Sacramento County Correctional Facility Master Planning Services

Phase I/II Report: Functional Assessment and Projected Needs

Section 3 - Current & Future Population Trends and Projected Capacity Requirements

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INTRODUCTION

This section summarizes the population analysis of Sacramento County's jail system, undertaken as part of the Comprehensive Correctional Facility Master Plan Study with the goal of identifying short-term and long-term capacity requirements and the capability of the existing jail facilities to accommodate these needs. For details regarding the population analysis, see **Appendix 3**.

The population analysis is a data-driven study of the Sacramento County justice system's needs over the next 10 to 20 years. This analysis is based on historical trends and accounts for the potential impact of pending legislation and policy changes. It is foundational to the planning process, informing current and future capacity requirements and the development and evaluation of facility approaches in Phase I/II of this project to meet future needs.

BACKGROUND

The operating environment of any correctional system is collectively shaped by the interplay of socioeconomic and demographic shifts, documented crime trends, and the impact of major legislative and criminal justice reforms. This section provides relevant background on each of these factors as context for Sacramento County's population analysis and capacity projections that follow.

County Demographics and Population Trends

Sacramento County is California's eighth most populous county, with approximately 1.6 million residents in 2024–2025.[1] As per the Sacramento Area Council of Governments (SACOG), the six-county Sacramento region will add approximately 600,000 residents and 278,000 housing units between 2020 and 2050.[2]

According to the U. S. Bureau's American Community Survey 2020–2024 Five-Year Estimates, Sacramento County's population is approximately 40.6% non-Hispanic White, 24.2% Hispanic or Latino (any race), 17.6% non-Hispanic Asian, 9% non-Hispanic Black or African American, and 6.7% non-Hispanic multiracial.[3]

The County's age structure is close to the California average. The median age is 38.1 years, essentially matching California's statewide median of 38.4.[4] Approximately 22.4% of the county's residents are younger than 18 years old, and about 16% are ages 65 or older, consistent with the respective statewide shares of 21.4% and 16.6%. The population between

[1] U.S. Census Bureau QuickFacts: Sacramento County, California. census.gov/quickfacts/fact/table/sacramentocountycalifornia/INC110224.

[2] Sacramento Area Council of Governments (SACOG), 2025 Blueprint Metropolitan Transportation Plan/Sustainable Communities Strategy, adopted November 20, 2025.

[3] U.S. Census Bureau, American Community Survey 2020–2024 Five-Year Estimates, Tables DP05/B03002; Census race categories use the "alone" classification; "alone or in combination" figures would be higher for each group. The "some other race" category (11.2% of total) is inflated because many Hispanic/Latino respondents select it rather than a single standard race. The ACS 2020–2024 five-year estimates should be interpreted with caution due to COVID-19-related disruptions to the 2020 data collection, per Census Bureau guidance.

[4] U.S. Census Bureau "Age and Sex," American Community Survey 5-Year Estimates (2020- 2024), Table DP05 (Demographic and Housing Estimates).

these two groups - the working-age population of which the jail system draws most of its bookings - constitutes roughly 62% of the county's residents.

The County's age composition is projected to meaningfully shift over the forecast horizon. The California Department of Aging's 2025 Profile of Older Adults for Sacramento County projects that the share of residents ages 60 and older will rise from 22% in 2025 to 26% by 2040, with a corresponding contraction in the younger than 60 share.[5] Because incarceration is concentrated among younger adults, this shift toward an older age structure exerts downward demographic pressure on the jail population over the forecast horizon, holding age-specific rates constant.

Sacramento County's median household income is approximately $92,000–$94,000 (ACS 2020–2024 five-year and single-year estimates, respectively), compared with a statewide median of approximately $100,149.[6] Per capita income is $44,225, below the statewide average of $49,934. The county's poverty rate is 12%, essentially equivalent to California's rate of 11.8%.

Reported Crime Trends

The crime statistics in this section are drawn from the California Department of Justice's annual Crime in California report, which compiles violent and property offenses reported to local law enforcement agencies statewide. These reported offenses serve as the principal official indicators of crime in Sacramento County and across the state.

