11th Sacramento County Remedial Plan Status Report

for the period of January 1, 2025 – June 30, 2025

August 14, 2025

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Introduction

Background

A Consent Decree in the matter of *Mays et al. v. County of Sacramento* was approved by United States District Judge Troy L. Nunley on January 8, 2020 (filed January 13, 2020). The Consent Decree was developed in response to a class action lawsuit filed on behalf of incarcerated people in Sacramento County's correctional facilities, claiming that conditions in the jail system do not meet minimum standards under the U.S. Constitution as well as federal and state disability law. The Consent Decree establishes a Remedial Plan with many sections, including:

- II. General Provisions
- III. Americans with Disabilities Act (ADA) Compliance
- IV. Mental Health Care
- V. Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities
- VI. Medical Care
- VII. Suicide Prevention
- VIII. Segregation/Restrictive Housing
- IX. Quality Assurance Systems for Health Care Treatment.

Every 180 days, the County of Sacramento is required to issue a Remedial Plan Status Report, which is sent to the Prison Law Office and the Law Offices of Aaron J. Fischer (collectively, Class Counsel) and Court-appointed subject matter experts (SMEs) and filed with the Court.

Each Court-appointed monitor (Class Counsel or a designated SME) completes Remedial Plan Monitoring Reports using document requests, chart reviews, and site visits to provide compliance determinations as well as feedback and recommendations to support County progress toward compliance with the Consent Decree Remedial Plan.

This is the eleventh County Remedial Plan Status Report, focused on the period of January 1, 2025 through June 30, 2025. This report describes Sacramento County's overall progress toward meeting Consent Decree requirements, including current compliance status, data or evidence to support current status, and plans in place to address areas not yet in full compliance. Attachment 1, Abbreviations and References, identifies abbreviations and terminology used throughout the report.

Jail Facilities and Operations

Sacramento County's jail system includes two facilities. The Main Jail (MJ) was opened in 1989 and is in downtown Sacramento (651 I Street). The Main Jail includes 85 medical beds; 23 of which are included in the Board of State and Community Corrections (BSCC) rated capacity of 2,348[1]. Rio Cosumnes Correctional Center (RCCC) was opened in 1960 and is located at 12500 Bruceville Road, Elk Grove. Its BSCC rated capacity is 1,625, which includes 34 medical beds.

The average daily population (ADP) of the jail system for the period of January 1 to June 30, 2025 was 3,265, remaining well below its rated capacity (82%). There has been an increase of 2.8% in ADP since the prior reporting period (July 1 to December 31, 2024). In comparison to the greater Sacramento County community, the jail population has higher average rates of health care needs, including chronic health conditions, serious mental illness (SMI), and substance use disorders.

Operation of the jail system requires multiple County and contracted entities.

- The Sacramento Sheriff's Office (SSO) has overall responsibility and management for the jail facilities.
- The County's Department of General Services (DGS) assists with facility construction, remodeling, and maintenance.
- Adult Correctional Health (ACH) within the County's Department of Health Services, Primary Health Division works to provide legally mandated health care services to adult inmates within the County's jail system. Services include physical health, behavioral health, dental, pharmaceutical services, and ancillary services. ACH contracts with hospital systems or other providers for psychiatry, specialty care and inpatient services.
- The primary contractor for on-site mental health services including an Acute Inpatient Psychiatric Unit (APU), Intensive Outpatient Program (IOP), outpatient mental health services, a Jail Based Competency Treatment (JBCT) program, and other services is UC Davis Department of Psychiatry & Behavioral Sciences, referred to as Adult Correctional Mental Health (ACMH).

[1] The BSCC rating for the Main Jail was recently adjusted as the 52 suicide prevention medical beds in 3-West were determined to not meet certain requirements, such as having a desk, two bunks, and two seats. The remaining medical beds (10 in 2-Medical, five in 2-East, and 18 in 2-West/APU) are all part of the BSCC's rated capacity. Currently, 17 of the APU beds are available for use.

Reporting Period Highlights

The following highlights represent a summary of activities undertaken since the 10th County Status Report published in January 2025.

- **Received and Reviewed Class Counsel and SME Reports and Feedback:** Since January 1, 2025, the County received four reports from Court-appointed monitors.
    - The 6th medical SME report noted "improvement in the booking process including privacy, two-phase screening process, and use of colored bands to indicate patient triage acuity; increase in custody medical escorts; reduction in the backlog of nursing health service request (HSR) appointments; improvement in the medication administration process and performance of mouth checks; further expansion of the MAT program; [and] successful hiring of registered nurse (RN) supervisors with correctional experience."
    - This was echoed in the 7th medical SME report, which commended the County for improvements in patient confidentiality during the intake screening process, the availability and collection of HSRs, utilization management reviews, provider decision-making, and training.
    - Upon review of the reports received, the County re-evaluated its self-assessed compliance ratings for many provisions. For more information, see pages 10-13, Comparison to Court-Appointed Monitoring Reports and Prior County Status Reports.
- **Filled ACH Leadership Roles:** ACH hired a new medical director, Dr. Thomas Bzoskie, who began on June 30, 2025. Dr. Bzoskie has extensive experience and passion with over 20 years in correctional medicine, clinical leadership, healthcare management, and various peer review roles. ACH also hired a second nursing director, Tammy Trant, to oversee nursing operations at the Main Jail. Ms. Trant has over 17 years of diverse healthcare experience, specializing in program management, quality improvement, regulatory compliance, and risk management across complex systems.
- **Revised Policies and Procedures:** ACH contracted with a nursing consultant recommended by the medical SME to review and revise medical policies. SSO continues to evaluate and improve its policies and procedures to reflect the Consent Decree requirements and feedback from Class Counsel and SMEs. Attachment 2 provides additional information about Policies and Procedures.
- **Resolved Specialty Services Backlog:** Through a modification of the Utilization Review (UR) process and additional staffing resources in case management, ACH

resolved the backlog of incarcerated individuals waiting for specialty services. Increased staffing, enhanced provider education – including both in-house providers and specialty providers – and the development of UR Standardized Nursing Procedures have contributed to improvements in the specialty care referral process. These efforts have resulted in a gradual reduction in the number of referrals, the elimination of a referral backlog, and a noticeable improvement in the quality and completeness of the referrals being submitted.

- **Eliminated Inmate Grievance Backlog with Improved Processes:** To resolve concerns from inmates and Class Counsel regarding delayed responses to inmates' written grievances, SSO evaluated and made changes to the grievance processing workflow, dramatically reducing response times and improving inmate communication with SSO. With the new process implemented, SSO's Compliance Unit worked to resolve a backlog of 1,400 grievances. Within seven days, through these dedicated efforts, SSO successfully processed the entire backlog, resulting in notifications to over 700 inmates. Grievances are now logged in the order in which they are received to minimize delays in responding to inmate concerns. Additional quality assurance steps have been put in place to proactively identify potential issues with the grievance system so that it continues to operate efficiently moving forward.
- **Increased Out-of-Cell Time:** Increases in SSO's custody staffing, along with a newly created recreational schedule, have increased supervision for out-of-cell activities and provided security for health-related tasks. These improvements have made it possible to cease planning efforts on a recreation yard split project, enabling staff time and other County resources to be directed to other initiatives.
- **Improved Confidential Contacts:** DGS added privacy curtains to the confidential interview booths throughout the Main Jail to enhance visual privacy during clinical encounters.
- **Expanded IOP Service Capacity:** DGS installed no-climb mesh and other facility improvements to convert 24 male beds at RCCC and 10 female beds at the Main Jail to IOP beds, increasing the total number of IOP beds to 125.
- **Continued Planning Efforts to Further Increase IOP and APU Capacity**
    - Planning efforts are underway to convert a further 32 male and 10 female beds in 2026, which will increase the total number of IOP beds to 167.
    - Work continues to expand the APU, which will add 24 Lanterman-Petris-Short (LPS) beds for involuntary (5150 hold) and voluntary inpatient psychiatric care and seven step-down beds. This is scheduled to be

completed in May 2026 and will increase the total number of APU beds to 41. This expansion is expected to resolve the waitlist for those needing an APU level of care.

- **Initiated Comprehensive Jail System Master Planning Efforts:**
    - In response to a third-party review of planning and programming documents developed by a prior consultant, the County Board of Supervisors approved several recommendations, including suspension on the development of an annex to the Main Jail, known as the Intake and Health Services Facility (IHSF), formation of a Jail System Planning/Compliance Oversight Committee, and completion of a comprehensive correctional system master planning process.
    - The Jail System Planning/Compliance Oversight Committee is chaired by the Public Safety and Justice Agency (PSJA) deputy county executive, Social Services Agency deputy county executive, Administrative Services Agency deputy county executive, and undersheriff. It is supported by county counsel and PSJA staff. This Committee replaces the Policy Group described in the 10th County Status Report, continues to guide the priorities for Jail Conditions Improvement Action Planning meetings, and solicits community input from the PSJA Advisory Committee, Sheriff Community Review Commission, and Community Corrections Partnership Advisory Board.
    - The County released a Request for Qualifications (RFQ) on April 11, 2025, for Correctional Master Planning services. RFQ proposals were due May 16, 2025 and the County determined that the Health Management Associates, Inc. (HMA) proposal would meet the County's needs. The County entered into an agreement with HMA on July 1, 2025. This comprehensive Master Planning process is expected to take 12 to 18 months and will include facilities conditions assessment, population analysis, operational analysis, and space program.

Remedial Plan Compliance

The Consent Decree lists numerous requirements and practices that the County is expected to meet and sustain. The hierarchical headings assigned to each of these provisions are inconsistent, creating confusion in both identifying the total number of requirements and determining which requirements should be assigned individual compliance ratings. There is further inconsistency among the different Court-appointed monitors in how they determine which requirements should be rated separately or remain grouped together.

To consistently track and monitor progress, the County is using the following to identify the requirements, referred to as provisions, to which it assigns ratings: Remedial Plan (Roman Numerals) + Category (Capital Letter) + Provision (Numeral)[2]. For example, **IV.G.3 r**efers to **Remedial Plan IV** (Mental Health), **Category G** (Medico-Legal Practices), **Provision 3** ("The County shall review all County and JPS policies and procedures for PREA compliance, and revise them as necessary to address all mental health-related requirements"). Many provisions further include sub-provisions, typically designated by lowercase letters (a, b, c, etc.) and romanettes (i, ii, iii, etc.), or variations of the above. Some provisions include up to 16 sub-provisions.

Based on this, the County has identified 319[3] provisions in the Consent Decree across eight Remedial Plan sections.

The County has elected to assign an overall compliance rating for each provision, and to address the compliance status of sub-provisions within the County's narrative response to each. For example, there will be a single rating given for Provision V.A.3. The compliance status of sub-provisions V.A.3.a, V.A.3.b.i, V.A.3.b.ii, V.A.3.b.iii, and V.A.3.c are discussed, but may not be given a standalone rating. All applicable sub-provisions are considered and evaluated when assigning a compliance rating for a provision. If some sub-provisions are in substantial compliance while others are in partial compliance or non-compliance, a rating of partial compliance is assigned.

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[2] There are three exceptions to this convention. The provisions in Remedial Plan II: General Provisions (II.A, II.B, and II.C) are not given a category designation. As a result, II.B.1 and II.B.2 are considered sub-provisions of Provision II.B.

[3] Prior status reports identified 320 provisions. In preparing for this report, it was discovered that both the County and Class Counsel has mis-identified provision III.Q.2.c as III.Q.3, resulting in the number of provisions being miscounted.

Compliance Rating Definitions

Compliance ratings are to be assigned using the definitions below:

- Substantial compliance: Indicates compliance with most or all components of the relevant provision of the Remedial Plan for both the quantitative (e.g., 90% performance measure) and qualitative (e.g., consistent with the larger purpose of the Consent Decree) measures.
- Partial compliance: Indicates compliance achieved on some of the components of the relevant provisions of the Remedial Plan, but significant work remains. A minimum requirement is that for each provision, relevant policies and procedures must be compliant with Remedial Plan requirements, contain adequate operational detail for staff to implement the policy, staff are trained, and the County has begun implementation of the policy.
- Non-compliance: Indicates that most or all the components of the relevant provision of the Remedial Plan have not yet been addressed and/or have not yet been met.

Comparison to Court-Appointed Monitoring Reports and Prior County Status Reports

Most Consent Decree provisions are monitored by a Court-appointed entity (Class Counsel or a designated SME). Since January 1, 2025, the County engaged with Class Counsel and the Court-appointed SMEs on several occasions. In addition to both regular and issue-specific meetings, these included the receipt of four reports:

- The "Sixth Monitoring Report of the Medical Consent Decree" by Madeleine L. LaMarre MN, FNP-BC and Angela Goehring RN, MSA, CCHP was submitted January 26, 2025. The report reflects a review of documents from January to September 2024 and an on-site tour at Sacramento County jail facilities in September 2024. The compliance ratings assigned to each Consent Decree provision from this report are summarized in Attachment 6, Medical Care Remedial Plan Expert Rating Reconciliation and Attachment 9, Quality Assurance Systems for Health Care Treatment Remedial Plan Expert Rating Reconciliation. Any comments or responses from the County are included in Section VI. Medical Care and Section IX. Quality Assurance Systems for Health Care Treatment of this report.
- The "Fourth Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails" by Patrick Booth, Margot Mendelson, Megha Ram, and Aaron J. Fischer was submitted June 26, 2025. The report reflects a

review of requested documents from January 1, 2024 to December 31, 2024 and interviews with inmates and Jail staff in July and August 2024. The compliance ratings assigned to each consent decree provision are summarized in Attachment 8, Segregation/Restricted Housing Remedial Plan Expert Rating Reconciliation. Any comments or responses from the County are included in Section VIII. Segregation/Restrictive Housing of this report.

- The "Seventh Monitoring Report of the Medical Consent Decree" by Angela Goehring RN, MSA, CCHP and Sylvia McQueen, MD, MBA, FACP, CCHP was submitted July 29, 2025. The report reflects a review of documents and on-site activities for the period of September 23, 2024 to March 21, 2025. The compliance ratings assigned to each Consent Decree provision from this report are summarized in Attachment 6, Medical Care Remedial Plan Expert Rating Reconciliation and Attachment 9, Quality Assurance Systems for Health Care Treatment Remedial Plan Expert Rating Reconciliation. Any comments or responses from the County are included in Section VI. Medical Care and Section IX. Quality Assurance Systems for Health Care Treatment of this report.
- The "Second Monitoring Report on Disability Practices in the Sacramento County Jails" by Patrick Booth, Margot Mendelson, Megha Ram, and Aaron J. Fischer was submitted July 30, 2025. The report reflects a review of requested documents from January to May 2025 and interviews with inmates and staff in February 2025. The compliance ratings assigned to each consent decree provision are summarized in Attachment 3, Americans with Disabilities Act (ADA) Remedial Plan Expert Rating Reconciliation. Any comments or responses from the County are included in Section III. Americans with Disabilities Act (ADA) of this report.

Pursuant to the Consent Decree[4] and stipulation between the Federal Court for the Eastern District of California and Class Counsel, some provisions have been released from external monitoring as the County has sustained a level of substantial compliance for at least a year. The County will continue to address ongoing compliance with these provisions in its status reports, but no external monitor ratings will be provided.

As previously noted, each Court-appointed monitor has a different approach to identifying and rating provisions. In some cases, Class Counsel and/or the designated SME assigned individual compliance ratings to items the County has identified as sub-provisions. Because of this, the number of provisions in the tracking tables included in the

[4] *See* Consent Decree paragraph 38.

attachments and future County status reports may not align with the number of provisions rated in Class Counsel and SME reports. For example, the most recent report from the medical SME ("Seventh Monitoring Report of the Medical Consent Decree") includes 80 ratings, 76 of which pertain to Remedial Plan XI. Since some of these ratings are applied to sub-provisions, it differs from the County's provision count of 67 for the same section.

To ensure the County can fairly compare its self-assessed ratings to the ratings assigned by the monitors, the County has resolved any conflicts among sub-provision ratings when determining the monitor's rating. When sub-provision compliance ratings conflict, the monitor's compliance rating for a particular provision is assigned a rating of partial compliance. A reconciliation of each monitor's rating structure and ratings in comparison to the County's structure and ratings is provided in each Remedial Plan section.

Adjustments to Self-Assessed Compliance Ratings

Since the 10th County Status Report, the County has provided a single compliance rating for each provision. Prior reports included separate ratings from different service lines operating in the correctional facilities (SSO and ACH). Information contained in this County Status Report builds on, and incorporates by reference, the information included in the 10th County Status Report.

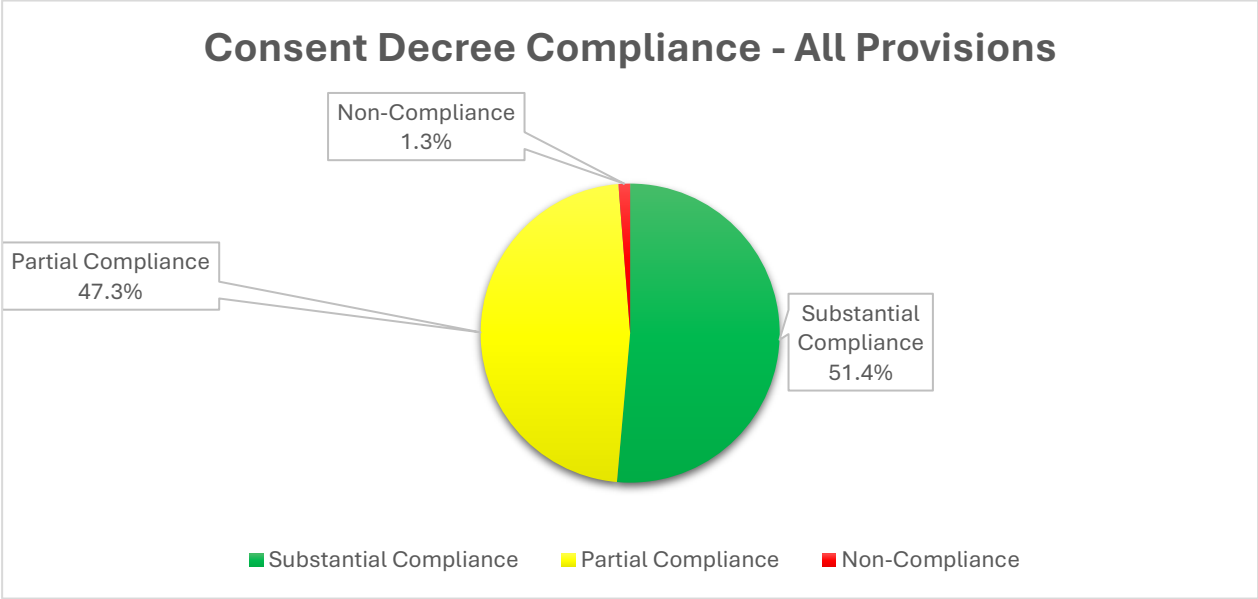
After a site visit, reports from Court-appointed monitors (Class Counsel and SMEs) may take many months, sometimes a year, to complete. This may result in a monitoring report containing comments and lower ratings on issues and concerns that have since been resolved; it can also delay the County from receiving the information needed to properly assess its own compliance status. For example, the "Second Monitoring Report on Disability Practices in the Sacramento County Jails," filed July 30, 2025, is only the second monitoring report received regarding remedial plan II – Americans with Disabilities Act (ADA) since entering the Consent Decree in 2020. It is also the first of the two reports received to include compliance ratings. In addition, subsequent 180-day monitoring visits may occur only a few months after receiving the previous monitoring report, not allowing adequate time for the County to implement changes recommended by the experts from the newly received prior report.

In preparation for this report, the County carefully reviewed the recent monitoring reports from Class Counsel and SMEs and, in some cases, based on feedback provided, reassessed its own compliance ratings to more closely align with the viewpoint and information shared by the assigned monitor. As a result, many provisions previously rated as being in substantial compliance have been reduced to partial compliance. This does not

reflect a decline in service levels but instead provides a more accurate self-assessment of the status of each provision. When a compliance rating has been reduced or increased, it is noted in the report. Throughout this report, the County may include references to feedback from Class Counsel or an SME to better convey the current compliance level for a particular provision.

Current Compliance Level and Progress

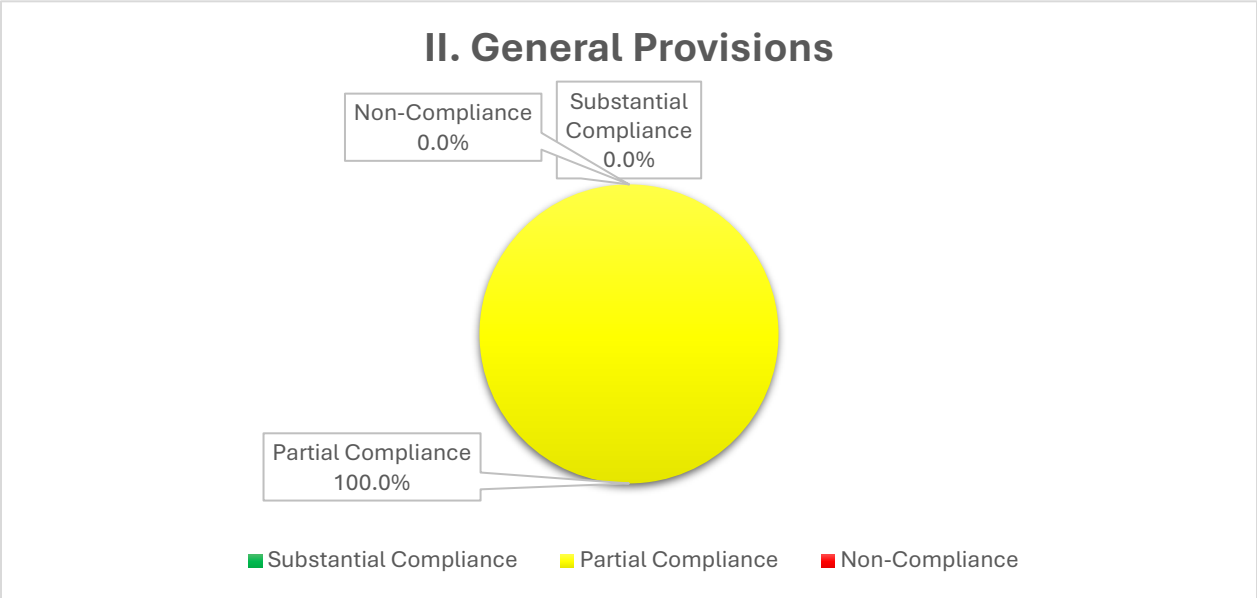
The County is in substantial compliance with 164 provisions (51.4%), partial compliance with 151 provisions (47.3%), and non-compliance with four provisions (1.3%).



In comparison to the County's self-assessed ratings, the Court-appointed monitors' compliance ratings are as follows:

- Substantial Compliance: 58 provisions (18.2%)
    - This includes 31 provisions that are no longer subject to external monitoring as the County has sustained a level of substantial compliance with these provisions for over one year.
- Partial Compliance: 190 provisions (59.6%)
- Non-Compliance: 40 provisions (12.5%)
- Assigned to a Court-appointed monitor, but not assessed: 25 provisions (7.8%)
- Not assigned to a Court-appointed monitor: 6 provisions (1.9%)

II. General Provisions



The County has identified three provisions in II. General Provisions. For this 11th County Status Report, the compliance ratings are as follows:

- Substantial Compliance: 0 provisions (0%)
- Partial Compliance: 3 provisions (100%)
- Non-Compliance: 0 provisions (0%)

Monitoring Status

The provisions in II. General Provisions have not been assigned to a Court-appointed monitor for external assessment.

Self-Assessment

II.A - Partial Compliance

"The County shall maintain sufficient medical, mental health, and custody staff to meet the requirements of this Remedial Plan."

The County began to add staff and/or contract augmentations prior to the finalization of the Consent Decree (January 2020). Vacancy rates increase as positions are allocated; therefore, monitoring the total full-time equivalents (FTEs) by position allocated in addition to vacancy rates is important to identify and monitor progress.

The County has increased staffing substantially since pre-Consent Decree levels as outlined below:

- County ACH medical staff and administrative FTEs have increased from 112.5 pre-Consent Decree to a total of 260.5 permanent allocated FTEs in the current FY, an increase of eight FTEs from the prior report.
    - ACH medical and administrative staff have a six percent (6%) vacancy rate as of June 11, 2025. The vacancy rate has decreased from the prior report.
- County ACMH (contracted) mental health and administrative staff have increased from 50.3 (FY 17/18) pre-Consent Decree to a total of 147.7 allocated positions in the current FY; an increase of 11 FTEs from the prior report.
    - ACMH staff have a 26.6% vacancy rate as of June 10, 2025. The higher vacancy rate is due to mid-year (January 2025) restoration of 13.5 positions and mid-year augmentation of 11 positions for the IOP expansion.
- SSO custody FTEs have increased from 650 pre-Consent Decree to a total of 810 permanent allocated FTEs in the current FY.
    - As of July 27, 2025, SSO custody staff have a combined 6.7% vacancy rate. The vacancy rate has decreased since the prior report.
    - Main Jail custody staff are authorized for 469 FTEs. Of these, 440 positions are filled as of July 27, 2025. The Main Jail has one captain and seven lieutenant positions; all are filled. The position of deputy sheriff is authorized for 249 positions and has 230 positions filled (8% vacancy rate). The sergeant position is authorized for 31 positions and 30 are filled (4% vacancy rate).
    - RCCC custody staff are authorized for 341 FTEs. Of these, 316 are filled as of July 27, 2025. RCCC has one captain and seven lieutenant positions; all are filled. The position of deputy sheriff is authorized for 203 positions and currently has 189 positions filled (7% vacancy rate). The sergeant position is authorized for 24 positions and currently filled with 20 (17% vacancy rate).
    - The level of acuity among individuals entering the jail has significantly increased, often requiring diagnostic testing, specialized care, or interventions that cannot be performed within the facility. As a result, there has been a substantial rise in hospital send-outs, each of which requires the escort of two deputies per patient. At any given time, there may be eight or more individuals hospitalized, effectively pulling at least 16 deputies away from their duties inside the jail. This strain on staffing directly reflects the increasingly complex medical and behavioral health needs of the population it now serves.

On July 1, 2025, the County contracted with Health Management Associates, Inc. (HMA). Over the next twelve to eighteen months, HMA will develop a comprehensive Correctional Facility Master Plan ("Master Plan"). The Master Plan requires an operational analysis of the current jail system, which will incorporate a staffing analysis of both the medical and mental health care staffing needs to meet the needs of the patient population and the custody staffing needs to meet the health care and safety needs of the inmate population.

II.B - Partial Compliance

"The parties agree that the custodial and health care staff must be increased to meet minimal constitutional and statutory standards. Presently, there are insufficient deputies to supervise out-of-cell activities for people in the general population and administrative segregation, and to provide security for health-related tasks. The parties agree that reduction in jail population is a cost-effective means to achieve constitutional and statutory standards.

1. *The County intends to hire additional custodial and health care staff. The parties agree that population reduction of the jails will facilitate compliance with this Remedial Plan. All population reduction measures should be designed to promote public safety through evidence-based programs.*
2. *If through the monitoring process it is determined that the County is not fulfilling the provisions of this Remedial Plan due to staffing deficiencies, the parties will meet and confer regarding what steps to take to reduce the population of the jail, including available resources to facilitate population reduction."*

The County continues to increase its custodial and health care staff to meet the provisions of the Consent Decree and continues to evaluate its staffing needs (see II.A). Increases in custody staffing, along with a newly created recreational schedule, have increased supervision for out-of-cell activities and provided security for health-related tasks.

In addition, Jail Population Reduction Plans (JPRP) have been developed per the 2022 Memorandum of Agreement; however, parties to the Consent Decree have limited ability to independently reduce the jail population as many booking justifications and nearly all release decisions are controlled by the Court. The Court is not a party to the Consent Decree. Despite extensive County efforts to expand pretrial service offerings, including supervision services by the Probation Department, support services through community-based organizations, and mental health assessments and community linkages for mental

health diversion, the time to process cases and to grant access to these programs is controlled by the Court.

A recent voter initiative, Proposition 36, which repealed parts of Proposition 47 by amending the state constitution to increase penalties and allow felony charges for certain crimes, passed in November 2024 and has contributed to increases in the jail population. Data analysis for Proposition 36 is still being developed; however, for the period of March 1 to August 2, 2025, there were 1,279 Proposition 36 bookings. As of August 2, 2025, an estimated 5.8% (186) of the jail system population for the same time frame (3,228) are in custody in connection with a Proposition 36 case (CA Health and Safety Code 11395 or Penal Code 666.1). Beyond the allegations associated with Proposition 36, individuals included in these data sets may be facing additional charges that would have resulted in a jail booking.

This provision remains in partial compliance.

II.C - Partial Compliance

"The parties agree to meet and confer regarding the gathering and posting of data related to the Jail population. The parties agree that the categories of information to be gathered and publicly posted on a quarterly basis are the following:

a. *the number of people with mental illness booked into jail;*
b. *their average length of stay;*
c. *the percentage of people connected to treatment;*
d. *their recidivism rates;*
e. *the total number of people in jail with a mental health need;*
f. *the number of people who were receiving mental health services at the time of booking; and*
g. *the number of sentenced and unsentenced inmates in custody.*
h. *For sentenced people in the jail, the nature of the commitment convictions, length of sentence(s), and level of mental health care (e.g., Acute, IOP, OPP).*
i. *For unsentenced people in the jail, the nature of the charges, length of pre-trial detention, and level of mental health care (e.g., Acute, IOP, OPP)."*

Portions of this information are completed and posted quarterly via the Mental Health Jail Population Report that is uploaded to SSO's Transparency website[5]. Data sharing and coordination between ACH, ACMH, SSO and County Behavioral Health Services (BHS) are vital partnerships to ensure that all portions of this provision are captured quarterly. The current report does not capture recidivism rates (II.C.d), the number of patients who were receiving mental health services at the time of booking (II.C.f), and the nature of charges and level of mental health care for the sentenced and unsentenced populations (II.C.h and II.C.i). The County's PSJA continues to review these requirements with ACH, ACMH, SSO, and additional partners while exploring the possibility of a dynamic dashboard to display key data elements related to the jail population. The first version of the jail dashboard, which will include data on jail bookings and lengths of stay in custody, is expected to be publicly posted by September 30, 2025 and will include data through June 30, 2025. Future iterations of the dashboard will add additional elements, including returns to custody, as well as Mental Health (MH) caseload information.

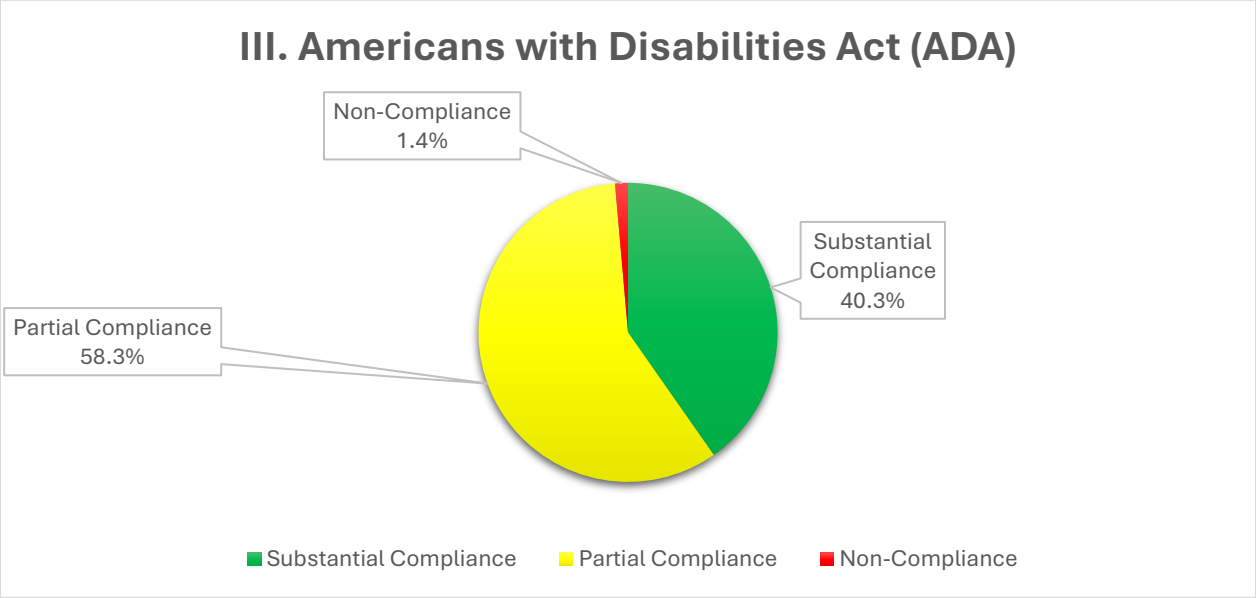
In preparation for fiscal year 2025-2026, ACH and ACMH recently developed, tested and put into production an automated MH Cases data report. The MH Cases data report allows ACMH service line staff to track caseloads as well as patient levels of care in the Main Jail and RCCC by the actual program level of care. This includes APU, IOP, Enhanced Outpatient Program (EOP), Outpatient Program (OP), and/or Critical Needs Assessment Program (CNAP).

In addition, with funding from a Prop 47 state grant, ACH went live on July 1, 2025, with the new Reentry Opportunities and Access to Resources (ROAR) program. ROAR focuses on helping formerly incarcerated individuals reintegrate into society and address core challenges like recidivism, homelessness, and unemployment. As a result of the new ROAR program, a plan is in place to develop a new automated report which will ultimately fill in the missing gaps of the current report.

Provision II.C will remain in partial compliance until the jail population dashboard is launched and the County can consistently compile and post information related to all data elements identified in II.C.a - II.C.i.

[5] https://www.sacsheriff.com/pages/transparency.php

III. Americans with Disabilities Act (ADA)



The County has identified 72 provisions in Remedial Plan III. Americans with Disabilities Act (ADA). For this 11th County Status Report, the compliance ratings are as follows:

- Substantial Compliance: 29 provisions (40.3%)
- Partial Compliance: 42 provisions (58.3%)
- Non-Compliance: 1 provision (1.4%)

Monitoring Status

Remedial Plan III. ADA is primarily monitored by Class Counsel. Provision III.O.1 is monitored by the mental health SME, whose latest report was "Mental Health Expert's Fourth Round Report of Findings" by Mary Perrien, Ph.D., dated May 1, 2024.

The "First Monitoring Report on Americans with Disabilities Act Compliance Practices in the Sacramento County Jails" was published in March 2021 and was completed by Aaron J. Fischer from the Law Office of Aaron J. Fischer, Margot Mendelson and Patrick Booth from the Prison Law Office, and Anne Handreas from Disability Rights California. While the assigned monitors provided narrative comments on the various categories in the remedial plan, no compliance ratings were assigned.

The "Second Monitoring Report on Disability Practices in the Sacramento County Jails" was filed with the Court on July 30, 2025. This report was written by Patrick Booth, Margot Mendelson, and Megha Ram from the Prison Law Office and Aaron J. Fischer from the Law

Office of Aaron J. Fischer. This report included compliance ratings for 61 of the 72 provisions in the ADA Remedial Plan (11 provisions were not evaluated). Given the extended period since the prior report and the previous lack of any compliance ratings provided by Class Counsel, the County appreciates the inclusion of ratings in this report and used the feedback received to thoughtfully reconsider several of its own compliance ratings. As a result, many provisions previously self-assessed as being in substantial compliance were reduced to partial compliance.

In comparison to the County's self-assessed ratings, the Court-appointed monitors' compliance ratings are as follows:

- Substantial Compliance: 5 provisions (6.9%)
- Partial Compliance: 43 provisions (59.7%)
- Non-Compliance: 13 provisions (18.1%)
- Not Assessed: 11 provisions (15.3%)

Attachment 3, Americans with Disabilities Act (ADA) Remedial Plan Expert Rating Reconciliation, aligns the Court-appointed monitor's compliance ratings with the provision structure used here and shows how the County's compliance ratings compare to those of the assigned monitor(s) on each provision.

Self-Assessment

III.A. Policies and Procedures

III.A.1 - Partial Compliance

"It is the County's policy to provide access to its programs and services to prisoners with disabilities, with or without reasonable accommodation, consistent with legitimate penological interests. No prisoner with a disability, as defined in 42 U.S.C. § 12102 shall, because of that disability, be excluded from participation in or denied the benefits of services, programs, or activities or be subjected to discrimination. The County's policy is to provide reasonable accommodations or modifications where necessary, consistent with 28 C.F.R. §§ 35.150 & 35.152, and other applicable federal and state disability law."

The following forms have been updated related to this provision.

- Grievance Form and Appeal Form (revised following feedback from the medical SMEs)
- Disabilities Screening Template in the Electronic Health Record (EHR) – Final
- Effective Communication Template (EHR; revision 08/31/21) – Final
- Alta Regional Center Referral Form (10/2021) – Final

- Mental Health Adaptive Support Survey (05/2022) – Final
- Mental Health Adaptive Support Program Screener (05/2022) – Final
- Refusal Form (06/2022) – Final
- Health Services Request form (02/2023) – Final

During this reporting period, ACH hired a nursing consultant recommended by the medical subject-matter expert (SME) Angela Goehring to review and revise medical policies. This consultant assisted in revising the following ADA-related ACH policies:

- 06-02 Patients with Disabilities
- 06-03 Effective Communication
- 06-04 Patients with Limited English Proficiency (formerly, Interpretation Services) - *Sent to Medical SMEs for review*
- 06-06 Patients with Disabilities or Other Special Needs.

The Sheriff's Office has engaged in several steps, some through policy revision, others through practice to ensure all inmates receive equal access regardless of disability. Notably, the Compliance Unit, through tracking mechanisms and personal visits, ensures equal access and effective communication on an individual basis for all inmates with disabilities. Practices involving lower bunks and lower tiers have been modified to ensure the maximum number of beds are available for those needing accommodation. Patients identified with mobility issues are escorted in or with the proper durable medical equipment (DME) to ensure they are not denied equal access to facilities, programs and services.

The County is working with Class Counsel to revise the programming rotation within the jail facilities to allow for equal access for all programming throughout every unit in the jail facilities. Until this new policy is finalized and implemented, this provision will be reduced to partial compliance.

III.A.2 - Substantial Compliance

"The County shall, in consultation with Plaintiffs' counsel, revise its Operations Order to establish standard and consistent procedures for the Jail to ensure compliance with the ADA and the remedial provisions outlined herein."

In collaboration with Class Counsel, the Sheriff's Office is continually revising and promulgating policies and procedures to ensure compliance with the ADA and remedial provisions. To enhance effectiveness while ensuring compliance with the ADA, multiple existing policies and procedures are in the process of being consolidated into a single

policy and procedure addressing incarcerated persons with disabilities in accordance with the ADA. The policies and procedures affected by this consolidation have already been approved by Class Counsel. While a final version of the updated policy will be provided to Class Counsel for their approval, the content has not significantly changed, therefore the compliance rating for this provision remains in substantial compliance.

III.A.3 - Substantial Compliance

"The County shall, within 12 months from court approval of the Settlement and in consultation with Plaintiffs' counsel, revise policies, procedures, and inmate orientation materials (e.g. Inmate Handbook), in accordance with the revised Operations Order and the remedial provisions outlined herein. A list of policies which the County will revise consistent with the provisions outlined herein, as appropriate and in consultation with Plaintiffs' counsel, is attached as Exhibit A-1."

Developing and revising policies and procedures is an iterative process, which includes input and feedback from Class Counsel. Information on ACH, ACMH, and SSO policies is included in Attachment 2, Policies and Procedures.

The inmate handbook was most recently revised in February 2025 and undergoes regular revisions incorporating any additional changes as necessary. In addition, orientation material is now displayed continuously in the Main Jail arrest report room. This provision remains in substantial compliance.

III.A.4 - Partial Compliance

"All staff will receive training appropriate to their position on policies and procedures related to compliance with the Americans with Disabilities Act (ADA) and related disability laws."

All ACH staff receive training in policies and procedures related to compliance with ADA. As the updated ADA-related policies are approved by SMEs, staff will be trained on the revisions. A nurse educator (supervising registered nurse) was hired during this reporting period to ensure compliance with mandatory training and nursing competencies. The nurse educator supports compliance with the ADA provisions by leading related training initiatives and monitoring training completion across the organization.

All staff assigned to corrections (sworn staff and records officers) have been assigned Consent Decree training since September of 2021. As new hires begin their employment, they are assigned the training and must attest to the completion of the training. Information on ADA/medical accommodations will be added to Jail Operations, which is

in-service training required for all new hires. Additionally, SSO's Compliance Units attend at least one nationally recognized ADA symposium per year. Additionally, the Commission on Peace Officer Standards and Training (POST) incorporates a learning domain regarding ADA. Learning Domain 17, Americans with Disabilities Act and Related Laws, is provided to all sworn staff through the academy.

During this rating period, an ADA training from Sacramento County was identified and provided to Class Counsel for their review with the intent of having it be completed by all non-sworn staff. Per Class Counsel, that training was not adequate due to it not being specifically geared towards corrections. SSO is exploring other training options that would satisfy this provision. This provision has been reduced to partial compliance and will remain in partial compliance until Class Counsel agrees to the content of an applicable ADA training course for SSO's non-sworn officers.

III.B. ADA Tracking System

III.B.1 - Partial Compliance

"The County shall develop and implement a comprehensive system (an "ADA Tracking System") to identify and track screened prisoners with disabilities as well as accommodation and Effective Communication needs."

The County has developed and implemented an ADA Tracking System in SSO's jail management system (ATIMS) to identify and track screened patients with disabilities as well as accommodation and effective communication needs. ATIMS can communicate with ACH's EHR system, which tracks patients with disabilities and patients with effective communication needs as required. This allows data to be shared between the systems and alert SSO users of the incarcerated person's ADA and effective communication needs. These alerts are prominent in the system and can be customized depending on the requests and needs of stakeholders.

For SSO, the ability to identify and track individuals with disabilities and/or effective communication needs has significantly improved within the County's correctional facilities. Although each facility continues to manage the relevant data in its own tracking system, the system and format are now the same at both jail facilities.

Specifically at the Main Jail, individuals with ADA/effective communication needs are now identified through a multitude of options. Some of the avenues for identifying and reporting these needs during the initial intake are as follows:

- ACH populates relevant ADA/effective communication needs in their EHR which is then populated in ATIMS for custody staff.
- ACH also sends email notifications directly to the Compliance Unit team when individuals are identified as needing ADA accommodation.
- Custody staff assigned to booking or classification have also been instructed to notify Compliance when they observe a new arrestee that may need special services while in custody. These notifications occur via email, phone, or in person.

After individuals are already housed in their respective facility, two additional notification systems exist to identify additional or newly approved accommodations. Compliance routinely receives all Armstrong Notifications directly from the California Department of Corrections and Rehabilitation and their in-house Parole Officers, ensuring no accommodation needs go unnoticed.

Additionally, the Compliance team generates a weekly report within ATIMS to track all newly approved and issued medical devices and accommodation; this report is populated based on ACH EHR flags. Between the intake notifications, the Armstrong notifications, and the newly created medical flags, SSO consistently and accurately captures disability accommodations for those in need.

SSO has identified rare cases where an inmate's ADA needs are not initially identified. The multiple mechanisms of communication, including a hotline in each housing unit, are in place for inmates to reach out directly to the Compliance Unit. If Compliance were to receive a request about a missing device, Compliance deputies will contact that individual as soon as reasonably possible, in person, to rectify the situation.

Class Counsel through their 2nd monitoring report, identified the need for more specificity in terms of an inmate's needed ADA and effective communication accommodations. As such, SSO is revising the current ADA and effective communication tracking sheet to add more specificity and improve readability. Until the improved tracking system is complete, this provision will be reduced to partial compliance.

III.B.2 - Partial Compliance

"The ADA Tracking System shall identify:

- *All types of disabilities, including but not limited to psychiatric, intellectual, developmental, learning, sensory, mobility, or other physical disabilities, and special health care needs;*

- *Prisoners with disabilities that may pose a barrier to communication, including but not limited to learning, intellectual, or developmental disabilities, and hearing, speech, or vision impairments;*
- *Accommodation needs, including as to housing, classification, Effective Communication, adaptive supports, and assistive devices;*
- *Prisoners who require specific health care appliances, assistive devices, and/or durable medical equipment (HCA/AD/DME);*
- *Prisoners who are class members in Armstrong v. Newsom (N.D. Cal. No. 94-cv-02307), with their applicable disability classification(s) and accommodation need(s).”*

The ADA Tracking System in ATIMS identifies all areas outlined as required in the Remedial Plan, including disability type/special health care needs, communication needs, accommodation needs, health care assistive (HCA) devices, and/or DME needed and class members in *Armstrong v. Newsom* (N.D. Cal. No. 94-cv-02307), with their applicable disability classification(s) and accommodation need(s). ACH developed and implemented a DME note for staff to use when delivering and/or collecting DME from a patient. This allows staff to easily determine if and when DME was physically provided to a patient, which enhances DME tracking abilities.

All inmates are screened and accommodations identified are displayed and tracked in ATIMS. ATIMS displays the information enumerated in this section to Sheriff employees. The information is entered by either the Sheriff’s Compliance Unit (ATIMS person alert flags) or can be entered by ACH through their EHR program (medical alert flags). The ATIMS medical alert flags below are used to identify the disabilities that may pose a barrier to communication enumerated in this section:

- Developmentally disabled
- Effective communication – other
- Hearing impairment description
- Intellectual disability
- Learning disability
- Speech impairment description; and
- Vision impairment description.

Until the improved tracking system mentioned under III.B.2 is complete, this provision will be reduced to partial compliance.

III.B.3 - Substantial Compliance

"The ADA Tracking System's prisoner disability information will be readily accessible to custody, medical, mental health, and other staff at the Jail who need such information to ensure appropriate accommodations and adequate program access for prisoners with disabilities."

The ADA Tracking System in ACH's EHR and SSO's ATIMS is readily accessible to SSO Custody, ACH Medical, ACH Mental Health, and other staff at the Jail who need such information to provide appropriate accommodations and adequate program access for patients with disabilities. ACH developed and refined EHR templates for screening and documenting disabilities and accommodations. These forms permit ongoing changes if the accommodation status needs to be modified.

A medical assistant (MA) has been assigned to review the EHR and verify accommodations have been provided. If accommodations have not been provided, the MA will notify Nursing to assess the patient. Interfaces between ACH's EHR and SSO's ATIMS are designed to support communication in this area.

Providers have been instructed to schedule provider follow-ups with patients prior to their DME prescription expiring (for example, crutches for three weeks). If it is determined that the patient continues to need the device/equipment, the order will be extended. SSO does not take away equipment from the patient even if it shows expired in their system. They will coordinate with medical staff to determine if the accommodation is still needed. If not, medical staff will collect the equipment. This provision remains in substantial compliance.

III.C. ADA Coordinator

III.C.1 – Substantial Compliance

"The County shall have a dedicated ADA Coordinator at each facility."

SSO has two ADA coordinators, one for each facility, as well as a dedicated compliance commander who oversees the ADA coordinators. This provision remains in substantial compliance.

III.C.2 - Substantial Compliance

"The ADA Coordinator position shall be dedicated to coordinating efforts to comply with and carry out ADA-related requirements and policies, shall have sufficient command authority to carry out such duties, and shall work with the executive management team regarding ADA-related compliance, training, and program needs."

Each SSO ADA coordinator has sufficient command authority to carry out their duties and works seamlessly with the executive management team regarding ADA-related compliance, training, and program needs. This provision remains in substantial compliance.

III.C.3 - Partial Compliance

"The County shall clearly enumerate, in consultation with Plaintiffs' counsel, the job duties and training requirements for the ADA Coordinator position and for ADA Deputies assigned to support the ADA Coordinator position."

Job duties have been established by SSO for the ADA coordinator and the deputies that support this area. SSO will communicate with Class Counsel in the next reporting period to obtain guidance regarding what training and qualifications are necessary to move this provision to substantial compliance. Until that dialogue occurs and training requirements are finalized, this provision remains in partial compliance.

III.C.4 - Partial Compliance

"The County shall ensure that ADA Coordinators and ADA Deputies possess requisite training to implement and ensure compliance with the Jail's disability program and services, including operating of the ADA Tracking System."

ADA coordinators and ADA deputies receive on-the-job training to ensure that they possess and maintain the requisite knowledge to implement and ensure compliance with the jail's disability program and services, including proper operation of the ADA Tracking System. This is supplemented by formal training presented by a nationally recognized ADA training organization on an annual basis.

In May of 2025, Main Jail and RCCC Compliance team members attended the ADA Coordinator Training and received ADA Coordinator Training Certification from The Great Plains ADA Center. The 2025 Symposium consisted of the following classes:

- 8A) Role of the ADA Coordinator: Practical Strategies & Tips for Success
- 10A) Emergency Preparedness
- 11A) Religious Entities and the ADA
- 12B) Service Animals
- 1B) Law Enforcement - Best Practices to Ensure Access & Safety for All
- 2B) A Comprehensive Guide to Ensuring Equitable Access to Court Users w/ Disabilities

- 3B) Criminal Justice within the Deaf & Disabled Community: Current Research & Future Needs
- 4B) Detention, Corrections & Courts: Do's & Don'ts
- 5A) Becoming a 'Game Changer' ADA Coordinator
- 6A) ADA Considerations & Best Practices for Virtual Meetings & Webinars
- 7A) Making Digital Geographic Maps ADA Compliant & Inclusive
- 9A) ADA & Effective Communication: Title II & Title III

While SSO acknowledges not all classes taught in the annual ADA symposiums attended by our Compliance members are specific to law enforcement and corrections, many are (i.e. Law Enforcement - Best Practices to Ensure Access & Safety for All, A Comprehensive Guide to Ensuring Equitable Access to Court Users w/ Disabilities, Criminal Justice within the Deaf & Disabled Community: Current Research & Future Needs, Detention, Corrections & Courts: Do's & Don'ts). While the ADA SME report recently received from Class Counsel primarily contained remarks about deficiencies in the qualifications of SSO's ADA coordinators specific to training, it did not provide any guidance regarding which training or qualifications would suffice. Until further dialogue with Class Counsel has taken place and an agreement has been reached as to the training required, this provision has been reduced to, and will remain in, partial compliance.

III.D. Screening for Disability & Disability-Related Needs

III.D.1 - Substantial Compliance

"The County shall conduct adequate screening of prisoners to be housed in the Jail in order to identify disabilities and disability-related accommodation, housing, classification, and other needs. All individuals detained at the Jail for any period of time will be assessed for Effective Communication needs, consistent with the provisions herein."

County ACH conducts an Intake Health Screening for anyone who will be housed in the Jails. The Health Intake Screening includes forms and questions to identify essential information regarding disabilities, accommodations, and effective communication needs consistent with policy and this Remedial Plan requirement. All individuals detained at the Jail for any period of time will be assessed for effective communication needs, consistent with the provisions herein.

The most recent audit conducted by the ACH Quality Improvement (QI) team, which included a sample size of 70 patients from the period of January 1, 2025 to March 31, 2025, indicated:

- 100% of patients entering the jail were screened for effective communication needs.
- 84% of patients entering the jail were screened for existing ADA issues.
- 97% of patients entering the jail were screened for intellectual disabilities.

This resulted in an overall compliance rate of 94% regarding ADA related screenings at intake. As a result, this provision remains in substantial compliance.

III.D.2 - Partial Compliance

"The County shall take steps to identify and verify each prisoner's disability and disability-related needs during medical intake screening, including based on:

a) The individual's self-identification or claim to have a disability;

b) Documentation of a disability in the individual's health record;

c) Staff observation that the individual may have a disability that affects placement, program access, or Effective Communication; or

d) The request of a third party (such as a family member) for an evaluation of the individual for an alleged disability."

ACH's Health Intake Screening process includes forms and questions to identify and verify disability-related needs based on an individual's self-identification or claim to have a disability, documentation of a disability in the individual's health record, and staff observation, or collateral (family report) information – information that indicates someone may have a disability that affects housing needs, program access, or effective communication needs. Intake training is provided to intake RNs annually, as policies change, as requested, and as recommended due to audit findings. Automatic referrals or prompts are triggered at intake based on responses to specific questions to mental health for post-intake assessment of psychiatric, developmental, or intellectual disabilities.

ACH QI conducts quarterly ADA audits to determine compliance with this provision; however, due to a temporary QI staffing shortage, Q2 of FY 24/25 was not completed. For the Q3 Audit for FY 24/25 completed on June 10, 2025, ACH increased the sample size from an average of 27 patients to 70 patients to reduce the margin of error, in alignment with an SME recommendation. Some of the findings are as follows:

- 100% (70/70) Effective Communication (EC) form completion. This remains consistent with data from the last reporting period.

- 84% (59/70) ADA Assessment Medical form completion. This reflects an increase from the prior reporting period (67%).
- 97% (68/70) Intellectual Disabilities (ID) Screening form completion. This reflects a slight decrease from the prior reporting period (100%).
- 94% (197/210) Forms completion rate. This reflects an increase from the prior reporting period (92%).
- 84% (328/392) Total compliance threshold. This reflects a decrease from the prior reporting period (90%).
- 43% (3/7) Medical disability proper documentation. This reflects a decrease from the prior reporting period (75%).
    - For this indicator, QI reviews the chart to determine if the RN properly documented the disability in the ADA intake form. ACH QI found that when the RN did not document the disability on the ADA intake form, they did document it in the notes.
- 78% (7/9) AD/DME proper documentation. This is an increase from the prior reporting period (75%).
    - For this indicator, QI reviews the chart to determine if the RN properly documented the AD/DME needs in the AD/DME intake form.
- 86% (6/7) Medical referrals were seen within policy time frames. This reflects an increase from the prior reporting period (67%).

ACH QI anticipated slight changes in audit results due to the increase in chart reviews. However, ACH is working to address the areas that had a significant drop in compliance during this audit period.

Over time, intake nurses have improved with respect to identifying and documenting disabilities and related needs. Staff developed and refined a tool to audit disabilities, accommodations, and effective communication. Data indicates that staff are improving with regard to identifying and documenting disabilities, accommodations, and effective communication. Audits will continue regularly, and data/trends will be reviewed for errors, systemic issues, and opportunities to improve detection and create individualized care plans. Data is reviewed during QIC meetings, but urgent issues are addressed more frequently with the service line directors.

Additionally, ACH continues to use the LanguageLine App (installed on all patient facing computers) to reduce barriers to care due to communication issues. This includes American Sign Language. All staff are trained to use this software during their onboarding process and on an as-needed basis. In addition, the Nurse Intake includes automatic

referral generation to MH when a patient responded affirmatively to having an intellectual disability.

A new flag has been created in ATIMS for tracking disability needs, which is utilized by SSO Compliance to be aware of those inmates with ADA equipment issued. When staff identify a disability or accommodation that requires follow-up, the SSO Compliance team is made aware through various means. If ACH staff add a flag to an inmate's medical record, ACH's system communicates directly with ATIMS. Custody staff utilize that information to communicate, engage, and assist the particular inmate while they are incarcerated.

As audit findings indicated an 84% (328/392) total compliance threshold, which is below the 90% benchmark, this provision has been reduced to partial compliance.

III.E. Orientation

III.E.1 - Partial Compliance

"The County shall ensure that, for the population to be housed in the Jails, prisoners with disabilities are adequately informed of their rights under the ADA, including but not limited to:

a) *Accommodations available to prisoners;*

b) *The process for requesting a reasonable accommodation;*

c) *The role of the ADA coordinator(s) and method to contact them;*

d) *The grievance process, location of the forms; and process for getting assistance in completing grievance process;*

e) *Instructions on how prisoners with disabilities can access health care services, including the provision of Effective Communication and other accommodations available in accessing those services."*

The inmate handbook advises prisoners with disabilities of their rights under the ADA. The inmate handbook is provided to all incarcerated persons either in a physical form or digitally available on the inmate tablet. Both facilities have signage posted in each pod which includes ADA information. The posting is directed to individuals who have difficulty seeing, hearing, talking, walking, moving, breathing, or learning.

Regarding sub-provision III.E.1.b, the inmate handbook outlines the process for requesting accommodation for non-medical related disabilities. Regarding sub-provision III.E.1.c, the role of the ADA Coordinator and the method of contacting the ADA Compliance teams is

located in the inmate handbook and on a poster in each housing area. In both facilities, inmates can call a toll-free hotline and leave a message for the ADA Compliance Teams. Regarding sub-provision III.E.1.d, the grievance process and the process for requesting assistance by writing is outlined in the digital and physical copies of the inmate handbook. Regarding sub-provision III.E.1.e, the inmate handbook also outlines how to access health care services. Accommodation needs and effective communication are addressed as it relates to these services through the following language: "If you have vision, speech, hearing, intellectual, learning, or other disabilities, please let staff know so they may assist you."

In response to the remedial plan, SSO has updated inmate orientation materials, specifically with the addition of an expanded orientation video. This closed-captioned video is played on a continuous loop within the arrest report room to ensure every individual who is booked into custody at the Main Jail has access to pertinent orientation material. The orientation video covers a wide range of topics such as Jail operations, procedures, the Prison Rape Elimination Act (PREA), and ADA information. The ADA portion specifically provides a visual guide to the accommodations and resources available, including devices for mobility, visual, and hearing impairments for effective communication. It also highlights the process to request an accommodation, the grievance process, and the ADA Compliance for the ADA coordinator hotline.

During the orientation process, if an intake deputy or classification staff member recognizes that the inmate may have a disability limiting their understanding of the material, the staff member will notify Compliance to ensure the orientation material is effectively communicated.

SSO continues to work towards further compliance in this provision by expanding the various methods of communicating this critical information to the inmate population. As recent updates to the orientation video have not yet been assessed by Class Counsel, this provision has been reduced to partial compliance.

III.E.2 - Partial Compliance

"Upon processing and classification, prisoners with disabilities shall receive, in an accessible format, the jail rulebook; orientation handbook; and a verbal orientation or orientation video regarding rules of expectations."

Verbal and written communications are presented by Compliance officers as needed. The inmate handbook is received at intake and available upon request; however, only one format/version of the handbook is available on the inmate tablet. SSO can print the

Handbook in an enlarged size for those that need larger print; inmates can also "zoom in" on the Handbook to increase the font size on the tablets. Inmates are also given a verbal orientation by deputies before being assigned to a housing unit. Additionally, Video Remote Interpreting (VRI) as a form of effective communication is available as needed. The orientation video is played on a continuous loop in the Main Jail and RCCC booking areas, complete with closed captioning.

Given feedback provided by Class Counsel with concerns in this area, this provision has been reduced to partial compliance. It will remain in partial compliance until SSO can implement a mechanism to demonstrate proof of practice.

III.E.3 - Partial Compliance

"The County shall accommodate individuals with disabilities in the orientation process through the use of alternative formats (e.g. verbal communication, large print, audio/video presentation), when necessary for Effective Communication of the information."

Upon intake, an orientation video with closed captioning is played in the arrest report room. During the booking process, accommodation needs are identified and confirmed. Once the accommodation has been noted, the Compliance team is notified for follow-up. The inmate handbook is available to all inmates prior to being housed. The handbook is also available on the inmate tablets and may also be printed. SSO has developed alternative formats, including a large-print inmate handbook in a further attempt to assist those who need that accommodation. Inmates can also use the "zoom in" feature on the tablets to increase the font size. A verbal orientation is also provided to all inmates before they are housed.

In the most recent ADA SME report, Class Counsel used several examples of non-compliance with this provision. It is important to point out that hundreds of inmates housed at both facilities with various ADA related accommodation needs are provided adequate and appropriate accommodations to ensure they comprehend the orientation materials. SSO is currently exploring options to track these encounters to show proof of practice. Until that occurs, this provision has been reduced to, and will remain in, partial compliance.

