personnel conduct a pre-booking screening of all individuals while they are still in the custody of an arresting officer to identify potentially urgent medical and/or emergent mental health issues and are deferred to outside treatment when necessary, including if arrestees indicate they are suicidal. Arrestees who express suicidality during the pre-booking screening shall be assessed to determine if they meet criteria under Welfare and Institutions Code § 5150 ("Section 5150"). Individuals who meet criteria under Section 5150 are deferred to psychiatric care and treatment and are not admitted to the Jail. Subsequent admission to the Jail of individuals who were deferred to outside medical or mental health treatment shall be predicated upon obtaining clearance from a community hospital.

Finding: Substantial Compliance – Consider Discontinuation of Monitoring

Policies: AFBH Santa Rita Jail Intake Policy

Training: N/A

Metrics: Interviews with Staff, Observations; Wellpath Policies & Procedures, Draft-HCD 110_E-02 "Receiving Screening-Alameda CA, Sampling of ACSO Intake/ Receiving Medical Review Form (Wellpath)

Assessment: Prior to accepting an arrestee into custody, Wellpath nursing staff perform an assessment of the arrestee's physical condition and mental health state to determine whether they are appropriate to accept into the SRJ. AFBH ITR staff are not involved in this assessment as this function is the responsibility of Wellpath, the medical provider. If the person is deemed inappropriate for booking for medical reasons and/or meets criteria for the Welfare and Institutions Section 5150, the arresting agency will be responsible for taking the individual for a medical clearance prior to returning to SRJ. Wellpath's Receiving Screening policy, which has been reviewed by this Joint Expert, addresses this process. Wellpath leadership has provided random proof-of-practice examples of their pre-booking screening process to this Joint Expert for the period January through June 2025.

Recommendation(s): This Joint Expert finds that the County has been in Substantial Compliance with this provision for the last four rating periods (in excess of 12 months). Accordingly, this Joint Expert recommends the parties consider requesting this provision be terminated from the Consent Decree. In the meantime, the Expert will reduce monitoring of this provision in future reports.

716 l. Defendants shall implement quality assurance policies and procedures that provide for periodic audits of the intake screening process in accordance with the standards set forth above.

Finding: Partial Compliance

Policies: AFBH Santa Rita Jail Intake Policy

Training: AFBH ITR Checklist

Metrics: Interviews with Staff, AFBH Monthly QA BIA Review-ITR

Assessment: Development and implementation of quality assurance measures continue to be developed following the approval of the SRJ Intake policy and the hiring of the AFBH Forensic Behavioral Health Clinical Manager as indicated in prior reports.

During this reporting period, ITR began to determine the length of time it takes to complete the BIA. At this time, they are obtaining this information manually using date/time stamp information provided by ACSO booking staff. A report to determine whether assessments were completed within the required four-hour timeframe has been developed and indicates that of the 9,227 intakes, 4,759 or 51% were initiated within four hours of booking. AFBH has been advised however that, for the next reporting period, the calculation must be altered to include the time it takes to complete the BIA, not just to begin the BIA process.

AFBH continues to conduct a monthly quality assurance review of completed BIAs conducted by ITR Clinical Supervisors and the ITR Clinical Manager. Quality assurance (QA) reviews for the months of January through June 2025 were reviewed by this Joint Expert and demonstrate a thorough review of a BIA sampling. According to AFBH leadership, findings of the reviews are discussed in weekly ITR leadership meetings, and corrective actions are identified and taken.

Recommendation(s):

1. Develop and implement an AFBH policy or modify existing policy to address quality assurance for the intake process with related forms and training.
2. AFBH supervisory staff need to continue service delivery audits according to the established policy.
3. Quality assurance processes need to be modified and enhanced as the service system is expanded.
4. ACSO to consider modifications to the ITR process to provide AFBH with persons at intake no more than three hours after admission to the SRJ to allow for the completion of the BIA within four hours as required by this provision.
5. AFBH to provide this Joint Expert with proof-of-practice to assess the four-hour BIA requirement.

717. a. Conduct all mental health clinical and psychiatric encounters in confidential settings, with consistent providers, and ensure such encounters are of appropriate clinical duration. Cell-side check-ins are presumed to be inappropriate for clinical encounters absent clinically appropriate extenuating circumstances, such as when an inmate refuses to leave their cell. ACSO escort staff shall be made available as necessary to ensure that clinical contacts occur in confidential settings. Defendants shall also assess the current space available for incarcerated persons housed in Step 1, Step 2, or Therapeutic Housing Units located in Maximum custody units for clinical interviews and develop a plan for increasing access to appropriate, private, spaces for clinical interviews within six (6) months of the Effective Date. Individuals housed outside of these areas shall continue to be seen confidentially, including in AFBH's clinical offices. In addition to interim measures to address these issues, Defendants shall use best efforts to construct and activate the Mental Health/Program Services Building which will provide programming, medical and mental health treatment and administrative space at SRJ.

Finding: Partial Compliance

Policies: N/A

Training: N/A

Metrics: Observations, Interviews with Staff, ACSO Capital Program, ACSO SRJ Construction Projects Update

Assessment: Since the last tour, ACSO followed through on its plans to renovate the C pods and multi-purpose rooms in HUs 1, 2 and 9 and multi-purpose rooms in HUs 24 and 35 to create confidential treatment space. Additional efforts are being made to convert areas within the C pods for confidential 1:1 interviews. Additionally, ACSO will pilot the deactivation of a pod in the women's HU 24 to explore repurposing that unit for programming purposes.

Furthermore, in response to ongoing assessments of program space requirements, the County has decided to convert HU 25 from a general population male unit to a Therapeutic Housing Unit (THU) due to the availability of classroom space within the unit. Consequently, during the next review period, HU 35 will be decommissioned as a THU, and its population will be relocated to HU 25.

AFBH continues to emphasize the delivery of tabletop therapeutic services with cell-side encounters occurring only when either the person refuses to exit their cell or when safety and security are an issue. In these limited circumstances, interventions are short in duration, lack clinical depth and confidentiality is forfeited.

Efforts to use the non-contact visitation booths in THU 9 as confidential meeting areas have not been as successful as expected. During this reporting period, AFBH staff have used areas in the Sandy Turner Center, a training room in HU 25, and the quasi-yard in HU 35 as space for confidential meetings.

To further address this provision, ACSO has purchased secure programming chairs for the THU multi-purpose rooms and RH Units which will allow these areas to be used for confidential group and/or individual interventions and there has been discussion about converting pods into treatment space and office space for AFBH.

As discussed in provision 204, ACSO has doubled the number of BHAT Deputies since the last report. There are now eight (8) dedicated Deputies to escort and support mental health services.

Recommendation(s):

1. AFBH to continue encouraging the use of the THU non-contact visitation booths for clinical encounters.
2. Continue active, frequent discussion of plans for establishing confidential meeting areas for the THUs.
3. Conduct staffing analysis to determine not just the space needs but the clinical and custodial personnel required to comply with the provision.
4. ACSO to finalize retrofitting C-pods and multi-purpose areas in HUs for therapeutic activities.
5. Maintain cell-side encounters to only those situations where the person adamantly refuses to leave their cell and/or true safety concerns for the person and staff exist.

718. b. Implement an electronic tracking system aimed at improving the process of referring patients to mental health services and tracking the timeliness of said referrals. This tracking system shall include alert and scheduling functions to ensure timely delivery of mental health services.

Finding: Partial Compliance

Policies: AFBH Santa Rita Jail Intake Policy, AFBH Santa Rita Jail Referral Policy

Training: Needs Development

Metrics: Interviews with Staff, AFBH Half-Sheet Referral Form, ATIMS Medical-Notes Report Samples, Case Record Reviews, ITR Call Logs

Assessment: The policy regarding referrals, which is essential to compliance with this provision, needs revision.

AFBH receives referrals and requests for assistance with mental health services and related issues in various ways. IPs can request services through paper or electronic medical request forms, ACSO and Wellpath refer persons for assessment and intervention via the AFBH Half-

Sheet Referral Form, by phone, in person, email, and on ATIMS (the ACSO Jail Management System). AFBH also receives referrals from attorneys, family members of IPs, and community-based providers by phone or email.

On a daily basis, AFBH staff receive a Medical-Notes report from ATIMS, which lists all referrals made via ATIMS. The report provides the IPs information and the reasons for the referral, which may be medication refusals. Samples of the Medical-Notes for the reporting period were reviewed. Information on the Medical-Notes documents is detailed and informative. Case record reviews indicate that referrals received from the ATIMS Medical Notes reports are being identified and handled.

Most referrals for AFBH assistance by ACSO are calls made to a dedicated AFBH line in the ITR area. Calls are documented on the ITR Call Log. These include requests for immediate/emergency assistance (emergent and urgent referrals), non-emergency assistance and informational notifications. As of January 1, 2025, the AFBH Crisis Response Team began tracking Emergent and Urgent referrals on the ITR Call Log, including the time each client was evaluated. As shown in the chart below, the average response time for Emergent referrals is well within the four (4) hour requirement (the maximum average response time in the month of January was 1 hour, 54 minutes). Similarly, the average response time for the Urgent referrals was also well within the 24-hour requirement (the maximum average response time in the month of March was 5 hours, 47 minutes). Tracking of Routine referrals to determine whether they are being evaluated within 14 days has not yet been implemented.

Month	Referral Type	Total # by Referral	Seen < 4 hours	Seen > 4 hours	Seen < 24 hours	Seen > 24 hours	Average Response Time
January	Emergent	241	222	15	-	-	1 hr, 54 mins.
	Urgent	150	-	-	144	6	3 hrs, 44 mins
February	Emergent	211	197	14	-	-	1 hr, 15 mins
	Urgent	99	-	-	97	2	4 hrs, 25 mins
March	Emergent	283	252	31	-	-	1 hr, 31 mins
	Urgent	92	-	-	88	3	5 hrs, 47 mins
April	Emergent	278	270	8	-	-	1 hr, 22 mins
	Urgent	130	-	-	125	5	4 hrs, 57 mins
May	Emergent	275	266	9	-	-	1 hr, 6 mins
	Urgent	123	-	-	120	3	4 hrs, 23 mins
June	Emergent	244	232	12	-	-	1 hr, 16 mins
	Urgent	93	-	-	93	0	3 hrs, 10 mins

A qualitative, random review of 120 Log entries in the six-month period found an extensive variety of requests for assistance at varying levels of necessity, some of which expressed concerns about possible suicidal/self-injurious behaviors. Based on the number and breadth of calls, ACSO staff is utilizing AFBH/contractual mental health staff. Information on the Logs indicates that calls are being handled in a clinically appropriate manner although the timeframe for responses is very often not clear.

AFBH has developed a new referral form which has been approved by this Joint Expert which needs to be implemented.

Recommendation(s):

1. Revise the policy regarding how referrals will be made; include discussions with ACSO, Wellpath and internally within AFBH.
2. Refer to provision 709 for additional recommendations.

719. c. Develop and implement a policy addressing timelines for the completion of routine and emergency mental health referrals in accordance with community correctional and professional standards.

Finding: Partial Compliance

Policies: AFBH Santa Rita Jail Referral Policy**,** AFBH Santa Rita Jail Intake Policy, Draft – AFBH Psychiatric Referrals and Appropriate Training

Training: Pending

Metrics: Interviews with Staff, Case Record Reviews, ITR Call Logs, SRJ ATIMS Medical-Notes Report

Assessment: The policy addressing referrals, responding to referrals, and how compliance will be monitored and audited needs revision. A new policy specific to the handling of psychiatric referrals has been developed during this reporting period and is in draft form.

Recommendation(s):

1. Revise the AFBH policies addressing referral processes and required timelines for routine and emergency mental health referrals with related forms and training.
2. AFBH supervisory staff needs to conduct audits of the referral process to assess compliance and determine correction actions.
3. Refer to provision 709 and 718 for additional recommendations.

720. d. Provide appropriate training to ensure that psychiatric referrals are submitted as clinically indicated.

Finding: Partial Compliance

Policies: AFBH Santa Rita Jail Intake Policy, Draft – AFBH Psychiatric Referrals and Appropriate Training Policy

Training: Pending

Metrics: AFBH Half-Sheet Referral Form, SRJ ATIMS Medical-Notes Report

Assessment: During this reporting period, AFBH has drafted the "Psychiatric Referrals and Appropriate Training" policy and procedure which addresses the various means and processes in place by differing SRJ entities when referring IPs to psychiatry. A training, "Psychiatric Referrals," has been developed and is under AFBH leadership review.

Recommendation(s):

1. AFBH needs to finalize the policy and procedure for psychiatric referrals.
2. Refer to provision 709 for further recommendations.
3. Following the update of the referral processes, AFBH provides training to all employees and contractors regarding the revised mental health referral policy and procedure.
4. Revise training when the policy is revised/updated.

721. e. Develop and implement quality assurance policies and procedures that provide for periodic audits of the mental health care provided at the Jail in accordance with the standards set forth in this section.

Finding: Partial Compliance

Policies: ACSO Policy and Procedure 13.22 Medical Quality Assurance Process for the Detention and Corrections Inmate Health Care System

Training: Requires Development

Metrics: Interviews with Staff

Assessment: AFBH continues with plans to increase its QA staff and establish a Quality Assurance Committee.

A policy outlining comprehensive quality assurance practices for the delivery and monitoring of mental health services delivery has not been developed. Also, if appropriate, all policies should include proof-of-practice measures with concomitant reports to support the efforts.

AFBH leadership presently compiles a variety of documentation which serve as quality assurance and compliance reviews. These "tools" include: logs/listings, monthly/quarterly aggregates, audit reports and meeting minutes. Examples of each type of tool are shown below:

- Logs/listings include:
    - Clients Served by Month, Ethnic Group, and Sex Report
    - Intakes Completed by Month
    - ITR Activity Logs
    - ITR Call Logs
    - Restraint Chair Logs
    - Telehealth Clinic Daily Activity Logs

- Monthly/Quarterly Aggregate Reports include:
    - Bi-weekly Level of Care Reports
    - Bridge Medications Log
    - Discharge Medications Report
    - Intake Times Report
    - Lifelong Groups
    - Telecare Groups
    - SMI Report
    - Structured Activities Report
    - Telecare Groups

- Audits include:

- BIA QA Monthly Review
- Bridge Medications Audit
- Continuity of Care Psychiatric Medications Audi
- Medication Refusal Audit
- Patient Polypharmacy Report

- Meeting Minutes/Documentation:
  - Restrictive Housing Committee Meetings
  - Suicide Prevention Meetings
  - Therapeutic Housing Committee Meetings

Given current and future developments in services provided to IPs by AFBH, it is essential that AFBH leadership develop additional tools (lists and audits) for clinical services. Prior to development, it is suggested that these be discussed with this Joint Expert to ensure that the tools and the process by which they are completed/obtained, e.g., random and sufficient sampling, will be usable and suffice for assessing provision compliance.