Violent Crime

The Public Policy Institute of California's (PPIC) analysis of California Department of Justice data indicates that between 2019 and 2022, Sacramento County experienced a 16% increase in violent crime and a 43% increase in aggravated assaults - one of four large California counties with double-digit violent crime increases during that period. As of 2024, the county's violent crime rate remained approximately 27% above its pre-pandemic (Q4 2019) baseline.[7] That rate, 521.2 per 100,000 population, was approximately 8.5% above the California statewide rate of 480.3. The county's 2024 total of 8,255 violent crimes represents a 2.5% year-over-year decline from 2023.[8]

Aggravated assault is the dominant violent crime category, consistently accounting for 55–65% of all violent crimes in the County. Robbery declined in both absolute numbers and rate over the 2011–2024 period, consistent with the statewide trend. In the City of Sacramento, homicide data show a spike to 54 incidents in 2022 before declining to 41 in 2023 and 45 in 2024.[9]

[5] California Department of Aging, '2025 Profile of Older Adults: Sacramento County.'
[6] U.S. Census Bureau, American Community Survey 2024 One-Year Estimates, via Census Reporter.
[7] Public Policy Institute of California, "Crime Trends in California," updated 2024–2025, authors' calculations based on CA DOJ CJSC data.
[8] California Department of Justice, 'Crime in California 2024.' Available at: dataopenjustice.doj.ca.gov/sites/default/files/2025-07/Crime%20In%20CA%202024%20final.pdf
[9] City-Data.com crime statistics, derived from FBI UCR/NIBRS submissions (accessed July 2026). Note: the City of Sacramento covers approximately one-third of the countywide population.

Property Crime

Property crime has followed a downward trajectory overall, with substantial volatility during and after the COVID-19 period. Countywide reported property crimes fell from a peak of 48,501 in 2012, to 36,588 by 2017.[10] The trajectory between 2018 and 2023 was shaped primarily by pandemic-era dynamics: California's property crime rate reached a six-decade low in 2020 as mobility and commercial activity contracted, then rose back toward pre-pandemic levels in 2021 and 2022. PPIC's analysis indicates Sacramento County's 2024 property crime rate was 19% lower than pre-pandemic (2019) levels, broadly mirroring the statewide trend.

Motor vehicle theft stands out as a notable exception to the property crime decline. Within the City of Sacramento, the auto theft rate surged to 702.8 per 100,000 in 2023 before declining to 512.3 in 2024.[11] Statewide, the 2024 motor vehicle theft rate of 424.6 per 100,000 remains 20.6% above 2019 despite a 15.2% decline from the 2023 peak.

Taken together, these trends present a mixed picture rather than a single direction. Property-related crime has declined markedly since its early-2010s peak, though motor vehicle theft remains well above pre-pandemic levels, while violent crime, despite a modest decline from 2023 to 2024, remains elevated relative to its pre-pandemic baseline.

It should be noted that these trends describe the operating environment. The relationship between reported crime and custody population is mediated by charging, sentencing, length of stay, and policy decisions made across multiple agencies.

Policy Reforms and Jail Population Trends

Sacramento County's jail population has moved through several distinct phases over the past two decades. The average daily population (ADP) rose through the mid-2000s to a peak of 4,768 in October 2008, then declined while remaining near or above 4,000 through the early 2010s (see **Figure 1**).

Statewide Policy Reforms

Since 2011, several major statewide legislative and ballot-initiative reforms have reshaped the legal landscape within which Sacramento County's jail population trends have developed. The following programs and initiatives are presented as a matter of stated intent and jurisdictional authority rather than demonstrated population effect. The recency of most reforms limits the ability of the current data to confirm measurable ADP reductions.

- **AB 109, Public Safety Realignment (2011).** Effective October 1, 2011, AB 109 transferred incarceration and supervision of individuals charged with "non-serious, nonviolent, non-sexual" (N3) felonies from state prison and parole to county jails and probation. In Sacramento County, realignment bookings averaged 554 per

[10] California Department of Justice, Crime in California annual reports, 2012–2020 series. data-openjustice.doj.ca.gov (accessed July 2026).
[11] City-Data.com crime statistics, derived from FBI UCR/NIBRS submissions (accessed September 2026).

month in 2012, declining to 240 per month by 2021.[12] The realigned population held in county jail (those sentenced to local custody for the N3 felonies described above, state parolees, and detainees under Post-Release Community Supervision) also declined as a share of the jail's ADP, from 8.3% (248 of 2,991) in 2020 to 5.1% in 2021.

