Sacramento County Correctional Facility Master Planning Services

Phase I/II Report: Functional Assessment and Projected Needs

Executive Summary

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We would like to thank the many Sacramento County staff and partners who contributed time, expertise, and candid feedback to support this master planning effort. Their participation in interviews, site visits, workshops, and interviews helped ground this report in the realities of current practice and future planning needs.

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INTRODUCTION AND PROJECT BACKGROUND

The Sacramento County jail system comprises two adult correctional facilities: the Main Jail (MJ) and the Rio Cosumnes Correctional Center (RCCC), also known as "the Branch," which operate under the authority of the Sacramento Sheriff's Office (SSO), Correctional Services Division. Ongoing concerns about the conditions of confinement in the Sacramento County jails, along with issues relevant to and the adequacy of medical and mental health services, compliance with the Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act (HIPAA), formed the foundation of a class action lawsuit against the County filed on July 31, 2018. After years of negotiations, the matter was resolved January 13, 2020, with the issuance of the Mays Consent Decree (hereinafter referred to as the Consent Decree).

In June 2022, the County and Class Counsel entered into a subsequent Memorandum of Agreement (MOA) focused on implementing foundational remedial measures at both the Main Jail and RCCC. The MOA required the County to develop two plans:

- One to remedy physical plant deficiencies impacting delivery of care, with an emphasis on achieving constitutional levels of physical health and behavioral health services.
- The other for jail population reduction measures to include funding and implementation schedule.

As part of the plan to remediate physical plant deficiencies, the County agreed to a number of changes and developed an entire plan (referred to as the Remediation Plan) to provide constitutionally adequate care and conditions of confinement.

To address a portion of the code physical plant violations and deficiencies, the County retained Nacht & Lewis in April 2020 to develop a plan for the future and criteria documents for the delivery of expanded detention facilities focusing on intake and specialized mental health housing and services. Nacht & Lewis prepared a detailed program and conceptual plans for the construction of an "Annex" to the Main Jail, located in the staff parking lot to the north of the existing jail, and Kitchell CEM prepared detailed cost estimates, culminating with a final estimate in August of 2023. This initial project would be known as the Intake and Health Services Facility (IHSF), designed to provide additional space for booking, as well as space for mental health and medical care.

The Annex project was proposed to and approved by the Sacramento County Board of Supervisors in December 2022. It was projected to take approximately five to eight years to complete. Throughout the planning, design and capital development process, costs continued to increase, and monitors and plaintiff representatives raised questions about the efficacy of the proposed expansion. Moreover, the Board of Supervisors expressed concern regarding the selection of a singular course of action without a more thorough investigation of facility approaches. At the recommendation of the Board of Supervisors, the completion of a third-party peer review was approved in 2024.

Completed by CGL Companies in 2025, the peer review comments noted that the documents reviewed reflected significant gaps in space needs for programs and support. It recommended

suspending the current IHSF project until several steps were completed, including the development of a comprehensive jail system Master Plan involving a range of stakeholders to "provide better functionality and improve justice system outcomes rather than focusing narrowly on minimum efforts required for the Main Jail." (County of Sacramento Intake and Health Services Facility, Comprehensive Peer Review, CGL Companies, Final Report, February 25, 2025) In April 2025, the Board of Supervisors adopted CGL Companies' recommendation and the proposed IHSF project was suspended in February 2025.

Mandate of the Mays Consent Decree

The Consent Decree identifies five major remedial focus areas mandated to bring the Sacramento County jail system into constitutional compliance, each with specific goals and requirements as follows:

1. **Medical Care.** Focuses on expanding clinical spaces, ensuring timely access to comprehensive healthcare services, adequate clinical staffing, and achieving consistent improvements in chronic disease management, pharmacy services and the medical intake screening process.
2. **Mental Health Care.** Focuses on overcoming persistent staffing vacancies, expanding mental health treatment, increasing out-of-cell time for therapeutic programming, consideration of mental health or intellectual disabilities in issues related to the disciplinary process, and reducing waitlists by establishing adequate capacity in specialized housing for individuals requiring higher levels of care.
3. **Restrictive Housing.** Places firm limitations on isolation practices, particularly protecting individuals with serious mental health conditions.
4. **Suicide Prevention.** Mandates integrating mental health screenings at the time of intake, improving suicide prevention policies and practices and continuous monitoring by utilizing designated safety and observation cells in areas of the facility that allow staff to provide the continuous staff supervision of individuals at risk.
5. **Accessibility.** Focuses on physical plant upgrades to ensure compliance with the ADA, guaranteeing equal access to programs, facilities, and auxiliary aids for individuals with disabilities.

Over the years, the County has sought to meet the requirements of the Consent Decree by evaluating how the two jails can be improved to better align with court-mandated healthcare access and service delivery and ADA requirements within the limitations of the existing infrastructure.

Recent findings from expert reports indicate that, while some progress has been made toward compliance with the Consent Decree provisions (12th Status Report, Feb 2026), the County is still struggling to reach substantial compliance across all provisions, particularly regarding mental health staffing and medical care delivery. All these reports have consistently recognized staffing challenges and physical facility limitations as main impediments to achieving full compliance.

In this context, the Sacramento County Correctional Facility Master Planning Services effort is intended to provide the County with a long-term correctional infrastructure roadmap, informing future system capacity and housing requirements, ADA transition planning, facility approaches to remedy physical plant deficiencies, and capital investments to achieve full compliance with the Consent Decree.

Project Purpose and Scope of Work

Formally launched on July 1, 2025, the planning effort has, as its primary objective, the development and analysis of a range of feasible, actionable facility remediation options and associated timelines and financing strategies for Sacramento County Board of Supervisors' consideration. Although focused on achieving full compliance with the provisions of the Consent Decree, this master planning effort is also intended to establish a vision for the future, enhance the functionality of the County's jail system and enhance the entirety of the justice system in consideration of available financial options.

The Master Planning Study progresses through four main phases. Phase I/II, the subject of this report, focuses on evaluating programs, staff, and operations; inventorying existing space and identifying space gaps; understanding and documenting existing physical conditions; and reviewing the results of the Facility Condition Assessment/functional suitability analysis as a basis for planning and defining the vision for the future desired jail system.

