

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

**Eighth Status Report**

**E. Carolina Montoya, Psy.D., P.A.  
Miami, Florida**

**May 11, 2026**

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 July 1<sup>st</sup> through December 31<sup>st</sup>, 2025. The chart below shows an overview of the specific provisions, utilizing the following codes:

**SC**            **Substantial Compliance**  
**PC**            **Partial Compliance**  
**NC**            **Non-Compliance**  
**DC**            **Monitoring Discontinued**

**Summary of Ratings**

<b>Provision</b>	<b>Rating</b>
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	SC
313. Referrals, Placement and Removal from THUs	SC
317. Development/implementation of Step-down Protocols for Therapeutic Housing Units	SC
404. Restrictive Housing Step 1 Population Evaluated Within 14 & 30 Days; SMI Cases Reviewed	SC
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

<b>Provision</b>	<b>Rating</b>
702. Develop a Plan to Implement Therapeutic Housing Units	DC
703. Individuals with SMI to Receive Therapeutic Services	PC
704. MH Staff Communication with Custody Staff	SC
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	DC
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	SC
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	SC
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

<b>Provision</b>	<b>Rating</b>
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	DC
745. Severely Curtail Use of Safety Cells	DC
746. Safety Cells Only Used in Exigent Circumstances	DC
747. Individuals in Safety Cells for Maximum of Eight Hours	DC
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)	Monitoring Discontinued (DC)	Total
#1 – July 2022	15	40	0	0	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
#8 – May 2026	1	56	16	6	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
- Draft – AFBH Psychiatric Referrals and Appropriate Training
- Draft – Refusals of Prescribed Psychiatric Medications and Compliance Audit Requirements
- AFBH Release Psychiatric Medication
- AFBH Response to Grievances
- Draft – AFBH Santa Rita Jail Re-Entry Services
- 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 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 July 1<sup>st</sup> through December 31<sup>st</sup>, 2025. The case records included incarcerated persons (IPs) 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:** Since the last report, all AFBH supervisory positions have remained filled. The vacancy rate in direct clinical positions has reduced from 46% to 38%, supporting a continued gradual improvement in the number of filled clinician positions. Strides have been made with ten additional clinicians hired in the last quarter of 2025. AFBH has also recently taken on a Masters-level intern 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.

As established in prior reports, 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. Efforts to address this issue by the County have included: streamlining the hiring process by establishing an "open" application process for clinical positions that allows interested persons to apply at any time; adding of supervisory positions (to increase the span of supervision) and allow the hiring of unlicensed clinicians; 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.

Despite these efforts there are still staffing deficits that keep AFBH from being able 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 recommended in prior reports, the total number and type of clinical/direct service positions should be regularly reevaluated. The total AFBH caseload and the average number of IPs 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.

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.

The lack of office space for AFBH staff cited as a serious concern in prior reports has been addressed by ACSO and the conversion of Housing Unit (HU) 31 as workspace for AFBH. At the time of the tour, this workspace is being utilized by AFBH staff with full implementation expected by the beginning of 2026.

Alameda County Behavioral Health Department's (ACBHD) contract with Telecare to increase clinical staffing continues and, during this reporting period, Telecare has provided intake

assessment services on the overnight shifts and in the Therapeutic Housing Units (THUs) during the evening hours.

As previously reported, 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.

ACSO’s expansion of the Behavioral Health Access Team (BHAT) from four to eight Deputies in August 2024 has increased the availability of Deputies to assist AFBH and the behavioral health population. The BHAT Deputies continue to escort and monitor group activities provided by AFBH as well as those provided by Telecare and Lifelong.

The chart below compares BHAT activity between this and the prior report period. BHAT reports indicate a significant increase of 30% in completed escorts since the last report while the number of groups supported by BHAT Deputies remain the same. This would seem to reflect the increased number of Deputies available to escort and assist in service delivery including supporting the activities of the AFBH’s Early Access to Stabilization Services Program (EASS) and those needed for IDD assessment functions.

<b>Month</b>	<b>Completed Escorts</b>	<b>Completed Groups</b>
July	682	130
August	759	140
September	716	145
October	837	170
November	570	150
December	597	158
<b>Current Totals/Averages</b>	<b>4,161/694</b>	<b>893/149</b>
<b>Prior Report Averages</b>	<b>484</b>	<b>144</b>
<b>Increases</b>	<b>+30%</b>	<b>&lt;1%</b>

**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. ACSO should continue the quarterly BHAT Deputies needs analysis 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.
4. 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, Training Sign-In Sheets

**Assessment:** Substantial Compliance with this provision has been sustained 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, 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 Intake and Release (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 has been sustained during this rating period. There have been no reported changes to the process in the delivery of telehealth services. The AFBH policy describes the straightforward process in detail and AFBH staff persons involved in providing the services have been trained. Formal training on this policy took place in November 2025.

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.

As in the past, this Joint Expert was provided with the Telehealth Psychiatrist's Daily Activity Logs for the period July through December 2025. A total of 81 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. For this reporting period, 38% (317) of the 823 appointments were not conducted because the clients refused to meet with the clinician. Poor compliance by the IPs with telehealth services has been brought into question in the last two reports with the recommendation that AFBH supervisors/leadership should investigate the reasons for the significant "no show" appointment rate and institute procedural changes as warranted.

Although Substantial Compliance is not diminished by the utilization rate nor is termination of this provision affected by the "no show" rates, it does beg to repeat the recommendation that the reasons for refusal be explored. In response to the prior report's recommendation, AFBH will be implementing a form that is to be completed when an IPs refuses services/to attend an appointment. AFBH staff will follow-up on this form and take necessary actions such as, for example, recontacting the IP or closing the casefile.

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 has been sustained during this 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 IPs 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 (RH), the process described in the AFBH Vetting Restricted Housing Committee Referrals policy is being implemented. This Joint Expert has attended RH Committee Meetings during the last five tours and has reviewed minutes of RH Committee Meetings within this 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 suitability assessments prior to RH Committee meetings. The findings of AFBH clinicians and assessment of suitability for placement in RH are being utilized and supported in the RH Committee Meetings.

**Recommendation(s):**

1. AFBH should continue complying with the process as detailed in policy to include 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.**

**Finding:** Substantial 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:** Substantial Compliance with this provision has been achieved during this reporting period. 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 AFBH clinicians and psychiatrists. As in prior tours, 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 Provision 312, 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. Therapeutic Housing Committee (THC) Meetings, held on a weekly basis, are required to discuss clients from the male and female 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.

Proof-of-practice documentation of weekly THC meetings for the months of July through December 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 and ACSO staff. THC meetings must address all IPs in THUs. To ensure that these committee meetings continue to be effective, AFBH Psychiatrists and Wellpath nurses should attend when possible, the meetings are to be conducted by the unit’s Treatment Team, and ACSO Classification representatives, as required by the provision, participate in the meetings.

As noted in the prior report, review of this period’s THC documentation continues to show 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 to comply with Provision 769. 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. THC documentation continues to support the 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.

**Recommendation(s):**

1. AFBH leadership to ensure that THC meetings review all appropriate male and female THU clients.
2. Continue proof-of-practice documentation of the THC meetings.

3. While not required by the Consent Decree, it is good clinical practice to continue review/discussion of IPs on LOC 4 for more than ten days during the THC meetings.

**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:** Substantial 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. As in prior tours, 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 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 313, weekly THC Meetings are required to discuss THU clients 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 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.

Weekly THU Treatment Meetings (formerly called the extended huddles) are now taking place on each THU. These meetings support the efforts of ensuring that the mental health status of IPs is regularly discussed and that IPs are considered for other appropriate services and placement in a less restrictive environment.