III.E.4 - Substantial Compliance

"The County shall develop an Americans with Disabilities Act Inmate Notice. The Notice shall be prominently posted in all prisoner housing units, in the booking/intake areas, in

medical/mental health/dental treatment areas, and at the public entrances of all Jail facilities."

There is ADA signage posted in all inmate housing units, the booking/intake areas, the medical/mental health/dental treatment areas, and at the public entrances of the facilities. The signage is compliant with ADA federal requirements. Consistent with the most recent ADA SME report, this provision remains in substantial compliance.

III.F. Health Care Appliances, Assistive Devices, Durable Medical Equipment

III.F.1 - Partial Compliance

"The County shall establish a written policy to ensure provision of safe and operational HCA/AD/DME, with a process for repair and replacement."

ACH has established a written policy (ACH PP 06-07, effective 02-08-21) to ensure the provision of safe and operational HCA/AD/DME, with a process for repair and replacement. During this reporting period, ACH revised its policy 06-07 Health Care Appliances, Assistive Devices and Durable Medical Equipment to address repeated issues of intentional damage to ACH provided equipment. As a publicly funded agency, ACH has a responsibility to use government resources in a fiscally responsible manner. Therefore, ACH collaborated with the court-appointed SMEs to address situations where damage to HCA/AD/DME may occur as a result of an underlying mental illness. With their feedback, ACH developed and received approval for language that limits device provision in cases where the damage is not attributable to the individual's mental health condition. ACH is addressing concerns raised by Class Counsel and intends to finalize this policy in July 2025.

In June 2023, SSO implemented a policy - Aids to Impairment. The policy states the following related to this provision:

- All requests for new or replacement medical or dental prostheses shall be individually evaluated by the Responsible Physician or dentist. Considerations for approval shall be based upon:
- Medical needs of the incarcerated person.
- The anticipated length of incarceration.
- The safety and security of the facility.

A further review of current SSO policies regarding this provision will be completed to address concerns raised by the SME in their most recent status report. Until the

appropriate policies have been expanded and finalized, this provision has been reduced to, and will remain in, partial compliance.

III.F.2 - Partial Compliance

"The County shall timely provide HCA/AD/DME to prisoners with disabilities who require such assistance. The County shall ensure an individualized assessment by medical staff to determine whether HCA/AD/DME is warranted to ensure equal and meaningful access to programs, services, and activities in the Jail."

In addition to the information included in the 10th County Status Report, ACH and SSO work closely to ensure that patients requiring AD/DME/HCA receive what they need. ACH has continued to expand the types of ADA-compliant devices and medical equipment to patients after individualized assessments. This includes expanding the number of optometry clinics to serve the greater demand of patients in need of prescription glasses. ACH no longer has a backlog of patients to be seen for this specialty service. ACH has expanded its pulmonology services to ensure it meets the demand for patients in need of CPAP machines. Staff work closely with ACH's hearing aid vendor to perform regular hearing tests to determine appropriateness of accommodations. A contracted podiatrist timely assesses patients for needs such as orthotic shoes and an orthopedic specialist assesses for braces, splints or other needed devices.

SSO's Compliance Unit has established supplemental advanced notification methods to ensure those in need of AD/DME/HCA are being identified when they are initially booked into custody. In addition to receiving ACH notifications stemming from a medical evaluation regarding inmates who are needing and/or being provided accommodation devices, the Compliance Unit now communicates directly with Intake, Classification, and Property deputies by phone, in person, and a shared dedicated email that is checked by the unit daily. These notifications have resulted in quicker completion of assessments and timely delivery of medical devices as needed.

SSO would argue the term "timely" used in this provision is overly broad and subject to interpretation. The lack of specificity regarding the "timely" term makes it impossible to determine substantial, partial, or non-compliance. Per the most recent ADA SME report, Class Counsel stated Sacramento County is "far" from substantial compliance in this provision. Like the term "timely", "far" is also subjective. Specifically, the SME report referenced two inmates who did not receive their DME in a "timely" manner and used that small sample as justification for their rating. Dozens of inmates between both facilities have disability-related accommodations to include DME.

ACH and SSO believe that AD/DME/HCA needs are largely being met within the jails. However, until a more in-depth analysis of the inmate population and the time frame of their receipt of prescribed ADA devices occurs to accurately assess the compliance rating in this provision, this provision has been reduced to partial compliance.

III.F.3 - Partial Compliance

"The County shall allow prisoners to retain personal HCAs/ADs/DME (which will include reading glasses), unless there is an individualized determination that doing so would create an articulated safety or security risk.

a) *Where Jail staff determine it is necessary to remove a prisoner's personal HCA/AD/DME for security reasons, the County shall provide an equivalent Jail-issued device unless custody staff, with supervisory review, determine and document, based on an individualized assessment, that the device constitutes a risk of bodily harm or threatens the security of the facility.*

b) *If such a determination is made, the ADA coordinator or supervisory-level designee shall document the decision and reasons for it, in writing, and shall consult with medical staff to determine an appropriate alternative accommodation."*

Medical staff approves/authorizes medical equipment. Medical and custody work together to determine appropriate alternative accommodations when needed for safety reasons such as when a patient has a history of turning equipment into contraband and/or weapons. These instances will be documented in the patient record.

The Compliance Unit has established direct and continuous communication with the Property deputies to ensure personal medical equipment, after inspection, remain with the inmate when they are housed. This practice has reinforced the expectation that medical devices do not always need to be provided by ACH and, in many cases, personally owned devices are perfectly acceptable to be retained by the inmate. Additionally, signage has been posted in dress-in areas to remind all those working that personal medical devices are to remain with each inmate after clearing inspection.

SSO personnel assigned to the Main Jail's front counter and RCCC's gatehouse have also been instructed to accept outside HCAs/ADs/DME equipment for inmates in custody. Those devices are then provided to the Compliance Unit for inspection before ultimately being issued to the inmate in need.

ACH staff conduct an assessment to determine if a device is clinically necessary and, if so, will work with custody staff to see if their personal device can be retained. If another device

or accommodation is determined to be more appropriate by the treating provider, it will be provided instead. Should HCA/AD/DME from outside of the facility be deemed a security risk, the HCA/AD/DME will be placed with the applicable inmate's property, and a reasonable alternative will be provided.

At RCCC, the gatehouse officers document all incoming HCA/AD/DME in a logbook and are directed to contact the Compliance Unit upon receipt of the item. Compliance is then solely responsible to retrieve the item, inspect it, coordinate with ACH, and, ultimately, ensure the device is promptly provided to the inmate.

In the most recent SME report, Class Counsel referenced two incidents during the rating period in which a device was not allowed to be retained by an inmate. To illustrate their position, Class Counsel used a singular example referencing a federal inmate who was not initially allowed his assistive device (digital magnifier) when he was booked into Sacramento County Jail.

While the Sheriff's Office makes every effort to prevent the confiscation of an assistive device, this incident is an example of a singular deficiency and is inadequate to be used to illustrate a widespread systemic issue. Once the Compliance Unit was made aware that this individual was not allowed to retain his magnifier upon his arrival at the jail, immediate action was taken to retrieve the device from the US Marshals and it was subsequently provided to the inmate. Staff were again reminded of the requirements relating to the retention of HCAs/ADs/DME for the inmate population. Class Counsel's use of a singular failure to determine its compliance rating is inappropriate and misrepresents the frequency with which this provision is met among the larger inmate population. Given the disagreement over proof of practice shown, this provision has been reduced to partial compliance.

III.F.4 - Partial Compliance

"The County shall, in consultation with Plaintiffs' counsel, implement a written policy governing the release of prisoners who need assistive devices upon release.

a) *The County will ensure that any personal mobility device belonging to a prisoner is returned to the prisoner prior to release from custody.*

b) *If a prisoner does not have a personal mobility device, but is ambulatory with the assistance of a cane, crutch, or walker, the prisoner will be permitted to retain such device that was used while in custody upon release, or will be provided a comparable device, upon release.*

c) *If a prisoner who is due for release requires a wheelchair, but does not have a personal wheelchair, Jail staff shall coordinate with the prisoner, the prisoner's family or friends, and other County agencies as needed to secure a wheelchair or take other steps to address the individual's needs upon release. The County shall document this process in the ADA Tracking System for purposes of individual tracking and quality assurance."*

ACH policy 06-07, which is currently in revision, covers this provision. If a patient who is due for release from custody required a device such as a wheelchair in custody, ACH nursing will, as part of the discharge planning process, coordinate with the patient, the patient's family or friends, and other County agencies as needed to secure a wheelchair. Discharge Planning/Reentry nursing staff monitors the above steps to ensure patients who require a wheelchair have one upon release, often by releasing patients with the wheelchair used while in custody. ACH releases many patients with Sacramento County purchased assistive devices monthly. There is an ATIMS Conditional Release order for "Do Not Release with ACH DME" for things such as CPAPs and there are only 31 instances of this order. Otherwise, patients are released with the medically necessary DME they receive in jail. These include wheelchairs, canes, walkers, braces, compression stockings, crutches, splints, orthotic shoes, prescription glasses, continuous glucose monitors, and hearing aids.

SSO will return any personal mobility device to the inmate upon release from custody. If a patient does not have a personal mobility device, but is ambulatory with the assistance of a cane, crutch, or walker, SSO will permit the patient to retain such device that was used while in custody or provide a comparable device upon release. These requirements have been memorialized in SSO's policy and procedure manuals, as noted below.

- Procedure "End of Term Release, Assistive Devices," ensures incarcerated persons are provided reasonable accommodations at the time of release or transfer.
- Policy "End of Term Release, Release Guidelines," specifically states, "All facility property must be returned by the incarcerated person. Any missing or damaged facility property should be documented. Incarcerated persons may be able to keep identified facility-owned medical equipment and/or assistive devices (e.g., wheelchair, walker, cane, crutches) For further guidance, refer to custody policy Aids to Impairment."

Class Counsel, in their ADA report, recommended the County implement a tracking log to demonstrate proof of practice that DMEs are being returned to the incarcerated person when released from custody. SSO and ACH will work with Class Counsel to develop this

tracking system. Until such time that this tracking system is complete and this provision has been reduced to partial compliance.

III.G. Housing Placements

III.G.1 - Partial Compliance

"The County shall house prisoners with disabilities in facilities that accommodate their disabilities."

SSO and ACH provide appropriate housing to the fullest extent possible with the structural limitations of the current facilities, given that the facility was built before the ADA was passed. Due to the Main Jail's structural limitations, SSO proactively recognized the need to provide accommodations to several inmates that were not feasible at the Main Jail.

In partnership with ACH, a review of ADA-affected inmates was conducted, and several of those inmates were moved to RCCC to better accommodate their needs. This is an ongoing process whose success depends on continued collaboration between ACH and SSO. SSO recognizes the additional challenges of housing pre-trial inmates needing accommodations at RCCC due to transportation complications for Court. SSO is currently exploring options to address this issue.

The County recognizes that significant physical facility limitations exist in both facilities and some level of construction will be needed to comply with this provision. The County released an RFQ on April 11, 2025, for Correctional Master Planning services as a result of recommendations made by a consultant (CGL Companies) hired by the County to perform a third-party review of planning and programming documents developed by a prior consultant (Nacht and Lewis) for the IHSF. CGL recommended that the County complete a Master Plan before proceeding further in the IHSF planning process to ensure that this significant investment will meet the correctional system needs and appropriately address the Consent Decree requirements.

RFQ proposals were due May 16, 2025 and the County determined that the Health Management Associates, Inc. (HMA) proposal would meet the County's needs. The County entered into an agreement with HMA on July 1, 2025. This comprehensive Master Planning process will include a review of existing ADA limitations and make recommendations on how best to address these requirements.

The County has developed a plan to address the Main Jail's and RCCC's physical plant barriers and has allocated some funding toward implementing components of the plan. The County plans to implement the required improvements as construction projects are

completed in the Main Jail and RCCC. Once the Correctional Facility Master Plan is completed, the County will update its ADA transition plan and design documents that are in progress as outlined below.

The County's transition plan was necessarily placed on hold while the proposed jail annex/IHSF project went through a peer review and while the County undertakes a Correctional Facility Master Planning effort to ensure that a selected correctional facility solution will best meet the County's needs now and into the future. The County cannot reasonably continue these comprehensive ADA plans and make significant investments in new construction or alterations without the benefit of these completed efforts. Should any significant operational changes be recommended through this process, these changes should be considered in the Sacramento County Jail Accessibility Update and Plan and the proposed design packages (as noted below). The County must be thoughtful about investing its available resources to ensure that investments made in construction will not be redone later and/or may not be necessary if the SSO and ACH choose to operate the correctional facility differently because of the master planning efforts. The County is investing in ADA upgrades as construction projects are planned for and completed in both the Main Jail and RCCC (such as expansions to the APU and IOP).

The County's Department of General Services (DGS) contracted with Nacht & Lewis to develop "The Sacramento County Jail Accessibility Update and Plan" (The Plan) for both the Main Jail and RCCC, a requirement of Title II entities to perform a self-evaluation to identify barriers and provide accessible programs and services. A final progress draft was provided to the County in January 2018. The report was limited to the physical environment at both correctional facilities and did not include non-physical improvements, such as procedural improvements, needed for program access compliance. This report considers the 2015 self-evaluation completed at the Main Jail and the request by Sacramento County that Nacht & Lewis review programs and services at RCCC when developing The Plan to take a more holistic approach to the County's Jail System.

This comprehensive plan considers ADA requirements, the architectural physical plant for each facility, the intake, booking, and release process, medical and mental health programs, other programs and services, and employee areas. The Plan considers the applicable ADA requirements when evaluating the physical environment and recommending remedies for barriers. The Plan includes three components: 1) extensive study of the existing conditions and facilities to identify barriers, 2) scope of alterations required to bring the existing conditions into compliance by eliminating barriers, and 3)

cost analysis and implementation schedule. While not fully funded, one of these packages has planned dollars allocated to it in the County Five-Year Capital Improvement Plan (CIP).

The Plan was relied upon to develop four design packages to address ADA compliance in the Main Jail.

- Design Package 1 addresses the inmate cells, showers, and recreational yards on floors 3-8; as of August 25, 2023, it was 95% completed. The County has planned in the CIP to utilize $3.5 million in Capital Construction Funds toward these efforts.
- Design Package 2 addresses inmate holding, transfer, and inmate program improvements; as of August 25, 2023, it was 95% completed. This package is currently unfunded.
- Design Package 3 addresses the public lobby, visitation, and classification; as of March 13, 2023, it was 25% completed. This package is currently unfunded.
- Design Package 4 addresses the courtrooms and public restrooms; it was 95% completed as of December 22, 2023. This package is currently unfunded.

While the comprehensive planning and implementation of The Plan are placed on hold pending the completion of the Master Planning effort, the County is making ADA improvements, as required, utilizing the design packages' proposed alterations. The County is undertaking a project to add the APU and Suicidal Inmate Temporary Housing Unit (SITHU) housing units, consisting of ADA upgrades in restrooms and cells as proposed in Design Package 1. The county will continue to make these required upgrades as it completes other construction projects in the Main Jail and RCCC.

For the rest of the Main Jail facility ADA upgrades, these design packages and The Plan will be revisited following the completion of the County's Correctional Facility Master Planning efforts to ensure they are responsive to the recommendations made during master planning.

Retrofitting Sacramento County's correctional facilities to comply with ADA requirements and accommodate the growing demand for medical and mental health services presents financial and structural challenges for the County. Much of the existing infrastructure is structural, and any modifications involve extensive and costly work, such as altering footings, sawing through concrete, welding or torching steel, and other disruptive construction that not only introduces products of combustion, but lots of construction dust and debris. Renovation in a correctional setting demands careful planning. Key considerations include relocating occupants from work zones, planning for fire suppression system impacts, sealing areas with air- and smoke-tight barriers, keeping exit

paths clear, and maintaining at least two compliant exits for areas with more than ten occupants. These tasks are increasingly complicated in secure environments. Additionally, workers must undergo strict background checks, which often limit the available contractor pool. Until the structural limitations within the County's jail facilities are resolved, this provision will be reduced to partial compliance.

III.G.2 - Partial Compliance

"The County shall implement a housing assignment system that includes an individualized assessment of each individual's functioning limitations and restrictions, including but not limited to:

a) *The need for ground floor housing;*

b) *The need for a lower bunk;*

c) *The need for grab bars in the cell and/or shower;*

d) *The need for accessible toilets;*

e) *The need for no stairs in the path of travel; and*

f) *The need for level terrain."*

SSO accommodates inmate disabilities as recommended by ACH to the extent feasible, given the facility limitations in both the Main Jail and RCCC. Through their EHR, ACH transmits an alert flag to ATIMS. The alert flag is used by the Classification Unit and custody staff to make appropriate housing assignments that meet an inmate's individual ADA needs, such as a housing assignment with a lower bunk, no stairs, or other requirements. All RCCC housing facilities have shower chairs available for inmates upon request from their control and/or floor officers. MJ 2E & 2M have grab bars; shower chairs are on every floor available upon request.

ADA-accessible social and attorney visits continue to be a challenge for the Main Jail as there is only one standard attorney visit booth and two social visit booths that are easily accessed without utilizing stairs (located on the 2-East housing unit). RCCC has visiting areas and medical areas with no stairs in the path of travel. A second, interim wheelchair accessible attorney visit booth was created in the court booking area which can be used during business hours.

As mentioned under III.G.1, the County Correctional Facility Master Planning efforts and underway to address the ADA deficiencies within the County jail facilities. Meanwhile, the

County is committed to adding grab bars and other appropriate devices to reduce barriers for inmates to access the facilities. Until all ongoing Master Planning efforts have been completed and subsequent construction occurs, this provision will remain in partial compliance.

III.G.3 - Partial Compliance

"Prisoners with disabilities shall be housed in the Jail consistent with their individual security classification. Prisoners prescribed or possessing HCAs/Ads/DME will not automatically be housed in a medical housing unit. Placement in a medical housing unit will be based on individual clinical determination of need for treatment."

SSO and ACH provide appropriate housing to the fullest extent possible with the structural limitations of the current facilities. Security classification is not determined by disability or HCA/AD/DME; Medical Housing Unit (MHU) housing is determined by ACH based on an individual assessment. ACH advises/makes recommendations about housing. People with mobility issues or that require the use of wheelchairs are housed on the MJ second floor. However, others are housed throughout the facility depending on security classification. Given feedback from Class Counsel and ongoing facility limitations, this provision has been reduced to, and will remain in, partial compliance.

III.G.4 - Partial Compliance

"Classification staff shall not place prisoners with disabilities in:

a) *Inappropriate security classifications simply because no ADA-accessible cells or beds are available;*

b) *Designated medical areas unless the prisoner is currently receiving medical care or treatment that necessitates placement in a medical setting; or*

c) *Any location that does not offer the same or equivalent programs, services or activities as the facilities where they would be housed absent a disability."*

Placements into and discharges from acute and sub-acute medical housing units are based on referrals from ACH and are not determined by custody staff. Custody staff may refer an individual to ACH for assessment if they believe the individual meets, or no longer meets, the criteria for housing in these medical units; however, the final determination rests with ACH. A program rework is currently underway to further equalize program availability and opportunities across all classifications and housing units. Until this is

completed, and until facility planning and construction are complete, this provision will remain in partial compliance.

III.H. Access to Programs, Services, and Activities

III.H.1 - Partial Compliance

"The County shall ensure prisoners with disabilities, including those housed in specialized medical units or mental health units (e.g., OPP, IOP, Acute) have equal access to programs services, and activities available to similarly situated prisoners without disabilities, consistent with their health and security needs. Such programs, services, and activities include, but are not limited to:

a) Educational, vocational, reentry, and substance abuse programs

b) Work Assignments

c) Dayroom and other out-of-cell time

d) Outdoor recreation and fitted exercise equipment

e) Showers

f) Telephones

g) Reading materials

h) Social visiting

i) Attorney Visiting

j) Religious services

k) Medical, mental health, and dental services and treatment"

An internal review of SSO's incarcerated populations access to programming was conducted earlier this year. SSO identified several limitations that have unfortunately resulted in all inmates, whether disabled or not, having varying access to classes, substance abuse programs, and other self-improvement classes. The primary factor contributing to this disparity is not due to a housing location or disability status, but rather, a lack of volunteers to properly accommodate the inmate population as a whole. Multiple options to address this problem have been submitted to Class Counsel. SSO is eagerly awaiting their response so action can be taken to ensure all inmates are afforded the same opportunities for programming moving forward.

Out of cell time/recreation numbers have improved significantly during this rating period. A historical evaluation for the past year was conducted which revealed over 90% compliance with the out-of-cell time/recreation requirement for the inmate population as a whole. However, certain housing locations at the Main Jail continue to be a challenge regarding out-of-cell time numbers, primarily due to classification complications and inmate behavior. SSO has taken a proactive approach to target those floors which have consistently not met the minimum requirements and believe there will be significant improvements in the out-of-cell time/recreation data during the next reporting period.

Due to physical plant limitations at the Main Jail, several inmates requiring accommodations for shower access were moved to RCCC. The overall feedback from many of the inmates who had been moved was overwhelmingly positive. RCCC barrack housing is substantially more suitable for individuals with movement limitations due to the shower design, bathroom layout, and housing configuration. Additionally, there are folding shower chairs and grab bars next to the toilet on the bottom floor of two secure facilities.

SSO has recognized the limited number of wheelchair accessible attorney visit rooms. Previously, only one attorney visiting area at the Main Jail was wheelchair accessible. Last year, an additional attorney visit booth was modified in the jail's bottom floor to allow wheelchair access.

As mentioned under III.A.1, in response to the most recent ADA report from Class Counsel, an audit was conducted to determine if inmates with disabilities were being given work opportunities while incarcerated. The data overwhelmingly confirmed that numerous individuals with a disability designation were actively working in various job assignments. SSO has no policy which precludes an inmate with a disability to act as a worker, and based on the audit conducted, proof of practice has revealed many of those inmates with disabilities are in job assignments during their custody period. Given the physical limitations at the Main Jail, this provision remains in partial compliance.

III.H.2 - Partial Compliance

"The County shall provide reasonable accommodations and modifications as necessary to ensure that prisoners with disabilities have equal access to programs, services, and activities available to similarly situated prisoners without disabilities."

Programs and activity availability differ based on the inmate's security classification. All inmates, including those with disabilities, are provided with a tablet which has various educational programs available to them. Additionally, inmates have the option to participate in a variety of programs, services and activities based on their classification

and can request an accommodation as necessary. A tracking system through ATIMS tracks inmates with disabilities who work within custody and notes can be added if a reasonable accommodation is necessary. This provision remains in partial compliance during ongoing efforts to increase programming on all floors, as described in III.H.1.

III.H.3 - Partial Compliance

"The County shall develop and implement a written policy for staff to provide appropriate assistance to prisoners with psychiatric, developmental, or cognitive disabilities so that they can fully participate in programs, services, and activities provided at the jail."

SSO is working diligently with its Legal and Policy Bureau to combine separate disability-related policies into one policy and procedure. Once published, this consolidation will specifically include text relating to providing appropriate assistance to inmates with disabilities and ensuring effective communication needs are met during contacts with staff members. This provision has been reduced to partial compliance pending the finalization of the policy.

III.H.4 - Partial Compliance

"The County shall implement a written policy for staff to provide assistance to prisoners with disabilities in reading or scribing documents."

The policy and procedure documents related to these requirements are undergoing review (see III.H.3). This provision has been reduced to partial compliance pending the finalization of the policy.

III.H.5 - Partial Compliance

"The County shall provide equal access to library, recreational, and educational reading materials for prisoners with disabilities, including easy reading and large print books for individuals who require such accommodations."

SSO provides equal access to reading materials, including large font publications. In addition, ACH now provides reading glasses and magnifiers free of charge, promptly to all who need or request them since they maintain stock of varying strengths. Based on input from Class Counsel, this provision has been reduced to partial compliance until proof of practice is demonstrated.

III.H.6 - Partial Compliance

"The County shall ensure equitable inmate worker opportunities for prisoners with disabilities, including by:

a) *Ensuring clear job duty statements, with essential functions and specific criteria, for each Worker position;*

b) *Ensuring that medical staff conduct an individualized assessment to identify work duty restrictions and/or physical limitations to facilitate appropriate work/industry assignments and to prevent improper exclusions from work opportunities;*

c) *Providing reasonable accommodations to enable prisoners with disabilities to participate in inmate worker opportunities."*

Job duties for various worker assignments (laundry, kitchen, etc.) have been established. SSO, in coordination with ACH, has provided job opportunities with appropriate accommodations for those with certain disabilities. ACH provides an individual evaluation for all requests received by SSO to determine if any restrictions apply. Additionally, SSO now tracks inmates with disabilities who are in worker assignments and will be able to show proof of practice to demonstrate compliance with this provision. Based on feedback from Class Counsel, this provision has been reduced to partial compliance until proof of practice is demonstrated.

III.I. Effective Communication

III.I.1 - Substantial Compliance

"The County shall assess all individuals detained at the Jail for any period of time for Effective Communication needs, and shall take steps to provide Effective Communication based on individual need."

ACH continually assesses all individuals for effective communication needs throughout their incarceration, recognizing that such needs may not always be fully identified at intake with limited information available. Because communication needs can emerge or evolve over time, ACH will reassess at different medical encounters to ensure effective communication support is provided when needed. As a result, steps are taken to provide effective communication based on individual need consistent with policy.

Additionally, upon an arrestee's initial interview with Classification, individuals are asked their preferred method of communication which is subsequently noted in ATIMS.

Both jail facilities are equipped with a VRI tablet. The tablet can be used at any time by staff to facilitate effective communication with our inmate population. One of the benefits of this system is access to a real time sign language interpreter in the event an inmate incarcerated in Sacramento County has a hearing impairment.

III.I.2 - Substantial Compliance

"The County's ADA policies shall include comprehensive guidance to ensure Effective Communication for prisoners with vision, speech, hearing, intellectual, learning, or other disabilities. The County shall, in consultation with Plaintiffs' counsel, ensure that sufficient guidance on the provision of Effective Communication is included in Jail custody and health care policies and procedures."

During this reporting period, ACH hired a nursing consultant recommended by the medical SME Angela Goehring to review/revise medical policies. This consultant assisted in revising the following ADA-related policies:

- 06-02 Patients with Disabilities
- 06-03 Effective Communication
- 06-04 Patients with Limited English Proficiency (formerly, Interpretation Services) - Sent to Medical SMEs for review.
- 06-06 Patients with Disabilities or Other Special Needs

The revised policies remain in compliance with the requirements within the Consent Decree; however, they have been revised to be more concise and simplified.

During this reporting period, SSO began a new update of SSO's inmate ADA policies (Incarcerated Persons with Disabilities and Aides to Impairment) into one single policy which includes the pre-approved components from Class Counsel and the Court-appointed SMEs. Like all other Consent Decree-related policy updates, Class Counsel and the Court-appointed SMEs will be consulted on any future revisions. This provision remains in substantial compliance

III.I.3 - Partial Compliance

"Standard for Provision of Effective Communication in Due Process Events and Clinical Encounters

a) A higher standard for the provision of Effective Communication shall apply in the following situations:

i. Due Process Events, including the following:

- *Classification processes*
- *Prisoner disciplinary hearing and related processes*
- *Service of notice (to appear and/or for new charges)*
- *Release processes*
- *Probation encounters/meetings in custody*

ii. Clinical Encounters, including the following:

- *Determination of medical history or description of ailment or injury*
- *Diagnosis or prognosis*
- *Medical care and medical evaluations*
- *Provision of mental health evaluations, rounds, group and individual therapy, counseling and other therapeutic activities*
- *Provision of the patient's rights, informed consent, or permission for treatment*
- *Explanation of medications, procedures, treatment, treatment options, or surgery*
- *Discharge instructions*

b) In the situations described in subsection (a), above, Jail staff shall:

i. Identify each prisoner's disability where there may be a barrier to comprehension or communication requiring reasonable accommodation(s);

ii. Provide effective reasonable accommodation(s) to overcome the communication barrier; and

iii. Document the method used to achieve Effective Communication and how the staff person determined that the prisoner understood the encounter, process, and/or proceeding."

Effective communication is utilized in all clinical encounters when needs are identified. As stated in III.I.1, ACH continually assesses all individuals for effective communication needs throughout their incarceration, recognizing that such needs may not always be fully identified at intake with the limited information available. Because communication needs

can emerge or evolve over time, ACH will reassess at different medical encounters to ensure effective communication support is provided when needed.

SSO's new policy and procedure will include language approved by Class Counsel and Court-appointed SMEs from the previous SSO Policies regarding effective communication for due process and clinical encounters. The Sheriff's Office recognizes prior deficiencies in the record keeping of these encounters. To address this issue, the Chief Disciplinary Hearing Officer (CDHO) will be tasked with ensuring all due process incidents include a statement from the hearing officer, if applicable. This provision remains in partial compliance while SSO and ACH work on documentation to demonstrate proof of practice.

III.I.4 - Substantial Compliance

"Effective auxiliary aids and services that are appropriate to the needs of a prisoner with Effective Communication needs shall be provided when simple written or oral communication is not effective. Such aids may include bilingual aides, SLIs, readers, sound amplification devices, captioned television/video text displays, Videophones and other telecommunication devices for deaf persons (TDDs), audiotaped texts, Braille materials, large print materials, writing materials, and signage."

Multiple devices for visual and hearing aids are available at both RCCC and Main Jail. A Video Relay Services (VRS) system provides Sign Language Interpretation (SLI), which is authorized through policy, as well as multiple spoken languages. Video visitation is in process. RCCC also employs telecommunications devices for deaf persons (TDD) and signage for hearing impaired inmates to communicate with friends and family. Bilingual aides are also available. The Main Jail has VRS & TDD SLI. Large print materials are available (for grievances, inmate kites, and the inmate handbook), reading glasses are given to all individuals who need or request them, and ACH assesses patients for hearing aids as part of a specialty service contract.

The VRI tablet is now stored in a centralized location for ease of access. Substantial efforts have been made to educate custody staff on the presence, use, and capabilities of the VRI tablet. In addition to the VRI, a VRS machine and multiple TTY machines are available for use throughout both jail facilities. This provision remains in substantial compliance.

III.I.5 - Substantial Compliance

"In determining what auxiliary aid service to provide, the County shall give primary consideration to the request of prisoner with Effective Communication needs."

RCCC and MJ offers a variety of auxiliary aids for inmates with effective communication needs and gives primary consideration to the request of the inmate. This is consistent with SSO policy and this provision remains in substantial compliance.

III.I.6 - Substantial Compliance

"Education providers (e.g., Elk Grove Unified School District) at the Jail will ensure Effective Communication for prisoners participating in education programs, including by providing necessary assistive equipment and take steps to accommodate learning strategies of those prisoner-students who have special needs, such as those with developmental, learning, vision, hearing, and speech disabilities."

SSO's Compliance Unit tracks inmates with special needs and works with the Elk Grove Unified School District (EGUSD) to provide accommodations. VRI has been used to assist in the past. Additionally, EGUSD has provided SSO with their policies (Regulation 6164.6 Identification and Education Under Section 504) related to ensuring free appropriate education to any student who has physical or mental impairments and providing reasonable accommodations as necessary.

Since the inception and distribution of tablets, individuals have been able to access educational classes independently. The ability to work at one's own pace, in a controlled and secured environment has allowed many more incarcerated persons to participate and complete courses and programs. These secured tablets are suitable for those with vision and hearing impairments, as well as those with learning disabilities as content can be accessed repeatedly and at a comfortable pace for the individual. An example of the classes provided on the tablet include:

1. Parenting Program: This program educates participants about the negative psychological and physical effects of harmful parenting on children. It offers strategies to develop nurturing behaviors and create a supportive family environment.
2. ABE/GED (Adult Basic Education / General Education Development): This course covers key academic subjects including math, English Language Arts (ELA), social studies, and science—aligned with the content assessed by the GED exam. Once participants complete practice tests and meet the requirements, they can take the official GED exam on-site.
3. Custodial Training: Participants in this course learn the fundamentals of custodial and housekeeping operations. Topics include janitorial equipment, basic repairs, cleaning materials, safety protocols, and training on handling blood-borne

pathogens and infectious waste. The program prepares individuals for custodial employment upon completion.

As the County has reviewed EGUSD's policies and found them to satisfy the requirements for this provision, the compliance rating for this provision has been increased to substantial compliance.

III.I.7 - Substantial Compliance

"The County shall assist prisoners who are unable to complete necessary paperwork (e.g., related to health care, due process, Jail processes) on their own with reading and/or writing as needed."

This is consistent with practices by ACH and SSO. SSO Policy "Incarcerated Persons with Disabilities" defines the guidelines for addressing the needs and rights of incarcerated persons detained by the Sheriff's Office in accordance with the ADA which includes helping inmates who need assistance with completing paperwork. This provision remains in substantial compliance.

III.I.8 - Substantial Compliance

"The County shall permit prisoners, including those who are illiterate, non-English speaking, or otherwise unable to submit written or electronic sick call requests, to verbally request care. Such verbal requests shall immediately be documented by the staff member who receives the request on an appropriate form and transmitted to a qualified mental health or medical professional for response in the same priority as those sick call requests received in writing."

It is County practice by SSO and ACH to allow verbal requests for care. ACH has designated a primary MA to work exclusively with SSO's Compliance Unit in assisting inmates who are illiterate, non-English speaking, or otherwise unable to submit written or electronic sick call requests. This liaison has proven to be invaluable in expediting care for all prisoners, and specifically those needing additional assistance with effective communication. Being able to initiate medical referrals on behalf of inmates has improved the level of service and speed at which these requests are received by ACH. The requirements of this provision are further documented in SSO policy and this provision remains in substantial compliance.

III.I.9 - Substantial Compliance

"The County shall post and disseminate notices, policies, job announcements, and other written material in alternative formats to promote Effective Communication."

Large information signs have been created and posted in all housing locations at both jail facilities. These posters include language related to the Consent Decree (in Spanish and English), PREA guidelines and resources, ADA information, medical care available, and cleaning protocols. This policy remains in substantial compliance.

III.J. Effective Communication and Access for Individuals with Hearing Impairments

III.J.1 - Substantial Compliance

"The County shall develop and implement a policy for newly arrived and newly identified prisoners with hearing disabilities to determine each prisoner's preferred method of communication."

During this reporting period, ACH hired a nursing consultant recommended by the medical SME Angela Goehring to review/revise medical policies. This consultant assisted in revising the following ADA related policies:

- 06-02 Patients with Disabilities
- 06-03 Effective Communication
- 06-04 Patients with Limited English Proficiency (formerly Interpretation Services) - Sent to Medical SMEs for review.
- 06-06 Patients with Disabilities or Other Special Needs

The revised policies remain in compliance with the requirements within the Consent Decree; however, they have been revised to be more concise and simplified.

SSO's ADA Coordinator has taken proactive steps to ensure any individuals coming into custody with hearing disabilities are identified immediately. Additional safeguards were put in place in the event there is a delay of communication between ACH and SSO regarding an arrestee's disability needs, including hearing disabilities, after the initial medical screening. The Compliance Unit has coordinated with Intake, Classification, and Property deputies to notify the Compliance Unit if they observe any accommodation needed by an inmate prior to their housing.

One of the mechanisms SSO utilizes to assist an individual with a hearing disability is the VRI device. Both the Main Jail and RCCC have a dedicated VRI tablet and have instructed custody staff in its use and capabilities. The VRI is utilized when an incarcerated

individual's preferred method of communication is sign language or when other languages are requested, and an on-site interpreter is not available. This provision remains in substantial compliance.

III.J.2 - Partial Compliance

"Qualified Sign Language Interpreters (SLIs) will be provided during intake and for due process functions, health care encounters, and Jail programming, when sign language is the prisoner's primary or only means of Effective Communication, unless the prisoner waives the assistance of an interpreter and/or delay would pose a safety or security risk.

a) *The County shall maintain a contract or service agreement with interpreter services in order to provide such services for deaf or hearing impaired prisoners. Jail staff will be informed of the availability of contract interpreter services.*

b) *Lip reading will not be the sole method of Effective Communication used by staff, unless the prisoner has no other means of communication.*

c) *In cases where the use of an SLI is not practicable, or is waived by the prisoner, Jail staff shall employ the most effective form of communication available.*

d) *The County will maintain a log of (a) when, for whom, and for what purpose an SLI was used; and (b) when, for whom, and why a SLI was not used for a prisoner with an identified need for SLI services (e.g., prisoner waived SLI or delay would have posed safety or security risk).*

e) *When a prisoner waives an SLI, the log must document (a) the method of communication of the waiver, and (b) the method staff used to determine that the waiver was knowing and freely given."*

Qualified SLIs are accessible and provided during Intake and health care encounters. The County maintains a contract with LanguageLine interpreter services and patients are informed of this service at all clinical encounters. The language line provides 24/7 interpretation services in a multitude of languages-including American Sign language. ACH utilizes video interpreting services for patients who need SLI. There are instances where written communication is initially used instead of SLI – often based on the individual's preference – and it may later be determined that a sign language interpreter is more appropriate to ensure effective communication.

All patient facing computers have a camera installed and a necessary icon to access the LanguageLine InSight application as of February 2024. ACH and ACMH received training on

the use of the LanguageLine. The training was provided by a representative of the LanguageLine. The training was recorded and is available to all staff via a shared drive. New medical staff are provided training as part of the onboarding process.

Since January 2025, the LanguageLine received 1,487 calls from ACH staff. Since January 2025, the language line received 1,110 audio calls and 388 video calls. 25 of the video calls required an American Sign Language interpreter.

MH utilizes tablets for all LanguageLine encounters. During the initial MH assessment, patients are asked preferred language for medical and mental health appointments, this is noted in the patient chart and a flag is created to alert all staff of the patient's preferred language.

Should SLIs be unavailable for custody-related communications, VRI tablets provide live interactive SLI services. The service is available 24/7 for use by custody staff for any procedure. The VRI tablet is located in a convenient, accessible location. VRI keeps a log by name and x-reference, spoken language and SLI on device. Feedback from Class Counsel indicated the County needs to log when individuals with hearing disabilities do not use SLI. Until this is fully tracked, this provision has been reduced to partial compliance.

III.J.3 - Substantial Compliance

"Jail Staff shall effectively communicate the contents of the Inmate Handbook and other materials providing information on Jail rules and procedures to all prisoners to be housed in the Jail who are deaf or hard of hearing. For those prisoners for whom written language is not an effective means of communication, Jail Staff may meet this obligation by providing a video of an SLI signing the contents of the Inmate Handbook, along with appropriate technology for viewing, or by providing an SLI to interpret the contents of the Inmate Handbook to the prisoner who is deaf or hard of hearing."

At RCCC and MJ, all inmates are provided with a copy of the inmate handbook however, there is no video with an SLI signing the contents. Assistance is provided by staff as necessary with the use of the VRI tablet, which is currently in use at both jail facilities. Its capabilities include over 250 languages including ASL. It can be used for inmates with hearing-related disabilities as well as provide interpretation services for those not fluent in English. An orientation video plays on a loop in the Main Jail's booking area. While this video does not reflect all aspects of the inmate handbook, critical information is displayed regarding jail operations and access to specialty services. The video is played with closed captioning on, to assist those who may have a hearing disability or spoken language processing challenges. Auditory orientation materials are relayed by Property deputies to

inmates prior to their movement to a floor for housing. This provision remains in substantial compliance.

III.J.4 - Substantial Compliance

"The County shall, within 12 months from court approval of the Settlement, make Videophones available for deaf and hard of hearing prisoners. The Videophones shall provide for calls through the use of Video-Relay Services (VRS) at no cost to deaf and hard of hearing prisoners or for calls directly to another Videophone."

There is a VRS/VRI system installed at RCCC and VRS at Main Jail. The VRS is provided at no cost to inmates and is available at all times, at both facilities. Despite not being assessed by the SME during the last ADA report, this requirement has been met for over a year and remains in substantial compliance.

III.J.5 - Partial Compliance

"Deaf/hard of hearing prisoners who use telecommunication relay services, such as Videophone or TDD/TTY machine, in lieu of the telephone shall receive equal access to the Videophone or TDD/TTY services as non-disabled prisoners are afforded for regular telephone usage."

The Main Jail has 2 TTY machines and a VRS machine located on 2 East available for use for all inmates. The TTY machines are checked out to specific individuals while in custody. The TTY machine are left within the Control Rooms for storage and charging capability. Inmates have access to use these services while on dayroom. At RCCC, the TTY process is the same. RCCC has two VRS machines (one in SBF for males and one in SLF for females). Inmates are not given a time limit when using the VRS.

SSO recently discovered a deficiency in this process when a deaf arrestee was temporarily held in booking. Due to the arrestee not yet establishing log-in information for the phone provider, the arrestee was unable to have access to free calls from the holding tank. SSO is in the process of exploring ways to expand TTY services to the Main Jail's booking area to prevent this unfortunate circumstance from occurring in the future. Until SSO can ensure equal access to TTY and VRS devices throughout the entirety of an individual's stay, this provision has been reduced to, and will remain in, partial compliance.

III.J.6 - Substantial Compliance

"The County shall provide deaf/hard of hearing prisoners with additional time for calls using telecommunication relay services, such as a Videophone or TDD/TTY, to account for

the fact that signed and typed conversations take longer than spoken conversations. The County shall document the time that each prisoner uses and has access to such equipment."

The County continues to allow unlimited telephone time. Despite not being assessed by the SME during the last ADA report, this requirement has been met for over a year and remains in substantial compliance.

III.J.7 - Partial Compliance

"Prisoners who require an SLI as their primary method of communication shall be provided an SLI for education, vocational, or religious programs and services."

SSO is exploring the specific requirements of this provision specifically regarding how having an SLI for an inmate during all educational, vocational, or religious programming can be feasibly implemented. As part of the feasibility study, SSO will attempt to determine the mechanism required to demonstrate proof of practice. Until this is demonstrated, the provision has been reduced to partial compliance.

III.J.8 - Partial Compliance

"Public verbal announcements in housing units where individuals who are deaf or hard of hearing reside shall be delivered on the public address system (if applicable) and by flicking the unit lights on and off several times to alert prisoners that an announcement is imminent. This includes announcements regarding visiting, meals, recreation release and recall, count, lock-up, and unlock. Verbal announcements may be effectively communicated via written messages on a chalkboard or by personal notification, as consistent with individual need. These procedures shall be communicated to prisoners during the orientation process and also shall be incorporated into relevant policies and post orders."

Consistent with SSO policies and procedures, custody staff take all reasonable steps to effectively communicate with incarcerated persons with disabilities during emergencies or alarms while in custody. All control points shall post notices for emergency and fire exit routes. Jail facilities are equipped with visual alarms appropriate for individuals who are deaf or hard of hearing, that comply with relevant fire code regulations. Verbal announcements in housing units where individuals who are deaf or hard of hearing are housed shall be delivered on the public address system (if applicable) and by flicking the unit lights on and off several times to alert incarcerated persons that an announcement is imminent.

Through ATIMS, SSO staff can identify the incarcerated persons with disabilities who may require accommodation during an alarm or emergency. Staff members in the housing units remain aware of which individuals are deaf or hard of hearing to ensure that effective communication is provided and incarcerated persons are made aware of verbal announcements, including announcements for visiting, meals, recreation, count, lock-up, and unlock. Procedures are also communicated during the orientation process (See Incarcerated Persons Handbook and Orientation Policy).

SSO is working with ATIMS to develop a report that identifies incarcerated persons with disabilities by housing facility. Once this report is completed, it will be regularly run and posted at control points throughout both facilities so that information about incarcerated persons with disabilities who may require accommodation is readily available to staff during an alarm or emergency. Until the ATIMS report is developed, this provision has been reduced to partial compliance.

III.K. Disability-Related Grievance Process

III.K.1 – Substantial Compliance

"The County shall implement a grievance system for prisoners with disabilities to report any disability-based discrimination or violation of the ADA, this Remedial Plan, or Jail ADA-related policy, and shall provide a prompt response and equitable resolution in each case."

ACH has a grievance process as outlined in policy approved by Class Counsel and court-appointed SMEs where patients with disabilities can report any disability-based discrimination or violation of the ADA, the Consent Decree, or ACH's ADA policy. During this reporting period, ACH onboarded a supervising registered nurse (SRN) who is assigned as the grievance coordinator. With the assistance of an RCCC SRN, the grievance coordinator is responsible for collecting, triaging, and responding to grievances within policy time frames. This individual is also responsible for tracking the lifespan of each grievance and appeals. With the onboarding of this SRN, ACH significantly improved its ability to consistently provide a "prompt response" to each grievance.

In 2024, the Main Jail began entering all grievances into the ATIMS system. RCCC began using the ATIMS grievance module in January of 2025. This implementation enables SSO's Compliance Unit to assign a tracking number to each grievance, including those related to the ADA, allowing for electronic monitoring. Initially, there was a slight backlog of grievances during the early stages of this process. However, the Main Jail is now compliant with grievance management, with only a few cases currently under investigation. All ADA-

related grievances are addressed by the Compliance Unit as quickly as possible. Information is posted in all housing units advising inmates of the ADA Hotline numbers at each facility to assist those inmates that may have difficulty communicating in writing. Given the improvements by ACH and SSO in this area, this provision has been increased to substantial compliance.

III.K.2 - Partial Compliance

"The County shall ensure that the grievance procedures are readily available and accessible to all prisoners.

a) *The County shall make reasonable efforts to ensure all prisoners are aware of the disability grievance procedures, including the availability of accommodations and staff assistance to submit a grievance and/or appeal.*

b) *The County shall ensure the prisoners with disabilities have meaningful access to grievance forms, including through provision of staff assistance and large print materials."*

The inmate handbook is provided to all incarcerated individuals and explains the grievance process. All inmates can request grievance forms, including large-print versions.

For medical grievance processes, ACH reviews and updates the handbook prior to each revision to ensure all pertinent medical information is included. ACH has grievance forms available in each pod. As staff collect grievances daily, they ensure forms are re-stocked. To allow for secure submission, confidential grievance lockboxes are also in each pod.

SSO is exploring updates to inmate correspondence (Kites & Grievances) to include a designation showing whether assistance was provided in filling out the applicable form and by whom. Until sufficient data is collected to properly analyze these encounters, this provision has been reduced to, and will remain in, partial compliance.

III.K.3 - Partial Compliance

"Response to Grievances

a) *The County shall develop and implement an ADA grievance process that includes (1) a reasonable timeline for response to ADA-related grievances and appeals, including an expedited process for urgent ADA grievance (e.g., involving prisoner safety or physical well-being); and (2) provision for interim accommodations pending review of the individual's grievances/appeals.*

b) *The County shall ensure that prisoners with communication needs are interviewed and provided assistance as part of the grievance/appeal process where necessary to ensure meaningful access and Effective Communication.*

c) *The County shall document each denial of a reasonable accommodation request and shall record the basis for such determination.*

d) *The County shall provide in writing a copy of the grievance (or appeal) response to the prisoner, including the resolution, the basis for a denial (if applicable), and the process for appeal.*

e) *The County shall ensure that completed grievance responses are effectively communicated to prisoners with disabilities."*

The grievance policy and forms were substantially revised based on medical SME feedback. Key additions include immediate review of each grievance by a nurse and immediate action when indicated, specific time frames for requesting and responding to appeals, and more detail on the grievance and appeal forms.

During this reporting period, ACH onboarded an SRN assigned as the grievance coordinator. With the assistance of an RCCC SRN, the grievance coordinator is responsible for collecting, triaging, and responding to grievances timely. They are also responsible for tracking the lifespan of each grievance and appeals. Progress on grievance response time frames has improved and the backlog of grievances has been addressed. With the backlog addressed, ACH staff are currently meeting the 14-day time frame.

All grievances, including ADA grievances and responses are now electronically stored. Grievance forms are two pages in length. A pink copy is to be kept by the inmate after a deputy signs the receipt for their records. The white copy is sent to the Compliance Unit for tracking and documenting. All custody grievances are uploaded and tracked through ATIMS which alerts approaching deadlines for responses and appeals increasing response times to the 14-day time frame. All responses to grievances, including reasons for denial, are fully documented within ATIMS. Inmates are provided a hard copy of their grievance response at the conclusion of the process.

The grievance tracking process allows the Compliance Unit to assign a tracking number to each grievance, including those that are ADA-related, for electronic monitoring. Each grievance is forwarded to the appropriate department for follow-up and is addressed following an internal review, investigation, or action by a supervisor. SSO recognizes the need to better address effective communication as it relates to the grievance

process/appeals and is looking at ways to show proof of practice. Until this occurs, this provision remains in partial compliance.

III.K.4 - Partial Compliance

"The submission, processing, and responses for disability-related grievances and complaints shall be tracked."

A medical grievances tracking system is in place and overseen by the ACH SRN grievance coordinator. The SRN grievance coordinator provides a report of the grievance tracking data to the ACH QI team monthly. The data for each monthly report is about the grievances tracked two months prior. For example, the June report will be about data from April. The ACH QI and the grievance coordinator will work together to monitor ACH medical and mental health grievances to identify opportunities for improvement. ACH and SSO custody staff continue to discuss an electronic grievance form process which will support more accurate tracking.

SSO logs all grievances into the ATIMS system. This allows Compliance to assign a tracking number to each grievance, including those related to the Americans with Disabilities Act (ADA), enabling electronic monitoring. Each grievance is routed to the appropriate entity for follow-up and is addressed after an internal review, investigation, or appropriate action is taken. All timelines including submission, processing and response times are electronically documented in ATIMS.

In the most recent SME report, Class Counsel referenced several deficiencies based on missing data in the tracking logs provided to them. It is unclear how these grievances were omitted from the tracking log as limited information was provided by Class Counsel, but SSO will investigate the matter promptly. Until SSO can confirm tracking data is accurately being captured and relayed, this provision remains in partial compliance.

III.L. Alarms/Emergencies

III.L.1 - Partial Compliance

"The County shall ensure that all written policies regarding alarms and emergencies contain mandatory provisions to accommodate prisoners with disabilities."

SSO Policy "Facility Emergencies" includes language regarding accommodations for prisoners with disabilities during alarms and emergencies. However, in the most recent ADA SME report, Class Counsel noted that the policy lacks specific language related to effective communication methods and support for mobility-related disabilities during such

events. While the policy does acknowledge the need for enhanced notifications and assistance for inmates requiring accommodations, the Sheriff's Office agrees that more detailed language may be necessary to achieve substantial compliance with this provision. The Compliance Unit plans to collaborate with Class Counsel in the next reporting period to revise the policy accordingly. Until those updates are made and the revised policy is published, this provision has been reduced to partial compliance.

III.L.2 - Partial Compliance

"The County shall implement written policies regarding the expectations of staff as to prisoners with identified disabilities during emergencies and alarms, including as to disabilities that may affect prisoners' ability to comply with orders or otherwise respond to emergencies and alarms. For example, the policies shall ensure appropriate handling of prisoners with mobility-related disabilities who are unable to prone or take a seated position on the ground during an alarm or emergency. Such policies shall be communicated to staff, incorporated into the relevant Operations Orders, and communicated to prisoners with disabilities using Effective Communication."

SSO Policy "Facility Emergencies" describes the expectations of staff for prisoners with identified disabilities during emergencies and alarms. Based on feedback from Class Counsel in the recent ADA SME report (see III.L.1), this provision has been reduced to partial compliance pending policy revisions.

III.L.3 - Partial Compliance

"The County shall implement written policies for staff regarding communicating effectively and appropriately with prisoners who have disabilities that may present barriers to communication during emergencies or alarms."

Per SSO Policy "Facility Emergencies, Alarms During Emergencies for Inmates Incarcerated with Disabilities," SSO correctional facilities are equipped with visual alarms appropriate for individuals who are deaf or hard of hearing, that comply with relevant fire code regulations. Verbal announcements in housing units where individuals who are deaf or hard of hearing are housed shall be delivered on the public address system (if applicable) and by flicking the unit lights on and off several times to alert incarcerated persons that an announcement is imminent. Based on feedback from Class Counsel in the recent ADA SME report (see III.L.1), this provision has been reduced to partial compliance pending policy revisions.

III.L.4 - Partial Compliance

"In order to facilitate appropriate accommodations during alarms or emergencies, the County shall offer, but shall not require, individuals who have disabilities visible markers to identify their disability needs (e.g., identification vests). The County shall maintain a list, posted in such a way to be readily available to Jail staff in each unit, of prisoners with disabilities that may require accommodations during an alarm or emergency."

In January of 2025, the Compliance Unit began offering high visibility vests with each ADA assessment completed. These vests are used for incarcerated persons to wear while outside of their cells and/or during alarms and emergencies for easy identification by staff. Each vest is labeled as "Vision Impaired", "Hearing Impaired", or "Mobility Impaired".

In July of 2025, a new medical flag was created in ATIMS to clearly indicate whether an inmate has ADA equipment. This flag enhances SSO's awareness regarding the jail's population with impairments and the need for accommodations when necessary.

This provision has been reduced to partial compliance as the Sheriff's Office recognizes the need to have a physical list displayed in each housing unit of those inmates potentially needing accommodations during an alarm or emergency. Moving forward, the Compliance Unit will ensure each housing facility has that list posted in the control room, so it is readily available if needed. Once proof of practice is shown, this provision may be increased to substantial compliance.

III.L.5 - Substantial Compliance

"The County shall install visual alarms appropriate for individuals who are deaf or hard of hearing, which shall comply with relevant fire code regulations."

At all jail facilities, visual alarms are currently installed compliant with relevant fire code regulations. This provision remains in substantial compliance.

III.L.6 - Substantial Compliance

"All housing units shall post notices for emergency and fire exit routes."

Emergency and fire exit routes are posted in all housing units at both facilities. This provision remains in substantial compliance.

III.M. Searches, Restraints, and Extractions

III.M.1 - Substantial Compliance

"The County shall modify its written policies to ensure that prisoners with mobility impairments, including those with prosthetic devices, receive reasonable accommodations with the respect to the following: (1) Pat searches and unclothed body searches; (2) Application of restraints devices, including Pro-Straint Chair; and (3) Cell extractions."

Various Sheriff's Office policies and procedures addresses the use of restraints on individuals with mobility impairments; this provision remains in substantial compliance. Applicable verbiage in these policies is listed below.

- "Searches": Pat-Down Searches – Incarcerated Persons with Mobility Impairments
    - "Deputies shall take reasonable measures to accommodate incarcerated persons/arrestees with mobility impairments during pat-down searches including those with prosthetic devices."
    - Deputies are trained that reasonable measures may include pat searching arrestees in their wheelchair or assisting them to a standing position to complete the search. Arrestees with a cane can use the cane during the pat search for stability, or they can be placed in a stationary chair or a temporary wheelchair. Prosthetics are treated similarly. The device is inspected by deputies for contraband, then returned to the arrestee, and then the pat search is conducted. If the arrestee is blind, booking deputies slowly and effectively walk the arrestee through the intake process. For deaf or hard of hearing individuals, the booking deputies walk the arrestee through the intake process and demonstrate to the arrestee what is required during the process.
- "Use of Restraints": Incarcerated Persons with Disabilities Requiring Communication Through Sign Language, Hand Gestures, or Written Notes
    - "Incarcerated persons with disabilities who communicate through sign language, hand gestures, or written notes (e.g., Deaf/hard of hearing) must be accommodated with respect to restraints, including to ensure that they are able to effectively communicate. Accommodations may include handcuffing in front or removing handcuffs during communications, as consistent with individualized security considerations. SSO no longer uses a Pro-Straint Chair."

- "Custody Emergency Response Team (CERT) and Force Application on Incarcerated Persons": Immediate and Coordinated Use of Force Response
    - "When conducting a coordinated planned use of force involving an incarcerated person with a known mental health or intellectual disability, absent an immediate threat to safety, Sheriff staff shall employ de-escalation methods that consider the incarcerated person's mental health or adaptive support needs. Where there is not an immediate threat to safety, staff shall provide for a "cooling down period," consistent with safety and security needs. This period shall include the involvement of mental health staff (and other staff if appropriate) to de-escalate the situation and to reach a resolution without use of force. Such efforts, including the use of adaptive supports, must be documented."
    - "Medical and/or mental health staff should be consulted if the purpose of the cell extraction is related to the delivery of treatment."

With the modified policies and explanatory examples provided, this provision remains in substantial compliance.

III.N. Transportation

III.N.1 - Substantial Compliance

"The County shall provide reasonable accommodations for prisoners with disabilities when they are in transit, including during transport to court or outside health care services."

The Main Jail and RCCC each have one ADA transport vehicle. These vehicles are used to transport inmates with mobility disabilities to medical appointments, hospital visits, Court hearings, or any other transportation that is needed where the ADA vehicles' abilities can be utilized. In the rare event both ADA vans are already being used, the Courthouse has an additional ADA van which can be used for custody transports.

Every effort is made by the Sheriff's Office transportation units to provide reasonable accommodations for inmates with disabilities while they are being transported to Court or outside medical appointments. During this reporting period, the Sheriff's Office recognized training deficiencies relating to securing wheelchairs properly during transport outside of the jails. A comprehensive training video was created and disseminated to jail staff which demonstrated the necessary steps required during a wheelchair transport.

While there were two identified incidents during this reporting period regarding wheelchair transports from the Main Jail, hundreds of other transports of inmates with disabilities

were accomplished without incident. Based on the sheer volume of successful transports in comparison to those two events, this provision remains in substantial compliance.

III.N.2 - Partial Compliance

"Prescribed HCAs/ADs/DME, including canes, for prisoners with disabilities shall be available to the prisoner at all times during the transport process, including in temporary holding cells, consistent with procedures outlined in Part VII."

SSO does not remove prescribed HCAs/ADs/DME from inmates during transport or temporary housing in a holding cell. This requirement will be specifically referenced in the revised and consolidated Incarcerated Persons with Disabilities policy, once published. This provision has been reduced to partial compliance pending publication of the updated policy.

III.N.3 - Substantial Compliance

"The County shall use accessible vehicles to transport prisoners in wheelchairs and other prisoners whose disabilities necessitate special transportation, including by maintaining a sufficient number of accessible vehicles."

The Main Jail, RCCC, and the Courthouse each have an ADA transport vehicle. Custody staff, including medical transport, coordinate to ensure an ADA vehicle is available as needed. If a vehicle is not accessible, all three entities can work together and borrow from each other to ensure the inmate is accommodated. This system is designed to be flexible, allowing SSO to handle unexpected situations as they arise. In a rare circumstance where an ADA vehicle is not available for unplanned transport of an ADA inmate, SSO can utilize ambulance transport if the situation warrants it. Although Class Counsel did not evaluate this provision during their most recent status report, this provision remains in substantial compliance.

III.N.4 - Substantial Compliance

"Prisoners with mobility impairments shall be provided assistance onto transport vehicles."

Consistent with SSO policy, incarcerated persons with mobility impairments or other relevant disability-related needs are provided assistance on and off the transport vehicles, and as needed during the transport process. This provision remains in substantial compliance.

III.O. Prisoners with Intellectual Disabilities

III.O.1 - Substantial Compliance

"The County shall, in consultation with Plaintiffs' counsel, develop and implement a comprehensive written policy and procedure regarding prisoners with an Intellectual Disability, including:

a) *Screening for Intellectual Disabilities;*

b) *Identification of prisoners' adaptive support needs and adaptive functioning deficits; and*

c) *Monitoring, management, and accommodations for prisoners with Intellectual Disabilities."*

The Nurse Intake policy and Mental Health Adaptive Support Program (ASP) policy were completed with approval with Class Counsel and the Court-appointed experts. As part of the Intake Health Screening, Nursing gathers information through screening, past history, self-identification, third party report or observation noting possible intellectual disability and refers patients identified to mental health staff for an assessment and treatment plan. However, on rare occasions, some intellectual disabilities, particularly those that are mild and previously unidentified, can be difficult to recognize during intake and may not become apparent until later. ACH and SSO work closely together to refer an individual for an assessment with ACMH when there are concerns.