- **Proposition 47 (2014).** Passed in November 2014, Prop 47 reclassified certain drug possession and property offenses (theft under $950) from felonies to misdemeanors. PPIC estimated that the reform contributed to an approximately 9% decline in the statewide jail population in the year following passage and a 50% decline in the number of individuals serving sentences for Prop 47-eligible offenses.[13] In Sacramento County, the jail population fell sharply to 2,418 in May 2020 amid COVID-19 emergency releases and booking restrictions, then partially recovered to 3,112 by December 2025, remaining below both its 2008 peak and its long-standing average of 3,743.
- **Proposition 57 (2016).** Prop 57 made individuals convicted of nonviolent felonies eligible for parole consideration after serving the full sentence for their primary offense and expanded the California Department of Corrections and Rehabilitation's (CDCR) authority to award good-behavior and rehabilitative credits. Unlike AB 109 and Prop 47, it primarily focused on the state prison population rather than county jails. Its effect on the Sacramento County jail population is likely indirect (for example, through changes in the community parole population, and subsequent parole-violation returns) and has not been isolated in published research.
- **Proposition 36 (2024).** Effective December 18, 2024, Prop 36 partially reverses Prop 47. It allows certain theft and drug offenses that Prop 47 had reduced to misdemeanors to be charged as felonies for repeat offenders and creates a treatment-mandated felony pathway for drug possession. A defendant with two or more prior drug convictions may be charged with a felony, and if they do not complete treatment may be sentenced to up to three years in prison. Statewide, the jail population has increased by approximately 2,700 (roughly 5%) since the measure took effect.[14] CDCR's Spring 2025 projections anticipated that Prop 36 prison admissions would stabilize by early 2026, with an average length of stay of approximately 11 months.[15] Its Fall 2025 projections then revised that estimate

[12]Magnus Lofstrom and Brandon Martin, "Public Safety Realignment: Impacts So Far," Public Policy Institute of California, September 2015; Lofstrom and Raphael, "Realignment, Incarceration, and Crime Trends in California," PPIC, 2015.
[13] Sonya Tafoya, Mia Bird, Ryken Grattet, and Viet Nguyen, "How Has Proposition 47 Affected California's Jail Population?" Public Policy Institute of California, March 2016.
[14]Lofstrom and Martin, "Early Implementation of Prop 36 Varies Widely across Counties," PPIC Blog, 2025; PPIC, "California's County Jails" Fact Sheet, data through June 2025; CDCR Spring 2025 Population Projections.
[15] California Department of Corrections and Rehabilitation, Office of Research. *Spring 2025 Population Projections*. May 2025. https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2025/05/Spring-2025-Population-Projections_May_2025_revised-1.pdf

downward, citing slower than expected admission rates attributable to local implementation challenges, fewer Prop 36-eligible offenses than initially assumed, and shorter lengths of stay for some offenses.[16] Because Prop 36 took effect only in December 2024, its longer-term effects cannot yet be assessed: PPIC's 2025 review noted that no causal crime-impact analysis has been published.

Local Initiatives

In parallel with the statewide reforms described above, Sacramento County has adopted a series of local initiatives intended to manage the size and composition of its jail population. The program-level metrics and progress reporting for these efforts are maintained in the County's semi-annual Jail Population Reduction Plan (JPRP) status reports and are not reproduced here. In instances in which an initiative's authority rests outside the County Board of Supervisors, that distinction is noted.

- **Probation Pretrial Monitoring (2019).** Since October 2019, the Probation Department has operated a dedicated Pretrial Unit that provides release monitoring for individuals granted pretrial release.[17] Because release decisions (including bail, own recognizance release, and conditions of release) remain under the authority of the Superior Court, the program's reach depends on judicial release practices.
- **The Jail Population Reduction Plans (JPRP) (2022).** In December 2022, the Sacramento County Board of Supervisors adopted the JPRP, a set of measures developed pursuant to the 2022 Memorandum of Agreement connected to the Mays Consent Decree. An April 2024 revision consolidated the original 33 efforts into six strategies addressing bookings, length of stay, and returns to custody. The JPRP is the framework under which most of the County initiatives below are organized and measured.
- **Community Wellness Response Team (2023).** The Community Wellness Response Team (CWRT) program, which began operating in March 2023, dispatches mental health professionals who can respond to behavioral health crises in the community as an alternative to a law enforcement response and jail booking. Because CWRT is oriented toward pre-arrest deflection, any effect on the average ADP would operate through booking volume rather than directly through length of stay.
- **Local Implementation of Proposition 36 (2024).** In Sacramento County, the Prop 36-related caseload has been weighted toward theft rather than drug offenses, consistent with PPIC's finding that fewer than 20% of the County's Prop 36 cases are

[16] California Department of Corrections and Rehabilitation, Office of Research. *Fall 2025 Population Projections*. January 2026. https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2026/01/Fall-2025-Population-Projections.pdf

[17] Sacramento County Office of the County Executive, Jail Population Reduction Plans Status Report (July–December 2025), draft dated March 20, 2026 (provided by Sacramento County).