This report presents the findings and recommendations of Phase I/II influencing the development of strategic approaches for the future County's jail system. As the basis for understanding and documenting existing conditions and establishing future needs, Phase I/II included the following tasks:

- Analyzing historical jail population trends to determine current and future capacity needs
- Evaluating ADA, medical, and mental health compliance needs, including staffing needs for all service lines
- Assessing the functional suitability of existing facilities, treatment programs and services, and related staffing and operational costs
- Performing an inspection and assessment of physical conditions and anticipated maintenance, lifespan, and replacement costs of existing jail facilities including PESTLE (political, economic, social, technological, legal, and environmental) factors and compliance with the County's Climate Action Plan

This report documents current and projected needs and the as-is conditions of the existing facilities and both functional and operational "gaps" in meeting the conditions of the Consent Decree and providing appropriate levels of service to meet the needs of the incarcerated population. This report is the foundation for identifying, developing and evaluating system-wide approaches to renovate, expand or replace existing facilities to remediate physical plant deficiencies and realize the desired jail system of the future.

The study includes engagement with stakeholders representing the Sacramento Sheriff's Office (SSO), County Health Services Adult Correctional Health (ACH) and Adult Correctional Mental Health (ACMH), County Counsel, Sacramento County Department of General Services (DGS), and various other representatives of County Administration and affected County Departments. Through the completion of Phase I/II, four major workshops were held with the Stakeholder Group, ranging from six to 12 hours over two days.

To guide the study and ultimately provide recommendations to the County Board of Supervisors, the Board established the Jail System Planning Compliance Oversight Committee (Executive Committee) composed of Executive Staff and the Sacramento Undersheriff. This group was briefed on all information presented and discussed with the stakeholders and provided direction for all key aspects of the planning process. Moreover, the Board of Supervisors was debriefed regularly on the findings of the planning study and direction given to the Planning Team.

The County is also cognizant of the importance of transparency in the process and initiated a community outreach process that began with an open invitation to a collaborative meeting. Representatives of the public and advocacy groups were invited to discuss the goals of the study and key concerns regarding jail facilities, the delivery of appropriate services to the in-custody population, and the justice system as a whole. This initial meeting was followed by a series of virtual meetings to continue gathering public input. While recognizing that opinions on the final outcome will differ, the process is intended to provide transparency and input before a decision is reached on the recommended course of action.

The County has been committed from the initiation of the study to provide for full participation by stakeholders and the public, providing the Jail System Planning Compliance Oversight Committee responsible for making recommendations to the Board of Supervisors with a broad perspective on issues to be considered in reaching a final recommendation to the Board.

Phase I/II Scope of Work and Report Organization

This report presents the findings and recommendations of Phase I/II, which inform the development of strategic approaches for the County's future jail system. As the basis for understanding and documenting existing conditions and establishing future needs, Phase I/II included the following tasks:

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Phase I/II Report is organized along five major tasks, as follows:

- **Population Analysis (Section 3):** This section provides a summarizes the findings from a population analysis of future criminal justice populations in Sacramento County with the goal of identifying short- and long-term capacity needs and the capability of the current jail facilities to accommodate these needs.
- **Mental Health Services Assessment (Section 4):** This section provides a general assessment of current mental health services, with a focus on key operations, staffing, care delivery, and infrastructure factors that influence access, quality, and efficiency, with observations and considerations for ongoing enhancement.
- **Medical Services Assessment (Section 5):** This section provides a general assessment of current medical services, with a focus on key operations, staffing, care delivery, and infrastructure factors that influence access, quality, and efficiency, with observations and considerations for ongoing enhancement.
- **Operational & Functional Assessment (Section 6)**: This section provides the findings of the as-is conditions of the site, buildings and existing departmental areas contained within the MJ and the RCCC to establish a baseline for planning related to spatial shortfalls or inadequacies based on standards and best practices, as well as safety, security, and staffing/operational costs. The evaluation of as-is conditions included an analysis of the IHSF proposal as previously documented.
  Key findings related to the Planning Team's assessment of the IHSF proposal will serve as a basis for the continued analysis of future approaches as a deliverable of this Master Planning Study. As part of the operational assessment, a preliminary staffing assessment of the SSO's Correctional Services Division provides an initial understanding of current facility operations, service levels and management, staffing coverage, scheduling of employees, and workplace environment, and its impact on facilitating access to medical and mental health services.
- **Facility Conditions & Accessibility Assessment (Section 7):** This section summarizes the facility conditions assessment that evaluated the current physical conditions, infrastructure, and systems to identify maintenance deficiencies, estimate repair costs, and plan long-term capital improvements. As part of this assessment, an ADA/Accessibility assessment was also conducted to identify physical barriers for people with disabilities.

Ultimately, this study will provide the County Board of Supervisors with a ranked order range of options based on a quantitative and qualitative comparative evaluation to meet current and projected needs along with rough order of magnitude costs and implementation timeframes.

SUMMARY OF FINDINGS

Jail Population Trends and Projected Capacity Requirements

This section examines past and likely future demands for jail beds in Sacramento County. It reviews trends and the external and internal factors that drive expectations and projects future needs through the year 2045.

The demand for jail beds is shaped by the interplay of several forces: the County's changing demographics, documented crime trends, and the major legislative and criminal justice reforms of the past decade, together with the admissions and the average daily population (ADP) patterns through which those forces register in the jail itself. Overlaying these factors is the structure of the justice system, in which the decisions that determine who enter custody and for how long are divided among independent agencies.

The County's ADP has remained within a relatively narrow range in recent years, roughly 3,100 to 3,400 people. That stability does not mean the underlying pressures have eased; rather, it likely reflects competing forces offsetting one another. Hence, the interpretation of these projections rests on how these factors coalesce.

As the quantitative foundation for facility planning and decisions that will commit public resources over a multi-decade horizon, a critical aspect of this study was the development of projections of future bed space capacity extended to 20 years, through 2045.

The projection framework adopted for this analysis employed a two-stage approach.

- A near-term time-series model that uses a seasonal time-series model (SARIMAX) tailored to the County's monthly ADP, which forecasts total ADP, including every population segment housed in the facilities. It is trained on monthly ADP from January 2022 through December 2025, a window that captures the full post-pandemic recovery and the stabilization of jail operations under current booking and release practices. Per a request from the Executive Committee, contract and state-funded bed counts were held constant (100 federal contract beds, 44 state contract beds), with growth applied only to the locally driven population.
- A long-term demographic projection that is anchored to county-level population projections published by the California Department of Finance. It applies age-specific incarceration rates (derived from the County's own 2018–2025 booking data) to Sacramento County population projections by single year of age.
  Sacramento County's projected population growth is concentrated disproportionately in cohorts ages 50 and older, who have incarceration rates (below 1.5 per 1,000) that are a fraction of the peak-booking 25–34 age band (approximately 5.4–5.8 per 1,000). As a result, the 50+ share of jail ADP rises from 15.4% in 2025 to 17.3% by 2040, meaning that each additional resident contributes less marginal jail demand than the current average. A linear extrapolation of total population growth to ADP would overstate future

jail needs by ignoring this compositional shift. The age-specific rate approach used here captures the dampening effect automatically.