This provision is addressed in the SSO policy pertaining to inmates with intellectual disabilities. With the existence of these policies, this provision remains in substantial compliance.

III.O.2 - Partial Compliance

"A multidisciplinary team that includes appropriate health care staff will monitor and ensure appropriate care for prisoners with an Intellectual Disability. The multidisciplinary team will develop an individualized plan for each prisoner with an Intellectual Disability, which addresses: (1) safety, vulnerability, and victimization concerns, (2) adaptive support needs, (3) programming, housing, and accommodation needs. The multidisciplinary team's plan will be regularly reviewed and updated as needed."

In March 2025, the mental health SME approved updated training for SSO on Effects of Brain Development in Forensic Settings and all deputies are trained at time of onboarding/orientation. In February 2025, ACMH implemented every two-year ASP,

Montreal Cognitive Assessment (MoCA) and Brain Development refresher training for clinicians. In April 2024, per the mental health SME recommendation, ACMH added ID specific items to the Multidisciplinary treatment team (MDT) audit and integrated the findings in QI studies. Per the mental health SME recommendation, ACMH now includes ID as a component of the Rule Violation Review (RVR) and Use of Force (UOF) review/QI. The ASP form meets the requirements of this provision.

All SSO custody staff received training on the MH ASP process which includes topics surrounding brain development and intellectual disabilities.

This provision remains in partial compliance pending the initiation of a formalized MDT process.

III.O.3 - Substantial Compliance

"Prisoners with an Intellectual Disability assigned to a work/industry position will be provided additional supervision and training as necessary to help them meet the requirements of the assignment."

SSO Policy "Incarcerated Persons with Disabilities" was published and outlines accommodations for workers with disabilities. There is no requirement under III.O.3 that the jail identify workers with disabilities. As mentioned under III.H.6, many workers with disabilities are assigned positions. Individuals with disabilities are not actively sought out to provide employment opportunities, rather they are given the same opportunity for positions as any other inmate. These same individuals are not restricted and denied access to employment. In fact, the Main Jail does have inmates specifically on the 3rd floor and Women's floors working as POD workers with developmental disabilities, SMI, and actively on ACMH mental health caseloads. No evidence has been provided demonstrating that inmates are "being improperly excluded" or "are not receiving reasonable accommodations." This provision remains in substantial compliance.

III.P. ADA Training, Accountability, and Quality Assurance

III.P.1 - Partial Compliance

"The County shall ensure all custody, health care, facility maintenance, and other Jail staff receive ADA training appropriate to their position.

a) *The County shall provide to all staff appropriate training on disability awareness, including the use and purpose of accommodations and modifications in accordance with the ADA.*

b) *The ADA training shall include: formalized lesson plans and in-classroom or virtual training for staff (including managers, supervisors, and rank-and-file staff) provided by certified or otherwise qualified ADA trainers."*

During this reporting period, ACH onboarded a nurse educator who is assigned to ensure compliance and tracking in all required trainings. All staff are required to take an ADA/effective communication training during onboarding with the approved ADA and EC Training and Documentation PowerPoints. This provision will increase to substantial compliance when the nurse educator can demonstrate proof of practice in this area.

Every single SSO deputy is POST certified and CA POST requires sworn staff to complete training on Learning Domain 37: People with Disabilities. Topics covered include disability laws, intellectual and developmental disabilities, physical disabilities, and mental illness. Following each chapter, recruits must respond to various scenarios that require applying the material reviewed and learned in that chapter.

New custody personnel (sworn and non-sworn) receive 79 hours of Jail Operations training which incorporates aspects of the ADA requirements. SSO acknowledges the overall intent of this training is not specifically focused on ADA law. However, the ADA coordinators at both facilities are developing a more specific and robust ADA/effective communication component to Jail Operations training to fulfill the requirements listed in this provision.

In May 2024, SSO's Compliance Unit attended the Virtual National ADA Symposium. Some of the topics covered were as follows:

- What the Chit?: The Impact of ADA on Corrections, Part I
- What the Chit?: The Impact of ADA on Corrections, Part 2
- Building Blocks to Effectively Respond to Court Disability Related Challenges & Difficult Situations
- High Risk Court Users: Tapping into the Value of Support Person as a Critical ADA Accommodation

In May 2025, the Compliance Unit again attended the Virtual National ADA Symposium. Some of the topics covered were as follows:

- Law Enforcement - Best Practices to Ensure Access & Safety for All
- A Comprehensive Guide to Ensuring Equitable Access to Court Users w/ Disabilities
- Criminal Justice within the Deaf & Disabled Community: Current Research & Future Needs
- Detention, Corrections & Courts: Do's & Don'ts

- Becoming a 'Game Changer' ADA Coordinator
- ADA Considerations & Best Practices for Virtual Meetings & Webinars
- Making Digital Geographic Maps ADA Compliant & Inclusive
- Role of the ADA Coordinator: Practical Strategies & Tips for Success
- ADA & Effective Communication: Title II & Title III
- Emergency Preparedness
- Religious Entities and the ADA
- Service Animals

This ADA-specific training is attended by the Compliance Unit yearly.

III.P.2 - Partial Compliance

"ADA instructors shall have appropriate ADA training and subject matter expertise necessary to effectively provide ADA training to staff."

As identified in III.P.1, every SSO deputy is POST certified, a requirement by CA POST for sworn staff to complete training on Learning Domain 37: People with Disabilities. This training covers a variety of topics, including disability laws, intellectual and developmental disabilities, physical disabilities, and mental illness. The instructor for this Learning Domain is also POST certified and has attended numerous trainings in this area. However, SSO is currently seeking specific guidance from the Class Counsel on what specifically qualifies an ADA instructor. Until agreement is reached on this topic, this provision has been reduced to partial compliance.

III.P.3 - Partial Compliance

"The County shall, in consultation with Plaintiffs' counsel, develop and implement written policies and procedures regarding monitoring, investigating, and tracking staff violations (or allegations of violations) of ADA requirements and Jail ADA policies."

ACH has, in consultation with Class Counsel, developed and implemented written policies and procedures regarding monitoring, investigating, and tracking staff violations (or allegations of violations) of ADA requirements and jail ADA policies. Alleged staff violations of ADA requirements are captured through the grievance process. A grievances tracking system is in place and overseen by the ACH SRN grievance coordinator. The SRN grievance coordinator provides a report of the grievance tracking data to the ACH QI team monthly. The ACH QI and the grievance coordinator will work together to monitor ACH medical and mental health grievances to identify opportunities for improvement, including allegations of staff violations. These allegations are investigated in the grievance response process. If

the allegations are found to be substantiated, the violation will be addressed within the guidelines of the progressive discipline system.

For SSO, monitoring, investigating, and tracking of staff ADA violations or allegations is done through the grievance process. Grievances are reviewed by the Compliance sergeant.

The County has reduced its rating to partial compliance pending follow-up discussions with Class Counsel to improve or update the written policies and procedures referenced in this provision.

III.P.4 - Substantial Compliance

"The County shall develop an ADA accountability plan that will ensure quality assurance and establish staff accountability for egregious, serious, or repeated violations of the ADA and Jail ADA-related policies and procedures."

ACH has created an ADA Accountability Plan and has established ADA related audits and patient grievances concerning ADA related issues as methods for identifying violations of policy (see III.P.3).

For SSO, in the event an incarcerated person files a complaint/grievance about their ADA related needs not being met, Compliance Unit personnel expeditiously investigate the claim and make every effort to resolve the issue. If an allegation is levied regarding egregious, serious, and repeated violations of the ADA and jail related ADA-Policies, an internal investigation into the matter will be conducted consistent with SSO policy.

As grievance response timelines are now met and concerns are addressed in a timely manner, this provision is being increased to substantial compliance.

III.Q. Accessibility Remedial Plan to Address Physical Plant Deficiencies

III.Q.1 - Partial Compliance

"The County shall, within 24 months from court approval of the Settlement and in consultation with Plaintiffs' counsel, develop and fully implement an Accessibility Remedial Plan to address Jail physical plant deficiencies that result in access barriers for prisoners with disabilities. In the interim, the Sheriff's Office shall house prisoners with disabilities in the most integrated and appropriate housing possible, providing reasonable accommodations and assistance where necessary to ensure appropriate accessibility to Jail programs, services, and activities."

Correctional staff use a flag system within ATIMS to identify incarcerated individuals with disabilities who require specific accommodations. These flags guide housing and placement decisions so that assignments are suited to each individual's disability-related needs. Admissions to and discharges from acute and sub-acute medical housing units are managed by ACH in coordination with Classification. When ACH determines an individual does not need or is discharged from an acute or sub-acute medical housing unit, Classification places that person in an appropriate housing location to best meet their ADA needs. Reasonable accommodations are provided as needed to ensure access to jail programs, services, and activities, and program schedules are structured to allow equitable opportunities to participate in out-of-cell activities.

Identification of disabilities begins at intake during the medical screening process. After Adult Correctional Health records an identified ADA need in the ATHENA system, a corresponding flag is transferred into ATIMS. When Classification staff identify an individual who may require ADA accommodations, they provide notification to the Compliance Unit. The Compliance Unit follows up on these referrals and works to ensure any identified ADA-related needs are addressed.

Assessment of ADA needs is not limited to the intake and booking process. Throughout an individual's incarceration, ACH staff review and adjust disability-related accommodations as medical needs change. Custody staff also monitor for signs that an incarcerated individual may have unmet medical needs and facilitate referrals to ACH for follow-up.

Due to facility space limitations, this provision remains in partial compliance. Recent steps and planning are underway to address jail physical plant deficiencies. The County is seeking the most economical solution to achieving compliance with the Mays Consent Decree and in turn better meet the needs of the County inmate population.

In accordance with concerns expressed by the Court at the March 2025 status conference, the County acted swiftly in response to the direction from the Board of Supervisors based on the findings and recommendations from CGL Companies regarding the need for jail facility master planning. The recently executed contract with Health Management Associates (HMA) for correctional services master planning will provide the County Board of Supervisors with a range of options and associated cost estimates, including but not limited to current facility remodel, expansion of existing facilities, proceeding with the IHSF design, new construction options with site selection analysis and recommended project delivery methods, project timelines associated with each option and financing options.

The County collaborated with Class Counsel and Court-appointed SMEs to draft the proposed scope of work for the operations assessment and space planning. The scope of work outlined in HMA agreement includes: (1) the inspection, assessment, inventory, and analysis of existing County facilities, (2) a population analysis, (3) operations assessment with a focus on compliance with the Consent Decree requirements for ADA, mental health and health care of the inmate population, and (4) space planning and assessment. The goal for this Master Planning process is to provide the County with feasible, actionable options in a ranked order based on input from the Jail System Planning/Compliance Oversight Committee, a formalized and structured version of the Policy Group created in 2024. The Committee's work will enable the County Board of Supervisors to select the best option for enhancing the functionality of the County's jail system and improving the justice system outcomes in consideration of available financial options. It is estimated the Master Planning process would be complete within twelve to eighteen months from the execution of the agreement.

Additional information about the ADA and facility remediation plans, including a description of the RFQ process and timeline used to reach the agreement with HMA, is provided in provision III.G.2.

III.Q.2 - Non-Compliance

"The Accessibility Remedial Plan shall ensure the following:

a) *Adequate provision of accessible cells and housing areas with required maneuvering clearances and accessible toilet fixtures, sanitary facilities, showers, dining/dayroom seating, and recreation/yard areas.*

b) *Accessible paths of travel that are compliant with the ADA.*

c) *Equal and adequate access for all prisoners with disabilities to Family and Attorney Visiting areas in reasonable proximity to their housing location."*

Note: The previous County Status Report (10th Report – January 2025) previously identified III.Q.2.c as III.Q.3. This has been corrected with this report.

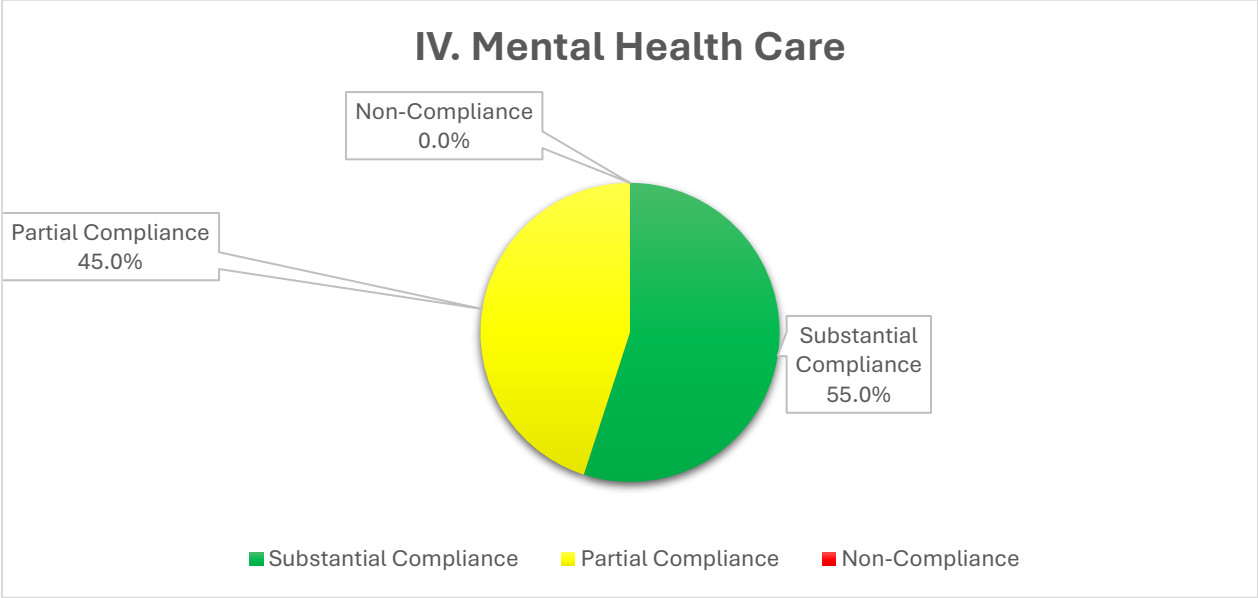
Due to facility space limitations, substantial compliance in this provision cannot be met without significant construction, and planning efforts for this work are ongoing. Work to develop long-term plans as well as interim/temporary remedies are ongoing through collaboration between SSO, ACH, DGS, Class Counsel, Court-appointed SMEs, and other stakeholders. Efforts toward facility remediation and facility planning are described in

III.G.2 and III.Q.1. While this provision remains in non-compliance, efforts are being made to provide appropriate housing and access to services to the extent possible.

Regarding III.Q.2.a, to assist with offering accessible access to showers, all SSO RCCC housing units have shower chairs available. Any inmate can request the chair from their control point. At RCCC, most dorm toilets have accessible bars. All RCCC yards are on the first floor and do not require steps.

Regarding III.Q.2.c, at RCCC, legal visitation areas provide equal and adequate access for inmates with disabilities. RCCC social visitation areas provide inmates with disabilities the same opportunity to visit with their family. SSO has recognized the limited number of wheelchair accessible attorney visit rooms at the Main Jail. Previously, only one attorney visiting area at the Main Jail was wheelchair accessible. Last year, an additional attorney visit booth was modified in the jail's bottom floor to allow wheelchair access. Two social visit booths at the Main Jail may be accessed without stairs (located on the 2-East housing unit).

IV. Mental Health Care



The County has identified 40 provisions in Remedial Plan IV. Mental Health Care. For this 11th County Status Report, the compliance ratings are as follows:

- Substantial Compliance: 22 provisions (55%)
- Partial Compliance: 18 provisions (45%)
- Non-Compliance: 0 provisions (0%)

Monitoring Status

Remedial Plan IV. Mental Health Care is monitored by Dr. Mary Perrien, whose latest report was "Mental Health Expert's Fourth Round Report of Findings", dated May 1, 2024. Dr. Perrien has not monitored the County's compliance with any mental health provisions since July 31, 2024, and is currently finalizing her report from the reporting period February 1 through July 31, 2024. The County has reviewed a draft version of Dr. Perrien's 5th Mental Health Monitoring Report; however, as of the writing of this County Status Report, a final version of Dr. Perrien's report has yet to be received by the County. As such, the County is unable to address any concerns raised during this reporting period by Dr. Perrien.

In comparison to the County's self-assessed ratings, the Court-appointed monitors' compliance ratings are as follows:

- Substantial Compliance: 4 provisions (10%)
- Partial Compliance: 33 provisions (82.5%)

- Non-Compliance: 0 provisions (0%)
- Not Assessed: 3 provisions (7.5%)

Attachment 4, Mental Health Care Remedial Plan Expert Rating Reconciliation, aligns the Court-appointed monitor's compliance ratings with the provision structure used here and shows how the County's compliance ratings compare to those of the assigned monitor.

Self-Assessment

IV.A. Policies and Procedures

IV.A.1 - Substantial Compliance

"The County shall establish policies and procedures that are consistent with the provisions of this Remedial Plan and include the following:

a) *A written document reflecting the complete spectrum of mental healthcare programming and services provided to prisoners;*

b) *Minimum and maximum timeframes for when each type of mental healthcare service will be completed, including but not limited to laboratory tracking and psychiatry follow-up services, in accordance with prevailing community and professional standards;*

c) *An intake and referral triage system to ensure timely and effective resolution of inmate requests and staff referrals for mental healthcare;*

d) *Specific credentialing requirements for the delivery of mental healthcare services, including but not limited to only qualified mental health professionals may make critical treatment decisions.*

e) *Clinical monitoring of inmates, including but not limited to those who are involuntarily medicated, clinically restrained or secluded, segregated, or on suicide watch;*

f) *Descriptions of specialized mental health programming that specifically identify admitting and discharge criteria and the staff members who have the authority to place inmates in specialized mental health housing;*

g) *Procedures for involuntary medications and other appropriate measures for the management of inmates with serious mental illness who lack the capacity to give informed consent, in accordance with relevant state law;*

h) *Training for all staff members who are working with inmates with mental illness in all aspects of their respective duty assignments."*

ACH and ACMH established policies and procedures that are consistent with the provisions of this Remedial Plan requirement as listed above. All SSO staff members working with inmates experiencing mental illness receive training tailored to support them in their respective roles. This includes Suicide Prevention, Mental Health in Jails, and Crisis Intervention Training (CIT). These trainings are designed to enhance staff awareness, promote safety, and ensure appropriate responses when managing individuals with serious mental health needs in a correctional setting. SSO is currently in the process of expanding the involuntary medication policy and making it a standalone procedure. All new custody staff are required to participate in eight hours of mental health training and current staff are required to participate in two hours of suicide prevention training annually. This provision remains in substantial compliance.

IV.A.2 - Substantial Compliance

"The County's policies and procedures shall be revised, as necessary, to reflect all of the remedial measures described in this Remedial Plan."

ACH policies and procedures are revised as necessary, to reflect all the Remedial Plan measures described in this Remedial Plan.

SSO's Legal and Policy Sustainment Bureau, in partnership with its vendor Lexipol LLC, continues to focus on maintenance and updates to all Sheriff's Office policies and procedures to ensure compliance with provisions of the Consent Decree as well as applicable law. In October of 2024, the Sheriff's Office created the corrections compliance manager position. One of the responsibilities of this employee is to ensure that Sheriff's Office policies and procedures are both consistent with the requirements of the Consent Decree and that proposed changes are communicated to Class Counsel through an open and collaborative process. This provision remains in substantial compliance.

IV.A.3 – Substantial Compliance

"The County shall continue to operate its acute inpatient program and its Outpatient Psychiatric Pod (OPP) program. The County shall establish a new Intensive Outpatient Program (IOP) for inmates who require a higher level of outpatient psychiatric care than what is provided in the OPP program."

ACMH's EOP program has a service capacity of 525 patients. ACMH is assigning patients to an EOP level of care as staff are hired. EOP services have assisted in decreasing the

number of disciplinary write ups, emergent referrals and the number of days a patient stayed in the Acute Psychiatric Unit (APU).

The IOP level of care continues to be expanded which has helped reduce the need for inpatient care. ACMH received FY 24/25 mid-year augmentation to increase the number of IOP beds at RCCC from 48 to 72 and female beds at the Main Jail from 23 to 33. Additionally, there are 20 male beds at the Main Jail. This brings the total number of IOP beds to 125. Further expansion of IOP is planned in February 2026 with the addition of 32 male and 10 female beds. This expansion will bring the total number of IOP beds to 167.

An expansion to the APU is also in development which will add 24 LPS beds and seven step-down beds for a total of 41 acute psychiatric inpatient beds. Projected completion for this project is May 2026.

Beyond APU, IOP, and EOP, the jail system has beds dedicated to mental health-related programming. RCCC has 32 male and 12 female beds for JBCT and 10 beds for Early Access to Stabilization Services (EASS). This provision remains in substantial compliance as the County continues operation of the APU, has significantly expanded IOP, and a planned expansion of APU is pending.

IV.A.4 - Partial Compliance

"The County shall operate its non-acute mental health programs – IOP, OPP, and General Population-Mental Health – consistent with the JPS Psychiatric Services overview, attached as Exhibit A-2 [in the Remedial Plan]."

EOP is budgeted to serve 525 patients; services include crisis intervention, case management, care coordination, advocacy, discharge planning, and therapeutic interventions including 1:1 and group programming. Services are being titrated as staff are hired. EOP expanded therapeutic group services for EOP patients housed on 3E & 3W, 7W, 4E & 4W and 8E. EOP participants are also supported by MDTs.

ACMH established a Positive Behavioral Support Team that provides specific Dialectal Behavior Therapy (DBT) interventions and staff consultation to address patient behaviors that interfere with patients participating in programming or being housed in the least restrictive setting.

ACMH has fully implemented CNAP which provides crisis intervention, enhanced observation, and stabilization for patients in crisis.

ACMH will continue to address and identify barriers that interfere with scheduled groups with supervisors. ACMH is working on refining the automated Group Participation report which will assist with tracking the average number of hours of structured treatment offered per patient per week, the average number of hours of structured treatment received/attended per patient per week, and the actual number of groups scheduled and canceled.

The assigned rating of partial compliance is due to titration of EOP services with long-term plan for all patients on the ACMH caseload to be assigned to an EOP level of care as well as the periodic cancellation of scheduled groups, particularly in the APU.

IV.B. Organizational Structure

IV.B.1 - Substantial Compliance

"The County shall develop and implement a comprehensive organizational chart that includes the Sheriff's Department ("Department"), Correctional Health Services ("CHS"), Jail Psychiatric Services ("JPS"), Chief Administrative Officer, Medical Director of the JPS Program, and any other mental health staff, and clearly defines the scope of services, chains of authority, performance expectations, and consequences for deficiencies in the delivery of mental health care services."

The County maintains a comprehensive organizational chart for ACH and ACMH that clearly outlines the chains of authority. ACH also developed and implemented position standards and job descriptions, outlining scope of services and performance expectations for each position. Both the County and UC Davis have County and organization-wide policies and disciplinary processes as it relates to not meeting standard performance and duties. The Sheriff's Office maintains and regularly updates an organizational chart that has been routinely provided to Court-appointed SMEs and Class Counsel on demand. This provision remains in substantial compliance.

IV.B.2 - Substantial Compliance

"A Medical Director of Jail Psychiatric Services shall be designated and shall oversee all mental health care functions in the jails, including psychiatric prescribers and psychiatric nurses. The Director shall possess clinical experience and a doctoral degree."

ACMH has a medical director designated to oversee all mental health care functions in the jails, including psychiatric prescribers and psychiatric nurses. The ACMH medical director possesses clinical experience and a doctoral degree. ACMH reorganized the leadership

structure to address Consent Decree requirements and support program and staff expansion. This provision remains in substantial compliance.

IV.B.3 - Substantial Compliance

"The Medical Director of Jail Psychiatric Services shall participate in jail executive leadership and shall be responsible for overseeing program development, clinical practice, and policy, as well as interfacing with jail and medical leadership and community mental health."

The ACMH medical director and MH program director participate in ACH Executive Team leadership meetings as well as a variety of meetings including Quality Improvement, Multidisciplinary Team Meetings, ACH leadership and SSO Custody leadership meetings, and ad hoc meetings. This provision remains in substantial compliance.

IV.C Patient Privacy

IV.C.1 - Partial Compliance

"All clinical interactions shall be private and confidential absent a specific, current risk that necessitates the presence of custody staff. In making such determination, custody and clinical staff shall confer and review individual case factors, including the patient's current behavior and functioning and any other security concerns necessary to ensure the safety of medical staff. Such determinations shall not be based on housing placement or custodial classification.

a) *For any determination that a clinical interaction with a patient requires the presence of custody staff, staff shall document the specific reasons for the determination. Such decisions shall be reviewed through the Quality Assurance process.*

b) *If the presence of custody staff is determined to be necessary to ensure the safety of medical staff for any clinical counter, steps shall be taken to ensure auditory privacy of the encounter.*

c) *The County's patient privacy policies, as described in this section, shall apply to contacts between inmates and Triage Navigator Program staff and/or other staff that provide mental health-related services on site at the Jail."*

ACMH understands the importance of seeing all patients confidentially. Confidential interview booths have been installed on all floors and ACMH has seen a significant increase in confidential contacts

ACMH supervisors monitor the use of confidential space in booking, classrooms, attorney booths, and confidential interview booths and have regular discussions with staff regarding challenges/barriers to use of confidential space. ACMH supervisors continuously reinforce the importance and requirements of confidential individual interviews and group programming during staff meetings and huddles.

ACMH and SSO custody staff meet regularly to discuss challenges/barriers preventing confidential encounters. ACMH and SSO's compliance lieutenant have a standing monthly meeting to discuss confidentiality issues and review for Quality Assurance (QA)/Quality Improvement (QI). ACMH and Custody implemented a plan to increase efficiency of using attorney booths on all floors, confidential interviews with patients who present with assaultive or high security/safety issues, and Custody standby while ensuring auditory privacy.

Due to ongoing collaboration and training between ACMH and SSO, audits of confidential encounters have shown a decrease in the number of "safety and security" reasons for non-confidential contacts. ACMH and SSO identified need for additional drop-down options in the confidential encounter form to better capture the specific reasoning for a non-confidential encounter due to safety and security. Changes have been implemented, and ACMH and SSO will use audit findings to identify any barriers or areas for improvement.

At the Main Jail, there is a confidential interview room on the first floor for booking related clinical interactions. Classrooms (with the door shut), attorney booths and confidential interview booths (located on all floors) are available for confidential contacts.

Designated ACMH outpatient staff moved to a nearby G St office and staff vacated a classroom on the third floor that was converted into IOP office space. This increased confidential programming space for groups and individual assessments and interventions.

Privacy curtains have been added during this reporting period to increase privacy in some booths. With the installation of interview booths completed in October 2024, ACMH has seen an increase in the number of confidential contacts at the Main Jail. In September 2024, an average of 66% of contacts were confidential. Following installation of the booths, in November 2024, an average of 81% of contacts were confidential and in May 2025, an average of 91% of contacts were confidential. In addition to interview booths, a "security chair" has been added to the booth on floor 8 West that facilitates a safe environment for clinicians while having a confidential encounter with high security or combative inmates.

At RCCC, ACMH obtained a custody escort five hours a day, four days a week to facilitate confidential contacts for patients housed in the barracks. This increase in coverage by SSO was implemented in late June 2025.

ACMH and ACH collaborated to develop a schedule for JKF/KBF interview room use to support both medical and ACMH with obtaining access to confidential interview space. ACMH expanded the use of the attorney booths at RCCC to increase confidential encounters. RCCC facilities have ACMH offices available for interviews. These areas are private and are not audio-recorded. The doors to these offices were modified to allow the officer to maintain visual observation and provide standby as needed based upon the patient's classification/behavior while offering the highest amount of privacy possible. This is also reflected in SSO's policy on Medical and Mental Health Confidentiality for Incarcerated Persons: "If a standby by custody is needed, the custody personnel should be positioned in a place that allows for observations but maintains sound privacy, unless there is an articulable security or safety risk. Custody may maintain visual supervision but may not be close enough to overhear or record communications between the incarcerated person and the health provider, unless security concerns, based on an individualized determination of risk dictate otherwise."

Although confidentiality booths have been added to all floors in the Main Jail, the APU lacks designated confidential space. APU staff use the attorney booth and have begun to utilize the confidential interview booth on 2M for patients who can be safely escorted. This provision remains in partial compliance due to limited confidential interview and group programming space on the APU.

IV.C.2 - Substantial Compliance

"Jail policies that mandate custody staff to be present for any mental health treatment in such a way that disrupts confidentiality shall be revised to reflect the individualized process set forth above. Custody and mental health staff shall be trained accordingly."

No policies exist mandating custody staff to be present for mental health treatment. This provision remains in substantial compliance.

IV.C.3 - Partial Compliance

"It shall be the policy of the County that mental health clinicians shall not conduct their patient contacts at cell front except pursuant to documented refusals or specific, documented security concerns that warrant cell front contacts."

As of April 2025, confidential booths have been installed on all floors of the Main Jail, including 2E. Also, a security chair (with leg shackles) was added to 8W to help with the safety and security of MH staff when needed. To further increase availability for confidential contacts between ACMH and inmates, SSO began utilizing attorney booths throughout the jail as an additional option in the event the confidential booths are unavailable.

All facilities at RCCC have designated confidential attorney booths which can be utilized for ACMH. Additionally, there is a designated, soundproof ACMH room on the secure side of the facility. The door has a window to allow for observation by a deputy for safety and security purposes. Furthermore, RCCC has increased ACMH escort hours to five hours a day, four days a week.

With the installation of interview booths, ACMH has seen an increase in the number of confidential contacts at the Main Jail. As noted in IV.C.2, as of May 2025, an average of 91% of contacts were confidential.

ACMH and SSO continue to meet monthly to discuss barriers to confidential contacts and refine reporting. Over the last reporting period, additional drop-down options were added to the confidential encounters form to ensure staff can adequately report reasons for non-confidential encounters. This provision will remain in partial compliance pending an audit of the confidential encounters form and a reduction in safety and security used as justification for completing a cell front contact instead of a confidential encounter.

IV.C.4 – Substantial Compliance

"For each clinical contact, mental health staff shall document whether the encounter was confidential, including whether it took place at cell front. If the contact occurred at cell front or otherwise was non-confidential, the reasons shall be clearly documented in the individual patient record and for purposes of Quality Assurance review procedures."

For each clinical contact, ACMH staff document whether the encounter was confidential, including whether it took place at cell front. If the contact occurred at cell front or otherwise was non-confidential, the reasons are clearly documented in the individual patient record and for purposes of Quality Assurance review procedures. ACMH routinely audits confidential contacts and reports findings at the ACMH Subcommittee Meeting.

Confidential booths composed of plexiglass enclosures with doors were installed in the indoor area of each housing unit at the Main Jail. As noted in IV.C.2, as of May 2025, an average of 91% of contacts were confidential.

ACMH and SSO Custody meet regularly to discuss challenges/barriers preventing confidential encounters. ACMH and SSO's compliance lieutenant have a standing monthly meeting to discuss confidentiality issues and review for QA/QI. This provision remains in substantial compliance.

IV.C.5 – Substantial Compliance

"A process shall exist for sick call slips or other mental health treatment-related requests to be collected without the involvement of custody staff."

The Health Services Request policy outlines the process allowing patients to submit requests or other mental health treatment-related requests to be collected without the involvement of SSO Custody staff. At both facilities, nurses collect mental health and sick call slips from the secured medical mailbox. Custody does not have any involvement in the collection or processing of these documents. Language was added to the inmate handbook that reminds all inmates that "kites" [inmate communication] and grievances shall not be distributed nor collected by inmate workers or by any other inmate. SSO staff were reminded that no one should interfere with the direct communication between an inmate and a provider. This provision remains in substantial compliance.

IV.D. Clinical Practices

IV.D.1 – Substantial Compliance

"Mental health staff shall develop and maintain at each jail facility an accurate case list of all prisoners requiring mental health treatment services at the jail ("caseload") which, at a minimum, lists the patient's name, medical chart number, current psychiatric diagnoses, date of booking, date of last appointment, date of next appointment, and the name of the treating prescriber."

ACMH can access all the required information noted in this provision via the patient's medical record in the EHR. ACH has developed an MH caseload report that includes relevant information regarding the current diagnosis and level of mental health services. In this reporting period, ACMH has further developed the MH Caseload Report to include all relevant information regarding patients on the MH caseload, including: patient name, X-reference number, MH diagnosis, booking and release date, date of last MH appointment and next appointment, custody level, housing location, and if the patient has an SMI. This provision remains in substantial compliance.

IV.D.2 – Substantial Compliance

"Qualified mental health professionals shall have access to the patient's medical record for all scheduled clinical encounters."

ACMH staff have full access to all areas of the EHR for pending clinical encounters. This provision remains in substantial compliance.

IV.D.3 – Partial Compliance

"Qualified mental health professionals shall provide individual counseling, group counseling, and psychosocial/psychoeducational programs based on individual patients' clinical needs."

ACMH provides individual and group counseling and psychosocial/psychoeducational programs in the IOP, APU, and EOP. This provision remains in partial compliance due to staffing and the need to scale (or expand) EOP services to the entire MH caseload.

IV.D.4 – Partial Compliance

"A qualified mental health professional shall conduct and document a thorough assessment of each individual in need of mental health care following identification."

MH completes a full assessment of patients identified as needing mental health services. This provision remains in partial compliance due to staffing and compliance with timelines to care.

IV.D.5 – Partial Compliance

"The County shall ensure prompt access to psychiatric prescribers following intake and in response to referrals and individual patient requests in accordance with the referral and triage timelines defined in the Access to Care provisions, below."

ACMH updated and renamed all prescriber encounters in Athena in order to standardize documentation across all program areas and allow staff to quickly identify a prescriber encounter.

ACMH continues to monitor compliance meeting the 48-hour timeline for medication verification. Substantial compliance was achieved for the period of June through August 2024:

- ACMH verified 100% (60/60) of referrals made for medication verification.
- ACMH verified 92% (55/60) of medications within 48 hours.

For medications verified and initiated by ACMH NP, the first dose was administered:

- 85% (23/27) within 24 hours of being initiated.
- 15% (4/27) on the same day it was verified (includes patients with LAI).

Medications for 33 patients were not started due to missing or outdated psychiatric medications in clinic/pharmacy profiles.

This area remains in partial compliance due to challenges in meeting timelines to care.

IV.D.6 – Substantial Compliance

"The County shall, in consultation with Plaintiffs' counsel, implement an electronic system for tracking mental health evaluation, treatment, and other clinical contacts, as well as sick call slips and other mental health treatment related requests or referrals."

The County has implemented an electronic system for tracking mental health evaluation, treatment, and other clinical contacts, as well as sick call slips and other mental health treatment-related requests or referrals.

ACMH utilizes ACH's EHR to track mental health treatment, encounters, HSRs, and other MH treatment-related requests or referrals. This provision remains in substantial compliance.

IV.D.7 – Substantial Compliance

"The County shall develop and implement an electronic tracking system with alert and scheduling functions to ensure timely delivery of mental health services to individual patients."

ACMH utilizes ACHs EHR to schedule all MH encounters. In addition to the updates included in the prior 10th County Status report, the following have been updated:

- MH Group Participation Report: The Fusion Group Notes application has been enhanced and is in production (completed and in use) and tracks attendance as well as scheduled and canceled groups.
- Interdisciplinary Case Conference Form was created in Athena for medical and MH to document case conferences. This allows staff immediate access to the document as well as the ability to easily locate the document in the EHR.
- The full development of the MH Caseload Report has been completed and includes all relevant information regarding patients on the MH caseload, including: patient name, X-reference number, MH diagnosis, booking and release date, date of last

MH appointment and next appointment, custody level, housing location and if the patient has an SMI. The report is currently in production and will be utilized to improve reporting and tracking of patients on the MH caseload.

This provision has increased to substantial compliance as the County has developed and implemented an electronic tracking system with scheduling functions to ensure timely delivery of mental health services to individual patients.

IV.D.8 – Partial Compliance

"Treatment planning:

a) *The County shall ensure that each prisoner on the mental health caseload receives a comprehensive, individualized treatment plan based on the input of the Multi-Disciplinary Treatment Team (MDT). The MDT shall include multiple clinical disciplines with appropriate custody and counseling staff involvement.*

b) *The treatment plan shall reflect individual clinical need, and the County shall ensure that all clinically indicated services are available and provided.*

c) *The treatment plan shall include, at a minimum, the frequency of follow-up for clinical evaluation and adjustment of treatment modality, the type and frequency of diagnostic testing and therapeutic regimens (which may include clinical contacts more frequent than the minimum intervals described herein), and instructions about adaptation to the correctional environment.*

d) *This treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.*

e) *Custody staff shall be informed of a patient's treatment plan where appropriate to ensure coordination and cooperation in the ongoing care of the patient.*

f) *The County shall, in consultation with Plaintiffs' counsel, develop and implement a Treatment Plan Form that will be used to select and document individualized services for prisoners who require mental health treatment.*

g) *The County shall implement guidelines and timelines for the initiation and review of individual treatment plans, consistent with the JPS Psychiatric Services overview, attached as Exhibit A-2."*

ACMH continues to monitor completion of treatment planning and MDTs in the APU, IOP and EOP. An audit completed for the report period of Jan-Mar 2025 found that for all program areas:

- 98% (59/60) of charts had documented MDTs.
- 100% (60/60) of charts had documented treatment plans.
- 98% (59/60) of charts had documented MDTs referencing treatment goals.
- 98% (59/60) of charts had documented MDT and treatment plans completed on the same day.
- 100% (2/2) of patients with an Adaptive Support Plan was referenced in the MDT.

Custody staff are appropriately informed of a patient's treatment plan in accordance with established procedures. This communication allows SSO to coordinate effectively with mental health and medical staff, ensuring continuity of care and promoting the safety and well-being of both the patient and the facility. ACMH provide custody staff with Adaptive Support Plans to ensure proper communication and the patient's needs are efficiently met.

ACMH continues to address barriers in meeting timeline requirements for completion of MDTs and treatment planning and is actively working with the individual program areas to improve compliance. This provision remains in partial compliance due to staffing and the need to scale (or expand) EOP services to the entire MH caseload.

VI.E. Medication Administration and Monitoring

IV.E.1 - Partial Compliance

"The County shall develop and implement policies and procedures to ensure that all medications are appropriately prescribed, stored, controlled, dispensed, and administered in accordance with all applicable laws and through the following:

a) *The County shall ensure that initial doses of prescribed medications are delivered to inmates within 48 hours of the prescription, unless it is clinically required to deliver the medication sooner;*

b) *The County shall make best efforts to verify a patient's prescribed medications and current treatment needs at intake, including outreach to pharmacies and community providers to request prescriptions and other health care records relating to ongoing care needs. The policy shall ensure that any ongoing medication, or a clinically appropriate alternative, shall be provided within 48 hours of verification of the prescription or from a determination by a physician that the medication is*

medically necessary. Any orders that cannot be reconciled or verified, such as those with conflicting prescriptions from multiple prescribers, shall be referred to a health care provider for reconciliation or verification the next clinic day after booking.

c) *The County shall ensure that medical staff who administer medications to inmates document in the inmate's Medical Administration Record (1) name and dosage of each dispensed medication, (2) each date and time medication is administered, and (3) the date and time for any refusal of medication."*

ACH staff document all required medication administration information in the eMAR. ACMH revised the medication verification workflow to streamline the process for triaging and verifying community medications. ACMH continues to audit the timeliness to medication verification to ensure patients are receiving community medication within the designated time frame.

Regarding IV.E.1.c., ACH pill call nurses are trained to document real-time during the medication administration process. They have the patient's MAR on a hand-held tablet and are required to mark whether the medication was administered or not administered. If not administered, there is a drop-down list of reasons that includes patient refusal and education provided. The name and dosage are automatically populated in the MAR as they indicate which medications were administered and which were not. While the County is substantially compliant with sub-provision IV.E.1.c, the remainder of provision IV.E.1 remains in partial compliance until ACH's medication verification processes are fully refined.

IV.E.2 - Substantial Compliance

"Qualified mental health professionals shall, for each individual patient, establish targets for treatment with respect to the use of psychotropic medication and shall assess and document progress toward those targets at each clinical visit."

Qualified mental health professionals (QMHPs) establish targets for treatment with respect to the use of psychotropic medication and shall assess and document progress toward those targets at each clinical visit. QMHPs establish targets for treatment with respect to psychotropic medication and assess and document progress toward those targets at each clinical visit. In addition to the program changes documented in the 10th County Status report, ACMH updated and renamed all prescriber encounters in Athena to standardize documentation across all program areas and allow staff to quickly identify a prescriber encounter. This provision remains in substantial compliance.

IV.E.3 - Substantial Compliance

"Qualified mental health professionals shall, for each individual patient, monitor and document the following with respect to psychotropic mediations: (1) levels of medications, (2) adverse impacts (including through renal and liver function tests where indicated), (3) side effects, and (4) efficacy."

QMHPs monitor and document levels of medications, and adverse impacts, order labs, and document side effects and treatment efficacy as appropriate. MH continues to complete peer reviews and report findings through the Psychiatric Prescriber Audit. For the period of December 2024 - January 2025, the following areas were substantially compliant:

- 100%, conducted in person meetings, if indicated, when making medication changes.
- 100%, completed ECG screening for patients on atypical antipsychotics.
- 100%, completed routine labs for patients on mood stabilizers.
- 94%, monitored for treatment efficacy.
- 90%, completed routine labs for patients prescribed antipsychotics.

IV.E.4 - Partial Compliance

"Qualified mental health professionals shall, for each individual patient, conduct and document baseline studies, including ECG, blood, urine, and other studies, as clinically appropriate, prior to the initiation of treatment."

Psychotropic treatment may be started prior to labs for a variety of reasons including emergency need, patient noncompliance, phlebotomist unavailability or other security issues within the facility. MH continues to monitor prescriber compliance though the Psychiatric Prescriber Audit. Psychiatric Prescriber Audit findings from December 2024 to January 2025, as noted in IV.E.3, support this provision being increased to substantial compliance.

IV.E.5 - Partial Compliance

"The County shall provide sufficient nursing and custody staffing to ensure timely delivery and administration of medication."

During this reporting period, ACH implemented changes to the medication administration process by reintegrating Suboxone into the general pill call. This adjustment allows two nurses at each facility who were previously dedicated solely to Suboxone administration to assist with overall medication distribution, improving efficiency. This change also released

two custody-escort officers for reassignment to other medical areas, as their presence is no longer required for a separate Suboxone pill call. While delays in timely administration still occur due to various factors, overall ACH staffing levels remain sufficient to support the recent changes to the pill call process.

Since April 2023, the Main Jail has been staffing medical escorts allowing medical staff better access to patients. While most of the escorts are for doctor and nurse sick-call, these escorts allow floor custody staff more time for other responsibilities such as medication administration. The Main Jail currently has four designated full-time deputy medical escorts. Daily, the Main Jail averages eight dedicated medical escorts on day shift, Monday through Friday, and three on night shift, Monday through Friday. On weekends, there are, on average, four designated medical escorts for the day shift and three for the night shift. In fiscal year 2025-2026, the County budgeted for an additional three medical escorts at the Main Jail to further support medical staff with their treatment of the inmate population.

RCCC has at least six dedicated medical escorts daily Monday to Sunday. These positions are filled by both full-time and on-call deputies. Full-time deputies work 0630-1830 and On-calls work 0700-1600. Deputies assigned to facilities are also available.

IV.E.6 - Partial Compliance

"Medication adherence checks that serve a clinical function shall be conducted by nursing staff, not custody staff. Custody staff shall conduct mouth checks when necessary to ensure institutional safety and security."

ACH pill call nurses have received extensive training on the importance of medication adherence checks as a critical component of the medication administration process. In-person audits have demonstrated strong compliance by both nursing and custody staff. However, this provision will remain in partial compliance until ACH is confident that adherence checks are consistently being performed as required.

IV.E.7 - Substantial Compliance

"Psychiatric prescribers shall consider clinically indicated considerations and conduct an in-person consultation, with the patient prior to changing or initiating medications. In the event there is no in-person consultation before prescribing or changing medications the psychiatric prescriber shall note and document the reasons for why there was not an in-person consultation with the patient."

ACMH completed a Psychiatric Prescriber Audit for the period of December 2024 to January 2025, and found that MH conducted an in-person meeting, if indicated, when making medication changes in 100% of the charts reviewed. Telepsychiatric visits may occur due to a variety of reasons and medications may be restarted when confirmed from community/ other collateral or as clinically indicated.

IV.F. Placement Conditions, Privileges, and Programming

IV.F.1 - Partial Compliance

"Placement:

a) *It shall be the policy of the County to place and treat all prisoners on the mental health caseload in the least restrictive setting appropriate to their needs.*

b) *Placement in and discharge from Designated Mental Health Units shall be determined by qualified mental health professionals, with consultation with custody staff as appropriate.*

c) *Absent emergency circumstances, the County shall obtain the assent of qualified mental health professionals before transferring prisoners with SMI into or out of Designated Mental Health Units.*

d) *It shall be the policy of the County to place prisoners with SMI in appropriate settings that ensure provision of mental health services, patient safety, and the facilitation of appropriate programs, activities, and out-of-cell time. Co-housing with other populations shall be avoided to the extent that such a practice prevents or hinders any of the above.*

e) *All patients requiring placement in a Designated Mental Health Unit shall be provided access to such placement and care based on current clinical need and without any requirement for director-level approval."*

Placement decisions for Mental Health Units are made by Adult Correctional Mental Health (ACMH). Custody staff attempts to house individuals in the least restrictive environment possible, based on their individual circumstances and needs, so they can receive the care and support they need. Custody coordinates closely with ACMH to move people into and out of these units as individuals are admitted or discharged. If any safety concerns arise regarding a placement, custody and ACMH staff will work together to find a reasonable solution.

ACMH received a FY 24/2025 mid-year augmentation to increase the number of IOP beds. An additional 24 male beds at RCCC and 10 female beds at Main Jail will bring the total number of IOP beds to 125. ACMH is hiring and onboarding staff. ACMH anticipates all 10 female and male beds will be filled by July 2025.

Further expansion of IOP is planned in February 2026 with the addition of 32 male at RCCC and 10 female beds at Main Jail. This expansion will bring the total number of IOP beds to 167.

An expansion to the APU is also in development which will add 24 LPS beds and seven step-down beds. This expansion of APU beds will bring the total number of LPS beds to 41. The projected completion for the APU expansion is May 2026.

The cases below highlight the effectiveness of integrated care approaches in addressing complex psychiatric needs within a correctional setting, made possible through the coordinated efforts of ACMH and SSO/Custody:

- Patient #5 is diagnosed with Bipolar I Disorder, and mild Intellectual Disability and was admitted to the Intensive Outpatient Program (IOP) due to limited ability to advocate for their basic needs and participate in medical and mental health treatment. While in IOP the clinician used Applied Behavior Analysis (ABA) techniques to support the patient in complying with medical care and activities of daily living. MH and the IOP deputies worked together to develop a behavior plan to support the patient and increase their ability to engage in IOP programming. While in IOP they were found incompetent to stand trial, and the court ordered the patient to the Department of State Hospitals (DSH) for treatment. The IOP team contacted DSH and provided a warm handoff to ensure DSH understood the patient's functional impairments and successful interventions utilized in IOP. Upon return from DSH they were immediately admitted to IOP. The patient was assigned to the same IOP clinician they had prior to being treated at DSH, and ABA interventions were implemented with greater success. In addition, the patient was willing to take psychotropic medication which appeared to decrease underlying agitation. Collateral contact was maintained with the patient's family throughout the IOP stay. When the courts dismissed the patient's charges without a plan for discharge, IOP was able to work with community providers and speak with the patient's family to ensure the patient was not released to the streets. While the patient's baseline functioning did not change, they were able to successfully program in IOP and the IOP team communicated with all stakeholders to ensure that that patient was returned to the care of their family.

- Patient #6 is diagnosed with Schizophrenia. The patient was admitted to the Intensive Outpatient Program (IOP) to address coping, medication adherence and underlying mental health symptoms. While in IOP, the patient was able to fully engage in groups and individual contacts with their clinician. Over the early course of the admission, the psychiatrist worked with the patient to adjust psychiatric medications to target distressing symptoms. The patient was able to successfully demonstrate use of distress tolerance skills and mindfulness to reduce anxiety and worry and increase his functioning. During the IOP stay, the patient was appointed as pod worker by the IOP deputies. The patient reported that they enjoyed supporting the pod and helping to bring positive dynamics to the peer group. While in IOP, a family member who was a main support died unexpectedly. The IOP team quickly mobilized to provide additional support for the patient during this crisis. After a period of stabilization, the patient expressed readiness for discharge from IOP. The patient was discharged from IOP into Outpatient Psychiatric Pod Barracks housing where they have maintained their current level of functioning and stability with continued support from ACMH.

This provision remains in partial compliance pending additional IOP and APU beds.

IV.F.2 - Substantial Compliance

"Programming and Privileges:

a) *All Designated Mental Health Units shall offer a minimum of 7 hours of unstructured out-of-cell time per week and 10 hours of structured out-of-cell time per week for each prisoner. While out-of-cell hours per prisoner may vary from day to day, each prisoner will be offered some amount of out-of-cell time every day of the week. All treatment and out-of-cell time shall be documented for each prisoner, and reviewed as part of Quality Assurance procedures.*

b) *The County shall ensure that prisoners on the mental health caseload have access and opportunity to participate in jail programming, work opportunities, and education programs, consistent with individual clinical input.*

c) *The County shall develop and implement, in the 2P inpatient unit and the IOP unit, a program for progressive privileges (including time out-of-cell, property allowances, etc.) for patients as they demonstrate behavioral progress. A patient's level of privileges and restrictions shall be based on both clinical and custody input regarding current individual needs. The County shall ensure a process to review*

custody classification factors when necessary, so that placement, privileges, and restrictions match current individual circumstances and needs.

d) *Individuals on a mental health caseload shall receive, at minimum, privileges consistent with their classification levels, absent specific, documented factors which necessitate the withholding of such privileges. Clinical staff shall be informed of the withholding of privileges and the reasons for the withdrawal shall be documented and regularly reviewed by clinical and custody staff. The restoration of privileges shall occur at the earliest time appropriate based on individual factors.*

e) *Where a prisoner in a Designated Mental Health Unit is subject to any restrictions of property, privileges, or out-of-cell time, the mental health treatment provider and Multi-Disciplinary Treatment Team will, on a weekly basis, assess and discuss with the prisoner progress and compliance with the prisoner's individual case plan. This process will include clinical contact in a private, face-to-face, out-of-cell setting. The Multi-Disciplinary Treatment Team will provide input to classification staff regarding the prisoner's mental health and appropriateness for removal of imposed restrictions. Classification staff will follow the recommendation of the Multi-Disciplinary Treatment Team to remove restrictions unless there is a clear, documented security reason to maintain the restriction."*

In Designated MH Units (APU, IOP, JBCT), structured (group treatment) out-of-cell time is scheduled by ACMH in conjunction with SSO. Patients in these programs generally have more than seven hours of unstructured out-of-cell time and more than ten hours of structured time per week. IOP offers, at minimum, 10 hours of structured out-of-cell time per week to each patient.

ACMH placed three social work staff on the APU which has increased structured out-of-cell time. APU offers, at minimum, 10 hours of group therapy/programming per week.

ACMH determines the level of privileges and restrictions for patients in the APU. Any removal or reinstatement of privileges, property or clothing is by MD order and follows LPS Denial and Restoration of Patient's Rights requirements. On an operational level, the IOP and Acute Unit custody staff work with ACMH on property and privileges. The IOP sergeant monitors compliance.

IOP patients who are subject to restrictions of property, privileges, or out-of-cell time are placed on an Alternative Treatment Program (ATP). The multidisciplinary team meets daily to discuss the patient's progress and the transition of the patient from ATP to general programming.

Regarding work opportunities, work assignments are based on an individual's ability to safely perform those functions given the appropriate level of supervision.

Both Main Jail and RCCC Compliance monitor out-of-cell times through ATIMS. The Main Jail has introduced a new report that lists cross-reference numbers of inmates who have consistently received less than 17 hours of out-of-cell time over a four-week period. The goal is to identify inmates who may be overlooked in terms of their out-of-cell hours. Currently, SSO is at three percent (3%) of the total combined average inmate population not receiving 17 hours out-of-cell time weekly. As proof of practice has been established, this provision is being increased to substantial compliance.

IV.F.3 - Substantial Compliance

"Conditions:

a) *Staff shall provide prisoners in Designated Mental Health Units with the opportunity to maintain cell cleanliness and the opportunity to meet their hygiene needs. Custody and clinical staff shall provide assistance to prisoners on these matters, as appropriate to individual patient needs.*

b) *The County shall ensure uniformity of practice with respect to cell searches, such that searches are not done for punitive or harassment reasons. The County shall monitor whether cell search practices may be serving as a disincentive for prisoners in Designated Mental Health Units to leave their cells for treatment or other out-of-cell activities, and shall take steps to address the issue as appropriate."*

ACMH and Custody assist patients in IOP and APU with maintaining cell cleanliness and promoting personal hygiene. Per SSO, the APU facilitates cell cleaning every Monday, Wednesday and Friday. Keeping APU cells may be challenging due to the willingness of participation on behalf of the inmate. Deputies attempt to remove trash and facilitate cell cleaning more often than the scheduled Monday, Wednesday and Friday, as long as an opportunity to do it safely arises.

The Main Jail 3W IOP does cell cleaning weekly. IOP females conduct cell cleaning on Saturdays and IOP males on Sundays.

Per SSO Procedure "Suicide Prevention and Intervention," SSO deputies ensure that any suicide resistant cell used for holding incarcerated persons on suicide precautions is cleaned prior to the placement of a new incarcerated person, as well as cleaned on a normal cleaning schedule. In practice, SITHU cells are cleaned by an inmate worker after every time an inmate is cleared and leaves the cell. The SITHU cell is also inspected by a

deputy before a new inmate with suicide precautions enter the cell. Inmates that are in the SITHU for longer periods of time are offered opportunities to clean their cell.

Furthermore, in accordance with SSO Policy "Incarcerated Person Hygiene," Custody staff provide incarcerated persons with mental health, physical, cognitive, or other disabilities with appropriate assistance in maintaining cell cleanliness and hygiene. Incarcerated persons with mental health, physical, cognitive, or other disabilities are not punished for difficulties in maintaining adequate cleanliness or hygiene. Custody and health care staff identify individual needs for assistance on these matters, and accommodate those needs through implementation of an individualized treatment plan. Custody staff review individualized treatment plan components in ATIMS to ensure appropriate assistance is provided.

Cell searches are done randomly on a revolving basis to ensure the inmates do not have any contraband or weapons that can harm themselves, ACMH staff or SSO staff, and are not done for punitive or harassment reasons. As the County continues to meet all required conditions, this provision remains in substantial compliance.

IV.F.4 - Partial Compliance

"Bed Planning:

a) *The County shall provide a sufficient number of beds in Designated Mental Health Unit, at all necessary levels of clinical care and levels of security, to meet the needs of the population of prisoners with SMI.*

b) *The County shall conduct a bed needs assessment, to be updated as appropriate, in order to determine demand for each category of Designated Mental Health Unit beds and shall ensure timely access to all levels of mental health care, consistent with individual treatment needs.*

c) *The County shall establish mental health programming for women that ensures timely access to all levels of care and is equivalent to the range of services offered to men."*

The Main Jail currently operates a 17-bed LPS designated Acute Psychiatric Unit (APU), serving individuals requiring both involuntary (5150 hold) and voluntary inpatient psychiatric care. It also provides a number of designated IOP beds. The completed and planned additions to APU and IOP are described in provision IV.F.1.

Regarding IV.F.4.c, ACMH provides mental health programming and access to all levels of care to female patients. ACMH recently increased female IOP beds from 23 to 33. APU and EOP services are also provided to female patients.

The coordinated efforts of the psychiatrist, nursing staff, and social work team are critical in stabilizing individuals experiencing acute psychiatric crises. This multidisciplinary approach ensured that Patients #7 and #8, described below, received individualized care that promoted recovery, reduced risk, and supported successful discharge to a lower level of care.

- Patient #7 is diagnosed with Schizoaffective Disorder, Bipolar Type. They were involuntarily admitted to the APU on a 5150 hold due to auditory and visual hallucinations, and disorganized and concerning behaviors that impacted their physical health. The patient was assessed by the psychiatrist following admission and agreed to continue to take psychiatric medications. Over the course of the hospitalization medications were adjusted to address symptoms and the psychiatrist, nursing and social work team provided support and encouragement to the patient to continue medication compliance and engage in treatment. Following discharge from the APU the patient was admitted to the IOP for four months. The patient attended groups and individual contacts, met with the treatment team and received regular medication monitoring visits from the psychiatric prescriber. The IOP team continued to support the patient to improve their ADL's, manage symptoms, improve coping and self-care and maintain medication compliance. The patient was discharged from IOP and transitioned to the EOP. The patient was seen weekly by the assigned EOP clinician and had regular follow-ups for medication management with the psychiatric prescriber. The patient remained stable until released. The EOP clinician was able to work with the public defender's office and link the patient to a Community Justice Support Program prior to their release date.
- Patient #8 is diagnosed with Unspecified Schizophrenia Spectrum. They were involuntarily admitted to the APU due to agitation, aggression, disorganized and threatening behaviors that were consistent with a manic presentation. The treatment team quickly built rapport, and the patient began engaging in individual contacts and taking medications. At the time of discharge the patient exhibited linear and organized thought processes, was calm and engaged, medication compliant and managing their ADLs. The patient was discharged to the IOP where they continue to receive treatment. The patient is attending groups, programming

appropriately with peers, and working with his treatment team to maintain their ADL's and medication compliance.

Although IOP has significantly increased its bed capacity and there are plans to expand the APU, this provision remains in partial compliance due to insufficient APU and IOP beds.

IV.F.5 - Partial Compliance

"General Exclusion of Prisoners with Serious Mental Illness from Segregation

b) Prisoners with Serious Mental Illness will not be housed in Segregation units, except in rare cases where the prisoner presents an immediate danger or significant disruption to the therapeutic setting, and there is no reasonable alternative, in which cases the provisions of Section VIII.D of the Segregation/Restrictive Housing Remedial Plan shall apply.

b) Where prisoners with a mental health condition meeting criteria for placement in a Designated Mental Health Unit are assessed a Disciplinary Segregation term, they will serve the term in a Designated Mental Health Unit, except in rare cases where the prisoner presents an immediate danger or significant disruption to the therapeutic setting, and shall receive structured out-of-cell time and programming as determined by the Multi-Disciplinary Treatment Team."

Multidisciplinary Intervention Plans are utilized for patients served in the Outpatient Program and EOP to address significant or dangerous behaviors or significant disruptions to the therapeutic milieu. Patients housed in IOP or APU are not placed in disciplinary segregation. Patients unable to program or engaging in assaultive behaviors or posing a security concern will be placed on an Alternative Treatment Plan. Daily meetings are held with the treatment team to determine interventions and transition the patient back to general programming. The completed and planned IOP expansions have reduced the number of Administrative Segregation inmates on the SMI caseload. A description of the current capacity and planned expansions are outlined in provision IV.F.1.

Regarding IV.F.5.a, "Mental illness or any other disability" (including SMI) is taken into consideration as a mitigating factor when determining if a lesser restrictive medical or mental health housing assignment is appropriate to meet the individual's medical or mental health needs. Custody staff has deferred Administrative Separation placement for individuals where ACMH has made a clinical determination that the individual should be admitted to a mental health program.

Regarding IV.F.5.b, if an individual is currently admitted to a mental health program and receives a Full Restriction (Disciplinary Segregation) sanction, current procedures have the

term served in place, unless there is a new substantial safety risk or a significant disruption to the therapeutic setting. If an individual receives a Full Restriction sanction while housed elsewhere and is later admitted to a mental health program, current procedures have them moved to the appropriate mental health unit to serve the remainder of their disciplinary term.