Recommendation(s):

1. Continue developing the QA team; assign appropriate staff to QA duties.
2. Develop and implement an AFBH policy addressing QA processes for the various services with related forms and training.
3. AFBH supervisory staff need to conduct service delivery audits according to established policy.
4. Modify and enhance QA as the service system is expanded.
5. Establish QA Committee meetings and provide this Joint Expert with minutes of the meetings.

722. Defendants shall develop and implement the mental health levels of care, including a list of the clearly defined levels of care which shall describe the following: (1) level of functioning, and (2) service components, including treatment services, programming available, and treatment goals ("Levels of Care").

Finding: Substantial Compliance

Policies: AFBH Levels of Care Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Exhibit C of CD, Case Record Reviews, AFBH Biweekly LOC Reports, ACSO SRJ Population 2024

Assessment: AFBH continues to appropriately implement the approved Levels of Care policy. The policy is consistent with Exhibit C of the CD which presents the Mental Health Levels of Care process which was initiated in April 2022. The document describes each level's clinical presentation and the service components (type and frequency) that are to be provided as well as LOC "X" which identifies IPs who have been assessed but are clinically determined to not need mental health services and are not requesting mental health services.

Over the past two years, as the AFBH system of care has developed, clinical criteria for the levels have been modified to provide greater clarity to the staff conducting the leveling assessments.

LOC information is entered into CG as well as ATIMS at intake and throughout the person's incarceration to reflect the state of the person's mental health. LOC designations allow ACSO staff to know the incarcerated person's mental health status and assist ACSO in making housing placement decisions.

Substantial Compliance is being granted given that AFBH has been diligently assessing LOC since November 2022 with progressive, responsible refinements to the process. At this point, there are over two years' worth of data that demonstrate consistent patterns (Refer to Joint Expert's Reports 2-6).

AFBH prepares three reports reflecting the AFBH caseload by LOC at regular intervals: the Biweekly LOC Percentage (summary), Biweekly Caseload Report (by client and level), and The LOC Data Report (weekly, by client).

Level of Care Reports for the Period 1/01/2025-6/30/2025

Report Date	LOC 1	LOC 2	LOC 3	LOC 4	LOC X	Pending LOC	Total LOC 1-4
1/13/25	36% N=505	18% N=249	6% N=92	2% N=35	38% N=538	0% N=0	881
1/27/25	37% N=552	17% N=245	6% N=93	3% N=48	36% N=538	0% N=0	936
2/15/25	37% N=533	17% N=238	8% N=112	3% N=38	36% N=508	0% N=0	919
2/24/25	38% N=549	17% N=247	8% N=109	2% N=35	35% N=497	.0% N=0	940
3/10/25	40% N=580	17% N=250	8% N=118	2% N=30	33% N=476	0% N=0	978
3/24/25	41% N=593	17% N=244	8% N=109	3% N=44	31% N=451	0% N=0	990
4/07/25	43% N=607	16% N=230	8% N=116	2% N=33	31% N=442	0% N=0	986
4/21/25	42% N=598	17% N=240	8% N=120	3% N=36	31% N=439	0% N=0	994
5/05/25	44% N=608	17% N=235	9% N=127	2% N=34	28% N=393	0% N=0	1,004
5/19/25	43% N=588	19% N=257	8% N=111	2% N=30	28% N=381	0% N=0	986
6/02/25	44% N=610	17% N=233	9% N=119	2% N=33	27% N=376	0% N=0	995
6/16/25	44% N=597	17% N=234	8% N=110	3% N=47	27% N=372	0% N=0	988
6/30/15	44% N=584	18% N=232	9% N=113	3% N=36	27% N=356	0% N=0	965
Average	41% N=577	17% N=241	8% N=111	3% N=37	32% N=444	0% N=0	966
Prior Report Average	33%/490	17%/246	6%/91	2%/34	40%/589	0%/0	861

Level of Care – Averages & Ranges for the Period 1/01/2025-6/30/2025

Level of Care	Percentage	Percentage Range	Number	Number Range
LOC 1	41%	36% - 44%	577	505 - 608
LOC 2	17%	16% - 19%	241	230 - 257
LOC 3	6%	6% - 9%	111	92 - 127
LOC 4	2%	2% - 3%	37	30 - 47
Average Caseload			**966**	881 - 1,004
Prior Report Average Caseload			**861**	809 - 903

The following observations of the AFBH caseload are worthy of mention and further consideration:

- AFBH's overall mental health caseload has shown an increase during this reporting period from an average of 861 to the current average of 966 IPs with a LOC 1-4.

- To further explain this increase, there appears to be a shift between LOC 1s and LOC Xs; with a decrease in the number of LOC Xs in favor of LOC 1s; thus increasing the overall AFBH caseload.

- For the past two reporting periods, all IPs in the SRJ have been assigned an LOC. Case record reviews show 100% compliance with the assessing of LOCs.

- The number of persons with an LOC 4 (range of 2-3% of the caseload), as previously reported, continues to be quite low relative to the size of the overall AFBH caseload and the population of the SRJ.

When compared with the entire SRJ population, the AFBH caseload is approximately 65% of the population. This is an approximate 10% increase in the AFBH caseload over the past six months despite a 5% decrease in the overall SRJ population. At this point, the SRJ mental health population figure at 65% is higher than national statistics (44% according to 2017 Bureau of Justice Statistics and NAMI) for mental health disordered persons in jail settings. The average monthly AFBH caseload size is now at 966 IPs and, given the increase of nearly 100 IPs since the last report, equates to at least two clinicians and may result in the need for other ancillary staff.

AFBH Caseload for January 2025 through June 2025 Compared to SRJ Population

Months	Average Caseload LOC 1-4	SRJ Population/ Last Day of Month	% of SRJ Population on AFBH Caseload
January 2025	908	1,520	59%
February 2025	930	1,466	63%
March 2025	984	1,551	63%
April 2025	990	1,485	66%
May 2025	995	1,408	70%
June 2025	983	1,410	69%
Average	966	1,473	65%
Prior Report Averages	871	1,550	54%

Recommendation(s): This Joint Expert finds that the County has been in Substantial Compliance with this provision for the last three rating periods (in excess of 12 months). Accordingly, this Joint Expert recommends the parties consider requesting this provision be terminated from the Consent Decree. In the meantime, the Expert will reduce monitoring of this provision in future reports.

723. Provide that mental health clinicians offer encounters that are clinically appropriate, of clinically appropriate duration and conducted in confidential settings with consistent providers. The phrase "clinically appropriate" shall be defined to refer to the quality and quantity of mental care necessary to promote individual functioning within the least restrictive environment consistent with the safety and security needs of the patient and the facility, to provide patients with reasonable safety from serious risk of self-harm, and to ensure adequate treatment for their serious mental health needs.

Finding: Partial Compliance

Policies: Need Development

Training: Needs Development

Metrics: Interviews with Staff, Observations, Case Record Reviews, ACSO SRJ Construction Projects Update

Assessment: The type and frequency of clinically appropriate services required by the THU Protocol are still not being provided. This is due largely to two factors: the availability of clinical staff and limited confidential treatment areas. The plan for Telecare to assume responsibility for ITR functions and facilitate additional AFBH clinical staff for assignment to the HUs has not yet come to fruition. Case record reviews demonstrate that intake assessments are taking place, suicide and self-harm is being identified and communicated, and the THUs are offering clinical presence (huddles, rounding), and interventions. However, the frequency of interventions according to the person's LOC as required by this provision, and the variety and scope of interventions are not being provided. According to AFBH leadership, they will be placing greater emphasis in the next reporting period on developing strategies for compliance with LOC treatment requirements.

Specifically, as noted in case record reviews, AFBH clinicians provide follow-up visits to persons on their assigned caseloads in HUs and in the clinic, follow-up on persons placed on IOL status, and respond to ACSO requests in the event of a referral due to crisis, "pre-planned uses-of-force" and safety cell placement. AFBH psychiatrists are conducting medication assessments and follow-up encounters. However, these therapeutic efforts are not sufficient to comply with the expected type, frequency and duration as defined in the THU protocol. Case record reviews indicate that while follow-up sessions by both clinicians and psychiatrists are occurring, they are not to the level of frequency required by the client's LOC and the THU Protocol.

Despite these limitations, the assigned Treatment Teams in the THUs and RH have improved the quality of mental health attention and services to IPs on these units.

Individualized support and counseling services (identifying triggers, developing coping skills, care and case management) are being provided. AFBH also provides supportive and therapeutic strategies such as informative hand-outs, art, worksheets, information on diagnoses, skill building exercises, sleep methods, information on breathing and meditation techniques, and information on community-based resources. However, intensive individual services are not being provided. During this reporting period, emphasis has been placed on developing treatment plans for IPs on LOC 4. It has been reported that over 300 treatment plans are in place, a significant increase from the prior report.

The ability to provide appropriate clinical services has also been negatively impacted by the lack of proper, confidential meeting areas. This results in most clinical encounters occurring at tables in the HU's dining/day room area and, when security and safety are concerns or cell-side when a client refuses to leave their cell. However, as described in provision 717, ACSO has converted C pods and multi-purpose rooms in HUs 1, 2 and 9 and multi-purpose rooms in HUs 25 and 35 for use as treatment areas for groups and individual encounters.

ACSO is in the process of ordering secure programming chairs for use primarily in HU 1 that will allow for treatment services to be provided without the presence of an ACSO deputy.

Recommendation(s):

1. AFBH needs to develop policies regarding the therapeutic services to be provided in the THUs and for IPs with a mental health LOC housed outside of the THUs.
2. As AFBH staff and contracted clinical services increase, a greater range and frequency of therapeutic services in the various housing areas where IPs on the mental health caseload are housed should be provided.
3. ACSO and AFBH to continue collaborating in the design of the THUs to ensure that sufficient staffing is available for clinically meaningful interventions and space is allocated for confidential meetings.

724. Identify clinically appropriate spaces for the provision of group and individual therapy and provide that these areas are available for use in providing confidential therapy and are given priority for such use.

Finding: Partial Compliance

Policies: N/A

Training: N/A

Metrics: ACSO SRJ Capital Program, ACSO SRJ Construction Projects Update

Assessment: As described in provision 717, ACSO has converted C pods and multi-purpose rooms in HUs 1, 2 and 9 and multi-purpose rooms in HUs 1, 2, 9, 24 and 35 for use as treatment areas for groups and individual encounters. The pods and multipurpose rooms became operational as of July 2025.

ACSO is in the process of ordering secure programming chairs for use primarily in HU 1 that will allow for treatment services to be provided without the presence of an ACSO deputy.

A few areas which have also served for confidential meetings will continue to be used. These include, non-contact visitation areas, specific spaces in the Sandy Turner Center, training rooms and quasi-yards.

The County has initiated a pilot for temporary use of the E pod in HU 21 for female clients and will evaluate the overall requirements during the next reporting period. Additionally, the County has proposed further concepts for individual interview spaces in the ITR, as well as HU 1, 2, and 9 C pod conversions, with plans to provide additional details in the next reporting cycle.

Recommendation(s):

1. ACSO to complete any remaining items related to the conversion of C pods and multi-purpose rooms in identified HUs.
2. ACSO and AFBH to continue encouraging using the non-contact visitation booths and other confidential spaces for individual sessions.
3. ACSO and AFBH to objectively review treatment space needs according to the THU LOC requirements. Nb v
4. ACSO and AFBH continue considering all options for repurposing and retrofitting space for clinical services.
5. ACSO to ensure sufficient staffing to support clinical encounters when spaces are identified.
6. ACSO, with assistance from AFBH, to develop and implement plans to create a more aesthetically pleasing and therapeutic environment on the THUs.
7. Refer to provisions 717 and 723 for additional recommendations.

725. Provide out-of-cell programming, including but not limited to group therapy, education, substance abuse counseling, and other activities for inmates housed in Restrictive Housing Units and Therapeutic Housing Units.

Finding: Partial Compliance

Policies: Require Development

Training: N/A

Metrics: Interviews with Staff, Observations, Case Record Reviews, Telecare Schedule and Service Logs, Lifelong Schedule and Service Logs

Assessment: Initiated during the last reporting period, AFBH has continued to provide three, eight-week “closed” groups for up to six clients in HUs 35. “Closed” groups rely heavily on the group members supporting and interacting with each other with the expectation that clients who start the group attend consistently over the length of the group process. The eight weeks of activities are created to build upon previous sessions and there are generally "homework" assignments given to participants in between sessions and, in some cases, bring back to the group for additional discussion/processing. In HU 35, AFBH provided two process groups, Expressive Arts and Coping Skills groups.

For HU 9 (currently in HU 2) and HU 24 (currently in HU 21), AFBH is providing three “open” Recreation Groups. In an "open" group, a client can attend one week and is not obligated to attend the following week; each group is structured and independent. These small groups are for clients who are on LOC-4/IOL (and some LOC-3 clients in the women's unit) and are generally held with up to three clients at a time. The purpose is to offer additional out-of-cell programming for AFBH's highest acuity clients. Activities and games are offered with a therapeutic overlay including music, mindfulness activities, practicing social skills and meaningful discussions with peers.

While AFBH was unable to offer small group activities to female population earlier this year, it is noted that groups are now being provided on the women's unit.

Group therapy is not being conducted in RH Units due to security concerns. ACSO has purchased secure programming chairs that will allow for treatment services to be provided without the presence of an ACSO deputy. The retrofitting of the C pod in RH will also address the provision of group services.

Therapeutic/educational groups are also provided by contracted staff from Telecare. Telecare is contracted to provide six groups per day (Monday through Saturday), with up to six participants per group, in THUs 9 (currently in HU 2), 24 (currently in HU 21) and 35. Telecare groups follow the nationally-recognized “Seeking Safety” curriculum and educational groups on co-occurring disorders (COEG), i.e., the relationship between substance use and mental health disorders.

