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

Ninth Status Report

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Miami, Florida

November 2, 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 January 1st through June 30, 2026. 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

Provision	Rating
200. Sufficient Mental Health Staff to Comply with Consent Decree	PC
204. Hiring of Additional Mental Health (MH) Staff	PC
205. Training of Third-Party MH Providers	SC
206. Telehealth MH Services	SC
304. Development/implementation of Formal Processes for Administrative Housing	SC
312. Develop Therapeutic Housing Committee	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

Provision	Rating
702. Develop a Plan to Implement Therapeutic Housing Units	DC
703. Individuals with SMI to Receive Therapeutic Services	SC
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	SC
714. MH Intake Interviews and Assessments in Private and Confidential Spaces	SC
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	SC
726. Provide Regular, Consistent Therapy and Counseling	PC
727. Provide In-Cell Activities to Decrease Boredom and Mitigate Isolation	SC
728. Develop Formal Clinical Treatment Teams	PC
729. Develop and Implement Policies/Procedures to Establish Treatment Teams	PC
730. Individualized MH Treatment Plans	PC
731. Develop and Implement Policies/Procedures for Treatment Teams	PC
732. Provide Information in Treatment Teams to Medical Providers	PC
733. Provide Calming and Restorative Instruction	SC
734. Provide Substance Abuse Programs for Co-occurring Disorders	PC
735. Provide Daily MH Rounds	PC

Provision	Rating
736. Offer Weekly Face-to-Face Clinical Contacts	PC
737. Provide Additional Clinical Contacts	PC
738. Ensure Individuals Expressing Suicidal Ideation are Provided MH Evaluation and Care	PC
739. Ensure Psychiatric Medications are Ordered in Timely Manner	SC
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	SC
758. QMHP Shall See Inmates on Suicide Precautions on an Individualized Schedule	PC
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	SC
767. Assess and Review Quality of Care Provided to Persons Sent to John George	SC
769. Re-orient How Units, Including the Therapeutic Housing Units, are Managed	SC
770. MH Programming for Women	SC
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**
#9 – November 2026	**0**	**46**	**27**	**6**	**79**

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

Policies:

- AFBH Adaptive Support for Developmental, Intellectual, Learning, and Cognitive Disabilities
- 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
    - Draft – AFBH Psychiatric Disability Protocol
- AFBH Polypharmacy Antipsychotic Medication Registry and Monitoring
- AFBH Preventing Suicide and Self-Harming Behavior
    - AFBH Psychological Autopsy Protocol
- 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
- AFBH Santa Rita Jail Intake
- AFBH Santa Rita Jail Referral
- AFBH Telehealth Provider Services
- AFBH Therapeutic Housing Units

    - Draft – Therapeutic Housing Committee Protocol
    - Draft – AFBH Treatment Plan Protocol
    - Draft – AFBH Treatment Team 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 January 1st through June 30th, 2026. 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 to an average of 30% during the period. A net gain of nine positions in the last six months supports a continued gradual improvement in the number of positions filled. The Masters-level intern at the Santa Rita Jail (SRJ) completed their training in July 2026.

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. The AFBH Table of Organization (TO) has undergone changes. Staff additions have included two staff persons for quality assurance efforts and two assigned to re-entry services. 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 and improvement in service delivery that will be discussed elsewhere in this report, 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 continue to 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.

AFBH is addressing the developing needs to identify and assess intellectual and developmental deficiencies (ID/DD) and psychiatric deficiencies. There are now two (2) Psychologists with sole responsibility to assess for ADA accommodations and adaptive supports.

Based on the efforts to comply with the CD, AFBH continues to consider 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.

ACSO has addressed the lack of office space for AFBH staff cited as a serious concern in prior reports with the conversion of a portion of Housing Unit (HU) 31 as workspace for AFBH staff. Full implementation of this workspace during this reporting period has significantly improved the availability and quality of professional office space.

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 and weekends. Telecare staff also provide extensive group therapy in the THUs as discussed elsewhere in this report.

ACBHD has also contracted with LifeLong Medical Care to provide group treatment primarily in the area of substance use.

As previously reported, AFBH relies upon agency, "locum tenens," medical personnel for staff positions that have been difficult to recruit and fill. Eight (8) of the 21 Psychiatric Provider positions are agency personnel. The locum tenens employees perform at the same level as AFBH staff.

ACSO's expansion of the Behavioral Health Access Team (BHAT) to nine (9) Deputies has been pivotal in directly assisting the behavioral health population as well as supporting AFBH efforts. 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 decrease of 456 completed escorts since the last report while the number of groups supported by BHAT Deputies increased by 213. The decrease in the number of escorts may in part reflect the greater ability to provide therapeutic services within the THUs. The increase in the number of completed groups reflects the greater availability of therapeutic services being provided AFBH and the contracted providers, Telecare and LifeLong.

Month	Completed Escorts	Completed Groups
January	687	158
February	519	155
March	607	219
April	701	218
May	594	150
June	597	206
Current Totals/Averages	3,705/617	1,106/184
Prior Report Averages	694	149
Increases	**-13%**	**+19%**

Recommendation(s):

1. It is recommended that AFBH continue assessing the need for possible additional contractual opportunities for clinical services, beyond Telecare and LifeLong 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 continue to be updated monthly to closely monitor the position vacancies and review possible changes in structure and position allocation.
3. 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 – Consider Discontinuation of Monitoring

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. ACBHD/AFBH has operationally committed that any contracted staff working in the SRJ will be provided with "on-boarding" and ongoing training consistent with the training required and provided to AFBH staff. Evidence of contracted staff participation in training was provided and reviewed by this Joint Expert for this reporting 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. Training records reviewed for this period support the participation of Telecare employes in training. LifeLong staff, a recent contract, has also begun participating in AFBH CD required training.

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 – Consider Discontinuation of Monitoring

Policies: AFBH Telehealth Psychiatric Provider, 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 again 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 IPs 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 January through June 2026. A total of 68 dates of service were reviewed. The Daily Activity Log lists the telehealth appointment schedule for each day, and the psychiatrist enters the outcome of the activity. For this reporting period, 332 telehealth appointments were conducted; 348 appointments were not conducted for a variety of reasons, but mostly because the IPs refused to meet with the clinician. The high rate of declined or missed telehealth appointments has been brought into question in the last several 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. AFBH has utilized the Mental Health Appointment Refusal Form to obtain a reason for the appointment "no show." The deputy who escorts is responsible for having the form completed and provided to AFBH. 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 including documentation of effective communication.

Recommendation(s):

1. AFBH Forensic Behavioral Health Clinical Managers should continue to regularly review the Telehealth Daily Activity Logs to ensure compliance with policy.
2. AFBH supervisors/leadership should continue efforts to determine the issues related to 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 – Consider Discontinuation of Monitoring

Policies: AFBH Vetting Restricted Housing Committee Referrals

Training: Completed for relevant staff and ongoing as necessary

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

Assessment: Substantial Compliance with this provision has been sustained during this reporting period. In line with Provision 304, 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 six tours and has reviewed minutes of RH Committee Meetings within this reporting period. Case record reviews have supported that assessments of AFBH IPs 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.

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.

Finding: Substantial Compliance

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

Training: Completed for relevant staff and ongoing as necessary

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

Assessment: Substantial Compliance with these provisions has been sustained during this reporting period.

As required by Provision 312, AFBH continues to implement the approved THU Policy which establishes the THUs as mental health service delivery areas within the SRJ. The policy describes the clinical criteria for IPs to be placed in a THU. 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. 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, in compliance with Provision 312, the THUs include weekly Therapeutic Housing Committee (THC) Meetings to discuss IPs from the male and female THUs who may be better served in a different THU or in general population housing. As an IP's mental health symptoms improve, the THC works with ACSO Classification to move IPs to a less restrictive environment whenever possible. The THC must consider the IP's ability to function in a less restrictive living environment, their current classification "points," and their history in SRJ HUs. For greater compliance with the wording of this provision, it has been agreed that all IP placements and clinical recommendations to step-down IPs to other THUs or to general population will be discussed in the weekly THCs.

Proof-of-practice documentation of weekly THC meetings for the months of January through July 2026 has been reviewed by this Joint Expert. Documentation includes an agenda, sign-in sheet, and an individual Therapeutic Housing Committee Referral Form for each IP formally discussed as required by provision. 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. To ensure that these committee meetings continue to be effective, AFBH Psychiatrists and Wellpath nurses should attend, when possible and the meetings are to be attended by the various units' Treatment Teams. At this time, 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 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 weekly THC meetings review all appropriate male and female THU IPs that have been recently placed on the units and/or those that being considered for step-down/movement from the THU.
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.

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, AFBH Levels of Care, 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

Regarding Provision 317 and the requirement for "step-down protocols," The AFBH LOC rubric and the Therapeutic Housing Unit policy comprehensively describe the step-down process and the services to be provided as IPs improve and "progress" through the continuum of care. Step-down within the LOC rubric allows for the provision of more clinical services within the units and placement in housing that supports greater interaction between IPs and between staff and IPs.

The conversion of C-Pods in the THUs for group programming and greater availability for confidential meeting space are improving the possibility of IP participation in treatment services.