**Recommendation(s):**

1. AFBH leadership to ensure that THC meetings review all appropriate male and female THU clients.
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 clinical 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:** Substantial 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 review of the portion of this provision requiring the 14-day review of the IPs in RH Step 1 was terminated in the CD having been found in Substantial Compliance by the Classification Joint Expert, Dr. James Austin.

The provision also requires that IPs with SMI diagnoses in RH for 30 days or longer are to be reviewed on a weekly basis. This portion of the provision has achieved Substantial Compliance during this rating period. Proof-of-practice (RH Meeting Agendas) confirming that IPs are being identified when meeting the 30-day mark and discussed at the weekly RH Committee meetings have been provided to this Joint Expert.

**Recommendation(s):**

1. AFBH and ACSO are 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 are to continue to review the options for placement of IPs 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 maintained 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 which provides the capacity 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 only 146 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 3,781 call in the period; less than 5% of all calls received by ITR. 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.

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:** During this reporting period, AFBH has continued training and formal implementation of the following policies and procedures: Bridge Medications, Levels of Care, Santa Rita Jail Intake, Release Psychiatric Medications, Effective Communication, Vetting Restrictive Housing Committee Referrals, and Telehealth Provider Services. Work continued on AFBH draft policies including those related to medication refusal, re-entry services, and referrals to psychiatrists.

It is critical that AFBH review all 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.

**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

**Policies:** AFBH Therapeutic Housing Units Protocol

**Training:** N/A

**Metrics:** N/A

**Assessment:** As discussed in the last monitoring report, this provision has been met, i.e., a plan for the THUs has been developed and THUs for both males and female IPs are in place and operate in accordance with the Protocol. A full complement of services is being provided albeit with some limitations due to 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, conduct huddles to discuss clients, rounds for LOC 4 clients, and weekly Treatment Team Meetings and bi-weekly THC meetings.

**Recommendation(s):** This Joint Expert finds that the County has been in Substantial Compliance with this provision for the last five 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:** As reported in the past, AFBH has continued to refine and improve their efforts to assess and identify IPs with SMI at SRJ. These enhancements include finalizing the policy, the “flagging” of SMI in CG, and ensuring that IPs with SMI being released from custody have a documented Re-entry Plan.

The average number of IPs identified as SMI per month during this reporting period (July through December) was 115, consistent with the figures in the last report period. However, when compared to last year’s figures, the increase in IPs identified as SMI is significantly increased (from 48 to 115). This attests to the greater sensitivity of the diagnostic process being utilized by clinical staff.

For this reporting period, the average number of IPs with SMI designation continues to be 11% of the total AFBH caseload thus the majority of the AFBH caseload is non-SMI. It is imperative that all IPs with SMI diagnoses be identified as such in CG. 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.

<b>Month</b>	<b>IPs with SMI Designation/All LOC</b>	<b>%age of SMI in Structured Activities</b>
July 2025	125	92
August 2025	109	91
September 2025	120	95
October 2025	111	94
November 2025	114	90
December 2025	115	87
<b>Monthly Average</b>	115	92
<b>Average Last Reporting Period (1-6/2025)</b>	113	91

AFBH compiles a monthly Structured Activities Report which details the type of clinical (individual and group) activities provided/attended by IPs designated as SMI. These reports indicate that IPs 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, 92% of IPs identified as SMI are receiving/participating in mental health treatment services to some extent. This report is essential in the assessment of what and how services are being provided to SMI-designated IPs and in determining compliance with this provision.

Furthermore, a “drill down” into those IPs that did not receive clinical services by month found only three particular IPs were listed on the “no participation” list for two months; the remainder of “no participation” IPs received some services over the report period.

The ongoing operation of several THUs, where IPs with SMI are most likely to be housed, allow for the placement of severely disturbed IPs in an environment that offers specific clinical services supported by more consistent observation and interaction. This variety of housing ensures that, as a person’s mental health stabilizes, they may 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.

HU 2 and HU 35 are entirely committed as THUs for males, LOC 2-4. HU 9 has three pods (D, E and F) which operate as a male THU, an “assessment” pod (A) for THU placement, and a pod which is used as a classroom pod (C). Cell options in THU 2 and THU 9 (single/double cells) are used for the more severely disordered males (LOC 3 and 4) as well as those that require higher security placements. THU 35’s dorm-like setting is principally for the LOC 2 male inmates. During this tour, it was noted that an IP assessed to be an LOC 3 was being placed in THU 35 and had been aggressive and unstable during the housing process. This incident raised the opportunity for discussion regarding the importance of clinical presentation as being the major determinant in the THU placement decision. Over the course of this report’s preparation, additional and successful conversations have taken place between AFBH and ACSO, one of which involved this Joint Expert, to discuss these situations and address the challenges of placing the person within the least restrictive environment when presenting with mental health issues.

The THU for women (HU 21) consists of three pods (D-E) with the F pod converted for clinical activities. THU 21 is composed of cells and, since most THU females are classified as minimum or medium custody, the unit does not allow the IPs to reside in the least restrictive environment. This supports the need to develop an area like HU 35, which serves as the least restrictive option for males, for the female population.

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.

At this time, THUs are providing follow-up and crisis management for the most acute clients as required by the THU Protocol. Group therapy services are also available to the extent necessary for compliance with the Protocol. AFBH staffing limitations due to vacancies are impacting the frequency and extent of individual therapeutic efforts on the THUs. 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 has completed renovation of the C pods and multi-purpose rooms in HUs 1, 2 and 9, and the multi-purpose rooms in HU 24 and 35. It was a pleasure to see that the renovation efforts included art, wall colors and other enhancements that create a more therapeutic environment. These areas will certainly provide an opportunity for greater therapeutic services within the THUs.

Future construction projects include the addition of six (6) confidential interview rooms in HUs that serve mentally disordered IPs (HUs 1, 2, 9 and 21).

**Recommendation(s):**

1. Emphasis should continue on identifying IPs 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. Housing assignments in the pods within HU 21 which currently serve as the female THU should reflect LOCs whenever possible.
5. 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.
6. Determine the type and number of clinical staff required to serve the mental health caseload; modify staffing plan and hiring of staff as necessary.
7. AFBH to increase the provision of treatment services as availability of staff increases.
8. Treatment Team rounds in the THU for LOC 4 IPs are to be conducted daily (seven days per week).

**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:** Substantial 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 BHAT Deputy Running Log, ACSO BHAT Groups, AFBH Suicide Prevention Meeting documentation

**Assessment:** Substantial Compliance with this provision has been achieved during this period. In keeping with prior reports and as observed during the tour, formal opportunities for communication between mental health and custody staff have been established and are ongoing. Both AFBH and ACSO have incorporated the communication/transfer of relevant information for all IPs on the AFBH caseload in current policies and procedures. Huddles in the THUs (HUs 2, 9,

21, 35) 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 and interaction was notably improved at the huddles which were observed by this Joint Expert during the most recent tour. Custody staff engaged in the dialogue regarding the status of IPs 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 as appropriate. During the last reporting period, AFBH leadership determined and implemented a weekly THU Treatment Meeting (formerly called the Expanded Huddle) at each THU during which more detailed review of clients can be conducted.

THC meetings to discuss AFBH THU clients (male and female) are being conducted on a weekly basis as discussed in the Assessment section of CD provision 312 of this report. These meetings include both AFBH and ACSO representatives and addressing clients of concern from all THUs. 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 IPs on the unit stabilize and become able for housing 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. During this reporting period, a total of 3,781 entries were made in the ITR Call Log. 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. As illustrated in the Call Log, 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.