The number of groups provided by Telecare has continued to increase during this reporting period from an average of 112 per month in the prior reporting period to an average of 138 in this reporting period; a 23% increase in groups. This is a significant impact in available groups. However, the number of groups conducted was 75% of the contracted amount. Telecare-led group activity records for the reporting period of January 2025 through June 2024 as follows:

Month	**# of Groups**
January 2025	196
February 20254	139
March 2025	143
April 2025	128
May 2025	124
June 2025	99
Total/Average per Month	829/138
Prior Report Average per Month	112

A cursory review of group participation suggests that more IPs are participating in the scheduled groups. However, AFBH is encouraged to work with Telecare to develop a reporting mechanism that will allow for a closer look at utilization in the next reporting period.

For the past year, Lifelong Medical Care has been providing on-site substance use counseling services through a contract with ACBHD. Lifelong is scheduled to provide six groups per week in HUs 9 (currently in HU 2), 24 (currently in HU 21) and 35. Records of groups provided by Lifelong over the current reporting period indicate a total of 121 groups provided in the months of January through June, with up to six AFBH clients per group. It is notable that groups are now being afforded to the female IPs in HU 21. The number of groups conducted was 77% of the contracted amount. The groups are psychoeducational and focus on substance use and trauma. Lifelong is also providing individual sessions on Tuesdays and Wednesdays for IPs with histories of substance use.

Even with the current efforts made through Lifelong and Telecare, substance abuse services are critical and need to be expanded. AFBH and ACSO need to intensify their efforts for these specialized community service providers to provide treatment services in the SRJ.

Recommendation(s):

1. Based on current estimates of the mental health caseload, AFBH needs to determine the number of out-of-cell programming service hours required in the various areas where IPs with a mental health LOC designation are housed.
2. AFBH to determine staff deployment based on service hours required; determine whether AFBH staffing requires modification.
3. ACBHD to establish contracts with outside vendors as necessary.
4. As staff and/or contracted clinical services increase, AFBH to increase the range and frequency of therapeutic services and out-of-cell programming for the mental health caseload.
5. AFBH and ACSO to establish accurate metrics to assist with monitoring out-of-cell and structured activity time which this Joint Expert understands is currently under review by ACSO through the Guardian RFID system in conjunction with Joint Expert Terri McDonald.
6. Therapeutic groups for AFBH clients in RH need to be developed and provided.

726. Provide regular, consistent therapy and counseling in group and individual settings as clinically appropriate.

Finding: Partial Compliance

Policies: Require Development

Training: N/A

Metrics: Interviews with Staff, Case Record Reviews, Telecare Schedule and Service Logs, Lifelong Schedule and Service Logs

Assessment: As explained in provision 723, clinically appropriate individual and group therapy are not being provided at this time to the extent required by the THU Protocol and the LOC policy. AFBH has an insufficient number of clinicians and limited involvement of community-based providers.

AFBH has been compiling a monthly Structured Activities Report which details the type of clinical (individual and group) activities attended by IPs designated as SMI. These reports indicate that persons designated as SMI are receiving/participating in clinical contacts with AFBH counselors and psychiatrists and participating in AFBH-run groups. As indicated in the chart above, on average, 91% of persons identified as SMI are receiving/participating (to some extent) mental health treatment services. This report, available for five months in this reporting period, is essential in the assessment of what and how services are being provided to SMI-designated IPs. This report, which also provides the amount of time for services rendered, will be of great value in determining compliance with this provision.

Initiated during the last reporting period, AFBH has continued to provide three, eight-week "closed" groups for up to six clients in HUs 35. "Closed" groups rely heavily on the group members supporting and interacting with each other with the expectation that clients who start the group attend consistently over the length of the group process. The eight weeks of activities are created to build upon previous sessions and there are generally "homework" assignments given to participants in between sessions for clients to work and in some cases bring back to the group for additional discussion/processing. In HU 35, AFBH provided two process groups, Expressive Arts and Coping Skills groups.

For HU 9 (currently in HU 2) and HU 24 (currently in HU 21), AFBH is providing three "open" Recreation Groups. In an "open" group, a client can attend one week and is not obligated to attend the following week; each group is structured and independent. These small groups are for clients who are on LOC-4/IOL (and some LOC-3 clients in the women's unit) and are generally held with up to three clients at a time. The purpose is to offer additional out-of-cell programming for AFBH's highest acuity clients. Activities and games are offered with a therapeutic overlay including music, mindfulness activities, practicing social skills and meaningful discussions with peers.

While AFBH was unable to offer small group activities to female population earlier this year, it is noted that groups are now being provided on the women's unit.

Individualized support and counseling services (identifying triggers, developing coping skills, care and case management) are being provided. AFBH also provides supportive and therapeutic strategies such as informative hand-outs, art, worksheets, information on diagnoses, skill building exercises, sleep methods, information on breathing and meditation techniques, and information on community-based resources. However, intensive individual services are not being provided as required by LOC, and treatment plans are not being developed for all IPs on the caseload.

Group therapy is not being conducted in RH Units due to security concerns but ACSO is in the process of procuring secure programming chairs that will allow treatment services to be provided without the presence of an ACSO deputy. The retrofitting of the C pod in RH will also address the provision of group services.

Therapeutic/educational groups are also provided by contracted staff from Telecare. Telecare is contracted to provide six groups per day (Monday through Saturday), with up to six participants per group, in THUs 9 (currently in HU 2), 24 (currently in HU 21) and 35. Telecare groups follow the nationally-recognized "Seeking Safety" curriculum and educational groups on co-occurring disorders (COEG), i.e., the relationship between substance use and mental health disorders.

The number of groups provided by Telecare has continued to increase during this reporting period from an average of 112 per month in the prior reporting period to an average of 138 in this reporting period; a 23% increase in groups. This is a significant impact in available groups.

However, the number of groups actually conducted was 75% of the contracted amount. Telecare-led group activity records for the reporting period of January 2025 through June 2024 are as follows:

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A cursory review of group participation suggests that more IPs are participating in the scheduled groups. However, AFBH is encouraged to work with Telecare to develop a reporting mechanism that will allow for a closer look at utilization in the next reporting period.

For the past year, Lifelong Medical Care has been providing on-site substance use counseling services through a contract with ACBHD. Lifelong is scheduled to provide six groups per week in HUs 9 (currently in HU 2), 24 (currently in HU 21) and 35. Records of groups provided by Lifelong over the current reporting period indicate a total of 121 groups provided in the months of January through June, with up to six AFBH clients per group. It is notable that groups are now being afforded to the female IPs in HU 21. The number of groups conducted was 77% of the contracted amount. The groups are psychoeducational and focus on substance use and trauma. Lifelong is also providing individual sessions on Tuesdays and Wednesdays for IPs with histories of substance use.

Even with the current efforts made through Lifelong and Telecare, substance abuse services are critical and need to be expanded.

As discussed in prior provisions (717, 724), the ability to provide appropriate clinical services is also limited by the lack of sufficient proper, confidential meeting areas. ACSO has converted C pods and multi-purpose rooms in HUs 1, 2 and 9 and multi-purpose rooms in HUs 25 and 35 for use as treatment areas for groups and individual encounters. The impact of these additional spaces will be evident in the next reporting period.

A few areas which have also served for confidential meetings will continue to be used. These include, non-contact visitation areas, specific spaces in the Sandy Turner Center, training rooms and quasi-yards.

Recommendation(s):

1. AFBH to develop policies regarding the therapeutic services, including descriptions and specifications of individual and group interventions, to be provided both in the THUs and wherever IPs with a mental health LOC designation are housed.
2. As AFBH staff and/or contracted clinical services increase, a greater range and frequency of therapeutic services in the various housing areas where IPs on the mental health caseload are housed should be provided.

3. AFBH to continue collaboration with ACSO in the design of permanent spaces and staffing allocation for the THUs which will allow for confidential, clinically appropriate encounters.

727. Provide in-cell activities, such as therapeutic and self-help materials to decrease boredom and to mitigate against isolation.

Finding: Partial Compliance

Policies: Need Development

Training: N/A

Metrics: Interviews with Staff, Observations, Case Record Reviews

Assessment: AFBH Forensic Behavioral Health Clinical Managers continue to report that clinicians provide clients with reading assignments/suggestions and therapeutic activities/worksheets. Some activities are also available through IP electronic tablets. AFBH also provides supportive and therapeutic strategies such as informative hand-outs, art, worksheets, and information on diagnoses, skill building exercises, sleep methods, breathing and meditation techniques, and community-based resources. IPs that attend group therapy activities are provided with "take-away" materials for further consideration/discussion. During this tour, AFBH leadership stated that they will request their consulting psychologist to identify and develop an in-cell activity protocol.

Recommendation(s):

1. AFBH to research current self-help materials for a range of clinical diagnoses and, upon review and approval, obtain/purchase as necessary.
2. AFBH to work with ACSO to ensure that selected self-help materials are acceptable to security.
3. AFBH to develop policies regarding the use of self-help materials to be disseminated wherever IPs with a mental health LOC designation are housed; to include documentation of efforts and training.
4. AFBH to research the availability and applicability of therapeutic, self-help materials on electronic tablets; discuss with ACSO and vendor.
5. AFBH and ACSO to develop a system to track issuance and engagement.

728. Develop formal clinical treatment teams comprised of clinicians and other appropriate staff for each Therapeutic Housing Unit and Restrictive Housing Unit to deliver mental health care services to Behavioral Health Clients housed in those units within six (6) months of the Effective Date. These teams shall work similar schedules and be co-located in an adequately sized space to allow for frequent treatment team meetings for each individual client and collective pods, which shall enable them to collaborate on providing programming for their assigned housing units. For Behavioral Health Clients not housed in a Special Handling Unit, a clinician and/or another provider shall be assigned as needed.

Finding Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol

Training: N/A

Metrics: Interviews with Staff, AFBH THU Master Schedule, AFBH SRJ Staff Assignments

Assessment: AFBH continues to operate THUs in Units 9 (currently in HU 2), 24 (currently in HU 21), and 35 with dedicated clinical Treatment Teams providing services. A clinical team is also assigned to RH (Unit 1). Current AFBH staffing allows for the designation and co-location of these clinical teams composed of clinicians and psychiatrists. However, the continued limitations in staff do not permit that the teams work similar schedules as required by the provision. Nevertheless, the frequent huddles and rounds support the sharing of treatment-related information between treatment team members. During this reporting period, AFBH leadership implemented a weekly "Expanded Huddle" at each THU during which more detailed review of clients would be conducted.

There is an insufficient number of clinicians to consistently implement all the required treatment services.

Recommendation(s):

1. Refer to provisions 200/204, 702, 723 and 726.

729. Develop and implement policies and procedures to establish treatment teams to provide formal, clinically appropriate individualized assessment and planning (treatment plans) for Behavioral Health Clients receiving ongoing mental health services. Assessment and planning for mental health services includes, at minimum, diagnosis or diagnoses; a brief explanation of the inmate's condition(s) and need for treatment; the anticipated follow-up schedule for clinical evaluation and assessment including the type and frequency of diagnostic testing and therapeutic regimens if applicable; and counsel the patient about adaptation to the correctional environment including possible coping strategies.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol, ACSO Policy and Procedure 13.01 Medical and Mental Health Care

Training: Requires Development

Metrics: Case Record Reviews

Assessment: AFBH operates THUs in Units 9 (currently in HU 2), 24 (currently in HU 21) and 35 with dedicated clinical Treatment Teams providing services. A clinical team is also assigned to RH (Unit 1). However, there is an insufficient number of clinicians to consistently implement all the required treatment services. Individual assessment and planning, as required by this provision, is not possible given current staffing levels.

A policy regarding Treatment Teams has not been developed.

Refer to provisions 200/204, 702, 723 and 726.

Recommendation(s):

1. Refer to provisions 200/204, 702, 723 and 726.
2. AFBH needs to develop a policy and procedures specific to Treatment Teams.

730. Individualized mental health treatment plans shall be developed for all Behavioral Health Clients by a Qualified Mental Health Professional within thirty (30) days of an incarcerated person's initial mental health assessment at intake or upon referral. Plans shall be reviewed and updated as necessary at least every ninety (90) days for Behavioral Health Clients generally and every thirty (30) days for SMI Clients, and more frequently as needed. The treatment plan shall include treatment goals and objectives including at least the following components: (1) documentation of involvement/discussion with the incarcerated person in developing the treatment plan, including documentation if the individual refuses involvement; (2) frequency of follow-up for evaluation and adjustment of treatment modalities; (3) adjustment of psychotropic medications, if indicated; (4) when clinically indicated, referrals for testing to identify intellectual disabilities, medical testing and evaluation, including blood levels for medication monitoring as required; (5) when appropriate, instructions about diet, exercise, incarcerated personal hygiene issues, and adaption to the correctional environment; (6) documentation of treatment goals and notation of clinical status progress (stable, improving, or declining); and (7) adjustment of treatment modalities, including behavioral plans, as clinically appropriate. The treatment plan shall also include referral to treatment after release where recommended by mental health staff as set forth in Section III(I) (Re-entry Planning). Where individuals are discharged from suicide precautions, the plan shall describe warning signs, triggers, symptoms, and coping strategies for if suicidal thoughts reoccur.

Finding: Partial Compliance

Policies: Require Development

Training: Ongoing

Metrics: Interviews with Staff, Case Record Reviews

Assessment: During this reporting period, AFBH has continued its efforts to develop the requirement for treatment plans. As previously reported, initial efforts began in November 2023 with training provided by the AFBH locum Psychologist, Dr. Warner, specific to developing treatment plans for personality, depressive, and psychotic disorders. Dr. Warner worked individually with each clinician on treatment plan development, implementation and follow-up. Incentives unitized as part of treatment planning include additional time with clinician, access to reading materials, playing basketball, coloring materials, etc. The following improvements were noted in the clients with active treatment plans: behavioral changes, improved psychotropic medication compliance and hygiene and improved communication of needs. Clinicians continue to meet with Dr. Warner weekly to review and develop treatment plans. Treatment plan efforts have expanded significantly since the prior report with an estimated 300 plans in effect.