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 daily huddles, weekly treatment team meetings, and frequent rounds to jointly assess the person's condition and improvement/progress or lack thereof. IPs in THUs are discussed in the weekly THC meetings where discussions of IPs placed in the units, their adjustment and progress occur, and where decisions regarding their placements, whether to remain in the THUs are made. 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. In certain situations, identifying an appropriate "step-down" placement may be challenging given the security level of the AFBH IPs. However, it is noted in THC documentation that ACSO and AFBH are working closely to determine and actualize the best placement options.

Weekly THU Treatment Meetings are also 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 IPs as appropriate.
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. 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.

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: Completed for relevant staff and ongoing as necessary

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 achieved Substantial Compliance during the last rating period and is continued during this reporting 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. 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, as required by this provision on a weekly basis. Proof-of-practice to be provided to this Joint Expert.
2. ACSO and AFBH are to continue to review the options for placement of IPs contraindicated for RH based on their mental health condition.

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 – Consider Discontinuation of Monitoring

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. This 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. In situations where IPs deteriorate, they are assessed for the appropriateness of being moved to another housing location.

In addition to the assigned Treatment Team, ACSO RH staff can 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 182 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 4,197 calls in the period; only 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 includes 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 and report the findings of their assessments, when appropriate.

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 cllients 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 conducted training and continued formal implementation of the following policies and procedures: Effective Communication, Identifying and Diagnosing "Severe Mental Illness," Therapeutic Housing Unit, Disciplinary Incident Response, AFBH and John George Psychiatric Hospital IP Care Coordination and Adaptive Support for Developmental, Intellectual, Learning, and Cognitive Disabilities. AFBH continued work on draft policies including those related to medication refusal, re-entry services, and referrals to psychiatrists. During this period, AFBH also developed four (4) additional "protocols" for specific clinical services/functions. The protocols provide specific criteria and guidance in relation to services. AFBH has written protocols for: Treatment Teams, Treatment Plans, Psychiatric Disability and Therapeutic Housing Committee. All protocols are in various stages of review and modification at this time.

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: Monitoring Discontinued

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: Substantial Compliance

Policies: AFBH Therapeutic Housing Units, AFBH Diagnosing Severe Mental Illness (SMI), ACSO Crisis Communications for Corrections Training, ACSO Policy and Procedure 1.14 Americans with Disabilities Act

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: This provision is rated Substantial Compliance during this rating period. As reported in the past, AFBH has continued to refine and improve their efforts to assess and identify IPs with SMI at SRJ. During this period, the SMI policy has been formally implemented

following training. Individuals continue to be “flagged” as SMI in CG and efforts continue to ensure that IPs with SMI have a documented Re-entry Plan upon release from custody.

The average number of IPs identified as SMI per month during this reporting period (January through June 2026) was 157, a 37% increase from the figures in the last report period. This increase in the number of SMI being identified considering the consistency in the overall AFBH caseload supports the emphasis being placed on identifying IPs with SMI.

For this reporting period, the average number of IPs with SMI designation is 17% 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 not be possible or prudent at intake due to limited and perhaps uncertain information, as clinical services are rendered and the person’s mental health condition is understood, the SMI designation should be added to the case record in CG.

Month	IPs with SMI Designation/All LOC	%age of SMI in Structured Activities
January	131	96
February	147	93
March	139	95
April	152	98
May	199	68
June	185	80
Monthly Average	157	88
Average Last Reporting Period (7-12/2025)	115	92

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 most 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 average, 90% of IPs identified as SMI are receiving/participating in mental health treatment services to some extent. The Structured Activities Report indicates that IPs identified with a SMI are receiving: psychiatric services, clinical services, groups therapies led by AFBH, Telecare and Lifelong, and are receiving Re-Entry services. 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.

Case record reviews for the period of IPs, some of which are “flagged” as SMI, 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. Treatment plans for IPs with SMI were found in 100% of the case records.

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 25 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 25's dorm-like setting is principally for the LOC 2 male inmates.

THU (HU 21) consists of two celled housing pods (D-E) for females classified as minimum or medium custody. Conversion of the unit's F pod for clinical activities – consistent with other projects to increase therapeutic activity space – was completed in May 2026. The unit, however, does not allow the lower-classification IPs to reside in the least restrictive environment; i.e., a dorm-style environment. The need to develop housing for females like HU 25, which serves as the least restrictive option for males, remains the ideal.

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. 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 IPs 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 Units, 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 maintained during this period. In keeping with prior reports and as observed during the tour, formal opportunities for communication between mental health and custody staff 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, 25) reportedly take place daily and five days per week in RH (HU 1). Significant involvement and participation by both custody and clinical personnel was noted 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. In addition to the huddles, prior to the last report, AFBH leadership had implemented a weekly THU Treatment Meeting at each THU at which more detailed review of IPs can be conducted.

THC meetings to discuss AFBH THU IPs (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 address IPs 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 appropriate for placement 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 4,197 entries were made in the ITR Call Log. As in prior reporting periods, a qualitative review of 120 random 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.

AFBH leadership meets with ACSO leadership to coordinate scheduling on a regular basis, at least once per month. Examples of discussed topics include proposed group activities, scheduling of existing groups, ADA assessments, and other clinical programming.

Recommendation(s):

1. Both ACSO and AFBH need to continue to assign consistent 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 – Consider Discontinuation of Monitoring

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 continued during this reporting period. AFBH uses 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 is completed electronically and becomes a part of the IP's AFBH 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 and continues as necessary.

The chart below presents the number of intakes completed monthly by either AFBH or contracted ITR staff. There weas a moderate increase in the intakes completed during this reporting period; a monthly increase of approximately 61 intakes.

Month/Year	# of Intakes Completed
January 2026	1,584
February 2026	1,692
March 2026	1,915
April 2026	1,777
May 2026	1,732
June 2026	1,754
Total/Average per Month	10,454/1,742
Prior Report Total & Monthly Average	10,089/1,682

The chart above indicates that there is relative consistency in the number of intakes conducted by AFBH each month. These figures allow AFBH leadership to better establish staffing requirements for the ITR functions, especially in the intake area where Telehealth staff are also completing this function on certain shifts.

During this reporting period, AFBH ITR supervisors continued to conduct monthly quality assurance (QA) review of completed BIAs . ITR Clinical Supervisors and the ITR Clinical Manager reviewed approximately 49 cases per month; a significant increase from last report's 20 cases. The QA reviews demonstrate a thorough assessment of BIA documentation and provide detailed and meaningful recommendations to staff for improvement. According to AFBH leadership, findings of these reviews are discussed in weekly ITR leadership meetings, with corrective actions identified and taken.

Similarly, Telecare supervisory staff continued to complete 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 and, when issues are found, detailed corrective actions are described.

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.

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 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

Assessment: These three provisions address the different levels of response for mental health services at intake. The AFBH model of service delivery at intake however is to assume all incoming "referrals" as Emergent. All persons entering the SRJ are viewed as Emergent referrals and a comprehensive intake assessment, the BIA, is to be conducted within the four-hour timeframe. Currently, the intake assessments are being completed on all who enter the SRJ with a 63% of compliance with the four-hour time limit. The principal reason that limits full compliance with the time limit is the lack of confidential interview space. ACSO has agreed to convert and allocate two (2) confidential interview booths for AFBH intake staff. It is expected that, when the spaces become available, the four-hour time limit will be met for all intakes. ACSO anticipates that construction for this project will begin in August 2026. Once the four-hour timeframe for completion of the initial assessment is achieved at a 90% compliance or above, the three provisions will be rated in Substantial Compliance.

Recommendations:

1. ACSO to complete renovations and conversion of the designated area into intake booths for AFBH.
2. AFBH to continue tracking compliance with the four-hour time limit for intakes.

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: Draft–FBH Santa Rita Jail Referral Policy, Draft–AFBH Psychiatric Referrals and Appropriate Training 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, AFBH Half-Sheet Referral Form, ITR Call Logs, SRJ ATIMS Medical-Notes Report Samples, Case Record Reviews

Assessment: This provision remains in Partial Compliance due to the policy not completed during this reporting period.

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. Upon review, medical referrals are forwarded to the appropriate psychiatric provider. The AFBH Officer of the Day (OD) supervisor refers to ITR as needed to address emergent or urgent referrals. In addition, Wellpath staff are also trained to call ITR for emergent or urgent referrals so information in the ATIMS referrals may be a duplicative notification. 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.

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 (N/A in chart below). As mentioned in provision 406, 4,197 calls were received in ITR during the six-month period from across areas of the SRJ. Most of these

calls were requests for AFBH assistance/intervention; some were informational. Calls for assistance are considered “referrals” and are categorized according to the issue and nature of the call. Compliance with provisions 706 and 707 requires that the referrals, determined to be “emergent” or “urgent,” are to be responded to within set timeframes.

	Referral Type				
	Emergent	**Urgent**	**Routine**	**N/A**	**Total**
January	312	87	118	154	671
February	310	116	97	180	703
March	321	112	99	239	771
April	272	118	89	152	631
May	261	106	112	211	680
June	280	118	93	250	741
Total/Average	293	110	84	198	4,197/699
Prior Report Tota/Average					3,781/630

Given these figures, AFBH received and addressed 416 more requests during this reporting period; an average of 23 requests per day or 699 per month. 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. Documentation attests to referrals being addressed in accordance with the nature of the issue.