AB 1950, passed in 2021, capped most felony probation terms at two years, accelerating the discharge of supervised individuals and reducing the pool of probationers subject to violation-based booking. Because the statute took effect within the COVID exclusion window used in the SARIMAX estimation, its impact on local ADP is embedded in the post-COVID baseline rather than separately identified, reinforcing the caveat that the model's post-exclusion anchor reflects not only pandemic recovery, but also concurrent policy changes whose individual effects cannot be disaggregated from the available data.

Applying the forecast methodology described above results in a total projected ADP of 3,490 by the year 2045. Compared with the 2025 ADP of approximately 3,264, this represents a 6.9% increase over the 20-year horizon (approximately 0.34% per year).

Following the framework in the National Institute of Corrections (NIC) Jail Capacity Planning Guide, a composite multiplier (peaking factor + operational (classification) buffer) is applied to the ADP projections. ADP is, by definition, an average. It describes the typical number of people in custody, not the higher counts that occur on peak days or in peak seasons. Facility capacity planning requires that projected population figures be supplemented by a buffer to account for a share of rated capacity held in reserve to accommodate day-to-day fluctuations and operational constraints that prevent a jail from functioning at its nominal bed count.

At the Executive Committee's direction, a +23% case was adopted as a conservative planning case rather than as a point estimate of expected buffer requirements. When the +23 agreed-upon percentage is applied to the projected ADP, the forecast demand shows a need of 4,313 beds by 2045 (rated capacity).

A critical component of planning for the future is understanding the impact of future population requirements on the medical and mental health populations, which are two of the five core issues addressed in the Consent Decree.

To determine future medical and mental health bed needs, a baseline of need was established based on current ADP numbers for these subpopulations. The calculated percentage that these cohorts represent in relation to the overall jail population count was then applied to the agreed projection of the probable or possible future population of 4,313 beds. Regarding the mental health population, this effort was complicated by the developing definitions of mental health levels of care and the lack of historical data reflecting those changes.

Current capacity needs were based on estimates from ACMH, a population analysis completed by the Planning Team as part of the base projections presented in Workshop 3 and an analysis of waiting lists to remove duplicate entries. In effect, the entire cohort of the mental health population was included in the analysis of current need to project future capacity requirements beyond the limited capacity requirements stipulated by the Consent Decree.

Mental Health Bed Capacity Projections

The Consent Decree established estimated capacity requirements for defined mental health levels of care and stipulated performance requirements for each, with the understanding that these were in fact estimates or ceilings. The Consent Decree is based on providing an appropriate level of care to all inmate-patients identified in need based on their clinical assessment, regardless of estimated capacity requirements. The following special populations were identified, with estimated capacity requirements noted.

Cohort	Consent Decree Estimated Capacity Requirements
Acute Psychiatric Unit (APU)	18 beds[1]
Intensive Outpatient Program (IOP)	85–120 beds, adjusted to 167 beds[2]
Outpatient Psychiatric Program (OPP)	200 beds
General Population – Mental Health Caseload (MH-GP)	No capacity estimate provided; caseload standards only

Subsequent to the Consent Decree, ACMH initiated a program for revised levels of care. Acute Psychiatric Unit (APU) and Intensive Outpatient Program (IOP) continued as levels of care, with the introduction of three levels of the Enhanced Outpatient Program (EOP) identified as EOP 1 Intensive, EOP-2 Moderate, and EOP-3 General Population (GP). As part of the evolution of these levels of care, the Outpatient Psychiatric Program in the Consent Decree became a housing classification, rather than a defined level of care. Because these were new levels of care, historical data on population distribution was unavailable. Thus, the planning team worked with available data and based on a collaborative effort with ACMH, developed the following analysis of current needs based on actual program assignments and a review of the various waiting lists to remove duplicate entries by assigning individuals to the highest level of care noted for the individual.

Cohort	Current Need	Current Capacity
Acute Psychiatric Unit (APU)	ADP 33 beds	41 beds; includes 24 beds under construction 3 East Pod 200 at time of study

[1]Beds designated for short-term mental health confinement for observation & treatment in accordance with the provisions of the Lanterman-Petris-Short (LPS) Act, based on currently available capacity. Adjusted to 17 beds as a former double-bunked cell was converted back to a single cell as appropriate for APU care.
[2] Second Memorandum of Agreement, September 2025.

Cohort	Current Need	Current Capacity
Intensive Outpatient Program (IOP)	ADP 145 beds	167 beds[3] per second MOA
Outpatient Psychiatric Program (OPP)	No longer level of care; housing designation Only	467 beds identified as OPP assumed to be EOP all levels; detailed housing assignment information not readily available
Enhanced Outpatient Level 1	ADP 160 beds	
Enhanced Outpatient Level 2	ADP 390 beds	
Enhanced Outpatient Level 3	ADP 214 beds	

This analysis was used to inform projections of future need based on revised levels of care developed in conjunction with the SMEs. Basically, EOP Level 1 was redefined as EOP and EOP Levels 2&3 were combined into a single category of Mental Health – General Population (MH-GP).

The following table summarizes current and projected need based on the revised levels of care. Note that these numbers are ADP for each cohort and do not include the recommended additional 15% for peaking and day-to-day variations in the ADP.

Cohort	Current Need			Projected Need		
	Total	Single	Double	Total	Single	Double
Acute Psychiatric Unit (APU)	41	41	n/a	42	42	n/a
IOP, includes developmentally disable (DD)	156	104	52	168	110	58
Enhanced Outpatient Program (EOP)	160	54	106	171	59	112
Mental Health Treatment General Population (MH-GP)	604	30	574	645	33	612

[3] Note while the County has met the intent of the terms of the Second Memorandum of Agreement as an interim measure pending the mental health needs assessment by designating 167 beds for IOP housing, the effective capacity is only 136 IOP designated inmate-patients due to limitations on double-celling portions of the population.