Based on feedback from Class Counsel, and pending completion of the IOP and APU expansions (see VIII.A.1), this provision has been reduced to partial compliance.

IV.F.6 - Partial Compliance

"Access to Care:

a) *The County shall designate and make available custody escorts for mental health staff in order to facilitate timely completion of appointments and any other clinical contacts or treatment-related events.*

b) *The County shall ensure sufficient and suitable treatment and office space for mental health care services, including the Triage Navigator Program and other mental health-related services provided on site at the Jail.*

c) *Locations shall be arranged in advance for all scheduled clinical encounters.*

d) *The County shall track and document all completed, delayed, and canceled mental health appointments, including reasons for delays and cancelations. Such documentation shall be reviewed as part of the Quality Assurance process.*

e) *Referrals and triage:*

    i. *The County shall maintain a staff referral process (custody and medical) and a kite system for prisoners to request mental health services. Referrals by staff or prisoners must be triaged within 24 hours.*

    ii. *Referrals and requests for mental health services shall be handled in accordance with the following timeframes, and based on the definitions and guidance in Exhibit A-2:*

    - *Prisoners with "Must See" (Emergent) mental health needs shall be seen for assessment or treatment by a qualified mental health professional as soon as possible, and within six (6) hours. Prisoners with emergent mental health needs shall be monitored through continuous observation until evaluated by a mental health professional.*

- *Prisoners with Priority (Urgent) mental health needs shall be seen for assessment or treatment by a qualified mental health professional within 36 hours*.
- *Prisoners with Routine mental health needs shall be seen for assessment or treatment by a qualified mental health professional within two (2) weeks;*
- *Prisoners whose requests do not require formal clinical assessment or intervention shall be issued a written response, with steps taken to ensure effective communication."*

IOP deputies have been structured to support MH treatment on the entire third floor. The JBCT/IOP and EASS programs at RCCC have 16 officers and one sergeant assigned to them. These officers are responsible for ensuring inmates receive what they need from a custody perspective. They act as escorts for the mental health staff. If the inmates need to be taken to an appointment off-site, that is facilitated by our medical escort team. This is also true for the Main Jail, where there are 20 deputies and a sergeant assigned to IOP.

At RCCC, office space for MH care providers and treatment is available and constantly being re-evaluated based on needs and advisement of ACMH administrators. At the Main Jail, SSO works collaboratively with ACMH when space needs arise.

IOP and APU have designated custody support to facilitate clinical contacts and treatment-related activities. Patients may request mental health services through an HSR. SSO staff make ACMH referrals based on personal observations or at the request of the inmate. Patients are provided a written response after submitting an HSR.

MH completed audits of referrals and timelines to care and will continue to utilize the report to monitor compliance with timelines to care. ACMH continues to experience a high level of referrals for services.

ACH and MH are implementing a new process for triaging MH HSRs. To ensure timely response, ACH RNs collect HSRs two times per day from housing units. HSRs are reviewed at time of retrieval and emergent referrals are seen by the RN immediately. The revised process now assigns ACH RNs to triage MH HSRs and immediately route them to the MH team for follow-up and response.

This area remains in partial compliance due to the high number of referrals, MH staffing challenges, and custody escorts to facilitate efficient patient assessments.

IV.G. Medico-Legal Practices

IV.G.1 – Partial Compliance

"The County shall provide access to appropriate inpatient psychiatric beds to all patients who meet WIC § 5150 commitment criteria. At the time a patient's need for inpatient care is identified, commitment paperwork shall be initiated immediately. Placement in an inpatient unit shall occur at the earliest possible time, and in all cases within 24 hours. For individual prisoners placed on a pre-admit or wait list for inpatient placement, affirmative steps to process and place them shall begin immediately."

ACMH has fully implemented CNAP which provides crisis intervention, enhanced observation and stabilization for patients in crisis who do not meet criteria for inpatient treatment.

An expansion to the APU is also in development which will add 24 LPS beds and seven step-down beds. This expansion will bring the total number of LPS beds to 41 with an additional seven step down beds. The projected completion for this project is May of 2026.

In January 2025, SSO received approval from the County Board of Supervisors to add eight additional deputy sheriffs and one sergeant as an expansion of services within the APU program at the Main Jail. This increase in staffing is intended to better facilitate safe and confidential interactions between health care and psychiatric care providers with inmates experiencing mental illness, assist in group activities and structured programming (either in collaboration with, or at the direction of, care providers to maximize the effective treatment and recreational needs of inmates involved in psychiatric care programs) and to communicate with and assist housing unit custody staff regarding the appropriate level of involvement with inmates experiencing mental illness. Inmates in this expanded program will be housed in various locations, requiring a collaborative effort between traditional housing units and this newly formed, specialized team to which they are assigned.

The additional APU sergeant will be responsible for daily oversight and management of deputy sheriffs assigned to the APU and work directly with ACH and ACMH at both facilities to ensure safety and security in the County's need to provide adequate mental health housing. They will serve as a direct liaison between line-level officers, medical staff, psychological staff, compliance units and command staff to ensure application of policies and procedures as well as consistent operations within the Main Jail Division.

They will mentor deputies in the areas of assertive supervision, effective communication, employee discipline, conducting and administering performance appraisals, conduct

disciplinary hearings for those patients housed in the APU, participate in meetings with sworn and non-sworn supervisors regularly to ensure the facilitation of information and compliance information exchange, as well as adherence to policy and procedures, conduct audits of ATIMS jail management system logs and associated CCTV video systems from all assigned housing floors to ensure accurate recording and documentation of inmate activity and movement through the facility as well as officer conduct. They will ensure that the deputies and records officers under their supervision properly execute their assigned duties in their housing units and they will be required to demonstrate proof of practice for all remedial plan provisions related to the APU.

This area remains in partial compliance due to insufficient APU beds which prevents placing some patients on the MH caseload in the least restrictive setting appropriate to their needs.

IV.G.2 – Substantial Compliance

"The County shall not discharge patients from the LPS unit and immediately readmit them for the purpose of circumventing LPS Act requirements. For patients with continuing need for LPS commitment, the County shall follow all required procedures under the LPS Act."

ACMH follows all LPS Act requirements regarding LPS commitments and does not discharge and readmit patients to circumvent the LPS Act. This provision remains in substantial compliance.

IV.G.3 – Substantial Compliance

"The County shall review all County and JPS policies and procedures for PREA compliance, and revise them as necessary to address all mental health-related requirements."

ACH has reviewed all County and ACMH (formerly, JPS) policies and procedures for PREA compliance and revised them as necessary to address all mental health-related requirements. This provision remains in substantial compliance.

IV.H. Clinical Restraints and Seclusion

IV.H.1 – Substantial Compliance

"Generally:

a) It is the policy of the County to employ restraints and seclusion only when necessary and to remove restraints and seclusion as soon as possible.

b) *It is the policy of the County to employ clinical restraints and seclusion only when less restrictive alternative methods are not sufficient to protect the inmate-patient or others from injury. Clinical restraint and seclusion shall not be used as punishment, in place of treatment, or for the convenience of staff.*

c) *The placement of a prisoner in clinical restraint or seclusion shall trigger an "emergent" mental health referral, and a qualified mental health professional shall evaluate the prisoner to assess immediate and/or long-term mental health treatment needs.*

d) *When clinical restraints or seclusion are used, Jail staff will document justification for their application and the times of application and removal of restraints.*

e) *There shall be no "as needed" or "standing" orders for clinical restraint or seclusion.*

f) *Individuals in clinical restraints or on seclusion shall be on constant watch, or on constant video monitoring with direct visualization every 15 minutes. All checks will be documented.*

g) *Fluids shall be offered at least every four hours and at meal times."*

ACMH only employs restraints and seclusion when clinically necessary and removes restraints and seclusion as soon as possible. SSO assists ACMH when restraints and seclusions are clinically indicated by ACMH. Per SSO policy "Use of Restraints," Incarcerated persons use of restraints shall be documented on appropriate logs and shall be video recorded unless exigent circumstances prevent staff from doing so. The documentation shall include, at a minimum, the type of restraint used, when it was applied, a detailed description of why the restraint was needed, the name of the person authorizing placement, any injuries sustained, when the restraints were removed and the duration of placement.

Additionally, deputies shall conduct continuous direct face-to-face observation at staggered intervals not to exceed every 15 minutes to check the incarcerated person's physical well-being and behavior. Restraints shall be checked to verify correct application and to ensure they do not compromise circulation. All checks shall be documented, with the actual time recorded by the person doing the observation, along with a description of the incarcerated person's behavior. Any actions taken should also be noted in the log.

Within the same policy under Food Hydration and Sanitation, incarcerated persons who are confined in restraints shall be given food and fluids. Provisions shall be made to

accommodate any toileting needs at least once every two hours. Food shall be provided during normal meal periods. Hydration (water or juices) will be provided no less than once every four hours and at all meal times. Offering food and hydration to incarcerated persons will be documented to include the time, the name of the person offering the food or water/juices, and the incarcerated person's response (receptive, rejected).

This provision remains in substantial compliance.

IV.H.2 – Substantial Compliance

"Clinical Restraints:

a) *The opinion of a qualified health care professional or qualified mental health professional on placement and retention in restraints will be obtained within one hour from the time of placement.*

b) *A thorough clinical assessment shall be conducted by qualified health care professional or qualified mental health professional every four hours to determine the need for continued restraint.*

c) *Individuals in restraints shall be checked every two hours by a nurse for vital signs, neurovascular assessment, and limb range, and offered an opportunity for toileting."*

ACMH does not utilize “as needed” or “standing” orders for clinical restraint and seclusion. ACMH actively utilizes de-escalation and less restrictive means prior to initiating clinical restraints and only when other interventions are not sufficient to protect the patient or others from injury. ACMH rarely employs clinical restraints on the APU.

ACMH never uses clinical restraint or seclusion as a punishment, in place of treatment, or for the convenience of staff. Hourly documentation of clinical restraints and seclusion includes justification, time of application, monitoring of restraints, patient assessment and range of motion, opportunity for toileting, circulation checks, patient presentation, discussion with patient regarding behaviors necessary for release from restraints, rationale for not removing restraints and offering of food and fluids every two hours.

Per SSO policy “Use of Restraints,” Clinical restraints and/or therapeutic seclusion shall only be used in an APU or infirmary when an inmates' safety or the safety of others cannot be protected by less restrictive means, and only upon the direct order of a qualified health care professional, in accordance with ACH policy, and notification of the jail commander or the authorized designee prior to taking action. In consultation with ACH or ACMH staff,

deputies may assist in the placement and removal of clinical restraints. ACH or ACMH staff is primarily responsible for the observations and monitoring (i.e., restraint checks, providing food, water, and toileting opportunities, etc.) of inmates who are placed in clinical restraints.

This provision remains in substantial compliance.

IV.H.3 – Partial Compliance

"Reentry Services:

a) *The County shall provide a 30-day supply of current psychotropic medications to inmates on the mental health caseload, who have been sentenced and have a scheduled released date, immediately upon release.*

b) *Within 24 hours of release of any inmate who is on the mental health caseload and classified as pre-sentence, the County shall transmit to a designated County facility a prescription for a 30-day supply of the inmate's current psychotropic medications.*

c) *The County, in consultation with Plaintiffs' counsel, develop and implement a reentry services policy governing the provision of assistance to prisoners on the mental health caseload, including outpatient referrals and appointments, public benefits, medical insurance, housing, substance abuse treatment, parenting and family services, inpatient treatment, and other reentry services.*

d) *The County agrees that, during the course of the implementation of the remedial plans contained in this agreement, it will consider Plaintiffs' input on measures to prevent unnecessary or avoidable incarceration of individuals with serious mental illness."*

Staff provide sentenced patients with a 30-day supply of prescribed medications upon release. Discharge medications continue to be provided to approximately 90% of eligible sentenced patients and 95% of court-ordered patients upon release. Sentenced status is now transmitted from ATIMs to Athena, providing a comprehensive view of patients' sentencing across all charges. This enhancement improves our ability to identify patients who are fully sentenced and potentially eligible for release.

A conditional release flag has been added to ATIMS to alert custody staff when a patient has discharge medications ready. A pharmacist delivers medications to the patient at release. Additionally, staff have been hired to support the implementation of a 24-hour

pharmacy at Main Jail. Training is currently underway, with full implementation is scheduled before the end of the year.

ACH has changed the practice of sending prescriptions directly to the County's Primary Care Clinic due to less than a 5% patient pickup rate, high provider and staff workload, and a high amount of Court-ordered Medication in hand. This decision was approved by the medical directors.

If a patient arrives at Primary Care within two weeks of discharge, patients can still request a 30-day medication supply. ACH will fulfill the prescription through the County's Primary Care Pharmacy. Upon arrival at Primary Care, staff will coordinate with ACH Pharmacy or the 2nd Floor MD Office for prescriptions. Providers will call in a verbal order to the Primary Care Pharmacy. Future enhancement to EHR Computerized Provider Order Entry (CPOE) allows for Electronic Prescribing to streamline delivery of prescriptions.

Many prerelease patients are being captured through Court-Ordered medications, sometimes in excess of 30 days. For these, the Pharmacy receives daily email for patient that were granted court-ordered discharge medications. Phone calls are received from SSO release deputies for last minute court-order medications. In these situations, the patient is held for release until the pharmacy can prepare medications. Medications are delivered to patients in the release area.

Meeting 1115 Waiver Requirements: The waiver mandates that all patients leaving custody must have a 30-day medication supply in-hand. ACH pharmacy are training staff for 24-hour pharmacy operations to meet this demand, including real-time monitoring of releases in partnership with SSO.

Interagency Communication Enhancements: ACH has created a monitored email inbox for public defenders, conflict attorneys, and district attorneys to share release info and medication needs. This has improved same-day release planning and care coordination.

This provision remains in partial compliance.

IV.I. Training

IV.I.1 – Partial Compliance

"The County shall develop and implement, in collaboration with Plaintiffs' counsel, training curricula and schedules in accordance with the following:

a) *All jail custody staff shall receive formal training in mental health, which shall encompass mental health policies, critical incident response, crisis intervention*

techniques, recognizing different types of mental illness, interacting with prisoners with mental illness, appropriate referral practices, suicide and self-harm detection and preventions, relevant bias and cultural competency issues, and confidentiality standards. Training shall be received every two years, at minimum.

b) *Custody staff working in Designated Mental Health Units shall receive additional training, including additional information on mental illness, special medico-legal considerations, de-escalation techniques, working with individuals with mental health needs, relevant bias and cultural competency issues, and the jail's mental health treatment programs.*

c) *Mental health staff shall receive training on the correctional mental health system, correctional mental health policies, suicide assessment and intervention, relevant bias and cultural competency issues, and treatment modalities to be offered in the jails."*

For IV.I.1.a, the SSO Academy now offers graduates the 24-hour CIT class, as well as an additional 20 hours of behavioral health as part of their final training before being employed. These classes cover many of the topics listed. Additionally, SSO staff will be assigned various classes through Lexipol, which they must complete online. Many of these topics are covered through these classes as well. All new employees receive four hours of in-person suicide prevention training developed in collaboration with the suicide prevention SME. Current employees will receive a two-hour refresher course annually. This was implemented in May 2021. IOP and JBCT deputies are given 24 hours of additional CIT training. Several deputies from the Main Jail and RCCC have received a two-hour negotiations class specific to a custody setting.

All new custody staff are now required to attend eight (8) hours of mental health training to include: Suicide Prevention, Understanding Mental Health Symptoms in a Correctional Setting, Mental Health Evaluations for Planned Use of Force, and Effects of Brain Development in Forensic Settings & Mental Health Adaptive Supports.

For IV.I.1.b, ACMH provides training to custody staff working in Designated Mental Health Units. ACMH has a training coordinator who monitors training compliance. Training was developed and provided on the following:

- Treatment Planning and MDT Meetings
- Brain Development/Intellectual Disability
- Effective Communication/ADA
- Consent Decree

- 5150 Certification
- Prison Rape Elimination Act
- Understanding Mental Health Symptoms in the Correctional Setting (Custody specific training)
- World Professional Association for Transgender Health (WPATH) Transgender Care
- MH Adaptive Support Plan
- Suicide Prevention – 2-Hour Training
- Suicide Prevention – 4-Hour Training
- Suicide Risk Assessment
- Planned Use of Force and De-escalation
- Updated Safety Planning Training (January 2023)
- MH RVR and Segregation Assessments
- Cultural Intelligence in Healthcare: The Impact of Unconscious/Implicit Bias in Healthcare (October 2023)

For IV.I.1.c, ACH leadership was able to procure a guest trainer on the topic of "Documentation Practices and Litigation" who has been featured at the National Commission on Correctional Health Care (NCCHC). Doug Bitner is an attorney who has defended the County in over 2,000 cases regarding inmate-patient lawsuits. He provided tailored training for Sacramento County Jail staff on the importance of documentation. This training is included as part of new employee onboarding.

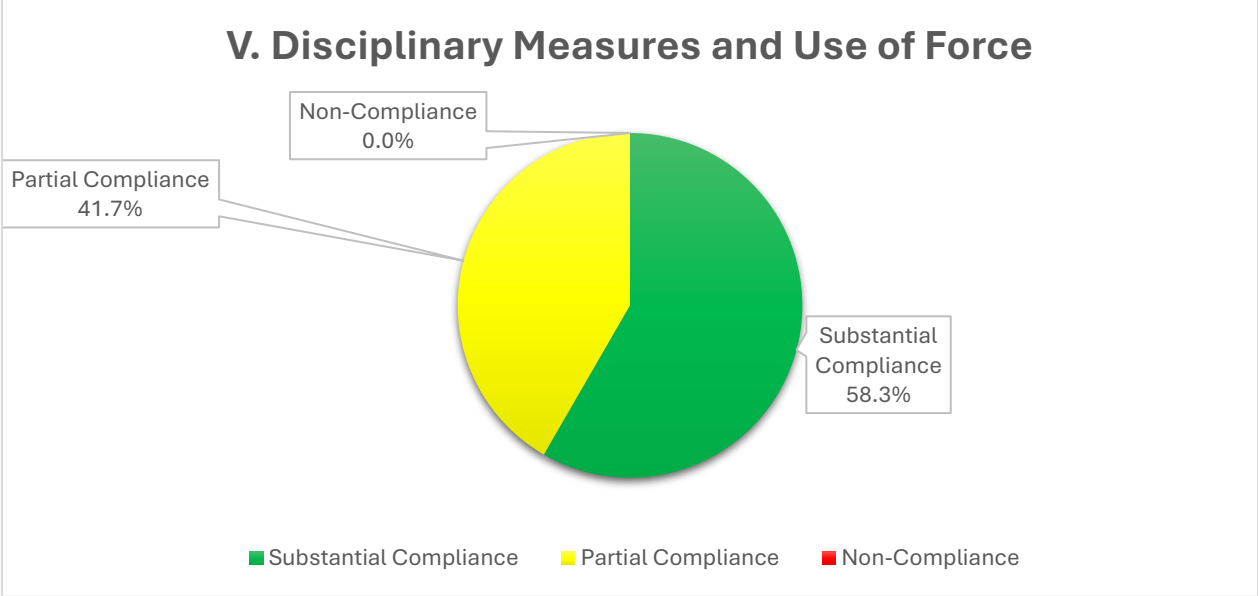
ACMH staff have completed Cultural Intelligence in Healthcare: The Impact of Unconscious/Implicit Bias in Healthcare.

ACMH has developed a "Diagnosing Serious Mental Illness with Jail Populations" training which will include a review of DSM 5 –TR criteria and Mental Status Exam training for all clinicians to provide a general update and strengthen clinical rationale.

ACMH developed an Adaptive Support Plan and MoCA refresher training that all clinical staff will take every two years.

This provision remains in partial compliance pending verification that all custody staff, including those who have worked in the corrections setting for a considerable amount of time, have received all relevant training.

V. Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities



The County has identified 24 provisions in Remedial Plan V. Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities. For this 11th County Status Report, the compliance ratings are as follows:

- Substantial Compliance: 14 provisions (58.3%)
- Partial Compliance: 10 provisions (41.7%)
- Non-Compliance: 0 provisions (0%)

Monitoring Status

Remedial Plan V. Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities is monitored by the Mental Health SME, Dr. Mary Perrien. As of August 1, 2025, four monitoring reports have been completed to evaluate the Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities remedial plan provisions in the Consent Decree. Ratings for these provisions were included in the fourth monitoring report completed by Mary Perrien, Ph.D. The "Mental Health Expert's Fourth Round Report of Findings" is dated May 1, 2024.

In addition to evaluating provisions within the Consent Decree, Dr. Perrien rated three additional provisions from Focus Area #4, Use of Force Policies and Practices, Class Members with Disabilities, from the June 2022 Memorandum of Agreement (MOA).

Sacramento County Status Reports have not historically assigned compliance ratings to provisions in the MOA.

In comparison to the County's self-assessed ratings, the Court-appointed monitors' compliance ratings are as follows:

- Substantial Compliance: 2 provisions (8.3%)
- Partial Compliance: 12 provisions (50%)
- Non-Compliance: 7 provisions (29.2%)
- Not Assessed: 3 provisions (12.5%)

Attachment 5, Disciplinary Measures and Use of Force for Prisoners with Mental Health or Intellectual Disabilities Remedial Plan Expert Rating Reconciliation, aligns the Court-appointed monitor's compliance ratings with the provision structure used here and shows how the County's compliance ratings compare to those of the assigned monitor.

Self-Assessment

V.A. Role of Mental Health Staff in Disciplinary Process

V.A.1 - Substantial Compliance

"The County's policies and procedures shall require meaningful consideration of the relationship of a prisoner's behavior to any mental health or intellectual disability, the efficacy of disciplinary measures versus alternative interventions, and the impact of disciplinary measures on the health and well-being of prisoners with disabilities."

ACMH policies and procedures contain meaningful consideration of the relationship of a patient's behavior to any mental health or intellectual disability, the efficacy of disciplinary measures versus alternative interventions, and the impact of disciplinary measures on the health and well-being of patients with disabilities, and are drafted in collaboration and coordination with ACMH, ACH, and the court-appointed expert(s).

All SSO policies related to the Consent Decree are drafted by the Lexipol project team, and in coordination with ACH/ACMH and County Counsel's office. A CDHO Post Order has been approved by Class Counsel. A CDHO, who works collaboratively with ACMH to identify mental health or intellectual disability needs and modify discipline to ensure health, well-being, and fairness, is involved with disciplinary processes at each facility. All discipline hearings on Designated Mental Health Unit housing areas (IOP and APU) and in OPP housing on 3W and 3E are conducted by the IOP sergeant. Before implementing

discipline, the IOP sergeant confers with an ACMH staff member about the proposed discipline.

The County has incorporated the Class Counsel-approved RVR form into the ATIMS incident reporting process to ensure that any incident involving a suspect with an identified mental health condition or intellectual disability is referred to ACMH for review. The assessment provided by ACMH is considered and utilized as a mitigating factor by the Sheriff's Office during disciplinary hearings and when determining any applicable sanctions. The CDHO reviews the incident report, hearing report, and the ACMH RVR assessment, taking all factors into consideration when evaluating whether any imposed sanctions should remain in place, be modified (reduced), or be removed in their entirety to ensure compliance with policy and procedure. If the CDHO does not follow the clinical recommendations provided by ACMH in the RVR assessment, justification is documented in the incident report. The RVR process has been found to be in substantial compliance, as described in subsection V.A.2.

When an incarcerated individual who has received disciplinary sanctions is identified by ACMH as experiencing mental health decompensation, ACMH notifies the CDHO. Upon such notification, the CDHO modifies the disciplinary sanctions to ensure they do not further compromise the individual's mental health and, in many instances, removes the sanctions entirely.

V.A.2 - Substantial Compliance

"Prisoners who are alleged to have committed a rules violation shall be reviewed by a qualified mental health professional if any of the following apply:

a) *Prisoner is housed in any Designated Mental Health Unit;*

b) *Jail staff have reason to believe the prisoner's behavior was unusual, uncharacteristic, or a possible manifestation of mental illness;*

c) *Prisoner is on the mental health caseload and may lose good time credit as a consequence of the disciplinary infraction with which he or she is charged."*

Custody consults ACMH staff concerning disciplinary measures when a patient is located in MH housing. ACMH collaborated with SSO Custody on development of an RVR and Administrative Separation referral form and trained custody on the referral process and workflow for Administrative Separation assessments (December 2021). ACMH began completing Administrative Separation assessments for patients on MH caseload in

November 2022 and in November 2023, for all patients placed in Administrative Separation.

ACMH and SSO continue to meet and refine the referral process and update the RVR and Administrative Separation referral form to ensure referrals are received timely and tracked appropriately.

ACMH received budget approval FY 2022/23 for additional clinicians to support RVR and Administrative Separation reviews, assessments, and recommendations. MH continues to actively recruit for these positions. A supervisor and three clinicians are assigned to this area. ACMH has staff available seven days a week to complete RVR and Administrative Separation Reviews. MH RVR/Ad Seg supervisor and clinicians access ATIMS to ensure that all patients placed on Administrative Segregation and/or full discipline are identified and assessed by MH. MH assigned a MH RVR/ADSP clinician to complete assessments at RCCC. MH continues to increase the number of RVRs completed.

In April 2024, per the MH SME recommendation, MH included ID as a component of the RVR and UOF review/QI. MH completed an audit of MH RVR and Administrative Segregation Referrals and identified areas for improvement in coordination with SSO.

JBCT, IOP, and EASS mental health workers are immediately notified of disciplinary write-ups that occur and they work closely with custodial staff to determine the best course of action. All discipline hearings on Designated Mental Health Unit housing areas (IOP and APU) are conducted by the IOP sergeant. Before implementing discipline, the IOP sergeant confers with an ACMH staff member about the proposed discipline.

A CDHO works collaboratively with ACMH to identify mental health or intellectual disability needs and modify discipline to ensure health, well-being, and fairness at each facility.

In August 2024, ACMH and SSO developed a new process to ensure the timely review of patients placed on full discipline and in Administrative Separation (ADSP). Custody granted the MH RVR/ADSP team elevated rights to ATIMS and ACMH now checks ATIMS daily to identify individuals placed on full discipline or ADSP and schedules required assessments.

In September 2024, a MH clinician began attending disciplinary hearings for patients diagnosed with an intellectual disability to provide support and advocacy.

For the period of January to March 2025:

- Main Jail received 509 RVR referrals during this report period. 89 patients were not included in this report due to restrictions already being imposed by the time MH received the RVR, the patient not meeting criteria for an RVR review, the patient being transferred to a different facility, or the patient being released.
- Main Jail completed 99% (417/420) of MH RVR referrals during this report period.
- Main Jail patients with RVRs who had Intellectual Disability and/or SMI:
    - 6% (33/509) had Intellectual Disability.
    - 82% (415/509) had an SMI.
- RCCC received 147 RVR referrals during this report period. 48 patients were not included in the report due to: restrictions already being imposed by the time MH received the RVR, the patient not meeting criteria for an RVR review, the patient being transferred to a different facility, or the patient being released. RCCC completed 100% (99/99) of MH RVR referrals this report period.
- RCCC patients with RVRs who had Intellectual Disability and/or SMI.
    - 2% (3/147) had Intellectual Disability.
    - 89% (131/147) had an SMI.

As ACMH has 90-100% compliance with completing received referrals since January 2024, and the last report from Jan-Mar 2025 showing 99% compliance at MJ and 100% compliance at RCCC, this provision remains in substantial compliance.

V.A.3 - Substantial Compliance

"If any of the above criteria is met, the qualified mental health professional shall complete the form attached as Exhibit A-3 (JPS-Rules Violation Mental Health Review) and indicate:

a) Whether or not the reported behavior was related to mental illness, adaptive functioning deficits, or other disability;

b) Whether the prisoner's behavior is, or may be, connected to any of the following circumstances:

i. An act of self-harm or attempted suicide

ii. A cell extraction related to transfer to a medical/mental health unit or provision of involuntary treatment

iii. Placement in clinical restraints or seclusion.

c) *Any other mitigating factors regarding the prisoner's behavior, disability, and/or circumstances that should be considered and whether certain sanctions should be avoided in light of the prisoner's mental health disability or intellectual disability, treatment plan, or adaptive support needs."*

ACMH completes the MH RVR form for every patient assessed for a rule violation. The review form was developed in consultation with Class Counsel and SME and incorporates all the above assessment factors. See V.A.3 for more information.

In July 2024, ACMH and SSO developed a process to remove discipline sanctions for patients exhibiting decompensation while on discipline. Any MH clinician can request a review to remove sanctions. This provision remains in substantial compliance.

V.B. Consideration of Mental Health Input and Other Disability Information in Disciplinary Process

V.B.1. - Substantial Compliance

"The County shall designate one Chief Disciplinary Hearing Officer for each jail facility, who shall be responsible for ensuring consistency in disciplinary practices and procedures."

There is one primary CDHO for corrections (both facilities) and one auxiliary. This role is currently filled by a Sheriff's sergeant whose primary responsibilities are to act as a final reviewing entity for any and all discipline resulting from a write-up. Additionally, the CDHO tracks incident reports, outcomes, RVR data, and whether or not ACMH's suggestions were followed. In the incidents where discipline is not modified after ACMH's input, the CDHO is responsible to justify the reasoning behind their decision. This provision remains in substantial compliance.

V.B.2 - Substantial Compliance

"The Disciplinary Hearing Officer shall ensure that prisoners are not disciplined for conduct that is related to their mental health or intellectual disability."

The County has incorporated the Class Counsel-approved RVR form into the ATIMS incident reporting process to ensure that any incident involving a suspect with an identified mental health condition or intellectual disability is referred to ACMH for review. The assessment provided by ACMH is considered and utilized as a mitigating factor by the Sheriff's Office during disciplinary hearings and when determining any applicable sanctions. The CDHO reviews the incident report, hearing report, and the ACMH RVR assessment, taking all factors into consideration when evaluating whether any imposed sanctions should remain in place, be modified (reduced), or be removed in their entirety to

ensure compliance with policy and procedure. If the CDHO does not follow the clinical recommendations provided by ACMH in the RVR assessment, justification is documented in the incident report. This provision remains in substantial compliance.

V.B.3 – Partial Compliance

"The Disciplinary Hearing Officer shall consider the qualified mental health professional's findings and any other available disability information when deciding what, if any, disciplinary action should be imposed."

As outlined in subsection V.B.1, this is the current procedure followed by the CDHO. SSO is in the final stages of modifying the role of the CDHO as it relates to the overall corrections discipline program. To ensure our entire inmate population is treated equally and sanctions are appropriate, the CDHO will be solely responsible for the administration of sanctions in addition to the tracking requirements. This modification to the CDHO's responsibilities will also ensure an increased level of cooperation with ACMH regarding rule violations that may have stemmed from an individual's mental health condition. This provision has been reduced to partial compliance as SSO and ACMH are currently working to revise this process, as described above, to better align with Consent Decree requirements.

V.B.4 - Partial Compliance

"The Disciplinary Hearing Officer shall consider the qualified mental health professional's input on minimizing the deleterious effect of disciplinary measures on the prisoner in view of his or her mental health or adaptive support needs."

As outlined in subsection V.B.1, this is the current procedure followed by the CDHO. This provision has been reduced to partial compliance as SSO and ACMH are currently working to revise this process to better align with Consent Decree requirements.

V.B.5 - Partial Compliance

"If the Disciplinary Hearing Officer does not follow the mental health staff's input regarding whether the behavior was related to symptoms of mental illness or intellectual disability, whether any mitigating factors should be considered, and whether certain sanctions should be avoided, the Disciplinary Hearing Officer shall explain in writing why it was not followed."

As outlined in subsection V.B.1, this is the current procedure followed by the CDHO. This procedure is noted in the incident report under the hearing sanction report section. This

provision has been reduced to partial compliance as SSO works to improve consistency with this process.

V.B.6 - Partial Compliance

"Prisoners will not be subjected to discipline which prevents the delivery of mental health treatment or adaptive support needs, unless necessary for institutional safety."

Disciplinary sanctions do not inherently interfere with an incarcerated person's access to mental health care or adaptive support services. Mental health care through ACMH continues regardless of disciplinary status, and individuals continue to receive treatment even while serving disciplinary sanctions. When an individual is enrolled in a structured mental health program, they typically remain in that program so their treatment continues without interruption. In these cases, any disciplinary sanction is served in place unless a housing move is necessary for institutional safety. If an individual must be removed from a mental health program, the reason for that change is documented in the related incident report. This provision has been reduced to partial compliance.

V.B.7 - Partial Compliance

"Prisoners shall not be subject to discipline for refusing treatment or medications, or for engaging in self-injurious behavior or threats of self-injurious behavior."

This has been codified in SSO's Discipline policy. Inmates with suicidal ideation or self-injurious tendencies are closely evaluated and monitored by ACMH staff. ACMH and SSO document the behaviors of these inmates; however, no disciplinary actions are taken. Inmates may refuse medications at any time unless the administration of medication is mandated by the court through a valid order. ACMH is heavily involved in these processes. This provision has been reduced to partial compliance.

V.C. Accommodations for Prisoners with Mental Health or Intellectual Disabilities During the Disciplinary Process

V.C.1 - Partial Compliance

"The County shall provide reasonable accommodations during the hearing process for prisoners with mental health or intellectual disabilities."

During the hearing process, the hearing sergeant is responsible for verifying that the inmate does not require any accommodations and understands that a disciplinary hearing is occurring or will soon take place.

The Sheriff's Office utilizes a flag system in ATIMS to identify incarcerated individuals with mental health needs or intellectual disabilities. One of these flags, "Method of Effective Communication," is provided by ACMH via the Athena system. This designation provides staff with guidance on the most effective ways to communicate with each individual. That information is expected to be reviewed and applied during pre-planned interactions, including disciplinary hearings, so that communication during the process is clear and effective. This provision has been reduced to partial compliance as SSO has identified a lack of documentation in this process and is developing training and quality assurance measures to ensure that reasonable accommodations are met and documented to demonstrate proof of practice.

V.C.2 - Partial Compliance

"The County shall take reasonable steps to ensure the provision of effective communication and necessary assistance to prisoners with disabilities at all stages of the disciplinary process."

For all inmates who are written up for a rule violation, a Mental Health RVR form is completed and reviewed by ACMH to identify necessary assistance to inmates with intellectual disabilities, which includes effective communication. Additionally, SSO's Discipline policy states "For those individuals with limited literacy, unable to read English, and for persons with disabilities, provisions shall be made for staff to instruct them verbally or provide them with material in an understandable form."

V.C.1 includes additional information about the flag/designation system for identifying individuals with effective communication needs. Efforts are being made to keep a record of these encounters to show proof of practice. Until SSO can demonstrate effective communication is occurring during all steps of the discipline process, this provision has been reduced to partial compliance.

V.D. Use of Force for Prisoners with Mental Health or Intellectual Disabilities

V.D.1 - Partial Compliance

"The County's Correctional Services Operations Orders shall include language that ensures meaningful consideration of whether a prisoner's behavior is a manifestation of mental health or intellectual disability."

SSO can identify and consider an inmate's behavior based on the inmate's flags in their ATIMS profiles which are created by ACH and ACMH (described in V.C.1). Per the Sheriff's Office "Custody Emergency Response Team (CERT) and Force Application on Incarcerated

Persons" policy and procedure, when conducting a coordinated planned use of force involving an incarcerated person with a known mental health or intellectual disability, absent an immediate threat to safety, SSO staff shall employ de-escalation methods that consider the incarcerated person's mental health or adaptive support needs. ACMH is to be notified prior to a coordinated planned use of force event involving an incarcerated person with a known mental health or intellectual disability. Where there is not an immediate threat to safety, staff shall provide for a "cooling down period," consistent with safety and security needs. This period shall include the involvement of mental health staff (and other staff if appropriate) to de-escalate the situation and to reach a resolution without use of force. Such efforts, including the use of adaptive supports, must be documented. This provision remains in partial compliance.

V.D.2 - Substantial Compliance

"For prisoners with a known mental health or intellectual disability, and absent an imminent threat to safety, staff shall employ de-escalation methods that take into account the individual's mental health or adaptive support needs."

At both facilities, ACMH is consulted and given the opportunity to participate in de-escalation during all preplanned use of force with inmates under MH care. Inmates with intellectual disabilities are housed on the IOP units where additional trained custody staff are available. SSO Policy "CERT and ForceForce Application on Incarcerated Person" addresses this provision, which includes a "cooling down period" when reasonable for persons with known mental health or intellectual disability. Several staff members from both facilities have received a two-hour negotiations class specific to a custody setting which can help facilitate de-escalation. This provision remains in substantial compliance.

V.D.3 – Substantial Compliance

"The County's Correctional Services Use of Force policies shall include a definition and a protocol for a planned Use of Force that provides appropriate guidance for a planned Use of Force that involves a prisoner with mental health or intellectual disability."

The Sheriff's Office Procedure "Custody Emergency Response Team (CERT) and Force Application on Incarcerated Persons" section on "Mental Health or Intellectually Disabled Incarcerated Person" specifies the following:

- Prior to a coordinated planned use of force event involving an incarcerated person with a known mental health or intellectual disability, Adult Correctional Mental

Health (ACMH) will be notified. The goal of ACMH is to reach a resolution without the use of force.

    - If an imminent threat to safety becomes apparent, the on-duty sworn supervisor can make the determination to bring the event to a safe conclusion.

- Sheriff's staff will collaborate with ACMH staff in regard to strategies and interventions used during the planned use of force.
- Consistent with safety and security needs there will be a "cooling down" period before planned use of force is used against an incarcerated person with mental health or intellectual disabilities.
    - This period includes a structured attempt by ACMH staff to de-escalate the situation and reach a resolution without the use of force.
    - The ACMH clinician (and other staff, as appropriate) will be allotted a reasonable amount of time to speak with and evaluate the incarcerated person.
    - The ACMH clinician will report to the Sheriff's sworn supervisor the clinician's evaluation, attempts at de-escalation/resolution, and the incarcerated person's response to the interventions.
- Video Documentation
    - Sheriff's staff shall endeavor to record the specific actions, behavior, or threats leading to the need for use of force, as well as efforts to resolve the situation without force. Any de-escalation attempts with the incarcerated person by Sheriff's employees shall be recorded.
    - After the ACMH Clinician speaks to the incarcerated person, the clinician shall be afforded the opportunity to summarize their attempts at de-escalation and resolution. The clinician's summary shall be video recorded.
- IM Medication Orders
    - ACMH often has intramuscular injection (IM) medication ordered as a means to administer needed mental health medication in addition to or in lieu of oral medication.

- This order does not preclude Sheriff's staff from providing immediate low-level controlling force to assist ACMH with IM medication on a semi-cooperative incarcerated person.

This provision remains in substantial compliance.

V.D.4 – Substantial Compliance

"Prior to any planned Use of Force, such as a cell extraction, against a prisoner with mental health or intellectual disabilities, there will be a "cooling down period," consistent with safety and security needs. This period includes a structured attempt by mental health staff (and other staff if appropriate), to de-escalate the situation and to reach a resolution without Use of Force. Such efforts, including the use of adaptive supports, will be documented in writing. Medical and/or mental health staff should be consulted if the purpose of the cell extraction is related to the delivery of treatment."

For SSO, this is the current practice with all planned use of force (PUOF) incidents, including those involving inmates in specialized units (see policy "Custody Emergency Response Team (CERT) and Force Application on Incarcerated Persons"). The officers assigned to MH units work closely with ACMH staff when incidents requiring a PUOF arise, including consultation with ACMH staff and ample opportunities for inmate consultation and intervention by ACMH.

In addition to the historical information documented in the 10th County Status Report, a recent audit found a total of 14 PUOF referrals were made in April 2025. 54% (7/13) were averted after the clinician met with the patient. 46% (6/13) resulted in a PUOF incident. All six of these patients had an SMI. 33% (2/6) Schizophrenia and 67% (4/6) Bipolar I Disorder. 13/14 PUOF incidents were related to the administration of involuntary court ordered medications. With proof of practice established, this provision has been increased to substantial compliance.

V.D.5 - Substantial Compliance

"The County shall require video documentation for any planned Use of Force, absent exigent circumstances. Jail staff shall endeavor to record the specific actions, behavior, or threats leading to the need for Use of Force, as well as efforts to resolve the situation without Use of Force."

SSO updated the Use of Force Policy (300) which requires such video documentation. Please also see the supervisor review process in V.D.6. This provision remains in substantial compliance.

V.D.6 - Substantial Compliance

"The County shall ensure the completion of supervisory review of Use of Force incidents, including video (for any planned Use of Force), interviews, and written incident documentation, in order to ensure appropriateness of Use of Force practices including de-escalation efforts. The County shall take corrective action when necessary."

Pursuant to SSO's Use of Force Policy, use of force incidents go through numerous levels of review to include supervisor, managers, and assistant commanders or their designee. Should violations of policy be recognized, corrective action is taken when necessary.

The specific procedure for documenting a use of force incident are as follows:

When a use of force incident occurs, it undergoes multiple levels of review. Typically, two written reports are created—one in the Sheriff's Office report-writing system and another in ATIMS. A supervisor reviews and approves both reports in full.

Key evidence is also uploaded to a third-party software system called Blue Team. This system serves as an internal tracking and evaluation tool, containing all relevant data for the incident. At a minimum, this includes written reports, photographic evidence (if applicable), body-worn camera footage, and closed-circuit television (CCTV) footage. The Blue Team report also records specific details such as the location where force was used, any injuries sustained, and other relevant factors.

Once completed, the Blue Team report is forwarded by the supervisor (sergeant) to the watch commander (lieutenant). Both the supervisor and the watch commander are responsible for ensuring the use of force was appropriate, legal, and in compliance with departmental policy. After the watch commander's review, the report goes to the jail commander (captain) or their designee for a third level of review. If the jail commander delegates this step, it is handled by an executive-level lieutenant.

If there are concerns that a policy violation may have occurred, the Blue Team report can be sent to SSO's Internal Affairs for a potential use-of-force investigation. Before this step is taken, the chief of corrections is notified.

This provision remains in substantial compliance.

V.D.7 - Substantial Compliance

"The County shall review and amend as appropriate its policies on Use of Force, including its policies on Custody Emergency Response Team (CERT) and Cell Extraction Procedures."

SSO is constantly reviewing and updating use of force policies based on a multitude of factors; the current procedure is described in V.D.6. Changes may be made in response to relevant changes in law, case law, and training standards. SSO regularly receives legal updates from Lexipol. SSO reviews and researches these updates to determine if it is appropriate to create or revise a policy or procedure to reflect the changes. Proposed revisions to policies based on legal updates are shared with Class Counsel and approved by SSO's executive leadership prior to publication. This provision remains in substantial compliance.

V.E. Training & Quality Assurance

V.E.1 - Substantial Compliance

"All custody staff, and mental health staff, shall be trained on the policies and procedures outlined herein that are relevant to their job and classification requirements. Custody staff will receive periodic training on identifying behaviors that may be manifestations of mental illness and other situations warranting a referral to mental health staff, including for a Rules Violation Mental Health Review or other mental health assessment."

All ACMH staff have been trained on the policies and procedures relevant to their job and classification requirements. All staff assigned to corrections (sworn staff and records officers) have received Consent Decree training since September of 2021. As new hires are onboarded, they are assigned the training and must attest to the completion of the training.

All newly assigned custody staff receive formal training through the Sheriff's Training Officer program which minimally consists of an eight-week program. All relevant policies and procedures are discussed and checked off by each respective training officer to ensure the trainees understand all topics covered in the program. Additionally, all custody staff attend a two-hour suicide prevention course every year addressing mental illness and the appropriate responses.

This provision remains in substantial compliance.

V.E.2 - Partial Compliance

"All custody staff shall be trained on the identification of symptoms of mental illness, the provision of adaptive supports, and the use of de-escalation methods appropriate for prisoners with mental health or intellectual disabilities."

ACMH added a training module for all staff, including SSO deputies, to follow the four-hour Suicide Prevention Training. This will ensure all new employees receive training on understanding and working with patients who have a mental health disorder.

Many aspects of this training are already covered during in-service and pre-service training for SSO. Every year, sworn and professional staff receive a two-hour course provided by mental health. A comprehensive review of current training offerings, compared against the needs of this element was reviewed.

In November 2024, ACMH and SSO developed a training plan to ensure all new deputies complete the following training over one day: Understanding Mental Health Symptoms in a Correctional Setting, Mental Health Evaluations in Planned Use of Force, and Effects of Brain Development in Forensic Settings & Mental Health Adaptive Supports.

This provision remains in partial compliance until proof of practice is established.

V.E.3 - Substantial Compliance

"The County shall track the outcomes of all disciplinary hearings for prisoners who are on the mental health caseload or who have intellectual disabilities, including whether the recommendation of the mental health professional was followed."

ACMH and SSO continue to meet regularly to discuss the MH RVR process and are developing an audit that will include whether SSO followed the recommendation(s) of the MH professional. Since September of 2024, a MH clinician has been attending disciplinary hearings for patients diagnosed with intellectual disability to provide support and advocacy.

Disciplinary hearing outcomes are tracked by the CDHO for each facility and documented in a comprehensive spreadsheet. This provision remains in substantial compliance.

V.E.4 - Partial Compliance

"The County shall track all Uses of Force (planned and reactive) involving prisoners who are on the mental health caseload or who have intellectual disabilities, including the number of Uses of Force and the number of cell extractions by facility."

In February 2024, MH began auditing PUOF and UOF incidents utilizing data from both MH and SSO. There continue to be regular meetings to discuss UOF and PUOF events.

All use of force is reviewed and tracked by the SSO division commander or designee. SSO has recently developed an easily accessible spreadsheet to better document tracking for these events. The tracking system includes all elements required under this provision

except when an incident involves a cell extraction. SSO is currently modifying the tracking system to include tracking of cell extractions. Until the tracking system is modified to include cell extraction data, this provision has been reduced to partial compliance.

V.E.5 - Substantial Compliance

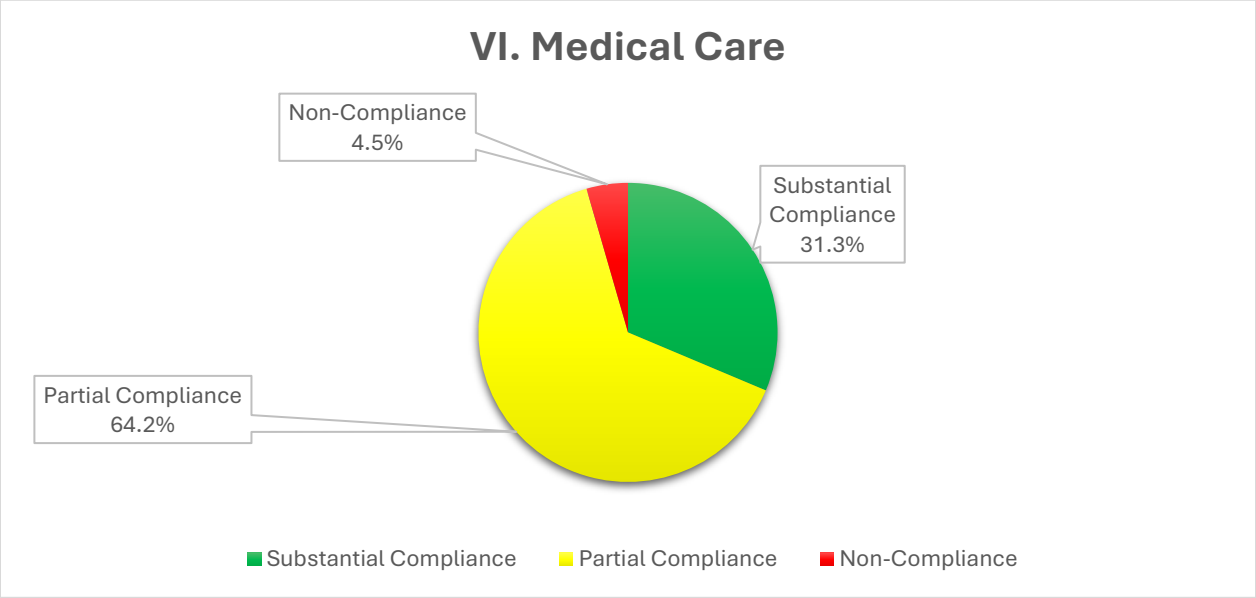
"The County shall implement a continuous quality assurance/quality improvement plan to periodically audit disciplinary and Use of Force practices as they apply to prisoners who are on the mental health caseload or who have intellectual disabilities."

In February 2024, ACMH began auditing PUOF and UOF incidents utilizing data from both MH and SSO. All use of force incidents are reviewed by SSO at a supervisory and management level for quality assurance.

In April 2024, per the MH SME recommendation, MH included ID as a component of the RVR and UOF review/QI.

As ACMH and SSO are auditing UOF/Wrap Restraint System (WRAP)/PUOF and disciplinary incidents and reporting findings to the Mental Health Quality Improvement Subcommittee, this provision remains in substantial compliance.

VI. Medical Care



The County has identified 67 provisions in Remedial Plan VI. Medical Care. For this 11th County Status Report, the compliance ratings are as follows:

- Substantial Compliance: 21 provisions (31.3%)
- Partial Compliance: 43 provisions (64.2%)
- Non-Compliance: 3 provisions (4.5%)

Monitoring Status

Remedial Plan VI. Medical Care is monitored by the medical SMEs, Angela Goehring RN, MSA, CCHP and Sylvia McQueen, MD, MBA, FACP, CCHP. As of July 2025, seven monitoring reports have been completed to evaluate the medical care remedial plan provisions in the Consent Decree.

In comparison to the County's self-assessed ratings, the Court-appointed monitors' compliance ratings are as follows:

- Substantial Compliance: 14 provisions (20.9%)

    - This includes 10 provisions that are no longer subject to external monitoring as the County has sustained a level of substantial compliance with these provisions for over one year.[6]
- Partial Compliance: 40 provisions (59.7%)
- Non-Compliance: 12 provisions (17.9%)
- Not Assessed: 1 provision (1.5%)

In the most recent medical monitoring report, the SMEs provided compliance ratings for several sub-provisions, including VI.C.3.a-d, VI.C.3.a-b, VI.D.1.a-d, and VI.F.1.a-b. The report also included four compliance ratings for provisions in XI.C.1-4. Attachment 6, Medical Care Remedial Plan Expert Rating Reconciliation, aligns the Court-appointed monitor's compliance ratings with the provision structure used here and shows how the County's compliance ratings compare to those of the assigned monitor.

Self-Assessment

VI.A. Staffing

VI.A.1 - Partial Compliance

"The County shall maintain sufficient medical, mental health and custody staffing to meet professional standards of care to execute the requirements of this remedial plan, including clinical staff, office and technological support, QA/QI units and custody staff for escorts and transportation."

During this reporting period, ACH hired a new medical director, Dr. Thomas Bzoskie, who began on June 30, 2025. Dr. Bzoskie has extensive experience and passion with over 20 years in correctional medicine, clinical leadership, healthcare management, and various peer review roles. The County is confident that he will greatly contribute to organizational goals and improvement of healthcare service provided to patients, achieving a constitutionally adequate level of care while helping to build a vibrant and caring healthcare team that addresses all the elements outlined in Consent Decree.

Also during this reporting period, ACH hired a second nursing director to oversee nursing operations at the Main Jail, while the existing nursing director continues to oversee operations at RCCC. Tammy Trant is a visionary nursing leader with over 17 years of

[6] In addition, one sub-provision (VI.F.1.a) has been removed from external monitoring; however, the remaining sub-provisions of VI.F.1 are in partial compliance.

diverse healthcare experience, specializing in program management, quality improvement, regulatory compliance, and risk management across complex systems.

The fulfillment of these critical leadership roles is expected to strengthen ACH compliance across multiple operational and clinical areas.

In mid-2024, the County authorized the establishment of four FTE deputy sheriff positions specifically designated for medical escorts. The Main Jail currently averages eight medical escorts Monday through Friday during dayshift hours, with three escorts assigned during night shift hours. On weekends, the Main Jail averages four medical escorts available during the day and three during the night shift. Furthermore, in response to requests from ACMH for support during efforts to eliminate the backlog for mental health services by temporarily bringing on additional providers through focused "blitzes" aimed at ensuring timely patient care, SSO provides two escorts to assist.

RCCC has a minimum of six deputies assigned as medical escorts during day shift. Additionally, custody escort for ACMH appointments has increased to five hours a day, four days a week to meet the demands of needed ACMH appointments. After hours, there are a minimum of three shift deputies assigned to assist with medical escorts as needed.

A full description of staffing levels, as well as the upcoming staffing analysis, is included with provision II.A. This provision remains in partial compliance.

VI.A.2 - Partial Compliance

"Provider quality shall be evaluated regularly to ensure that relevant quality of care standards is maintained. This review shall be in addition to peer review and quality improvement processes described in this plan. The parties shall meet and confer regarding any deficiencies identified in the evaluation. Should the parties disagree regarding matters of provider quality, the Court Expert shall evaluate the quality of provider care and to complete a written report."

During this reporting period, ACH drafted a Peer Review Policy with heavy input from the new medical director (pending finalization) and began utilizing the Peer Review forms developed by the previous medical director and the provider consultant. For this process, the appointed reviewers, comprising of the assistant medical director and lead physicians, conduct structured chart reviews for each provider. When issues are identified, the reviewers are responsible for providing direct feedback, which may include disciplinary actions when appropriate. Quality improvement feedback has already been issued, and

results are shared with the providers. All reviews are documented and tracked for accountability and follow-up.

ACH anticipates ongoing refinements to this process as the new medical director becomes more familiar with the system. Given his strong background in peer review, this will be a key area of focus moving forward. This provision remains in partial compliance.

VI.B. Intake

VI.B.1 - Substantial Compliance

"All prisoners who are to be housed shall be screened upon arrival in custody by Registered Nurses (RNs). RN screening shall take place prior to placement in jail housing."

All patients booked into the Jails are screened upon arrival by a Registered Nurse prior to placement in jail housing. ACH worked closely with the medical SMEs to create a two-phased nurse intake format and streamline the questions for better flow and reduce redundancy. This new system was implemented in September 2024 with phase 1 being a brief, ten-minute screening to determine if the arrestee needs clearance from the hospital first or can proceed to phase 2.

One nurse has been designated at all times for phase 1, and the fit/unfit criteria is utilized. At this stage, a color-coded wristband is used to help inform decisions on the arrestee's needs.

- Green - meets all the fit criteria during phase 1 and has no medical issues.
- Red - needs expedite to detox, Medication Assisted Treatment (MAT), or type 1 diabetes, etc. This patient will have priority to move through phase 2.
- Yellow - those having identified issues that may need follow up or orders.

Phase 2 contains the majority of the questions but has been shortened and changed to have better flow. The redundant questions were removed and questions were made clearer and in a more thoughtful order.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VI.B.2 - Substantial Compliance

"Health Care intake screening shall take place in a setting that ensures confidentiality of communications between nurses and individual patients. Custody staff may maintain visual communication, unless security concerns based upon an individualized determination of risk that includes a consideration of requests by the health care staff that custody staff be closer at hand. There shall be visual and auditory privacy from other prisoners."

Beginning August 2024, ACH now has four private nurse intake rooms at the Main Jail, therefore meeting all privacy requirements. Each room has a door with a large window that allows the arresting officer to stand by for safety. This allows for auditory privacy from both officers and other arrestees.

Arrestees who are combative have their intake completed in an open nurse station, ensuring their safety. Rooms are equipped with alarms, restraint points and lights that indicate when the nurse is ready for the next arrestee.

A trailer was added at RCCC. This trailer has been designated for intakes, therefore reducing the impact at the Main Jail. DGS is currently in the process of making the trailer ADA compliant with the addition of a bathroom installation.

This provision remains in substantial compliance.

VI.B.3 - Partial Compliance

"The County shall, in consultation with Plaintiffs, revise the content of its intake screening, medical intake screening, and special needs documentation to reflect community standards and ensure proper identification of medical and disability related concerns."

ACH worked closely with the medical SMEs to create a two-phased nurse intake format and streamline the questions for better flow and reduce redundancy. This new system was implemented in September 2024 and has been working very well. During this reporting period, continued refinements to the phase 1 criteria have been made, with heavy input from the new medical director. The medical SMEs reviewed and approved the changes, and the modifications are being made in the EHR. ACH anticipates utilizing the new phase 1 criteria in August 2025.

During this reporting period, ACH and SSO worked together to address concerns surrounding wait times during the booking process. Leadership conducted a process walk through and identified areas of inherent delays. A significant area of concern surrounded

the lack of communication between arresting agencies and SSO when there were issues with required paperwork. Problems with paperwork cause the process to halt at several process points. To remedy this issue, SSO stationed a records officer in the arrest report room to ensure steady flow of arrestees throughout the booking process. They are to identify any delays and work with the arresting agency or ACH to quickly resolve them. As a result, wait times for the entirety of the intake process have significantly reduced.

During the upcoming reporting period, ACH and SSO are going to pilot the implementation of the new phase 1 criteria as a formal FIT/UNFIT determination. The goal is to enable the arresting agency to return to the field more quickly and for SSO to assume responsibility of the arrestee sooner. Phase 2 will be completed shortly after the pat down/body scan procedures following phase 1.

Also concerning nurse intake, ACH previously dedicated SRNs during the dayshift 7 days per week and have since added one SRN for the night shift. A second night shift SRN has been hired and is in the background process. This 24/7 nurse leadership coverage assists with troubleshooting any issues that arise, and ensures patient safety in the arrest report room, medical intake, medical observation cell and the booking loop in general.

Based on a review of the recent medical SME report, this provision has been reduced to partial compliance.

VI.B.4 - Partial Compliance

"Nurses who perform intake screening shall consult any available electronic health care records from prior incarcerations or other county agencies. The form shall include a check box to confirm that such a review was done."

Nurses are required to check a box in the EHR to confirm previous records were reviewed. QI has observed the nurse intake process in person and found previous history is reviewed consistently; however, there have been instances where ACH leadership has discovered discrepancies with new intake data and historical information. Therefore, ACH leadership is working to modify the EHR to ensure previously documented problems, including allergies, are checked off to move to the next intake screen. The leadership team is strategizing other ways to ensure important historical health information is automatically carried over into a new intake. Based on a review of the recent medical SME report, this provision has been reduced to partial compliance.

VI.B.5 - Substantial Compliance

"The County shall make best efforts to verify a patient's prescribed medications and current treatment needs at intake, including outreach to pharmacies and community providers to request prescriptions and other health records related to ongoing care needs. The policy shall ensure that any ongoing medication, or clinically appropriate alternative, shall be provided within 48 hours of verification or from a determination by a physician that the medication is medically necessary. Any orders that cannot be reconciled or verified, such as those with conflicting prescriptions from multiple providers, shall be referred to a health care provider for reconciliation or verification the next clinic day after booking."

ACH Intake policy outlines that any ongoing medication, or a clinically appropriate alternative, shall be provided within 48 hours of verification of the prescription or from a determination by a physician that the medication is medically necessary. Any orders that cannot be reconciled or verified, such as those with conflicting prescriptions from multiple prescribers, shall be referred to a health care provider for reconciliation or verification the next clinic day after booking.

Through QI audits of this provision, ACH has determined that substantial compliance (above 90%) has been maintained since August 17, 2022 for meeting timeliness standards for patients receiving initial medications. Regarding renewal medication, ACH has remained at 100% compliance since the audit conducted on February 16, 2024. Due to staffing turnover (see section IX.A.3), the QI team was unable to complete Continuous Quality Improvement (CQI) studies regarding medication initiation and renewal. The QI team recently onboarded three new staff and will resume these CQI studies during the next reporting period. This provision remains in substantial compliance; supporting data will provided in the upcoming reporting period.