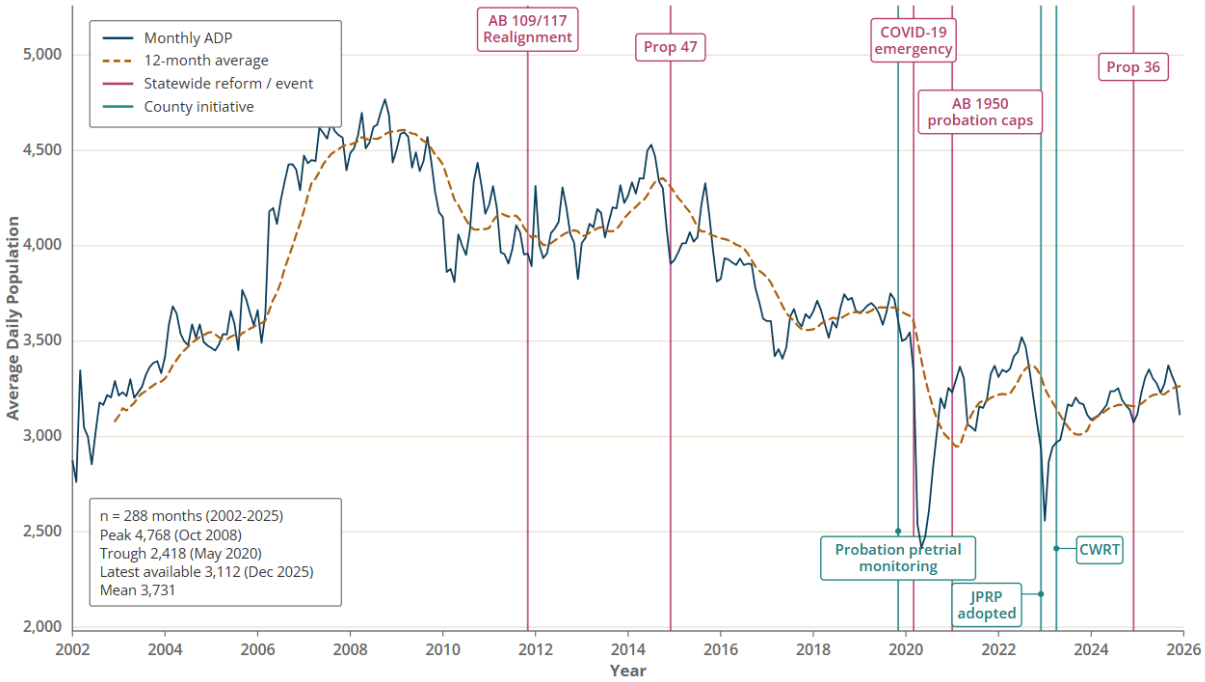
drug-related.[18] This pattern has been partly attributed to elevated retail theft in the area. To date, Prop 36 has had only modest effects on the number of people being booked in the County's jail system. The County's behavioral health leadership has expressed concerns that local treatment capacity may be insufficient to absorb the individuals mandated into treatment under the measure.[19] Despite its modest impact on bookings, a further consideration is that the population entering under Prop 36 may present higher risk of mental health and substance use disorder comorbidities, which could raise in-custody care needs. The data available for this report does not allow that effect to be quantified.

- **Mental Health Diversion (ongoing).** The County has continued to expand felony mental health diversion (MHD) under Penal Code section 1001.36, which allows eligible defendants to be diverted into treatment in lieu of prosecution. As a court-administered process, MHD depends on judicial determinations, although the County's behavioral health system supplies the treatment capacity on which it relies.
- **Reentry Opportunities and Access to Resources (2025).** Funded by an $8 million Prop 47 grant, the Reentry Opportunities and Access to Resources (ROAR) program provides reentry and care-coordination services for justice-involved individuals with behavioral health needs. Because it launched July 1, 2025, its effect on the jail population cannot yet be assessed.
- **New Criminal Courthouse (2026).** The Superior Court's anticipated transition to the new Tani Cantil-Sakauye Courthouse, and the associated elimination of night court, represent court-driven operational changes that may affect arraignment timeliness and release processing. As with other court functions, these changes fall outside the County's direct operational control, and because they postdate the period covered by this report's data, their effect on the jail population cannot yet be observed.