As of January 2025, the AFBH Crisis Response Team began tracking response times for Emergent and Urgent referrals on the ITR Call Log. Since evaluation of compliance began, reports indicate that the average response time for Emergent referrals and Urgent referrals are 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
January	Emergent	312	297	9	-	-	1 hr, 4 mins.
	Urgent	87	-		86	1	3 hrs, 59 mins
February	Emergent	310	300	8	-	-	1 hr, 13 mins
	Urgent	116	-	-	116		2 hrs, 47 mins
March	Emergent	321	316	3	-	-	1 hr, 05 mins
	Urgent	112	-	-	112		2 hrs, 49 mins
April	Emergent	272	267	5	-	-	58 mins
	Urgent	118	-	-	118		2 hrs, 45 min
May	Emergent	251	239	6			1 hr, 12 mins
	Urgent	106	-	-	106		3 hrs, 19 mins
June	Emergent	280	272	4	-	-	1 hr, 5 mins
	Urgent	118	-	-	118		3 hrs, 45 mins

According to these reports, compliance with responding to Emergent referrals within four (4) hours is 97% and compliance with responding to Urgent referrals within 24 hours is 100%.

During this reporting period, AFBH initiated the time-tracking of referrals identified as "routine." As discussed in provisions 706 and 707, all referrals for AFBH assistance and services are categorized according to the nature and urgency of the contact. Routine referrals are to be responded to within 14 days of receipt. AFBH began assessing compliance with this timeframe during this reporting period and results are available as shown below.

Month	Referral Type	Total # by Referral	Seen < 14 days	Seen > 14 days	NIC < 14 days	Compliance %age
May	Routine	112	99	1	12	88%
June	Routine	93	92	0	1	99%

The AFBH referral policy remains in need of revision. Once completed, the provision will be in Substantial Compliance.

Recommendation(s):

1. The AFBH Referral Policy needs to be completed and formal training conducted.
2. AFBH needs to continue the capacity to have Emergent, Urgent and Routine referrals consistently seen for a clinically relevant assessment within the required timeframes.
3. Refer to provisions 406, 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: 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. As noted in the discussion on provision 706. the AFBH model of service delivery at intake is to assume all incoming "referrals" as Emergent. Since all persons entering the SRJ are viewed as Emergent referrals, the comprehensive intake assessment is to be conducted within the four-hour timeframe. 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. ACSO has determined that an additional two (2) confidential intake spaces in the ITR area will be renovated. Completion of renovations is expected in 2027.

The chart below presents the number of intakes completed monthly by either AFBH or contracted ITR staff. There weas a moderate increase in the intakes completed during this reporting period; a monthly increase of approximately 61 intakes.

Month/Year	# of Intakes Completed
January 2026	1,584
February 2026	1,692
March 2026	1,915
April 2026	1,777
May 2026	1,732
June 2026	1,754
Total/Average per Month	10,454/1,742
Prior Report Total & Monthly Average	10,089/1,682

The chart above indicates that there is relative consistency in the number of intakes conducted by AFBH each month. These figures allow AFBH leadership to better establish staffing requirements for the ITR functions, especially in the intake area where Telehealth staff are also completing this function on certain shifts.

During the last reporting period, ITR began to determine the length of time it takes to complete the BIA as required by this provision. The BIA is to be conducted within the four-hour timeframe. In the last report it was explained that compliance with the four-hour timeframe was being measured 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. On the average over this time period, the BIA is being completed 63% of the time. The results for the reporting period are shown below.

	Intake Time				
	# of Intakes	**# Time Recorded**	**< 4 Hours**	**> 4 Hours**	**%age Compliance**
January	1,761	1,584	1,083	501	69%
February	1,692	1,516	947	569	63%
March	1,915	1,662	1,117	545	68%
April	1,777	1,599	947	452	60%
May	1,732	1,543	895	648	58%
June	1,754	1,564	939	625	60%
Total/Average	10,454	9,468	5,928	3,340	63%

AFBH continues to operate an Assessment Pod in THU 9 (for males) and provide the function in HU 21 for the females. The pods are staffed every day by clinicians. 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 is 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 person's adjustment to the jail environment and more reliable understanding of the IP's mental health issues. AFBH staff remain positive about the opportunity to more closely monitor new arrivals to the jail or newly-identified IPs with mental health issues. Staff also 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. ACSO to follow through on the proposed renovations for additional intake space.
2. AFBH needs to continue monitoring compliance with completion of the BIA within the four-hour timeframe required by the provision.

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

Finding: Substantial Compliance – Consider Discontinuation of Monitoring

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

Training: Completed for relevant staff and ongoing as necessary

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

Assessment: This provision 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.

Suicide and self-harm flags were found to be in place, when appropriate, in the 75 case record reviews conducted during this reporting period.

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 CD. 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: Substantial Compliance

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

Training: Completed for relevant staff and ongoing as necessary

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: This provision has achieved Substantial Compliance during this reporting period. 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 1,258 medication verifications occurred during the six-month reporting period; fairly consistent with the last reporting period. A revised Bridge Medications Log was implemented just outside of this reporting period (in June 2026) to address previously identified duplicated and inconsistent information. The improvements will be addressed in future monitoring reports.

	# of Verified Meds Processed
January	191
February	211
March	247
April	195
May	191
June	233
Total	**1,258**
Last Report Total	**1,367**

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

Audit Month	**Meds Verified ≤ 24 Hours**	**Psychiatric Meds Ordered ≤ 24 Hours**	**All Meds Ordered ≤ 24 Hours**	**Meds Delivered ≤ 24 Hours**
January 2026	100%	94%	94%	100%
April 2026	100%	95%	96%	96%

The audits indicated compliance rates between 94% and 100% on the audit tool items which comprise this provision.

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: Substantial 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: This provision has achieved Substantial Compliance during this rating period. AFBH has access to two dedicated booths in the ITR area for intake assessments that offer a confidential interview process. All BIAs are conducted in these confidential booths. ACSO has agreed to provide AFBH with two (2) additional confidential intake booths in the ITR area. Renovations are set to begin in September 2026. Once in use, the additional confidential assessment areas are expected to result in the initial assessments occurring within the required four-hour timeframe.

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. ACSO to complete renovation converting two additional intake booths in the ITR area.

715. k. Prior to accepting custody of any arrestee, Jail personnel conduct a pre-booking screening of all individuals while they are still in the custody of an arresting officer to identify potentially urgent medical and/or emergent mental health issues and are deferred to outside treatment when necessary, including if arrestees indicate they are suicidal. Arrestees who express suicidality during the pre-booking screening shall be assessed to determine if they meet criteria under Welfare and Institutions Code § 5150 ("Section 5150").

Individuals who meet criteria under Section 5150 are deferred to psychiatric care and treatment and are not admitted to the Jail. Subsequent admission to the Jail of individuals who were deferred to outside medical or mental health treatment shall be predicated upon obtaining clearance from a community hospital.

Finding: Monitoring Discontinued

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

Finding: Partial Compliance

Policies: AFBH Santa Rita Jail Intake Policy

Training: AFBH ITR Checklist

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

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

In the last report, it was explained that AFBH had begun begun to determine the length of time it takes to complete the BIA as required by this CD. At that time, available reports showed that while 71% of the intakes were initiated within four hours of booking, there was no calculation as to the time it took to complete the BIA. .

During this reporting period, ITR is now able to determine the length of time it takes to complete the BIA as required within a four-hour timeframe by this provision. In the last report it was explained that compliance with the four-hour timeframe was being measured 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. On average over this time period, the BIA is being completed as required 63% of the time. The results for the reporting period are shown below.

	Intake Time				
	# of Intakes	**# Time Recorded**	**< 4 Hours**	**> 4 Hours**	**%age Compliance**
January	1,761	1,584	1,083	501	69%
February	1,692	1,516	947	569	63%
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May	1,732	1,543	895	648	58%
June	1,754	1,564	939	625	60%
Total/Average	10,454	9,468	5,928	3,340	63%

During this reporting period, AFBH ITR supervisors continued to conduct monthly quality assurance (QA) review of completed BIAs . ITR Clinical Supervisors and the ITR Clinical Manager reviewed approximately 49 cases per month; a significant increase from last report's 20 cases. The QA reviews demonstrate a thorough assessment of BIA documentation and provide detailed and meaningful recommendations to staff for improvement. According to AFBH leadership, findings of these reviews are discussed in weekly ITR leadership meetings, with corrective actions identified and taken.

Similarly, Telecare supervisory staff continued to complete 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 and, when issues are found, detailed corrective actions are described.

Recommendation(s):

1. Continue to develop and implement quality assurance measures 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: Within the past year, ACSO has completed renovation of the C pods and multi-purpose rooms in HUs 1, 2 and 9, the multi-purpose rooms and F pod in HU 21, and the multi-purpose room in HU 25. These changes have significantly altered the appearance and support a therapeutic "feeling." These additional areas have increased AFBH's opportunity to render therapeutic services within the THUs.

Secure programming chairs have been 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 opportunities for IPs in restrictive housing to participate in activities.

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), including RH.