VI.B.6 - Partial Compliance

"The County shall follow a triage process in which intake nurses schedule patients for follow-up appointments based upon their medical needs and acuity at intake and shall not rely solely on patients to submit Health Services Requests once housed. The policy shall, in consultation with Plaintiff's counsel, establish clear protocols that include appropriate intervals of care based on clinical guidelines, and that intake nurses shall schedule follow-up appointments at the time of intake based upon those protocols."

ACH policies are consistent with this requirement and were implemented with approval of the court-appointed experts. The nurse intake encounter has been configured to have automatic orders placed based on responses to intake questions. Each order has a priority

level dependent upon the response to all service lines. Orders can be easily made by clicking the button within the nurse intake encounter.

During this reporting period, ACH piloted the placement of a provider within the booking loop. This small-scale pilot aimed to assess how frequently nursing staff would seek provider input and to reduce the time an arrestee might wait for fit/unfit determination. Based on initial findings, ACH plans to implement a permanent provider presence in the booking loop to more effectively address critical needs at intake, such as chronic care issues and withdrawal monitoring concerns.

In consultation with the SMEs, significant changes have been made to the Medical Observation Cell (MOC). ACH has developed criteria that regulates which patients should be placed in the MOC, what provider can authorize placing a patient in the MOC, the frequency of rounds monitoring the MOC, and criteria for releasing patients from the monitoring cell. This assessment will ensure that there is a face-to-face encounter between the medical staff and the patient which allows ACH to ensure patient safety during this potentially high-risk time.

Based on a review of the recent medical SME report, this provision has been reduced to partial compliance.

VI.B.7 - Substantial Compliance

"All nurses who perform intake screenings will be trained annually on how to perform that function."

The QI RN developed a new nurse intake training that incorporated all the changes and trained staff prior to implementation. The QI RN transitioned to the SRN nurse educator in mid-December. Since then, he has worked with the QI RNs, and SRNs to ensure compliance in this area. This area remains in substantial compliance, as all intake nurses are trained annually.

VI.C. Access to Care

VI.C.1 - Substantial Compliance

"The County shall ensure that Health Service Requests (HSRs) are readily available to all prisoners, including those in segregation housing, from nurses and custody officers."

Health Service Requests (HSRs) are readily available to all patients throughout the facility, including those in segregation housing from ACH or SSO Custody. HSRs are available at medical appointments, pill call, and in housing units. Nursing collects health service

requests (HSRs) at least twice daily, once in the morning and once in the evening, and designated staff are responsible for ensuring adequate supplies. This provision remains in substantial compliance.

VI.C.2 - Substantial Compliance

"The County shall provide patients with a mechanism for submitting HSRs that does not require them to share confidential information with custody staff. The county shall install lockboxes or other secure physical or electronic mechanism for the submission of HSRs (as well as health care grievances) in every housing unit. Designated staff shall collect (if submitted physically) or review (if submitted electronically) HSRs at least two times per day in order to ensure that CHS receives critical health information in a timely manner. Designated health care staff shall also collect HSRs during pill call and go door to door in all restricted housing units at least once a day to collect HSRs. HSRs and health care grievances will be promptly date- and time-stamped. The county may implement an accessible electronic solution for secure and confidential submission of HSRs and grievances."

Confidential locked boxes labeled "Health Service Requests" are installed in multiple locations at both jail facilities for patients to submit HSRs to protect confidentiality. Locked boxes are also throughout both facilities' housing units to submit grievances. Designated staff collect HSRs at least two times per day as well as during medication administration and door-to-door in all restricted housing units at least once a day. QI completes in-person observations as well as chart audits to ensure that HSR collection and time-stamping processes are occurring accordingly.

ACH has created an HSR and Grievance collection form for staff to fill out each time they make rounds to collect both forms in the housing units. This provides supervisors and QI a mechanism to ensure HSRs and Grievances are being collected regularly and timely. Use and tracking of this form was implemented this reporting period.

HSRs are turned in directly to nursing staff during pill call twice a day, seven days a week. Nursing staff promptly date and time stamp all HSRs (within two hours) of receipt. Lockboxes for Medical Grievances and HSRs have been installed in all housing units at RCCC and Main Jail to ensure privacy. The lockboxes are checked twice a day.

SSO is exploring an inmate hotline where the inmate would speak with a telehealth representative to document the medical request without custody involvement.

As there is consistent time-stamping and timely collection as evidenced by designated nursing staff physically scanning HSR forms immediately after collecting, this provision remains in substantial compliance.

VI.C.3 - Partial Compliance

"The County shall establish clear time frames to respond to HSRs:

a) *All patients whose HSRs raise emergent concerns shall be seen by the RN immediately upon receipt of the HSR. For all others, a triage RN shall, within 24 hours of receipt of the form (for urgent concerns) or 72 hours of receipt of the form (for routine concerns).*
    i. *Conduct a brief face-to-face visit with the patient in a confidential clinical setting.*
    ii. *Take a full set of vital signs, if appropriate.*
    iii. *Conduct a physical exam, if appropriate.*
    iv. *Assign a triage level for a provider appointment of emergent, urgent, routine, or written response only.*
    v. *Inform the patient of his or her triage level and response time frames.*
    vi. *Provide over-the-counter medications pursuant to protocols; and*
    vii. *Consult with providers regarding patient care pursuant to protocols, as appropriate.*
b) *If the triage nurse determines that the patient should be seen by a provider:*
    i. *Patients with emergent conditions shall be treated or sent out for emergency treatment immediately.*
    ii. *Patients with urgent conditions shall be seen within 24 hours of the RN face-to-face; and*
    iii. *Patients with only routine concerns shall be seen within two weeks of the RN face-to-face.*
c) *Patients whose requests do not require formal clinical assessment or intervention shall be issued a written response, with steps taken to ensure effective communication, within two weeks of receipt of the form.*

d) *The County shall permit patients, including those that are illiterate, non-English speaking, or otherwise unable to submit verbal or electronic HSR's to verbally request care. Such verbal requests shall immediately be documented by the staff member who receives the request on an appropriate form and transmitted to a qualified medical professional for response in the same priority as those HSRs received in writing."*

Regarding VI.C.3.a., ACH cleared the nurse sick call backlog prior to this reporting period and patients are now being seen within time frames the majority of the time. During this upcoming reporting period, ACH nursing will implement a process by which they are triaging all HSRs (including mental health and dental) to meet time frames accordingly. This sub-provision is in partial compliance.

Regarding VI.C.3.b, ACH continues to experience a provider backlog, resulting in patients being seen outside of the required time frames. In the upcoming reporting period, the new medical director will be prioritizing efforts to eliminate the backlog by temporarily bringing on additional providers and organizing focused "blitzes" to ensure timely patient care. This sub-provision is in non-compliance.

Regarding VI.C.3.c, patients whose concerns do not require a formal clinical assessment or intervention receive a letter in response, within the required time frame. The EHR includes numerous letter templates to support consistent communication for common requests. This sub-provision is in substantial compliance.

Regarding VI.C.3.d, this is current practice, and this sub-provision is in substantial compliance.

As ratings of the sub-provisions are mixed, provision VI.C.3 remains in partial compliance.

VI.C.4 - Partial Compliance

"The County shall designate and make available custody escorts for medical staff in order to facilitate timely and confidential clinical contacts or treatment-related events."

While the escorts have continued to increase at both facilities, more coordination is needed to improve patient flow. It is difficult to determine the number of escorts needed without the ability to stage patients, as staging patients may free up an escort in the afternoon to assist in other areas. However, during this reporting period two dedicated escorts have been rerouted from Suboxone pill call to other medical areas.

RCCC has been consistent in staffing the minimum medical escorts needed. Medical escorts are only dedicated to assisting medical staff; this includes a dedicated escort for Suboxone.

Main Jail still has four designated medical escorts and four on-call medical escorts. The Main Jail averages eight medical escorts Monday - Friday for dayshift, and four medical escorts on Saturdays and Sundays. SSO also averages three night shift medical escorts seven days a week.

This provision remains in partial compliance. As noted in II.A, there has been a substantial rise in hospital send-outs, each of which requires the escort of two deputies per patient, for individuals requiring diagnostic testing, specialized care, or interventions that cannot be performed within the jail facilities. These send outs impact available custody staffing for in-facility escorts. Part of the planned correctional facility master planning process will include a staffing analysis that will assess the custody staffing needs to meet the health care and safety needs of the inmate population.

VI.C.5 - Non-Compliance

"The County shall track and regularly review response times to ensure that the above timelines are met."

ACH continues to work closely with Sacramento County's Department of Technology (DTech) on a "Timelines to Care Report" that will capture all the data indicators to determine if required time frames were met for the entire patient population rather than a small sample size that occurs with audits. As this report is still not finalized and since there were no audits conducted during this reporting period, this provision has been reduced to non-compliance.

VI.C.6 - Substantial Compliance

"The County shall discontinue its policy of prohibiting patients from reporting or inquiring about multiple medical needs in the same appointment."

ACH discontinued prohibiting patients from reporting or inquiring about multiple medical needs in the same appointment shortly after execution of the Consent Decree. Patients are permitted to report or inquire about multiple medical needs on a single HSR or during a single appointment.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the

Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VI.C.7 - Partial Compliance

"When a patient refuses a medical evaluation or appointment, such refusal will not indicate a waiver of subsequent health care.

a) *When a patient refuses a service that was ordered by medical staff based on an identified clinical need, medical staff will follow-up to ensure that the patient understands any adverse health consequences and to address individual issues that caused the patient to refuse a service.*

b) *Any such refusal will be documented by medical staff and must include: (1) a description of the nature of the service being refused, (2) confirmation that the patient was made aware of and understands any adverse health consequences by medical staff, and (3) the signature of the patient, and (4) the signature of the medical staff. In the event the signature of the patient is not possible, the staff will document the circumstances."*

Ongoing healthcare is offered and provided as medically indicated, regardless of previous refusals for services. ACH staff are required to follow-up to ensure that the patient understands any adverse health consequences and to address individual issues that caused the patient to refuse service per policy. The follow-up discussion is also documented in the EHR. Record review shows that nurses and providers are following up with patients who are refusing to come out of their cell for an encounter and/or refusing care in general. Refusal forms are documented in the chart. However, there are instances where there is a note that the patient refuses and a form is not signed. ACH leadership will continue to stress the importance of patient education and refusal form signatures in the upcoming reporting period. This provision remains in partial compliance.

VI.D. Chronic Care

VI.D.1 - Partial Compliance

"Within three months of the date the Remedial plan is issued by the Court, the County shall, in consultation with Plaintiffs' counsel, develop and implement a chronic disease management program that is consistent with national clinical practice guidelines. The chronic disease program will include procedure for the identification and monitoring of

such patients and the establishment and implementation of individualized treatment plans consistent with national clinical practice guidelines.

a) *The chronic disease management program shall ensure that patients with chronic illness shall be identified and seen after intake based upon acuity (on the day of arrival for patients with high acuity and not to exceed 30 days for all others). The County will timely provide clinically indicated diagnostic testing and treatment, including prior to this post-intake appointment. Follow-up appointments will be provided in intervals that do not exceed 90 days unless patients are clinically stable on at least two consecutive encounters, in which case, follow-up appointment intervals will not exceed 365 days (and sooner if clinically indicated), subject to a chart review every 6 months.*

b) *The chronic disease management program shall ensure patients are screened for hepatitis C at intake. If medical staff recommend Hepatitis testing based upon screening results, such testing shall be offered on an "opt-out" basis for those individuals who remain in custody long enough to receive a housing assignment. If the patient declines testing the refusal shall be documented in the health record. Patients found to have hepatitis C shall be offered immunizations against hepatitis A and B.*

c) *The chronic disease management program shall include a comprehensive diabetic management program consistent with the American Diabetes Association (ADA) Diabetes Management in Correctional Institutions. The protocol shall be developed in coordination with custody administration to address normal circadian rhythms, food consumption times and insulin dosing times.*

d) *The chronic disease management program shall ensure that patients who take medications for their chronic conditions shall have the medications automatically renewed unless the provider determines that it is necessary to see the patient before renewing the medication. In that case, the patient shall be scheduled to be seen in a reasonable time period to ensure medication continuity."*

ACH is in the process of implementing a chronic disease management program aligned with the VA Chronic Care Guidelines. ACH has expanded its Chronic Disease Monitoring Program and developed a quarterly Chronic Disease Management Audit. The Intake nurse places an order for a History and Physical (H&P) exam for anyone identified as having a chronic disease. Chronic disease patients are identified at intake; if they are deemed to be a chronic care patient during previous incarcerations, they will always be identified as a

chronic care patient on subsequent intakes. At this initial H&P, the provider will assess the level of disease control and schedule chronic care follow-up appointments based on medical acuity and level of disease control.

The Chronic Disease Management Program includes a process to ensure chronic care patients are referred for an H&P based upon acuity. Monitoring to the adherence to this process is included in the Chronic Disease Management Audit. A corrective action plan has been implemented by QI to address a backlog in lab orders to ensure patients receive timely and effective treatment.

Providers have been trained and have started managing chronic diseases according to VA chronic care guidelines. Trainings on the content of the VA chronic care guidelines are done at every other provider meeting. As staffing improves, more dedicated chronic care providers will be assigned to manage patients with multiple chronic diseases and higher acuity. Given lower patient turnover and lower acuity patients, consistency in chronic care providers for individual patients has been very successful at RCCC. As more regular, full-time providers are working at the Main Jail, ACH has more consistency with assigning the same provider to a particular floor, which aids in having an assigned provider to these patients.

ACH has hired a clinical pharmacist to provide Chronic Care Management for diabetes, hypertension, and hyperlipidemia (Metabolic Syndrome). However, this position is currently on hold until the new medical director determines the preferred course of action.

Education regarding the VA Chronic Care guidelines are provided at provider meetings, and new providers are required to review it as part of onboarding. Providers have been trained to use the right document type to capture the chronic care encounter and to address all chronic care problems during a provider sick call, as clinically appropriate. A new provider document type has been created, to easily allow a provider to address multiple acute sick call concerns, as well as chronic care concerns, within a single encounter.

A primary care provider with additional training in HIV conducts a minimum of twice weekly HIV Clinics. Infectious disease consultation is also available through RubiconMD or an Infectious Disease specialist is contracted off-site as clinically necessary.

A primary care provider with additional training in gender affirming care conducts a Transgender Care Clinic every two weeks. Patients on hormones, prior to incarceration, have their medication continued as part of the essential medications process. The County is in partial compliance with sub-provision VI.D.1.a.

Regarding sub-provision VI.D.1.b, the chronic disease management program ensures patients are screened for Hepatitis C, HIV, syphilis, and GC/CT at Intake and offered testing on an "opt- out" basis for those individuals who remain in custody long enough to receive a housing assignment. If the patient declines testing, the refusal is documented in the patient's health record. Patients found to have hepatitis C are offered immunizations against hepatitis A and B. A specialist provides on-site Gastroenterology and Hepatology clinics every other week since October 2021. The County is in substantial compliance with sub-provision VI.D.1.b.

Regarding sub-provision VI.D.1.c, the chronic disease management program includes a diabetes management clinic consistent with the American Diabetes Association (ADA) Diabetes Management in Correctional Institutions. Diabetic medications are scheduled to coincide with food consumption times. Continuous glucose monitors have been approved for our most brittle diabetics. Patients with type 1 diabetes that are expected to stay six months or greater are evaluated for use of an insulin pump. ACH currently has two patients using county issued insulin pumps who have maintained a hemoglobin A1c less than seven percent (7%) due to the pumps. The County is in partial compliance with sub-provision VI.D.1.c.

Regarding sub-provision VI.D.1.d, currently, medications are prescribed for one year. Prior to expiration, pharmacy sends an EHR alert for the providers to renew. The new medical director will work with the pharmacy director to make renewals automatic. The County is in partial compliance with sub-provision VI.D.1.d.

ACH has piloted stationing a provider at intake. When patients with high acuity or chronic care conditions are flagged at intake as having more critical needs, they are seen for evaluation at intake. This pilot program was well received by providers and nursing staff, and ACH has plans to hire a permanent provider in intake. Priorities for an H&P include those identified with diabetes, hypertension, seizures, heart failure, liver disease (including cirrhosis), sickle cell, and lung disease (COPD and asthma). This will include those with abnormal vital signs or self-reported disease that is not immediately verifiable. Also included will be those hospitalized or had an emergency department visit in the last week.

A Hemoglobin A1C lab and laboratory panel is ordered prior to the H&P. For every patient who comes through ACH and is identified as having chronic medical condition, they will have chronic care initial visit and initial H&P within 14 days of intake. Those identified as having a high acuity chronic condition, or multiple chronic conditions and medications, receive an urgent H&P and chronic care initial visit within 24 hours of intake.

Chronic disease management has been an area of focus during this reporting period and will continue to be in the upcoming reporting period. ACH understands the extreme importance of the chronic care program. The new medical director plans to develop Care Teams to improve chronic care and utilization management.

ACH is fundamentally transforming the culture of healthcare delivery in the jail. ACH is shifting from a traditional, provider-centric, episodic care model to a team-based, patient-centered, and value-driven approach that prioritizes compassion, continuity, and clinical excellence. This transformation is anchored in a comprehensive care redesign package that enhances our ability to identify and respond to both acute and chronic patient needs, while advancing our population health management capabilities. Through the strategic development and application of data analytics, ACH will stratify patient risk, coordinate individualized care plans, and actively engage patients in their ongoing health journeys—ultimately improving outcomes and reducing preventable hospitalizations. A robust utilization management framework will be embedded within this model to ensure that healthcare resources are used appropriately and efficiently, supporting clinical decision-making and promoting high-value care. Daily interdisciplinary huddles will be implemented as a core operational practice, enabling the newly formed healthcare delivery teams to align on priorities, anticipate barriers, and maintain seamless communication. By integrating optimized clinical workflows with collaborative care teams, utilization oversight, and data-informed decision-making, ACH is building a sustainable model that delivers proactive, efficient, and personalized care while fostering a culture of accountability, innovation, and continuous improvement.

Based on the mixed ratings for the sub-provisions, the County remains in partial compliance with provision VI.D.1.

VI.D.2 - Partial Compliance

"The County shall track compliance with the chronic disease management program requirements for timely provision of appointments, procedures, and medications. The County shall ensure that its electronic medical record system is adequate to support these critical functions."

ACH QI has conducts chronic care audits regularly on compliance with diabetic chronic care requirements, the most recent audit completed for Q3 of FY 2024/2025 (see below for the results of the audits.).

Providers have been trained to create alerts in the EHR to ensure a particular patient will return to that provider for follow-up care when possible. Initial H&P and provider chronic

care follow-up forms have been embedded within the Provider Visit encounter form in EHR. Both include several fields for data collection, such as periodic health assessment and patient education details. The asthma form in the EHR was updated to capture additional information during chronic care follow-up visits. The practitioner assessment & plan form in the EHR has been updated to include chronic care follow up reasons and automatically generated future appointment orders as well as a link to the necessary documentation should the patient require to be sent for an emergency room visit.

During this reporting period, ACH continued peer review of charts by the medical director, assistant medical director, and the lead physicians. A standardized form was created based on a recommendation and review of the previous provider consultant and is being utilized. The policy has been drafted and approve by County stakeholders; however, it is pending SME and Class Counsel review. The policy has been revised to address chronic care needs by reviewing the chart for adherence to Veterans Health Administration (VHA) clinical practice guidelines. Feedback is being given to providers when issues are identified, including disciplinary actions when needed. Part of the chart review includes review of a provider's adherence to chronic care guidelines. During this reporting period, ACH implemented the VHA/DoD Primary Care Clinical Practice Guidelines after receiving approval form the SME. The providers have been educated on these guidelines.

ACH continues to work with DTech to develop a chronic care registry/PowerBI to track patients with complex medical problems. It is a major area of focus in the upcoming reporting period. The new medical director will be heavily involved in developing the Chronic Care registry. Meanwhile, ACH is creating an excel tracking sheet to monitor these complex patients. Staff meet twice monthly to discuss progress. Also in the upcoming reporting period, the providers will use Agency for Healthcare Research and Quality (AHRQ) Quality Prevention Indicators when selecting records to review pre-hospital and post-hospital care.

Staff are pulling data reports on chronic conditions and labs which will help with chronic disease management. See tables below:

Chronic Conditions Reports – Point in Time				
	9/25/24	12/27/24	3/26/25	6/25/25
% of patients with chronic conditions	84%	85%	83%	83%
Of those with a chronic condition, % have two or more conditions	70%	69%	69%	68%
% of patients on medication	86%	89%	88%	88%

Chronic Physical Health Conditions Reports – Point in Time				
	9/25/24	12/27/24	3/26/25	6/25/25
% of Patients with chronic physical health conditions	46%	45%	45%	45%
Of those with a chronic physical health condition, % have two or more conditions	41%	40%	39%	40%

QI has continued to conduct this audit on a quarterly basis. In Q3 of FY 24/25, QI increased the sample size as requested by the SMEs to decrease the margin of error. The data showed consistency with previous findings, however, ACH found many improvements. Findings include:

- Diabetes Chronic Care Visits occurred within the required time frame 80% of the time—increased from 31% compared to the previous audit.
- The follow-up Chronic Care appointment was scheduled for 60% of the patients reviewed.
- 94% of the upcoming scheduled appointments were scheduled within the appropriate time frame- increase from 74%.
- HbA1c tests occurred within the required time frame 73% of the time—remains the same compared to the previous audit.
- The follow-up HbA1c was scheduled for 85% of the cases reviewed—increased from 73% compared to the previous audit.
- 86% of the follow up HbA1C appointments were scheduled within the appropriate time frame—increased from 79% compared to previous audit.
- “Degree of Disease Control” is documented in 70% of cases—slight decrease from 73% compared to previous audit.
- 98% of patients have a documented degree of disease control of fair or good.

While finding are demonstrating improvement in many areas, this provision remains in partial compliance.

VI.D.3 - Substantial Compliance

"The County shall review its infection control policies and procedures for dialysis treatment to ensure that appropriate precautions are taken to minimize the risk of transmission of blood-borne pathogens, given the proximity of HCV+ and HCV- patients receiving dialysis in the same room."

ACH contracts with Spectrum to provide on-site dialysis treatment, who is required to maintain and follow regulations and policies surrounding appropriate precautions to minimize the risk of transmission of blood-borne pathogens while providing dialysis. ACH Infection Control has recently worked with the California Department of Public Health to update the infection control policies to be consistent with standards.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VI.E. Specialty Services

VI.E.1 - Substantial Compliance

"The County shall develop and implement policies regarding specialty referrals using an algorithm with evidence-based referral criteria and guidelines."

Policies approved by the SMEs and Class Counsel remain in effect during this reporting period. Utilization Review (UR) Standardized Nursing Protocols (SNPs) for CM nurses to conduct general UR of on-site specialty care referrals (SCRs) are currently in development. Two such SNPs (Physical Therapy and Podiatry Toenail clinic) have already been developed and are actively in use. ACH UR providers continue to draft UR SNPs for all on-site specialty care clinics.

The County is also in the process of procuring InterQual to further enhance the efficiency and quality of Utilization Management (UM) within Adult Correctional Health Services and anticipates the rollout will occur in the next reporting period. The newly appointed medical director brings prior experience implementing InterQual in other correctional health settings and has expressed confidence in its effectiveness. Once implemented, ordering providers will directly input the required clinical information into the InterQual platform,

streamlining the referral process by eliminating the need for case management (CM) RNs and UM providers to retrospectively review documentation for completeness. This shift is expected to significantly reduce the administrative burden on Case Management staff, improve processing times, and enhance overall workflow efficiency.

This provision remains in substantial compliance.

VI.E.2 - Partial Compliance

"Within 3 months of the date the Remedial plan is issued by the Court, the County shall develop and implement policies and procedures to ensure that emergency consultations and diagnostic treatment procedures, as determined by the medical provider; are provided immediately; high priority consultations and procedures, as determined by the medical provider are seen within 14 days of the date of the referral; and routine consultations and procedures, as determined by the provider are seen within 90 days of the date of the referral."

ACH has implemented policies regarding specialty referrals in collaboration and agreement with court-appointed monitors. Urgent referrals are required to be seen within 14 days of referral rather than the 21 days stated in the Remedial Plan.

Due to the volume of referrals coming into CM (approximately 500 per month), staff were not able to keep up with the timelines to process the referrals and send for appointments. Many of the referrals were incomplete, which took time to go back and forth with the providers to get the information needed to move the referral forward. However, now that CM/UM staffing has increased significantly, the backlog of referrals was completed as of May 2025 and CM staff are able to keep up with the SCRs. As of July 2025, the CM team now consists of one health program manager, one CM SRN (recently vacant due to promotion into Nursing Director), six CM RNs, two CM office assistants (one vacant), and two CM MAs (RCCC) (one vacant MJ), and two part-time UR providers. For reference: In June 2024, CM staff consisted of one CM SRN, one CM RN, one CM OA and one part-time UR provider.

Extensive education has been provided to providers regarding the necessary documentation and information required for referrals. CM has attended provider staff meetings, and discussed referral issues during case reviews. Despite these efforts, a significant number of inappropriate or incomplete referrals continue to be submitted, resulting in delays in the referral process. The CM SRN attended provider meetings to educate on necessary CM Specialty Care processes and changes. As of November 2024, UM provider lead, Dr. Abdalla, has been instrumental in supporting quality improvement

efforts and enhancing care processes. She played a vital role in delivering training aimed at addressing barriers to care. Her contributions included training both in-house and specialty providers on case management practices, specialty care processes, workflow changes, EHR ordering, and the use of Rubicon MD's eConsult platform. She also provided hands-on procedural training for nurse practitioners, such as toenail trimming.

Addressing issues with specialty referrals has been a major area of focus during this reporting period. A second Office Assistant was trained on requesting, receiving, uploading and indexing medical records into the EHR to address problems with Case Management/Specialty care records not being received timely for provider follow-up. Despite this enhancement, delays in receiving Specialty Care records persist. To address this, a new strategy is being implemented to include language on a standardized medical form that links provider payment to the timely submission of medical records. This approach aims to reinforce accountability, as it has been identified that delays are often due to external healthcare facilities not submitting records promptly.

Increased staffing, enhanced provider education – including both in-house providers and specialty providers - and the development of UR SNPs have contributed to improvements in the specialty care referral process. These efforts have resulted in a gradual reduction in the number of referrals, with approximately 440 SCRs April, 410 SCRs May, and 400 in June 2025. Additionally, there is a noticeable improvement in the quality and completeness of the referrals being submitted.

The CM SRN implemented a daily CM huddle, weekly Case Management team meeting, monthly Case Management and SSO custody medical transport meeting, and included all CM staff in the weekly Provider UR meeting to increase collaboration and improve communication amongst team members. She also worked in conjunction with contract staff and accounting staff to review existing contract terms and address financial or administrative barriers impacting access to care. This collaboration supported improved utilization management and the strategic request of additional services to expand access to specialty care for incarcerated patients.

This area will continue to be a major area of focus and ACH anticipates substantial compliance in this area in the next reporting period.

Patient #1 illustrates the effectiveness of the changes made in this provision during this reporting period. Patient #1 is a 33-year-old male with stage 4 (metastatic) lung cancer who was undergoing chemotherapy treatment through Kaiser when he became incarcerated. ACH's pharmacy team was able to obtain and administer his chemotherapy drug three

days after incarceration to minimize any missed doses. A referral for oncology was placed by the ACH provider on February 10, 2025. ACH's CM team advocated on behalf of the patient that he be able to continue care with his primary oncology team, given his case was complex and he had already required brain surgery for a metastatic tumor. To re-establish/transfer care to a new oncology team would delay his care and potentially give the cancer time to spread. ACH was successful and coordinated a tele-medicine appointment with his Kaiser oncologist on February 18, 2025. The oncologist recommended an MRI of the brain and CAT-Scan of the body to evaluate for any new spread of the cancer. These were ordered the same day.

Again, the ACH successfully advocated to Kaiser and the United States Marshal Service (as patient was a federal inmate) to have these completed at Kaiser to be able to compare accurately to previous images. Both were completed on March 7, 2025 at Kaiser. As they were completely timely, a small new brain tumor was found on the MRI and ACH was able to have follow-up with his oncologist on March 18, 2025 to discuss the treatment options. It was recommended he meet with the radiation oncologist for a consultation, which was ordered on March 25, 2025 and completed on April 2, 2025. Over the course of the next three months at the Main Jail, the patient required three further imaging studies to closely monitor the spread of the cancer, and two additional appointments with the oncologist, and one additional appointment with the radiation oncologist. Due to the prompt interventions and advocacy by ACH staff, when the patient was transferred out of the facility in June, he was stable and had minimal interruption of his comprehensive cancer care.

This provision remains in partial compliance.

VI.E.3 - Partial Compliance

"Patients whose routine specialty consultation or procedure do not take place within 90 calendar days from the date of the referral shall be examined by a clinician monthly and evaluated to determine if urgent specialty care is indicated."

ACH CM has a system to schedule provider follow-up appointments for patients who have not yet had their specialty consultation or procedure and therefore fall outside of the 90-day time frame. CM creates an order for the visit, indicates the purpose of the visit and has a system to track the number of follow-up visits that occur per policy. Providers have been trained on this requirement and how this visit is flagged in the health record. If appointments are scheduled outside of the priority time frame, which is now an uncommon occurrence, the CM RN notifies the ordering provider and orders an urgent

Provider Sick Call so that the patient can be evaluated for stability and an alternative treatment plan can be implemented, if appropriate. In addition, these cases are discussed during a weekly meeting between CM staff and UR providers. Based on the improvements in this area, this provision is being increased to partial compliance.

VI.E.4 - Partial Compliance

"Within 5 days of the completion of a high priority specialty consultation or procedure, or within 14 days of a routine specialty consultation or procedure, patients returning to the Sacramento County Jail shall have their specialty reports and follow-up recommendations reviewed by a jail nurse practitioner, physician assistant or physician."

Previously, ACH medical records department was significantly short-staffed leading to delays in receiving medical records for CM specialty care. As of January 2025, a second Case Management Office Assistant was trained on requesting, receiving, uploading and indexing medical records into the EHR to address problems with Case Management/Specialty care records not being received timely for provider follow-up. Despite this enhancement, delays in receiving specialty care records persist. To address this, a new strategy is being implemented to include language on a standardized medical form that links provider payment to the timely submission of medical records. This approach aims to reinforce accountability, as it has been identified that delays are often due to external healthcare facilities not submitting records promptly. This provision remains in partial compliance.

VI.E.5 - Partial Compliance

"Specialty care consultations and outside diagnostic and treatment procedures shall be tracked in a log that identifies the referral request date, the date the referral was sent to the specialty care provider, the appointment date for the consultation or procedure is scheduled, the date the appointment takes place, and, if the appointment is rescheduled or cancelled, the reason it was rescheduled or canceled."

Historical actions pertaining to this provision are described in the 10th County Status Report. During this reporting period, the CM SRN finalized the CM Timelines to Care tracking report which includes tracking for both on-site and off-site specialty care referrals and contains these required elements. In June 2025, the CM SRN (now serving as the MJ nursing director) provided a demonstration of the tracking system to the SMEs. With these improvements, this provision is increased to partial compliance.

VI.E.6 - Partial Compliance

"Requests for specialty consultations and outside diagnostic and treatment procedures shall also be tracked to determine the length of time it takes to grant or deny the requests and the circumstances and reasons for denials."

See VI.E.5. This provision is also increased to partial compliance.

VI.E.7 - Non-Compliance

"At least twice a year, the County shall conduct an audit of specialty care referral logs described in subsections (5) and (6), above, and complete a report as to whether each category of specialty care is provided in a reasonable timeframe, consistent with established timeframes. If any specialty care area has a record of untimely appointments as determined by the Correctional Health Service Continuous Quality Improvement Committee, the County shall report to Plaintiffs and the parties shall meet and confer to take prompt steps to address the issue. The County will provide Plaintiffs access to the specialty care referral logs and audit reports periodically and upon written request. The parties will work to resolve issues with untimely specialty care in individual patient cases and with respect to systemic trends, including through the dispute resolution process."

Historical actions pertaining to this provision are described in the 10th County Status Report. Although a tracking system for all specialty referrals was finalized during this reporting period, an audit has yet to be completed since it is in development. ACH anticipates an audit will be conducted in the first quarter of the 25/26 FY. Until this has been completed, the provision remains in non-compliance.

VI.E.8 – Substantial Compliance

"The County shall consider implementing an e-referral system to reduce delays and facilitate communication between specialists and primary care providers, as well as reducing unnecessary transportation costs and unnecessary specialist appointments by ensuring that the specialist has all the information he or she needs before an appointment takes place."

The Rubicon MD e-consult platform has been made available to all ACH providers. Although it is not a formal, face-to-face specialty consultation, ACH providers utilize the specialist's consult to advance pt care in-house. At times, this negates the need for off-site consultation, other times it helps expedite care while arranging the off-site consultation.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was

suspended. The County is pleased to report it remains substantially compliant with this provision.

VI.E.9 - Partial Compliance

"The County shall ensure that utilization management and/or scheduling staff provides notification of whether a patient's specialty care appointment is scheduled to occur within the timeline pursuant to the referral and/or clinical recommendation, including as follows:

a) *Medical staff may request and obtain information as to whether any patient's specialty care appointment is scheduled, and as to the general timing of the appointment (e.g. within a one-week's date range).*

b) *If a specialty care appointment is denied or is not scheduled to occur within the timeline pursuant to the referral and/or clinical recommendation, such information will be affirmatively provided to the treatment team and to the patient.*

c) *If a previously scheduled specialty care appointment is postponed to a date that is outside the timeline pursuant to the referral and/or clinical recommendation, such information will be affirmatively provided to the treatment team and to the patient."*

In addition to the information provided in the 10th County Status Report, all ACH Medical providers were granted access to view the private CM SCR encounter which now includes the date the appointment was secured. The actual date of the appointment is not documented, for security reasons. There was also an entry added to the EHR CM SCR encounter indicating when appointments are scheduled outside of ordered priority time frames, notifying the provider to re-evaluate the patient accordingly. The CM SCR encounter is also "routed" to the ordering provider for signature in which a comment is added allowing the CM RN to provide additional information to the ordering provider as necessary. The County is also in the process of procuring InterQual to further enhance the efficiency and quality of UM within Adult Correctional Health Services. The newly appointed medical director brings prior experience implementing InterQual in other correctional health settings and has expressed confidence in its effectiveness. Once implemented, ordering providers will directly input the required clinical information into the InterQual platform, streamlining the referral process by eliminating the need for CM RNs and UM providers to retrospectively review documentation for completeness. This shift is expected to significantly reduce the administrative burden on Case Management staff, improve processing times, and enhance overall workflow efficiency. Moreover, the decision-support structure provided by InterQual will guide ordering providers through the clinical criteria required for Specialty Care Referrals (SCRs), thereby improving the

appropriateness and quality of referrals submitted. This is anticipated to reduce the volume of unnecessary or premature send-outs and support more effective utilization management practices across the system. ACH anticipates that the implementation of InterQual will play a key role in sustaining compliance, promoting appropriate care delivery, and supporting long-term operational improvements.

Procedurally, ACH sends the referral to the specialty clinic and the SSO scheduler within the expected time frame. The SSO scheduler makes the appointment and notifies ACH of the appointment via email and/or calendar invite. ACH CM is notified if a referral is denied by an outside provider. ACH is also notified if the appointment is not within the time frame ACH provided. If an inmate refuses, ACH is notified via email or calendar invite for ACH to revisit the inmate.

This provision remains in partial compliance.

VI.E.10 – Substantial Compliance

"The County shall consider creating a physical therapy clinic at the jail to more efficiently meet the significant demand for this service."

Physical Therapy (PT) clinics are held at each site at least once every 2 weeks. Urgent cases (which include post-op orthopedic patients, post-stroke patients, patients recently discharged from the hospital with PT recommendations, etc.) are seen within 2 weeks.

Additionally, PT clinics were increased temporarily along with targeted education for both specialty and on-site providers on the appropriate use of RubiconMD eConsults. The implementation of patient-directed PT exercise programs significantly contributed to the resolution of the PT referral backlog. With these operational improvements in place and the backlog eliminated, providers are now better positioned to identify and prioritize clinically appropriate patients, ensuring that medically necessary therapy is delivered more promptly and effectively. As a result of these improvements, this provision is being increased to substantial compliance.

VI.F. Medication Administration and Monitoring

VI.F.1 - Partial Compliance

"The County shall develop and implement policies and procedures to ensure that all medications are appropriately prescribed, stored, controlled, dispensed, and administered in accordance with all applicable laws through the following:

a) *Ensuring that initial doses of prescribed medications are delivered to patients within 48 hours of the prescription, unless it is clinically required to deliver the medication sooner.*

b) *Ensure that medical staff who administer medications to patients document in the patient's Medication Administration Record (1) name and dosage of each dispensed medication, (2) each date and time medication is administered, (3) the date and time for any refusal of medication, and (4) in the event of patient refusal, documentation that the prisoner was made aware of and understands any adverse health consequences by medical staff."*

ACH has implemented policies regarding medication administration in collaboration and agreement with court-appointed experts. In addition, several key changes have been completed including changes in pharmacy schedules, deployment of new pill carts, reassigning some tasks, and improving the network capacity. Additional medical escorts are required to ensure efficient operations. Historical information associated with this provision is found in the 10th County Status Report.

QI has begun auditing to this provision and found that staff have maintained substantial compliance in both the audit of August 2022 (100% compliance), February 2023 (96% compliance), August 2023 (100% compliance), and February 2024 (100% compliance) meeting timeliness standards for patients receiving initial medications.

Due to staffing turnover (please see section IX.A.3), the QI team was unable to complete CQI studies regarding medication initiation and renewal. The QI team recently onboarded three new staff and will resume these CQI studies during the next reporting period.

Regarding VI.F.1.a, the County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

Regarding VI.F.1.b, ACH pill call nurses are trained to document real-time during the medication administration process. They have the patient's MAR on a hand-held tablet and they are required to mark whether the medication was administered or not administered. If not administered, there is a drop-down list of reasons that includes patient refusal and education provided. The name and dosage are automatically populated in the MAR as they indicate which medications were administered and which were not. There are times when ACH has connectivity issues and that impedes the ability for the nurses to document real-

time. While this is becoming less frequent, this sub-provision remains in partial compliance.

Due to the mixed ratings in sub-provisions, provision VI.F.1 remains in partial compliance.

VI.F.2 - Partial Compliance

"The County shall provide sufficient nursing and custody staffing to ensure timely delivery and administration of medication."

Historical information associated with this provision is found in the 10th County Status Report. During this reporting period, ACH implemented changes to the medication administration process by reintegrating Suboxone into the general pill call. This adjustment allows two nurses at each facility who were previously dedicated solely to Suboxone administration to assist with overall medication distribution, improving efficiency. This change also released two custody-escort officers for reassignment to other medical areas, as their presence is no longer required for a separate Suboxone pill call. It also aligns with community standards by transitioning to a twice-daily dosing schedule.

In addition, this change addresses prior privacy concerns. Previously having a separate Suboxone pill call inadvertently disclosed patient's treatment to others. Since the change was implemented in January, the process has gone smoothly. While concerns about potential diversion remain, ACH is actively addressing them through ongoing collaboration and regular meetings with custody staff.

While delays in timely administration still occur due to various factors, overall staffing levels remain sufficient to support the recent changes to the pill call process. This provision remains in partial compliance.

VI.F.3 - Partial Compliance

"The County shall provide pill call twice a day in each housing unit, at regular times that are consistent from day to day, except as may be required by non-routine facility security concerns. The County shall develop and implement policies and procedures to ensure that prescribed medications are provided at therapeutically appropriate times as determined by the ordering physician. Any patient who requires administration of medications at times outside the regular pill call shall be provided that medication at the times determined by the ordering physician."

ACH provides medication administration three times a day in each housing unit, at regular times that are consistent from day to day, except as may be required by non-routine facility

security concerns. ACH Medication Administration policy outlines that prescribed medications are provided at therapeutically appropriate times as determined by the ordering physician and that any patient who requires administration of medications at times outside the regular pill call shall be provided that medication at the times determined by the ordering physician. Medication administration times have been changed to improve efficiency. Additional random audits - both in person and through chart reviews - will be necessary to verify substantial compliance. This provision has been reduced to partial compliance to reflect this challenge.

VI.F.4 - Partial Compliance

"The County shall develop and implement policies and procedures to ensure that patients are provided medications at therapeutically appropriate times when out to court, in transit to and from any outside appointment, or being transferred between facilities. If administration times occurs when a patient is in court, in transit, or at an outside appointment, medication will be administered as close as possible to the regular administration time. "

The ACH/ATIMS project team created "turn on" and "turn off" flags and alerts accordingly depending on the patient's current condition(s). This includes sending an alert when a patient is on medication so that custody staff can be readily aware. The team is working to enhance the information to identify the actual pill call schedule for individual patients to allow staffing. Three pill call schedules are identified: AM, PM, and HS.

With close collaboration between custody, pharmacy and nursing, ACH uses a method of daily court notification, medication preparation and administration prior to patients leaving for court in the morning. This process ensures there are no issues with medications that would prevent the court process from occurring. This provision remains in partial compliance.

VI.F.5 - Partial Compliance

"The County shall develop policies and procedures to ensure that medication efficacy and side effects are monitored by staff and reviewed by appropriate clinicians at appropriate intervals."

ACH developed policies and procedures listed above with approval from medical experts to ensure that medication efficacy and side effects are monitored by staff and reviewed by appropriate clinicians at appropriate levels. However, ACH does not currently have a formal system in place to monitor or track medication side effects or efficacy. Providers

are expected to document this information within the medical record. If side effects occur, medication adjustments are made accordingly. As a result, this provision has been reduced to partial compliance.

VI.F.6 - Substantial Compliance

"The County shall explore the expansion of its Keep-on-Person medication program, (especially for inhalers and medications that are available over-the-counter in the community) and to facilitate provision of medications for people who are out to court, in transit, or at an outside appointment."

Keep On Person (KOP) medications were expanded to include inhalers, chronic disease medications, over-the-counter medications, and others. It has also expanded KOP eligibility. Staff developed a Patient Medication Guide handout to inform patients of the KOP and discharge medication programs. Pharmacy staff monitors compliance upon dispensing refilled medications and educate patients on proper use, use of the EHR to document participants' compliance, and use the Pharmacy Information System for data management. Historical actions related to this provision are described in the 10th County Status Report.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision

VI.G. Clinical Space and Medical Placements

VI.G.1 – Partial Compliance

"The County shall provide adequate space in every facility to support clinical operations while also securing appropriate privacy for patients. Adequate clinical space includes visual and auditory privacy from prisoners, and auditory privacy from staff, the space needed reasonably to perform clinical functions as well as an examination table, sink, proper lighting, proper equipment, and access to health records."

Historical actions related to this provision are described in the 10th County Status Report. During this reporting period, ACH nursing staff continue to utilize confidential booths for nurse sick call encounters that do not require a physical exam. When an exam is necessary, nurses conduct it in an open exam room located on the floor. ACH has explored multiple types of exam beds to enhance the functionality of the confidential booths.

However, most standard exam beds have proven too large for the available space. As a result, ACH is actively exploring creative solutions to ensure compliance with all aspects of this provision, including fold-up exam tables. Additionally, a handwashing station was purchased in July with funding for FY 25/26, once approved by Compliance, one will be purchased for each medical booth. Based on a review of the recent medical SME report, this provision has been reduced to partial compliance.

VI.G.2 - Partial Compliance

"The County shall ensure that any negative pressure isolation rooms meet community standards, including an antechamber to ensure that the room remains airtight, appropriate pressure gauges, and regular documented checks of the pressure gauges."

The Main Jail's four negative pressure rooms are checked daily by DGS to ensure the requested standards are met. With the current facility limitations, an anteroom cannot be added. The County has contracted with a consultant to develop a comprehensive Correctional Facility Master Plan ("Master Plan"); this effort is expected to take 12 to18 months. Future facilities improvements that result from the resulting Master Plan may include construction, allowing for complete compliance with this provision. The County is of the opinion that this provision is in partial compliance due to not having the anteroom but the negative pressure rooms do meet the required standards.

VI.G.3 - Partial Compliance

"The County shall ensure that absent individualized, documented safety and security concerns, patients in acute medical or quarantine placements shall be allowed property and privileges equivalent to what they would receive in general population based upon their classification levels."

All inmates in medical or quarantine placements are allowed to keep personal property with them as well as participate in programs that do not interfere with safety and security concerns. While there are occasional challenges with this due to the lack of space on the medical floor, the variety of classifications of inmates, and the unpredictable nature of the medical needs of the individuals housed there, the County continues to engage with Class Counsel to identify options to improve access to privileges equivalent to a general population floor. Ongoing efforts are being made to increase programming for the most severely ill occupants of the jail. Until new programming policies are agreed upon by Class Counsel and the County, this provision will be reduced to partial compliance.

VI.G.4 - Partial Compliance

"The County shall ensure that patients in medical placements are not forced to sleep on the floor, including providing beds with rails or other features appropriate for patients' clinical needs and any risk of falling."

During this reporting period, based on recommendations made by the medical monitoring experts, the Medical Observation Cell was relocated within the booking loop to address concerns related to patient care during intoxication. Previously, individuals were observed lying on the floor, which raised clinical and operational concerns. The new location now accommodates multiple sleds allowing patients to be monitored in a more safe, supportive, and medically appropriate setting.

There was a concern from the medical SMEs regarding the lack of designated infirmary beds for female patients at RCCC. However, female patients are currently being appropriately accommodated at the Main Jail, where infirmary beds are available. Additionally, space has been cleared in the 2 East 100 pod to provide increased flexibility should a female patient require a medical bed. Based on a review of the recent Medical SME report, this provision has been reduced to partial compliance.

VI.G.5 - Substantial Compliance

"The County shall not discriminate against patients in medical placements solely because of their need for C-Pap machines, but instead shall provide access to programs and services in accordance with their classification level, as set forth in the ADA remedial plan."

Battery powered CPAP machines have now been distributed throughout both correctional facilities. Inmates are now able to have CPAP machines in various housing units and are no longer limited to MHU or 2 Medical. This also allows inmates with CPAP machines to participate in programs and services.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VI.H. Patient Privacy

VI.H.1 - Partial Compliance

"The County shall develop and implement policies and procedures to ensure that appropriate confidentiality is maintained for health care services. The policies shall ensure confidentiality for clinical encounters, including health care intake screening, pill call, nursing and provider sick call, specialty appointments, and mental health treatment. The policies shall also ensure confidentiality for written health care documents, such as health care needs requests and grievances raising medical care or mental health concerns, which shall not be collected by custody staff."

Historical activities related to this provision are detailed in the 10th County Status Report. ACH QI plans to conduct an audit on confidential encounters in the upcoming reporting period to assess adherence to the established privacy policies. Until this audit is completed and evaluated to determine if documentation is included in the record whenever a patient presents a security concern that interferes with their confidential evaluation, and after review of the recent medical SME report, this provision has been reduced to partial compliance.

VI.H.2 - Partial Compliance

"The County shall provide adequate clinical space in each jail to support clinical operations while also securing appropriate privacy for patients, including visual and auditory privacy from prisoners and auditory privacy from staff."

Historical activities related to this provision are detailed in the 10th County Status Report. During this reporting period, ACH nursing staff continue to utilize confidential booths for nurse sick call encounters that do not require a physical exam. Also in this period, privacy curtains were added to enhance visual privacy during clinical encounters. When an exam is necessary, nurses conduct it in an open exam room located on the floor. ACH has explored multiple types of exam beds to enhance the functionality of the confidential booths. However, most standard exam beds have proven too large for the available space. As a result, ACH is actively exploring creative solutions to ensure compliance with all aspects of this provision, including fold-up exam tables. Additionally, a handwashing station was purchased in July with funding for FY 25/26. Once approved by Compliance, one will be purchased for each medical booth. This provision remains in partial compliance.

VI.H.3 - Partial Compliance

"All clinical interactions shall be private and confidential absent a specific, current risk that necessitates the presence of custody staff. In making such a determination, custody and clinical staff shall confer and review individual case factors, including the patient's current behavior and functioning and any other security concerns necessary to ensure the safety of medical staff. Such determinations shall not be made based on housing placement or custodial classification. The issuance of pills does not constitute a clinical interaction.

a) *For any determination that a clinical interaction with a patient requires the presence of custody staff, staff shall document the specific reasons for the determination. Such decisions shall be reviewed through the Quality Assurance process.*

b) *If the presence of a correctional officer is determined to be necessary to ensure the safety of staff for any clinical encounter, steps shall be taken to ensure auditory privacy of the encounter.*

c) *The County's patient privacy policies, as described in this section, shall apply to contacts between patients and all staff who provide health-related services on site at the jail."*

Historical activities related to this provision are detailed in the 10th County Status Report.

Regarding provision VI.H.3.b, deputies currently remain near medical staff while they treat inmates, making every effort to maintain confidentiality. If a deputy observes an inmate displaying safety concerns and medical attention is needed, the deputy will inform ACH and adjust their proximity based on the inmate's behavior during the interaction, with safety as the top priority.

As noted in VI.H.1, ACH QI plans to conduct an audit on confidential encounters in the upcoming reporting period to assess adherence to the established privacy policies. Until this audit is completed and evaluated to determine if documentation is included in the record whenever a patient presents a security concern that interferes with their confidential evaluation, and based on a review of the recent medical SME report, this provision has been reduced to partial compliance.

VI.H.4 - Substantial Compliance

"Jail policies that mandate custody staff to be present for any medical treatment in such a way that disrupts confidentiality shall be revised to reflect the individualized process set forth above. Custody and medical staff shall be trained accordingly."

No jail policy mandates custody staff to be present for any medical treatment. This provision remains in substantial compliance.

VI.I. Health Care Records

VI.I.1 - Partial Compliance

"The County shall develop and implement a fully integrated electronic health care record system that includes medical, psychiatric, and dental records and allows mental health and medical staff to view the medical and mental health information about each patient in a single record. This shall be accomplished within 12 months of the date the Remedial plan is issued by the Court."

All EHR integration and enhancements as described in the 10th County Status Report response continue to be in place and are utilized on a daily basis by ACH staff. Medical EHR Updates for this reporting period:

- Updates to existing forms/functionality:
    - Blood Pressure/Blood Sugar check orders – instructions to include "Duration"
    - Automatic order for Urgent Addiction Treatment Provider
    - Updated prompts for HgBA1C lab orders with instructions
    - Capture Chronic Care patient indicator on Provider H&P
    - Updated Common Order custom list for more efficient order processing
    - Wound Care order instructions updated to include more details
    - Additional orders added to Prenatal Labs custom list for more efficient order processing
    - Updated radiology orders to include more specific instructions to ensure proper order is used
- New EHR Forms:
    - Provider Visit Type – includes which type of visit is being provided (H&P, Chronic Care, Acute, etc.)
    - MH Interdisciplinary and Multidisciplinary Case Conference to document this process
    - MH Multidisciplinary Case Conference
    - Orthopedic Templates for better consistency with documentation and appropriate treatment/orders
    - Digitized Bowel Function Assessment form
    - Pharmacist Medication Refusal Consultation

    - Flowsheet view created for ADA
- New EHR Orders:
    - 2E 100 Housing – improved coordination with custody for proper treatment delivery
    - Daily ADL Care – ensures patients with ADL needs receive proper care
    - Assistive Device – Catheter
    - ATIMS appointments for Nephrology and Dialysis
- SSRS Reports put into Production:
    - Patients with Injectable Medication Orders
    - Mental Health Cases – CNAP and JBCT added
    - Mental Health Encounters – MH Prescriber Subjective, Objective, Assessment and Plan (SOAP) added
    - Unsigned Documents by User
    - MH Group Participation – absence reasons added
    - MH Group Availability
    - Open Orders (LIVE) - contingency/backup report to access all open orders if Order Manager interface is inoperable

Due to the upgrades needed to improve the functionality of the EHR, such as the CIPS interface, and review of the recent medical SME report, this provision has been reduced to partial compliance.

VI.I.2 - Substantial Compliance

"Until such a system is implemented, the County shall develop and implement policies and procedures to ensure that medical staff have access to mental health information and mental health staff have access to medical information, as needed to perform their clinical duties. This information shall include all intake records. Medical and mental health staff shall be trained in these policies and procedures within one month of the date the Remedial plan is issued by the Court."

The EHR provides access and contains information regarding medical, mental health and intake records. This provision remains in substantial compliance.

VI.I.3 - Substantial Compliance

"The County shall develop and implement policies and procedures to monitor the deployment of the CHS Electronic Health Record (EHR) to ensure the records system is modified, maintained, and improved as needed on an ongoing basis, including ongoing information technology support for the network infrastructure and end users."

All ongoing IT support mechanisms as described in the 10th County Status Report response continue to be in place and are utilized daily by ACH staff. This provision remains in substantial compliance.

VI.J. Utilization Management

VI.J.1 - Partial Compliance

"The County shall revise its utilization management (UM) system to ensure that critical health decisions about patients' access to care are made with sufficient input from providers and a thorough review of health care records."

ACH has implemented policies regarding the UM system in collaboration and agreement with court-appointed experts. Historical activities related to this provision are described in the 10th County Status Report.

During this reporting period, ACH has increased the number of UM providers to strengthen oversight of specialty referrals. Each referral is reviewed to determine if it meets medical necessity criteria, in accordance with the UM Policy. When appropriate, referrals are authorized with urgent priority. The review process includes a comprehensive evaluation of the patient's health care record and direct consultation with the ordering provider and, when needed, the specialty provider.

If, after reviewing the UM provider's documentation, the ordering provider disagrees with the decision, they may initiate a formal appeal. This triggers a collaborative case review meeting involving the medical director, the UM provider, and ordering provider to reach a final decision.

This provision remains in partial compliance.

VI.J.2 - Partial Compliance

"The County shall ensure that decisions about a patient's access to, timing of or need for health care are made by a physician, with documented reference to the patient's medical record. Nurses may gather information and coordinate the UM process, so long as it does not interfere with that requirement. All decisions by the UM committee shall be documented, including the clinical justification for the decision."

Standardized Nursing Protocols have been developed through collaboration among CM nursing staff, UM providers, ACH leadership, and input from the on-site specialists. These protocols enable nursing staff to determine whether certain non-complex cases meet

criteria for on-site specialty referrals without requiring additional authorization. All UM decisions are documented in the electronic health record.

Off-site referrals are reviewed by a physician, unless they fall under specific pre-identified categories that allow for automatic scheduling without delay or physician review – for example, routine post-operative orthopedic follow up or regular pacemaker interrogations.

The following example demonstrates proof of practice of timely evaluation and recommendations by the ACH medical team resulting in successful medical outcomes for patients.

Patient #2, a 47-year-old male with a history of multiple injuries requiring hospitalization prior to incarceration, was evaluated by our in-house orthopedic specialist after a fall. Due to concern for a potentially occult cervical fracture not detectable on plain radiographs, a CT scan of the neck was recommended. The order was placed May 23, 2025, which was sent and approved by UR provider within three days, the appointment was secured on May 28, 2025, and appointment completed on June 4, 2025.

The patient initially refused the appointment scheduled for June 4, 2025. However, custody staff promptly contacted an in-house physician, who met with the patient in person. Following counseling, the patient agreed to proceed with the appointment. Our physicians often engage in multiple discussions with patients to explain the benefits of recommended specialty services and the potential consequences of refusal. Close communication between custody and the medical team has been instrumental in preventing delays in such cases. Fortunately, the CT scan revealed no evidence of fracture, allowing the patient to be safely removed from the cervical collar and begin physical therapy. Physical therapy was also ordered on May 23, 2025 for fall prevention, with CM authorizing the referral for processing. The initial session was completed on June 6, 2025.

Additionally, on May 23, 2025, the patient was evaluated by an in-house optometrist for a concern related to a foreign body in his eye—an issue that had not been addressed prior to incarceration. The optometrist diagnosed the condition and placed a referral for off-site ophthalmology on the same day. The referral was submitted to UR on May 25, 2025 and authorized the following day. The appointment was completed on June 6, 2025 where the ophthalmologist recommended surgical removal of the foreign body in the operating room, which was successfully completed on June 17, 2025. Thanks to timely evaluation and treatment, the patient's vision was preserved without complication or infection. A recent Snellen exam showed 20/30 vision. Without these prompt interventions, the patient could have experienced permanent vision loss. This provision remains in partial compliance.

VI.J.3 - Partial Compliance

"The UM system shall ensure that providers and patients are promptly informed about decisions made by the UM committee, including denial of a specialist referral request."

As outlined in VI.J.2, UM provider notes are immediately routed to the ordering provider through the electronic health record for review and signature. The ordering provider is then responsible for communicating the outcome to the patient using the method deemed most appropriate – either in person or via written correspondence - based on the anticipatory guidance provided during the initial encounter. There have been significant changes in the County's UM system over the past eight months. All UM decisions are documented in the electronic health record. This provision remains in partial compliance.

VI.J.4 - Partial Compliance

"The UM system shall include an appeal process to enable patients and providers to appeal a decision denying a referral request."

In addition to the process description included in the 10th County Status Report, a formal appeals process has been implemented, involving a collaborative case review between the ordering provider, the UM provider, and the medical director. During this meeting, the patient's chart is thoroughly reviewed, and the case is discussed by the team before a final determination is made. This provision remains in partial compliance.

VI.K. Sanitation

VI.K.1 - Substantial Compliance

"The County shall consult with an Environment of Care expert to evaluate facilities where patients are housed and/or receive clinical treatment, and to make written recommendations to address issues of cleanliness and sanitation that may adversely impact health."

The County consulted with an Environment of Care expert to evaluate facilities where patients are housed in medical and mental health units and in medical clinic areas to address consistency with environmental cleaning and sanitation standards. An action item tool was developed to follow up on the recommendations from the Environment of Care Report and was sent to the SMEs.

ACH/DGS continues to have a contract with Olympic Cleaning Service (formally known as Bissel Brothers) for environmental cleaning services requested in the Environment of Care Report. The contract was first executed in February 2024. They are on-site daily and ensure

cells and other areas that need deep cleaning are conducted promptly. The use of the contracted cleaner vendor continues to provide the desired results.

The County has updated the Infection Prevention and Control Manual to include policies and procedures with guidelines on proper cleaning and disinfecting approved by the California Department of Public Health for the medical and mental health areas.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VI.L. Reproductive and Pregnancy Related Care

VI.L.1 - Partial Compliance

"The County shall ensure that pregnant patients receive timely and appropriate prenatal care, specialized obstetrical services when indicated, and postpartum care (including mental health services)."

ACH maintains a weekly OB/GYN clinic at the Main Jail. Pregnant patients are identified and followed by UC Davis (UCD) OB on site consistent with policy and federal and state regulations.

When acute issues arise, on-site providers evaluate the patient and consult with UCD OB/GYNs via phone as needed. ACH QI developed audit indicators to review reproductive and pregnancy-related care. With the onboarding of two QI RNs, ACH QI was able to conduct their first official audit on Women's Health Screening at intake- with a focus on reproductive care in June 2025. The following are some of the findings:

- The Women's Health intake form was completed for 91% of female patients.
- In about 62% of cases, the nurses were able to conduct an hCG test during the intake process- resulting in only three confirmed pregnancies. All three were successfully referred to and seen by an OB/GYN provider within the recommended time frame.
- Of the women that did not complete an hCG test at intake, about 15% of women completed it within 72 hours while 17% completed it beyond the 72 hours. The remaining women were released without completing the hCG test.
- Only 9% of the women reported being on a form of birth control. ACH continued the birth control for about 50% of the women. The other 50% reported having a form of

long-term birth control and did not require follow-up treatment during this audit period.

- Only about 3% of women not on birth control stated that they were interested in birth control.

This provision remains in partial compliance.