In addition, further discussion with ACMH and workshop participants indicated that the following additional cohorts, while not defined as levels of care, should be considered in analyzing special housing needs. These groups are considered part of the acute care cohort for operational efficiency because they require a similarly intense level of service.

Cohort	Current Need	Current Capacity
Gravely Disabled (GD)	ADP 6 bed	6 Beds, ultimately combined with APU beds
Suicide Inmate Temporary Housing Unit (SITHU)	ADP 16 Beds	28 Beds varies with CNAP
Critical Needs Assessment Program (CNAP)	ADP 32 Beds	20-bed capacity, varies with SITHU
Early Access Stabilization Services (EASS)	Contract Limit 10 beds	10 Beds
Jail-Based Competency Treatment (JBCT)	Contract Limit 44 Beds	44 Beds

Also, as part of this exercise, housing parameters were determined for each of these cohorts to inform the assessment of existing conditions.

Level of Care	Cohort	Housing Parameters/Comments
Acute Levels of Care	Acute Psychiatric Unit (APU)	Includes individuals who are gravely disabled when that housing assignment reflects waiting for APU space; single-cell, smaller units, one level, no tiered housing
	Suicide Inmate Temporary Housing Unit (SITHU)	Single-cell, smaller units, one level, no tiered housing
	Critical Needs Assessment Program (CNAP)	Single-cell, smaller units, one level, no tiered housing
	Early Access Stabilization Services (EASS)	Single-cell, smaller units, one level, no tiered housing
	Jail-Based Competency Treatment (JBCT)	Single-cell, smaller units, one level, no tiered housing
Subacute Levels of Care	Intensive Outpatient Program/Developmentally Disabled or Intellectual Disability	66% single cells/34% double cells; one level, no tiered housing; double cells with both bunks on the floor; no stacked bunks

Level of Care	Cohort	Housing Parameters/Comments
Treatment Beds, General Population	Enhanced Outpatient Program (EOP)	34% single cells/66% double cells; may be tiered with stacked bunks in existing housing
	Mental Health Treatment General Population (MH-GP)	5% single cells/95% double cells; may be tiered with stacked bunks in existing housing

It is important to recognize that just as the levels of care were evolving, so too were recommendations regarding the most appropriate treatment environment based on best practices, and experience gained in planning other facilities comparable in mission and purpose. The initial analysis presented at Workshop 4 (February 2026), assumed that 30% of IOP and the EOP 1 population would be housed in subacute housing and the balance in treatment beds in the general population. Generally, the single and double cell distribution followed this distribution (see detailed table in Appendix 3).

Based on the revised levels of care, the assignment of the cohorts and distribution was revised, with 100% of IOP assigned to the subacute cohort, along with the developmentally disabled population, with a distribution of 66% in single cells and 34% in doubles with both bunks on the floor. The revised EOP level of care was defined as treatment beds in the general population, with a distribution of 34% in single cells and 66% in double cells that have stacked bunks, consistent with clinical recommendations.

For the revised MH-GP level of care (formerly EOP Levels 2 & 3), treatment beds in the general population were determined to be appropriate, with a distribution of 5% single and 95% double celling. These ratios are consistent with current needs and best practices. For future flexibility, it was recommended that all single-cell beds for both the EOP and MH-GP categories be collocated with the IOP beds to better accommodate fluctuations in the ADP by treatment cohort.

As illustrated by current bed distribution where the 167 beds provided under MOA #2 are housing 136 inmates based on 60% requiring single-celling and 40% appropriate for double-celling, current housing utilization assignments (as defined for IOP and data gathered from OPP housing assignment data), do not support the current distribution of bed needs. In addition, consideration should be given to removing the second bunk from cells used for special needs individuals because it creates a potential safety risk (i.e., diving off the upper bunk resulting in physical trauma to the individual).

Future capacity needs based on a target year of 2045 for dedicated mental health treatment are projected at 1,295 beds, including:

- A projected 163 beds for acute care and 193 beds for subacute care. In accordance with best practices, these 356 new acute and subacute beds should be planned and designed

specifically to reflect a treatment-oriented environment - single-level, smaller housing units, with a mix of single and double cells.
- An estimated 939 beds in the general population to accommodate the EOP and MH – General Population levels of care in existing housing.

Medical Bed Capacity Projections

Although the Consent Decree addressed a portion of the mental health bed needs with specific capacities, medical needs were addressed primarily based on standard of care and performance metrics, with no specific capacity requirements.

The projected need for medical beds was developed using the same methodology applied to mental health beds. First, data was compiled on current utilization and capacity, which was in turn applied to the base projections of year 2045 ADP to determine medical bed needs in the future.

The following cohorts were identified as the basis for planning medical bed capacity needs for the future:

Cohort	Comments
Infirmary	Inpatient treatment and/or recovery (non-rated beds)
Chronic Medical/Long-Term Care	General population beds, rated capacity
Medically Assisted Treatment (MAT)	Short-term general population beds, rated
Geriatric/Medically Fragile Population	General population beds, rated capacity

Future capacity needs for dedicated medical care are projected at 182 beds. Of these:

- **48 beds are projected for acute medical/infirmary care** including eight negative pressure rooms.
- **55 beds are projected for chronic medical care.**
- **79 beds are projected for the medically assisted treatment (MAT)/detoxification (withdrawal)** program based on most recent experience. (Note: the analysis of the MAT cohort was revised to increase capacity after consultation with stakeholders at Workshop 3.)
- **76 beds are projected for the geriatric** in-custody population.

It should be noted that the 48 beds projected for APU as well as the 48 beds projected for acute medical/infirmary care, including eight negative pressure rooms, are not part of the 4,313 projected rated capacity. Per California Bureau State and Community Corrections Standards and accepted industry practices, these beds are considered temporary assignments and are

not intended to be occupied as permanent housing assignments; hence, they are not considered as part of rated capacity.

Mental Health Services Assessment

Sacramento County's correctional facilities continue to face significant challenges in meeting the behavioral health needs of people in custody. Available reports and stakeholder input indicate a high prevalence of serious mental illness, substance use disorders, and co-occurring conditions among the jail population, creating sustained demand for screening, stabilization, treatment, and reentry planning.