Treatment services are delivered to IPs by the THU's assigned treatment team (Clinicians, Psychiatrists). The treatment team will consistently provide the primary therapeutic services and have the most frequent contact with the IPs. Additional clinicians, designated to provide group therapy services or other therapeutic services such as re-entry planning, interact with the IPs as appropriate.

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. Clinical notes in the case record reviews generally indicate when the IP was offered a confidential meeting place and their response (when they at times insisted upon meeting cellside despite being able to leave their cell).

In December 2023, the County exhausted all efforts to build a Mental Health Building at SRJ after the State Public Works Board removed this project from their agenda for a second time due to community voiced concerns. In May 2024, ACSO, ACBHD and GSA Leadership met to review alternatives, which were incorporated into projects that were put into the County's operating and capital budgets and approved by the Board of Supervisors in Summer 2024. These alternatives included modifying pods in housing units to create space for therapeutic programming, modifying cells to create space for confidential individual therapy, increasing the number of confidential booths in ITR for behavioral health assessments at intake, and modifying an entire housing unit to create workspace for AFBH and ACSO staff. These project, for the most part, have been completed.

Recommendation(s):

1. Continue active, frequent discussion of plans for establishing confidential meeting areas for the THUs.
2. 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, Draft – AFBH Santa Rita Jail Referral Policy

Training: Completed for relevant staff and ongoing

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. As explained in prior provisions, 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.

An Excel-based worksheet/report is compiled and monitored by the Forensic Behavioral Health Clinical Manager responsible for ITR.

Recommendation(s):

1. Revise the policy regarding how referrals will be made; include discussions with ACSO, Wellpath and internally within AFBH.
2. Continue calculating and reviewing response times for all levels of 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: Draft – AFBH Santa Rita Jail Referral Policy**,** AFBH Santa Rita Jail Intake Policy, Draft – AFBH Psychiatric Referrals and Appropriate Training

Training: Completed for relevant staff and ongoing as necessary

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

Assessment: The policy addressing the various types of referrals, responses 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.

As of January 2025, the AFBH Crisis Response Team began tracking response times for Emergent and Urgent referrals on the ITR Call Log. Since evaluation of compliance began, reports indicate that the average response time for Emergent referrals and Urgent referrals are 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
January	Emergent	312	297	9	-	-	1 hr, 4 mins.
	Urgent	87	-		86	1	3 hrs, 59 mins
February	Emergent	310	300	8	-	-	1 hr, 13 mins
	Urgent	116	-	-	116	0	2 hrs, 47 mins
March	Emergent	282	277	5	-	-	1 hr, 09 mins
	Urgent	76	-	-	76	3	3 hrs, 12 mins
April	Emergent	256	249	7	-	-	1 hr, 10 mins
	Urgent	100	-	-	100	5	4 hrs, 1 min
May	Emergent	251	239	6			1 hr, 12 mins
	Urgent	106	-	-	106	21	3 hrs, 19 mins
June	Emergent	280	272	4	-	-	1 hr, 5 mins
	Urgent	118	-	-	118	0	3 hrs, 45 mins

According to these reports, compliance with responding to Emergent referrals within four (4) hours is 97% and compliance with responding to Urgent referrals within 24 hours is 100%.

During this reporting period, AFBH initiated the time-tracking of referrals identified as “routine.” As discussed in provisions 706 and 707, all referrals for AFBH assistance and services are categorized according to the nature and urgency of the contact. Routine referrals are to be responded to within 14 days of receipt. AFBH began assessing compliance with this timeframe during this reporting period and results are available as shown below.

Month	Referral Type	Total # by Referral	Seen < 14 days	Seen > 14 days	NIC < 14 days	Compliance %age
May	Routine	112	99	1	12	88%
June	Routine	93	92	0	1	99%

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 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: Completed for relevant staff and ongoing as necessary

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: Completed for relevant staff and ongoing as QA measures are established

Metrics: Interviews with Staff, Review of various QA measures

Assessment: AFBH continues with plans to increase its QA staff and establish a Quality Assurance Committee. AFBH has two designated clinical review specialists reporting to the QA Medical Director. A QA Psychiatrist is anticipated to begin in October 2026, who will report to the AFBH QA Medical Director. AFBH also anticipates increasing QA clinicians by the next monitoring period to support responses to Disciplinary Incidents and Grievances.

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 has 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
    - Clinician Gateway Reviews/Audits by AFBH Supervisors
    - Continuity of Care Psychiatric Medications Audi
    - Medication Refusal Audit
    - Patient Polypharmacy Report
    - ITR Call Log Audit

- 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, Draft – AFBH Psychiatric Disability Protocol

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.

An initial AFBH LOC document was presented in the CD as Exhibit C. Modifications to the LOC system of care were anticipated as, expressly stated in Exhibit C, that the document "would be subject to further modification as the provisions in Section III(G) (Mental Healthcare) of the CD are developed and implemented." 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. Modifications and exclusions to certain LOC "criteria" in the original CD Exhibit C have been made to ensure that IPs are provided services and housed in the least restrictive environment possible given their mental health state.

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 IP and level), and The LOC Data Report (weekly, by IP).

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

- AFBH's overall mental health caseload has remained overall consistent over the past year.

- While, generally speaking, totals for all four LOCs appear to remain consistent, there has been a 10% increase in the LOC 2 figures, a 6% increase in the LOC 1 and an 8% decrease in the LOC X figures. So, it would seem that there's an increase in the number of persons identified with mental health issues.
- For the past four reporting periods, all IPs in the SRJ have been assigned an LOC. Case record reviews show 100% compliance with the assessment of LOCs.

LOC Reports - 1/01/2026-6/30/2026

Report Date	LOC 1	LOC 2	LOC 3	LOC 4	LOC X	Pending LOC	Total LOC 1-4
1/12/26	46% N=564	20% N=244	7% N=91	2% N=26	24% N=289	0% N=0	925
1/26/26	46% N=585	21% N=260	7% N=92	3% N=34	23% N=297	0% N=0	971
2/09/26	49% N=541	20% N=221	7% N=81	2% N=24	22% N=248	0% N=0	867
2/23/26	47% N=612	21% N=268	7% N=97	3% N=37	22% N=281	0% N=0	1,014
3/09/26	46% N=584	22% N=279	7% N=94	2% N=28	22% N=276	0% N=0	985
3/23/26	47% N=589	22% N=274	8% N=98	2% N=24	21% N=264	0% N=0	985
406/26	48% N=596	22% N=278	7% N=89	2% N=24	21% N=261	0% N=0	987
4/20/26	46% N=571	23% N=284	8% N=101	2% N=22	20% N=251	0% N=0	978
5/04/26	48% N=606	22% N=276	7% N=90	1% N=16	21% N=267	0% N=0	988
5/18/26	48% N=591	24% N=294	7% N=86	1% N=18	20% N=243	0% N=0	989
6/01/26	46% N=565	24% N=292	7% N=74	2% N=22	20% N=223	0% N=0	898
6/15/26	48% N=534	24% N=268	7% N=87	2% N=22	24% N=287	0% N=0	920
6/29/26	46% N=542	24% N=281	8% N=91	2% N=20	21% N=244	0% N=0	935
Average	47% N=575	22% N=289	8% N=90	2% N=24	24% N=264	0% N=0	957
Prior Report Average	44%/588	20%/261	7%/99	2%/33	26%/342	0%/0	981

LOC Averages & Ranges - 1/01/2026-6/30/2026

Level of Care	Percentage	Percentage Range	Number	Number Range
LOC 1	47%	46% - 49%	575	505 - 608
LOC 2	22%	20% - 24%	289	221 - 294
LOC 3	8%	7% - 8%	90	92 - 113
LOC 4	2%	2% - 3%	24	22 - 43
Average Caseload			957	898 – 1,014
Prior Report Average Caseload			981	894 – 1,019

AFBH Caseload Compared to SRJ Population-January through June 2026

Months	Average Caseload LOC 1-4	SRJ Population/ Last Day of Month	% of SRJ Population on AFBH Caseload
January	948	1,258	76%
February	941	1,295	73%
March	985	1,334	74%
April	983	1,263	78%
May	989	1,245	80%
June	918	1,227	75%
Average	961	1,271	76%
Prior Report Averages	985	1,384	70%

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.

In the last two reporting periods, efforts have focused, with the assistance of the ADA Joint Expert, on the ongoing identification of psychiatric disabilities. Awareness and identification of possible psychiatric disabilities and appropriate referrals are being addressed during each clinical encounter. During this reporting period, AFBH has developed the Psychiatric Disability Protocol, with assistance from the ADA Joint Expert. The Protocol addresses AFBH's role in assessing for disabilities.

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 CD. In the meantime, the Expert will reduce monitoring of this provision in future reports.

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 remained in Substantial Compliance during this reporting period. As reported in the past, ACSO has identified additional areas within the THUs and has been actively repurposing space in various HUs for therapeutic activities conducted by AFBH and its mental health contractors. During this year, ACSO initiated monthly meetings attended by AFBH representatives, Joint Experts and ACSO staff to discuss the construction projects and updates.