[18] Magnus Lofstrom and Brandon Martin, "Early Implementation of Prop 36 Varies Widely across Counties," Public Policy Institute of California, April 23, 2025. https://www.ppic.org/blog/early-implementation-of-prop-36-varies-widely-across-counties/

[19] CalMatters, "California ballot measure promises 'mass treatment' for drug crimes. Can counties provide it?" October 16, 2024. https://calmatters.org/justice/2024/10/prop-36-mass-treatment/

Figure 1. Sacramento County Jail Average Daily Population, 2002–2025 (Monthly ADP and 12-Month Average, with Statewide Reforms and County Initiatives)



Note. *Early 2023 population dip due to flood-related evacuation at Rio Cosumnes Correctional Center (RCCC).*
Reforms and initiatives shown are illustrative, not exhaustive, and are not necessarily causally linked to observed population trends.

The demographic profile, crime trajectory, institutional structure, and sequence of statewide reforms and county initiatives described above collectively shape the operating context of the Sacramento County jail system. The analyses that follow examine how these contextual forces express themselves in the jail population itself: how individuals move through custody, which charge categories concentrate at which length of stay, how return patterns vary by supervision type and jurisdictional authority, and how each of these dynamics maps onto the institutional levers described herein.

Structural Factors Impacting Admissions to Jail and Length of Stay

Jail is only one component of the overall criminal legal system. Variables such as *who is arrested, charged and detained, for what reason, and for how long,* are the result of decisions made by multiple interfacing agencies along the criminal justice continuum. Accordingly, the population analyses required an understanding of which institutional actors exercise operational authority over specific population segments and decision points, as well as how those decisions affect the demand for jail beds.

Law Enforcement

Sacramento County has 12 law enforcement agencies with active arrest authority. Because each agency maintains independent discretion over policing and enforcement practices, their specific use of cite and release, deflection and other pre-booking alternatives directly contributes to bookings and jail admissions.

County District Attorney's Office

The Sacramento County District Attorney's Office is responsible for filing criminal charges and prosecuting cases; the Sacramento County Public Defender's Office and Conflict Criminal Defenders provide court-appointed representation for defendants unable to afford private counsel. Charging decisions issued by the District Attorney, and the availability and pace of defense representation, shape case processing timelines and, by extension, pretrial length of stay.

Sacramento Superior Court

The Sacramento Superior Court is the California trial court of general jurisdiction for the County and controls the legal decisions that shape pretrial custody and sentencing decisions, including arraignment scheduling, bail determinations, own recognizance release, conditional release orders, and the pace of case processing through disposition. The Court also imposes sentences, including the choice between custody and probation and, for felonies served locally under Penal Code 1170(h), the length and structure of the jail term.

County Sheriff's Office

The Sacramento County Sheriff's Office through the Correctional Services Division is responsible for the operations, secure management and custody of the in-custody population housed at the Main Jail and the Rio Cosumnes Correctional Center (RCCC).

County Probation Department

The Sacramento County Probation Department administers supervision of adults placed on probation by the Superior Court. The Department also supervises the Post-Release Community Supervision (PRCS) and mandatory supervision populations established under California's 2011 Public Safety Realignment (AB 109). Since 2019, Probation has operated a dedicated Pretrial Unit that provides release monitoring for individuals granted pretrial release. Probation initiates bookings for probation and PRCS violations subject to court review but does not control parole-related bookings.

California Department of Corrections and Rehabilitation

Finally, the CDCR, through its division of Adult Parole Operations, administers state parole supervision. Parole holds and revocation decisions, including the decision to return a parolee to county jail custody and the duration of the hold pending revocation adjudication by the Board of Parole Hearings, are made by CDCR and the Board, not the County. The County houses state

parolees in its jail pursuant to Penal Code 3056 but does not control their admission or length of stay.[20]

The distribution of authority is as follows:

- The District Attorney and Public Defender Offices are responsible for prosecution and defense.
- The Superior Court manages pretrial release and case processing.
- The Sheriff's Office operates the Main Jail and RCCC.
- Probation supervises individuals on community supervision and PRCS populations.
- CDCR oversees state parole populations.
- Federal and state agencies have responsibility for contract populations who occupy dedicated beds under fixed agreements.