Treatment plans are now being developed for clients: in custody for more than 30 days, on an IOL for 14 days or more, when IOL status is discontinued, in the Early Access to Stabilization Services Program (EASS) program, and those contraindicated for RH.

Since the last report, treatment plans have been written into CG. Very recently, a separate Treatment Plan form was incorporated into CG and will be used to document the effort. The Treatment Plan form as required by the CD is to present clearly delineated initial problems and goals, and progress towards those goals and completed within the required timeframes.

During this tour, this Joint Expert attended an AFBH training on treatment plans which was attended by clinicians and psychiatrists. The information was well-presented and received with appropriate questions from attendees. In addition to explaining how to develop the treatment plan format in CG, attendees were advised of the informational "banks" of treatment goals and interventions for DSM 5 diagnoses. This information is monumental in assisting in the development and writing of meaningful treatment plans.

This Joint Expert expects AFBH to address how treatment plans will be developed for all IPs on the mental health caseload in keeping with the provision.

Recommendation(s):

1. AFBH to continue expanding the development of treatment plans across all LOCs.
2. AFBH needs to develop a policy related to mental health treatment plans (initial and follow-up) as specified in the Consent Decree; develop the appropriate form(s); submit for review and approval.
3. Continue conducting training on the treatment plan policy/procedures as necessary.
4. AFBH must develop an auditing/monitoring process for compliance with treatment plan policy.

731. Develop and implement policies and procedures to provide consistent treatment team meetings to increase communication between treating clinicians, provide a forum for the discussion of difficult or high-risk individuals, and assist in the development of appropriate treatment planning. AFBH shall consult with ACSO regarding an individual's treatment plan as deemed appropriate by a Qualified Mental Health Professional and in a manner which protects client confidentiality to the maximum extent possible consistent with HIPAA requirements.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol, AFBH Levels of Care Policy, ACSO Crisis Communications for Corrections Training

Training: Requires Development

Metrics: Interviews with Staff, Suicide Prevention Meeting documentation, AFBH Rounding Notes, Therapeutic Housing Committee Meeting documentation

Assessment: As previously reported, a biweekly Therapeutic Housing Committee (THC) meeting, which constitutes a multi-disciplinary treatment team meeting, is held to discuss clients from the current THUs and their mental health issues. Clients who remain at the LOC 4 designation for more than ten days are also discussed at these meetings. The goal of the THC meeting is to discuss the clinical presentation of IPs and how the unit's Treatment Teams can improve the adaptation and stabilization of the persons on the units.

THC documentation for this reporting period is extensive and includes an agenda, sign-in sheet and specific information for all IPs presented for discussion. It is noted that ACSO rank staff is present at every meeting.

It is essential that the Therapeutic Housing Committee meetings address all the clients in need of discussion from the various THUs. While individual unit meetings may not be necessary, sufficient attention to clients in all the units must be afforded.

Huddles, held at the THUs and RH five days per week, also provide a forum for treatment team members to share and discuss IPs of concern. An "expanded huddle" is also occurring at each THU once per week with focus on individual clients. Refer to provisions 702 and 704.

Monthly Suicide Prevention Meetings also occurred during this reporting period. The meetings serve an opportunity to discuss IPs with "Code 3" incidents and those that have required a Section 5150 transfer as well as at-risk clients who remain at the LOC 4 designation for 30 days. The purpose of these interagency reviews is to exchange information and determine other possible strategies to assist in the person's improvement and step down from LOC 4 status. A review of the meeting documentation showed that a total of 42 persons were discussed at the meetings. Each Code 3 and 5150 IPs was discussed over the course of at least two meetings. These ongoing discussions can be very helpful for staff and improve interventions and responses towards the clients.

Recommendation(s):

1. Conduct Therapeutic Housing Committee/treatment team meetings in the separate HUs, as necessary, to afford sufficient opportunity for discussion and planning.
2. Continue monthly Suicide Prevention Meetings; continue emphasis on IPs on LOC 4 for more than 30 days.
3. Refer to provisions 702 and 704.

732. Provide information discussed in treatment team meetings to medical providers when indicated to ensure communication of relevant findings and issues of concern.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol, ACSO-Crisis Communications for Corrections Training, Draft-Psychiatric Referrals and Appropriate Training Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff

Assessment: Medical providers **(**AFBH Psychiatrists and nursing representatives from the medical provider, Wellpath) do not routinely participate in the THU Committee meetings. Medical providers do attend huddles, but these meetings do not ensure a formal means of communicating relevant findings and issues of concern. The THU Committee Meetings could serve as a forum for communication of medical information. Refer to Provision 731.

The Draft-Psychiatric Referrals and Appropriate Training Policy is expected to assist in ensuring that psychiatrists are notified and apprised of IP needs.

Recommendation(s):

1. A formal means of communicating treatment team meeting issues to medical providers need to be developed.
2. AFBH to finalize the Draft-Psychiatric Referrals and Monitoring Training Policy and train staff accordingly.
3. Refer to provision 731.

733. Provide calming and restorative instruction, which may include incarcerated person classes or groups on a regularly scheduled basis in units housing Behavioral Health Clients.

Finding: Partial Compliance

Policies: Require Development

Training: N/A

Metrics: Observation, Interviews with Staff, Case Record Reviews

Assessment: Individual AFBH clinicians provide services throughout the SRJ wherever AFBH clients are housed with concentrated efforts in the THUs (8, 9 (currently in HU 2), 24 (currently in HU 21) and 35) and RH (Unit 1). Refer to provisions 725 and 726.

Initiated during the last reporting period, AFBH has continued to provide three, eight-week “closed” groups for up to six clients in HUs 35. “Closed” groups rely heavily on the group supporting and interacting with each other with the expectation that clients who start the group to attend over the length of the group process. The eight weeks of activities are created to build upon previous sessions and there are generally "homework" assignments given to participants in between sessions for clients to work and, in some cases, bring back to the group for additional discussion/processing. In HU 35, AFBH provided two process groups, Expressive Arts and Coping Skills groups.

For HU 9 (currently in HU 2) and HU 24 (currently in HU 21), AFBH is providing three “open” Recreation Groups. In an "open" group, a client can attend one week and is not obligated to attend the following week; each group is structured, but stand alone. These small groups are for clients who are on LOC-4/IOL (and some LOC-3 clients in the women's unit), and are generally held with up to three clients at a time. The purpose is to offer additional out-of-cell programming for AFBH's highest acuity clients. Activities and games are offered with a therapeutic overlay including; music, mindfulness activities, practicing social skills and meaningful discussions with peers.

While AFBH was unable to offer small group activities to female population earlier this year, it is noted that groups are now being provided on the women's.

Recommendation(s):

1. AFBH to increase the delivery of therapeutic/counseling services as their staffing increases.
2. AFBH to research the possibility of meditation, yoga, and other calming and restorative therapies for use; determine how these might be made available.

734. Provide substance abuse programs targeted to individuals with co-occurring mental health and substance abuse issues on a regularly scheduled basis for Behavioral Health Clients.

Finding: Partial Compliance

Policies: Require Development

Training: N/A

Metrics: Interviews with Staff, Telecare Schedule and Service Logs, Lifelong Schedule and Service Logs

Assessment: AFBH has been increasing its attention to the issue of substance use among the IPs. AFBH has added a substance use flag to its Community Health Record (CHR), the database used to track LOC and SMI and to schedule clients.

IPs identified with only a substance use disorder at intake will be identified as an LOC 1 and followed by AFBH clinicians. According to AFBH leadership, since the initiation of efforts to formally identify substance use disorders among the detainees, over 2,000 referrals have been made to AFBH.

AFBH has entered into an agreement with Options Recovery Services to provide individual SUD counseling primarily for non-THU AFBH clients.

For clients in the THUs, therapeutic/educational groups are provided by contracted staff from Telecare. Telecare is contracted to provide six groups per day (Monday through Saturday), with up to six participants per group, in THUs 9 (currently in HU 2), 24 (currently in HU 21) and 35. Telecare groups follow the nationally-recognized "Seeking Safety" curriculum and educational groups on co-occurring disorders (COEG), i.e., the relationship between substance use and mental health disorders.

The number of groups provided by Telecare has continued to increase during this reporting period from an average of 112 per month in the prior reporting period to an average of 138 in this reporting period; a 23% increase in groups. This is a significant impact in available groups. However, the number of groups conducted was 75% of the contracted amount. Telecare-led group activity records for the reporting period of January 2025 through June 2024 are as follows:

Month	# of Groups
January 2025	196
February 20254	139
March 2025	143
April 2025	128
May 2025	124
June 2025	99
Total/Average per Month	829/138
Prior Report Average per Month	112

A cursory review of group participation suggests that more IPs are participating in the scheduled groups. However, AFBH is encouraged to work with Telecare to develop a reporting mechanism that will allow for a closer look at utilization in the next reporting period.

For the past year, Lifelong Medical Care has also been providing on-site substance use counseling services to THU clients through a contract with ACBH. Lifelong is scheduled to provide six groups per week in HUs 9 (currently in HU 2), 24 (currently in HU 21) and 35. Records of groups provided by Lifelong over the current reporting period indicate a total of 121 groups provided in the months of January through June, with up to six AFBH clients per group. It is notable that groups are now being afforded to the female IPs in HU 21. The number of groups conducted was 77% of the contracted amount. The groups are psychoeducational and focus on substance use and trauma. Lifelong is also providing individual sessions on Tuesdays and Wednesdays for IPs with histories of substance use.

Even with the current efforts made through Lifelong and Telecare, substance abuse services are critical and need to be expanded. AFBH and ACSO need to intensify their efforts for these specialized community service providers to provide treatment services in the SRJ.

In support of its re-entry efforts, AFBH is utilizing Center Point, Inc., as the contracted provider for "secondary-level" SUD assessment at SRJ. When an IP is identified with SUD and states they are interested in services and agrees to an assessment, AFBH refers them to Center Point. Center Point conducts an ASAM (American Society of Addiction Medicine) Criteria Level of Care Assessment, a nationally recognized assessment tool. Based on assessment results, Center Point identifies the SUD level of care best suited for the client and works with the AFBH Re-Entry Team on securing appropriate placement upon release. AFBH initiated a small pilot program with Center Point, Inc. to help facilitate the implementation of this new secondary screening process. Further information on the outcome of this additional service will be available for the next report.

Recommendation(s):

1. Additional contracted and/or volunteer community-based substance use treatment providers should be permitted to provide on-site services.
2. In the future, ACBHD will need to increase the contractual arrangement with providers and/or AFBH staff will need to provide the substance use programming to meet the Consent Decree provisions.
3. AFBH to ensure that policies, with related forms and training, for substance abuse services are developed and followed by AFBH and contracted staff.

735. Provide daily mental health rounds in Restrictive Housing Units and Therapeutic Housing Units to allow for direct observation of and interaction with the incarcerated individual, including face-to-face contact and specific outreach to people on psychiatric medications to check their status. Individuals shall be permitted to make requests for care during these rounds. Where a Qualified Mental Health Professional determines that an individual's placement in Restrictive Housing Unit is contraindicated, they may initiate transfer of the individual to a higher level of care in a Therapeutic Housing Unit.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Observations, Case Record Reviews, AFBH Rounding Notes

Assessment: Implementation of the THUs in 9 (currently in HU 2), 24 (currently in HU 21) and 35 include the assigning of dedicated clinical teams and interdisciplinary huddles to discuss unit issues and identify specific persons in need of clinical attention. Rounds for LOC 4 IPs and persons identified in need of clinical attention were initiated in April/May of 2023 and continue to date. Rounds are being conducted five days per week for any IPs with a LOC 4 in THU 9 and in THU 24 (currently in HU 21) Monday through Friday. Rounds should be occurring daily and need to include the Treatment Team, including the Psychiatrist.

Rounds provide an opportunity for a brief overview of the person's functioning. The rounds process is directed by the AFBH Rounding Report which is prepared daily and provided to THU staff. The document lists the IPs with a LOC 4 designation and allows for notes regarding the rounds to be added. Individual rounds are documented in CG. Case record reviews support that Deputies, Wellpath nurses and psychiatrists are participating in rounds.

A designated clinical Treatment Team is also present in the RH unit and conducts huddles five days per week. If an IP in RH experiences symptom exacerbation or displays signs of mental health decompensation, the team will take measures to move the person from RH to a more appropriate housing environment.

Refer to provisions 200/204 and 702.

Recommendation(s):

1. Refer to provisions 200/204 and 702.
2. Treatment Team rounds in THUs for LOC 4 clients are to be conducted daily (seven days per week).

736. Offer weekly face-to-face clinical contacts, that are therapeutic, confidential, and conducted out-of-cell, for Behavioral Health Clients in Restrictive Housing Units and Therapeutic Housing Units.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol

Training: N/A

Metrics: Interviews with Staff, Case Record Reviews

Assessment: Refer to provisions 200/204, 702 and 723 to 726.

Recommendation(s):

1. Refer to provisions 200/204, 702 and 723 to 726.

737. Provide additional clinical contacts to individuals in Restrictive Housing Units and Therapeutic Housing Units, as needed, based on individualized treatment plans.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol

Training: Requires Development

Metrics: Interviews with Staff, Case Record Reviews

Assessment: Dedicated Treatment Teams on the THUs and RH provide therapeutic contacts and rounds (for LOC 4 persons) for certain IPs but are not based on individualized treatment plans.

The development of confidential treatment areas because of the C pod and multi-purpose room conversations in the THUs will assist in increasing out-of-cell clinical activities.

As discussed in provision 730, there are approximately 300 IPs on the AFBH caseload with current treatment plans. However, AFBH is continuing to expand treatment planning with a goal for 2025 to have treatment plans in place for all AFBH clients: who are at SRJ for more than 30 days, on an IOL for greater than 14 days, contraindicated for placement in RH, in the EASS program or when an IOL is discontinued.

Case record reviews for this rating period show that re-entry clinicians are also establishing contact with AFBH clients to assess and discuss re-entry plans. Casenotes support that re-entry services are ongoing, in addition to and complementing services provided by the assigned Treatment Teams.

Recommendation(s):

1. Refer to Provisions 728, 730, 736 and 900 through 903.
2. Treatment Team rounds in THUs for LOC 4 clients are to be conducted daily (seven days per week).