Specifically, ACSO has completed renovation of the C pods and multi-purpose rooms in HUs 1, 2 and 9, the multi-purpose room and F pod in HU 21, and the multi-purpose room in HU 25. These areas are now available for use as treatment areas for groups and individual encounters by AFBH and contracted staff. In addition to making the areas appropriate for individual and group meetings, ACSO has incorporated wall art, improved flooring, and decorative features that create a more therapeutic environment. These areas will certainly provide an opportunity for greater therapeutic services within the THUs.

Secure programming chairs have been 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).

Recommendation(s):

1. ACSO and AFBH to objectively review treatment space needs according to the THU LOC requirements.
2. ACSO to complete renovations for the six individual interview rooms.
3. ACSO, with assistance from AFBH, to continue efforts to create a more aesthetically pleasing and therapeutic environment on the THUs.
4. Refer to provisions 717 and 723 for additional recommendations.

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.

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

Finding: Partial Compliance

Policies: AFBH Therapeutic Housing Units, AFBH Levels of Care

Training: N/A

Metrics: Interviews with Staff, Case Record Reviews, Telecare Schedule and Service Logs, LifeLong Schedule and Service Logs, AFBH Master Schedule

Assessment: Case record reviews during this reporting period show a marked improvement in the type and frequency of clinically appropriate services being rendered, as required by the THU Protocol. Specifically, the review of case records shows that:

- All IPs are being assessed at intake using the BIA and an initial LOC is being identified;
- IPs are provided ”bridge” medications at intake or are quickly being assessed by psychiatry for medications;
- Clinicians are conducting the required extensive assessments on all IPs within the 14-day requirement;
- Psychiatric Providers are conducting initial and extensive assessments;
- An initial re-entry plan is being developed within 72 hours of intake; re-entry staff is meeting with IPs to individualize the plans;
- When a person is declared “Incompetent to Stand Trial,” clinical services are being provided in accordance with Early Access Stabilization Services (EASS) programming;
- Daily rounding of LOC 4 and some LOC 3 IPs (not required by protocol) are occurring;
- Referrals for clinical services are being discussed in “huddles” and subsequent clinical and psychiatric interventions are taking place;
- Follow-up with IPs based on discussions/plans from Suicide Prevention Meetings and Treatment Team Meetings are taking place;
- Refusals and cancellations are being documented; supporting consistency in services;
- Medication refusals are triggering “wellness checks” by nursing staff;
- Psychiatric Providers are attending huddles and rounds;
- More encounters are occurring in confidential settings; significant decrease in cellside or table-top meetings;
- A variety of group treatments are being offered, with greater frequency;
- “Effective Communication” is being assessed and documented in CG;
- Situations that require “Crisis Intervention” by AFBH clinical staff are being identified, communicated and appropriately addressed; and
- Initial Treatment Plans are in CG for a significant portion of LOC 2-4 IPs.

Case record reviews indicate that the type and frequency of interventions required by the THU Protocol for IPs identified as LOC 4 and LOC 3 are being met and, in some higher acuity cases, the requirements for clinical and psychiatric services are exceeded.

Individualized support and counseling services (identifying triggers, developing coping skills, care and case management) are being provided when the mental health stability of the IPs permits. 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.

During this reporting period, emphasis has continued on developing treatment plans for IPs on LOC 2-4. Case record reviews found informative treatment plans in place and found that these were being updated. However, not all case records had treatment plans; especially lacking were treatment plans for LOC 1 IPs.

Recommendation(s):

1. AFBH to continue to assess staff deployment based on service hours required; determine whether AFBH staffing requires modification.
2. 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.

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: Substantial Compliance

Policies: AFBH Therapeutic Housing Units, AFBH Levels of Care

Training: N/A

Metrics: Interviews with Staff, Case Record Reviews, Telecare Schedule and Service Logs, LifeLong Schedule and Service Logs, AFBH Master Schedule

Assessment: The Master Schedule of therapeutic activities indicates numerous groups taking place in all THUs. During this reporting period, groups have been initiated in RH. The Master Schedule is discussed with ACSO on a regular basis (at a minimum quarterly) to ensure the availability of BHAT Deputies to support activities.

Therapeutic groups are being conducted primarily by Telecare and LifeLong, with a few additional groups led by AFBH staff, and a specialized substance use group led by an ACBHD Psychiatrist. Telecare offers groups following 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. In April 2026, Telecare began offering four groups in RH including the Seeking Safety and Co-EG curriculum and a new group called “Real Talk” described as a process group with a restorative (relaxing, contemplative activities) component. These groups will continue to be offered after this reporting period. Groups in RH were an ongoing goal which was realized upon the installation of the secure programming chairs in the unit.

Clinicians from LifeLong provide substance use groups. An increase in the agency’s service allocation is expected to significantly increase the group therapy programming.

The table below indicates the average number of groups scheduled per week (by housing unit) over the last six months. As can be seen, there are more groups being held in the female THU than in the other THUs:

	HU 1	HU 2	HU 9	HU 21	HU 35
Telecare/LifeLong	4	15	7	18	11
AFBH/ACBHD	0	2	0	0	3

The table below shows the number of groups held by month for each agency:

	AFBH	LifeLong	Telecare
January	16	33	11
February	16	32	52
March	19	24	195
April	14	10	193
May	23	23	198
June	17	19	188

During this reporting period, two new process groups have been added to the schedule for the female IPs in THU 21. Telecare is now offering "Real Talk" and "The Hang Out" which blend information with conversation and include a "restorative" component such as relaxation and meditation. A total of four groups (two per night) have been added to the treatment schedule.

AFBH has continued providing three weekly ongoing Recreation Groups in THU 2. The groups offer additional out-of-cell programming for AFBH's highest acuity IPs. Activities and games are offered with a therapeutic overlay including music, mindfulness activities, practicing social skills and meaningful discussions with peers.

In THU 35, for the lower acuity IPs, AFBH has added some groups during this reporting period with topics such as "Expressive Arts and Stress Management," "Daily Functioning and Coping Skills," and the "Recovery Skills Group."

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 . 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 will likely need to be expanded.

Recommendation(s):

1. ACBHD to establish contracts with outside vendors as necessary.
2. 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.

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

Finding: Substantial Compliance

Policies: N/A

Training: N/A

Metrics: Interviews with Staff, Observations, Case Record Reviews

Assessment: AFBH Forensic Behavioral Health Clinical Managers continue to report that clinicians provide IPs 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. Case records contain ample proof of this practice.

In May, coping skills handouts and brochures regarding adjustment to jail were included in the IP tablets. By the end of August, Spanish translations to documents will be available on the tablets. AFBH expressed a plan to add self-help materials to tablets on a quarterly basis.

Recommendation(s):

1. AFBH to continue researching the availability and applicability of therapeutic, self-help materials on electronic tablets; discuss with ACSO and vendor.

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

Finding Partial Compliance

Policies: AFBH Therapeutic Housing Units, Draft – Treatment Team Protocol

Training: Completed for relevant staff and ongoing as necessary

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

Assessment: AFBH continues to operate THUs in HUs 2, 9, 21 and 25 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. AFBH adopted an annual work schedule for staff to improve consistency of clinical teams in January 2026.

To ensure the quality of the Treatment Team efforts, AFBH developed a Treatment Team Protocol. While currently in draft form, the protocol provides direction on how the treatment teams

operate in the THUs. Upon final approval and training on the Treatment Team Protocol, this provision will likely be in Substantial Compliance.

The frequent huddles and rounds support the sharing of treatment-related information between treatment team members. During the last reporting period, as previously reported, AFBH leadership implemented a weekly THU Treatment Meeting at each THU during which more detailed review of IPs is conducted.

Case record reviews provide ample examples of team members communicating with one another about the condition and status of the IPs.

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, AFBH Levels of Care, ACSO Policy and Procedure 13.01 Medical and Mental Health Care, Draft – Treatment Team Protocol

Training: Completed and ongoing as necessary

Metrics: Case Record Reviews

Assessment: AFBH operates THUs in HUs 2, 9, 21 and 25 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 adopted an annual work schedule for staff, in part, to improve consistency of clinical teams.

During this reporting period, AFBH has developed its Treatment Team Protocol which details the goals of the treatment team process and its responsibilities. This protocol is currently under review by this Joint Expert.

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 finalize the Treatment Team Protocol.

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: Draft – Treatment Plan Protocol

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews

Assessment: During this reporting period, AFBH has continued its efforts to develop the requirement for treatment plans. A Treatment Plan Protocol has been developed and reviewed with this Expert. 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 IPs 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.

While the provision requires that all IPs on the AFBH caseload have a treatment plan, at this time, AFBH leadership has focused on developing treatment plans for IPs: in custody beyond 30 days, with a focus on higher acuity IPs, 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 is used to document the effort.

For this reporting period, case record reviews found many more initial and follow-up treatment plans in place. As the chart below shows, significant efforts are being made to develop plans for IPs identified as LOC 2-4.