As previously mentioned, ACSO and AFBH meet quarterly (last meeting in September 2025) to review the THU treatment schedules for the next quarter to ensure BHAT Deputy support for scheduled AFBH therapeutic activities.

**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.

**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:** Substantial Compliance with this provision has been maintained during this reporting period. AFBH continues to use the Brief Initial Assessment (BIA) to assess all incoming IPs. 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 monthly by either AFBH or contracted ITR staff. There were 861 more intakes completed during this reporting period; a monthly increase of approximately 140 intakes.

Month/Year	# of Intakes Completed
July 2025	1,862
August 2025	1,393
September 2025	1,780
October 2025	1,696
November 2025	1,694
December 2025	1,663
<b>Total/Average per Month</b>	10,088/1,681
<b>Prior Report Average per Month</b>	1,538

Beginning in 2025, AFBH ITR supervisors conducted a monthly quality assurance (QA) review of completed BIAs. ITR Clinical Supervisors and the ITR Clinical Manager reviewed approximately 20 cases per month. As reported in the last monitoring, the QA reviews for the months of January through June 2025, reviewed by this Joint Expert, demonstrated a thorough assessment of BIA documentation that provided meaningful recommendations to staff for improvement. According to AFBH leadership, findings of these reviews were discussed in weekly ITR leadership meetings, with corrective actions identified and taken. During this reporting period however, staffing limitations resulted in there being only two (of the six) BIA QA Reviews completed. However, Telecare supervisory staff completed BIA QA Reviews on the assessments completed by their staff on the overnight shift for all six months. Their reviews followed the same format and focused on the same issues as the AFBH reviews. Results of these reviews indicate that BIAs are being completed as required,

**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.**

**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.**

**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:** As of January 2025, the AFBH Crisis Response Team began tracking Emergent and Urgent referrals on the ITR Call Log, including the time each client was evaluated. The last report indicated that the average response time for Emergent referrals and Urgent referrals were well within the required four (4) and 24-hour requirements, respectively. As shown on the chart below, these requirements continue to be met during this reporting period.

Month	Referral Type	Total # by Referral	Seen < 4 hours	Seen > 4 hours	Seen < 24 hours	Seen > 24 hours	Average Response Time
<b>July</b>	Emergent	284	262	22	-	-	1 hr, 43 mins.
	Urgent	106	-	-	102	6	3 hrs, 33 mins
<b>August</b>	Emergent	262	254	8	-	-	1 hr, 17 mins
	Urgent	89	-	-	88	1	3 hrs, 29 mins
<b>September</b>	Emergent	282	277	5	-	-	1 hr, 09 mins
	Urgent	76	-	-	76	3	3 hrs, 12 mins
<b>October</b>	Emergent	256	249	7	-	-	1 hr, 10 mins
	Urgent	100	-	-	100	5	4 hrs, 1 min
<b>November</b>	Emergent	259	245	14	-	-	1 hr, 24 mins
	Urgent	103	-	-	81	21	2 hrs, 41 mins
<b>December</b>	Emergent	294	275	12	-	-	1 hr, 16 mins
	Urgent	86	-	-	86	0	3 hrs, 10 mins

The AFBH referral policy remains in need of revision. Once completed, these two provisions will be in Substantial Compliance.

**Recommendation(s):**

1. The AFBH Referral Policy needs to be revised.
2. AFBH needs to continue the capacity to have Emergent referrals consistently seen for a clinically relevant assessment within four (4) hours of referral.
3. AFBH needs to continue maintaining capacity to consistently address referral appointments within 24 hours of Urgent referrals for mental health services.

**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:** AFBH tracking of referrals identified as “routine” has not been completely developed.

**Recommendation(s):**

1. The AFBH Referral Policy needs to be revised.
2. AFBH needs to develop capacity to report compliance in responding to Routine referral appointments within five business days/seven calendar days of referral.

**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 was 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 IPs 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. According to AFBH leadership, 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.

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 3,781 entries were made on the Log over the six months of this reporting period. As such, AFBH received an average of three (3) requests per day or 630 notifications per month. As identified in the prior report, the number of calls continues to decrease. Although the reason for this decline is not actually known, it is likely that the increase in AFBH services in the THUs, availability of staff on the units to address issues, improved quality in service delivery, and ongoing communication between ACSO and AFBH are factors in the decline of calls. 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.

Referrals for mental health and psychiatry are also initiated during the THU huddles. Any follow-up related to these referrals would be documented in the IPs case record.

The CD also requires that agencies within the SRJ (ACSO, AFBH and Wellpath) monitor the welfare of all IPs and act when IPs are isolating themselves, refusing to come out of their cells, refusing medications and/or food. When these issues are noted, the agencies must contact and refer the incarcerated person to 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 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. Accurate completion of the ITR Call Log should require entry of the time of the response to the request and outcome information whenever possible.
4. Refer to provisions 708, 718 and 719 for additional recommendations.

**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. (Currently, 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. Since the last tour, ACSO has determined that an additional four (4) confidential intake spaces in the ITR area will be renovated. A completion date, however, is not known at this time.

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
July 2025	1,863
August 2025	1,393
September 2025	1,780
October 2025	1,696
November 2025	1,694
December 2025	1,663
<b>Total/Average per Month</b>	10,089/1,682
<b>Prior Report Average per Month</b>	1,538

The chart above indicates that there is relative consistency in the number of intakes conducted by AFBH each month with the exception of about 300 less intakes in the month of August. These figures allow AFBH leadership to better establish staffing requirements for the ITR functions.

During the last reporting period, ITR began to determine the length of time it takes to complete the BIA as required by this provision. Staff obtain 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 was available for review. The reports show that 1,186 or 11% of the intakes had no time reported. But, of the 8,903 intakes with time recorded, 6,397 or 71% were initiated within four hours of booking. AFBH has

been advised however that the calculation must be altered to include the time it takes to complete the BIA, not just to begin the BIA process.

Regarding the length of time to conduct the BIA, the Custody Joint Expert Terri McDonald, based on her review of data for this reporting period has reported:

“the data reflects a modest increase in the average number of individuals held in ITR beyond eight hours at the 4:00 a.m. checkpoint... driven by a limited number of high-impact days rather than a sustained pattern... Focusing specifically on the 4:00 a.m. checkpoint, review of the July through December sample weeks shows that approximately one quarter of sampled days included at least one individual held in ITR beyond eight hours due to awaiting Wellpath or AFBH clinical clearance. These instances were not evenly distributed throughout the week, but were concentrated during early-morning weekend hours, particularly on Saturday and Sunday mornings. These periods frequently coincide with higher intake volume and complexity... When extended intake holds occurred and a reason was documented, medical and behavioral health screening requirements were the predominant drivers. Approximately one-half of extended-hold cases involved awaiting medical clearance or Wellpath screening, and roughly one-third involved pending AFBH screening or behavioral health evaluation.”

Also, during this reporting period, AFBH with assistance from ACSO initiated the “THU Assessment Pod” in THU 9. Following intake, the pod is used as short-term, therapeutic housing for IPs that present with questionable mental health related signs and symptoms (possibly related to the impact of arrest, substance use and other confounding factors). It’s also used in cases when a LOC and or decision regarding placement in a THU cannot be readily determined. Placement allows for further assessment and clinical observation of the persons’ adjustment to the jail environment and more reliable understanding of the IPs’ mental health issues. The activation of the THU Assessment Pod is quite new and several questions regarding its operation have been raised. AFBH staff, however, are positive about the opportunity to more closely monitor new arrivals to the jail or newly-identified IPs with mental health issues. Also, staff believe that placing IPs in the THU Assessment Pod during their adjustment to the jail environment is less disruptive to the milieu of the established THU environment.