The resource documents reviewed for the Mental Health Report show that Sacramento County has made important policy changes in recent years, including implementation of an EOP, and interim measures to improve confidentiality and observation practices. At the same time, core compliance issues remain unresolved in several areas that are central to this report: physical plant deficiencies, inadequate mental health staffing, and insufficient APU and IOP capacity. This report's findings are consistent with the Mays Consent Decree Mental Health Subject Matter Experts (SME) reports, which emphasize that Sacramento County's compliance challenges reflect the interaction of treatment capacity, staffing, physical plant limitations, and the need for timely access to clinically appropriate levels of care. More recent agreement materials, including the 2025 second MOA, also indicate that current need may be significantly underestimated and that the jail system remains under-resourced relative to the acuity of the population.

The Mental Health Report provides a practical assessment of mental health service delivery in Sacramento County's correctional facilities. It considers current operations and the County's broader planning challenge—aligning clinical services, staffing, housing, and facility design with a population characterized by high acuity, rapid turnover, and significant mental health treatment needs.

Based on data analysis, stakeholder input, and alignment with national best practices, Sacramento County's correctional system requires a comprehensive, multi-tiered mental health service continuum that is appropriately scaled to both the volume and acuity of need.

There is a clear need to expand capacity across the full continuum of mental health and substance use disorder (SUD) care across the criminal legal system with an emphasis on prevention, alternatives to incarceration, and custody-to-community transition; this approach includes jail deflection and diversion initiatives, as well as acute psychiatric stabilization. In addition, there is a need to enhance community-led reentry planning within the jail to ensure access to transition programs, community-based supports and wrap-around services.

Many individuals with behavioral health needs cycle repeatedly through jail, emergency, homelessness, crisis, and community systems without sustained engagement in treatment. The planning and compliance documents reviewed for this report consistently emphasize that jail population reduction, diversion, treatment alternatives, and coordinated reentry are not separate from Mays Consent Decree compliance work; they are essential to it. This includes strengthening pre-release care coordination, improving connections to community treatment

and housing, reducing failures to appear and warrant-driven returns to custody when clinically appropriate, and aligning in-custody treatment with community-based behavioral health pathways.

For those incarcerated, there is a need to provide adequate bed space capacity and improve continuity of care within the jail setting through the provision of intensive treatment and outpatient services. Currently, existing mental health resources do not appear sufficient to meet current demand, as reflected in waitlists, delays in access to levels of care, and continued reliance on crisis-driven interventions. Expanding program capacity, treatment space, and clinically appropriate housing is necessary to align services with both current demand and need.

This assessment is also consistent with the Mays Consent Decree Mental Health Subject Matter Experts' findings that staffing shortages remain one of the primary barriers to timely access, continuity of care, treatment delivery, and sustained compliance. Across interviews, site visits, document review, and operational data, staffing limitations emerged as a recurring factor affecting assessment capacity, program access, waitlist management, release planning, and the delivery of clinically appropriate levels of care. While facility design and treatment space are critical considerations, sufficient mental health staffing remains foundational to effective system performance. For a greater discussion of physical plant and infrastructure-related deficiencies impacting delivery of adequate mental health services to the in-custody population, please refer to Section 6.0 Functional/Operational Assessment of the Phase I/II Report: Functional Assessment and Projected Needs report.

At the point of entry into the correctional system, enhanced intake and early stabilization capacity are essential. Many individuals enter custody with acute behavioral health needs, and most individuals remain in jail for only a short period of time. That creates a narrow window to complete screening, assess risk, initiate treatment, and connect people to the appropriate level of care or community follow-up. The system therefore needs sufficient staffing, treatment space, and workflow support to manage both high-acuity clinical presentations and rapid turnover.

The system requires a fully developed a step-down approach within housing units to support individuals with moderate and serious mental health needs who do not require acute care but need dedicated housing and ongoing services as they transition to general population housing. Operationally, this includes regular clinical contact, group programming, medication management, and case management.

From a design perspective, delivering these services in housing units equipped with program and staff office space where custody and clinician personnel work as an integrated team within the same physical footprint remains an essential consideration. This will improve access to services and reduce operational barriers.

The Mental Health Report identifies these key priority actions:

- Expand mental health capacity across the full continuum, including acute psychiatric care, intensive outpatient treatment, enhanced outpatient services, routine outpatient care, crisis response, and reentry planning
- Strengthen real-time tracking of referrals, waitlists, level-of-care status, service delivery, and release-before-placement outcomes
- Align treatment space, housing design, and staffing with the clinical acuity and functional needs of the jail population
- Build a stronger custody-to-community bridge through earlier release planning, warm handoffs, medication continuity, benefits linkage, housing navigation, and community behavioral health access

Medical Services Assessment

Sacramento County has made meaningful progress in strengthening correctional healthcare services through leadership recruitment, intake process redesign, improved grievance management, expansion of competency review and onboarding programs, enhancement of withdrawal management services, development of provider productivity reporting, and planning for future technology improvements. These efforts reflect significant organizational commitment to improving care quality, enhancing patient safety, and addressing long-standing compliance concerns identified through the Consent Decree monitoring process.

Despite this progress, healthcare operations continue to be affected by several interconnected challenges. Staffing vacancies, recruitment difficulties, provider backlogs, inconsistent clinical workflows, limited productivity and performance data, care coordination barriers, medication administration inefficiencies, specialty care access constraints, and facility limitations collectively affect timely access to care and operational performance. These challenges are particularly important given the growing number of medically fragile, aging, chronically ill, mobility-impaired, and high-utilizer patients who require intensive coordination across multiple clinical disciplines and levels of care.

The medical assessment finds that future success will depend not only upon filling vacancies but also upon continued evolution toward a team-based, data-informed model of correctional healthcare. This model should emphasize coordinated primary care teams, housing-unit-based service delivery where feasible, expanded telehealth capacity, stronger chronic disease management, improved specialty care coordination, integrated behavioral health collaboration, and a robust quality assurance infrastructure capable of demonstrating sustained compliance and measurable performance improvement. As Sacramento County continues to invest in staffing, technology, facility improvements, and treatment capacity, greater emphasis should be placed on performance measurement, proof-of-practice monitoring, and continuous quality improvement to ensure that operational reforms produce measurable improvements in patient care and system outcomes.

Together, these changes should position ACH to move from a primarily reactive model of care delivery toward a more proactive correctional healthcare system that identifies high-risk

patients earlier, manages chronic and complex conditions more consistently, reduces preventable delays, and demonstrates through reliable data that required services are being delivered.