As a result, various population segments and distinct forms of length of stay pressure respond to different institutional levers. The analyses that follow, along with the projection methodology, reference this structure. They distinguish between population dynamics the County can directly affect and those shaped by actors outside the County's operational authority.

Mental Health Levels of Care

Acute Psychiatric Unit

The Acute Psychiatric Unit (APU) provides the highest level of mental health care in the Sacramento County jail system. It is intended for individuals experiencing acute psychiatric instability that can only be managed safely or effectively in less restrictive settings. Patients typically present with severe psychiatric symptoms, significant functional impairment, or conditions that require intensive intervention, close observation, and frequent multidisciplinary treatment, and the unit provides enhanced psychiatric services, intensive nursing support, and structured treatment programming.

Suicidal Inmate Temporary Housing Unit

The Suicidal Inmate Temporary Housing Unit (SITHU) provides specialized housing to individuals who require observation, safety monitoring, and rapid clinical reassessment. According to Adult Correctional Mental Health (ACMH), it is not a separately staffed treatment program like APU, Intensive Outpatient Program (IOP), or Enhanced Outpatient Program (EOP). Instead, mental health care is provided by staff assigned to other levels of care, including Critical Needs Assessment Program (CNAP), outpatient services, and IOP when clinically indicated. Even as a housing designation, SITHU creates significant clinical and operational workload, requiring urgent assessment, frequent monitoring, crisis intervention, coordination with custody staff, and timely movement to other levels of care as symptoms stabilize or worsen.

[20] Cal. Penal Code §§ 3056, 3000.08.

Jail-Based Competency Treatment

Jail-Based Competency Treatment (JBCT) serves individuals who have been found incompetent to stand trial through a judicial process and who require competency restoration services. It provides structured psychiatric treatment, psychoeducation, skill development, and competency restoration interventions intended to help participants regain the ability to understand legal proceedings and assist in their defense. Although many participants have significant behavioral health needs, placement is determined by legal status rather than psychiatric need alone.

Early Access and Stabilization Services

Early Access and Stabilization Services (EASS) operates in conjunction with JBCT, providing early stabilization and treatment support for individuals newly determined to be incompetent to stand trial. Placement is tied to legal status and early restoration-related service needs rather than psychiatric acuity alone. It is intended to begin stabilization, treatment engagement, psychiatric support, and competency-related interventions earlier in the custody episode, reducing delays while individuals await further restoration placement or transition to JBCT.

Critical Needs Assessment Program

CNAP is a high-priority assessment and stabilization area for individuals whose mental health presentation requires closer monitoring and shorter-term intervention than routine outpatient care can provide. It serves patients with recent crisis indicators, acute behavioral health symptoms, or uncertain level of care needs, using rapid assessment and coordinated follow-up to determine whether a patient can be safely managed through outpatient services or requires referral to a higher level of care such as the APU, IOP, or EOP.

Intensive Outpatient Program

The IOP serves individuals with serious mental illness who require a highly structured treatment environment but not inpatient psychiatric care. Patients generally require frequent intervention, multidisciplinary treatment planning, regular psychiatrist involvement, group therapy, and structured out-of-cell therapeutic programming to support stabilization and recovery. As an intermediate level of care between the APU and lower intensity settings, IOP is intended to reduce mental health decompensation while promoting functional improvement.

Enhanced Outpatient Program

The EOP, organized as levels 1 through 3 at the time of the survey and now EOP and Mental Health–General Population (MH–GP), serves individuals with serious mental illness who require more intensive treatment and monitoring than routine outpatient services but whose symptoms are sufficiently stable to be managed outside an intensive treatment unit. Patients often require ongoing psychiatric treatment, regular clinical monitoring, multidisciplinary case review, structured group programming, and coordinated treatment planning to prevent deterioration and promote continued stabilization. EOP serves both as a step-down for patients

transitioning from higher-acuity settings and as a step up for those with symptoms that exceed what routine outpatient services can manage.

Outpatient Mental Health Services

Outpatient Mental Health Services are the least intensive level of mental health treatment in the jail and are intended for individuals with behavioral health needs that can be managed through routine clinical intervention, such as psychiatric medication management, brief therapeutic interventions, crisis follow-up, referral services, monitoring, or periodic reassessment, without the intensive structure of EOP, IOP, or APU placement. Outpatient services serve the largest portion of Sacramento County's mental health caseload, providing timely access to care while supporting symptom stabilization and treatment engagement. Patients may be moved to higher levels of care when symptoms worsen or to lower intensity monitoring when their condition improves.