**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 follow through on the proposed renovations for additional intake space.
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.
4. AFBH needs to ensure that time for completing all intakes is recorded.
5. ACSO to consider modifications to the ITR process to provide AFBH with IPs 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.
6. AFBH to provide this Joint Expert with proof-of-practice to assess the four-hour BIA requirement.

**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 has been in Substantial Compliance since November 2024. Suicide and self-harm flags are 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 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.

**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 Continuity of Care Psychiatric Medication Audits

**Assessment:** The process for the verification of current medications for newly arriving inmates to maintain continuity of medications is 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 monthly Bridge Medications Log tracking report. 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). A total of 1,367 medication verifications occurred during the six-month reporting period. Although a valuable tool, it was noted in the last report that the Bridge Medications Log has duplicated and inconsistent information. AFBH leadership has plans to revise the reporting form and processes between ITR staff to AFBH prescribers to ensure reporting in the form/logs is consistent with the numbers and outcome of actual bridge medications prescribed and or non-verified med referrals appointments completed by prescribers.”

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. Three audits, prepared during this reporting period, have been reviewed and the results are shown in the chart below.

<b>Audit Month</b>	<b>Meds Verified ≤ 24 Hours</b>	<b>Psychiatric Meds Ordered ≤ 24 Hours</b>	<b>All Meds Ordered ≤ 24 Hours</b>	<b>Meds Delivered ≤ 24 Hours</b>
April 2025 n=27	100%	100%	92%	100%
July 2025 n=44	100%	95%	96%	96%
October 2025 n=50	90%	93%	96%	97%

Bridge medication information for the month of April 2025 was reviewed in July 2025 (the audit was prepared during this reporting period) in a sample of 27 case records. The audit indicates compliance rates between 92% and 100% on the audit tool items which comprise this provision. The second audit with data for the month of July 2025 was completed in November with compliance results between 95 and 100%. Finally, the third audit with data from October 2025 of 50 case records was completed in January 2026. The results of the audit are exceptional. Future monitoring by this Joint Expert will involve case record reviews of the selected samples.

As previously reported, compliance is also dependent upon the delivery of medications by Wellpath staff. To this end, the appropriate Wellpath policy has 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. Since the last tour, ACSO has determined that an additional four (4) confidential spaces in the ITR area will be renovated. A completion date, however, is not known at this time.

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.
2. ACSO to advise on completion date for the additional confidential interview areas in ITR.

**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 – No longer subject to monitoring

**Assessment:** No changes to the Assessment described in the Seventh Status Report

**716 I. 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 the last reporting period, ITR began to determine the length of time it takes to complete the BIA as required by this provision. Staff obtain 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 was available for review. The reports show that 1,186 or 11% of the intakes had no time reported. But, of the 8,903 intakes with time recorded, 6,397 or 71% were initiated within four hours of booking. AFBH has been advised however that the calculation must be altered to include the time it takes to complete the BIA, not just to begin the BIA process.

For the first half of 2025, AFBH conducted monthly quality assurance reviews of completed BIAs. However, during this reporting period, only two reviews were conducted due to supervisory staffing limitations. Quality assurance (QA) reviews for the months of July and August 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.

Separately, on-site Telecare Supervisors conduct monthly reviews of BIAs completed by their staff during the overnight ITR shifts following the same feedback guidelines as AFBH. The Telecare reports for the months of August through December, on at least 10 BIAs per month, indicate detailed review of the BIAs with appropriate and clinically valid comments.

**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 monthly service delivery audits according to the established policy.

**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 has completed renovation of the C pods and multi-purpose rooms in HUs 1, 2 and 9, and the multi-purpose rooms in HU 24 and 35. It was a pleasure to see that the renovation efforts included art, wall colors and other enhancements that create a more therapeutic environment. These areas will certainly provide an opportunity for greater therapeutic services within the THUs.

Secure programming chairs are being allocated to the C pods and multi-purpose rooms in RH (HU 1) and THU 2 to further address this provision. These chairs now allow greater opportunity

Future construction projects include the addition of six (6) confidential interview rooms in HUs that serve mentally disordered IPs (HUs 1, 2, 9 and 21).

Furthermore, in response to ongoing assessments of program space requirements, there is continued discussion about ACSO converting HU 25 to a THU due to the availability of classroom space within the unit. Consequently, it is expected that ACSO will be making its decision in the near future and THU 35 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.

**Recommendation(s):**

1. Continue active, frequent discussion of plans for establishing confidential meeting areas for the THUs.
2. Conduct staffing analysis to determine not just the space needs but the clinical and custodial personnel required to comply with the provision.
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.

**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, essential to compliance with this provision, remains in need of revision. A new referral form has been approved by this Joint Expert as a part of the revisions.

As explained in prior reports, 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 IPs 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.

Daily, AFBH staff receive a Medical-Notes report from ATIMS, listing 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 to a dedicated AFBH line in the ITR area. Calls are documented on the ITR Call Log and include requests for immediate/emergency assistance (Emergent and Urgent referrals), non-emergency assistance and informational notifications.

Since January 2025, the AFBH Crisis Response Team has been tracking Emergent and Urgent referrals on the ITR Call Log. The last report indicated that the average response time for Emergent referrals and Urgent referrals were well within the required four (4) and 24-hour requirements, respectively. As shown below, requirements continue to be met during this reporting period.

Month	Referral Type	Total # by Referral	Seen < 4 hours	Seen > 4 hours	Seen < 24 hours	Seen > 24 hours	Average Response Time
<b>July</b>	Emergent	284	262	22	-	-	1 hr, 43 mins.
	Urgent	106	-	-	102	6	3 hrs, 33 mins
<b>August</b>	Emergent	262	254	8	-	-	1 hr, 17 mins
	Urgent	89	-	-	88	1	3 hrs, 29 mins
<b>September</b>	Emergent	282	277	5	-	-	1 hr, 09 mins
	Urgent	76	-	-	76	3	3 hrs, 12 mins
<b>October</b>	Emergent	256	249	7	-	-	1 hr, 10 mins
	Urgent	100	-	-	100	5	4 hrs, 1 min
<b>November</b>	Emergent	259	245	14	-	-	1 hr, 24 mins
	Urgent	103	-	-	81	21	2 hrs, 41 mins
<b>December</b>	Emergent	294	275	12	-	-	1 hr, 16 mins
	Urgent	86	-	-	86	0	3 hrs, 10 mins

Response time for Routine referrals are not being calculated at this time.

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 utilize 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.

**Recommendation(s):**

1. Revise the policy regarding how referrals will be made; include discussions with ACSO, Wellpath and internally within AFBH.
2. Initiate determination of response times for Routine referrals.
3. Refer to provisions 709 and 719 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 remains 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:** The AFBH “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 remains in draft form. Training on the policy will be conducted after final policy approval.

**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.

During this reporting period, AFBH leadership continued to compile 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
  
- 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:** This provision remains in Substantial Compliance. AFBH continues to appropriately implement the approved Levels of Care policy that 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.

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.

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).