	LOC 1	LOC 2	LOC 3	LOC 4
Treatment Plans in Reviewed Case Records	12%	90%	100%	100%

However, 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 finalize the protocol related to mental health treatment plans (initial and follow-up) as specified in the CD.
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, AFBH Levels of Care, Draft – Treatment Team Protocol, ACSO Crisis Communications for Corrections Training, Draft – Therapeutic Housing Committee Protocol

Training: Completed for relevant staff and ongoing as necessary

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

Assessment: Weekly Therapeutic Housing Committee (THC) meetings, which constitute a multi-disciplinary treatment team meeting, are being held to discuss IPs from the current THUs and their mental health issues. IPs 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. Given recent conversations with AFBH, the THC will be expected to review all IPs recently placed in the THUs as well as those that have been moved to a less restrictive placement.

As in the prior reporting period, THC documentation 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 IPs in need of discussion from the various THUs. While individual unit meetings may not be necessary, sufficient attention must be afforded to IPs in all the THUs.

Huddles are being held daily at the THUs and five days per week in RH. These huddles also provide a forum for treatment team members to share and discuss IPs of concern. A THU Treatment Meeting is also occurring at each THU once per week with focus on individual IPs. 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 IPs who remain at the LOC 4 designation for 30 days. Each Code 3 and 5150 IP is discussed over the course of at least two meetings. 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. Extensive meeting documentation with detailed description of the IPs and the pertinent issues are included. Documentation of a "Plan" for the persons discussed, a requirement of the documentation, has improved but is still sometimes left blank. These ongoing discussions can be very helpful for staff and improve interventions and responses towards the IPs.

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

Recommendation(s):

1. Continue to conduct Therapeutic Housing Committee/treatment team meetings to afford sufficient opportunity for discussion and planning.
2. AFBH to finalize the Treatment Team Protocol.
3. Continue monthly Suicide Prevention Meetings; continue emphasis on IPs on LOC 4 for more than 30 days. Ensure that the "Plan" for each person reviewed is documented.
4. 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, ACSO-Crisis Communications for Corrections Training, Draft – Psychiatric Referrals and Appropriate Training Policy, Draft – Treatment Team Protocol

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 and the Draft-Treatment Team Protocol are 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 Treatment Team Protocol 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: Substantial Compliance

Policies: N/A

Training: N/A

Metrics: Observation, Interviews with Staff, Case Record Reviews

Assessment: This provision has achieved Substantial Compliance during this rating period. The format and content for groups afforded to IPs by AFBH, Telecare and LifeLong have been modified to ensure "calming and restorative" component. Groups begin and/or end with a meditative and/or contemplative exercise. Individual AFBH clinicians provide services throughout the SRJ wherever AFBH IPs are housed with concentrated efforts in THUs 2, 9, 21 and 25. Dedicated treatment teams in the THUs and RH (Unit 1) provide continuity in services and foster rapport building. Refer to provisions 725 and 726. Case record reviews reflect clinical interventions that are considerate and respectful.

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 possible use.

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 IPs.

IPs identified with only a substance use disorder at intake or during their incarceration will be identified as an LOC 1 and followed by AFBH clinicians.

As previously reported, LifeLong Medical Care has been providing on-site individual and group substance use counseling services through a contract with AFBH. The groups are psychoeducational and focus on substance use and trauma. LifeLong is also providing individual sessions for IPs with histories of substance use.

The AFBH Master Schedule identifies over 40 groups substance use-related groups scheduled each week in the THUs. Even with these efforts, substance abuse services are critical and likely need to be expanded. Treatment group efforts should be considered for the LOC 1 IPs.

During this reporting period, AFBH initiated a SUD group in THU 2 in collaboration with ACBHD's Medical Director for the 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.

Substantial Compliance will likely be achieved in the next reporting period.

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 CD provisions.

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

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 25 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 daily for any IPs with a LOC 4 in THU 2, 9 and in THU 21. However, daily rounds are not taking place in Restrictive Housing (HU 1). AFBH is in the process of implementing rounds in RH for IPs on psychotropic medications.
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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 present in 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.

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

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, Draft – Treatment Plan 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). Although the majority of contacts are made in accordance to the person's LOC, when clinical contacts such as rounds or interventions (e.g., potentially subsequent to discussion in huddles or reported otherwise by ACSO or clinical staff) occur, AFBH clinicians are responding on an individualized basis whether this is documented in the treatment plan or not. These contacts are recorded in the IP case records.

The development of confidential treatment areas resulting from the conversion of C pod and multi-purpose room conversations in the THUs is assisting in increasing out-of-cell clinical activities and the pleasant, therapeutic environment should assist to encourage participation by the IPs. This reporting period it was evident in case record reviews and on the schedules of activities that there has been a notable increase in the number and scope of group activities being offered in the THUs and, with the addition of the secure chairs, in RH.

As discussed in provision 730, AFBH is continuing to expand treatment planning with the goal to have treatment plans in place for all AFBH IPs: 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. Again, this emphasis on treatment planning was evident in the case records reviews for this reporting period. Not only were initial treatment plans in the files but updated treatment plans were also available.

Case record reviews for this rating period show that re-entry clinicians are also establishing contact with AFBH IPs 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.

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. However, the formal training did not occur during this reporting period. 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 that appropriate initial interventions are being provided and that follow-up care, commensurate with the concerns, are also being provided.

Recommendation(s):

1. Ensure that clinicians are updating treatment plans commensurate with the IPs LOC and document any additional treatment efforts/interventions being provided.

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: Substantial 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: This provision has achieved Substantial Compliance during this rating period. 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; fairly consistent with the last reporting period. A revised Bridge Medications Log was implemented just outside of this reporting period (in June 2026) to address previously identified duplicated and inconsistent information. The improvements will be addressed in future monitoring reports.

Months	# of Verified MedsProcessed
January	191
February	211
March	247
April	195
May	191
June	233
Total	**1,258**
Last Report Total	**1,367**

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

Audit Month	Meds Verified ≤ 24 Hours	Psychiatric Meds Ordered ≤ 24 Hours	All Meds Ordered ≤ 24 Hours	Meds Delivered ≤ 24 Hours
January 2026	100%	94%	94%	100%
April 2026	100%	94%	94%	100%

The audits indicated compliance rates between 94% and 100% on the audit tool items which comprise this provision.

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.

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 fourth 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: Completed for relevant staff and ongoing as necessary

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 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 January and April 2026 were made available for review by this Joint Expert. The audit involved a random selection of case records equivalent to 5% of the current population on psychotropic medications for each month. The findings of the medication refusal referral m(MRR) audits are shown in the chart below.

Audit Months →	January	April
Audit Sample Size (5%)	50	51
Total Psychotropic Med Refusals in Sample	181	244
Total # of Correct MRR by WP Nurses	32/18%	32/13%

These audits and the low compliance rates with referrals continue to indicate that medication refusal are not reported/referred to AFBH providers 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: Draft – Refusals of Prescribed Psychiatric Medications and Compliance Audit Requirements

Training: Completed for relevant QA staff and ongoing as necessary

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: This provision remains in Partial Compliance given that training on the corresponding policy did not occur during this reporting period. The AFBH Preventing Suicide and Self-Harming Behavior Policy received approval from ACBHD and formal training was completed in August 2026; just outside this reporting period. The policy explains how AFBH assesses suicide and responds to suicide risk and how Safety Cells will be used.

As previously reported, Safety Cell use has been phased out in favor of IOL placements.

Recommendation(s):

1. Refer to Provision 738.
2. 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.

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: Monitoring Discontinued

748. Defendants shall adopt graduated suicide precautions, including use of special purpose cells, reconfigured suicide resistant cells, one-on-one suicide watch, and a step

down to suicide precautions with less intensive observation. Cells with structural blind spots shall not be used for housing individuals on suicide precautions. Once Defendants have completed reconfiguration and/or construction of suicide resistant cells, the use of safety cells shall be limited to no more than four (4) hours.

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

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

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

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.

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 Suicide Prevention Meeting Documentation

Assessment: These provisions remain in Partial Compliance given that training on the corresponding policy did not occur during this reporting period. The AFBH Preventing Suicide and Self-Harming Behavior Policy and Procedure was approved by ACBHD leadership and formal training was scheduled for August 2026, just outside this reporting period. 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.

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.

Case record reviews for this reporting period support that graduated precautions are being utilized. IPs are being placed in THUs and referred for treatment at JGPH, if necessary. There have been very limited placements in restraint chairs during this reporting period. According to Terri McDonald, the Custody Joint Expert:

> "The County's January and February internal audits found that restraint-chair logs …two did not document an AFBH evaluation within four hours. A case-by-case review of all 36 March through June placements found documentation of AFBH involvement within four hours in 36 of 36 placements (100 percent)."

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. 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.
2. AFBH to continue to respond, as required by policy and procedure, to pre-planned use-of-force incidents and restraint chair placements.
3. 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.

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 Suicide Prevention Meeting Documentation

Assessment: These provisions remain in Partial Compliance given that training on the corresponding policy did not occur during this reporting period. The AFBH Preventing Suicide and Self-Harming Behavior Policy and Procedure was approved by ACBHD leadership and formal training was scheduled for August 2026, just outside this reporting period. 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.

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 continue complying 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. During this reporting period, according to the Custody Joint Expert, Terri McDonald, AFBH responded as expected in all but one pre-planned use-of-force incident.

AFBH is also required by policy to assess all restraint chair placements within specified time periods and document as appropriate. A case-by-case review of all 36 March through June placements found documentation of AFBH involvement within four hours in 36 of 36 placements (100 percent).