738. Defendants shall ensure individuals expressing suicidal ideation are provided clinically appropriate mental health evaluation and care. Individuals who express suicidal ideation shall be assessed by a Qualified Mental Health Professional and shall not be placed in restrictive housing if a Qualified Mental Health Professional determines they are at risk for suicide.

Finding: Partial Compliance

Policies: AFBH Preventing Suicide and Self-Harming Behavior Policy, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews, ITR Call Logs

Assessment: The AFBH Preventing Suicide and Self-Harming Behavior Policy and Procedure has been approved. The policy explains how AFBH assesses suicide at intake (using the BIA) and post-intake with the AFBH Suicide Risk Assessment tool. Based upon the information on the

assessments as well as the LOC designation, the person may be placed in a THU, on IOL status, or may warrant an immediate Welfare and Institutions Code Section 5150 referral. AFBH's ITR Crisis Team conducts an assessment when notified of an incarcerated person expressing suicidal ideation. According to AFBH leadership, the suicide risk assessment is typically conducted within one hour of receiving the notification.

Emergent and urgent referrals for AFBH assistance in situations that involve concerns of suicide and self-harm are often made by phone to the ITR Crisis Team and documented in ITR Call Logs. As requested, the Log has been modified to require the time of the response to the request. A review of the response time for emergent and urgent referrals made to ITR are occurring within the established required timeframes (See provisions 706-708).

Recommendation(s):

1. Training of all clinicians on the policy must take place.
2. AFBH needs to develop a plan to ensure a timely response to referrals related to suicide risk.
3. ITR staff are to be required to enter the time of the response and appropriate comments on the ITR Call Log.

739. Defendants shall ensure that psychiatric medications are ordered in a timely manner, are consistently delivered to individuals regardless of where they are housed, and are administered to individuals in the correct dosages. Defendants shall integrate the Jail's electronic unit health records systems in order to share information regarding medication administration and clinical care as appropriate between the Jail's medical and mental health providers and outside community providers operated through the County. Psychiatric medications prescribed by community-based providers shall be made available to Behavioral Health Clients at the Jail unless a Qualified Mental Health Professional makes a determination that it is not clinically appropriate. Any decision to discontinue and/or replace verified medication that an individual had been receiving in the community must be made by a prescribing mental health provider who shall document the reason for discontinuing and/or replacing the medication and any substitute medication provided. Defendants shall ensure that, absent exigent circumstances, initial doses of prescribed psychiatric medications are delivered to inmates within forty-eight (48) hours of the prescription, unless it is clinically required to deliver the medication sooner.

Finding: Partial Compliance

Policies: AFBH Bridge Medication Policy, AFBH Santa Rita Jail Intake Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews, Bridge Medications Log, ITR Call Logs, Continuity of Care Psychiatric Medications Audit Tool

Assessment: The AFBH Bridge Medications policy has been approved, and training has occurred and will continue as part of ITR training. This policy comprehensively addresses the process required by the CD.

At intake, AFBH staff obtain information regarding current medication prescriptions and process documentation to obtain verification of prescriptions. In policy, current medications are to be

verified within 24 hours of intake by ITR staff and entered in CorEMR (the Wellpath EMR). Efforts to comply with this procedure are made and documented in the person's case record. If medications cannot be verified according to timelines established in policy, the person will be placed on the scheduled psychiatrist's Immediate Care Clinic (ICC) schedule for the following day. Case record reviews support the process of verifying bridge medications at intake.

AFBH clerical compiles a Bridge Medications Log tracking report monthly. The Log is available for review. The Log lists each person for whom a verification request was made and the outcome of the verification (e.g., person referred to ICC, medications ordered, verification received). Although a valuable tool, it has been determined that the Bridge Medications Log has duplicated and inconsistent information. It Is recommended that AFBH address the reliability of the information in the Bridge Medications Log.

To further assess the process of providing bridge medications, AFBH is expected to conduct a quarterly audit utilizing the Continuity of Care Psychiatric Medications Audit Tool. This audit reviews the actions of the psychiatrists and nursing staff in the process of rendering bridge medications. One audit was prepared during this reporting period in April 2025 and reviewed for the purposes of this provision. The audit indicates compliance rates between 92% and 100% on the audit tool items which assessed if medications were verified within 24 hours, ordered within 24 hours by psychiatric providers, and if medications were delivered within 48 hours by Wellpath nurses. It is encouraging that AFBH is now conducting audits of their processes. Future monitoring by this Joint Expert will focus on the quality of these audits.

As compliance is also dependent upon the delivery of medications, the appropriate Wellpath policy has also been reviewed and found to be consistent with the CD provision. According to their policy, once initial doses of psychiatric medications are ordered, the medications are immediately placed for the next available medication administration line. Specifically, daily and evening (HS) medication will be provided within 24 hours, twice a day (BID) medication within 12 hours, and three times a day (TID) medication within 12 hours.

Recommendations:

1. Formal training of all appropriate staff on the policy will be necessary.
2. The Continuity of Care Psychiatric Medications audits need to be continued and provided to this Joint Expert as proof-of-practice.
3. AFBH and Wellpath need to develop and provide proof-of-practice for the delivery of medications within the 48-hour timeframe.

740. Defendants shall maintain an anti-psychotic medication registry that identifies all inmates receiving two (2) or more anti-psychotic medications, the names of the medications, the dosage of the medications, and the date when each was prescribed. The lead psychiatrist shall review this registry every two (2) weeks to determine: (1) continued justification for medication regimen, (2) whether one medication could be used to address symptoms, and (3) whether medication changes are needed due to an adverse reaction. All determinations and required actions shall be documented.

Finding: Substantial Compliance

Policies: AFBH Polypharmacy Antipsychotic Medication Registry and Monitoring Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, AFBH Antipsychotic Polypharmacy Report

Assessment: This provision was considered in Substantial Compliance as of the last report. The AFBH Polypharmacy Antipsychotic Medication Registry and Monitoring policy which addresses the specific requirements of this Provision has been implemented. Formal training on the policy has been completed.

As required by policy, a Antipsychotic Polypharmacy Report is to be completed every two weeks. Reviews of the documents for every two-week period in this reporting period are consistent with the findings of the last period with prescribers appearing to consider the critical questions, i.e., whether more than one antipsychotic medication is warranted, if one medication could be used to address symptoms and reduce adverse effects, and whether medication changes are needed due to an adverse reaction. A notable and positive addition to the Report is a Summary of the findings.

Recommendation(s):

1. AFBH to continue compiling the Antipsychotic Polypharmacy Report and Summary on a biweekly basis as required by policy.
2. Continue to submit proof of compliance with the audit process to this Expert.

741. Defendants shall ensure that health care staff document when individuals refuse prescribed psychotropic medications and follow-up by referring the patient to the AFBH prescribing provider after four refusals of the same medication in a one-week period or three (3) consecutive refusals of the same medication in a one-week period.

Finding: Partial Compliance

Policies: Draft – Refusals of Prescribed Psychiatric Medications and Compliance Audit Requirements

Training: Pending

Metrics: Interviews with Staff, SRJ ATIMS Medical-Notes Report, Case Record Reviews, Medication Refusal Audit

Assessment: AFBH has drafted a policy to address the reporting and handling of medication refusals in accordance with this provision.

As previously reported, when an incarcerated person refuses three medication doses, Wellpath nursing enters a notification into ATIMS. Each day, ACSO runs the Medical-Notes Report and forwards it to AFBH supervisory personnel. The AFBH Medical Assistant (MA) reviews the ATIMS report and identifies any IPs with medication-related issues and notifies the appropriate psychiatric Provider who handles the referral and determines the response. The Wellpath policy on “Informed Consent and Right to Refuse” specifies that “if a patient misses four (4) doses in a seven (7) day period, or establishes a pattern of refusal, the patient is referred to the prescribing provider…after the fourth missed dose.”

Case record reviews conducted by this Joint Expert found that referrals by Wellpath regarding medication non-compliance are being made and that follow-up interventions by psychiatry,

identified as “Medication Support” in CG, are being provided and documented. The ITR Call Log also lists numerous occasions when ACSO Deputies have contacted AFBH to inform of medication-related situations including non-compliance.

Using the information entered in ATIMS by Wellpath, AFBH staff review and take steps, such as case record reviews, discussing the person in a huddle, or making an appointment to see the person to address medication refusals. The process needs to be formalized in policy which should also include formal audits of the medication refusal process.

A Medication Refusal Audit for the month of February 2025 was made available for review by this Joint Expert. The audit involved a random selection of case records equivalent to 5% of the current population on psychotropics (N=63). The audit found that 33 of the 63 clients had refused medications for a total of 133 medication refusals. However, only 14 of the 133 refusals were referred by nursing staff. A mere 11% compliance with the referral process. It is recommended that these audit findings be considered for possible procedural modifications. This Joint Expert has had discussion with AFBH regarding the audit tool procedures to ensure that it can be used as proof-of-practice for the provision.

Recommendation(s):

1. AFBH to revise and finalize the draft policy that addresses the requirements of this provision.
2. Conduct formal training as necessary.
3. Conduct audits as stipulated in policy.
4. Revise the audit tool process and submit proof-of-practice of the audit process to this Joint Expert.

742. Defendants shall conduct audits on a periodic basis of 5% of charts of all patients receiving psychotropic medications with the frequency of such audits to be established in consultation with the joint neutral mental health expert to ensure that psychotropic medication is appropriately administered and that referrals for psychotropic medication refusals are being made consistent with policy. Charts will be randomly selected and are to include patients in all applicable housing units.

Finding: Partial Compliance

Policies: Draft – Refusals of Prescribed Psychiatric Medications and Compliance Audit Requirements

Training: N/A

Metrics: None

Assessment: Compliance with this provision requires a clinical audit of the medication administration process for 5% of the population receiving psychotropic medications. The current Medication Refusal Audit process, discussed in provision 741, can serve to identify the 5% sample but the required audit must consider more details regarding medication administration than medication refusals. It is recommended that a Quality Assurance policy for AFBH services be drafted and that this be included in that policy.

Recommendation(s):

1. AFBH to develop a policy/modify existing policy that addresses the requirements of this provision.
2. Conduct formal training as necessary.
3. Conduct audit as stipulated in policy.
4. Submit proof-of-practice of the audit process to this Joint Expert.

743. Defendants shall develop, in consultation with Plaintiffs, a new mutually agreed upon Suicide Prevention Policy and associated training that shall include (a) Safety Cells.

Finding: Partial Compliance

Policies: AFBH Preventing Suicide and Self-Harming Behavior Policy, ACSO Policy and Procedure 8.12 Inmate Observation and Direct Visual Supervision, ACSO Policy and Procedure 8.13 Safety Cells, Temporary Holding Cells, and Multipurpose Rooms, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: N/A

Assessment: The AFBH Preventing Suicide and Self-Harming Behavior Policy received approval from ACBHD but formal training is still pending. The policy explains how AFBH assesses suicide and responds to suicide risk and how Safety Cells will be used.

Over the past three reporting periods, there had been no incidents involving the use of Safety Cells. As previously reported, Safety Cell use has been phased out in favor of IOL placements. IOL restrictions are being individualized to allow for less restrictive arrangements during an IOL placement. In this reporting period, there was one IP which required placement in a Safety Cell due to their continuous self-injurious behavior. This placement was a consensus decision involving ACSO and AFBH made in order to ensure that the IP was closely monitored and that his self-injurious behavior was kept to a minimum. This Joint Expert was also involved in the decision to use the Safety Cell in this instance.

Recommendation(s):
1. Formal training of all clinicians and other relevant staff must take place.
2. Refer to Provision 738.
3. AFBH and ACSO should continue to use Safety Cells only in the most exigent of circumstances to protect IPs and adhere to the 8-hour limit for placement.

744. Use of a safety cell should only be used as a measure of last resort for inmates expressing suicidal ideation and actively demonstrating self-harm. It is a primary goal of this Agreement to phase out the use of such cells to the maximum extent feasible as soon as it is safe to do so. To this end, Defendants shall reconfigure and/or construct suicide resistant cells within six months of the Effective Date. The Parties shall meet and confer within three (3) months of the Effective Date regarding: (1) the status of reconfigurations and/or construction efforts; (2) methods to expedite such efforts including areas to prioritize; and (3) any interim actions necessary to protect the mental health and safety of class members pending the completion of reconfiguration and/or construction efforts.

Finding: Substantial Compliance – Consider Discontinuation of Monitoring

Policies: AFBH Preventing Suicide and Self-Harming Behavior Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: ACSO Construction Update, Safety Cell Report

Assessment: As stated in 743, there had been no Safety Cell use for the past three reporting period. However, there was one incident during this reporting period. The determination to use the Safety Cell in the incident was warranted and a consensus decision between ACSO and AFBH.

Recommendation(s): This Joint Expert finds that the County has been in Substantial Compliance with this provision for the past three reporting periods (in excess of 12 months). Accordingly, this Joint Expert recommends the parties consider requesting this provision be terminated from the Consent Decree. In the meantime, the Expert will reduce monitoring of this provision in future reports.

745. Once that work is completed, Defendants agree to severely curtail the use of safety cells, except as a last resort, and to only use safety cells when an inmate expresses suicidal ideation and is actively demonstrating self-harm and there is no other safe alternative, subject to the limitations set forth below.

746. In the interim, safety cells should only be used in exigent circumstances in which the inmate poses an imminent risk of self-harm. A Qualified Mental Health Professional must evaluate the need to continue safety cell placement within one (1) hour of the initial placement to the extent feasible.

747. Individuals may not be housed in a safety cell for longer than eight (8) hours. During that time, the individual shall be re-assessed by mental health and either transported on a 5150 hold if appropriate or transferred from the safety cell to another appropriate cell, including a suicide resistant cell if necessary.

Finding: Substantial Compliance – Consider Discontinuation of Monitoring

Policies: AFBH Preventing Suicide and Self-Harming Behavior Policy, ACSO Policy and Procedure 9.04 Behavioral Health Clients and Therapeutic Housing Inmates, ACSO Policy and Procedure 8.12 Inmate Observation and Direct Visual Supervision, ACSO Policy and Procedure 8.13 Safety Cells, Temporary Holding Cells, and Multipurpose Rooms, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: ACSO Construction Update, Safety Cell Report

Assessment: These three provisions (745, 746 and 747) continue to have a rating of Substantial Compliance. There has been only one incident involving the use of a Safety Cell during this past

rating period. While difficult management situations have continued to occur involving IPs with psychiatric disorders, other management options are being utilized including placement in a THU, initiation of an IOL, and a Welfare and Institutions Code Section 5150 transfer. IOL restrictions are being individualized whenever possible to allow for less restrictive arrangements during the IOL placement. Increased AFBH staffing and presence on the THUs, emergency coverage and response when necessary, and the clinical Treatment Teams, which have a greater understanding of the clients in custody, are supporting the use of responses other than the use of Safety Cells.