**LOC Reports - 7/01/2025-12/31/2025**

Report Date	LOC 1	LOC 2	LOC 3	LOC 4	LOC X	Pending LOC	Total LOC 1-4
7/14/25	45% N=583	19% N=241	8% N=109	2% N=22	26% N=342	0% N=0	955
7/28/25	44% N=583	19% N=251	8% N=113	3% N=37	26% N=353	0% N=0	984
8/11/25	43% N=579	19% N=264	8% N=113	3% N=33	27% N=367	0% N=0	989
8/25/25	44% N=598	20% N=272	7% N=93	3% N=40	26% N=359	0% N=0	1,003
9/08/25	43% N=585	19% N=261	7% N=92	3% N=38	28% N=376	0% N=0	976
9/22/25	44% N=607	19% N=262	7% N=102	3% N=43	27% N=372	0% N=0	1,019
10/05/25	43% N=593	20% N=277	8% N=98	3% N=44	26% N=352	0% N=0	1,012
10/20/25	45% N=602	20% N=264	8% N=106	2% N=33	25% N=334	0% N=0	1,005
11/03/25	44% N=603	20% N=277	7% N=99	2% N=34	26% N=350	0% N=0	1,013
11/17/25	44% N=596	21% N=283	8% N=101	2% N=30	25% N=336	0% N=0	1,010
12/01/25	45% N=585	21% N=271	7% N=85	2% N=28	25% N=317	0% N=0	969
12/15/25	47% N=570	20% N=241	7% N=87	2% N=22	24% N=287	0% N=0	920
12/29/25	46% N=554	19% N=229	7% N=87	2% N=24	25% N=300	0% N=0	894
<b>Average</b>	44% N=588	20% N=261	7% N=99	2% N=33	26% N=342	0% N=0	981
<b>Prior Report Average</b>	41%/577	17%/241	8%/111	3%/37	32%/444	0%/0	966

**LOC Averages & Ranges - 7/01/2025-12/31/2025**

Level of Care	Percentage	Percentage Range	Number	Number Range
LOC 1	44%	43% - 47%	588	505 - 608
LOC 2	20%	19% - 21%	261	241 - 271
LOC 3	7%	7% - 8%	99	92 - 113
LOC 4	2%	2% - 3%	33	22 - 43
<b>Average Caseload</b>			<b>981</b>	920 - 1,019
<b>Prior Report Average Caseload</b>			<b>966</b>	881 - 1,004

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

- AFBH’s overall mental health caseload seems to have stabilized and consistent with the last report.
- All four LOCs appear to remain consistent.
- For the past three reporting periods, all IPs in the SRJ have been assigned an LOC. Case record reviews show 100% compliance with the assessing of LOCs.

**AFBH Caseload Compared to SRJ Population**

Months	Average Caseload LOC 1-4	SRJ Population/ Last Day of Month	% of SRJ Population on AFBH Caseload
July 2025	970	1,378	70%
August 2025	996	1,436	69%
September 2025	997	1,479	67%
October 2025	1,008	1,356	74%
November 2025	1,011	1,403	72%
December 2025	928	1,253	74%
<b>Average</b>	985	1,384	70%
<b>Prior Report Averages</b>	966	1,473	65%

When compared with the entire SRJ population, the AFBH caseload is approximately 70% of the population. An approximate 10% increase in the AFBH caseload has been noted within the past year despite relative consistency in the overall SRJ population. As such, it seems that the number of IPs at the SRJ appears to be increasing. At this point, the SRJ mental health population figure at 70% continues to be higher than national statistics (44% according to 2017 Bureau of Justice Statistics and NAMI ) for mental health disordered IPs in jail settings.

**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.

**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 has been due largely to two factors: the availability of clinical staff and limited confidential treatment areas. However, with the increased treatment space afforded by the repurposing of the C pods and multi-purpose rooms in the THUs, it is expected that future monitoring will reflect greater participation in therapeutic activities. During this reporting period, Telecare staff have been assigned to THUs to provide clinical services.

Case record reviews demonstrate that intake assessments are taking place, suicide and self-harm incidents are 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 IPs on their assigned caseloads in HUs and in the clinic, follow-up on IPs 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 450 treatment plans have been developed, a significant increase from the 300 reported following the last monitoring period.

To date, the ability to provide appropriate clinical services has also been negatively impacted by the lack of proper, confidential meeting areas. 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. As such, it is expected that more IPs will avail themselves of therapeutic services.

The recent installation of secure programming chairs to the C pods and multi-purpose rooms in RH (HU 1) and THU 2 to further address this provision. These chairs now allow greater opportunity for IPs to participate.

Future construction projects include the addition of six (6) confidential interview rooms in HUs that serve mentally disordered IPs (HUs 1, 2, 9 and 21).

**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:** Substantial Compliance

**Policies:** N/A

**Training:** N/A

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

**Assessment:** This provision has attained Substantial Compliance during this reporting period. For the past year, ACSO has been actively planning and repurposing space in various HUs for therapeutic activities by AFBH and its mental health contractors. The areas necessary for clinical encounters have been “identified” as required by the provision and significant work has been completed in the numerous projects. Furthermore, during this year, ACSO initiated monthly meetings attended by AFBH representatives, Joint Experts and ACSO staff to discuss construction projects and updates.

Specifically, since the last tour, ACSO has completed renovation of the C pods and multi-purpose rooms in HUs 1, 2 and 9, and the multi-purpose rooms in HU 24 and 35 for use as treatment areas for groups and individual encounters. It was a pleasure to see that the renovation efforts included art, wall colors and other enhancements that create a more therapeutic environment. These areas will certainly provide an opportunity for greater therapeutic services within the THUs.

Secure programming chairs are being allocated to the C pods and multi-purpose rooms in RH (HU 1) and THU 2 to further address this provision. These chairs now allow greater opportunity for IP participation.

Future construction projects include the addition of six (6) confidential interview rooms in HUs that serve mentally disordered IPs (HUs 1, 2, 9 and 21).

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

**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.
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 eight-week "closed" groups for up to six clients in THU 35. From August through October 2025, AFBH provided one weekly Coping Skills group. Starting in January of 2026, AFBH plans on adding an additional two groups, totaling 3 groups per week. "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 THU 21, AFBH provided "open" Recreation Groups from July through September 2025. 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 LOC 3 clients 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. These groups were not held in Q4, but AFBH/Telecare

has plans to offer a combination of eight (8) weekly open and closed groups in HU 21 starting in early March 2026.

Similarly, AFBH is providing three weekly ongoing “open” Recreation Groups which started in July 2025 and continue to date in THU 2. In Q3, these small groups were for clients who are on LOC 4/IOL. In Q4 (2025), these groups were made available to all clients in THU 2 and generally held with up to five clients at a time. The groups 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.

Group therapy has not been conducted in the RH (HU 1) unit due to security concerns. However, with the installation of the secure programming chairs in the retrofitted C pod, it is anticipated that small, confidential groups can be offered. AFBH is coordinating with the BHAT team to initiate two Telecare-led groups in RH. Plans for additional groups beginning in March 2026 have also been discussed. As such, there will soon be a total of five structured, open groups in RH per week.

Therapeutic/educational groups are also provided by contracted staff from Telecare. Telecare is scheduled to provide 33 groups per day (Monday through Saturday), with up to six participants per group, in THUs 2, 8, 9, 21 and 35. Telecare groups follow the nationally-recognized “Seeking Safety” curriculum and educational groups on co-occurring disorders (CO-EG), i.e., the relationship between substance use and mental health disorders. However, review of participation data appears to indicate that the groups are not being held as scheduled. Telecare-led group activity records for the reporting period of July through December 2025 are as follows:

<b>Month</b>	<b># of Groups</b>
July 2025	106
August 2025	116
September 2025	123
October 2025	142
November 2025	158
December 2025	134
<b>Total/Average per Month</b>	<b>779/129</b>
<b>Prior Report Average per Month</b>	<b>138</b>

Group participation, i.e., the number of IPs that participate in each group, appears to be increasing. Telecare reports attendance/utilization for each group and AFBH has access to the names of the IPs that attend each group.