VI.L.2 - Substantial Compliance

"The County will provide pregnant patients with comprehensive counseling and timely assistance in accordance with their expressed desires regarding their pregnancies, whether they elect to keep the child, use adoptive services, or have an abortion."

ACH provides pregnant patients with comprehensive counseling and timely assistance in accordance with their expressed desires regarding their pregnancies, whether they elect to keep the child, use adoptive services, or terminate the pregnancy. If patients elect for termination, coordination with UCD occurs immediately and their team prioritizes patients to be scheduled based on their gestational age, as is done in the community.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VI.L.3 - Partial Compliance

"The County will provide non-directive counseling about contraception to female prisoners, shall allow female prisoners to continue an appropriate method of birth control while incarcerated (with consideration given to the patient's preference and/or current method of birth control), and shall provide access to emergency or other contraception when appropriate."

ACH provides non-directive counseling about contraception to female prisoners, allows female patients to continue an appropriate method of birth control, provides access to emergency or other contraception when appropriate. All forms of contraception including Depo-Provera, combined oral contraceptives, Progesterone only pill, and intrauterine devices are offered. Although the non-directive counseling regarding contraception is occurring, ACH documentation does not appropriately reflect it. ACH will work with the EHR team to create a check box in the female H&P note to not only remind the provider of

this requirement and provide proof of practice. Until this occurs, this provision is reduced to partial compliance.

VI.M. Transgender and Gender Non-Conforming Health Care

VI.M.1 - Substantial Compliance

"The County shall implement policies and procedures to provide transgender and intersex prisoners with care based upon an individualized assessment of the patient's medical needs in accordance with accepted standards of care and prevailing legal and constitutional requirements, including, as appropriate:

a) Hormone Therapy

b) Surgical Care

c) Access to gender-affirming clothing

d) Access to gender affirming commissary items, make-up, and other property items"

ACH has implemented policies and procedures to provide transgender and intersex patients with care based upon an individualized assessment of the patient's medical needs in accordance with accepted standards of care and prevailing legal and constitutional requirements, including, as appropriate, hormone therapy, surgical care, access to gender-affirming clothing, and access to gender affirming commissary items, make-up, and other property items.

For continuity of care, patients who are identified as receiving hormone treatment from a community licensed provider continue the medication while incarcerated. A provider will assess the patient and include the medication as part of the patient's treatment plan. This provision will be in substantial compliance when all patients who qualify are referred and seen in a timely manner at the gender-affirming clinic.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

V1.M.2 - Substantial Compliance

"The County shall ensure that medical and mental health staff have specific knowledge of and training on the WPATH Standards of Care."

ACMH staff worked with a consultant to develop training on the WPATH Standards of Care, LGBTQIA, and Health Equity. Feedback from medical, mental health and suicide prevention experts has been incorporated. In consideration of the medical expert recommendation, ACH has created additional slides regarding the WPATH standards in relation to ACH policy to be included in the training. The training was approved, and training began in March 2023. Newly hired staff are expected to complete it within three months of hire and trainings are offered about every four to six months.

- As of June 2025, 100% of ACMH staff have completed LGBTQ+ WPATH Training.
- As of June 2025, 93% of permanent ACH staff and 3% of registry staff have completed LGBTQ+ WPATH Training.

ACH hired a nurse educator in December 2024. He maintains required staff training and ensuring compliance moving forward. He has also retrained intake nurses on referring patients to the transgender affirming clinic during his most recent intake training.

The training structure below will be used in the future to ensure substantial compliance is maintained.

- WPATH transgender training by an SME from UC Davis Mental Health has been recorded with a study guide and test. A link to the new training model was announced in the ACH monthly newsletter last month
- Staffing will notify Registry Agencies: WPATH transgender care training completion within 30 days will be a condition of employment. A mass training notice with online training link was shared in July 2025. Registry staff will need to complete a quiz at the end of the training to demonstrate understanding. The quiz will also be used as an attestation of completion.
- WPATH training will remain part of the core onboarding for new employees.
- Biennial training may be integrated into annual Policy and Procedure training. This is because WPATH provides general transgender guidelines, while the ACH Policy & Procedure offers specific medical care protocols health staff need to manage care effectively.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VI.N. Detoxification Protocols

VI.N.1 - Partial Compliance

"Within three months of the date the Remedial plan is issued by the Court, the County shall develop and implement protocols for assessment, treatment, and medication interventions for alcohol, opiate, and benzodiazepine withdrawal that are consistent with community standards."

Historical activities related to this provision are included in the 10th County Status Report. Withdrawal and detox policies and procedures, SNPs as well as MAT induction guidelines, are being revised with the input of addiction medicine trained physicians as well as nursing staff. Fixed dose treatment regimens for alcohol withdrawal as well as benzodiazepine withdrawal have been in place and part of the protocol. For opioid withdrawal, all medications are fixed dose, with the exception of Loperamide, which is currently used as needed for diarrhea.

Intake forms are being modified to enhance clarity regarding substance use history, withdrawal history, and time of last use, and nurses will be trained on which patients need to urgently be evaluated by the addiction provider within 24 hours.

Early in the upcoming monitoring period, addiction medicine trained physicians will hold trainings for intake nursing staff as well as withdrawal monitoring nursing staff once the new policies and SNPs are finalized. Trainings will include clear guidance regarding Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA) and Clinical Opiate Withdrawal Scale (COWS) assessments.

ACH continues to operate a full MAT induction program to manage patients in withdrawal from opioids. In partnership with ACH to better support the MAT/detox inmate population, SSO has designated Pods 100, 200, and 300 on 6 East as a designated MAT/detox unit. This centralization enables more effective monitoring of inmates undergoing withdrawal. On May 17, 2025, to streamline medical supervision, the female MAT/detox population was transferred from 7 East, Pod 100 to 6 East, Pod 100. Due to the MAT/detox program, ACH has helped thousands of patients that would otherwise experience withdrawal for an extended period and face potentially negative outcomes.

To support the program, SSO designated four full-time deputy medical escort positions. Each escort is paired with a medical provider, RN, or MA to facilitate quicker access for MAT/detox inmates receiving care. These positions are dedicated to supporting operations on 6 East and other acute care areas.

The following examples demonstrate proof of practice for success of the MAT program in stabilizing patients in withdrawal, leading to positive outcomes.

- Patient # 3 is a 36-year-old male with a history of opiate use disorder, stable on Suboxone for many years. He came in as a transfer from an outside facility. At that outside facility, he was denied access to Suboxone. When he was evaluated by an addiction medicine provider, he reported withdrawal symptoms and severe fentanyl cravings. He stated that he was close to relapsing and would likely use fentanyl if he came across it within the facility. He was started on his outside dose of Suboxone immediately, and he was able to maintain his sobriety.
- Patient #4 is a 44-year-old male with a history of opioid use disorder who was started on Suboxone while in jail. He was seen the next day for follow-up, and he reported significant improvement in his withdrawal symptoms as well as his cravings. He noted he was happy on his dose of Suboxone and has since taken it daily with no refusals.

This provision remains in partial compliance.

VI.N.2 - Partial Compliance

"The protocols shall include the requirements that:

i. nursing assessments of people experiencing detoxification shall be done at least twice a day for five days and reviewed by a physician.

ii. nursing assessments shall include both physical findings, including a full set of vital signs, as well as psychiatric findings.

iii. medication interventions to treat withdrawal syndromes shall be updated to provide evidenced-based medication in sufficient doses to be efficacious.

iv. the County shall provide specific guidelines to the nurses for intervention and escalation of care when patients do not respond to initial therapy; and

v. patients experiencing severe-life threatening intoxication (an overdose), or withdrawal shall be immediately transferred under appropriate security conditions to a facility where specialized care is available."

For VI.N.2.i, ACH worked in collaboration with custody at the Main Jail to designate a specific housing pod for a detox unit to support consistent withdrawal monitoring because of a decreased need for quarantine pods. Two RNs are designated for MAT services and designated nurses are assigned to administer medications daily. Due to the

implementation of the detox units, twice-daily checks are improving and being closely monitored.

For VI.N.2.ii, nursing assessments include both physical findings, including a full set of vital signs, as well as psychiatric findings. If patients refuse their withdrawal monitoring checks, the RN goes to the cell and has SSO open the door. The nurse will attempt to engage the patient and get as much information on their status as they can.

For VI.N.2.iii, medication interventions have been updated to treat withdrawal syndromes and in sufficient doses to be efficacious. ACH medical leadership will develop a protocol for starting patients on opiate withdrawal medications at intake based on history and self-reporting– rather than solely dependent upon assessment scoring. ACH will continue to discuss initiating medications at intake for patients not yet in alcohol and benzodiazepine withdrawal with experts, custody, and County Counsel due to patient safety concerns related to compounding depressants as well as risks associated with quick releases from custody.

For VI.N.2.iv, detoxification protocols are in place to instruct nurses on intervention and escalation when needed.

For VI.N.2.v, nurse intake screening will declare patients experiencing life-threatening intoxication unfit and send them to the ER for appropriate treatment. For those experiencing life-threatening withdrawal post intake – the nurse conducting monitoring will alert SSO and providers of the need to transport to the ER when identified. The unfit criteria was recently updated and the medical director trained all nursing staff.

The MAT policy was revised in December 2023. The minimum requirement for withdrawal (WD) monitoring is twice per day for the prescribed number of days for the designated medication. During this reporting period, a second SRN was assigned to WD monitoring. This area now has seven day per week coverage and oversight. A major emphasis has been placed on the WD monitoring nurses to conduct their assessments timely and according to the order. ACH now tracks and reports weekly on the number of twice daily monitoring and six- hour monitoring that occurs with WD. ACH monitoring percentages have greatly increased. The provider stationed on the WD monitoring floor (6th) has been assigned to making daily rounds five days per week. On the weekends, an on-site MAT provider sees the patients who are most critical.

There have also been significant changes made to the “sobering cell”, now called “medical observation cell” (MOC). This assessment will ensure that there is a face-to-face encounter between the medical staff and the patient which allows ACH to ensure patient

safety during this potentially high-risk time. ACH and SSO meet weekly to problem-solve and discuss any issues that arise. This provision remains in partial compliance.

VI.O. Nursing Protocols

The Remedial Plan states that SNPs shall include assessment protocols that are sorted based on symptoms into low, medium, and high-risk categories. Information on SNPs is included in the 10th County Status Report and summarized in Attachment 2.

VI.O.1 - Partial Compliance

"Nurses shall not act outside their scope of practice."

The description of this provision remains unchanged from the 10th County Status Report. This provision remains in partial compliance.

VI.O.2 - Partial Compliance

"To that end, the County shall revise its nursing standardized protocols to include assessment protocols that are sorted, based on symptoms, into low, medium, and high-risk categories.

a) *Low-risk protocols would allow RNs to manage straightforward symptoms with over-the-counter medications;*

b) *Medium-risk protocols would require a consultation with a provider prior to treatment; and*

c) *High-risk protocols would facilitate emergency stabilization while awaiting transfer to a higher level of care."*

ACH is currently updating the SNPs to provide clear nursing guidance on sick call management, appropriate placement, and transfer to a higher level of care when necessary. Once finalized, the updated SNPs will be integrated into the EHR system. The nurse educator is developing onboarding and ongoing training to ensure nursing staff are well-versed in the new protocols. This provision remains in partial compliance.

VI.P. Review of In-Custody Deaths

VI.P.1 - Partial Compliance

"Preliminary reviews of in-custody deaths shall take place within 30 days of the death and shall include a written report of the circumstances of the events leading to the death, with

the goal to identify and remedy preventable causes of death and any other potentially systemic problems."

Preliminary reviews of in-custody deaths take place within 30 days of the death and include a written Clinical Mortality Review Report of the circumstances of the events leading to the death, with the goal to identify and remedy preventable causes of death and any other potentially systemic problems.

During this reporting period, the medical director responsible for completing mortality reviews accepted a position outside of the County. The assistant medical director assumed responsibility for the morality reviews associated with deaths occurring during this time frame. Due to this being a new process for her, one review was finalized outside of the 30-day time frame. This is not anticipated to be an issue moving forward as the assistant medical director now has a clear understanding of the responsibilities and has since completed the reviews within the required time frame. Additionally, the newly appointed medical director brings extensive experience in completing mortality reviews and can assume responsibility immediately. This provision remains in partial compliance.

VI.P.2 - Partial Compliance

"Mortality reviews shall include an investigation of the events occurring prior to the death, an analysis of any acts or omissions by any staff or prisoners which might have contributed to the death, and the identification of problems for which corrective action should be undertaken."

In addition to the information included in the 10th County Status Report, ACH updated the Review of In-Custody Death policy concurrently with the development of a new Sentinel Event policy. Both policies were submitted to Class Counsel and the SMEs in April 2025. As of June 2025, the County has not received any feedback.

ACH continues to strengthen its Corrective Action Plans (CAPs) by ensuring they are more comprehensive, clearly identifying responsible individuals, timelines for completion, and specific action steps. In response to recent SME feedback that mortality-related CAPs have become overly complex and difficult to track, monitor, and evaluate, ACH has made several improvements. For example, the CAP form was updated to include root causes and specific goals for each action item. Additionally, ACH has refined the mortality CAP process to emphasize systemic issues with the greatest potential to improve future outcomes.

This provision remains in partial compliance.

VI.Q. Reentry Services

VI.Q.1 - Substantial Compliance

"The County shall provide a 30-day supply of current medications to patients who have been sentenced and have a scheduled release date, immediately upon release."

Discharge medications continue to be provided to approximately 90% of eligible sentenced patients and 95% of court-ordered patients upon release. As of March 2025, sentenced status is now transmitted from ATIMS to Athena, providing a comprehensive view of patients' sentencing across all charges. This enhancement improves our ability to identify patients who are fully sentenced and potentially eligible for release.

A conditional release flag has been added to ATIMS to alert custody staff when a patient has discharge medications ready. A pharmacist delivers medications to the patient at release. Additionally, staff have been hired to support the implementation of a 24-hour pharmacy at Main Jail. Training is currently underway, with full implementation is scheduled before the end of the year. This provision remains in substantial compliance.

VI.Q.2 - Non-Compliance

"Within 24 hours of release of any patient who receives prescription medications while in custody and is classified as pre-sentence, the County shall transmit to a designated County facility a prescription for a 30-day supply of the patient's current prescription medications."

ACH has changed the practice of sending prescriptions directly to the County's Primary Care Clinic due to less than a 5% patient pickup rate, high provider and staff workload, and a high amount of Court-ordered medication in hand. This decision was approved by the medical directors. A description of the process is outlined in VI.H.3. ACH anticipates that the implementation of the 24-hour pharmacy in the next reporting period will increase this provision to partial compliance.

VI.Q.3 - Partial Compliance

"The County, in consultation with Plaintiffs, shall develop and implement a reentry services policy governing the provision of assistance to chronic care patients, including outpatient referrals and appointments, public benefits, inpatient treatment, and other appropriate reentry services."

All elements of the 10th status report remain current. However, ACH has been watching the Statewide rollout of California Advancing and Innovating Medi-Cal (CalAIM) carefully to

help best inform our implementation timeline and approach, learning from the challenges the early counties have faced and what additional work remains to be done. The County made the decision to delay the start of this initiative from June 2025 to October 2026 to ensure a more seamless and effective rollout, addressing potential issues in advance.

Key reasons for deferral include process complexity: Implementation requires establishing 14 new processes, including screening and enrolling eligible inmates into Medi-Cal, documenting medical, behavioral health, and care management services using Medi-Cal billing codes, billing DHCS for services, managing denials and resubmissions, and ensuring post-release care management.

In addition, there are additional workforce requirements that this initiative will necessitate. The proposal will require adding and hiring approximately 40 positions, which will take time to hire, train, and background check for service in the County's jails. Additionally, all providers currently working in the jail will need to be set up to bill Medi-Cal.

However, in July 2025, Mental Health and County BHS launched a pilot project to improve coordination of BHS' assessments and linkage to community providers prior to a patient's release from jail. The initial focus will be on patients with a projected release date who have an SMI and are receiving care in IOP, JBCT or APU. This initiative aims to improve the timeliness of community linkage and strengthen warm handoffs to community behavioral health providers.

Additionally, significant progress has been made during this reporting period to support the rollout of the Reentry Opportunities and Access to Resources (ROAR) program. The program, which launched on July 1, 2025, will initially focus will be on individuals leaving jail within the first three days; Its primary goals are to expand access to mental health and substance use prevention and treatment services as well as strengthen housing linkages. To support this effort, we have secured a contract with a community-based shelter to provide 70 dedicated beds for individuals transitioning out of custody. This shelter offers 24/7 access, which is a critical resource given that patients are released from jail at all hours.

The emphasis of the grant is on funding shelter beds and short-term housing, along with supporting linkages to Sacramento County BHS, and other community-based services. Contacts with ROAR participants will vary for the services provided outside of the congregate shelter or short-term housing where Prop 47 participants will reside. The congregate shelter and short-term housing (beds vary) staff will make daily contact with participants.

The contracted ROAR agency for care coordination will have case managers to assist ROAR participants pre-release and upon release to ensure connection with housing and other required supports. The care coordination contractor will have embedded staff in the jail for pre-release coordination and discharge planning, as well as staff available outside the jails 24/7 for transportation and additional supports. The congregate shelter and short-term housing facilities will have on-site staff to provide basic case management services in coordination with the ROAR care coordination contractor.

This provision remains in partial compliance due to the need for more discharge planners.

VI.R. Training

VI.R.1 - Partial Compliance

"The County shall develop and implement, in collaboration with Plaintiffs' counsel, training curricula and schedules in accordance with the following:

a) *All jail custody staff shall receive formal training in medical needs, which shall encompass medical treatment, critical incident response, crisis intervention techniques, recognizing different types of medical emergencies, and acute medical needs, appropriate referral practices, relevant bias and cultural competency issues, and confidentiality standards. Training shall be received every two years, at minimum."*

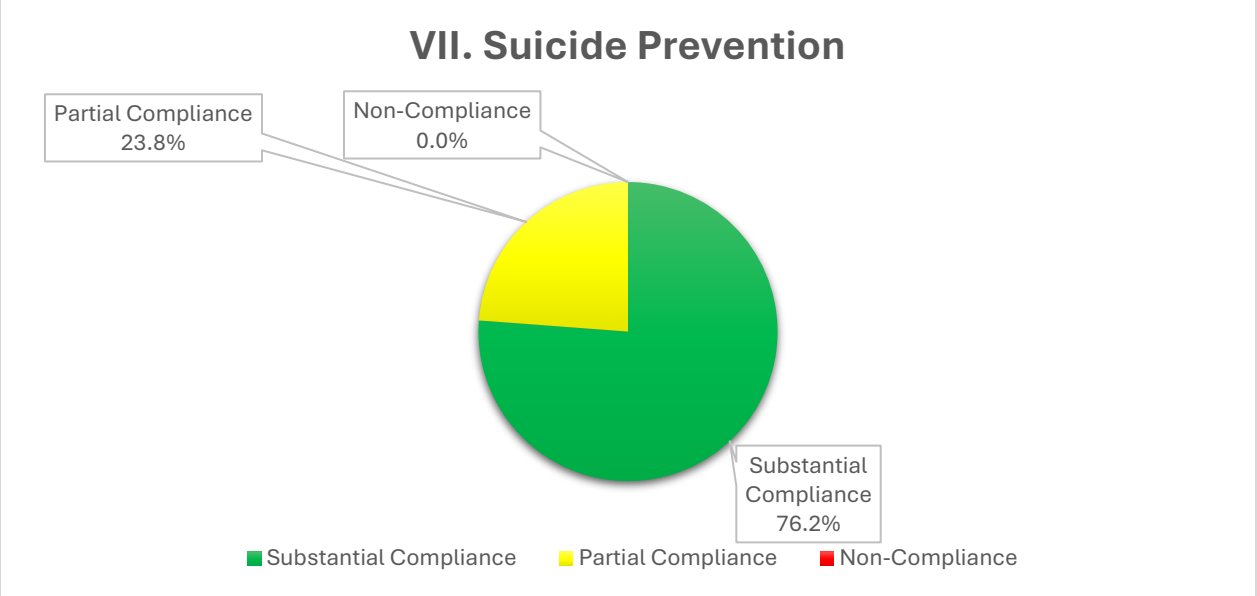
Sworn staff complete 21 hours of First Aid and CPR training (LD 34) as part of a POST-approved academy. Additionally, every two years, they participate in Advanced Officer Training (AOT), which includes nine hours of instruction in First Aid, CPR, and Emergency Response. Sworn staff also receive 16 hours of Cultural Diversity and Discrimination training (LD 42) during the POST-approved academy. Furthermore, they are required to complete POST-approved training on Bias, Racial, and Identity Profiling every two years.

Newly assigned custody staff complete an eight-hour Suicide Prevention and Crisis Intervention course. Following the initial training, custody staff also receive a two-hour suicide prevention refresher course annually.

All custody staff with access to confidential information are required to complete confidentiality-related training, take a certification test related to right-to-know vs need-to-know confidential data, and sign a user agreement related to privileged and confidential information every two years. SSO has identified Health Insurance Portability and Accountability Act (HIPAA) training geared specifically towards law enforcement. It will be

forwarded to Class Counsel for their approval before implementation. This provision remains in partial compliance.

VII. Suicide Prevention



The County has identified 63 provisions in Remedial Plan VII. Suicide Prevention. For this 11th County Status Report, the compliance ratings are as follows:

- Substantial Compliance: 48 provisions (76.2%)
- Partial Compliance: 15 provisions (23.8%)
- Non-Compliance: 0 provisions (0%)

Monitoring Status

Remedial Plan VII. Suicide Prevention is monitored by the suicide prevention SME, Lindsay M. Hayes. As of July 2025, five monitoring reports have been completed to evaluate the suicide prevention remedial plan provisions in the Consent Decree. The most recent report from Mr. Hayes was received by the County on November 11, 2024.

In comparison to the County's self-assessed ratings, the Court-appointed monitors' compliance ratings are as follows:

- Substantial Compliance: 24 provisions (38.1%)
    - This includes 19 provisions that are no longer subject to external monitoring as the County has sustained a level of substantial compliance with these provisions for over one year.
- Partial Compliance: 33 provisions (52.4%)
- Non-Compliance: 6 provisions (9.5%)
- Not Assessed: 0 provisions (0%)

Attachment 7, Suicide Prevention Remedial Plan Expert Rating Reconciliation, aligns the Court-appointed monitor's compliance ratings with the provision structure used here and shows how the County's compliance ratings compare to those of the assigned monitor.

Self-Assessment

VII.A. Substantive Provisions

VII.A.1 - Substantial Compliance

"The County recognizes that comprehensive review and restructuring of its suicide assessment, monitoring, and prevention practices are necessary to address the risk of suicide and self-harm attendant to detention in a jail setting."

In addition to the information included in the 10th County Status Report, the County continues to demonstrate compliance with this provision.

ACMH completes weekly audits of MH compliance for determining and documenting housing, observation level, property, privileges, and clothing restrictions for patients placed on suicide precautions. Findings are reported to the Suicide Prevention Subcommittee on a quarterly basis. ACMH implemented the Constant Observation Program and has filled all vacancies. Staff are available 24/7 to provide 1:1 constant observation.

ACMH embedded the Suicide Risk Assessment (SRA) into the MH Clinical SOAP note. This will improve consistency of documentation, ease of locating SRA, and eliminate duplication/redundancy of documentation.

Audit results of Suicide Risk Assessment and Safety Planning from Sep-Nov 2024 are as follows:

- ACMH completed a suicide risk assessment for 100% (60/60) of patients referred for being a danger to self.
- 100% (38/38) of patients placed on suicide precautions had a safety plan completed at the time of initial SRA.
- 100% (20/20) of charts had a completed suicide risk assessment for patients discharged from suicide precautions.
- 95% (19/20) of charts had completed safety plans for patients discharged from suicide precautions.
- Of the 22 patients without a safety plan at the time of the initial SRA:

- 11 patients were cleared from suicide precautions during the initial SRA and therefore did not require a safety plan as per the Suicide Prevention Policy.
- 11 patients had documentation indicating they were unable to engage in safety planning during the initial SRA.
- All 11 of these patients had a completed safety plan in place prior to being discharged from suicide precautions.

ACMH continues to audit documentation of suicide precautions and clinical determinations regarding restoration of privileges and property, the removal of privileges and property, removal of clothing and/or safety smock, and daily assessments for restoration of clothing. During the report period of February to April 2025:

- 100% (75/75) of suicide precautions forms were completed for each patient encounter.
- 100% (75/75) of clinical justification for removal of privileges and property were documented for each patient encounter.
- 100% (75/75) of MH staff made recommendations regarding removal of clothing or use of safety smock for each patient encounter.
- 95% (36/38) of daily assessments for restoration of privileges and property were completed.
- 95% (36/38) of daily assessments to determine restoration of clothing or continued use of safety smock were completed.

ACMH has fully implemented CNAP which provides crisis intervention, enhanced observation and stabilization for patients in crisis.

This provision remains in substantial compliance.

VII.A.2 - Substantial Compliance

"The County shall establish, in consultation with Plaintiffs' counsel, a new Suicide Prevention Policy that shall be in accordance with the following: [see section B. Training]."

County ACMH established a Suicide Prevention Policy in agreement/approval with Class Counsel and the Court-appointed SMEs. SSO Suicide Prevention and Intervention Policy and Procedure was updated on in September 2023. This provision remains in substantial compliance.

VII.B. Training

VII.B.1 - Partial Compliance

"The County shall develop, in consultation with Plaintiffs' counsel, a four-to-eight-hour pre-service suicide prevention curriculum for new Jail employees (including custody, medical, and mental health staff), to be conducted in person in a classroom or virtual classroom setting, that includes the following topics:

a) avoiding obstacles (negative attitudes) to suicide prevention;
b) prisoner suicide research;
c) why facility environments are conducive to suicidal behavior;
d) identifying suicide risk despite the denial of risk;
e) potential predisposing factors to suicide;
f) high-risk suicide periods;
g) warning signs and symptoms;
h) components of the jail suicide prevention program
i) liability issues associated with prisoner suicide;
j) crisis intervention."

In addition to the information shared in the 10th County Status Report, County ACMH provides a four-hour required training for the Suicide Prevention Program to new Jail employees (including SSO Custody, medical, and mental health staff) in agreement and approval from Class Counsel and Court-appointed SMEs.

As of June 2025, 99% of ACMH staff are compliant with the four-hour training requirement and 99.4% of permanent ACH staff are compliant with the four-hour training requirement.

As of June 2025, 96.1% of registry staff are out of compliance with the training requirement. Low training compliance for registry staff is due to logistical and administrative challenges including scheduling complexities and training delivery obstacles (required in-person training and aligning registry staff schedules with available training). ACH continues to identify barriers, alternative delivery methods, and expanded weekend and evening training opportunities.

This provision remains in partial compliance due to the low percentage of registry staff who have received training.

VII.B.2 - Partial Compliance

"The County shall develop, in consultation with Plaintiffs' counsel, a two-hour annual suicide prevention curriculum for all custody, medical, and mental health staff, to be conducted in person in a classroom or virtual classroom setting, that includes:

a) review of topics (a)-(j) above

b) review of any changes to the jail suicide prevention program
c) discussion of recent jail suicides or attempts"

The County developed a two-hour annual Suicide Prevention Training for all staff (SSO Custody, medical, and mental health staff) in agreement and approval from Class Counsel and Court-appointed SMEs.

As of June 2025, 98% of ACMH staff are compliant with the two-hour training requirement and 97.5% of permanent ACH staff are compliant with the two-hour training requirement.

As of June 2025, 96.1% of registry staff are out of compliance with the training requirement. Low training compliance for registry staff is due to logistical and administrative challenges including scheduling complexities and training delivery obstacles (required in-person training and aligning registry staff schedules with available training). ACH continues to identify barriers, alternative delivery methods, and expanded weekend and evening training opportunities.

This provision remains in partial compliance due to the low percentage of registry staff who have received training.

VII.B.3 - Substantial Compliance

"Custody officers assigned to Designated Mental Health Units shall receive additional specialized training on suicide prevention and working with prisoners with serious mental illness."

All custody staff are required to take four hours of suicide prevention training, and SSO requires four hours combined of Understanding Mental Health Symptoms in a Correctional Setting, Mental Health Evaluations in Planned Use of Force, and Effects of Brain Development in Forensic Settings & Mental Health Adaptive Supports. This training is in addition to mental health training received in the POST Basic Academy, Corrections Supplemental Core Course, and SSO mandated 24-hour Crisis Intervention Training (CIT).

Custody officers assigned to Designated Mental Health Units receive additional specialized training on suicide prevention and working with prisoners with SMI. IOP and JBCT deputies receive 24 hours of advanced CIT training. Several IOP/JBCT deputies also attended negotiation training specific to custody. This provision remains in substantial compliance.

VII.B.4 - Substantial Compliance

"All mental health staff, including nurses, clinicians, and psychiatrists, shall receive additional training on how to complete a comprehensive suicide risk assessment and how to develop a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation."

All mental health staff, including clinicians, and psychiatrists, receive additional training on how to complete a comprehensive suicide risk assessment and how to develop a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation.

The Suicide Risk Assessment Training was approved by SME. Staff complete the training within three months of hire and again every two years. As of June 2025, 95% of ACMH staff are compliant with required Suicide Risk Assessment training.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.B.5 - Substantial Compliance

"All mental health staff and custody officers shall be trained on the appropriate use of safety suits—i.e., not to be utilized as a default, not to be used as a tool in behavior management, not to be utilized for patients being observed at 30-minute observations."

Safety suits are used at the discretion of ACMH based on collaboration with custody staff and not as a behavior management tool. During the four-hour mandated suicide prevention training for all new correctional employees, the topic relating to the proper use of safety suits is covered.

ACMH monitors the use of safety suits through the Suicide Precautions Weekly Audit-Quarterly Report. Audit findings from February to April 2025 are as follows:

- Suicide precautions form is being completed 100% (75/75) of the time for each patient encounter.
- Clinical justification for removal of privileges and property is completed 100% (75/75) of patient encounters.
- MH is making recommendations regarding removal of clothing/safety smock in 100% (75/75) of patient encounters.

With these findings demonstrating proof of practice, this provision remains in substantial compliance.

VII.B.6 - Substantial Compliance

"The County shall ensure that all staff are trained in the new Suicide Prevention Policy."

For ACH, the Suicide Prevention Policy is incorporated in the Annual Suicide Prevention Training that is required for all staff. For SSO, the Suicide Prevention and Intervention Policy and Procedure was updated on in September 2023. Staff are prompted to review and acknowledge the policy which is electronically recorded in Lexipol. This provision remains in substantial compliance.

VII.C. Nursing Intake Screening

VII.C.1 - Substantial Compliance

"Intake screening for suicide risk will take place at the booking screening and prior to a housing assignment. If clinically indicated, JPS will then perform an additional clinical assessment after the inmate is placed in a housing assignment."

Intake screening for suicide risk takes place at the booking Receiving Screening and prior to a housing assignment. If clinically indicated, a referral is made to ACH MH, who will then perform an additional clinical assessment after the patient is placed in a housing assignment. This provision remains in substantial compliance.

VII.C.2 - Substantial Compliance

"All nursing intake screening shall be conducted in an area that provides reasonable sound privacy and confidentiality. If a custody officer is present, the officer should be positioned in a place that allows for observation of the prisoner but maintains sound privacy, unless there is a clearly identified security or safety risk."

To resolve compliance issues, the County developed a comprehensive plan to restructure the arrest report room/medical intake area. DGS repurposed the current room where the breathalyzer is stored, a bathroom, an exam room and an office into four confidential medical intake spaces. This plan was shared in detail with the SME's and Class Counsel and the response was favorable in that it would meet requirements to achieve compliance. This project was completed during the previous monitoring period. The SMEs had an opportunity to see these changes during their most recent monitoring visit. They agreed that the physical restructure of the intake area meets the requirements for this provision. Therefore, this provision will remain substantial compliance.

VII.C.3 - Substantial Compliance

"The County shall revise its nursing intake assessment procedures and screening forms to ensure timely identification of acute and high-risk mental health conditions, consistent with the recommendations made by Lindsey Hayes. Intake screening, as documented on screening forms, 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, 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;
e) Transporting officer's impressions about risk."

County ACH revised the nursing Intake assessment procedures and screening forms to ensure timely identification of acute and high-risk mental health conditions, consistent with the recommendations made by the Court-appointed suicide prevention SME to be consistent with this requirement.

Training has been developed for intake nurses on screening for mental health issues, suicide risk assessment screening, danger-to-self or others and grave disability and referral process for emergent MH evaluations. Formal Intake training by the Training Coordinator began December 2022.

During the prior reporting period, the nurse intake was revised to be conducted in two phases. The suicide risk questions were also revised in coordination with the SME. The questions are clearer and less redundant. They have automatic orders associated with them to be referred to ACMH staff depending on the answer from the patient.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.C.4 - Substantial Compliance

"Regardless of the prisoner's behavior or answers given during intake screening, a mental health referral shall always be initiated if there is a documented history related to suicide or self-harm, including during a prior incarceration."

Regardless of a patient's behavior or answers given during intake screening, an automatic mental health referral is initiated if there is a documented history related to suicide or self-harm, including during a prior incarceration. This provision remains in substantial compliance.

VII.C.5 - Substantial Compliance

"The County shall develop and implement a written policy and procedure for referrals to mental health by intake staff. The policy shall correspond with the triage system and timeframes set forth in the Mental Health Remedial Plan."

County ACH updated and implemented the Nurse Intake policy and procedure that includes referrals to mental health by Intake staff. The policy corresponds with the triage system and time frames set forth in the Mental Health Remedial Plan.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.C.6 - Substantial Compliance

"Any prisoner expressing current suicidal ideation and/or current suicidal/self-injurious behavior shall be designated as an emergent referral and immediately referred to mental health staff."

Any patient expressing current suicidal ideation and/or current suicidal/self-injurious behavior shall be designated as an emergent referral and immediately referred to mental health staff. There has been a significant increase in emergent referrals since nurse intake questions and orders were changed due to this provision.

Due to ongoing challenges with Intake nursing asking all suicide risk screening questions, QI Nursing began on-site monitoring of the nurse intake process, including suicide risk assessment questions to ensure compliance with screening requirements. This led to a substantial increase in the percentage of suicide risk screening questions being asked verbatim during the intake process, increasing from 64% to 93% over a period of one year.

Nursing updated the intake form to auto generate referrals for patients expressing suicidal ideation or other risk factors.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.D. Post-Intake Mental Health Assessment Procedures

VII.D.1 - Partial Compliance

"All mental health assessments shall be conducted in an area that provides reasonable sound privacy and confidentiality. If a custody officer is present, the officer should be positioned in a place that allows for observation of the prisoner but maintains sound privacy, unless there is a clearly identified security or safety risk."

ACMH clinicians document whether assessments are confidential or non-confidential including rationale.

ACMH and SSO Custody meet regularly to discuss challenges/barriers preventing confidential encounters. ACMH and the compliance lieutenant have a standing monthly meeting to discuss confidentiality issues and review of QA/QI. ACMH and Custody implemented a plan to increase efficiency of using attorney booths on all floors for confidential interviews with patients who present with assaultive or high security/safety issues and provides Custody with the ability to stand by while ensuring auditory privacy.

With the installation of interview booths completed in October 2024, ACMH has seen an increase in the number of confidential contacts at the Main Jail. In September 2024, an average of 66% of contacts were confidential. Following installation of the booths, in November 2024, an average of 81% of contacts were confidential and in May 2025, an average of 91% of contacts were confidential. Confidential interview booths were recently installed on 2 Medical, and ACMH and Custody are identifying opportunities to provide confidential interviews/assessments to patients on the APU.

At RCCC, ACMH obtained a custody escort five hours a day, four days a week to support confidential contacts for patients housed in the barracks. ACMH and ACH collaborated to develop a schedule for JKF/KBF interview room use to support both medical and ACMH with obtaining access to confidential interview space. ACMH expanded the use of the attorney booths at RCCC to increase confidential encounters. RCCC facilities have ACMH offices available for interviews.

This provision remains in partial compliance as efforts to ensure confidential encounters are consistently occurring at both facilities.

VII.D.2 - Partial Compliance

"Mental health staff shall conduct assessments within the timeframes defined in the mental health referral triage system."

During the period of December 2024 to February 2025:

- On average, patients who required an emergent assessment within four-hours due to suicidal ideation and placement in safety cells were seen within 6.21 hours.
- Patients who required an emergent assessment within six-hours due to suicidal ideation, on average, were seen within 7.84 hours.

ACMH continues to monitor and identify barriers to meeting timelines to care. Staff have been redirected to assist with emergent, urgent and routine referrals. This provision remains in partial compliance.

VII.D.3 - Substantial Compliance

"The County shall revise its mental health assessment procedures and related forms to ensure identification of historical and current patient mental health and suicide risk information, consistent with the recommendations of the subject matter expert."

ACMH has revised its mental health assessment procedures and related forms to ensure identification of historical and current patient mental health and suicide risk information, consistent with the recommendations of the subject matter expert. Nursing Intake and SRA forms have been updated and approved by SME.

ACMH worked with ACH and embedded the Suicide Risk Assessment into the MH Clinical SOAP note. This will improve consistency of documentation, ease of locating SRA, and eliminate duplication/redundancy of documentation. This provision remains in substantial compliance.

VII.E. Response to Identification of Suicide Risk or Need for Higher Level of Care

VII.E.1 - Partial Compliance

"When a prisoner is identified as at risk for suicide and placed by custody staff in a safety cell, on suicide precautions, and/or in a safety suit, mental health staff shall be contacted immediately. A qualified mental health professional, or other appropriately trained medical staff in consultation with mental health staff, shall complete a confidential in-person

suicide risk assessment as soon as possible, consistent with the "must-see" referral timeline."

This provision is consistent with SSO Procedure "Suicide Prevention and Intervention," "Deputies shall immediately remove the suicidal incarcerated person from their cell or dayroom and relocate them to an area where the person may be continuously observed while awaiting a mental health evaluation; "continuous observation" means the incarcerated person is in the direct line of sight of deputies. Once Mental Health Services staff has completed the incarcerated person's evaluation, the Mental Health Services staff member shall consult with deputies to determine the appropriate housing location for the suicidal incarcerated person. Staff members shall promptly refer any incarcerated person who is at risk for suicide to classification, health services, and mental health services. The incarcerated person shall remain under direct and constant observation in a safe setting until designated staff members make appropriate health care and housing decisions."

Audit findings from December 2024 to February 2025 indicated challenges in meeting emergent timelines to care, described in VII.D.2.

A description of efforts undertaken to facilitate confidential contacts is described in provision VII.D.1. This provision remains in partial compliance due to not consistently meeting emergent timelines to care.

VII.E.2 - Substantial Compliance

"Consistent with current RCCC policy, if there is no mental health staff on site at RCCC at the time that an emergent mental health need is identified, the prisoner shall be transported to the Main Jail for emergency evaluation within two hours of the initial report."

ACMH provides a televisit option for after-hours emergent referrals. If a Main Jail MH clinician is not available to complete the televisit assessment, SSO transports the patient to the Main Jail for an evaluation.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.E.3 - Substantial Compliance

"The County shall revise its JPS suicide risk assessment procedures and forms in consultation with Plaintiffs. The County shall ensure that its JPS suicide risk assessment process, policies, and procedures consider and document the following:

a) *Review of suicide risk notifications and records from any previous incarcerations at the Jail, including records pertaining to suicide attempts, self-harm, and/or mental health needs;*
b) *Other prior suicide ideation or attempts, self-harm, mental health treatment or hospitalization;*
c) *Current suicidal ideation, threat, or plan, or feelings of helplessness and/or hopelessness;*
    i. *Suicide risk factors and protective factors, such as:*
    ii. *Recent significant loss (job, relationship, death of family member/close friend);*
    iii. *History of suicidal behavior by family member/close friend;*
    iv. *Upcoming court appearances;*
d) *Transporting officer's impressions about risk;*
e) *Suicide precautions, including level of observation."*

The Suicide Risk Assessment captures the information listed in this provision. Suicide Risk Assessment and Suicide Prevention Program policy developed and revised in conjunction with SME and Class Counsel. ACMH staff complete a review of the patient's EHR, including previous and current records pertaining to suicide attempts, self-harm and/or mental health needs.

ACMH has begun audits of Suicide Risk Assessments to ensure all required questions in SRA are completed and documented. Due to auditing, ACMH identified areas for improvement and is providing feedback to staff and supervisors. ACMH will continue to complete regular auditing to ensure compliance with this provision.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.E.4 – Substantial Compliance

"The County shall ensure that the meal service schedule or other custody-related activities cause no delay in the completion of suicide risk assessments for prisoners."

Per ACH, SRAs take priority and MH staff are able to see patients without meal service schedule or custody-related delays.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.F. Housing of Inmates on Suicide Precautions

VII.F.1 - Substantial Compliance

"The County's policy and procedures shall direct that prisoners, including those identified as being at risk for suicide, be treated in the least restrictive setting appropriate to their individual clinical and safety needs. "

ACMH policies state all patients, including those identified as being at risk for suicide, are treated in the least restrictive setting appropriate to their clinical needs.

The Sheriff's Office works collaboratively with ACMH staff to ensure individuals are housed in the least restrictive setting appropriate to their mental health needs. Clinical recommendations from ACMH for program placement are followed unless the placement would pose a significant risk that is not able to be effectively mitigated. The development of CNAP has created a new mental health program to better support individuals experiencing suicidal ideation and chronic self-injurious behavior. From May 1, 2025 to August 1, 2025, at least 85 individuals have received treatment through the CNAP program.

Additionally, SSO's current policy related to Suicide Prevention and Intervention states the following: "Once Mental Health Services staff have completed the incarcerated person's evaluation, deputies shall consult with the mental health staff member to determine the appropriate housing location for the person; incarcerated persons identified as being at risk for suicide should be treated in the least restrictive setting appropriate to their individual clinical and safety needs. Incarcerated persons on suicide precautions will not automatically be placed on lockdown, and access to dayroom and other out-of-cell activities will be based upon security and clinical judgment."

This provision remains in substantial compliance.

VII.G. Inpatient Placements

VII.G.1 - Partial Compliance

"The County shall ensure that prisoners who require psychiatric inpatient care as clinically indicated are placed in the 2P unit within 24 hours of identification, absent exceptional circumstances. In all cases, the provision of clinically indicated treatment to any prisoner requiring inpatient level of care shall be initiated within 24 hours."

ACMH staff ensures that patients are assessed for the APU and placed in the unit as soon as possible and within 24 hours when there is bed availability. Patients who are on the pre-admission list beyond 24 hours are assessed daily for continuous need of placement or clearance. ACMH meets daily to discuss patients pending APU admission and triage level of care.

An APU expansion is planned to begin in February 2026. These cells will be all single cell, suicide resistant on both upper and lower tiers. This expansion of the APU will add 24 LPS beds and seven step-down beds. The additional 24-beds will increase the total number of LPS beds to 41.

The IOP level of care continues to be expanded which has helped reduce the need for inpatient care. ACMH received FY 24/2025 mid-year augmentation to increase the number of IOP beds. An additional 24 male beds at RCCC and 10 female beds at Main Jail will bring total number of IOP beds to 125. ACMH anticipates all additional female and male beds will be filled by August 2025. Further expansion of the IOP is planned in February 2026 and will include 32 male beds at RCCC and 10 female beds at the Main Jail. This expansion will bring the total number of IOP beds to 167.

ACMH fully implemented CNAP which provides crisis intervention, enhanced observation and stabilization for patients in crisis. CNAP has been successful in identifying, stabilizing, and reducing the number of patients who may have required an acute level of care if CNAP services had not been available.

This provision remains in partial compliance as the County works to expand IOP and APU bed availability.

VII.H. Temporary Suicide Precautions

VII.H.1 - Partial Compliance

"No prisoner shall be housed in a safety cell, segregation holding cell, or other Temporary Suicide Precautions Housing for more than six (6) hours. If mental health or medical staff

determine it to be clinically appropriate based on detoxification-related needs, this time limit may be extended to no more than eight (8) hours. If exceptional circumstances prevent transfer within these timelines, those circumstances shall be documented, and transfer shall occur as soon as possible. This does not preclude the housing of a prisoner in the IOP unit if clinically indicated."

The County currently follows these time frames as much as possible with the limited number of cells in the APU. Custody staff places the inmate/patient in the least restrictive setting as possible contingent on available space. If custody staff makes the determination to place an inmate in a safety or segregation cell, current practice involves documenting the justification in an incident report.

The IOP level of care continues to be expanded which has helped reduce the need for inpatient care. ACMH received FY 24/2025 mid-year augmentation to increase the number of IOP beds. An additional 24 male beds at RCCC and 10 female beds at Main Jail will bring total number of IOP beds to 125. ACMH anticipates all additional female and male beds will be filled by July 2025.

Further expansion of IOP is planned in February 2026 and will include 32 male beds at RCCC and 10 female beds at the Main Jail. This expansion will bring the total number of IOP beds to 167.

The APU expansion is planned to begin in February 2026. These cells will be all single cell, suicide resistant on both upper and lower tiers. for a total of 30 cells. This expansion of the APU will add 24 LPS beds and seven step-down beds. The additional 24-beds will increase the total number of LPS beds to 41. This provision remains in partial compliance until time frames are met consistently.

VII.H.2 – Substantial Compliance

"The County shall ensure, including by revising written policies and procedures where necessary, the timely and adequate completion of medical assessments for prisoners in need of suicide precautions, as required under Operations Order 4/05 (i.e., within 12 hours of placement of the next daily sick call, whichever is earliest, and then every 24 hours thereafter)."

Custody staff shall notify medical staff within fifteen (15) minutes that a prisoner is temporarily housed in a safety or segregation cell and medical staff shall complete an assessment within 12 hours of placement or the next sick call, whichever is earliest.

ACH revised the Mental Health policy 04-09 Acute Psychiatric Unit Admission, Program and Discharge (revised November 2022) to include procedures to ensure the timely and adequate completion of medical assessments for patients in need of suicide precautions. The ACH suicide prevention policy exceeds the requirements of this provision by stating that medical assessments are conducted "within one hour of placement and every four hours thereafter."

Patients are receiving a medical assessment within 12 hours of placement and every 24 hours after; these assessments are documented in Nurse Sick Call encounters. If the patient is not transferred to the APU, the nurse continues to evaluate the patient. The APU Certified Nursing Assistant will monitor the patient once they move to the APU.

The County has remained in substantial compliance with the requirements of this provision for over one year. As such, pursuant the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.H.3 - Substantial Compliance

"The County shall ensure that any cell used for holding prisoners on suicide precautions is clean prior to the placement of a new prisoner, as well as cleaned on a normal cleaning schedule."

SSO Policy "Safety, Separation, and Sobering Cells" was published in May 2024. Per SSO procedure "Housekeeping and Maintenance", it is the Sheriff's Office member's responsibility to ensure that all housing units and cells, including holding tanks and safety cells, are searched and cleaned prior to the placement of a new incarcerated person. Cell clean-up shall include the disinfection of mattresses. If the cell requires more thorough cleaning, the contracted company (Epic) responds to clean the cell. This provision remains in substantial compliance.

VII.H.4 - Substantial Compliance

"The County shall create and implement a written policy ensuring adequate frequency for meals, fluids, hygiene, showers, prescribed medications, and toileting when a prisoner is in cell used for holding prisoners on suicide precautions."

SSO added the required language to ensure adequate frequency for meals, fluids, hygiene, showers, prescribed medications, and toileting when a prisoner is on suicide precautions. This provision remains in substantial compliance.

VII.H.5 - Substantial Compliance

"Inmates on suicide precautions shall not automatically be on lockdown and should be allowed dayroom or out-of-cell access consistent with security and clinical judgments."

This language has been included in the updated SSO Suicide Prevention policy. Monthly audits are conducted by the Main Jail IOP supervisor for those inmates housed in the SITHU. Audits include access to showers and out of cell time and are shared with the Suicide Prevention subcommittee.

Data from the most recent audits (March to May 2025) is below:

- March 2025 (21 patients):
    - 19 (90%) were offered the opportunity to shower one or more times than the number of days spent in SITHU.
    - Dayroom minutes were offered to all patients. The seven (33%) who accepted received an average of 54 minutes of out-of-cell time per day.
    - A total of 110 hours of dayroom were offered; 35 hours were accepted.
- April 2025 (20 patients):
    - 20 (100%) were offered the opportunity to shower one or more times than the number of days spent in SITHU.
    - Dayroom minutes were offered to all patients. 17 (85%) who accepted received an average of 96 minutes of out-of-cell time per day.
    - A total of 55 hours were offered; 32 hours were accepted.
- May 2025 (23 patients):
    - 23 (100%) were offered the opportunity to shower one or more times than the number of days spent in SITHU.
    - Dayroom minutes were offered to all patients. 14 (61%) who accepted received an average of 60 minutes of out-of-cell time per day.
    - A total of 52 hours of dayroom was offered; 23 hours were accepted.

This provision remains in substantial compliance.

VII.H.6 - Substantial Compliance

"The classrooms or multipurpose rooms adjacent to the housing units in the Main Jail are designed for, and should be made available for, prisoner programs and treatment. Absent an emergency, the County shall not use the classrooms and multipurpose rooms to hold prisoners pending a mental health evaluation or on suicide precautions. Where such emergency occurs, the County shall document the reasons for retention and move the

prisoner, within six (6) hours, to the inpatient unit or other appropriate housing location for continued observation, evaluation, and treatment."

Classrooms are only being used for programs and treatment and no longer used to hold patients pending an evaluation or on suicide precautions. This is supported by SSO policy "Safety, Separation and Sobering Cells."

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.I. Suicide Hazards in High-Risk Housing Locations

VII.I.1 - Substantial Compliance

"The County shall not place prisoners identified as being at risk for suicide or self-harm, or for prisoners requiring IOP level of care, in settings that are not suicide-resistant as consistent with Lindsay Hayes's "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities.""

Inmates at risk of suicide, self-harm, or IOP level of care are housed in suicide-resistant cells. This provision remains in substantial compliance.

VII.I.2 - Substantial Compliance

"Cells with structural blind spots shall not be used for suicide precaution."

This has been incorporated into SSO's Suicide Prevention policy. The Main Jail has a total of 26 SITHU level cells available. The IOP deputies that work in this area do not use the corner cells, those with a partially obstructed view, for those inmates who are suicidal; those cells are only used for CNAP. The safety cells used in booking have an unobstructed view. This provision remains in substantial compliance.

VII.J. Supervision/Monitoring of Suicidal Inmates

VII.J.1 - Partial Compliance

"The County shall ensure adequate visibility and supervision of prisoners on suicide precautions."

SSO expanded the number of suicide resistant observation cells in the SITHU at the Main Jail. This provision remains in partial compliance due to inadequate space and staff to

provide constant observation. This will be addressed with the installation of the Security Corridor on the 3W 200 pod.

VII.J.2 - Substantial Compliance

"The County shall not cover cell windows with magnetic flaps or any other visual barrier preventing visibility into any cell that is housing a prisoner on suicide precautions or awaiting an inpatient bed, unless there is a specific security need and then for only a period of time necessary to address such security need."

SSO Procedure "Suicide Prevention and Intervention" was published in February 2024. Through continuous supervision provided by the on-duty Sheriff's sergeant, SSO ensures that custody staff does not cover cell windows with magnetic flaps or any other visual barrier preventing visibility into any cell that is housing a prisoner on suicide precautions or awaiting an inpatient bed, unless there is a specific security need and then for only a period of time necessary to address such security need.

The sergeant conducts a direct observation check of those inmates on suicide precautions every two hours to ensure compliance with this section, and a watch commander conducts a check every eight hours, when available. This provision remains in substantial compliance.

VII.J.3 - Partial Compliance

"The County shall revise its policies regarding the monitoring of prisoners on suicide precautions to provide for at least the following two defined levels of observation:

b) Close observation shall be used for prisoners who are not actively suicidal but express suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) or have a recent prior history of self-destructive behavior. Close observation shall also be used for prisoners who deny suicidal ideation or do not threaten suicide but are engaging in other concerning behaviors indicating the potential for self-injury. Staff shall observe the prisoner at staggered intervals not to exceed every 15 minutes and shall document the observation as it occurs.

b) Constant observation shall be used for prisoners who are actively suicidal, either threatening or engaging in self-injury, and considered a high risk for suicide. An assigned staff member shall observe the prisoner on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals. Staff should be physically stationed outside of the prisoner's cell to permit continuous, uninterrupted observation."

ACMH has revised its policies regarding the monitoring of patients on suicide precautions to provide for at least the following two defined levels of observation:

Close Observation: Staff shall observe the patient at staggered intervals not to exceed every 15 minutes and shall document the observation as it occurs. SSO Procedure "Suicide Prevention and Intervention" was published in February 2024. The revised policy addresses this issue. The SSO Suicide Prevention policy language has been agreed upon by Class Counsel and SSO. The policy was updated in September of 2023, and each Sheriff's Office staff member must read and acknowledge the policy. SSO's audits of visual checks for the SITHU indicate that SSO has sustained a level of substantial compliance in this sub-provision since December 2024. Monthly audits are based on four randomly selected patients on suicide precautions, with a total of 400 visual checks audited for each individual selected. The most recent audits are described below.

- March 2025: 98% of cell checks were on time; 2% were late between 1-5 minutes; 0% were late 5-10 minutes
- April 2025: 96% of cell checks were on time; 4% were late between 1-5 minutes; 0% were late 5-10 minutes
- May 2025: 97% of cell checks were on time; 3% were late between 1-5 minutes; 0% were late 5-10 minutes

Constant Observation: An assigned staff member shall observe the patient on a continuous, uninterrupted basis. Inmates deemed necessary for close observation are checked at a minimum of every fifteen minutes by custody staff. Constant observation designated inmates are watched by ACMH staff members physically stationed outside of the patient's cell to permit continuous, uninterrupted observation. This is included in the ACH PP 02-05 Suicide Prevention Program policy. Constant observation began in March 2023 with the addition of mental health worker (MHW) positions. The County implemented the Constant Observation Program and has filled all vacancies. Staff are available 24/7 to provide 1:1 constant observation. However, this area remains in partial compliance due to a limited number of MHWs available to provide constant observation.

VII.J.4 - Substantial Compliance

"For any prisoner requiring suicide precautions, a qualified mental health professional shall assess, determine, and document the clinically appropriate level of monitoring based on the prisoner's individual circumstances. Placement in a safety cell shall not serve as a substitute for the clinically-determined level of monitoring."

For any patient requiring suicide precautions, a qualified mental health professional assesses, determines, and documents the clinically appropriate level of monitoring based on the patient's individual circumstances. Placement in a safety cell shall not serve as a substitute for the clinically determined level of monitoring. Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS. Once ACMH staff has completed the inmate's evaluation, the ACMH staff member shall consult with custody staff to determine the appropriate housing location for the inmate.

SSO expanded the number of suicide resistant observation cells in the Suicidal Temporary SITHU at the Main Jail. ACMH hired staff and implemented constant observation level of monitoring in March 2023.

ACMH completes weekly audits on compliance determining and documenting housing, observation level, property, privileges, and clothing restrictions for patients placed on suicide precautions. Findings are reported to Suicide Prevention Subcommittee on quarterly basis.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.J.5 - Substantial Compliance

"Video monitoring of prisoners on suicide precaution shall not serve as a substitute for Close or Constant observation."

Video monitoring of suicidal inmates ended in November 2021. Direct monitoring occurs every 15 minutes for deputies, two hours for sergeants, and eight hours for watch commanders.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.K. Treatment of Inmates Identified as at Risk of Suicide

VII.K.1 - Partial Compliance

"Qualified mental health professionals shall develop an individualized treatment plan and/or behavior management plan for every prisoner that mental health staff assesses as being a suicide risk."

ACMH established a Positive Behavior Support Team (PBST) that provides consultation and specific DBT interventions to staff and treatment teams to assist in working with patients who present with treatment interfering and/or self-harming behaviors. The MH Suicide Precautions Multidisciplinary Team meets monthly and completes a case conference for patients who have chronic self-injurious behaviors and/or report conditional suicidal ideation. The team discusses specific interventions that ACMH, custody, and/or medical can utilize or implement to address and support patients who present with challenging, maladaptive and/or unsafe behaviors. ACMH will initiate a Multidisciplinary Intervention Plan separately, or in conjunction with the PBST, for identified patients who require additional support and interventions to address mental health symptoms and/or maladaptive behaviors.

This provision remains in partial compliance as ACMH continues to implement structured treatment planning in all levels of care.

VII.K.2 - Partial Compliance

"Treatment plans shall be designed to reduce suicide risk and shall contain individualized goals and interventions. Treatment plans shall be reviewed following discharge from suicide precautions and updated as clinically indicated."

ACMH staff have received training on this requirement in both SRA and Treatment Planning training. Treatment plans for patients in DMHUs have goals and interventions that address reduction of suicide risk. This provision remains in partial compliance as ACMH continues to implement structured treatment planning in all levels of care.

VII.K.3 - Partial Compliance

"All assessments, treatment, and other clinical encounters shall occur in an area that provides reasonable sound privacy and confidentiality. If a custody officer is present, the officer should be positioned in a place that allows for observation of the prisoner but maintains sound privacy, unless there is a clearly identified security or safety risk."

With the installation of interview booths completed in October 2024, ACMH has seen an increase in the number of confidential contacts at the Main Jail. In September 2024, an average of 66% of contacts were confidential. Following installation of the booths, in November 2024, an average of 81% of contacts were confidential and in May 2025, an average of 91% of contacts were confidential.

This practice is supported by language in two SSO policies.

- Portable Audio/Video Recorders: "All medical and mental health assessments shall be private and confidential absent a specific current risk that necessitates the presence of an officer. All medical and mental health assessments should be conducted in an area and manner that provides reasonable sound privacy and confidentiality for the incarcerated person. If a member is present during the medical or mental health assessment, the member should be positioned in a place that allows for observation but maintains sound privacy, unless there is an articulable security or safety risk. Members may maintain visual supervision but may not be close enough to overhear or record communications between the incarcerated person and the health provider, unless security concerns, based on an individualized determination of risk dictate otherwise."
- Privacy of Care: "Health care intake screenings shall take place in a setting that ensures confidentiality of communications between nurses and individual patients. Deputies may maintain visual supervision but may not be close enough to overhear communication, unless security concerns based on an individualized determination of risk that includes a consideration of requests by the health care staff require that custody staff be closer at hand. There shall be visual and auditory privacy from other incarcerated persons."

This provision remains in partial compliance due to limited confidential interview and group programming space on the APU and the need to increase the percentage of confidential contacts in some housing units at RCCC.

VII.L. Conditions for Individual Inmates on Suicide Precautions

VII.L.1 - Substantial Compliance

"The County's Suicide Prevention Policy shall set forth clear and internally consistent procedures regarding decisional authority for determining the conditions for individual inmates on suicide precautions. Mental health staff shall have primary authority, consistent with individualized classification and security needs, with respect to the following: [see M. Property and Privileges]."

The Suicide Prevention Policy addresses ACMH's role as the primary authority to make decisions on property and privileges, use of safety suits, and discharge from suicide precaution based on clinical assessment. Per SSO, Mental Health staff's recommendations are taken into consideration when making housing decisions for inmates with mental health concerns. This provision remains in substantial compliance.

VII.M. Property and Privileges

VII.M.1 - Substantial Compliance

"Qualified mental health professionals shall have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff, depending on suicide risk, the removal and/or return of routine privileges (e.g., visits, telephone calls, recreation) that are otherwise within the limitations of a prisoner's classification security level. Any removal of privileges shall be documented with clinical justification in the prisoner's medical/mental health record and reviewed on a regular basis."

Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS. The Suicide Precautions and/or Grave Disability Observations – Custody Instructions Form was developed to document ACMH staff's directions regarding housing, observation level, property, privileges, and clothing restrictions. ACMH provided training and created a workflow for staff on responsibilities related to suicide precautions and clinical decisions regarding housing, observation levels, privileges, clothing, and property in August 2021. SSO allows prisoners placed in a safety cell to retain enough clothing or be provided with a suitably designed "safety garment" to provide for the prisoner's personal privacy unless specific identifiable risks to the prisoner's safety or to the security of the facility exist and are documented. The Procedure "Suicide Prevention and Intervention" was updated in February 2024.

ACMH continues to audit documentation of suicide precautions and clinical determinations regarding restoration of privileges and property, the removal of privileges and property, removal of clothing and or safety smock and daily assessments for restoration of clothing. From February to April 2025:

- 100% (75/75) of suicide precautions forms were completed for each patient encounter.
- 100% (75/75) of clinical justification for removal of privileges and property were documented for each patient encounter.

- 100% (75/75) of MH staff made recommendations regarding removal of clothing or use of safety smock for each patient encounter.
- 95% (36/38) of daily assessments for restoration of privileges and property were completed.
- 95% (36/38) of daily assessments to determine restoration of clothing or continued use of safety smock were completed.

With these audit findings, this provision remains in substantial compliance.

VII.M.2 - Substantial Compliance

"Qualified mental health professionals shall have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff depending on suicide risk, the removal and/or return of a prisoner's clothing and possessions (e.g., books, slippers/sandals, eyeglasses) that are otherwise within the limitations of a prisoner's classification security level. The removal of property shall be documented with clinical justification in the prisoner's medical/mental health record and reviewed on a regular basis."

Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS. ACH developed workflow and implemented procedure for posting suicide precaution forms outside of patient cells in the APU and SITHU. If deemed necessary by ACMH staff, the inmate's clothing shall be taken and the inmate will be given a "safety suit" to wear. Prisoners shall otherwise be allowed to retain personal clothing except for shoelaces, shoes, belts, or any other clothing articles which could threaten his/her safety or damage property. SSO Procedure "Suicide Prevention and Intervention" was updated in February 2024.

ACMH staff received updated training on the new process of developing safety plans at the time of an SRA evaluation starting in January 2023. All ACMH staff have been trained and a compliance audit was completed to identify areas for process improvement.

For the period of September to November 2024:

- 100% (60/60) of patients referred for danger-to-self had a completed SRA documented in their chart.
- 100% (38/38) of patients placed on suicide precautions had a completed safety plan documented in their chart that was completed at the same time as the SRA.
- 100% (20/20) of patients discharged from suicide precautions had a completed SRA in their chart.

- 95% (19/20) of patients discharged from suicide precautions had a completed safety plan documented in their chart. One patient without a safety plan was cleared from suicide precautions and admitted to CNAP for additional support.
- Of the 22 patients without a safety plan at the time of the initial SRA:
    - 11 patients were cleared from suicide precautions during the initial SRA and therefore did not require a safety plan as per the Suicide Prevention Policy.
    - 11 patients had documentation indicating they were unable to engage in safety planning during the initial SRA. All 11 of these patients had a completed safety plan in place prior to being discharged from suicide precautions.

Based on these findings, this provision remains in substantial compliance.

VII.M.3 - Substantial Compliance

"Cancellation of privileges should be avoided whenever possible and utilized only as a last resort."

Cancellation of privileges is done only as a last resort or if deemed necessary per ACMH. SSO's Procedure on Suicide Prevention and Intervention was updated in February 2024. This section is monitored by monthly audits conducted by the Main Jail IOP sergeant. This provision remains in substantial compliance.

VII.N. Use of Safety Suits

VII.N.1 - Substantial Compliance

"Decisions about the use of a safety suit (smock) or removal of normal clothing will be under mental health staff's authority, based on individualized clinical judgment along with input from custody staff."

Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS. This provision aligns with current practice for SSO, as outlined in the Suicide Prevention Program Operations Order. SSO Procedure "Suicide Prevention and Intervention" was updated in February 2024. The use of the "Safety Suit" shall be at the discretion of ACMH, based on collaboration with intake or custody staff. This provision remains in substantial compliance.

VII.N.2 - Partial Compliance

"Custody staff may only temporarily place an inmate in a safety suit based on an identified risk of suicide by hanging until the qualified mental health professional's evaluation, to be completed within the "must see" referral timeline. Upon completion of the mental health evaluation, the mental health professional will determine whether to continue or discontinue use of the safety suit."

In these instances, a qualified mental health professional completes an evaluation within the "must see" referral timeline. Upon completion of the mental health evaluation, the mental health professional determines whether to continue or discontinue use of the safety suit. Absent direction from ACMH deeming a "safety garment" necessary, a sworn supervisor must authorize custody staff to take the clothing and supply the prisoner with a "safety garment." Unless a "safety garment" is necessitated by the prisoner's behavior, prisoners shall be allowed to retain personal clothing except for shoelaces, shoes, belts, or any other clothing articles which could threaten his/her safety or damage property.

ACMH continues to monitor and identify barriers to meeting timelines to care. Staff have been redirected to assist with emergent, urgent and routine referrals. During the period of December 2024 to February 2025, on average, patients who required an emergent assessment within four-hours due to suicidal ideation and placement in safety cells were seen within 6.21 hours. Patients who required an emergent assessment within six-hours due to suicidal ideation, on average, were seen within 7.84 hours. SSO is consistently above 90% compliance in returning clothing within two hours after ACMH clears an inmate from the safety suit. This provision remains in partial compliance due to not consistently meeting emergent timelines to care.

VII.N.3 - Substantial Compliance

"If an inmate's clothing is removed, the inmate shall be issued a safety suit and safety blanket."

The Main Jail and RCCC ensure there are an adequate number of safety suits on hand to ensure anyone who is deemed needing a safety suit per ACMH is given one. SSO provides a safety suit and safety blanket if an inmate's clothing is removed. The SSO Procedure "Suicide Prevention and Intervention" was updated in February 2024. SSO is implementing a new procedure that includes an inventory of all safety suits that will be audited quarterly by the respective IOP sergeants.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Consent Decree and stipulation between the Federal Court for the Eastern District of California and Class Counsel, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.N.4 - Substantial Compliance

"As soon as clinically appropriate, the provision of regular clothing shall be restored. The goal shall be to return full clothing to the inmate prior to discharge from suicide precautions."

ACMH assesses the need for continued safety suit daily. Regular jail issued clothing is restored as soon as clinically indicated. The IOP sergeant conducts QA audits of safety smock use and timely return of clothing and property when notified by ACMH. This provision remains in substantial compliance.

VII.N.5 - Substantial Compliance

"A qualified mental health professional shall conduct daily assessments of any prisoner in a safety suit and document reasons for continued use when clinically indicated."

All patients on the pre-admit list and in the APU are seen daily to assess continued use of safety suit, observation level and restriction of property and privileges. ACMH documents clinical justification for continued use of the safety suit and/or restriction of property and privileges. This provision remains in substantial compliance.

VII.N.6 - Substantial Compliance

"If a qualified mental health professional determines that 30-minute (or less frequent) observations are warranted for a prisoner, safety suits shall not be used on that prisoner."

When ACMH determines that 30-minute (or less frequent) observations are warranted for a patient, safety suits are not used for that patient. Current practice by SSO, as use of safety suit and 30 minute or less frequent observations are done only if determined by ACMH. The MH medical director reinforced this policy requirement with the APU attending psychiatrist and nursing team in September 2024. This provision remains in substantial compliance.

VII.N.7 - Substantial Compliance

"Safety suits shall not be used as a tool for behavior management or punishment."

Safety suits are not used as a tool for behavior management or punishment. Safety suits are only used when necessary for the safety and security of the inmate. All ACH staff are trained on this during the Annual Suicide Prevention Training. The Sheriff's Office specifically prohibits the use of Safety Suits as a tool for behavior management or punishment as articulated in Sheriff's Office Custody Procedure - "Suicide Prevention and Intervention, Safety Suit Use".

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.O. Beds and Bedding

VII.O.1 - Substantial Compliance

"All prisoners housed for more than four hours on suicide precautions and/or in an inpatient placement shall be provided with an appropriate bed, mattress, and bedding unless the prisoner uses these items in ways for which they were not intended (e.g., tampering or obstructing visibility into the cell). Such a determination shall be documented and shall be reviewed on a regular basis."

Inmates housed in safety cells in the booking area are moved to appropriate suicide resistant housing as soon as a bed/cell opens up. 26 SITHU cells are available at the Main Jail. Custody distributed new suicide-resistant mattresses to the high acuity MH housing areas and safety cells in May 2022. ACMH staff are responsible for determining the appropriate level of precautions for each inmate placed on suicide watch, based on individual assessments. Inmates on suicide precautions may be issued safety items such as safety suits and safety blankets and are restricted from having access to items that could be used to cause self-harm. The use or removal of standard bedding and other items is guided by clinical judgment and safety considerations, and such decisions are regularly reviewed and documented. This provision remains in substantial compliance.

VII.P. Discharge from Suicide Precautions

VII.P.1 - Substantial Compliance

"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 discharge is appropriate and that appropriate treatment and safety planning is completed."

An ACMH mental health professional completes and documents a suicide risk assessment prior to discharging a patient from suicide precautions to ensure that the discharge is appropriate, and that appropriate treatment and safety planning is completed. This provision remains in substantial compliance.

VII.P.2 - Partial Compliance

"Treatment plans shall be written for all prisoners discharged from suicide precautions. The treatment plan shall describe signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur."

This provision remains in partial compliance as ACMH continues to implement structured treatment planning in all levels of care.

VII.P.3 - Substantial Compliance

"Qualified mental health professionals shall provide clinical input regarding clinically appropriate housing placement (e.g., whether isolation is contraindicated for the prisoner) upon discharge. Custody and classification shall consider such clinical input in determining post-discharge placement and conditions of confinement. Once clinically discharged from suicide precautions, the prisoner shall be promptly transferred to appropriate housing."

ACMH provides clinical input regarding clinically appropriate housing placement (e.g., whether isolation is contraindicated for the prisoner) upon discharge. Custody and classification shall consider such clinical input in determining post-discharge placement and conditions of confinement. Once clinically discharged from suicide precautions, the prisoner shall be promptly transferred to appropriate housing. Patients are transferred to the IOP (based upon bed availability) and/or assigned a clinically appropriate level MH care at time of discharge from the APU.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.P.4 - Partial Compliance

"Prisoners discharged from suicide precautions shall remain on the mental health caseload and receive regularly scheduled clinical assessments and contacts. Unless a prisoner's individual circumstances direct otherwise, a qualified mental health professional shall provide follow-up assessment and clinical contacts within 24 hours of discharge, again within 72 hours of discharge, again within one week of discharge."

Patients who are discharged from the APU after being treated for a suicide attempt or ideation or who have been placed on the APU pre-admit list and discharged from suicide precautions receive follow up ACMH appointments (24 hours/one day, 72 hours/three days, and seven days).

ACMH audited timelines to care for patients discharged from suicide precautions from the APU or the APU preadmit list. For the period of January - April 2025, ACMH meet timelines to care for 24 hour/one day (93%), 72 hours/three days (98%) and seven days (92%).

ACMH continues to monitor and identify barriers to meeting timelines to care. Staff have been redirected to assist with emergent, urgent and routine referrals. This provision remains in partial compliance pending further audits to ensure continued compliance with timelines for follow-up assessments.

VII.Q. Emergency Response

VII.Q.1 - Substantial Compliance

"The County shall keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambu bag, and emergency rescue tool in close proximity to all housing units. All custodial and medical staff be trained on the location of this emergency response bag and shall receive regular training on emergency response procedures, including how to use appropriate equipment."

As part of ACH's ongoing efforts to ensure the availability of emergency medications and supplies, emergency red bags have been placed in the east side control room on floors three through eight, effective January 2025. Each red bag has been carefully inspected to confirm the presence of emergency medication boxes, all of which are secured with zip tags. To support staff unfamiliar with the contents, a detailed inventory list is included inside each red bag for quick and easy reference.

Additionally, a tracking spreadsheet has been developed to monitor all red bags and emergency medication boxes. This log includes key information such as floor number,

emergency box number, expiration dates, and zip tag numbers. The spreadsheet is maintained in the SRN office binder for easy staff access. All red bags have been securely locked, and the zip tag numbers have been documented in the log to ensure accountability and ease of verification.

Custody staff (sworn and nonsworn) participate in man down trainings/scenarios quarterly. The training/scenarios are conducted in conjunction with ACH. Man-down trainings are conducted at both the Main Jail and RCCC. SSO Custody Procedure – Suicide Prevention and Intervention Policy dictates both the MJ and RCCC keep an emergency response bag that includes a first aid kit, CPR mask and emergency rescue tool near all housing units. All custody staff are trained on the location of this emergency response bag and receive regular training on emergency response procedures, including how to use appropriate equipment during Advanced Officer Training every two (2) years for sworn staff.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.Q.2 - Substantial Compliance

"All custody and medical staff shall be trained in first aid and CPR."

All medical staff are required to be trained in first aid and CPR. The training coordinator tracks this area for compliance and reporting. The training coordinator also provides this information to the QI team. All sworn staff receive 21 Hours of First Aid and CPR (LD 34) training in a POST approved academy prior to being hired. Sworn staff continue to receive additional CPR training every two years. It is part of the Advanced Officer Training (AOT) program.

All staff shall receive regular training on emergency procedures, which includes the use of emergency equipment. Although our policy states that Man down drills are practiced once a year on each shift at each jail facility, man down drills have been practiced several times since the last reporting period. ACH purchased, and began utilizing, a CPR manikin for the man down drills. These drills are interdisciplinary, they are debriefed, and results are shared with all health staff, and recommendations for health staff are acted upon.

As requested, ACH provided the CPR and First Aid training data to the court-appointed monitor more frequently for better assessment. In June 2025, ACH was 100% compliant with BLS requirements, increasing this provision to substantial compliance.

VII.Q.3 - Substantial Compliance

"It shall be the policy of the County that any staff who discovers an inmate attempting suicide shall immediately respond, survey the scene to ensure the emergency is genuine, and alert other staff to call for medical personnel. Trained staff shall begin to administer standard first aid and/or CPR, as appropriate."

It is the policy of the County that any staff who discovers an inmate attempting suicide shall immediately respond, and trained staff begin to administer standard first aid and/or CPR. This is reinforced in staff meetings and man-down drills. Attempted suicide response guidelines are dictated in Sheriff's Office Custody Procedure relating to Suicide Prevention and Intervention. This procedure minimally includes defining an attempted suicide as a medical emergency, the requirement of notifying a medical professional immediately, and rendering appropriate first aid or CPR if needed.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.R. Quality Assurance and Quality Improvement

VII.R.1 - Substantial Compliance

"The County shall establish regularly scheduled multidisciplinary meetings related to treatment, and plan of care issues, on a monthly basis, between medical, and mental health personnel."

ACMH implemented monthly Suicide Prevention Multidisciplinary meetings to discuss patients with complex mental health needs who engage in self-injurious behaviors (July 2022).

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was

suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.R.2 - Substantial Compliance

"The County shall, in consultation with Plaintiffs' counsel, revise its in-custody death review policy and procedures. Reviews shall be conducted with the active participation of custody, medical, and mental health staff. Reviews shall include analysis of policy or systemic issues and the development of corrective action plans when warranted."

ACH has, in consultation with Class Counsel, revised its in-custody death review policy and procedures. Reviews are conducted with the active participation of custody, medical, and mental health staff. Reviews include analysis of policy or systemic issues and the development of corrective action plans when warranted.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Consent Decree and stipulation between the Federal Court for the Eastern District of California and Class Counsel, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.R.3 - Substantial Compliance

"For each suicide and serious suicide attempt (e.g., requiring hospitalization), the County's Suicide Prevention Task Force shall review: 1) the circumstances surrounding the incident; 2) the procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; and 5) any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt. Where applicable, the Review Team shall generate recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures."

The Suicide Prevention Subcommittee established a Morbidity and Mortality (M&M) Review for cases meeting provision criteria in December 2021. The M&M Workgroup reviews cases and reports findings back to Suicide Prevention Subcommittee. The M&M Review Committee continues to refine the documentation and timely reporting from each service line when reviewing serious suicide attempts. Recent updates include shared documents that increase efficiency of review and prompt response to issues that require systems changes or staff follow-up.

The M&M Review Committee also established a tracking system for Corrective Action Plans that are generated from M&M reviews. This provision remains in substantial compliance.

VII.R.4 - Substantial Compliance

"The County will track all critical incidents which include prisoner suicides, attempted suicides, and incidents involving serious self-harm. The County shall review critical incidents and related data through its quality assurance and improvement processes."

ACMH tracks incidents of suicide, attempted suicide and serious self-harm. ACMH completes incident reports and reviews on deaths by suicide, attempted suicide and serious self-harm and submits incident reports to ACH QI for review and tracking.

This is consistent with SSO Custody Procedure Policy – Suicide Prevention and Intervention which dictates "The Suicide Prevention Subcommittee shall also be responsible for the comprehensive morbidity and mortality review of inmate serious suicide attempts and suicides. The review by the Suicide Prevention Subcommittee includes:

- The circumstances surrounding the incident
- The procedures relevant to the incident
- All relevant training received by involved staff members
- Pertinent medical and mental health services and/or reports involving the victim
- Any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt

The Suicide Prevention Subcommittee tracks all incidents of self-harm, regardless of severity, however only incidents of serious self-harm/attempts and suicides will be reviewed."

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VII.R.5 - Substantial Compliance

"The County shall implement a continuous quality assurance/quality improvement plan to periodically audit suicide prevention procedures that include, but are not limited to: intake

screening (to include audits to ensure that staff ask and record all suicide screening questions), mental health assessments, suicide risk assessments, crisis response, and treatment plans/behavior management plans for prisoners identified as being at risk of suicide or self-harm."

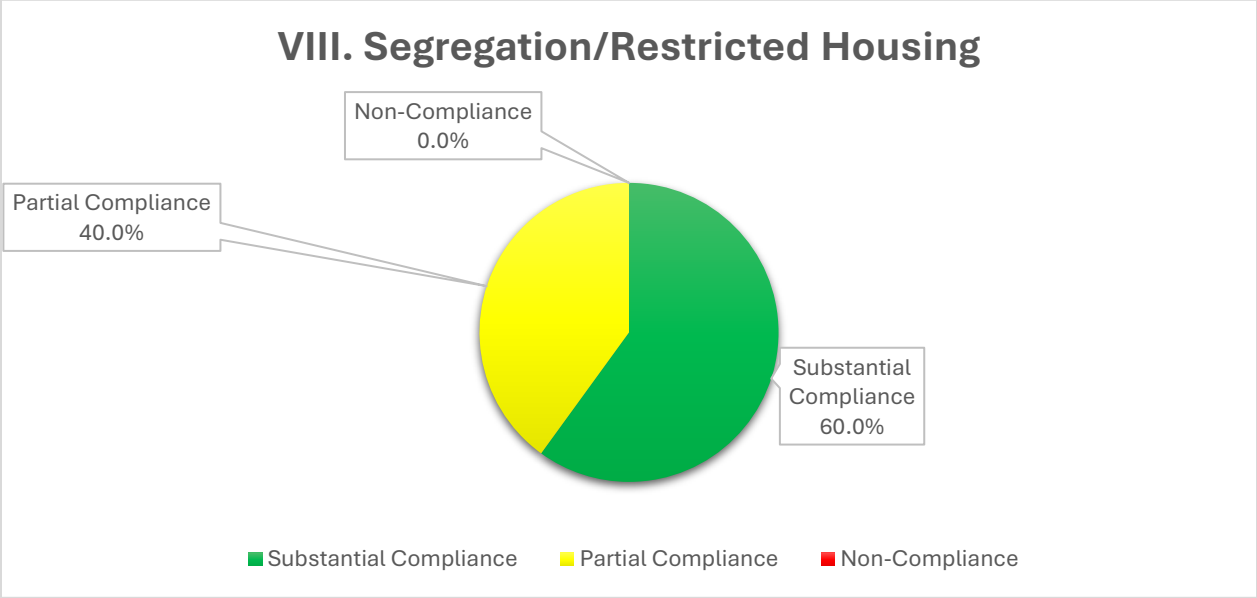
Beyond the information historical activities related to this provision included in the 10th County Status Report, in February 2024, the ACH QI team began to conduct quarterly in-person audits of the Suicide Risk Inquiry section of the intake process. The purpose of the audit is to ensure the intake RNs are asking the Suicide Risk questions verbatim. The baseline audit (February 2024) showed that the questions were being asked verbatim about 64% of the time. Since then, QI has worked with the MH, EHR, and Nursing teams to increase the percentage of questions being asked verbatim. As of March 2025, intake RNs are asking the Suicide Risk questions verbatim about 93% of the time. This places the measure above the QI compliance threshold of 90%.

ACMH updated all audit forms with an action item section that includes person responsible, due date, and status of recommendation.

ACMH developed audit to review timelines to care for patients discharged from suicide precautions from the APU or the APU preadmit list. For the period of January to April 2025, ACMH met timelines to care for 24 hour/one day (93%), 72 hours/three days (92%).

ACMH implemented audits of Suicide Risk Assessments to ensure all required questions in SRA are completed and documented. Due to auditing, ACMH identified areas for improvement and is providing feedback to staff and supervisors. ACMH will continue to complete regular auditing to ensure substantial compliance with this provision is sustained.

VIII. Segregation/Restricted Housing



The County has identified 40 provisions in Remedial Plan VIII. Segregation/Restricted Housing. For this 11th County Status Report, the compliance ratings are as follows:

- Substantial Compliance: 24 provisions (60%)
- Partial Compliance: 16 provisions (40%)
- Non-Compliance: 0 provisions (0%)

Monitoring Status

Remedial Plan VIII. Segregation/Restricted Housing is primarily monitored by Class Counsel. As of July 2025, four monitoring reports have been completed to evaluate the segregation/restricted housing remedial plan provisions in the Consent Decree. Additionally, some provisions were evaluated by the Court-appointed mental health SME, Mary Perrien, Ph.D; four reports have been completed by the mental health SME.

In comparison to the County's self-assessed ratings, the Court-appointed monitors' compliance ratings are as follows:

- Substantial Compliance: 9 provisions (22.5%)
    - This includes 2 provisions that are no longer subject to external monitoring as the County has sustained a level of substantial compliance with these provisions for over one year.
- Partial Compliance: 23 provisions (57.5%)
- Non-Compliance: 1 provision (2.5%)

- Not Assessed: 7 provisions (17.5%)

Attachment 8, Segregation/Restricted Housing Remedial Plan Expert Rating Reconciliation, aligns the Court-appointed monitor's compliance ratings with the provision structure used here and shows how the County's compliance ratings compare to those of the assigned monitor.

Self-Assessment

VIII.A. General Provisions

VIII.A.1 - Partial Compliance

"Prisoners will be housed in the least restrictive setting necessary to ensure their own safety, as well as the safety of staff, other prisoners, and the public.

a) *The County shall not place prisoners in more restrictive settings, including Segregation, based solely on a mental illness or any other disability. Prisoners will be housed in the most integrated setting appropriate to their individual needs.*

b) *The County shall not place prisoners into Segregation units based solely on classification score.*

c) *The County shall review the housing and restrictions of female prisoners classified as high security to ensure that this population is not subject to Segregation conditions of confinement.*

d) *Specialized medical units (e.g., Main Jail 2 West Med/Psych, Main Jail 2 East) and mental health units (e.g., OPP, IOP, MHU, 2P) are not Segregation housing units. The County shall ensure that prisoners housed in these units receive daily access to out-of-cell time, telephones, showers, and other programs, services, and activities consistent with their classification and treatment plan."*

Sub-provision VIII.A.1.a remains in substantial compliance. All placements into ADSP require supportive documentation through ADSP forms, which were created with the assistance of Class Counsel. These forms are uploaded to each individual's ATIMS file in compliance with SSO Policy/Procedure "Special Management Incarcerated Persons." "Mental illness or any other disability" is not a factor when determining if an individual requires ADSP placement. "Mental illness or any other disability" is taken into consideration as a mitigating factor when determining if a less restrictive medical or mental health housing assignment is appropriate to meet the individual's medical or mental health needs.

Sub-provision VIII.A.1.b continues to remain in substantial compliance. All incarcerated subjects are initially classified as Minimum, Medium, or Maximum per SSO Policy/Procedure "Classification." This classification system is hardcoded into ATIMS and classifications are determined by an electronic decision tree based on a series of answers provided by the classification officer and obtained during the classification interview. Any manual change in classification to Administrative Separation 1 or Administrative Separation 2 must be leveraged in ATIMS and such placement requires supportive documentation through ADSP forms.

Sub-provision VIII.A.1.c remains in partial compliance. The County continues to expand the programming available for those housed on 7 West and Ramona at RCCC. Work to expand dayroom space at Ramona is currently underway.

Sub-provision VIII.A.1.d remains in partial compliance. The County received a FY 24/2025 mid-year budget augmentation to increase the number of IOP beds. An additional 24 male beds at RCCC and 10 female beds at Main Jail will bring total number of IOP beds to 125. ACMH anticipates all additional female and male beds will be filled by July 2025. Further expansion of IOP is planned in February 2026 with the addition of 32 male beds at RCCC and 10 female beds at Main Jail. This expansion will bring the total number of IOP beds to 167. An expansion to the APU is also in development which will add 24 LPS beds and seven step-down beds. This expansion will bring the total number of LPS beds to 41. Projected completion for this project is May 2026. Even though adding these beds will increase and improve the level of patient care for patients requiring IOP and APU services, jail facility limitations remain. The County is undergoing a comprehensive Correctional Facility Master Plan ("Master Plan") that will identify assist the County in better understanding the needs of its population and the steps, including construction, needed to achieve compliance in many areas of the Consent Decree.

While improvements continue, due to the mixed rating on its sub-provisions, provision VIII.A.1 remains in partial compliance.

VIII.A.2 - Partial Compliance

"The County shall not place a prisoner in Segregation units without first determining that such confinement is necessary for the safety of the staff, other prisoners, or the public. The County shall clearly document in writing the specific reason(s) for a prisoner's placement and retention in Segregation housing. The reason(s) shall be supported by clear, objective evidence. Prisoners will remain in Segregation housing for no longer than necessary to address the reason(s) for placement.

a) *A qualified mental health or medical professional shall conduct check-ins at least once a week, to assess and document the health status of all prisoners in Segregation, and shall make referrals as necessary. The check-in shall include a brief conversation with each prisoner, a visual observation of the cell, and an inquiry into whether the prisoner would like to request a confidential meeting with a mental health or medical provider. Steps shall be taken to ensure effective communication, as well as auditory privacy consistent with security needs. When a prisoner in Segregation requests a confidential meeting with a mental health or medical provider, or the medical or mental health professional identifies a mental health or medical need, staff shall make appropriate arrangements to include triage, examination and treatment in an appropriate clinical setting. In such cases, staff shall give the prisoner the opportunity to complete a health care request but will otherwise initiate a referral without requiring the prisoner to complete a request form."*

In addition to the information included in the 10th County Status Report, patients on ADSP 1 or 2 who are on the MH caseload are being seen as required by ACMH. ACH is developing a process to ensure all others are seen weekly as required. All placements into ADSP have supportive documentation through ADSP forms which were created with the assistance of Class Counsel. These forms are uploaded to each individual's ATIMS file in compliance with SSO Policy/Procedure "Special Management Incarcerated Persons." This provision has been reduced to partial compliance pending until weekly check-ins are occurring for all ADSP patients as required.

VIII.A.3 - Substantial Compliance

"The County shall not place the following prisoners in a Segregation setting unless necessary to address a serious risk of physical harm, and in such cases only for the minimum time necessary to identify an alternative appropriate placement:

a) *Prisoners with acute medical needs that require an inpatient level of care and/or daily nursing care;*

b) *Prisoners who are pregnant, post-partum, who recently had a miscarriage, or who recently had a terminated pregnancy."*

This is current practice and an inmate's medical concern will take priority over their need for separation. In a single-cell medical cell, if needed, both the treatment of the medical need as well as the separation can be accomplished. There is regular collaboration with both ACMH and ACH for proper housing for those who need to be separated from others. VIII.A.1 describes the documentation requirements and SSO policy/procedure relevant to this provision. This provision remains in substantial compliance.

VIII.B. Conditions of Confinement

VIII.B.1 - Substantial Compliance

"The County will provide at least 17 hours of out-of-cell time per week for all prisoners, with the exception of prisoners subject to Administrative Segregation Phase I and Disciplinary Segregation in accordance with this remedial plan. The County will monitor out-of-cell time, and if minimum out-of-cell time requirements are routinely not being met at a particular facility or in a particular housing unit, the Sheriff's Department division commander or designee will review the situation and take appropriate steps to resolve the issue.

a) *The County shall implement a policy to document out-of-cell time provided to each prisoner. The County shall conduct monthly audits to ensure that prisoners have been provided the required treatment and recreation time out of cell. This data will be regularly reviewed as part of the County's Quality Assurance procedures."*

Out-of-cell time is monitored and recorded in the current ATIMS system. Weekly reports are generated to assess compliance, which are then distributed to supervisors and managers at both the Main Jail and RCCC to encourage adherence to the standards. The Compliance Unit is continually refining these reports to ensure they serve as valuable tools for shift leadership. In early May, the Main Jail outdoor recreation schedule was completely overhauled to provide greater access to recreation activities throughout the entire Main Jail. The weekly reports related to out-of-cell time were also redesigned to offer an overview of the Main Jail's overall performance. To date, the Main Jail has achieved a compliance rate of 93% for out-of-cell time. RCCC also audits out-of-cell time numbers for their jail population weekly. Due to the physical layout of the RCCC facility, dayroom and recreational opportunities are substantially more available, so out-of-cell time is more easily and consistently met. The County recognizes that select individuals may not consistently meet the out-of-cell time requirements due to logistical factors and these challenges are addressed in subsequent provisions. Based on the overall out-of-cell time for both facilities being over 90%, this provision has been increased to substantial compliance.

VIII.B.2 – Partial Compliance

"Out-of-cell time with the opportunity to exercise shall be provided to each prisoner seven (7) days per week, including outdoors/recreation time when feasible. The County shall offer out-of-cell time at appropriate times of day."

The Main Jail has recently introduced a new outdoor recreation schedule that provides more flexibility for different floors and shifts to improve recreation opportunities for the inmate population. Additionally, various floors have started utilizing the internal recreation area to further increase out-of-cell times. Recreation technicians at Main Jail have begun identifying floors and inmates who may have limited access to recreational areas. A report is generated at the beginning of each week, highlighting x-reference numbers of those who have not met their out-of-cell goals over the past four weeks. Compliance deputies at Main Jail continue to implement strategies across all shifts to ensure adherence to recreation policies and address any internal objections regarding access to these areas. This provision remains in partial compliance.

VIII.B.3 - Substantial Compliance

"The County shall modify its non-disciplinary Segregation policies and procedures to allow reasonable access to the following: (1) Personal phone calls for all prisoners, including at least five hours or three weekdays per week of phone access during normal business hours; (2) Education, rehabilitation, and other materials (e.g. writing implements, art supplies, tablets), for in-cell activities; (3) Personal and legal visiting; (4) Religious services; and (5) Commissary.

a) The conditions and privileges described above shall be provided unless there is a specific safety or security issue preventing provision of such materials or the prisoner is subjected to disciplinary action."

At both facilities, phones are available during any out-of-cell time. The SSO Policy "Exercise and Out of Cell Time" was published in May 2024. The SSO Procedure "Special Management of Incarcerated Persons" was updated in July 2024.

Both facilities enabled the function on the inmate assigned tablets allowing the use of the telephone feature. The tablets are distributed to inmates in the morning and collected before 11PM. The tablets also provide another opportunity for inmates to access educational material, digital books, health and mental health educational material, as well as order commissary directly from the device. This provision remains in substantial compliance.

VIII.B.4 - Substantial Compliance

"Cell windows shall not be covered with magnetic flaps, towels, sheets, or any other visual barrier preventing visibility into and out of the cell, unless there is a specific security or privacy need that is documented, and then for only a period of time necessary to address such security or privacy need. This provision shall apply to all cells housing prisoners."

This has been codified in SSO's Suicide Prevention and Intervention Policy and Procedure. Supervising SSO staff monitor the appropriate use of magnetic flaps during emergency/tactical situations. Staff must acknowledge review and receipt of the policy as part of their training.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VIII.B.5 - Substantial Compliance

"The County shall establish procedures so that all housing unit cells are searched and cleaned prior to a prisoner's placement in the cell."

An SSO Procedure "Housekeeping and Maintenance" was published and outlines the housing officer's responsibility to ensure cells are searched and cleaned prior to placement of new incarcerated persons. This provision remains in substantial compliance.

VIII.B.6 - Substantial Compliance

"The County shall establish procedures to ensure that no prisoner is placed in a Segregation housing cell without a mattress and appropriate bedding."

SSO's Incarcerated Person Hygiene Policy and Procedure was published in November 2024. The procedure outlines the clothing and bedding requirements for inmates. This policy requires blankets and mattresses to be issued to all inmates. This provision remains in substantial compliance.

VIII.C. Mental Health Functions in Segregation Units

VIII.C.1 - Partial Compliance

"Segregation Placement Mental Health Review

a) *All prisoners placed in a non-disciplinary Segregation housing unit and all prisoners housed in a Disciplinary Detention unit shall be assessed by a qualified mental health professional within 24 hours of placement to determine whether such placement is contraindicated. All prisoners subjected to Disciplinary Segregation conditions for 72 hours in their general population housing unit (i.e., confined to cell 23 hours per day) shall also be assessed by a qualified mental health professional no later than the fourth day of such placement.*

b) *Any decision to place prisoners with Serious Mental Illness in Segregation shall include the input of a qualified mental health professional who has conducted a clinical evaluation of the prisoner in a private and confidential setting (absent a specific current risk that necessitates the presence of custody staff), is familiar with the details of the available clinical history, and has considered the prisoner's mental health needs and history.*

c) *Mental Health Staff shall consider each prisoner's age and cognitive functioning as part of the Segregation Placement review. Staff shall receive training regarding the features of youth and brain development of young adults (i.e., 24 years old and younger) and the needs of individuals with intellectual disabilities.*

d) *If mental health or medical staff find that a prisoner has a Serious Mental Illness or has other contraindications to Segregation, that prisoner shall be removed from Segregation absent exceptional and exigent circumstances.*

e) *The County shall document and retain records of all Segregation Placement mental health evaluations, as described above. The County shall consult with Plaintiffs regarding such documentation, including the development of new forms where necessary."*

In addition to the information provided in the 10th County Status Report, a high security IOP program has been implemented at RCCC. SSO and ACMH have added staffing to provide enhanced services to this population.

The IOP level of care continues to be expanded. ACMH received FY 24/2025 mid-year augmentation to increase the number of IOP beds. An additional 24 male beds at RCCC and 10 female beds at Main Jail will bring total number of IOP beds to 125. ACMH anticipates all additional female and male beds will be filled by July 2025. Disciplinary housing is issued only with clearance from ACMH staff assigned to these programs. Consultation with SMI inmates and ACMH in these programs are confidential.

Regarding sub-provision VIII.C.1.a, all placements into ADSP require supportive documentation through ADSP forms which were created with the assistance of Class Counsel. These forms are uploaded to each individual's ATIMS file in compliance with SSO Policy/Procedure "Special Management Incarcerated Persons". One of the required forms is an ACMH referral which is completed and submitted during placement as well as part of each ADSP review where an individual is retained in ADSP. The ACMH referral form is not required if the ACMH notification was completed in person, via telephone, or email; in

these such cases, the classification officer includes a remark in the individuals classification file to identify when and how they contacted ACMH.

For sub-provision VII.C.1.b, VIII.C.1.c, and VIII.C.1.d, as noted in SSO policy, a "Mental illness or any other disability" (including SMI) is not a factor when determining if an individual requires ADSP placement. "Mental illness or any other disability" (including SMI) is taken into consideration as a mitigating factor when determining if a lesser restrictive medical or mental health housing assignment is appropriate to meet the individual's medical or mental health needs. SSO will take into consideration as a mitigating factor ACMH's determination on the potential mental health impact for an incarcerated subject based on their age and needs.

It is not always appropriate to remove an inmate from ADSP, even if an SMI exists, as SSO may be found to be deliberately indifferent if custody staff have knowledge of a substantial safety risk the individual poses to other incarcerated subjects and disregard that risk. In these circumstances, the exceptional and exigent circumstances requirements are met, and the inmate may be required to remain in segregation.

Regarding sub-provision VII.C.1.e, all placements into ADSP require supportive documentation through ADSP forms which were created with the assistance of Class Counsel. These forms are uploaded to each individual's ATIMS file in compliance with SSO Policy/Procedure "Special Management Incarcerated Persons."

This provision remains in partial compliance as there are ongoing efforts to expand IOP and APU capacity. A full description of ongoing expansions to IOP and APU beds are described in VIII.D.1.

VIII.C.2 - Partial Compliance

"Segregation Rounds and Clinical Contacts

a) *Cell checks (to ensure that prisoners are safe and breathing) shall be conducted for all prisoners in Segregation at least every 30 minutes, at staggered intervals. Completion of cell checks will be timely documented.*

b) *A qualified mental health or medical professional shall conduct check-ins at least once a week, to assess and document the health status of all prisoners in Segregation, and shall make referrals as necessary. The check-in shall include a brief conversation with each prisoner, a visual observation of the cell, and an inquiry into whether the prisoner would like to request a confidential meeting with a mental health or medical provider. Steps shall be taken to ensure effective communication,*

as well as auditory privacy consistent with security needs. When a prisoner in Segregation requests a confidential meeting with a mental health or medical provider, or the medical or mental health professional identifies a mental health or medical need, staff shall make appropriate arrangements to include triage, examination and treatment in an appropriate clinical setting. In such cases, staff shall give the prisoner the opportunity to complete a health care request but will otherwise initiate a referral without requiring the prisoner to complete a request form."

The SSO Policy "Special Management Incarcerated Persons" was published in 2024. The policy outlines the need for safety checks every 30 minutes. Checks are documented in ATIMS. Sergeants review these electronic logs twice a shift, and a Watch Commander reviews once per shift.

The County began Administrative Separation MH assessments in December 2021. MH staff provide case management to patients with SMI who are in segregated housing. MH continues to collaborate with custody on efficient use of attorney booths for patients in administrative segregation for confidential contacts. Additional booths consisting of plexiglass enclosures with doors are situated in the indoor area of each housing unit. Some booths are planned to have a partition for safety as well as a security desk/chair. SSO has purchased specialized security desk/chairs which allow leg shackles to be secured. This allows clinicians to safely speak to higher security inmates in privacy without custody staff standing nearby.

Custody staff facilitate inmate access to medical and mental health staff. No inmate is denied a request for access to medical or mental health care regardless of housing or classification. If an inmate requests to see medical staff, they submit an HSR if it is not an emergency. If it is an emergency, officers notify ACH or ACMH. SSO and ACMH meet regularly to discuss confidential MH visits and troubleshoot non-compliance.

Please see section VIII.A.2 for ACH weekly health status check-ins for inmates placed in Administrative Segregation. This provision will remain in partial compliance until ACH can provide proof of practice that weekly checks for patients placed in administrative segregation are conducted as required.

VIII.C.3 - Partial Compliance

"Response to Decompensation in Segregation

a) *If a prisoner in Segregation develops signs or symptoms of mental illness where such signs or symptoms had not previously been identified, suffers deterioration in his or her mental health, engages in self-harm, or develops a heightened risk of suicide, the prisoner shall immediately be referred for appropriate assessment and treatment from a qualified mental health professional who will recommend appropriate housing and/or programming.*

b) *Jail staff shall follow a mental health recommendation to remove a prisoner from Segregation unless such removal poses a current safety risk that is documented. In such a case, the Commander or management-level designee shall be notified and staff shall work to remove the prisoner from Segregation and secure a placement in an appropriate treatment setting at the earliest possible time."*

SSO follows Policy/Procedure "Special Management Incarcerated Persons" which addresses the requirements of VIII.C.3.a and VIII.C.3.b.

Additionally, in July 2024, SSO and ACMH developed a joint workflow to address individuals who mentally decompensate while in disciplinary segregation. ACMH will complete reviews of inmates placed in disciplinary segregation. If ACMH determines an individual is mentally decompensating while on discipline, the ACMH employee who completed the assessment will submit/contact the classification unit and advise of the mental health decompensation. The classification unit will modify the inmate's sanctions to remove all discipline and remove the person from any disciplinary housing.

For any inmate in Administrative Separation who is identified by AMCH as mentally decompensating, ACMH will follow the same process of notifying the classification unit. Due to the additional security concerns with individuals that are in the Administrative Separation classification, these individuals are not automatically removed from this classification assignment. The classification unit receives notification of an Administrative Separation inmate decompensating and will immediately contact the classification supervisor for consideration for alternate housing options. This provision remains in partial compliance.

VIII.D. Placement of Prisoners with Serious Mental Illness in Segregation

VIII.D.1 - Partial Compliance

"Prisoners with a mental health condition meeting criteria for placement in a Designated Mental Health Unit (2P, IOP, OPP) will not be placed in Segregation, but rather will be placed in an appropriate treatment setting – specifically, the inpatient unit or other Designated Mental Health Unit providing programming as described in Exhibit A-2."

In June 2024, SSO in coordination with ACMH, developed a structured approach to identify and prioritize inmates with SMI and/or on Outpatient Psychiatric status housed on upper floors of the Main Jail, to be rehoused in other areas of the correctional system. Each Monday, SSO generates a current housing roster for the upper floors and provides it to ACMH. ACMH reviews and ranks each incarcerated subject by urgency (High, Moderate, Low), with a sub-numerical prioritization. This ranking guides Classification in rehousing inmates to settings better suited for their mental health needs. The system allows for mid-week urgent updates and is further supported by bi-weekly meetings between the SSO Classification Supervisor and ACMH to reassess and adjust the program.

As it relates to Administrative Separation, "Mental illness or any other disability" (including SMI) is taken into consideration as a mitigating factor when determining if a lesser restrictive medical or mental health housing assignment is appropriate to meet the individual's medical or mental health needs. In addition, custody now completes a documented mental health review during placement, retentions, and reclassifications of subjects in Administrative Separation. For initial placements into Administrative Separation, classification staff will review the following:

Classification proceeding ADSP placement (Example – Protective Custody (PC) Medium):

- The proceeding classification was a mental health classification (OPP, IOP, SITHU, JBCT, EASS).
- Currently assigned Mental Health flags:
    - Serious Mental Illness
    - Mental Health Caseload
    - Grave Disability
    - Intellectual Disability
    - Developmental Disability
    - Other:
- For Administrative Separation retentions and reclassifications, Classification staff will review the following:
    - Most recent Administrative Separation Mental Health Assessment:
    - Date of Assessment:
    - Does the assessment identify any new mental health concerns or recommend alternative housing: (If yes, provide details)
    - Currently assigned Mental Health flags (see above list).
    - Other Notes:

Based on the mental health review, the classification supervisor will work with ACMH to determine if any lesser restrictive mental health housing or programs are clinically recommended.

This provision remains in partial compliance due to insufficient APU and IOP beds, which the County has undertaken efforts to increase. This includes an increase in IOP capacity – currently with a patient capacity of approximately 91 – with an additional 76 beds, including: (a) 24 additional male IOP beds by July 31, 2025; (b) ten additional female IOP beds by July 31, 2025; (c) 32 additional male IOP beds by February 26, 2026; and (d) ten additional female IOP beds by February 26, 2026. The APU will be expanded from a current capacity of 17 patients to 48 patients, to be completed by May 15, 2026. The County is starting a facilities work project at Main Jail in Fall 2025, and have agreed to make the APU a top priority for that project. The project will also include modification of the SITHU to add suicide-resistant features, ADA-compliant facilities, and a safety corridor for health care staff to conduct Constant Observation of SITHU patients when clinically indicated.

VIII.D.2 - Partial Compliance

"In rare cases where a prisoner with a mental health condition meeting criteria for placement in a Designated Mental Health Unit presents an immediate danger or significant disruption to the therapeutic milieu, and there is no reasonable alternative, such a prisoner may be housed separately for the briefest period of time necessary to address the issue, subject to the following:

- *a) The prisoner shall receive commensurate out-of-cell time and programming as described in Exhibit A-2 (including for IOP and OPP, 10 hours/week of group treatment/structured activities, 7 hours/week unstructured out-of-cell time, weekly individual clinical contact) with graduated programming subject to an individualized Alternative Treatment Program.*
- *b) The prisoner shall receive the following:*
  - *i. As part of the weekly confidential clinical contact, the clinician shall assess and document the prisoner's mental health status and the effect of the current placement on his or her mental health, and determine whether the prisoner has decompensated or is at risk of decompensation.*
  - *ii. The weekly check-ins described in Section VIII.C.2.b shall supplement, and not be a substitute for, the weekly treatment session described herein.*
  - *iii. Treatment provided in the least restrictive setting that is appropriate based on the prisoner's circumstances.*
  - *iv. Privileges commensurate with the Designated Mental Health Unit program, unless modified in an Alternative Treatment Program based on individual case factors that are regularly reviewed.*
  - *v. Daily opportunity to shower."*

This is SSO's current practice and relies on strong collaboration with ACMH. Often because of the Designated Mental Health Units (DMHUs), separation is not needed. Alternative Treatment Plans are utilized in IOP and Multidisciplinary Intervention Plans are utilized in Outpatient Services and EOP to address significant or dangerous behaviors or significant disruptions to the therapeutic milieu.

ACMH established a Positive Behavioral Support Team that provides specific DBT interventions and staff consultation to address patient behaviors that interfere with patients participating in programming or being housed in the least restrictive setting.

At both facilities, IOP no longer removes patients that are disruptive without clinical assessment and agreement by ACMH. When patients are moved, they are monitored by ACMH CM. Custody and ACMH staff now have more housing options with the MJ single celled outpatient pod, expanded female IOP program, and RCCC's 72 bed male high security IOP unit. Expansions in progress are described in VIII.D.1.

Inmates in DMHUs housed without a cellmate receive program and recreation time with other inmates. Incentives programs are utilized as advised by ACMH staff. Out-of-cell time generally exceeds the 17-hour minimum per weekly reports. ACMH determines when an inmate in these housing facilities must be housed in a solitary cell. Custody has deferred all decisions related to property and privileges to ACMH unless deemed a safety or security risk which is documented with articulable facts. Four dedicated deputies are assigned to the Acute Psychiatric Unit (2P) to facilitate programing during the day. Their schedule allows for coverage 12 hours day/7 days a week for better availability requested by ACMH. An additional two deputies were added to the evening shift allowing for additional programing and treatment. Hygiene opportunities are available during any recreation time and incentivized in some programs.

Based on recommendations by Class Counsel, the County is working towards a system to better support proof of practice of this provision; thus, this provision is being reduced to partial compliance.

VIII.D.3 - Substantial Compliance

"A prisoner with Serious Mental Illness requiring restraints (e.g., handcuffs, belly chains, etc.) shall not be denied clinically indicated group or individual treatment due to security factors, absent exceptional circumstances that are documented. Prisoners with Serious Mental Illness housed in Segregation who require restraints when out of cell shall have the opportunity to work their way out of restraints through graduated programming subject to an individualized Alternative Treatment Program."

Patients with SMI housed in ADSP who require restraints when out of cell can graduate out of restraints through programming subject to an individualized ATP. IOP patients who are subject to restrictions of property, privileges, or out-of-cell time are placed on an ATP.

ACMH currently utilizes ATPs for patients in DMHU. Patients who require restraints when out-of-cell would be placed on an ATP with plan to graduate them to regular programming as soon as clinically possible. The multidisciplinary team meets daily to discuss the patient's progress and the transition of the patient from ATP to general programming. While there are security chairs, they are not routinely utilized for groups. This provision remains in substantial compliance.

VIII.E. Administrative Segregation

VIII.E.1 - Substantial Compliance

"Use of Administrative Segregation

a) *Only the Classification Unit can assign a prisoner to Administrative Segregation.*
b) *The County may use Administrative Segregation in the following circumstances:*
    i. *Objective evidence indicates that a prisoner participated in a recent assault and the assaultive behavior involved an assault on staff or visitors, serious injury, use of a weapon, gang removals, or multiple prisoner assaults. Mutual combat situations that do not otherwise qualify for Administrative Segregation are excluded.*
    ii. *During a brief investigative period not to exceed ten days while Classification staff attempts to verify the need for Protective Custody or while the prisoner is awaiting transfer to another facility.*
c) *The Compliance Commander shall have the authority to place prisoners in Administrative Segregation under the following circumstances:*
    i. *The prisoner poses an extraordinary safety risk and no other housing unit is sufficient to protect the prisoner from harm;*
    ii. *The prisoner has failed to integrate into a lesser restrictive housing setting because of repeated and recent history of assaultive behavior or current threats of violence associated with being in a lesser restrictive setting; or*
    iii. *Objective evidence indicates that the prisoner attempted to escape or presents an escape risk."*

The SSO Policy and Procedure "Special Management Incarcerated Persons" was updated in July 2024 and reflects the requirements in sub-provisions VIII.E.1.a, VIII.E.1.b, and VIII.E.1.c, much of it verbatim. Administrative Separation is not used outside these parameters. The ADSP Placement, ADSP Review – Retention or Reclassification, and ADSP Advisement and Behavioral Plan forms also include these requirements.

Many inmates on floor 8-West have been stepped down to general population and are no longer classified as in ADSP or Disciplinary housing. While the complexity of classifications on that specific housing unit wing make programming and out-of-cell time difficult within the current facility constraints, overall, the provision remains in substantial compliance.

VIII.E.2 - Substantial Compliance

"Notice, Documentation, and Review of Administrative Segregation Designations

a) *The Classification Unit shall document the rationale for designating a prisoner for Administrative Segregation in the classification file using objective evidence. For prisoners younger than 24, the Classification Unit shall consider the prisoner's age as a mitigating factor when assigning the prisoner to Administrative Segregation.*

b) *Classification shall attempt to down-class prisoners to a lesser restrictive housing setting at the earliest possible opportunity, consistent with safety and security.*

c) *County shall provide prisoners in Administrative Segregation with a written notice within 72 hours of the prisoner's initial placement in Administrative Segregation, explaining the reasons for the prisoner's Administrative Segregation designation and how the prisoner may progress to a lesser restrictive housing setting.*

d) *Prisoners housed in Segregation units will, at least every thirty (30) days, receive face-to-face interviews in a private out-of-cell setting, consistent with individual security needs, to discuss progress and compliance with their individual case plan as part of a classification review. Consideration will be given to their mental health and to their appropriateness for transfer to a less restrictive setting.*

e) *The Compliance Commander or higher-ranked officer will review and approve the decision to designate a prisoner for Administrative Segregation for longer than 15 days.*

f) *The County shall document the reason the prisoner is retained in the same Administrative Segregation Phase. The prisoner will be given written notice of the reasons the prisoner is being retained in the same Phase of Administrative Segregation and what conduct the prisoner is required to exhibit to progress to a lesser restrictive housing setting.*

g) *The Compliance Commander or higher-ranked officer must approve the continued retention of a prisoner in Administrative Segregation for longer than 90 days, and the Compliance Commander or higher-ranked officers must reauthorize such placement at least every 90 days thereafter."*

The SSO Policy and Procedure “Special Management Incarcerated Persons” was updated in July 2024. The procedure is published with this language outlining the process. Administrative Separation is not used outside these parameters.

Each stage of the ADSP process is tracked by the Classification sergeant in the Administrative Separation tracking log. The log includes the dates placed into ADSP, the reason for placement and/or retention, document face to face interviews with the inmate and sergeant. The tracking log also alerts the Classification Sergeant to the next deadline in the review process.

Regarding VIII.E.2.a, documentation for the rationale in designating a prisoner for Administrative Separation is included in the custody ADSP forms which are uploaded to each individual’s classification file; ADSP Placement, ADSP Review – Retention or Reclassification, and ADSP Advisement and Behavioral Plan. The documentation includes a designation for considering the prisoner’s age as a mitigating factor.

Regarding VIII.E.2.b, during every review period, ADSP prisoners are, by default, considered for a lesser restrictive housing setting. Documentation is included on the ADSP forms to substantiate the designation if a prisoner is retained in ADSP.

Regarding VIII.E.2.c, the current ADSP Advisement and Behavioral Plan form is completed, printed, and either hand delivered to the prisoner or placed in the housing unit's mailbox (for the floor officers to deliver) on the same day as the ADSP placement or ADSP review. The form provides the prisoner with the reason for the ADSP designation and provides them with an Individualized Behavioral Plan informing them what actions need to be taken to be reclassified to lesser restrictive housing.

Regarding VIII.E.2.d, Classification procedures state all prisoners housed in ADSP must receive a face-to-face classification interview at least every 30 days. The interview shall be conducted in a private, out-of-cell setting, consistent with individual security needs. If the individual’s security needs prevented custody staff from completing this interview in a private, out-of-cell setting, ensure the justification is documented on the ADSP form or in the Classification File. During the interview, custody staff should discuss progress, compliance with the behavioral plan, and classification status. The ADSP classification interview should be recorded on body-worn cameras. The ADSP Placement and ADSP Review – Retention or Reclassification forms both have been updated to include a designated section for a custody mental health review. This is a review of current ACMH documentation, mental health flags, and mental health housing during their initial placement or since their last ADSP review. The classification supervisor uses this

information when determining if ADSP placement is indicated or to make referrals to ACMH for diversion to lesser restrictive mental health programs/housing.

Regarding VIII.E.2.e, this is the current classification procedure.

Regarding VIII.E.2.f, see VIII.E.2.a, VIII.E.2.b, and VIII.E.2.c.

Regarding VIII.E.2.g, the Classification ADSP Review – Retention or Reclassification form includes a designated section for the Compliance commander or higher-ranked officer review and approval of continued retention of a prisoner in Administrative Separation every 90 days.

As all requirements in this provision are met, the County is of the opinion that provision VIII.E.2 remains in substantial compliance.

VIII.E.3 - Partial Compliance

"Administrative Segregation Phases

- *a) The County shall develop and implement a phased system for prisoners designated as Administrative Segregation to achieve a lesser restrictive housing setting.*
- *b) Administrative Segregation Phase I:*
  - *i. This is the most restrictive designation for prisoners in Administrative Segregation.*
  - *ii. Prisoners shall be offered a minimum of one hour per day out of cell time for a total of seven hours per week.*
  - *iii. Prisoners shall be offered an opportunity for Out-of-Cell Activities for at least five of the seven hours per week.*
  - *iv. Prisoners shall not remain in Phase I for longer than 15 days unless the prisoner engages in new conduct warranting retention in Administrative Segregation as specified in Section VIII.E.1.b.*
- *c) Administrative Segregation Phase II:*
  - *a. Prisoners shall be offered a minimum of 17 hours of out of cell time per week.*
  - *b. Prisoners shall be offered an opportunity for Out-of-Cell Activities for at least 10 of the 17 hours per week.*
  - *c. Prisoners shall be offered the opportunity to program in groups of two to four prisoners, unless pairing with another prisoner is not possible for safety or security reasons, and those reasons are documented by the County.*
  - *d. The County shall develop a program of incentives for good behavior.*
  - *e. Prisoners shall not remain in Phase II for longer than 30 days unless the prisoner commits a serious behavioral violation while in Administrative Segregation: fighting; threatening staff or other prisoners; resisting or delaying an order from staff that impedes Jail operations (e.g., failure to lock down); refusing to submit to a search of person or property; destroying or*

damaging Jail property (excluding property issued to a prisoner and/or minor defacing of property or destruction of low-value property) or facilities"

Out-of-cell time is monitored weekly, but not all individuals on Phase II regularly receive 17 hours of out-of-cell time. When possible, those on Phase II are grouped with other individuals either on ADSP status or not. This also helps to increase the out-of-cell time as inmates can recreate with others instead of by themselves. ACMH utilizes an incentive program consisting of commissary items as clinically indicated and to increase compliance with treatment goals and custody directive.

Steps have been taken with Classification to create more defined groups of inmates who are able to recreate together. Additionally, the daily schedule (including dayroom and outdoor recreation) has been updated as a guide for shifts to follow to increase out-of-cell time.

Regarding VIII.E.3.a, the current ADSP process is phased; with ADSP1 being 15 days and ADSP2 being 30 days. Inmates classified into ADSP1 who have not committed additional violations to maintain placement in ADSP1 or do not pose a documentable extraordinary safety risk associated with being in a lesser restrictive setting (ADSP2 or lower) will be reclassified into ADSP2. Inmates classified into ADSP2 who have not committed a serious behavioral violation to maintain placement in ADSP2 or do not pose a documentable extraordinary safety risk associated with being in a lesser restrictive setting (Maximum or lower) will be reclassified out of ADSP. The inmate's mental health and ACMH's recommendations are taken into account when determining if ADSP placement or retentions are necessary.

The County is in substantial compliance with sub-provisions VIII.E.3.a, VIII.E.3.b.i, VIII.E.3.b.iv, VIII.E.3.c.c, and VIII.3.c.e. As all other sub-provisions are in partial compliance, provision VIII.E.3 remains in partial compliance.

VIII.F. Protective Custody

VIII.F.1 - Substantial Compliance

"When a prisoner faces a legitimate threat from other prisoners, the County will seek alternative housing, by transferring the threatened prisoner to the general population of another facility or unit, or to a special-purpose housing (Protective Custody) unit for prisoners who face similar threats."

Inmates who face threats from other inmates are transferred to other housing units of the same classification and are not automatically classed to a higher security level. This has

been codified in the Special Management Incarcerated Persons Policy. This provision remains in substantial compliance.

VIII.F.2 - Substantial Compliance

"The County will not operate Protective Custody units with Segregation-type conditions of confinement. Prisoners placed in Protective Custody shall have the same programs and privileges as general population prisoners, absent exceptional circumstances that are documented."

Protective custody inmates are provided with comparable housing opportunities in both celled and dormitory/barracks-style settings and receive out-of-cell (dayroom and recreation) access consistent with that afforded to general population inmates. A program rework is currently underway to further equalize program availability and opportunities across all classifications. This provision remains in substantial compliance.

VIII.F.3 - Substantial Compliance

"The County shall create a policy that describes the process and criteria for placement of prisoners into Protective Custody. The County shall consult with Plaintiffs to develop such a policy."

SSO Policy "Special Management Incarcerated Persons" was published in 2024. This provision remains in substantial compliance.

VIII.F.4 - Substantial Compliance

"Prisoners who are lesbian, gay, bisexual, transgender, or intersex (LGBTI) or whose appearance or manner does not conform to traditional gender expectations should not be placed in Segregation or Protective Custody solely on the basis of such identification or status, or because they are receiving gender dysphoria treatment.

a) *When a prisoner who is LGBTI or gender nonconforming faces a legitimate threat, the County shall identify alternative housing, with conditions comparable to those of general population. Privileges and out-of-cell time for this population will be documented and regularly reviewed by supervisory level staff to ensure appropriate housing, out-of-cell-time, and related conditions for this group of prisoners.*

b) *In deciding whether to assign a transgender or intersex prisoner to a facility or program for male or female prisoners, the County shall consider on a case-by-case basis whether a placement would ensure the prisoner's health and safety, and the*

health and safety of other prisoners, giving serious consideration to the prisoner's own views.

c) *Jail staff will receive training on the unique issues of managing transgender prisoners, with refresher training at least bi-annually."*

SSO's Classification Policy and Procedure were updated in May 2024 to include the language outline in sub-provision VII.F.4.b. A lesson plan and PowerPoint has been implemented for the topic of Cultural Awareness, which covers managing transgender prisoners. This training has been provided in the Adult Corrections Officer Supplemental Core Course starting 2021 with all new hires after the completion of a six-month POST Basic Academy in which Learning Domain 42 covers Sexual Orientation and Gender Identify. This provision has been increased to substantial compliance.