ACSO's "cell softening" projects to retrofit and make cells more suicide resistant in HUs 9 and 24 were completed in early 2024.

Recommendation(s): This Joint Expert finds that the County has been in Substantial Compliance with these provision for the last three rating periods (in excess of 12 months). Accordingly, this Joint Expert recommends the parties consider requesting this provision be terminated from the Consent Decree. In the meantime, the Expert will reduce monitoring of this provision in future reports.

748. Defendants shall adopt graduated suicide precautions, including use of special purpose cells, reconfigured suicide resistant cells, one-on-one suicide watch, and a step down to suicide precautions with less intensive observation. Cells with structural blind spots shall not be used for housing individuals on suicide precautions. Once Defendants have completed reconfiguration and/or construction of suicide resistant cells, the use of safety cells shall be limited to no more than four (4) hours.

752. Defendants shall develop new policies and associated training, as set forth in Section IV(A), regarding the use of suicide precautions, including one-on-one suicide watch, step down to suicide precautions, and associated cleaning schedules for any cells used for suicide precautions. Defendants shall identify and implement a suicide risk assessment tool to assist staff in the appropriate determination of suicide risk described in Section III(F)(1)(A).

755. Custody staff, medical staff, or mental health staff may initiate suicide precautions to ensure client safety. If the suicide precaution was not initiated by mental health staff, as soon as possible but at least within four (4) hours absent exigent circumstances, a Qualified Mental Health Professional must conduct a face-to-face assessment of the individual and decide whether to continue suicide precautions using a self-harm assessment and screening tool establishing actual suicide risk as described in Section III(F)(1)(A). The assessment shall be documented, as well as any suicide precautions initiated, including the level of observation, housing location, and any restrictions on privileges.

756. Individuals placed on suicide watch shall be placed on Close Observation. Individuals on Close Observation shall be visually observed at least every fifteen (15) minutes on a staggered basis. A Qualified Mental Health Professional may determine that Constant Observation is necessary if the individual is actively harming themself based on the application of specific criteria to be set forth in written policy. Individuals on Constant Observation shall be observed at all times until they can be transported in accordance with the Jail's Emergency Referral process as outlined in Section III(G)(5) or until a Qualified Mental Health Professional determines that Constant Observation is no longer necessary.

A Qualified Mental Health Professional shall oversee the care provided to individuals placed on either Close Observation or Constant Observation status.

Finding: Partial Compliance

Policies: AFBH Preventing Suicide and Self-Harming Behavior Policy, ACSO Policy and Procedure 8.12 Inmate Observation and Direct Visual Supervision, ACSO Policy and Procedure 8.13 Safety Cells, Temporary Holding Cells, and Multipurpose Rooms, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews, AFBH Monthly Suicide Prevention Meeting Documentation

Assessment: The AFBH Preventing Suicide and Self-Harming Behavior Policy and Procedure was approved by ACBHD leadership prior to the last report. The policy explains how AFBH assesses suicide and responds to suicide risk. The policy is consistent with the requirements of Provisions 748, 752, 753, 755, 756, 759 and 762. Formal training on the approved policy is pending; the training has been approved by this Joint Expert.

Specific to Provision 748, the policy addresses the use of "graduated" responses to suicide risk dependent upon the degree of the assessed risk. These include placement in a THU, transfer to JGPH, placement in Safety Cells, placement in IOL status and placement in a Restraint Chair. With the completion of the "cell softening" project, the timeframe for use of Safety Cells (if used) should be decreased to four hours.

Specific to provisions 755 and 756, when ACSO identifies a person with concerns of suicide risk, AFBH is notified to conduct a Suicide Risk Assessment. This typically occurs within one hour of notification by ACSO. Pending assessment, the person is likely to be placed on IOL status, i.e., Close Observation with 15-minute checks by Deputies.

Specific to provision 752, AFBH continues to assess for suicidality using the AFBH Suicide Risk Assessment Tool embedded in the BIA tool. The tool is available in the AFBH EHR. The tool is used at intake, whenever a person is considered for placement on suicide precautions, and prior to being removed from precautions. The decision to remove the person from suicide precautions is consulted with an AFBH psychiatrist, supervisor, or manager.

Recommendation(s):

1. All documents related to the AFBH Preventing Suicide and Self-Harming Behavior policy need to be finalized and approved training provided to all clinicians and relevant staff.
2. AFBH Supervisors and Managers need to conduct case record reviews to ensure that policies regarding the handling of incidents of suicide risk are being followed.
3. AFBH to continue to respond, as required by policy and procedure, to pre-planned use-of-force incidents and restraint chair placements.
4. Refer to provisions 738 and 743.

753. Defendants shall also continue to provide ongoing training regarding the appropriate use and development of safety plans with supervisory monitoring and

feedback regarding the adequacy of safety plans developed. To the extent it occurs, Defendants shall discontinue the use of language referencing suicide and/or safety contracts.

759. A Qualified Mental Health Professional shall complete and document a suicide risk assessment prior to discharging a prisoner from suicide precautions in order to ensure that the re-entry is appropriate, that appropriate treatment and safety planning is completed, and to provide input regarding a clinically appropriate housing placement. Individuals discharged from suicide precautions shall remain on the mental health caseload and receive regularly scheduled clinical assessments and contacts as deemed clinically necessary by a mental health clinician. Unless individual circumstances direct otherwise, mental health staff shall conduct an individualized follow-up assessment within twenty-four (24) hours of re-entry, again within seventy-two (72) hours of re-entry, and again within one week of re-entry.

762. All clinical mental health staff shall receive additional training on how to complete a comprehensive suicide risk assessment and how to develop a reasonable safety plan that contains specific strategies for reducing future risk of suicide.

Finding: Partial Compliance

Policies: AFBH Preventing Suicide and Self-Harming Behavior Policy, ACSO Policy and Procedure 8.12 Inmate Observation and Direct Visual Supervision, ACSO Policy and Procedure 8.13 Safety Cells, Temporary Holding Cells, and Multipurpose Rooms, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews, AFBH Monthly Suicide Prevention Meeting Documentation

Assessment: The AFBH Preventing Suicide and Self-Harming Behavior Policy and Procedure was approved by ACBHD leadership prior to the last report. The policy explains how AFBH assesses suicide and responds to suicide risk. The policy is consistent with the requirements of Provisions 748, 752, 753, 755, 756, 759 and 762. Formal training on the approved policy is pending; the training has been approved by this Joint Expert.

Specific to provisions 753 and 762, the policy also addresses the use of Safety Plans in response to an assessment of suicide risk. When necessary, Safety Plans are being completed in CG after an IP is discontinued from suicide watch.

As required by provision 762, training efforts on identifying suicide risk and preventing suicidal and self-harm behaviors are ongoing and will be modified as necessary as all the documentation is finalized.

AFBH needs to comply with ACSO policy regarding their role in pre-planned use-of-force incidents. When summoned, AFBH needs to respond and assist in these attempts to deescalate of an incident. AFBH needs to document their efforts in the person's mental health case record and/or ACSO documents.

AFBH is also required by policy to assess all restraint chair placements within specified time periods and document as appropriate. The review of ACSO placements for this period (January through June 2025) by the Custody Joint Expert, Terri McDonald, appears to indicate that a mental health clinician was involved either prior to or immediately after placement into the chair in all 19 recorded incidents. This is the second reporting period in which AFBH has achieved 100% compliance with this provision.

Case record reviews and reviews of the ITR Call Logs for this reporting period indicate that AFBH clinical staff are responding to communication from ACSO HU staff and ITR staff when inmates report suicidal ideation or display suicide risk behavior. AFBH clinical staff are responding by meeting with the person and conducting assessments of suicide risk within hours of the referrals and appropriately respond by changing the person's LOC, placing them in a THU and notifying psychiatry for a medication consult. However, the timeframe for responding was not consistently noted in the Log.

Recommendation(s):

1. All documents related to the AFBH Preventing Suicide and Self-Harming Behavior policy need to be finalized and approved training provided to all clinicians and relevant staff.
2. AFBH Supervisors and Managers need to conduct case record reviews to ensure that policies regarding the handling of incidents of suicide risk are being followed.
3. AFBH to continue to respond, as required by policy and procedure, to pre-planned use-of-force incidents and restraint chair placements.
4. Refer to provisions 738 and 743.

757. Individuals placed on suicide precautions shall continue to receive therapeutic interventions and treatment, including consistent out-of-cell therapy and counseling in group and/or individual settings and medication, as clinically appropriate. AFBH shall document in the individual's mental health record any interventions attempted and whether any interventions need to be modified, including a schedule for timely follow-up appointments. All individuals shall be encouraged to be forthcoming about any self-injurious thoughts and all reports of feeling thoughts of self-harm shall be taken seriously and given the appropriate clinical intervention including the use of positive incentives where appropriate.

Finding: Partial Compliance

Policies: AFBH Preventing Suicide and Self-Harming Behavior Policy,, ACSO Policy and Procedure 9.04 Behavioral Health Clients and Therapeutic Housing Inmates, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews

Assessment: As previously reported, with the implementation of the THUs, clients on suicide precautions (LOC 4) are receiving greater attention due to the efforts of the dedicated Treatment Team on the units. All clinical efforts, whether provided or refused, are documented in the IPs individual mental health case file.

Case record reviews conducted for this report and reviews of the ITR Call Log indicate that AFBH clinical staff are responding to communication from ACSO HU and ITR staff when inmates report suicidal ideation or display suicide risk behavior. AFBH clinical staff are responding by meeting with the persons and conducting assessments of suicide risk within hours of the referrals and appropriately respond by changing the person's LOC, placing them in a THU and notifying psychiatry for a medication consult. Typically, the person is also placed on an IOL which renders them in close supervision by ACSO Deputies; AFBH staff then assess persons on IOL a minimum of every three days.

Persons on LOC 4 and considered to be at risk of self-injury/suicide are "rounded" by the clinical Treatment Team. Rounds provide an opportunity for a brief overview of the person's functioning and are occurring on the THUs five days per week (THU 9; currently in HU 2). The rounds process is directed by the AFBH Rounding Report which is prepared daily and provided to THU staff. The document lists the IPs with a LOC 4 designation and allows for notes regarding the rounds to be added. Individual rounds are documented in CG.

IPs on LOC 4 for at least ten (10) days are also discussed in the bi-monthly Therapeutic Housing Committee meetings and those that remain at least 30 days on LOC 4 are discussed at the monthly Suicide Prevention Meeting.

Interdisciplinary huddles are occurring to discuss unit issues and identify specific persons in need of clinical attention and weekly "expanded huddles" can serve as an opportunity for greater assessment of the needs of LOC 4 clients.

Clients designated as an LOC 4 are expected to be seen at least every three days given their status of IOL as required by CD. Case record reviews support that IOL reviews are occurring, but not as often as required. Other therapeutic sessions are also taking place and documented in CG.

A treatment plan is being developed for any IP designated as an LOC 4 as well as any IP on an IOL. When appropriate, some treatment plans utilize positive incentives to assist in motivating treatment and medication compliance.

Recommendation(s):

1. As AFBH staffing levels increase, leadership should allocate staff to perform more frequent, as needed (individualized) clinical encounters with IPs on suicide precautions/IOL status in accordance with the Therapeutic Housing Protocol.
2. Frequency/pattern of individualized assessments need to be documented in the person's mental health case record.
3. Review of ACSO's current IOL status policy to reflect the requirements of the CD with concomitant training needs.

758. Qualified Mental Health Professionals shall see inmates on suicide precautions on an individualized schedule based on actual suicide risk, for instance, daily or hourly as needed to assess whether suicide precautions shall be continued. These assessments shall be documented including any modifications to suicide precautions deemed necessary, whether the individual refused or requested the assessment cell-side. Where individuals refuse assessment, a Qualified Mental Health Professional shall continue to attempt to see the individual and document all follow-up attempts. Psychiatrists, clinicians, or other providers as appropriate shall meet with custody staff on a daily basis

to review any individuals placed on suicide precautions regarding any collaborative steps that should be taken. These meetings shall be documented in the form of minutes stored and maintained by mental health staff or by entry in the individual inmate's record.

Finding: Non-Compliance

Policies: AFBH Preventing Suicide and Self-Harming Behavior Policy, ACSO Policy and Procedure 9.04 Behavioral Health Clients and Therapeutic Housing Inmates, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews

Assessment: Compliance with this provision requires that a QMHP "see inmates on suicide precautions on an individualized schedule based on actual suicide risk, for instance, daily or hourly as needed." This is not occurring. However, IPs at risk for suicide are housed in a THU and designated as LOC 4 which requires daily rounds, IOL assessments and other therapeutic assessments. The THUs also afford greater clinical interaction given the dedicated Treatment Teams assigned to the units. LOC 4 IPs are considered to be on IOL and are monitored every 15 minutes by ACSO staff.

While individual and group therapy is not denied to IPs in the THUs or on IOL status, the availability of these interventions is limited due to staffing and security concerns. Clinical efforts, whether provided or refused, are documented in the IPs individual mental health case record. At this time, all IPs designated as LOC 4 will have a treatment plan developed within 14 days after IOL is discontinued and a safety plan.

Recommendation(s):

1. As AFBH staffing levels increase, leadership should allocate staff to perform more frequent and individualized clinical encounters with IPs on suicide precautions/IOL status.
2. Supervisors to ensure that the frequency/pattern of individualized assessments are documented in the person's mental health case record.
3. Maintain cell-side encounters to only those situations where the person adamantly refuses to leave their cell and/or true safety concerns for the person and staff exist.
4. Policies regarding therapeutic services need to be developed and implemented.
5. Service delivery needs to be monitored by supervisory staff. AFBH supervisory staff needs to regularly audit clinician caseloads and client records to ensure that all clinical encounters are documented.
6. Refer to provisions 748 and 752.