Priority Actions for Continued Improvement

- Stabilize staffing and provider coverage through accelerated recruitment, onboarding, retention initiatives, and development of a team-based care model
- Reduce provider backlogs and improve access to care through workflow redesign, enhanced care coordination, and expanded housing-unit-based and telehealth-enabled services
- Strengthen chronic disease management, specialty care access, and transition planning for medically complex and high-utilizer patients
- Develop a comprehensive data-driven quality assurance and performance management program capable of supporting Consent Decree compliance, proof-of-practice reporting, grievance analysis, clinical auditing, and continuous process improvement
- Improve integration between ACH, ACMH, custody operations, and community providers to promote continuity of care, reduce operational fragmentation, and improve outcomes for individuals with co-occurring medical, mental health, and substance use disorders
- Continue investing in technology modernization, including medication administration tools, electronic health record (EHR) enhancements, referral tracking, and performance reporting capabilities

Operational and Functional Assessment

This section provides assessments of the existing jail facilities and their ability to support the requirements of the Consent Decree. It also provides recommendations and alternative approaches to remediate existing deficiencies and planning tenets for the development of new facilities based on applicable industry standards and best practices.

The SSO operates as a constitutional office and part of the executive branch of government, providing law enforcement, court transport and security, and jail operations. Within the SSO, the Correctional Services Division is responsible for the security management, custody, and safety of the in-custody population, remaining an essential partner in ensuring that people in custody have access to care, programs, and essential services. Reentry programming and rehabilitative services to the in-custody population are provided by the SSO's Reentry Services Unit. These programs are designed to reduce recidivism by preparing individuals for successful community reintegration.

Sacramento County Main Jail

The Sacramento County Main Jail is a Type II maximum-security facility designed in the early 1980s, with construction completed in 1989. When was first built, its original capacity was 1,250 beds, with all cells designed for single occupancy. Later, these single cells were converted to

doubles, and the rated capacity increased to 2,380 beds (current California Board of State and Community Corrections [BSCC]-rated capacity).

Located at 651 I Street in downtown Sacramento, the Main Jail is the primary intake center for the detention system. Most of the bookings performed by law enforcement agencies within Sacramento County occur at the downtown jail. It predominantly houses pretrial individuals of varying custody levels awaiting adjudication, and other individuals transferred from the RCCC because of special needs such as acute and sub-acute medical and mental health needs, suicidal behavior, disciplinary confinement, administrative segregation, etc.

The building consists of two towers of nine floors with a vertical spine between them. Initially designed as remote indirect supervision, it operates with hybrid direct supervision. On the second floor, the jail houses a 17-bed APU, and a 10-bed acute medical unit. The facility also has dedicated single level subacute medical housing units and mental health housing (intensive and enhanced outpatient programs), for individuals diagnosed with serious mental illnesses who cannot be housed in general population given the severity of their symptoms, potential for victimization, and moderate impairment.

Main Jail Challenges

- Construction of the building predates ADA, and the 1982 UBC Code and Title 24 State Building Standards were less prescriptive with regard to accessibility requirements. As a result, the facility does not meet current accessibility requirements—a minimum of 3% of cells; accessible housing, program, and support components; and accessible routes of travel.
- As documented in the Facilities Condition Assessment, the jail has significant deferred maintenance needs, with over 60% of materials and systems beyond their useful life, falling into the "aged but functional" category. Without significant investment in the next three years the total facility will be considered in poor condition.
- Bed space capacity misalignment: The rated capacity of the Main Jail is 2,380 beds. Utilizing point in time data, as of 10.02.2025, the Main Jail housed 1,727 individuals. Despite the vacancy rate, the MJ could never safely operate using all available beds:
    - The need to safely and appropriately keep separate and house individuals with diverse classification levels and complex criminal history, medical and mental health needs, reduces significantly the jail's actual usable capacity.
    - Matching individuals to the right type of beds consumes space, with proper separation of population by gender, risk and need categories being particularly challenging in the large housing pods.
    - The existing housing units, with 64- and 80-bed capacities, fail to address the complexity of today's separation requirements and classification categories based on gender, risk, and needs:

        - It is difficult to find people of the same classification level who can be housed together.
        - In addition, the two-tier configuration of the housing pods significantly impacts where someone can be safely housed. For example, on the 6th East floor, used for detoxification/MAT purposes, only the 16 cells located at the bottom of each of three pods can be used (and used as single cells), rendering a total of 48 double-occupancy cells (or a total of 96 beds) on the upper tier unusable. This is also the case regarding the housing of individuals with acute mental health needs, for whom bunk-beds and two-story housing configurations are inappropriate.
        - These factors all lead to bed space inefficiencies and potential overcrowding in certain housing areas (above 90%), even with some available beds throughout the facility.

- Shifts in the inmate population profile have severely taxed facility resources, resulting in significant operational challenges and impacting on daily access to necessary programs and services:
    - The high prevalence of mental health and co-occurring disorders among the jail population (approximately two out of every three people) is not only a significant driver of the need for services, but it also affects the need for specialized, purpose-built mental health housing.
    - No accessible cells showers or seating are provided on any typical housing pod; individuals requiring medical accommodation are housed in pods 200 and 300 with accessibility accommodations but not code compliant.
    - With approximately one-third of the population requiring specialized housing, there are too few specialized beds and purpose-built housing accommodations to safely satisfy the needs of a population requiring intensive clinical support.
        - Some general population housing units are used for the housing of specialized groups and programs—IOP, OPP/EOP, SITHU, CNAP, GD, developmentally/intellectually disabled, and detox (withdrawal). These large-format units lack the dedicated confidential treatment and programming spaces, and small-scale therapeutic environment needed to support specialized and individualized clinical needs.
        - All of these factors present significant barriers to effective housing, treatment, and safety.
        - Additionally, the two-tier design of the pods and double-bunk cell configuration significantly impacts where someone can be safely housed.