VIII.F.5 - Substantial Compliance

"For prisoners who are LGBTI or whose appearance or manner does not conform to traditional gender expectations, the County shall identify the prisoner's preferred gender of jail staff who will perform searches of the prisoner. The County shall honor the request except in exigent circumstances when doing so is not possible."

Statement of preference forms completed by transgender/gender diverse prisoners allow them to request the gender of searching officer(s). The preference form and pronouns are also included in ATIMS on the inmate profile.

SSO's Search Policy and Procedure were last updated in October 2024 to include the following language: "As standard practice and absent exigent circumstances, searches of incarcerated persons shall be conducted by deputies of the same gender as the incarcerated person. For incarcerated persons who are LGBTI or whose appearance or manner does not conform to traditional gender expectations, members shall inquire and attempt to identify the person's preferred gender of the searching deputy to perform the search. Staff shall honor the incarcerated person's request except in exigent circumstances when doing so is not possible." As this policy remains the current practice, this provision remains in substantial compliance.

VIII.G. Disciplinary Segregation

VIII.G.1 - Substantial Compliance

"The County will not place a prisoner in disciplinary housing pending investigation of, and due process procedures for, an alleged disciplinary offense unless the prisoner's presence

in general population would pose a danger to the prisoner, staff, other prisoners or the public."

SSO Policy and Procedure "Discipline" was published in May 2024. There has been no change in this procedure since the 10th County Status Report. Incarcerated persons pending a disciplinary write-up remain in place until the disciplinary hearing concludes, and an appropriate housing determination is made. However, certain circumstances may be a factor in the timeliness of rehousing an individual after an incident occurs. One common example would be an inmate fight where the participants require separation from one another for the safety and security of the facility and involved parties. While the housing move may occur prior to the disciplinary hearing taking place, that does not mean they would begin a restrictive housing sentence prematurely. This provision remains in substantial compliance.

VIII.G.2 - Substantial Compliance

"The County will adhere to a discipline matrix, developed in consultation with Plaintiffs, that clearly defines when disciplinary housing may be imposed."

Both facilities continue to utilize a discipline matrix approved in 2023 that was developed with input from Class Counsel. This provision remains in substantial compliance.

VIII.G.3 - Partial Compliance

"Prisoners who are found to have violated disciplinary rules following due process procedures will be placed in Segregation only after the County has determined that other available disciplinary options are insufficient, with reasons documented in writing."

The Sacramento County Sheriff's Office follows the sentencing guidelines of the Inmate Discipline Plan, which was developed in coordination with Class Counsel. The Inmate Discipline Plan identifies specific faciality violations for which Full Restriction (Segregation) is appropriate. The Sheriff's Office follows this discipline plan during the disciplinary hearing and imposition of sanctions. This provision has been reduced to partial compliance as SSO does not currently have a standardized procedure to document that other available disciplinary options are insufficient, but is exploring appropriate mechanisms to track and monitor this.

VIII.G.4 - Substantial Compliance

"The denial of out-of-cell time for more than four (4) hours will not be imposed as a sanction absent a formal disciplinary write-up and due process hearing."

SSO's Policy and Procedure on Disciplinary Separation was published in May 2024. This includes the following language: "No incarcerated person shall be denied more than four hours out-of-cell time, as a disciplinary sanction, without a disciplinary write-up and hearing." This provision reflects current practice and remains in substantial compliance.

VIII.G.5 - Partial Compliance

"Prisoners serving a Disciplinary Segregation term shall receive at least seven (7) hours per week of out-of-cell time. Out-of-cell time with the opportunity to exercise shall be provided to each prisoner one (1) hour a day, seven (7) days per week."

Out-of-cell time is monitored and recorded in the current 'ATIMS' jail management system. Weekly reports are generated to assess compliance and are distributed to supervisors and managers to assist in adherence to the established standards. Additionally, reports covering a four-week period are created to identify any inmates who have not received the appropriate amount of out-of-cell time consistently, including those in discipline and ADSEP. A new process has recently been implemented when an inmate has habitually not met their out-of-cell time minimums. Once those individuals are identified, a compliance deputy will respond and conduct an in-person interview. The intention of this interview will be to determine if there are factors, whether it be mental health, physical health, or other, impacting the inmates desire or ability to spend time out of their cell. These contacts are documented in the inmate's record and appropriate referrals will be made if necessary.

Ongoing efforts to adhere to this provision span beyond just tracking and include updated recreation scheduling, utilizing recreation technicians to target areas of deficiencies, using indoor recreation space in addition to outdoor areas, and weekly notifications to shift supervisors highlighting those inmates or housing areas which failed to meet out-of-cell requirements. This provision has been reduced to partial compliance until proof of practice is consistently demonstrated.

VIII.G.6 - Partial Compliance

"Prisoners in Disciplinary Segregation shall, absent an individualized assessment of security risk that is documented be provided at least one book (which prisoners may regularly exchange), legal documents, hygiene materials, legal phone calls, and legal visits."

SSO's Policy and Procedure on Disciplinary Separation was updated and published in July 2024 to include reading material, legal documents, legal visits, and telephone privileges for legal phone calls as well as family emergencies. This provision has been reduced to partial compliance until proof of practice is demonstrated.

VIII.G.7 - Partial Compliance

"No Disciplinary Segregation term for non-violent rules violations will exceed 15 days."

In addition to developing the Inmate Discipline Plan and implementing Policy/Procedure for Disciplinary Separation in collaboration with Class Counsel, the Sheriff's Office transitioned from having a separate CDHO at each facility to a single CDHO for the entire correctional system. This single point of review was created to promote consistency in the disciplinary process.

Ongoing monitoring of the disciplinary process, including audits of incident reports, revealed that the Sheriff's Office is not yet in substantial compliance with the Consent Decree, specifically with Sections VIII.G.3, VIII.G.7, and VIII.G.8.

To reach substantial compliance, the Sheriff's Office, in consultation with Class Counsel, is updating the incident report process by expanding the CDHO's role and adding support from a Sheriff's Records Officer. Under the updated process, incident reports will continue to move forward to a disciplinary hearing as they do now. Following the hearing, the hearing sergeant will determine guilt or innocence on the cited violations but will not be responsible for imposing disciplinary sanctions. The incident report will then be routed to the CDHO, who will review the incident report, the ACMH Rules Violation Review assessment (as applicable), and the hearing report before imposing any discipline. This updated process aligns with the Inmate Discipline Plan, Disciplinary Separation Policy/Procedure, and the requirements of VIII.G.3, VIII.G.7, and VIII.G.8, and will also strengthen compliance with VIII.G.9, VIII.G.10, and VIII.G.11.

Centralizing the authority to impose disciplinary sanctions for both facilities with the CDHO is expected to improve consistency and adherence to policy. Future process changes can also be implemented more efficiently by the CDHO without the need to retrain all shift supervisors across both facilities. Given these recent changes, this provision has been reduced to partial compliance, but is expected to be restored to substantial compliance in the next monitoring report.

VIII.G.8 - Substantial Compliance

"The County will, in consultation with Plaintiffs' counsel, modify its inmate discipline policy and practice to limit placements in Disciplinary Segregation conditions to no more than 15 days, absent cases of serious violations stemming from distinct incidents and with Watch Commander-level approval."

SSO's Procedure on Disciplinary Separation was published on 05/14/2024 and outlines the following: "A disciplinary separation term shall not exceed 15 days for any non-violent rule violations.

a) Multiple non-violent rule violations shall not be combined to exceed 15 days.
b) Multiple non-violent rule violations may be combined to reach a maximum of 15 days.
c) Non-violent rule violations committed while serving discipline shall not extend the discipline beyond the initial 15-day period."

This procedure has not changed and the provision remains in substantial compliance.

VIII.G.9 - Substantial Compliance

"No prisoner shall be placed in Disciplinary Segregation for more than 30 consecutive days."

In addition to maintaining the processes outlined in the 10th County Status Report, the Sheriff's Office conducts weekly audits of individuals on Full Restriction (Disciplinary Segregation) to ensure they receive a gap day after 15 consecutive days and are not placed on a new Full Restriction period until at least two days have passed following the conclusion of their previous 30-day term (or a total of 30 continuous days on full restriction). This provision remains in substantial compliance.

VIII.G.10 - Substantial Compliance

"If after a Disciplinary Segregation term, Jail staff, with the input of a mental health clinician, determine that the prisoner cannot safely be removed from Segregation, placement on Administrative Segregation status may occur only subject to the process set forth in Section VIII.E."

Once an inmate is at the end of a disciplinary term, evaluation for placement to ADSP status would follow the procedure as outlined in that order. SSO remains in substantial compliance with this section by following the reclassification process outlined in Section VIII when, after a Disciplinary Segregation term, an individual cannot safely be removed from segregation.

VIII.G.11 - Substantial Compliance

"Once a prisoner has been moved out of Disciplinary Segregation, that prisoner shall not be placed back into Disciplinary Segregation absent (a) a new incident warranting

discipline, and (b) completion of all mental health review procedures required for new Segregation placements."

The SSO Procedure "Disciplinary Separation" was published in May 2024 and outlines this process. The procedure states that "Upon removal from disciplinary separation, no incarcerated person shall be placed back into disciplinary separation without a new rule violation warranting disciplinary separation and the appropriate Mental Health Services review has been completed." The CDHO is responsible for ensuring adherence to this procedure. This provision remains in substantial compliance.

VIII.H. Avoiding Release from Jail Directly from Segregation

VIII.H.1 - Substantial Compliance

"The County will avoid the release of prisoners from custody directly from Segregation-type housing, to the maximum extent possible."

Those placed on ADSP are tracked by the Classification sergeant. Individuals housed in Administrative Separation with a projected release date are routinely reviewed for potential classification step-down, with the goal of removing them from Administrative Separation prior to release whenever feasible. Continued placement in Administrative Separation at the time of release occurs only when the individual presents a substantial safety risk that cannot be otherwise mitigated. The Classification Unit follows this practice for all individuals pending release to ensure compliance with established policy and institutional safety. This provision remains in substantial compliance.

VIII.H.2 - Partial Compliance

"If a sentenced prisoner housed in Segregation has an upcoming expected release date (i.e. less than 120 days), the County will take and document steps to move the prisoner to a less restrictive setting, consistent with safety and security needs. If Segregation becomes necessary during this time, the County will provide individualized discharge planning to prepare the sentenced prisoner for release to the community."

The SSO Procedure "Special Management Incarcerated Persons" was published on July 3, 2024 and describes this process. This provision will remain in partial compliance until SSO and ACH develop a process for monitoring compliance of this provision and establish proof of practice.

VIII.I. No Food-Related Punishment

VIII.I.1 - Substantial Compliance

"The County shall modify its policy and take steps to ensure that the denial or modification of food is never used as punishment. The County shall eliminate use of "the loaf" as a disciplinary diet. Nothing in this paragraph shall be read to preclude the County from denying a prisoner use of the commissary."

The SSO Policy "Disciplinary Separation" was published in May 2024 and outlines this provision with the following language: "Under no circumstances will an incarcerated person be denied food as a means of punishment (15 CCR 1083(e))." The disciplinary diet (loaf) is no longer used.

The County has remained in substantial compliance with the requirements of this provision for a period of at least one year. As such, pursuant to the Federal Court for the Eastern District of California court order, the monitoring by the Court for this provision was suspended. The County is pleased to report it remains substantially compliant with this provision.

VIII.J. Restraint Chairs

VIII.J.1 - Substantial Compliance

"Restraint chairs shall be utilized for no more than six hours."

This is consistent with current SSO practice and policies, The Sheriff's Office no longer uses the restraint chair and has transferred to the utilization of the WRAP restraint device. SSO created a report flag within ATIMS allowing a review of all WRAP related incidents. SSO and ACMH meet regularly to monitor the use of the WRAP device as well as both agencies' coordination with an application. This provision remains in substantial compliance.

VIII.J.2 - Partial Compliance

"The placement of a prisoner in a restraint chair shall trigger an "emergent" mental health referral, and a qualified mental health professional shall evaluate the prisoner to assess immediate and/or long-term mental health treatment needs."

A WRAP Restraint Audit for the period of April 2025, utilized SSO's WRAP log. ATIMS and a chart review for each WRAP encounter. For April 2025, five patients were placed in the WRAP.

100% (5/5) of the individuals had SMI:

- 20% (1/5) Intellectual Disability
- 20% (1/5) Schizophrenia
- 20% (1/5) Unspecified Bipolar Disorder
- 40% (2/5) Unspecified Schizophrenia

ACMH continues to monitor and identify barriers to meeting timelines to care. Staff have been redirected to assist with emergent, urgent and routine referrals. During the period of December 2024 to February 2025, patients who required an emergent assessment within six hours were seen on average within 7.84 hours.

This provision remains in partial compliance pending further audits to ensure prompt referral by custody to ACMH and ACMH meeting the emergent timelines to care requirement.

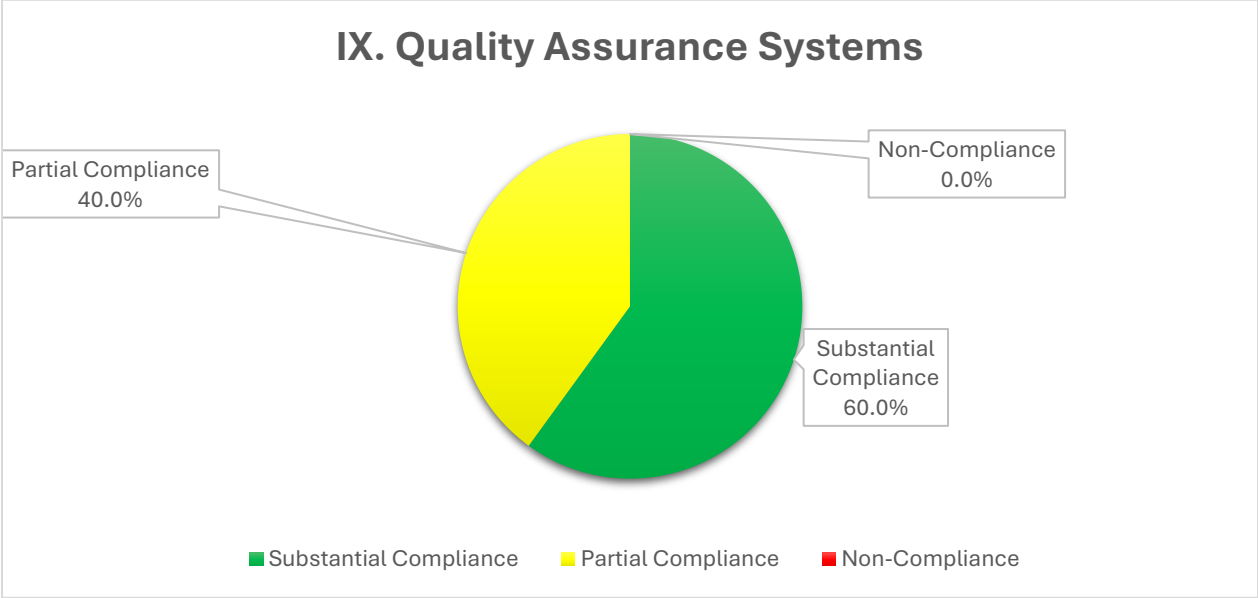
VIII.J.3 - Partial Compliance

"The opinion of a qualified medical professional on placement and retention in a restraint chair will be obtained within one hour from the time of placement."

ACMH and SSO continue to meet regularly to review WRAP incidents and identify process improvement related to referrals to ACMH following initiation of WRAP and MH timelines to care. To ensure the appropriate steps and notifications are being followed when the WRAP is used, periodic audits are conducted by ACMH. If a deficiency is recognized, ACMH brings that to the attention of SSO so follow-up and corrective action can be taken. See VIII.J.2 for recent audit findings.

It is the policy of SSO to notify ACH as soon as practicable when an inmate is placed in restraints. Additionally, an emergent referral to ACMH is required to be made. ACH nurses work closely with custody to meet time frames and conduct health monitoring checks. This provision remains in partial compliance.

IX. Quality Assurance Systems for Health Care Treatment



The County has identified 10 provisions in Remedial Plan IX. Quality Assurance Systems for Health Care Treatment. For this 11th County Status Report, the compliance ratings are as follows:

- Substantial Compliance: 6 provisions (60%)
- Partial Compliance: 4 provisions (40%)
- Non-Compliance: 0 provisions (0%)

Monitoring Status

Remedial Plan IX. Quality Assurance Systems for Health Care Treatment is monitored by the Mental Health SME (provisions IX.B.1-3) and Medical Care SMEs (provisions IX.C.1-4). Provisions IX.A.1-3 are not assigned to a Court-appointed monitor for evaluation.

In comparison to the County's self-assessed ratings, the Court-appointed monitors' compliance ratings are as follows:

- Substantial Compliance: 0 provisions (0%)
- Partial Compliance: 6 provisions (60%)
- Non-Compliance: 1 provision (10%)
- Not Assessed: 3 provisions[7] (30%)

[7] As noted, IX.A.1-3 have not been assigned to a Court-appointed monitor for external assessment.

Attachment 9, Quality Assurance Systems for Health Care Treatment Remedial Plan Expert Rating Reconciliation, aligns the Court-appointed monitors' compliance ratings with the provision structure used here and shows how the County's compliance ratings compare to those of the assigned monitors.

Self-Assessment

IX.A. Generally

IX.A.1 - Partial Compliance

"The County shall develop and implement, in collaboration with Plaintiffs' counsel, a quality assurance ("QA") plan to regularly assess and take all necessary measures to ensure compliance with the terms of this Remedial Plan."

ACH QI has continued to produce data reports to support ongoing monitoring and decision-making. Due to staff turnover and temporary understaffing within ACH Quality Improvement (QI) team, the capacity to complete scheduled audits was impacted during this reporting period. Please see section IX.A.3 for more information on staffing changes. Despite the challenges during this reporting period, the QI team has been able to conduct several audits including disability identification and documentation, diabetes management, and a newly developed women's reproductive health audit at intake. Additionally, ACH is utilizing SRNs to conduct in-person observations/audits of the medication administration process, intake, withdrawal monitoring, nurse sick call, and occupational hazards/safety. Audit data is shared with service line managers for appropriate corrective actions. Results are also shared in the quarterly Quality Improvement Committee (QIC) meetings. The QI director has onboarded two new QI nurses and a QI coordinator, giving them appropriate training to begin monitoring the critical areas of focus. This provision remains in partial compliance.

IX.A.2 - Substantial Compliance

"The QA/QI Unit shall meet regularly and include representatives from all levels of the organization and from all facilities. The meeting shall include custody representatives for topics that are relevant to custody operations."

The QIC and several subcommittees (Pharmacy & Therapeutics, Mental Health QI, and Safety) meet quarterly. The meetings are multidisciplinary and all meetings include custody representatives.

- The Suicide Prevention Subcommittee changed to monthly meetings, effective November 2021.
- A Utilization Management Subcommittee was formed and began meeting quarterly in October 2021.
- The Safety Subcommittee was refocused to include infection control in 2023 and is led by a designated QI Coordinator.

QI staff updated a list of reports and created a list of audits based on the indicators listed in the remedial plan. The lists clarify types of data for review in each subcommittee. These documents have been reviewed with service line managers in the QIC and the MH QI Committee. QI monitors progress. This provision remains in substantial compliance.

IX.A.3 - Substantial Compliance

"The County shall provide sufficient resources to the QA/QI program."

The QI team currently includes a total of nine (8) positions, including:

- QI director
- Two (2) QI coordinators
- Two (2) QI nurses
- Two (2) senior office assistants
- Administrative services officer (ASO) I

There is a nurse educator (who began in this reporting period) with significant correctional experience that works closely with QI. This nurse educator SRN was formerly a QI nurse, and brings a QI mindset into this position. The QI director was previously a QI coordinator. The vacant QI coordinator position was filled in June 2025. The second QI coordinator left ACH in March 2025. Their position was filled in July 2025. The two QI RN positions became vacant in December 2024. One of the new QI RNs started in mid-April 2025, while the other started in mid-May.

The ASO II became vacant in December 2024. This position was converted into an ASO I and was filled in May 2025. The current ASO I was promoted from within the QI team, leaving a senior office assistant position vacant. ACH is working to fill this position, which is currently the only vacancy within the QI unit. This provision remains in substantial compliance.

IX.B. Quality Assurance, Mental Health Care

IX.B.1 - Substantial Compliance

"The JPS Medical Director, the JPS Program Manager, jail administrators, and the medical psychiatric, dental, and nursing directors, or appropriate designees, will attend and participate in this process at a minimum of every quarter. Formal minutes will be taken and maintained whenever the committee convenes."

Mental health representatives participate in all QI meetings. There are three specific mental health multidisciplinary subcommittees: Mental Health (chaired by the MH program director), Suicide Prevention (chaired by the MH medical director). The MH QI Subcommittee meets quarterly, and Suicide Prevention Subcommittee meets monthly. The chair will attend all subcommittee meetings or will assign a designee. This provision remains in substantial compliance.

IX.B.2 - Substantial Compliance

"The mental health care quality assurance plan shall include, but is not limited to, the following:

a) Intake processing;

b) Medication services;

c) Screening and assessments;

d) Use of psychotropic medications;

e) Crisis response;

f) Case management;

g) Out-of-cell time;

h) Timeliness of clinical contacts;

i) Provision of mental health evaluation and treatment in confidential settings;

j) Housing of inmates with SMI, including timeliness of placements in higher levels of care and length of stay in various units;

k) Number of commitments pursuant to Welf. & Inst. Code § 5150, et seq.;

l) Use of restraint and seclusion;

m) Tracking and trending of agreed upon data on a quarterly basis;

n) Clinical and custody staffing;

o) Morbidity and mortality reviews with critical analyses of causes or contributing factors, recommendations, and corrective action plans with timelines for completion; and

p) Corrective action plans with timelines for completion to address problems that arise during the implementation of this Remedial Plan and prevent those problems from reoccurring."

Audit tools and reports have been developed related to mental health and suicide prevention Remedial Plan provisions and include:

- APU Involuntary Detention Audit
- APU Daily Patient Activity Report
- APU Clinical Restraint Report
- APU Discharge Follow-ups-Timelines to Care
- APU Involuntary Medication & Riese Audit
- Confidential Contacts-Main Jail & RCCC
- Discharge from Suicide Precautions Follow-up Assessments -Timelines to Care Report
- Emergent, Urgent and Routine Timelines to Care Report
- Health Service Requests-Timelines to Care
- Medication Refusals Audit
- Medication Verification and Initiation
- MDIP Outcome Report
- MDT & Treatment Plan Report
- MH Groups Scheduled & Canceled
- MH Referrals and Encounters
- MH RVR Audit-Main Jail & RCCC
- Prescriber Audit
- Provider Timeline to Care Report for Urgent and Routine Referrals & Encounters
- Planned and Unplanned Use of Force Referrals & Assessments
- Suicide Precautions Quarterly Audit
- Suicide Risk Assessment Audit
- Suicide Risk Assessment & Safety Planning

- WRAP Audit

ACMH and ACH have completed development of the MH Caseload Report to include all relevant information regarding patients on the MH caseload, including: patient name, X-reference number, MH diagnosis, booking and release date, date of last MH appointment and next appointment, custody level, housing location and if the patient has an SMI. The report is currently in production and will be utilized to improve reporting and tracking of patients on the MH caseload.

Audit tools and reports for Administrative Segregation Referrals and Assessments are in development.

M&M reviews of serious suicide attempts are reviewed at each Suicide Prevention Subcommittee meeting. Staff adopted a Review Checklist suggested by the Suicide Prevention expert. Committee Chairs are responsible to ensure indicators are reviewed and tracked.

The M&M Review Committee continues to refine the documentation and timely reporting from each service line when reviewing serious suicide attempts. Recent updates include shared documents that increase efficiency of review and prompt response to issues that require systems changes or staff follow-up. The M&M Review Committee established a tracking system for Corrective Action Plans that are generated as a result of M&M reviews.

This provision remains in substantial compliance.

IX.B.3 - Substantial Compliance

"The County will conduct peer and supervisory reviews of all mental health staff and professionals at least annually to assess compliance with policies and procedures and professional standards of care."

Annual performance evaluations are required for all ACMH staff and more often for probationary employees. ACMH completes monthly prescriber peer reviews and addresses any areas for improvement through direct feedback and during monthly prescriber meetings and huddles. All reviews are tracked. This provision remains in substantial compliance.

IX.C. Quality Assurance, Medical Care

IX.C.1 - Partial Compliance

"The County shall establish a Quality Assurance/Quality Improvement (QA/QI) Unit to develop accurate tracking mechanisms and monitor the timeliness and effectiveness of

the following processes of health care, ensuring that all are reviewed at least annually, and shall recommend corrective action for all deficiencies:

a) *intake screenings;*

b) *emergent, urgent, and routine requests from patients and staff referrals for health care, including Health Service Request availability;*

c) *clinical monitoring of patients, including the delivery of chronic care services to those patients who qualify as chronic care patients;*

d) *prescriptive practices by the prescribing staff;*

e) *medication administration, including the initiation of verified medications, the first doses of medications, medication errors, patient refusals, and patterns of medication administration;*

f) *grievances regarding healthcare;*

g) *specialty care (including outside diagnostic tests and procedures);*

h) *clinical caseloads;*

i) *coordination between custody staff and medical staff, including escorts to medical appointments and delivery of care."*

ACH developed a QA/QI CQI program, which has implemented several tracking systems and audits to monitor the timeliness and effectiveness of health care delivery consistent with community standards. Corrective Action Plans are developed and implemented to address areas of deficiency.

Audits include, but are not limited to, the following:

- Nurse Intake Audits monitoring referrals at intake and ADA identification and documentation.
- Access to Care Audit monitoring timeliness of emergent, urgent, and routine requests from patients and staff from Health Service Requests.
- Chronic Disease Management Audit monitoring delivery of chronic care services for those with chronic conditions. A separate Chronic Disease Management - Diabetes Management, specifically assesses the quality of services related to Diabetes.
- Medication Initiation and Renewal Audit monitoring initiation of verified medication, first dose of medications, medication errors, and patient refusals.

- Grievance Report monitors all grievances by type, service area, frequency, and response timeliness.
- Women's Health Care Intake Audit determines if women entering the facility are being screened appropriately for reproductive services.
- Specialty Care Audit, which includes monitoring service types and appointment timeliness. QI and Case Management will include on-site specialty clinics in a separate On-site Specialty Care Audit during the next fiscal year.
- Withdrawal Monitoring Audit analyzes the frequency and timeliness of required face-to-face monitoring, medication, and referrals as appropriate.
- QI tracks SSO escort allocation for daily medical activities and delivery of care. Since the last monitoring period, QI developed a Daily Huddle template and implemented Daily Huddle meetings to ensure continuous coordination between custody and medical staff. Additionally, the ACH and SSO leadership team meets in person monthly to discuss operational needs and plans.

ACH continues to develop audits to monitor clinical caseloads, prescriptive practices by prescribing staff, and coordination between medical staff and SSO Custody, including medical appointments and delivery of care. ACH QI adopted the medical SME's recommendation to expand the time frames of audits and avoid "point-in-time" data collection and are working to improve the sample size per audit. This element will be reflected in audits moving forward. The QI team is in the process of completing outstanding audits that were delayed in the previous months due to vacancies. As audits are completed, service line directors are required to submit Corrective Action Plans for deficiencies that do not improve over time. This provision will remain in partial compliance until all audits are developed and completed in a timely manner.

IX.C.2 - Partial Compliance

"The studies shall be done with sufficient sample numbers to arrive at statistically valid conclusions. The studies shall include (a) a clearly articulated goals, objective, and methodology to determine if standards have been met, including a sampling strategy; (b) data collection; (c) analysis of data to identify trends and patterns; (d) analysis to identify the underlying causes of problems; (e) development of remedies to solve problems; (f) a written plan that identifies responsible staff and establishes a specific timeline for implementing remedies; (g) follow-up data collection; and (h) analysis to determine if the remedies are effective."

Studies are completed with sufficient sample numbers, include clear goals, objectives, and methodology to determine if standards are met, including sampling strategy. Studies include overall findings, recommendations, and comparative analysis. The underlying causes of the problems are reflected in the audits' findings section. As stated previously, QI has improved the sampling strategy and expanded the data collection time frames as opposed to "point-in-time" sampling, as recommended by the medical SMEs.

QI is continuously improving efforts to implement recommendations derived from the audits via corrective action plans and monthly CQI meetings. Corrective Action Plans and CQI identify responsible staff and specific timelines for implementing improvement strategies. QI uses Plan-Do-Study-Act (PDSA) for focused interventions. This provision will remain in partial compliance until proof of practice showing compliance with this provision is demonstrated.

IX.C.3 - Substantial Compliance

"The QA/QI Unit study recommendations shall be published to all staff."

QI shares recommendations in Executive team meetings, QIC meetings, and subcommittee meetings as appropriate. Medical representatives participate in all QI meetings. Each forum is quarterly. QIC Chairs are responsible for ensuring indicators are reviewed and tracked. Recommendations and corrective actions are discussed, and follow-up is conducted as needed. Audits and recommendations are published on the ACH intranet for all staff. This provision remains in substantial compliance.

IX.C.4 - Partial Compliance

"The County will conduct peer and supervisory reviews of all medical staff and professionals at least annually to assess compliance with policies and procedures and professional standards of care."

QI staff have created and implemented a UR nurse chart review tool and began utilizing it in the last reporting period. In-person observation audits are conducted on the nurse intake, HSR, and Withdrawal Monitoring processes. QI will continue to work on additional review tools in the next monitoring period as well as in-person audits on medication administration and mouth-check adherence.

Performance evaluations are required annually for permanent County staff and more frequently for probationary staff (ACH PP 03-09 Performance Evaluations).

During this reporting period, ACH drafted a Peer Review Policy with heavy input from the new medical director (pending finalization) and began utilizing the Peer Review forms developed by the previous medical director and the provider consultant. For this process, the appointed reviewers - comprising the assistant medical director and lead physicians - conduct structured chart reviews for each provider. When issues are identified, the reviewers are responsible for providing direct feedback, which may include disciplinary actions when appropriate. Quality improvement feedback has already been issued, and results are shared with the providers. All reviews are documented and tracked for accountability and follow-up.

ACH anticipates ongoing refinements to this process as the new medical director becomes more familiar with the system. Given his strong background in peer review, this will be a key area of focus moving forward. This provision will remain in partial compliance until proof of practice showing compliance with this provision is met.

Attachments

1. Abbreviations and References

Abbreviation	Description
ABE	Adult Basic Education
ACH	Sacramento County Adult Correctional Health
ACMH	Adult Correctional Mental Health
AD	Assistive Device
ADA	Americans with Disabilities Act
ADSP	Administrative Separation
AHRQ	Agency for Healthcare Research and Quality
AOT	Advanced Officer Training
APU	Acute Psychiatric Unit
ASP	Adaptive Support Program
ATIMS	Advanced Technology Information Management Systems (Jail Management Software)
ATP	Alternative Treatment Program
BSCC	Board of State and Community Corrections
CAP	Corrective Action Plan
CDHO	Chief Disciplinary Hearing Officer
CERT	Correctional Emergency Response Team
CIT	Crisis Intervention Training
CIWA	Clinical Institute Withdrawal Assessment for Alcohol Scale
CM	Case Management
CNAP	Critical Needs Assessment Program
CO	Constant Observation
COWS	Clinical Opiate Withdrawal Scale
CPAP	Continuous Positive Airway Pressure
CPOE	Computerized Provider Order Entry
CQI	Continuous Quality Improvement
DBT	Dialectical Behavior Therapy
DGS	Sacramento County Department of General Services
DME	Durable Medical Equipment
DMHU	Designated Mental Health Unit
DTech	Sacramento County Department of Technology
EASS	Early Access and Stabilization Services
EGUSD	Elk Grove Unified School District

Abbreviation	Description
EHR	Electronic Health Record
ELA	English Language Arts
eMAR	Electronic Medication Administration Record
EOP	Enhanced Outpatient Program
ER	Emergency Room
FTE	Full-Time Equivalent
GED	General Education Development
HIPAA	Health Insurance Portability and Accountability Act
HCA	Health Care Appliance
HS	Hours of Sleep
HSR	Health Service Request
H&P	History and Physical
ID	Intellectual Disability
IM	Intramuscular injection
IHSF	Intake and Health Services Facility
IOP	Intensive Outpatient Program
JBCT	Jail-Based Competency Treatment
JPRP	Jail Population Reduction Plans
JPS	Jail Psych Services (now, ACMH)
KOP	Keep On Person
MA	Medical Assistant
MAT	Medication Assisted Treatment
MDT	Multidisciplinary Treatment Team
MH	Mental Health
MHU	Medical Housing Unit
MHW	Mental Health Worker
MJ	Main Jail
MOC	Medical Observation Cell
MoCA	Montreal Cognitive Assessment
M&M	Morbidity and Mortality
OB/GYN	Obstetrics and Gynecology
OPP	Outpatient Psychiatric Pod (SSO housing classification)
PC	Protective Custody
PDSA	Plan-Do-Study-Act
POST	Commission on Peace Officer Standards and Training
PREA	Prison Rape Elimination Act
PSJA	Sacramento County Public Safety and Justice Agency

Abbreviation	Description
PT	Physical Therapy
PUOF	Planned Use of Force
QA	Quality Assurance
QI	Quality Improvement
QMHP	Qualified Mental Health Professional
RCCC	Rio Cosumnes Correctional Center
RFQ	Request for Qualifications
RN	Registered Nurse
ROAR	Reentry Opportunities and Access to Resources
RVR	Rule Violation Review
SBF	Stuart Baird Facility
SCR	Specialty Care Referral
SITHU	Suicidal Inmate Temporary Housing Unit
SLI	Sign Language Interpretation/Interpreters
SME	Subject Matter Expert
SMI	Serious Mental Illness
SNP	Standardized Nursing Protocol
SOAP	Subjective, Objective, Assessment and Plan
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SSO	Sacramento County Sheriff's Office
TDD	Telecommunications Device for Deaf Persons
UCD	University of California, Davis
UM	Utilization Management
UOF	Use of Force
UR	Utilization Review
VHA	Veterans Health Administration
VRI	Video Remote Interpreting
VRS	Video-Relay Services
WD	Withdrawal
WPATH	World Professional Association for Transgender Health
WRAP	Wrap Restraint System

2. Policies and Procedures

SSO policies and procedures are available on the Sheriff's Office Transparency website (https://www.sacsheriff.com/pages/transparency.php) under the "Policy and Training Materials" heading. The online materials are updated any time a policy or procedure has been finalized. As policy and procedure numbers are periodically changed, only policy and procedure names have been provided throughout the report.

The status of ACH and ACMH's policies, as well as Provider Treatment Guidelines and Standardized Nursing Procedures, are identified below.

ACH Policies	Total Policies
Total	51 (100%)
In Process (Revision/Development)	20 (39.2%)
Pending Subject Matter Expert/Class Counsel Review	16 (31.4%)
Not currently under revision or SME review	15 (24.4%)

ACH Policies – Includes administration, medical, and joint (medical/mental health) policies.

ACH Provider Treatment Guidelines	Total Provider Guidelines
Total	11 (100%)
In Process (Revision/Development)	0 (0%)
Pending Medical Expert Review	0 (0%)
Total	11 (100%)

**ACH is using the VA's treatment guidelines. Approved by the SMEs.*

ACH Standardized Nursing Procedures (SNP)	Total SNPs
Total	49 (100%)
In Process (Revision/Development)	3 (6%)
Pending Medical Expert Review	0 (0%)
Not currently under revision or SME review	46 (94%)

Note: SNPs describe specific RN actions (RN to manage, requires consult with provider, or emergency stabilization needed) vs. categorization of low, medium, and high risk.

Mental Health Policies	Total Policies
Total	27 (100%)
In Process (Revision/Development)	1 (4%)
Pending Mental Health Expert Review	0 (0%)
Not currently under revision or SME review	26 (96%)

3. Americans with Disabilities Act (ADA) Remedial Plan Expert Rating Reconciliation

Two monitoring reports have been completed to evaluate the ADA remedial plan provisions in the Consent Decree. On July 30, 2025, the "Second Monitoring Report on Disability Practices in the Sacramento County Jails" was filed with the Court by Class Counsel (Patrick Booth, Margot Mendelson, and Megha Ram from the Prison Law Office and Aaron J. Fischer from the Law Office of Aaron J. Fischer) evaluating the American with Disabilities Act (ADA) remedial plan provisions in the Consent Decree.

Prior to this report, an ADA monitoring report had not been completed since March 2021. In the March 2021 report, while the Court-appointed experts provided narrative comments on the various categories in the remedial plan, no compliance ratings were assigned.

On page 25 of the "Mental Health Expert's Fourth Round Report of Findings" by Mary Perrien, Ph.D., dated May 1, 2024, Dr. Perrien assigned a rating of Partial Compliance to provision III.O.1.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
III.A.1	Partial	Partial
III.A.2	Substantial	Partial
III.A.3	Substantial	Partial
III.A.4	Partial	Partial
III.B.1	Partial	Partial
III.B.2	Partial	Partial
III.B.3	Substantial	Partial
III.C.1	Substantial	Substantial
III.C.2	Substantial	Substantial
III.C.3	Partial	Partial
III.C.4	Partial	Partial
III.D.1	Substantial	Partial
III.D.2	Partial	Partial
III.E.1	Partial	Partial
III.E.2	Partial	Partial
III.E.3	Partial	Partial
III.E.4	Substantial	Substantial

Provision	County Compliance Rating	Court-Appointed Monitor Rating
III.F.1	Partial	Partial
III.F.2	Partial	Partial
III.F.3	Partial	Non-Compliance
III.F.4	Partial	Non-Compliance
III.G.1	Partial	Non-Compliance
III.G.2	Partial	Non-Compliance
III.G.3	Partial	Non-Compliance
III.G.4	Partial	Non-Compliance
III.H.1	Partial	Partial
III.H.2	Partial	Partial
III.H.3	Partial	Partial
III.H.4	Partial	Non-Compliance
III.H.5	Partial	Non-Compliance
III.H.6	Partial	Partial
III.I.1	Substantial	Partial
III.I.2	Substantial	Substantial
III.I.3	Partial	Non-Compliance
III.I.4	Substantial	Partial
III.I.5	Substantial	Partial
III.I.6	Substantial	Partial
III.I.7	Substantial	Partial
III.I.8	Substantial	Partial
III.I.9	Substantial	Not Assessed
III.J.1	Substantial	Substantial
III.J.2	Partial	Partial
III.J.3	Substantial	Partial
III.J.4	Substantial	Not Assessed
III.J.5	Partial	Not Assessed
III.J.6	Substantial	Not Assessed
III.J.7	Partial	Non-Compliance
III.J.8	Partial	Partial
III.K.1	Substantial	Partial
III.K.2	Partial	Partial
III.K.3	Partial	Partial

Provision	County Compliance Rating	Court-Appointed Monitor Rating
III.K.4	Partial	Partial
III.L.1	Partial	Partial
III.L.2	Partial	Partial
III.L.3	Partial	Partial
III.L.4	Partial	Partial
III.L.5	Substantial	Not Assessed
III.L.6	Substantial	Not Assessed
III.M.1	Substantial	Partial
III.N.1	Substantial	Partial
III.N.2	Partial	Not Assessed
III.N.3	Substantial	Not Assessed
III.N.4	Substantial	Not Assessed
III.O.1	Substantial	Partial[8]
III.O.2	Partial	Not Assessed
III.O.3	Substantial	Not Assessed
III.P.1	Partial	Partial
III.P.2	Partial	Partial
III.P.3	Partial	Non-Compliance
III.P.4	Substantial	Partial
III.Q.1	Partial	Non-Compliance
III.Q.2[9]	Non-Compliance	Non-Compliance

[8] Not assessed by Class Counsel in 2nd ADA Monitoring Report, but assessed in Mental Health Expert's Fourth Round Report of Findings (May 1, 2024).

[9] Previously, the County and Class Counsel had misidentified III.Q.2.c as III.Q.3.

4. Mental Health Care Remedial Plan Expert Rating Reconciliation

Four monitoring reports have been completed to evaluate the mental health remedial plan provisions in the Consent Decree. The fourth monitoring report was completed by Mary Perrien, Ph.D. The "Mental Health Expert's Fourth Round Report of Findings" is dated May 1, 2024.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
IV.A.1	Substantial	Partial[10]
IV.A.2	Substantial	Partial
IV.A.3	Substantial	Not Assessed[11]
IV.A.4	Partial	Partial
IV.B.1	Substantial	Partial
IV.B.2	Substantial	Substantial
IV.B.3	Substantial	Substantial
IV.C.1	Partial	Partial
IV.C.2	Substantial	Partial
IV.C.3	Partial	Not Assessed
IV.C.4	Substantial	Partial
IV.C.5	Substantial	Partial
IV.D.1	Substantial	Partial
IV.D.2	Substantial	Partial[12]
IV.D.3	Partial	Partial
IV.D.4	Partial	Partial
IV.D.5	Partial	Partial
IV.D.6	Substantial	Partial
IV.D.7	Substantial	Partial
IV.D.8	Partial	Partial
IV.E.1	Partial	Partial
IV.E.2	Substantial	Partial
IV.E.3	Substantial	Partial

[10] "Mental Health Expert's Fourth Round Report of Findings," pg. 27- Dr. Perrien mis-identifies IV.A.1.a-h as IV.A.1-8. Dr. Perrien rated IV.A.1.a-g as Substantial Compliance; however, since IV.A.1.h was rated with Partial Compliance, the entire provision is reduced to Partial Compliance.

[11] "Mental Health Expert's Fourth Round Report of Findings," pg. 28 - Dr. Perrien skips IV.A.3, moving from IV.A.2 to IV.A.4 instead.

[12] "Mental Health Expert's Fourth Round Report of Findings," pg. 36 - Dr. Perrien provides a rating for "IV.D." Based on context provided, it is inferred that this rating was intended to apply to IV.D.1.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
IV.E.4	Partial	Partial
IV.E.5	Partial	Partial
IV.E.6	Partial	Partial
IV.E.7	Substantial	Partial
IV.F.1	Partial	Partial[13]
IV.F.2	Substantial	Partial[14]
IV.F.3	Substantial	Partial
IV.F.4	Partial	Partial[15]
IV.F.5	Partial	Not Assessed[16]
IV.F.6	Partial	Partial[17]
IV.G.1	Partial	Partial[18]
IV.G.2	Substantial	Partial
IV.G.3	Substantial	Partial
IV.H.1	Substantial	Substantial
IV.H.2	Substantial	Substantial
IV.H.3	Partial	Partial
IV.I.1	Partial	Partial

[13] "Mental Health Expert's Fourth Round Report of Findings," pg. 46 - Dr. Perrien provides a rating for "IV.F." Based on context provided, it is inferred that this rating was intended to apply to IV.F.1.

[14] "Mental Health Expert's Fourth Round Report of Findings," pg. 48 - Dr. Perrien rates the Non-Acute Units as being in Partial Compliance, and Acute Units as being in Non-Compliance.

[15] "Mental Health Expert's Fourth Round Report of Findings," pg. 51 - Dr. Perrien rates the Non-Acute Units as being in Partial Compliance, and Acute Units as being in Non-Compliance.

[16] "Mental Health Expert's Fourth Round Report of Findings," pg. 52 - Dr. Perrien skips IV.F.5, moving from IV.F.4 to IV.F.6 instead.

[17] "Mental Health Expert's Fourth Round Report of Findings," pg. 52-55 - Dr. Perrien rates IV.F.6.a-d separately from IV.F.6.e; however, both portions were assigned a rating of Partial Compliance.

[18] "Mental Health Expert's Fourth Round Report of Findings," pg. 55 - Dr. Perrien rated all of category IV.G as Partial Compliance. As a result, all provisions within this category have been rated with Partial Compliance.

5. Disciplinary Measures and Use of Force Remedial Plan Expert Rating Reconciliation

Four monitoring reports have been completed to evaluate the disciplinary measures and use of force for prisoners with mental health or intellectual disabilities remedial plan provisions in the Consent Decree. Ratings for these provisions were included in the fourth monitoring report completed by Mary Perrien, Ph.D. The "Mental Health Expert's Fourth Round Report of Findings" is dated May 1, 2024.

In addition to evaluating provisions within the Consent Decree, Dr. Perrien rated three additional provisions from Focus Area #4, Use of Force Policies and Practices, Class Members with Disabilities, from the June 2022 Memorandum of Agreement (MOA). Sacramento County Status Reports have not historically assigned compliance ratings to provisions in the MOA, so these ratings are not included here.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
V.A.1	Substantial	Substantial
V.A.2	Substantial	Partial
V.A.3	Substantial	Substantial
V.B.1	Substantial	Non-Compliance
V.B.2	Substantial	Non-Compliance
V.B.3	Partial	Non-Compliance
V.B.4	Partial	Partial
V.B.5	Partial	Partial
V.B.6	Partial	Not Assessed
V.B.7	Partial	Partial
V.C.1	Partial	Not Assessed
V.C.2	Partial	Not Assessed
V.D.1	Partial	Partial
V.D.2	Substantial	Partial
V.D.3	Substantial	Partial
V.D.4	Substantial	Non-Compliance
V.D.5	Substantial	Partial
V.D.6	Substantial	Partial
V.D.7	Substantial	Non-Compliance
V.E.1	Substantial	Partial

Provision	County Compliance Rating	Court-Appointed Monitor Rating
V.E.2	Partial	Partial
V.E.3	Substantial	Non-Compliance
V.E.4	Partial	Partial
V.E.5	Substantial	Non-Compliance

6. Medical Care Remedial Plan Expert Rating Reconciliation

Seven monitoring reports have been completed to evaluate the medical care remedial plan provisions in the Consent Decree. Ratings for these provisions were included in the seventh medical care monitoring report completed by Angela Goehring RN, MSA, CCHP and Sylvia McQueen, MD, MBA, FACP, CCHP. The "Seventh Monitoring Report of the Medical Consent Decree" is dated July 29, 2025.

Some provisions, identified as "Self-Monitoring Only," are no longer subject to monitoring from the Court, pursuant to the Consent Decree and stipulation between the Federal Court for the Eastern District of California and Class Counsel. These provisions reflect sustained substantial compliance for an extended period. The County will continue to address ongoing compliance with these provisions in its status reports, but no external monitor ratings will be provided.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
VI.A.1	Partial	Partial
VI.A.2	Partial	Partial
VI.B.1	Substantial	Self-Monitoring Only
VI.B.2	Substantial	Substantial
VI.B.3	Partial	Partial
VI.B.4	Partial	Partial
VI.B.5	Substantial	Partial
VI.B.6	Partial	Partial
VI.B.7	Substantial	Partial
VI.C.1	Substantial	Substantial
VI.C.2	Substantial	Partial
VI.C.3	Partial	Partial
VI.C.4	Partial	Partial
VI.C.5	Non-Compliance	Non-Compliance
VI.C.6	Substantial	Self-Monitoring Only
VI.C.7	Partial	Non-Compliance
VI.D.1	Partial	Partial
VI.D.2	Partial	Non-Compliance
VI.D.3	Substantial	Self-Monitoring Only
VI.E.1	Substantial	Partial
VI.E.2	Partial	Partial

Provision	County Compliance Rating	Court-Appointed Monitor Rating
VI.E.3	Partial	Non-Compliance
VI.E.4	Partial	Partial
VI.E.5	Partial	Partial
VI.E.6	Partial	Partial
VI.E.7	Non-Compliance	Non-Compliance
VI.E.8	Substantial	Self-Monitoring Only
VI.E.9	Partial	Non-Compliance
VI.E.10	Substantial	Partial
VI.F.1[19]	Partial	Partial
VI.F.2	Partial	Partial
VI.F.3	Partial	Partial
VI.F.4	Partial	Partial
VI.F.5	Partial	Partial
VI.F.6	Substantial	Self-Monitoring Only
VI.G.1	Partial	Partial
VI.G.2	Partial	Non-Compliance
VI.G.3	Partial	Partial
VI.G.4	Partial	Non-Compliance
VI.G.5	Substantial	Self-Monitoring Only
VI.H.1	Partial	Partial
VI.H.2	Partial	Partial
VI.H.3	Partial	Partial
VI.H.4	Substantial	Substantial
VI.I.1	Partial	Partial
VI.I.2	Substantial	Partial
VI.I.3	Substantial	Substantial
VI.J.1	Partial	Partial
VI.J.2	Partial	Partial
VI.J.3	Partial	Partial
VI.J.4	Partial	Not Assessed
VI.K.1	Substantial	Self-Monitoring Only
VI.L.1	Partial	Partial

[19] Sub-provision VI.F.1.a remains in substantial compliance and is only subject to self-monitoring.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
VI.L.2	Substantial	Self-Monitoring Only
VI.L.3	Partial	Partial
VI.M.1	Substantial	Self-Monitoring Only
VI.M.2	Substantial	Self-Monitoring Only
VI.N.1	Partial	Partial
VI.N.2	Partial	Non-Compliance
VI.O.1	Partial	Partial
VI.O.2	Partial	Partial
VI.P.1	Partial	Non-Compliance
VI.P.2	Partial	Non-Compliance
VI.Q.1	Substantial	Partial
VI.Q.2	Non-Compliance	Non-Compliance
VI.Q.3	Partial	Partial
VI.R.1	Partial	Partial

7. Suicide Prevention Remedial Plan Expert Rating Reconciliation

Five monitoring reports have been completed to evaluate the suicide prevention remedial plan provisions in the Consent Decree. Ratings for these provisions were included in the fifth monitoring report completed by Lindsay M. Hayes. The "Fifth Monitoring Report of Suicide Prevention Practices" is dated November 11, 2024.

Some provisions, identified as "Self-Monitoring Only," are no longer subject to monitoring from the Court, pursuant to the Consent Decree and stipulation between the Federal Court for the Eastern District of California and Class Counsel. These provisions reflect sustained substantial compliance for an extended period. The County will continue to address ongoing compliance with these provisions in its status reports, but no external monitor ratings will be provided.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
VII.A.1	Substantial	Partial
VII.A.2	Substantial	Partial
VII.B.1	Partial	Partial
VII.B.2	Partial	Partial
VII.B.3	Substantial	Partial
VII.B.4	Substantial	Self-Monitoring Only
VII.B.5	Substantial	Substantial
VII.B.6	Substantial	Partial
VII.C.1	Substantial	Non-Compliance
VII.C.2	Substantial	Non-Compliance
VII.C.3	Substantial	Self-Monitoring Only
VII.C.4	Substantial	Non-Compliance
VII.C.5	Substantial	Self-Monitoring Only
VII.C.6	Substantial	Self-Monitoring Only
VII.D.1	Partial	Partial
VII.D.2	Partial	Partial
VII.D.3	Substantial	Partial
VII.E.1	Partial	Partial
VII.E.2	Substantial	Self-Monitoring Only
VII.E.3	Substantial	Self-Monitoring Only
VII.E.4	Substantial	Self-Monitoring Only
VII.F.1	Substantial	Non-Compliance

Provision	County Compliance Rating	Court-Appointed Monitor Rating
VII.G.1	Partial	Non-Compliance
VII.H.1	Partial	Partial
VII.H.2	Substantial	Self-Monitoring Only
VII.H.3	Substantial	Partial
VII.H.4	Substantial	Partial
VII.H.5	Substantial	Partial
VII.H.6	Substantial	Self-Monitoring Only
VII.I.1	Substantial	Partial
VII.I.2	Substantial	Substantial
VII.J.1	Partial	Non-Compliance
VII.J.2	Substantial	Substantial
VII.J.3	Partial	Partial
VII.J.4	Substantial	Self-Monitoring Only
VII.J.5	Substantial	Self-Monitoring Only
VII.K.1	Partial	Partial
VII.K.2	Partial	Partial
VII.K.3	Partial	Partial
VII.L.1	Substantial	Partial
VII.M.1	Substantial	Partial
VII.M.2	Substantial	Partial
VII.M.3	Substantial	Partial
VII.N.1	Substantial	Substantial
VII.N.2	Partial	Partial
VII.N.3	Substantial	Self-Monitoring Only
VII.N.4	Substantial	Partial
VII.N.5	Substantial	Partial
VII.N.6	Substantial	Partial
VII.N.7	Substantial	Self-Monitoring Only
VII.O.1	Substantial	Substantial
VII.P.1	Substantial	Partial
VII.P.2	Partial	Partial
VII.P.3	Substantial	Self-Monitoring Only
VII.P.4	Partial	Partial
VII.Q.1	Substantial	Self-Monitoring Only

Provision	County Compliance Rating	Court-Appointed Monitor Rating
VII.Q.2	Substantial	Partial
VII.Q.3	Substantial	Self-Monitoring Only
VII.R.1	Substantial	Self-Monitoring Only
VII.R.2	Substantial	Self-Monitoring Only
VII.R.3	Substantial	Partial
VII.R.4	Substantial	Self-Monitoring Only
VII.R.5	Substantial	Partial

8. Segregation/Restricted Housing Remedial Plan Expert Rating Reconciliation

Four monitoring reports have been completed to evaluate the segregation/restricted housing remedial plan provisions in the Consent Decree. Ratings for these provisions were included in the fourth monitoring report completed by Patrick Booth, Margot Mendelson, and Megha Ram of the Prison Law Office and Aaron J. Fischer from the Law Office of Aaron J. Fischer. The "Fourth Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails" is dated June 26, 2025.

Additionally, some provisions were evaluated by the Court-appointed mental health SME, Mary Perrien, Ph.D. in the "Mental Health Expert's Fourth Round Report of Findings" dated May 1, 2024. Provisions that are completely or partially rated by the mental health SME are indicated with an asterisk(*).

Some provisions, identified as "Self-Monitoring Only," are no longer subject to monitoring from the Court, pursuant to the Consent Decree and stipulation between the Federal Court for the Eastern District of California and Class Counsel. These provisions reflect sustained substantial compliance for an extended period. The County will continue to address ongoing compliance with these provisions in its status reports, but no external monitor ratings will be provided.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
VIII.A.1	Partial	Partial
VIII.A.2	Partial	Partial
VIII.A.3	Substantial	Partial
VIII.B.1	Substantial	Partial
VIII.B.2	Partial	Partial
VIII.B.3	Substantial	Partial
VIII.B.4	Substantial	Self-Monitoring Only
VIII.B.5	Substantial	Partial
VIII.B.6	Substantial	Partial
VIII.C.1*	Partial	Partial
VIII.C.2*	Partial	Partial

Provision	County Compliance Rating	Court-Appointed Monitor Rating
VIII.C.3	Partial	Partial[20]
VIII.D.1*	Partial	Non-Compliance[21]
VIII.D.2*	Partial	Partial[22]
VIII.D.3*	Substantial	Partial
VIII.E.1	Substantial	Substantial
VIII.E.2	Substantial	Substantial[23]
VIII.E.3	Partial	Partial[24]
VIII.F.1	Substantial	Substantial
VIII.F.2	Substantial	Partial
VIII.F.3	Substantial	Partial
VIII.F.4	Substantial	Substantial[25]

[20] "Fourth Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails", pg. 35 assigned a rating of Non-Compliance for Provision VIII.C.3.a and a rating of Partial Compliance for Provision VIII.C.3.b. Due to the mixed rating, a rating of Partial Compliance has been assigned.

[21] "Fourth Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails", pg. 36 assigned a rating of Non-Compliance for Provision VIII.D.1. However, pgs. 79-80 of the 4th Mental Health Expert report assigned a rating of Partial Compliance for Provision VIII.D.1. As the 4th Monitoring Report on Restricted Housing is the more recent of the two, Class Counsel's rating stands.

[22] "Fourth Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails", pg. 36 assigned a rating of Non-Compliance for Provision VIII.D.2.a and VIII.D.2.b.iv, and a rating of Partial Compliance for VIII.D.2.v. Pg. 36 identifies VIII.D.2.b.i, VIII.D.2.b.ii, and VIII.D.2.b.iii as being evaluated by the Mental Health Expert. Pgs. 79-80 of the 4th Mental Health Expert report assigned a rating of Partial Compliance for Provision VIII.D.2. As the rating between the sub-provisions and the court appointed experts is mixed, a rating of Partial Compliance is assigned.

[23] "Fourth Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails", pgs. 37-38 includes separate ratings for its sub-provisions. VIII.E.2.d was Not Rated (described as Not Evaluated), while all other sub-provisions are identified as being in Substantial Compliance (described as "Compliant" in the report).

[24] "Fourth Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails", pg. 38 includes separate ratings for its sub-provisions. VIII.E.3.a, VIII.E.3.b.i, VIII.E.3.b.iv, VIII.E.3.c.c, and VIII.E.3.c.e were assigned a rating of Substantial Compliance (described as "Compliant"). VIII.E.3.b.ii, VIII.E.3.b.iii, VIII.E.3.c.a, and VIII.E.3.c.b were assigned ratings of Partial Compliance. VIII.E.3.c.d was assigned a rating of Non-Compliance.

[25] "Fourth Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails," pg. 39 includes separate ratings for each sub-provision. VIII.F.4, VIII.F.4.a, and VIII.F.4.c were assigned ratings of Substantial Compliance (described as Compliance). VIII.F.4.b was described as Not Evaluated.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
VIII.F.5	Substantial	Substantial
VIII.G.1	Substantial	Partial
VIII.G.2	Substantial	Not Assessed
VIII.G.3	Partial	Partial
VIII.G.4	Substantial	Not Assessed
VIII.G.5	Partial	Partial
VIII.G.6	Partial	Partial
VIII.G.7	Partial	Partial
VIII.G.8	Substantial	Partial
VIII.G.9	Substantial	Substantial
VIII.G.10	Substantial	Substantial
VIII.G.11	Substantial	Partial
VIII.H.1	Substantial	Not Assessed
VIII.H.2	Partial	Not Assessed
VIII.I.1	Substantial	Self-Monitoring Only
VIII.J.1	Substantial	Not Assessed[26]
VIII.J.2	Partial	Not Assessed
VIII.J.3	Partial	Not Assessed

[26] "Fourth Monitoring Report on Restrictive Housing, Discipline, and Classification Practices in the Sacramento County Jails," pg. 41 describes provisions VIII.J.1, VIII.J.2, and VIII.J.3 as being evaluated by the Mental Health Expert. There is no reference to this provision in the 4th Mental Health Expert Report.

9. Quality Assurance Systems for Health Care Treatment Remedial Plan Expert Rating Reconciliation

Four monitoring reports have been completed to evaluate the mental health remedial plan provisions and seven monitoring reports have been completed to evaluate the medical care remedial plan provisions. Both reports included ratings for provisions in IX. Quality Assurance Systems for Health Care Treatment.

The fourth mental health monitoring report was completed by Mary Perrien, Ph.D. The "Mental Health Expert's Fourth Round Report of Findings" is dated May 1, 2024.

The seventh medical care monitoring report was completed by Angela Goehring RN, MSA, CCHP and Sylvia McQueen, MD, MBA, FACP, CCHP. The "Seventh Monitoring Report of the Medical Consent Decree" is dated July 29, 2025.

Rating Assignments:

- IX.A was not assigned to a Court-appointed monitor for evaluation.
- IX.B is evaluated by the mental health SME.
- IX.C is evaluated by the medical care SME.

Provision	County Compliance Rating	Court-Appointed Monitor Rating
IX.A.1	Partial	Not Monitored
IX.A.2	Substantial	Not Monitored
IX.A.3	Substantial	Not Monitored
IX.B.1	Substantial	Partial[27]
IX.B.2	Substantial	Partial
IX.B.3	Substantial	Partial
IX.C.1	Partial	Partial
IX.C.2	Partial	Partial
IX.C.3	Substantial	Partial
IX.C.4	Partial	Non-Compliance

[27] "Mental Health Expert's Fourth Round Report of Findings," pgs. 82-83 includes a single rating of Partial Compliance to IX.B. Based on context provided, it is inferred that this rating was intended to apply to each provision in IX.B.