As previously reported, Lifelong Medical Care has been providing on-site substance use counseling services through a contract with AFBH . Lifelong is scheduled to provide three groups per week in THUs 9, 21 and 35. Records of groups provided by Lifelong over the current reporting period are incomplete. However, between August 14<sup>th</sup> and November 6<sup>th</sup>, available records indicate a total of 121 groups with up to six AFBH clients per group. 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. In response to this recommendation from the last monitoring report, AFBH intends to initiate a 10-week SUD group in THU 2 in February 2026. This is in collaboration with ACBHD's Medical Director, Substance Use Continuum of Care, Dr. Josh Kayman, who will be leading the initial training with two Forensic Mental Health Specialists. The goal is to expand this training to other THUs.

**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 provided as planned in early 2026.
7. AFBH needs to ensure that both Telecare and Lifelong correctly report their activities.

**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.

See provision 725 for greater details.

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 activities, 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. AFBH has focused on being available to the highest acuity clients in the last six months, both by assessing LOC 4 clients sooner after intake in the THU Assessment Pod, reducing the

number of IOLs on base as clinically appropriate, and increasing the frequency of clinical contacts with LOC 4 clients.

As discussed in prior provisions (717, 724), the ability to provide appropriate clinical services has improved considerably since ACSO's conversion of the 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. AFBH has been using these spaces as they've become available since May 2025. A few areas which have also served for confidential meetings will continue to be used including the 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 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 activities, 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. In Q3 2025, in tandem with staff training on treatment plans and diagnoses, AFBH and their consulting psychologist (Dr. Warner) introduced a compilation of resource handouts and interventions for QMHPs to use with clients as clinically appropriate. These handouts/client activities are organized by diagnosis and symptoms and are being offered as session interventions and in-cell activities for IPs as part of their Treatment Plan.

**Recommendation(s):**

1. 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.

2. AFBH to research the availability and applicability of therapeutic, self-help materials on electronic tablets; discuss with ACSO and vendor.
3. 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** Substantial Compliance

**Policies:** AFBH Therapeutic Housing Units Protocol

**Training:** N/A

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

**Assessment:** This provision has attained Substantial Compliance in this reporting period. AFBH continues to operate THUs in HUs 2, 9, 21 and 35 with dedicated clinical Treatment Teams for each unit 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. In January 2026, AFBH will adopt annual work schedule for staff to improve consistency of clinical teams.

The frequent huddles and rounds support the sharing of treatment-related information between treatment team members. During the last reporting period, AFBH leadership implemented a weekly “THU Treatment Meeting” formerly called the “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, AFBH Levels of Care Policy and Procedure, ACSO Policy and Procedure 13.01 Medical and Mental Health Care

**Training:** Requires Development

**Metrics:** Case Record Reviews

**Assessment:** AFBH operates THUs in HUs 2, 9, 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. In January 2026, AFBH will adopt annual work schedule for staff to improve consistency of clinical teams. 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 utilized 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 plans are now being developed for clients: in custody for more than 30 days, with a focus on higher acuity clients, e.g., on an IOL/LOC 4 for 14 days or more, when IOL/LOC 4 status is discontinued, in the Early Access to Stabilization Services Program (EASS) program, and those contraindicated for RH.

The Treatment Plans form is now available in CG and will be used to document the effort.

This Joint Expert expects AFBH to address how treatment plans will be developed for all IPs on the mental health caseload after 30 days in custody 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.
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:** Biweekly Therapeutic Housing Committee (THC) meetings, which constitute a multi-disciplinary treatment team meeting, are being 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 IPs 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 must be afforded to clients in all the THUs.

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. A THU Treatment Meeting (formerly called "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 continued to occur 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 31 IPs 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.

As mentioned in provision 721, a QA policy that includes these interagency efforts and clinical reviews needs to be developed.

**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, 704 and 721.

**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 needs 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 IPs are housed with concentrated efforts in the THUs 2, 9, 21 and 35. A treatment team also attends to IPs in RH (Unit 1). Refer to provisions 725 and 726.

In THU 21, AFBH provided "open" Recreation Groups from July through September 2025. 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 LOC 3 clients 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. These groups were not held in Q4, but AFBH/Telecare has plans to offer a combination of eight (8) weekly open and closed groups in HU 21 starting in early March 2026.

Similarly, AFBH is providing three weekly ongoing "open" Recreation Groups which started in July 2025 and continue to date in THU 2. In Q3, these small groups were for clients who are on LOC 4/IOL. In Q4 (2025), these groups were made available to all clients in THU 2 and generally held

with up to five clients at a time. The groups 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.

Group records for AFBH-led activities indicate a total of 92 groups between August 8<sup>th</sup> and November 7<sup>th</sup>, 2026. Groups were conducted in THUs 2, 8, 9, 21 and 35.

**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 are identified as an LOC 1 and followed by AFBH clinicians.

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

Therapeutic/educational groups are also provided by contracted staff from Telecare. Telecare is scheduled to provide 33 groups per day (Monday through Saturday), with up to six participants per group, in THUs 2, 21 and 35. Telecare groups follow the nationally-recognized "Seeking Safety" curriculum and educational groups on co-occurring disorders (CO-EG), i.e., the relationship between substance use and mental health disorders. However, the groups are not being held as scheduled. In fact, the number of groups conducted by Telecare has decreased significantly during this reporting period from an average of 138 per month in the prior reporting period to an average of 88 per month in this reporting period; a 36% decrease. Telecare-led group activity records for the reporting period of July through December 2025 are as follows:

<b>Month</b>	<b># of Groups</b>
July 2025	106
August 2025	116
September 2025	123
October 2025	142
November 2025	158
December 2025	134
<b>Total/Average per Month</b>	<b>779/129</b>
<b>Prior Report Average per Month</b>	<b>138</b>

Despite the decrease in the number of groups held, group participation appears to be increasing. Telecare reports attendance/utilization for each group and AFBH has access to the names of the IPs that attend each group.

As previously reported, Lifelong Medical Care has been providing on-site substance use counseling services through a contract with ACBHD. Lifelong is scheduled to provide three groups per week in THUs 9, 21 and 35. Records of groups provided by Lifelong over the current reporting period are incomplete. However, between the August 14<sup>th</sup> and November 6<sup>th</sup>, available records indicate a total of 121 groups with up to six AFBH clients per group. 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. In response to this recommendation from the last monitoring report, AFBH intends to initiate a 10-week SUD group in THU 2 in February 2026. This is in collaboration with ACBHD's Medical Director, Substance Use Continuum of Care, Dr. Josh Kayman, who will be leading the initial training with two Forensic Mental Health Specialists. The goal is to expand this training to other THUs.

Since last report, AFBH has been 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.

**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 2, 9, 21 and 35 include the assigning of dedicated clinical teams and interdisciplinary huddles to discuss unit issues and identify specific IPs in need of clinical attention. Rounds for LOC 4 IPs and IPs 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 2, 9 and in THU 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 (HU 1) 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 for all IPs in the THUs and rounds (for LOC 4 IPs) but are not based on individualized treatment plans.

The development of confidential treatment areas resulting from the conversion of C pod and multi-purpose room conversations in the THUs will assist in increasing out-of-cell clinical activities and the pleasant, therapeutic environment should assist to encourage participation by the IPs.