764. Defendants shall develop and implement updated policies, practices, and associated training regarding reviews of suicides and suicide attempts at the Jail. All suicide and serious suicide attempt reviews shall be conducted by a multi-disciplinary team including representatives from both AFBH and custody and shall include: (1) a clinical mortality/morbidity review, defined as an assessment of the clinical care provided and the circumstances leading to the death or serious suicide attempt; (2) a psychological autopsy, defined as a written reconstruction of the incarcerated person's life with an emphasis on the factors that led up to and may have contributed to the death or serious

suicide attempt, (3) an administrative review, defined as an assessment of the correctional and emergency response actions surrounding the incarcerated person's death or serious suicide attempt; and (4) a discussion of any changes, including to policies, procedures, training, or other areas, that may be needed based on the review.

Finding: Partial Compliance

Policies: AFBH Preventing Suicide and Self-Harming Behavior Policy, ACSO Policy and Procedure 8.18 Inmate Death, ACSO Policy and Procedure 13.06 Suicide Prevention and Suicide Reviews

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Suicide Prevention Meeting documentation

Assessment: Monthly SRJ Suicide Prevention Meetings continued to occur during this reporting period. These meetings involve a clinical and custodial review of all incidents involving "Code 3" and 5150 transfers due to danger to self and depend upon the participation of AFBH, ACSO and Wellpath staff. Meeting documentation for the months of January through June 2025 was reviewed by this Joint Expert. The documentation details the client's suicidal behavior and incidents.

In cases of suicides or serious suicide attempts, ACSO and AFBH conduct individual agency reviews as described in their individual policies. Interagency meetings are also held within ten business days and further discussed at the monthly Suicide Prevention Meeting. However, there have been no suicides during this reporting period.

In the AFBH Preventing Suicide and Self-Harming Behavior policy, AFBH will conduct an internal review within 72 hours of these events to ascertain information in a timely manner. This internal AFBH review will encompass an assessment of the clinical care provided and the circumstances leading to the death or serious suicide attempt.

This Joint Expert has not reviewed any formal "psychological autopsy" defined in this provision as a written reconstruction of the incarcerated person's s life with an emphasis on the factors that led up to and may have contributed to the death or serious suicide attempt. AFBH leadership is in the process of contracting with a professional instructor for their supervisory staff.

Recommendation(s):

1. Training on the approved policy needs to be conducted.
2. Monthly Suicide Prevention Meetings should continue to be held with emphasis on developing a plan following case discussion. Documentation of the meetings should be forwarded to this Joint Expert.
3. AFBH Supervisors to complete the "psychological autopsy" training and utilize this tool to better understand suicidal behavior and develop preventative measures.

766. Defendants shall develop and implement standards and timelines for emergency referrals and handling of 5150 psychiatric holds for incarcerated persons. For individuals sent to John George Psychiatric Hospital, AFBH in coordination with ACSO, shall coordinate with John George to promote continuity of care, including sharing records and information about what led to decompensation, strategies for treatment, and treatment

plans to promote patient well-being after returning to the jail. AFBH shall further reassess the individual upon return to the jail to ensure the individual is stabilized prior to returning them to a housing unit. If AFBH staff determine that the individual is not sufficiently stabilized to safely function in a jail setting, they shall re-initiate a 5150 to John George. AFBH shall track the number of 5150 holds initiated from the Jail and perform a review of all cases where individuals were sent to John George, on at least a quarterly basis, to identify any patterns, practices, or conditions that need to be addressed systematically.

767. The County shall assess and review the quality of the care provided to incarcerated persons sent to John George, or any other psychiatric facilities that accept 5150s from the Jail, including continuity of care between John George and the Jail, the types and the quality of services provided to incarcerated clients and resultant outcomes including any subsequent suicide attempts or further 5150s. In particular, AFBH shall assess inmate/patients upon their return to the Jail to confirm they are no longer gravely disabled and/or suicidal. The County shall develop a process and procedures by which AFBH shall seek input from treating clinicians at John George regarding any needed changes to the individual's treatment plan. The County shall conduct this analysis within sixty (60) days of the Effective Date and develop a plan for addressing any issues, including whether the County could create any alternatives to sending Behavioral Health Clients in crisis to John George. A copy of the analysis and plan shall be provided to Class Counsel.

Finding: Partial Compliance

Policies: AFBH and JGPH Client Care Coordination Protocol, ACSO Policy and Procedure 8.12 Inmate Observation and Direct Visual Supervision, AFBH Santa Rita Jail Intake Policy and Procedures, AFBH Therapeutic Housing Units Protocol

Training: N/A

Metrics: Interviews with Staff, Case Record Reviews

Assessment: The Client Care Coordination Protocol, which addresses the emergency referral process from SRJ to John George Psychiatric Hospital (JGPH) and return from JGPH was approved by ACBHD leadership during this reporting period. However, as stated in the last report, the protocol is being reviewed for further improvements.

When a client is sent out on a 5150 psychiatric hold by AFBH, clinicians have a responsibility to call JGPH to notify them as well as send documentation to JGPH via email including: recent client casenotes, ATIMS and Clinician's Gateway face sheets, and a copy of the 5150 application. When a client is sent out on a 5150 by ACSO, either an ITR Clinician or clerical staff will send this packet.

When a person is coming into custody from JGPH, both as a new intake or an in-custody 5150 return, JGPH will email any evaluations, daily notes, discharge notes and medication lists to AFBH. Upon return to SRJ from JGPH, AFBH Clinicians will assess the person and determine whether the person can be taken into custody.

Case record reviews support the 5150 referral process and documentation.

AFBH and ACSO continue to meet with JGPH leadership monthly to discuss any topics related to client care coordination.

Recommendation(s):

1. Complete policy revisions and conduct training, as necessary, on the final policy.
2. AFBH needs to conduct a review of all referrals to JGPH on a quarterly basis to determine whether the policy and its procedures are being followed and to assess the efficacy of the arrangement.

769. Defendants shall re-orient the way in which all units, including the Therapeutic Housing Units, are managed so that all units provide appropriate access to therapeutic and behavioral health services as appropriate. Placement in and re-entry from a Therapeutic Housing Unit shall be determined by a Qualified Mental Health Professional, in consultation with custody staff as appropriate. Defendants shall provide a sufficient number of beds in the Therapeutic Housing Units at all necessary levels of clinical care and levels of security, including on both the Maximum and on the Minimum and Medium sides of the Jail, to meet the needs of the population.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol, AFBH Levels of Care Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: AFBH THU Master Schedule, Therapeutic Housing Committee Meeting, Lifelong Schedule and Service Logs, Telecare Schedule and Service Logs

Assessment: In the course of this tour, it was apparent that AFBH has been assuming greater operational control the THUs. The presence of dedicated clinical Treatment Teams and the structured opportunities for communication with ACSO such as huddles, rounds, and Therapeutic Housing Committee meetings are resulting in support for the delivery of mental health services. The processes and communication between entities regarding the appropriate placement in and removal of persons from the THUs appear to be occurring more smoothly.

The THU model requires that the inmate's housing environment/restrictions "match" their mental health condition, i.e., their LOC. As such, those most at risk of self-harm are placed in a setting that reduces the risk of self-harm, e.g., single cell with more frequent observation. But, as the person's mental health improves, the environment becomes less restrictive, e.g., dorm-like setting with less frequent observation. These adjustments in housing will allow the person to function within an environment that supports their mental health needs while also allowing for the person to be "challenged" to adjust to a less clinical/restrictive environment. It is understood that ACSO may have concerns and policies and practices that conflict with the delivery of mental health services, e.g., classification and housing placement when persons do not require a high level of mental health services such as a LOC 2 but are security risks and require placement in cells. These situations need to be discussed, and options developed to ensure security while placing the person in the environment most amenable to their mental health treatment needs. The weekly Therapeutic Housing Committee is an excellent venue for these discussions.

In order to comply with this provision, it is imperative that decisions regarding the placement and removal of a person from a THU be made by the members of the clinical treatment team. At the Classification level, ACSO and AFBH are working together to address the housing issues raised by attempting to accommodate both LOC and security risk but there needs to be sufficient

placement options. AFBH and ACSO administration need to continue to have regular dialogue regarding the operations of the THUs and possible need for additional THU space allocation and space for clinical activities.

It is imperative that AFBH continue to assess all persons in the SRJ at intake or upon referral and determine their LOC, if any. This will allow for the determination of how many THU areas are needed for the different levels of classification.

Recommendation(s):

1. AFBH needs to document when a placement decision is not being implemented by ACSO for further discussion.
2. ACSO and AFBH continue to discuss the need for more dedicated THU designations.
3. Refer to provisions 312 and 702.

770. Defendants shall also ensure that mental health programming and care available for women is equivalent to the range of services offered to men.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units Protocol

Training: N/A

Metrics: AFBH Master Schedule, Telecare Schedule, Telecare Schedule and Service Logs, Lifelong Schedule and Service Logs

Assessment: AFBH operates a female THU in pods C, D and F of HU 21 (until the reopening of HU 24). Women have the same clinical service options as men in the THUs, including services provided by Lifelong and Telecare. The number of groups provided in HU 24 during this reporting period appears to have increased but is likely still insufficient, compared to the number of groups in the male THUs. Lifelong began providing group counseling services during this reporting period to the women in the THU.

As AFBH resources expand, specialized treatment services and approaches for women should be considered for implementation.

Recommendation(s):

1. Refer to provision 702.
2. AFBH to explore “best practice” therapeutic interventions for women.
3. Telecare to provide an equivalent number of therapeutic groups in HU 24.

771. The Parties shall meet and confer within three (3) months of the Effective Date regarding Defendants proposed plan for the Therapeutic Housing Units including staffing of these units, number of beds required for each level of care, programs and treatment services to be provided on the units, timing of any required construction and development of benchmarks with respect to measuring the efficacy of programs and treatment components offered on these units. Within six (6) months of the Effective Date, Defendants shall finalize and begin to implement the plan for creating the Therapeutic Housing Units

and implement policies for the management of the Therapeutic Housing Units including providing access to AFBH staff in these units as appropriate and according to the severity of the unit's mental health needs. Delays in the re-configuration of the Therapeutic Housing Unit(s) due to construction shall not delay implementation of therapeutic services, including but not limited to: mental health intake screening process, provision and monitoring of psychiatric medications, referral processes, treatment plans, and AFBH's involvement in re-entry planning as set forth in Section III(I). Admission and re-entry decisions shall be made by a multi-disciplinary team led by an AFBH staff member and focused on the individual's treatment needs. At a minimum, the plan shall also include: (1) the criteria for admission to and re-entry from the Therapeutic Housing Units as well for each level of care overall; (2) clear behavioral expectations for progression to less restrictive settings including step-down units and/or general population; (3) positive incentives for participation in treatment; (4) privileges and restrictions within each level of care with the goal of housing individuals in the least restrictive setting possible; and (5) an orientation at each level or pod as to the rules and expectations for that level or pod.

Finding: Substantial Compliance – Consider Discontinuation of Monitoring

Policies: AFBH Therapeutic Housing Units Protocol, AFBH Levels of Care Policy

Training: N/A

Metrics: Case Record Reviews

Assessment: During the last reporting period, the THU Protocol was approved by ACBHD leadership although THU pilots have been operating under the protocol for over a year. Refer to provision 702.

Case record reviews support the provision of assessments at intake, identification of needs and assignment of LOC, placements in THUs according to LOC, clinical interventions and follow-up, medication support, and discharge planning. It is important to note that AFBH is making efforts to implement the THU Protocol as written despite not being able to provide all services as required due to staffing limitations.

Recommendation(s): This Joint Expert finds that the County has been in Substantial Compliance with this provision for the last three rating periods (in excess of 12 months). Accordingly, this Joint Expert recommends the parties consider requesting this provision be terminated from the Consent Decree. In the meantime, the Expert will reduce monitoring of this provision in future reports.

772. The Therapeutic Housing Units shall be sufficiently staffed with appropriate Mental Health Providers and dedicated custodial staff including on nights and weekends. ACSO staff assigned to these units shall receive specialized training in mental health. AFBH shall have qualified staff available onsite twenty-four (24) hours a day, seven (7) days a week to address crisis situations in-person as needed throughout the Jail. Additionally, AFBH staff shall be assigned to the Behavioral Health Units and Therapeutic unit(s) during the day to allow for constant client contact and treatment, and give AFBH the ability to provide programming and other therapeutic activities.

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Protocol, AFBH Levels of Care Policy

Training: ACSO Crisis Communications for Corrections Training

Metrics: Refer to provisions 200/204 and 702, AFBH SRJ Staff Assignments

Assessment: Consistent with prior reports, there are qualified staff available at the SRJ to address mental health issues in the population 24 hours/7 days per week. Coverage is provided by either AFBH clinicians and supervisors or contracted staff (Telecare). There is 24/7 coverage in the ITR area by either AFBH or Telecare staff. Clinical treatment teams provide services in the THUs in 9 (currently in HU 2), 24 (currently in HU 21) and 35. A clinical treatment team has also been assigned to the RHU (HU 1). As explained in provisions 200/204, AFBH has been challenged with finding clinicians to fill their vacant positions. AFBH needs to continue deploying clinicians to assignments in the THUs to effectuate the reforms required by the CD.

AFBH clinical staff is available in the HUs, Monday through Friday from 7:00 a.m. to 9:30 p.m. Crisis Team "Runner" clinicians, both AFBH employees or Telecare staff, are available 24/7 and are responsible for coverage and response beyond the AFBH clinical schedule.

THUs are not staffed by clinicians past 9:30 pm on weekdays or on Saturdays and Sundays. During these times, assessment and intervention needs on the THUs are addressed by the ITR Crisis Team.

During this site visit, ACSO reported that they have been making efforts to assign consistent custody staff to the THUs.

ACSO reported that two full Crisis Communications for Corrections Trainings have been held in 2025 with another scheduled for this year. ACSO has also developed and implemented a special three-day Crisis Communications for Corrections Training for Sergeants. This is a very forward-thinking approach to changing the culture towards a more mental health-minded approach to managing IPs.

Recommendation(s):

1. Refer to provisions 200/204 and 702.

900. Defendants shall implement systems, including through close coordination between Alameda County Behavioral Health and the Jail, to facilitate the initiation or continuation of community-based services for people with mental health disabilities while incarcerated and to transition seamlessly into such services upon release, as described below.