- Increases in demand for additional programs and enhanced services to address the risk and needs of the population have also exacerbated space needs, particularly in relation to the lack of programming, counseling, and treatment rooms:
    - Available program space is limited to one multipurpose room per housing floor (servicing up to 288 individuals). These rooms are poorly ventilated and too small for the delivery of group therapy.
    - Because of the lack of private rooms, non-contact visitation and professional booths must be used for one-on-one counseling. These rooms are located on the mezzanine level, which is inaccessible for individuals with physical disabilities.
    - Interview rooms for individual therapy (plexiglass cubicles with open ceilings) added as temporary response to the Consent Decree are noncompliant with HIPAA privacy requirements and result in "fishbowl" effect for those receiving treatment.
- The increased jail population has necessitated more custody staff and healthcare personnel and outside providers of care and services, while the existing facility lacks the office space and support components to support these additional employees. As a result, portions of the support staff are located in off-site locations, which hinders efficiency and can lead to service delays. This arrangement directly affects working conditions and results in inefficiencies and delays in providing services.
    - Mental health personnel are scattered throughout the facility. Recently, ACMH staff were relocated to the "G Street" office building two blocks from the MJ.
    - On-site conference rooms and workspaces are limited.
    - Staff office spaces are inadequate, shared by multiple personnel, and provide limited privacy for confidential conversations. Additionally, they do not represent a professional atmosphere focused on care.
    - Limited respite space is provided for personnel, which is an evidence-based best practice to support better care.
    - Staff support facilities (lockers, storage, etc.) are poor to non-existent.
- While the County has continually made efforts to update them, detention and electronic security systems are beyond their life cycle. Parts are difficult to locate for locks, toilets and other specialties. The backbone of the computer-driven operating system for electronic security components is outdated and no longer supported. The last major upgrade of electronic security systems was completed by a company that closed its California office and is based in Canada, and service is provided by a local technician who works with the supplier via cell phone during repairs.

- Elevator capacity: Number and speed affects staff operational efficiency and efficacy as well as the timely delivery of programs and services, and elevators regularly suffer service breakdowns.

Rio Cosumnes Correctional Center

The RCCC is a Type II medium-security facility originally constructed as an Air Force base, which was transferred to the County in 1947 for use as county jail-farm, and converted to a jail around 1960. RCCC has a BSCC-rated capacity of 1,625 beds.

The facility serves as the County's branch jail facility. It houses overflow pretrial detainees to comply with the population cap in the MJ, as well as sentenced individuals by the Sacramento County Courts of all custody classifications. RCCC also houses inmates "enroute" to other jurisdictions, federal inmates under contract with the U. S. Bureau of Prisons, and reciprocal inmates from other counties.

RCCC follows a campus-like configuration and is divided into three separate compounds for high-security male, low-security male, and female detainees. The female side of the compound is known as the Sandra Larsen Facility (SLF), built in 1973. This facility is entirely self-contained and has no interaction with the male side. A variety of trailers and modular buildings have been added over time to meet increasing program demands, with today's infrastructure involving more than 20 permanent and temporary buildings of various vintages and uses.

RCCC Main Issues:

- The campus is located adjacent to flood plains with only one available route in and out that becomes impassable during flood events. The Planning Team has been authorized to complete a preliminary hydrology study to understand the impacts of the flood plain on current development and possible future expansion.
- RCCC originally housed a low-security, county-sentenced population. The facility now houses a primarily higher security, pretrial population.
- The overall campus has grown organically and lacks a clear organizational parti.
- Numerous buildings at RCCC will reach physical obsolescence over the next 3–10 years.
- Many buildings also have functional deficiencies, including lack of necessary support space, accessibility, and Prison Rape Elimination Act (PREA) compliance.
- Clinical treatment and office support spaces are limited in all areas. The only specialized treatment space provided is dialysis, located in Building M. The Pharmacy is housed in an adapted space (in the welding vocational tech building), is overcrowded, and is not in proximity to other medical services.
- The facility operates on treated well water with on-site storage. The closest municipal supply is more than 1.5 miles away.

Preliminary options for partial remediation of currently identified physical deficiencies in the existing facilities (captured as remediation recommendations) are provided as interim actions

to further compliance with the provisions of the Consent Decree. In addressing current deficiencies impacting operations, programs and the delivery of care, this report incorporates a discussion of the best practices for modern detention systems from across the industry to reflect the ways in which Sacramento County would like to operate its jail system safely and effectively as reflected in the desired jail system of the future.

Based on current operations, the operational assessment also included a preliminary assessment of staffing for its impact on access to services and service delivery, as well as the impact of transportation activity on operations. The major findings from the analysis can be summarized as follows:

- Operating two correctional facilities creates duplication of services (e.g., kitchen operations, laundry services, maintenance and supplies, medical and mental health staff, etc.). This also creates additional maintenance costs associated with duplicative systems and equipment.
- Inefficient facility design/layout also wastes money. The outdated physical plant and layout configuration of the facilities also affect staffing levels and service delivery. Extra officers are required to maintain a safe line of sight in the housing units at the Main Jail and at the RCCC dormitory-style units, and to manage movement throughout the facilities. Compared with more contemporary jail designs, the county jail system requires more staff for basic operations in supervision, security, and movement, particularly at the Main Jail. A newly designed and constructed facility could result in reduced operational and staffing costs, if modern design principles and best practices are incorporated into the new design. A single facility could reduce staffing operations and maintenance costs for systems and equipment deployed. A new correctional facility would create an effective staffing model to better serve the jail population.
- Overall, although the current staffing plans for custody staff are reported as being generally sufficient to meet the minimum staffing numbers, staffing levels are impacted by several factors and changes that have occurred over time. These are working against staffing efficiency, making staffing requirements more complex and extensive, particularly at the Main Jail:
    - Changes in the profile and needs of the jail population (more complex histories of trauma and abuse, more violence, more gangs, increase in substance use, mental health problems and co-occurring disorders) resulting in the proliferation of different levels of care and security classification subcategories as well as the expansion of specialized housing units.
    - Requirements to keep different people in custody strictly apart for safety and security reasons (e.g., by security level, gang affiliation, protective custody, etc.), requiring increased security staffing on high-security floors.

    - Changes in program needs, enhancement of services and extended range of services provided necessitating additional staffing positions. The challenge is for SSO to ensure that sufficient custody staff are present in specialized housing units as well as to support access to programs and extended service hours and days to facilitate confidential contacts.