Housing for People with Intellectual and Developmental Disorders (I/DD) and Cognitive or Adaptive Functioning Needs

Developmentally disabled (DD) housing refers to specialized housing for individuals with developmental disabilities or significant cognitive or adaptive functioning needs who require additional structure, monitoring, support, and accommodations. These individuals may not require a higher psychiatric level of care solely because of their developmental disability, but they may need modified communication, predictable routines, assistance understanding rules and expectations, enhanced clinical monitoring, and coordination among mental health, medical, custody, and disability-accommodation staff.

Like SITHU, DD is not a separately staffed treatment program; rather, care is provided by staff assigned to other levels of care, including CNAP, outpatient services, and IOP when clinically indicated. DD housing provides a safer, more supportive environment that reduces vulnerability, promotes access to services, and ensures that treatment, programming, and custody practices are adapted to the individual's functional needs.

Continuum

Together, these levels of care form a mental health continuum designed to match treatment intensity with patient need, with the APU providing the highest level of psychiatric intervention, followed by IOP, EOP, and outpatient services. Patients move between levels based on clinical need, the intent being that each individual receives the least restrictive level of care capable of meeting their needs, with timely assessment when symptoms worsen and step-down opportunities when stability improves. The effectiveness of this continuum depends on adequate treatment capacity, sufficient staffing, confidential treatment space, multidisciplinary coordination, and timely access to the appropriate level of care.

UNDERSTANDING THE JAIL POPULATION AND DRIVERS OF BED SPACE DEMAND

The population projections presented in this report depend on an understanding the jail population's composition—who enters custody, how long they stay, and why they return. This section summarizes three analyses conducted for this study:

- Pretrial population dynamics
- Short-term releases and service delivery timing, including an analysis of individuals found incompetent to stand trial (IST)
- Supervision violation custody

Each is presented in full, with methods and limitations, in **Appendix 3**. The analysis draws different extracts of the County's records; therefore, each states its own observation window (the time period that analysis covers), a consequence of differing data availability across source systems. All three should be read with the qualifications described in the Data Availability and Limitations section.

Data Availability and Limitations

The analyses presented in this section rest on a foundational assumption that the records transferred from the County accurately represent the bookings, custody movements, and service episodes they document. These records are drawn from the systems the County uses to run its jail facilities and mental health services—separate systems built for day-to-day operations rather than to conduct research. Linking a custody stay to its associated court case or treatment record required careful matching across multiple data sources. If a record could not be linked with confidence, it was removed from the analyses rather than assigned by assumption.

Reasonable measures were taken to ensure that only valid and complete records were carried into the analysis: anomalous values were reviewed manually, improbable outliers were examined and, where appropriate, removed, and ambiguous patterns were resolved in consultation with jail staff. These corrections were made to improve the fidelity of the analytical dataset to the events it represents.

Notwithstanding these measures, the findings that follow should be interpreted with due caution. This review can assess internal consistency and address identifiable anomalies, but it cannot independently verify the completeness and accuracy of the full body of source data, which originates in operational systems maintained by the County. Limitations of this kind are common to analyses using operational justice system data and are not unique to Sacramento County; rather, they reflect how the underlying systems were built. The conclusions presented in this section, therefore, reflect the best available interpretation of the data as received rather than statements of certainty about the underlying events.

Pretrial Population Dynamics

This analysis examined 35,709 pretrial bookings recorded between January 1, 2024, and July 21, 2025, to describe how long pretrial individuals stay, the charges against them, and how often they return (full analysis: Appendix 3, Pretrial Population Dynamics).