As discussed in provision 730, AFBH is continuing to expand treatment planning with the goal 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).

Review of case records support that IPs expressing ideation of self-harm (injury and suicide) are being clinically assessed and appropriate interventions are being provided.

**Recommendation(s):**

1. Training of all clinicians on the policy must take place.
2. 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 process for the verification of current medications for newly arriving inmates to maintain continuity of medications is 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 monthly Bridge Medications Log tracking report. 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). A total of 1,367 medication verifications occurred during the six-month reporting period. Although a valuable tool, it was noted in the last report that the Bridge Medications Log has duplicated and inconsistent information. AFBH leadership has plans to revise the reporting form and processes between ITR staff to AFBH prescribers to ensure reporting in the form/logs is consistent with the numbers and outcome of actual bridge medications prescribed and or non-verified med referrals appointments completed by prescribers.”

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. Three audits, prepared during this reporting period, have been reviewed and the results are shown in the chart below.

<b>Audit Month</b>	<b>Meds Verified ≤ 24 Hours</b>	<b>Psychiatric Meds Ordered ≤ 24 Hours</b>	<b>All Meds Ordered ≤ 24 Hours</b>	<b>Meds Delivered ≤ 24 Hours</b>
April 2025 n=27	100%	100%	92%	100%
July 2025 n=44	100%	95%	96%	96%
October 2025 n=50	90%	93%	96%	97%

Bridge medication information for the month of April 2025 was reviewed in July 2025 (the audit was prepared during this reporting period) in a sample of 27 case records. The audit indicates compliance rates between 92% and 100% on the audit tool items which comprise this provision.

The second audit with data for the month of July 2025 was completed in November with compliance results between 95 and 100%. Finally, the third audit with data from October 2025 of 50 case records was completed in January 2026. The results of the audit are exceptional. Future monitoring by this Joint Expert will involve case record reviews of the selected samples.

As previously reported, compliance is also dependent upon the delivery of medications by Wellpath staff. To this end, the appropriate Wellpath policy has 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. The Continuity of Care Psychiatric Medications audits need to be continued and provided to this Joint Expert as proof-of-practice.
2. 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—Consider Discontinuation of Monitoring

**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 continues to be in Substantial Compliance for the third reporting period. 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, an Antipsychotic Polypharmacy Report is 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 Audits

**Assessment:** AFBH continues to work on the draft 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 is expected to enter 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.

Medication Refusal Audits for the months of June and October 2025 were made available for review by this Joint Expert. For June, a random selection of case records equivalent to 5% of the current population on psychotropic medications for each month were audited. The findings of the medication refusal audits are shown in the chart below.

<b>Audit Months →</b>	<b>June 2025</b>	<b>October 2025</b>
Total Patients in Audit (5%)	104	46
Total Patients Refusing Meds	40/38%	46/100%
Total Psychotropic Med Refusals	151	175
Total # of <b>Correct</b> Med Refusal Referrals Sent by WP Nurses	13/9%	12/6%
Total Patients That Refused/No Referral Sent by WP Nurses	25	28

The method for identifying the IPs included in the audits was modified between the two audits. Whereas the June audit included a sample of all IPs, the October audit sample only included IPs that had refused medications. Interestingly, both audits were based on similar numbers (40 IPs in June and 46 IPs in October).

These audits highlight that medication refusals are not reported as required by this provision or current Wellpath policy. AFBH leadership has presented and discussed these findings with Wellpath Quality Assurance. As in the prior report, it is recommended that these audit findings be considered for procedural modifications.

**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. Discuss the audit findings with the medical provider; identify possible procedural modifications.

**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:** None

**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 four reporting periods, there has been one incident involving the use of Safety Cells; none during this reporting period. 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 IOL placement.

**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 – No longer subject to monitoring

**Assessment:** No changes to the Assessment described in the Seventh Status Report

**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 – No longer subject to monitoring

**Assessment:** No changes to the Assessment described in the Seventh Status Report

**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 themselves 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 John George Psychiatric Hospital (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 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. During the July through December 2025 reporting period, documentation has improved substantially according to the Custody Joint Expert, Terri McDonald. Logs and incident reports consistently reflect that AFBH staff were alerted/notified during these incidents and observation logs document clinical engagement at or near the time of placement. Furthermore, according to Ms. McDonald, "Review of the 18 restraint chair placements with complete documentation during this reporting period reflects that qualified mental health assessment occurred within four hours of initiation of the restraint log in 100 percent of cases and prior to release in all cases. In most instances, mental health clinicians were involved on the front end, assessing the inmate at or near placement and conducting additional reassessments during the episode."

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 IPs and conducting assessments of suicide risk within Emergent and Urgent referral timeframes and appropriately responding 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 IPs on IOL a minimum of every three days.

IPs 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 that house LOC 4 IPs five days per week. 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 each client's CG record.

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 IPs in need of clinical attention and weekly "THU Treatment Meetings" (formerly called "Expanded Huddles) can serve as an opportunity for greater assessment of the needs of LOC 4 clients.

Clients designated as a 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.

**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 on IOL and 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:** The relevant policy needs final approvals and trainings need to be conducted. 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 July through December 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 life with an emphasis on the factors that led up to and may have contributed to the death or serious suicide attempt. In this reporting period, six AFBH supervisory staff members obtained psychological autopsy training from an American Correctional Association (ACA) certified instructor. As such, they are now prepared to conduct "psychological autopsies" as necessary in accordance with this provision.

**Recommendation(s):**

- 1, The policy needs final approval, and relevant trainings need 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.

**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 and 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:** Over this entire year (2025), it has been increasingly apparent that AFBH has been assuming greater operational control of the THUs with the assistance and cooperation of ACSO. 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 IPs 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 IPs 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 need 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 IPs 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:** The AFBH THU for women is in HU 21, pods D and E. The “F Pod” in HU 21 has been converted into a classroom that offers space for clinical interventions. Women have the same clinical service options as men in the THUs, including services provided by Lifelong and Telecare and are also receiving group activities/services provided by AFBH.

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. AFBH to ensure equivalent access to therapeutic groups for women in THU 21.

**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:** Qualified staff are 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 THUs in 2, 9, 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. However, strides have been made with ten additional clinicians hired in the last quarter of 2025. 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. ITR clinicians and 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.

ACSO reported that Crisis Communications for Corrections Training is now a requirement for all Deputies in the department. Trainings are now being scheduled to occur on a continuous basis.

**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:** Draft-AFBH Santa Rita Jail Re-Entry Policy and Procedure, AFBH Release Discharge Medication Policy

**Training:** N/A

**Metrics:** Case Record Reviews

**Assessment:** AFBH has continued to develop its comprehensive SRJ Re-Entry Policy and Procedure that aligns with the mandates of the CD. These procedures will ensure continuity of care for incarcerated individuals with mental health disabilities between the “systems” which affect the community re-entry of IPs

During this reporting period, the AFBH Forensic Behavioral Health Clinical Manager assigned to Re-Entry Services was on leave. In his absence the Re-Entry Forensic Behavioral Health Clinical Supervisor has been acting in his stead providing support and oversight of the re-entry efforts to ensure continued forward movement.