- Although some improvements in equipment and technology have proven helpful and, in some instances, have reduced staffing pressures, a modern jail design would allow for seamless integration of new and pending security-related technologies to help improve operational and staffing efficiencies, such as Radio-Frequency Identification (RFID) bracelets, tablets controlling cell ingress/egress, etc.
- Unscheduled medical runs (i.e., the process of transporting people in custody to a local hospital or medical provider for medical treatment) is the single biggest strain on staffing. These medical runs remove officers (10 to 12 on average) from their primary duties and drive up overtime costs. Send outs typically require two to three deputies per run/hospitalized person, with the number and frequency resulting in reduced shift staffing and modified operations.
- Over the past decade, the SSO has had approximately 100 vacancies driven by high-rate attrition, retirements, and difficulty in recruiting. Although SSO is committed to continuing to address the challenge of filling vacant positions, an overarching issue is the impact of the work environment on retention and recruitment. Staff should be provided with a professional work environment. Notoriously at the Main Jail, there is insufficient space to adequately accommodate the staffing growth that has occurred over time with the expansion/implementation of new programs and the addition of the new medical escort team. To reduce staff turnover and bolster recruitment and retention, space should be devised such that personnel are provided with adequate office space and support facilities (employee cafeteria, resource center, lactation and quiet rooms, external entrance to employee gym for off-hours workout, etc.). These amenities are in poor condition or lacking in the current facilities.

Finally, as the IHSF was identified as the baseline for future alternative approaches, an assessment of the viability of the proposal is provided in light of the update projection of future need for medical and mental health treatment beds as well as changes in the proposed levels of care developed concurrent with the assessment of existing conditions. The findings from this assessment can be summarized as follows:

- The IHSF Proposal is not a systemic solution to the conditions of the Consent Decree.
- Planned capacity under IHSF falls short of projected capacity needs, with the total need for treatment beds being more than double the planned capacity under IHSF.

- The proposed supervision model, with a secure control room provided for every two housing units, results in staff-intensive ratios and is challenging to accomplish based on current and projected staffing requirements.
- Similarly, as envisioned, the staffing plan for ACH personnel appears to be staff intensive.
- Multiple concerns have been expressed regarding the proposed vertical and horizontal connections between the Main Jail and the new Annex. For example, there are limited horizontal connections between the two buildings, exacerbating the current delays in vertical movement in the Main Jail. This configuration also increases response time between the two facilities in case of an emergency.
- The recommendation to replace the kitchen on-site should be evaluated further versus remodeling the existing kitchen or constructing a cook-chill facility and converting the existing kitchen to a retherm kitchen.
- Additionally, there is no solution for accessible access to courtrooms or accessible holding and attorney/client visiting facilities.

Facility Conditions and Accessibility Assessment

As recommended by the peer review performed by CGL Companies, Phase I/II assessment of existing conditions included a detailed Facility Condition Assessment of existing conditions, similar in scope to what DGS is in the process of completing for non-carceral county facilities.

This assessment examines every piece of equipment based on condition and life cycle and provides a roadmap for capital improvement planning and budgeting for facility maintenance. Common observations include:

- Most facility assets were at or near the end of expected useful life.
- The assets and systems were kept operational through the diligence and resourcefulness of the Facility's Management Team.
- Given the age of the equipment and systems, a significant and excessive number of repairs had to be undertaken on an emergency basis, exacerbating the maintenance staffing and repair cost beyond typical industry standards for correctional facilities.

In addition to the detailed assessment, the evaluation also included a separate evaluation of detention specialties and electronic security systems and technology upgrades comparable to contemporary detention facilities.

Budgeting was adjusted to reflect project costs based on a conceptual approach to phasing required system upgrades in an occupied, operational detention facility, so that costs could be understood in terms of project costs. The analysis assumed that multiple phases would be required, limiting swing space needs to 300–400 beds, which may be possible as long as the population remains constant, but would require contract beds if the population experiences significant growth. A preliminary review of adjacent jurisdictions indicated a shortfall in

available capacity, and it is doubtful that an organization would in fact contract with Sacramento County to house in-custody individuals given that it would then be subject to the conditions of the Consent Decree as well.

This analysis assumed that all potential work would be completed to bring the facility to a state of good repair since portions of the existing facility would be vacated during each phase, which provides the best opportunity to correct all deficiencies. The reports note that without major investment both facilities will be considered as in overall "poor" condition by 2029, with over half of their materials and systems beyond their life cycle and considered in "aged but functional" condition (i.e., operating but subject to major breakdown at any time).

As used in this study, "state of good repair" means:

- An asset or facility is functioning as intended
- Structurally sound
- Meets safety code requirements
- Does not require immediate major repairs or a replacement, defined as Immediate Needs in the FCA Report
- Deficiencies impacting safety, security, and efficient operations will be addressed even if such would be considered enhancements

Maintaining a state of good repair ensures safety, reliability, and cost-effectiveness. For this planning study and comparison of approaches (reuse to new construction), it is assumed that all deficiencies and deferred maintenance will be completed to provide comparability to "new" construction and allow an apples-to-apples comparison of alternative approaches for informed decision-making. Moreover, since any new construction will have to be compliant with the County's Climate Action Plan, budgeting for renovations carries a percentage increase to convert to comparable electric or clean energy equipment, however given the limitations of the FCA, infrastructure costs to support the conversion may be greater than the allowance.

In addition, it is assumed that since working in an operating facility to do repairs carries a higher overhead burden than if the County is vacating areas for major functional renovations, logic would suggest that it is beneficial to repair major systems while the facility or a portion of the facility is vacant.

Finally, a separate detailed evaluation of accessibility was also completed as this is a specific area of compliance in the Consent Decree.

TODAY IS NOT YESTERDAY

Since the completion of the Main Jail in 1982 and the evolution of the Rio Cosumnes Correctional Center over the period from 1959 through 1999, the role of county detention centers has undergone a transition. The population housed has changed significantly, from a high percentage of detainees held for a short time for court appearance or short-term sentencing to housing a pretrial population with more serious offenses and significant medical,

mental health and substance use-related issues. Facilities of this vintage were not designed to serve this population. Their primary purpose was simply to detain people in a secure environment.

Today, as the medical and mental health needs of the population have been evidenced by this higher level of acuity, the demand for specialized treatment has increased exponentially, resulting in significant growth in treatment staff and demands for individual and group space for providing these services that was never anticipated in the original design. Hence, the Mays litigation, Consent Decree, and subsequent MOAs cite the need to correct physical deficiencies that are contributing to the inability to deliver adequate medical or mental health care that respond to the needs of the in-custody population from assessment at intake to placement in an appropriate treatment program. In total, this is a complex challenge, with the ultimate resolution of the Mays litigation being a combination of staffing, operations, and treatment modalities—all impacted by the physical environment provided to support better outcomes for all.

This report documents as-is conditions as a basis for planning for the future, both in terms of facility needs and, equally important, staffing and the timely and consistent delivery of medical and mental health services with an emphasis on best practices related to providing an appropriate patient- and treatment-centered environment.