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. 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.
2. AFBH to continue to respond, as required by policy and procedure, to pre-planned use-of-force incidents and restraint chair placements.
3. 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: Substantial Compliance

Policies: AFBH Preventing Suicide and Self-Harming Behavior, 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: This provision has achieved Substantial Compliance during this rating period. As previously reported, with the implementation of the THUs, IPs on suicide precautions (LOC 4) are receiving greater attention due to the efforts of the dedicated Treatment Teams 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 are taking place daily. 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 IP'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 IPs.

IPs 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 as required; an improvement since the last report. Other therapeutic sessions are also taking place and documented in CG.

Recommendation(s):

1. AFBH staff to continue to provide intervention, assessment and treatment services to persons on suicide precautions as needed (individualized) clinical encounters and in accordance with the Therapeutic Housing policy.

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: 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: IPs on suicide precautions are identified as either an LOC 4 or LOC 3, dependent on the assessed level of risk and housed in the appropriate THU. An IP considered to be at imminent risk of self-harm is placed on LOC 4, for the shortest length of time possible. LOC 4 requires that the IP be on 15-minute checks by custody and daily rounds by clinical staff. During these rounds, the person's suicide risk is assessed and the LOC is updated. These assessments are documented in the case record and discussed in the daily THU huddles. Clinical attention is persons on LOC 4 suicide precautions is abundant and documented in the case records.

When the suicide risk is no longer imminent, the person will be "downgraded" to a LOC 3 although still considered to be at-risk of self-harm. Case record reviews support that persons on LOC 3 and 4 receive greater psychiatric and clinical attention. The THUs also afford greater clinical interaction given the dedicated Treatment Teams assigned to the units.

During this reporting period, the availability of individual and group interventions for LOC 4 and LOC 3 IPs has increased, e.g., "recreation" groups. 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. Supervisors to ensure that the frequency/pattern of individualized assessments are documented in the person's mental health case record.
2. 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.
3. 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, AFBH Suicide Prevention Meeting documentation

Assessment: Similar to prior provisions, this provision remains in Partial Compliance given that training on the corresponding policy has not occurred. The AFBH Preventing Suicide and Self-Harming Behavior Policy and Procedure was approved by ACBHD leadership and formal training was scheduled for August 2026, just outside this reporting period.

Monthly SRJ Suicide Prevention Meetings continued to occur during this reporting period. These meetings involve a clinical and custodial review of all incidents involving "Code 3" and 5150 transfers due to danger to self and depend upon the participation of AFBH, ACSO and Wellpath

staff. Meeting documentation for the months of January through June 2026 was reviewed by this Joint Expert. The documentation details the IPs' 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.

During this reporting period, the Psychological Autopsy Protocol was developed and approved. It is now an appendix to the AFBH Preventing Suicide and Self-Harming Behavior Policy. At this time, AFBH is prepared to comply with this provision's requirements. As previously reported, six AFBH supervisory staff members were trained on how to conduct a psychological autopsy from an American Correctional Association (ACA) certified instructor.

Recommendation(s):

1. 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: Substantial Compliance

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

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews

Assessment: These provisions have maintained Substantial Compliance during this reporting period. The AFBH and JGPH Client Care Coordination Protocol, which addresses the emergency referral process between SRJ and JGPH was approved by ACBHD leadership and formal training on the protocol has taken place.

When an IP 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 casenotes, ATIMS and Clinician's Gateway face sheets, and a copy of the 5150 application. When a IP 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. IPs that have been deemed 5150 and have been sent to JGPH are discussed extensively at the monthly Suicide Prevention Meetings.

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

Recommendation(s):

1. 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: Substantial Compliance

Policies: AFBH Therapeutic Housing Units, 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: Since 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 provide continuous support in the delivery of mental health services and a therapeutic orientation. 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.

Compliance with this provision has required that decisions regarding the placement and removal of a person from a THU be made by the members of the clinical treatment team and reflect the treatment needs of the IPs. 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.

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 continue the weekly THC meetings and document when a placement decision is not being implemented by ACSO for further discussion.
2. 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: Substantial Compliance

Policies: AFBH Therapeutic Housing Units

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. In March, four additional groups (two per day) were added to the schedule of services in the female THU. The groups are called "The Hang Out" and "Real Talk" and incorporate a restorative component by using relaxing and contemplative activities. The effort to develop specialized treatment services and approaches for women is commendable.

Daily huddles and rounds are taking place in the female unit.

Recommendation(s):

1. Refer to provision 702.
2. AFBH to explore additional "best practice" therapeutic interventions for women.

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, AFBH Levels of Care

Training: N/A

Metrics: Case Record Reviews

Assessment: The THU Protocol was approved by ACBHD leadership and training has been completed. 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.

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 CD. 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, 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 25. A clinical Treatment Team has also been assigned to the Restrictive Housing (HU 1). As explained in provisions 200/204, AFBH has been challenged with finding clinicians to fill their vacant positions. AFBH needs to continue deploying clinicians to assignments in the THUs to effectuate the reforms required by the CD.

AFBH clinical staff is available in the HUs, Monday through Friday from 7:00 a.m. to 9:30 p.m. 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. Training courses 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

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews

Assessment: Over the past two reporting periods, AFBH has developed its Re-Entry Team. The Team is headed by a Forensic Behavioral Health Clinical Manager, to oversee re-entry operations and help develop program protocol and procedures, two Re-Entry Supervisors, two Forensic Behavior al Health Counselors and 14 Mental Health Specialists. In the recent absence of the Manager, one of the Supervisors has been selected to the position. The dedicated efforts of the Re-Entry Team have resulted in focused attention to the related CD provisions.

The AFBH Re-entry Team is currently developing a policy and procedure for the re-entry efforts which will include CD and CalAIM requirements. These procedures will ensure processes for IP continuity of care for incarcerated individuals with mental health disabilities.

Towards the goal of effort coordination, during this reporting period, AFBH has continued to meet on a monthly basis with ACSO, Wellpath and Probation to support reentry efforts. The frequency of these collaborative meetings has increased with the upcoming deadlines associated with Cal-AIM. Information sharing systems and procedures are in the development process to ensure continuity of care for IPs. Care is being taken to ensure HIPAA compliance while increasing collaboration among ACSO, AFBH and Wellpath.

Additionally, AFBH has instituted a bi-weekly meeting dubbed AFBH Re-Entry Multidisciplinary Team Meeting (MDT). During this meeting THU IPs who have known release dates within two weeks are discussed to ensure final re-entry planning occurs. In attendance are representatives from ACSO, Wellpath, and Probation. Representatives from Horizon's Diversion Triage Center and ROOTS have also been added to enhance referral coordination for identified IPs. A portion of this meeting is also used to discuss Enhanced Care Management (ECM) referrals, MAT aftercare, chronic care medications, and for ensuring any Durable Medical Equipment (DME) has been made available to the IP. AFBH's role in this meeting is to ensure that release psychiatric medications are ordered, and to discuss referrals and warm handoffs made to community based

behavioral health providers. Additionally, AFBH may coordinate release details with ACSO to ensure a smooth transition to any provider picking the IP up from the jail. Minutes of the MDT meetings were reviewed by this Expert and found to be detailed, informative and in line with the expectations of this provision.

In the near future, AFBH Re-Entry Team will begin incorporating LOC 1 IPs with known release dates to the list of IPs sent to the MDT. Wellpath will identify IPs with complex co-occurring diagnoses who will require further collaboration and conversation and these IPs will be added to the agenda.

At this time, AFBH identifies IPs who have been served by community-based mental health services and makes efforts to reconnect IPs to their community-based (CBO) providers. The AFBH Re-Entry Team has a dedicated email (AFBHReEntry@acgov.org) which is monitored six days a week (daily except Saturday). Community-based outpatient teams can request release medications or follow up with their IPs while they are incarcerated through this email.

Additionally, the Re-Entry Team makes new referrals for IPs to be connected to various community-based re-entry providers. IPs with higher mental health disorder acuity are referred for more intensive case management through the Alameda County Behavioral Health ACCESS unit.

AFBH has designated a Post Release Re-Entry Clinician responsible for gathering clinical history from charts to prepare and submit referrals to ACCESS and facilitating warm handoffs with CBOs. The focus of the efforts is to support IPs with known release dates in connecting with their community providers and ensuring these IPs make their aftercare appointments. These efforts are tracked in both a tracking log as well as documented in progress notes in CG.

To date in 2026, the AFBH Re-Entry Team has been able to make the following:

- 28 referrals to full-service partnerships (the highest level of community-based care);
- 188 referrals to re-entry treatment teams;
- 12 referrals to an outreach and engagement team;
- 127 referrals to Crisis Residential Treatment centers; and
- 4 referrals to the individual's health plan for enhanced care management.

The Re-Entry Team also handles referrals for advocacy for Social Security income; Wellpath Medi-cal clinic; and continues to assist the Public Guardian's Office with several referrals to sub-acute treatment facilities. The team also continues to make referrals to Bay Area Legal Aid and Homeless Action Center for Social Security income (SSI) advocacy supports to those applying for SSI benefits.