As previously reported, AFBH continues to host multi-agency meetings in support of re-entry services. Meetings continue monthly between AFBH, Wellpath, ACSO and Probation to discuss general system issues impacting re-entry efforts. Additionally, AFBH has a bi-weekly meeting dubbed the AFBH Re-Entry Multidisciplinary Team Meeting. During this meeting THU clients who have known release dates in the coming two weeks are discussed to ensure final re-entry planning occurs. In attendance are representatives from ACSO, Wellpath and, more recently, Probation has been participating. The first portion of the meeting is devoted to any referrals initiated by ACSO or Probation. Once those updates are gathered, the meeting continues with Wellpath and AFBH to discuss Enhanced Care Management (ECM) referrals, MAT aftercare, chronic care medications and the obtaining of any necessary Durable Medical Equipment (DME). AFBH's role in this meeting is to ensure that release psychiatric medications are ordered, and to discuss referrals and "warm handoffs" to community based behavioral health providers.

AFBH is also coordinating with ACSO's separate re-entry services provided via Operation My Home Town (OMHT) to streamline re-entry planning efforts. This coordination with ACSO-specific re-entry supports occurs in the biweekly AFBH Re-Entry Multidisciplinary Tem Meeting. AFBH Re-Entry Team have been directing clients housed in mainline housing units to reach out to ACSO Re-Entry Team for support. OMHT is a service team run by ACSO, and available for clients with lower mental health acuity and can be referred to via the ACSO Re-Entry Team.

The AFBH Re-Entry Team 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 previously engaged in services. The Team also makes new referrals for clients to be connected to various community-based 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.

The AFBH Re-Entry Team has a dedicated email, [AFBHReEntry@acgov.org](mailto:AFBHReEntry@acgov.org), that is checked Sunday 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 can 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 :

- 28 individuals to full-service partnerships
- 188 individuals to re-entry treatment teams,
- 127 individuals to Crisis Residential Treatment centers,
- 86 clients to prior community based mental health providers, and
- 27 to Social Security Administration advocacy.

During this reporting period there was a notable increase in the number of IPs released to re-entry treatment programs and Crisis Residential Treatment centers.

AFBH is working with ACSO to ensure that providers have access to THUs to enhance service delivery to clients. AFBH has been utilizing phones, tablets and computers to facilitate virtual warm handoff meetings with community providers so that clients are connected or reconnected with said providers prior to release. Community-based re-entry mental health providers have also provided overviews and training at AFBH staff meetings to educate staff about their services and how to make referrals to those programs to support re-entry efforts.

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.

Following SRJ release, the Post-Release Re-Entry Clinician follows-up with community-based mental health providers for all behavioral health clients who are assessed as LOC 3 or LOC 4. These efforts are tracked in a tracking log. More recently, the Post Release Re-entry Clinician has also been tasked with the direct follow up of released clients to ensure that they attended their post-release appointments with their case manager and psychiatrist.

In Q4, the AFBH Re-Entry team began meeting with the Behavioral Health Court (BHC) and Care Court teams weekly to discuss clients who overlap between the three programs. The purpose of this meeting is to ensure that the programs coordinate with each other and avoid any potential duplication of services or support offered to the clients.

Since July 2025, the AFBH Re-Entry Team has been collaborating 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 37 clients that have participated in the process:

- 37 clients completed the Center Point ASAM Assessment
  - 11 of the assessed were recommended for residential SUD treatment
- 258 IPs attended the Lifelong T2T groups
- 458 IPs attended the Telecare COEG groups
- 71 IPs were served by Options Recovery.

**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 CD 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:** Draft-AFBH Santa Rita Jail Re-Entry Policy and Procedure, 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 total number of Re-Entry Plans initiated by month were as follows:

	<b>August</b>	<b>September</b>	<b>October</b>	<b>November</b>	<b>December</b>
<b># of Plans</b>	221	255	209	153	170

The prior monitoring report explained that initial re-entry planning begins with a chart review immediately (of information in CG and ATIMS) within 72 hours of IPs arrival to SRJ. As such, all IPs have a re-entry plan.

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.

All re-entry plans are saved in CG and printed for clients when they have a known release date or are being court-released. Copies of these re-entry plans are placed in the client's jacket in the Santa Rita Jail Records Department and flagged for ACSO release deputies to ensure the client receives a copy at the time of release.

In this reporting period, AFBH has implemented a new and more detailed Re-Entry Plan form with the SMI Re-Entry Pilot Program. As part of the greater SMI Pilot, all persons with a SMI and a known, upcoming release date will have a documented Re-entry Plan. 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 begin discussing re-entry plans with the client at that time. AFBH makes necessary referrals and provides the client with a written copy of their plan at the time of release. For these IPs, AFBH coordinates direct contact (in-person or via telehealth) with a community-based mental health/substance abuse provider with a history of having treated the person or initiates a new referral and, as necessary, provides the agency with records such as case notes and prescriptions.

In the next quarter, AFBH will expand the early engagement re-entry pilot program into THUs 9 and will begin creating re-entry plans for clients in those housing units within the first 72 hours of their incarceration. This will bring AFBH closer to compliance with this provision.

**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:** Draft-AFBH Santa Rita Jail Re-Entry Policy and Procedure, 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:** As explained in earlier reports, 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.

AFBH Re-Entry Team continues to make referrals to the community -based program ACCESS for clients meeting criteria for FSP assignment. ACCESS reviews these referrals and assigns to the FSP team if they concur with the AFBH Re-Entry assessment.

**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 identification of IPs that meet FSP criteria and re-entry services for these IPs; 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:** Draft-AFBH Santa Rita Jail Re-Entry Policy and Procedure, 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 are preparing initial re-entry plans within 72 hours of arrival to the SRJ. These plans are updated following face-to-face assessments and other encounters, including referrals to community-based providers. AFBH continues to re-connect clients to their previous community-based mental health providers whenever appropriate and possible. A Re-entry Tracking Log is utilized to document when these types of connections occur and enter 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 coordinates with the client's provider to connect the client to another provider better suited to meet their needs.

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

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 follows up with the provider to facilitate the appointments upon release, e.g., confirming that the client has transportation from SRJ, and 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). These IPs are referred to the Medi-Cal Clinic that is staffed by Wellpath thus ensuring that clients with known release dates have active Medi-Cal insurance in place.

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.

Each week, the AFBH Re-Entry Supervisor sends a list of all IPs with known releases within the next 90 days to the AFBH Re-Entry team. This list prompts clinicians to meet the clients, update the re-entry plans, contact community-based agencies regarding referrals, and finalize re-entry arrangements. The Re-entry Team will also prepare a Post-Release Instructions form for each person which includes medication information/order, referrals and other information.

AFBH has an assigned clinician stationed in ITR (Monday through Friday) to receive the batch court release lists from the ACSO Records Department. These lists are reviewed as they come in and clients from the THUs on this list are provided a copy of their re-entry plan, release medications ordered and sent to a pharmacy of the client's choosing, coordination with community case managers are made (as needed), flyers for relevant community resources are provided, and referrals to the Horizon Diversion Triage Center can be made.

**Recommendation(s):**

1. AFBH to review existing draft policy to ensure that all provision requirements are met; finalize policy and all related forms.
2. Ensure staff compliance with procedures via regular reviews of documentation.
3. 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.
4. 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, at the time of release, IPs are provided with a 30-day supply of their psychiatric medications. 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 similar over the months with an average of 88 releases per month, with a higher number in the month of December. During this report period, an average of 38% of IPs received discharge medications. However, the actual number of release medications provided per month ranged from eight (8) to 57 IPs. 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
July 2025	82	8 - 0
August 2025	98	49- 50
September 2025	82	34 - 41
October 2025	75	35 - 46
November 2025	83	57 - 68
December 2025	109	48 - 44
<b>Monthly Average</b>	88	38 - 43
<b>Prior Report Average</b>	74	38 - 56

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