Finding: Partial Compliance

Policies: AFBH Re-Entry Services for Clients with Serious Mental Illness Policy, AFBH Release Discharge Medication Policy

Training: N/A

Metrics: Case Record Reviews

Assessment: Since the last report, AFBH has continued to develop its comprehensive Re- Entry Services Policy and Procedure that aligns with the mandates of the Consent Decree. These procedures will ensure continuity of care for incarcerated individuals with mental health disabilities between the "systems" which affect re-entry of IPs.

The Re-Entry Team makes new referrals for clients to be connected to various community-based re-entry providers. Clients with higher mental health disorder acuity are referred for more intensive case management services through the Alameda County Behavioral Health Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) unit.

At this time, AFBH identifies clients who have been served by community-based mental health services and makes efforts to reconnect clients to community-based organizations (CBO) where they were previously engaged in services. The AFBH Re-Entry Team has a dedicated email, AFBHReEntry@acgov.org, that is checked Monday through Friday. This email is where outpatient, community-based agencies can request release medications or follow up with their clients while they are incarcerated. This email also receives re-entry referrals for clients needing mental health services who are represented by the Public Defender's Office. If the client signs a Release of Information (ROI), the Re-Entry Team is able to coordinate release planning and referrals with the Public Defender.

Through these efforts during this reporting period, the AFBH Re-Entry Team accomplished the following referrals/linkages:

- 26 individuals to full-service partnerships
- 105 individuals to re-entry treatment teams,
- 55 individuals to Crisis Residential Treatment centers,
- 326 clients to prior community based mental health providers, and
- 36 to Social Security Administration advocacy.

AFBH continues to meet with ACSO and Wellpath to support re-entry efforts. Information sharing systems and procedures have developed and are occurring with ACSO, Wellpath, and AFBH to ensure continuity of care for clients. A multidisciplinary team meeting occurs bi-weekly, and care is being taken to ensure HIPAA compliance while coordinating referrals for clients that are housed in THUs and have a scheduled release date within 14 days.

Internally, the AFBH Re-Entry Team meets weekly to discuss all SMI clients that have imminent release dates. At this meeting the team reviews: re-entry plans to ensure completion of the release process and appropriate placement; possible transportation needs of the client to the community-based provider, possible ACSO release deputy coordination with the client and community-based mental health provider to ensure that clients with higher acuity have a better transition back into the community, and a 30-day supply of release medications available at the time of release.

AFBH has expanded the role of the Post Release Re-Entry Clinician to include follow-up with community-based mental health providers for all behavioral health clients who are assessed as LOC 3 and LOC 4.

In the month of July 2025, the AFBH Re-Entry Team conducted a small pilot through collaboration with Center Point, Inc. to develop the availability of substance use disorder (SUD) secondary screening and services for individuals incarcerated at SRJ. Center Point provides SUD level of care determination for SRJ non-Medication Assisted Treatment (non-MAT) clients who seek residential treatment, recovery programs and coordinated care management upon release. These

services are particularly aimed at Medi-Cal eligible clients at Santa Rita Jail. Of the 20 clients that participated in the pilot:

- 20 expressed an interest in treatment
- 18 were referred to Center Point
- 19 clients expressed interest in a Center Point Assessment
- 13 clients signed the 42 CFR ROI form
- 10 clients completed the Center Point ASAM Assessment
- 3 clients were admitted to Center Point
- 8 clients were referred to Lifelong T2T Group
- 10 clients were referred to Telecare COEG Group, and
- 1 client was referred to Options

Recommendation(s):

1. AFBH should modify as necessary and finalize the comprehensive policy related to re-entry services.
2. AFBH should continue collaborative efforts with ACSO and Wellpath as necessary to meet Cal-AIM requirements.
3. AFBH to continue establishing contacts with appropriate agencies that assist IPs with obtaining entitlement benefits and discuss their ability to work with the SRJ's population.
4. Arrangements for services should be reviewed with ACSO and converted into agreements.

901. AFBH staff shall work to develop a written plan prior to release for inmates who are current Behavioral Health Clients and who remain in the Jail for longer than seventy-two (72) hours following booking. Transition and re-entry planning for current Behavioral Health Clients shall begin as soon as feasible but no longer than seventy-two (72) hours following booking or identification as a Behavioral Health Client in an effort to prevent needless psychiatric institutionalization for those individuals following release from Jail. The re-entry plan shall be updated by AFBH on at least a quarterly basis, regardless of whether a release date has been set.

Finding: Partial Compliance

Policies: AFBH Re-Entry Services for Clients with Serious Mental Illness Policy, AFBH Release Discharge Medication Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: AFBH Client Re-Entry Plan, Case Record Reviews

Assessment: In June of 2025, the most recent version of the Re-entry Plan was added to CG. The re-entry plan is now part of the electronic health record and will be readily available to AFBH team members. The current version of the Re-entry Plan has been submitted to the Joint Experts for review.

In March, a small pilot with one Forensic Mental Health Specialist (FMHS) was initiated that involved a restructured process of initial re-entry planning for clients. This process develops initial re-entry plans based upon a case record review of the client in CG and ATIMS to identify client

needs within 72 hours of booking. Also, if a client is connected to a community-based mental health provider, re-entry staff reconnect the client with that provider whenever possible. Based upon the results of this pilot, the re-entry planning process has been modified. Currently, AFBH is testing the updated re-entry plan process.

AFBH continues to update the Re-Entry Plans for behavioral health clients quarterly or sooner depending on the clients' known release dates. AFBH has created a system wherein clerical staff will notify Re-Entry staff when SMI clients have a release date within 90 days. Re-entry staff will then schedule appointments to discuss re-entry plans with the IPs accordingly.

Recommendation(s):

1. AFBH should continue developing collaborative efforts with area mental health and substance abuse providers to increase referral mechanisms for re-entry plans.
2. AFBH Re-Entry Team to continue developing re-entry plans for SMI clients with known release dates and expand re-entry planning when possible.

905. AFBH shall coordinate informing each Full Service Partnership in the County when a client or individual with whom they have had contact is incarcerated. Defendants shall also collect data regarding the number of individuals with a serious mental illness in the jail, including the number of days that these individuals spend in the Jail, the number of times these individuals have been booked in the Jail previously, the number of times that these individuals have returned to the jail due to probation violations, and the number of Behavioral Health Clients released with a written release plan.

Finding: Partial Compliance

Policies: AFBH Re-Entry Services for Clients with Serious Mental Illness Policy, AFBH Release Discharge Medication Policy, AFBH Identifying and Diagnosing "Severe Mental Illness Policy

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, AFBH Client Re-Entry Plan, Case Record Reviews

Assessment: When an incarcerated person on AFBH's caseload meets the level of care required for a Full-Service Partnership (FSP) referral, AFBH continues to make efforts to ensure that the person's Re-entry Plan includes referrals to agencies that offer services to meet their mental health needs. ACBHD has an established process for ACSO to send a list of newly incarcerated individuals to ACBHD. In turn, ACBHD reviews this list and identifies those who are enrolled in services with FSP agencies as well as all other community-based providers. From there, a list is generated through the ACBHD database and sent out to each service team to notify them of clients on their caseload who have been incarcerated.

Recommendation(s):

1. AFBH to finalize the Re-Entry policy detailing the assistance to be provided including notification to CBOs and Full-Service Partners.
2. AFBH to continue enhancing the re-entry services of IPs meeting FSP criteria; develop appropriate procedures.

902. AFBH shall work with Alameda County Social Services to facilitate evaluating the individual's eligibility for benefits, as appropriate, including SSI, SSDI, and/or Medicaid and to assist in linking clients to those possible benefits. Where AFBH is notified of upcoming release or transfer, AFBH shall work with the Behavioral Health Client to update their re-entry plan and provide the individual with a copy of the plan prior to release. The written plan shall help link the individual to community service providers who can help support their transition from jail to community living. The written plan shall identify community services, provider contacts, housing recommendations, community supports (if any), and any additional services critical to supporting the individual in complying with any terms of release. In no case shall these efforts conflict with or interfere with the work of the Mental Health Courts.

903. Defendants shall cooperate with community service providers, housing providers, people with close relationships to the individual (including friends and family members), and others who are available to support the individual's transition and re-entry from jail are able to communicate with and have access to the individual, as appropriate and necessary for their release plan. Where an individual authorizes it, Defendants shall facilitate access to mental health and other records necessary for developing the release plan. If an individual has a relationship with a community provider at the time of incarceration, AFBH staff shall meaningfully attempt to engage that provider in the re-entry planning for that individual and facilitating visits where requested by the provider. To facilitate a warm hand-off, Defendants shall initiate contact with community mental health providers in advance of a scheduled release for all incarcerated persons with serious mental illness, including assisting in facilitating meetings between incarcerated individuals and community mental health providers prior to or at the time of release and arranging a follow-up appointment as needed. With respect to planned and unplanned releases of Behavioral Health Clients, custody staff shall notify AFBH as soon as possible so that they can take appropriate steps to link these individuals with community services and resources as needed.

Finding: Partial Compliance

Policies: AFBH Re-Entry Services for Clients with Serious Mental Illness Policy, ACSO Policy and Procedure 11.09 Inmate Release Process

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, AFBH Post-Release Instructions form, Case Record Reviews, AFBH Client Re-Entry Plan

Assessment: As described in provisions 900 and 901, AFBH re-entry staff continue to re-connect clients to their previous community-based mental health providers whenever appropriate and possible. Re-entry staff maintain a Re-entry Tracking Log to document when these types of connections occur and document these efforts in the client's CG record. In cases where the prior community-based mental health provider was not a good "fit" for either the client or the provider, re-entry staff then connects the client to another provider.

AFBH staff facilitate visits when appropriate between the community mental health provider and the client via tablet or cell phone.

The AFBH Post-Release Clinician maintains a list of all clients with SMI and the clinician utilizes a daily SMI Release List to connect the clients to their community based mental health provider before they are released. The AFBH Post-Release clinician also follows up with the provider to confirm that the client has transportation from SRJ when applicable. The AFBH Re-Entry clinician also follows up with the client and the community based mental health provider to confirm the client attended their first appointment.

AFBH Re-Entry staff are currently referring and linking any IPs without medical benefits to Medi-Cal (California's Medicaid program) and are referred to the Medi-Cal Clinic that is staffed by Wellpath.

AFBH continues to make referrals to Bay Area Legal Aid (BALA) and Homeless Action Center (HAC) for SSI advocacy. These referrals are being tracked by staff and liaisons at both agencies. HAC and BALA can also support referred individuals with a subsidy for friends or family willing to house individuals with pending SSI applications through a program known as "Mending Bridges". Individuals referred to these programs may also be eligible for limited housing through HAC or BALA.

Recommendation(s):

1. AFBH to review existing policy to ensure that all provision requirements are met.
2. Ensure staff compliance with procedures via regular reviews of documentation.
3. AFBH should continue efforts to coordinate with ACSO/ACBHD's separate re-entry services provided via Operation My Home Town (OMHT) to streamline re-entry planning efforts.
4. AFBH to continue working to establish contacts with the appropriate agencies that assist IPs with obtaining entitlement benefits and discuss their ability to work with the SRJ's population.
5. Arrangements for the services should be reviewed with ACSO and converted into agreements.

904. If the individual takes prescription psychiatric medications in Jail (at the time of release), Defendants shall ensure that the individual leaves the Jail with access to a 30-day supply of the medication from a local pharmacy, when provided with adequate advance notice of the individual's release. Additionally, Defendants shall educate individuals who are prescribed psychiatric medications regarding the location and availability of drop-in clinics to obtain a refill of their medication in the community upon release. In addition to the 30-day supply of medication, Defendants shall coordinate with the County's outpatient medication services to have individuals' prescriptions refilled if necessary to ensure an adequate supply of medication to last until their next scheduled appointment with a mental health professional. Defendants shall ensure that SMI clients who are already linked to services have referrals to mental health providers and other service providers upon release, unless the individual refuses such referrals, or if staff was not provided adequate advance notice of release. SMI individuals who are not already linked to services shall be referred to the 24 (currently in HU 21)-7 ACCESS line.

Finding: Partial Compliance

Policies: AFBH Release Psychiatric Medication Policy, ACSO Policy and Procedure 11.09 Inmate Release Process

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Release Psychiatric Medication Report

Assessment: AFBH's policy to address this process has been approved. By policy, IPs are provided with a 30-day supply of their psychiatric medications at the time of release. Medications are either provided to the IP or a prescription is sent to a local pharmacy. While medications are made available, sometimes they are refused by the person at the time of release.

A monthly log of discharge medications is available. The chart below provides a summary of the six-month reporting period. The number of releases was fairly similar over the months with an average of 74 releases per month. During this report period, an average of 56% IPs received discharge medications at release. However, the actual number of release medications provided per month ranged from nine (9) to 47 persons. This significant range points to a lack of procedural consistency. There was also a significant number of log entries that lacked any information regarding the fate of the release medications. AFBH leadership has explained that, given the many steps in this process, the Discharge Medication Disposition (DMD) form (completed by Wellpath when medications are issued) is sometimes missing. It is recommended that AFBH closely review this process with Wellpath and determine how the two systems of care can successfully address this provision.

Month	# of Discharges	# - % Received Medications	# - % Lacking Documentation
January 2025	68	41 - 60	18 - 26
February 2025	87	37 - 42	42 - 48
March 2025	73	47 - 64	11 - 15
April 2025	60	9 - 15	49 - 81
May 2025	80	44 - 55	28 - 35
June 2025	74	38 - 51	29 - 39
Average	74	36 - 56	30 - 41
Prior Report Average	65	38 - 55	18 - 24

Wellpath has developed an automated process to report the outcome of medication distribution at release and has been piloting this process for at least six months. It was anticipated that the automated process would have improved the data. This Joint Expert has been apprised that full implementation of a modified process will be in place by the next reporting period.

On going, weekly meetings with Wellpath administration and the AFBH Medical Director of Quality Assurance reportedly occur to review quality Improvement processes for release medications including the automated process and other joint quality Improvement matters.

Recommendation(s):

1. AFBH to provide formal training on the approved policy regarding release medications and document training.

2. Continue reporting on the re-entry medication process; determine why some medications are not received at re-entry; modify processes as necessary.
3. Modify the proof-of-practice documentation (Discharge Medication Log) to increase its usefulness in identifying issues of procedural deviations.