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

Recommendation(s):

1. AFBH should continue collaborative efforts with ACSO and Wellpath on all re-entry related matters.
2. AFBH to continue establishing contacts with appropriate agencies that assist incarcerated persons with obtaining entitlement benefits and discuss their ability to work with the SRJ's population.
3. 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 IPs 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

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Case Record Reviews, AFBH Re-Entry Plans Post-Release Instruction forms), AFBH Re-Entry Tracking Log

Assessment: In this reporting period, AFBH has continued to refine its Re-Entry Plan form. AFBH Re-Entry team staff begins re-entry plans for all new THU IPs with a chart review within 72 hour of booking. The process of developing the re-entry plan is discussed in detail in the draft policy.

The total number of Re-Entry Plans initiated during this reporting period is 2,219 with a monthly average of 370. This is a significant increase from the average of 202 re-entry plans completed in the last reporting period; nearly 94% more completed plans in the past six months. The monthly numbers during this period were as follows:

	January	February	March	April	May	June
# of Plans	343	311	452	361	359	393
Total						2,219

Re-Entry plans are developed over the course of the IP's detention , with the participation of the IP. As the re-entry process continues, these plans are updated in CG and, as such, are "ready" for the IP at the time of their release from custody, whether they have a known release date or an "unplanned" court release.

IPs with a known release date will receive their re-entry plans on the day before their scheduled release. Whenever possible these plans will be reviewed in person with IPs who have ADA

accommodations to ensure effective communication is established. IPs on psychotropic medications are also seen in person to facilitate their obtaining medications after release.

A special team emphasis for developing re-entry plans is on IPs with a SMI and a known, upcoming release date. AFBH has created a system wherein clerical staff will notify Re-Entry staff when SMI IPs have a release date within 90 days. Re-Entry staff will then begin discussing re-entry plans with the IP. AFBH will make necessary referrals and provide the IP with a written copy of their plan at the time of release. For these IPs, AFBH will also coordinate a 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 initiate a new referral and, as necessary, provide the agency with records such as case notes and prescriptions.

The Re-entry Team will prepare a Post-Release Instructions form for each person which includes medication information/order and referrals and will refer persons to the Felton Re-Entry Program (REP) when appropriate. AFBH utilizes other providers as appropriate on case-by-case basis.

Recommendation(s):

1. AFBH should continue developing its ability to formulate re-entry plans as required by this provision.
2. AFBH Re-entry Team to continue developing re-entry plans for SMI IPs 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.

905(1):*AFBH shall coordinate informing each Full Service Partnership in the County when a client or individual with whom they have had contact is incarcerated.*

Finding: Partial Compliance

Policies: Draft–AFBH Santa Rita Jail Re-Entry, AFBH Diagnosing Severe Mental Illness (SMI) Policy and Procedure

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff; Case Record Reviews, SMI Report

Assessment: As explained in earlier reports, when an incarcerated person on the mental health caseload meets the level of care required for Full Service Partnership (FSP) referral, AFBH will make efforts to ensure that the person's re-entry plan includes referrals to agencies that offer the level of care.

AFBH has established a process for ACSO to send a list of new IPs to ACBH. ACBH 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 ACBH database and sent out to each service team to notify them of IPs on their caseload who have been incarcerated.

AFBH has two Forensic Behavioral Health Clinicians on the Re-EntryTeam with specialized functions to serve the needs of the more complex IPs. One clinician's role is to facilitate ACCESS referrals, referrals to CRTs and other care coordination for these referrals. The second clinician is stationed in ITR to receive the batch court release lists from ACSO Records Department. These lists are reviewed as they come in throughout the evening. The clinician will provide a copy of the re-entry plans to the IPs, arrange release medications from psychiatric providers, and support connections with assigned community case managers, and screen for 5150 holds. Coverage for this part of AFBH Re-Entry operations will move to full PM shift (3:30-11:30 PM), which will cover the majority of court releases in October 2026.

Recommendation(s):

1. AFBH to continue efforts to improve the referral of IPs meeting FSP criteria for appropriate agencies; develop appropriate procedures.

905(2). ***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.***

This section of Provision 905 will be addressed by the Custody Expert, Terri McDonald in her report.

905(3). the number of Behavioral Health clients released with a written release plan.

Finding: Partial Compliance

Policies: Draft – AFBH Santa Rita Jail Re-Entry, AFBH Diagnosing Severe Mental Illness (SMI) Policy and Procedure

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff; Case Record Reviews, SMI Report, AFBH Re-Entry Tracking Log

Assessment: The number of completed re-entry plans for this reporting period is addressed in 901.

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, Case Record Reviews, Re-Entry Tracking Log

Assessment: During this reporting period, the AFBH Re-Entry team began regular meeting with the Behavioral Health Court (BHC) and Care Court teams to discuss IPs who overlap between the three programs. The purpose of this meeting is to ensure inter-agency coordination and avoid duplication of services or supports offered to the IPs. IPs being discussed in this meeting are tracked in the AFBH Re-Entry Tracking Log.

Re-Entry staff have been receiving information/training during AFBH's all-staff meetings regarding referrals and services available to SRJ IPs. Referrals to the following agencies are being arranged: Felton Institute, La Familia, Center Point, Building Opportunities for Self Sufficiency (BOSS) and Bay Area Community Services among others.

AFBH is working with ACSO to ensure the providers are granted access to THUs to enhance service delivery to IPs. "Warm handoffs" are being tracked by the AFBH Re-Entry team and reported on monthly. "Handoffs" may be in person or by video using cell phone, computer or tablets. AFBH has a designated manager who is overseeing all CBOs and clearance forms for their staff to ensure access to the incarcerated IPs.

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.

The AFBH Re-Entry Team makes referrals to Roots Community Health (a community-based provider) and directs IPs needing more immediate resources/assistance upon release to the Roots trailer outside SRJ.

AFBH leadership has been working with ACSO on the process of approving CBOs to return to the SRJ. During this reporting period, CBO access to their incarcerated IPs has improved, and issues related to provider clearances have been greatly reduced. AFBH continues to work in partnership with ACSO to ensure that providers requiring jail clearance move through the process swiftly to avoid delays in service delivery to AFBH IPs.

The Re-Entry Team coordinates calls between outpatient teams and their IPs, as do most AFBH clinicians. These calls/visits are also coordinated with ACSO Visiting Unit. Additionally, these calls can happen independent of the Visiting Unit when done using technology such as phones/tablets.

Towards the goal of assisting more SRJ IPs with re-entry, AFBH staff have been directing IPs housed in non-THUs to reach out to ACSO Re-Entry Team for support. Operation My Home Town (OMHT)is a service team run by ACSO, and available for IPs with lower mental health acuity and can be referred to via the ACSO Re-Entry Team.

Recommendations:

1. AFBH to continue efforts to establish contacts with appropriate agencies that assist incarcerated persons with obtaining entitlement benefits; discuss their ability to work with the SRJ's population.
2. Confidentiality/HIPAA concerns in sharing re-entry related referrals with ACSO should be addressed.
3. Refer to provisions 900 and 901.

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, ACSO Policy and Procedure 11.09 Inmate Release Process, Draft–AFBH Re-Entry

Training: Completed for relevant staff and ongoing as necessary

Metrics: Interviews with Staff, Release Psychiatric Medication Report. AFBH Re-Entry Plans/Post-Release Instruction forms

Assessment: AFBH's policy to address this process is 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.

The AFBH Re-Entry Team provides IPs being released with a Post-Release Instructions form (Re-Entry Plan) which outlines the IPs psychotropic re-entry medications. In preparation for a IP's release, the AFBH Re-Entry Team will check the IP's chart to verify medications and email the MD OD to request the 30-day supply of release medications. With advance notice, these are physically provided at the time of release. For unexpected court-released IPs, the AFBH Re-Entry Team can also reach out to the MD OD to request that a prescription for release medications be sent to a local pharmacy of the IP's choice. Additionally, all IPs are provided with a flyer outlining the county's Urgent Care Clinics which provide psychiatric assessment and can refill prescriptions for IPs who were recently released from the SRJ.

A monthly log of discharge medications (for IPs on medications) ordered at the time of release 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 79 releases per month; slightly lower than last reporting period (with the exception of February). During this report period, an average of 58% of the discharge medications ordered were taken by the IPs at the time or release. These relatively low figures as well as the inter-month inconsistencies suggest continued procedural inconsistencies. It was noted, as opposed to the last report, that the information on whether medications were taken by the IP at release has improved. Although improved, AFBH needs to continue addressing the importance of Wellpath completing the Discharge Medication Disposition (DMD) forms. 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 w/ Medication Orders	# - % Received Medications
January	88	43 - 49
February	49	25- 51
March	86	43 - 50
April	86	57 - 67
May	70	42 - 60
June	96	70 - 73
Monthly Average	79	47 - 58
Prior Report Average	88	38 - 43

Wellpath has recently achieved full implementation of an alternate tracking and automated reporting system for release meds. Part of the workflow is having Wellpath notify AFBH providers of pending client release when psychotropic medications are prescribed . This system includes a flagging of release medications given and release meds refused in ATIMS. AFBH QA staff is currently exploring how to integrate the Wellpath notification system data and the AFBH Monthly Discharge Data to have more accurate reporting on the Monthly logs.

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

Recommendation(s):

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