Findings

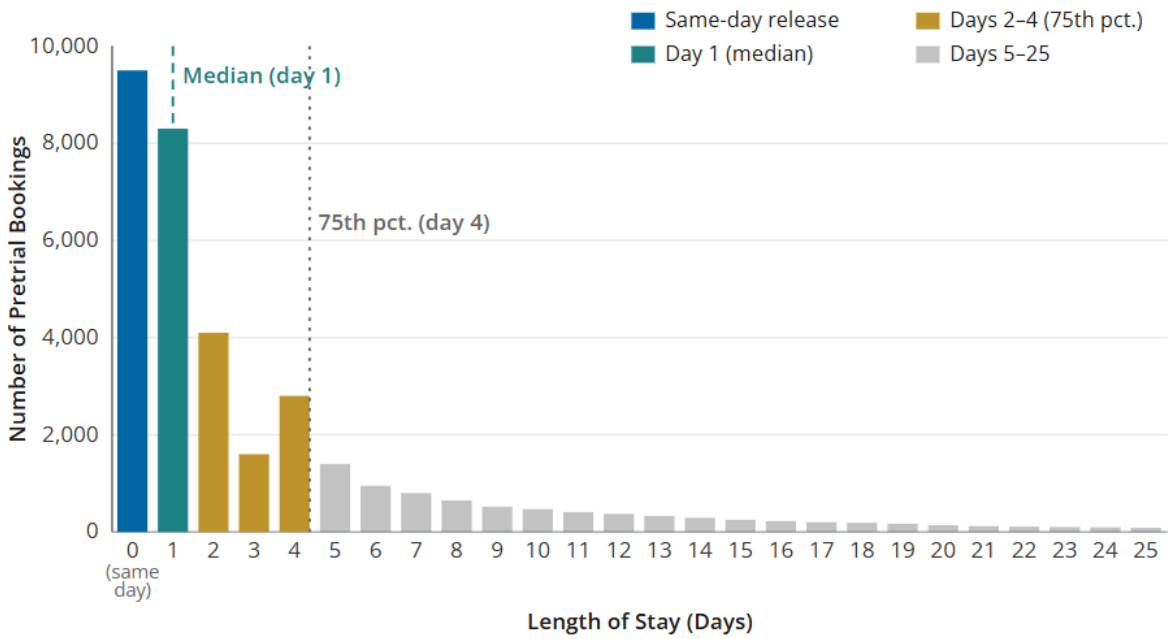
Most Jail Admissions Result In Short Stays

Nearly one-third of people booked pretrial (31.6%) are released on the same day (a recorded stay of 0 days), half are released within one day, and three quarters within four days. Only 9.8% of pretrial bookings remain in custody for 21 days or more (**Figure 2**). These figures describe the flow of people through the jail, including who is booked and how quickly they leave. They do not describe who occupies the jail on a given day, which is a separate measure and gives a different picture.

For example, a single person held for two months occupies as much jail space as 60 people booked and released within a day. Because short stays turn over quickly, they account for a large share of total bookings but only a small share of beds occupied at any time. The standing population in the jail (everyone in custody on a given day) is dominated by the smaller group of people with longer stays. Approximately 92% of the ADP is held on felony charges,[21] and the County reports a felony average length of stay of 58 days in 2025[22]—a duration governed primarily by court case processing timelines rather than jail policy.

[21] Sacramento County monthly population census reports, January–December 2025 (average daily population: 3,264 total; 2,994 felony; 269 misdemeanor).
[22] Sacramento County Office of the County Executive, Jail Population Reduction Plans Status Report (July–December 2025), draft dated March 20, 2026 (provided by Sacramento County).

Figure 2. Distribution of Pretrial Bookings by Length of Stay (January 2024–July 2025)



Note. Days 0–25 shown; tail extends to 554 days (99th percentile = 170 days). Sentenced individuals excluded.

Charge Type and Length of Stay Are Closely Linked

Among bookings with custody lengths of 5–20 days, the largest charge category was supervision violations (bookings in which the primary recorded charge was a violation of parole, probation, or other community conditions rather than a new offense). For bookings associated with long stays (21 or more days), the most common types of charges were for acts related to property damage, supervision restrictions, and violence.

Returns to Custody Are Common

Of the 24,786 unique individuals in the pretrial dataset, 53% had more than one booking during the observation window, with a median of 91 days between release and the next booking.[23] Supervision violations had the highest rate of returning to custody for any reason (52.0%), but the rate drops to 19.9% when looking only at returns for new criminal offenses. Most supervision-related returns (62%) were revocations or administrative holds rather than new crimes. Limitations, including the observation window and the primary charge classification method, are detailed in **Appendix 3**.

The County reports several initiatives relevant to these return patterns:

- A dedicated pretrial services unit operated by the Probation Department since October 2019

[23] This figure reflects all re-bookings observed during the 18.5-month window. Because individuals released late in the window had less time in which return could be observed, the figure is not directly comparable to standard recidivism measures.

- Expanded behavioral health services and MHD
- The ROAR reentry program, established through an $8 million Prop 47 grant awarded in October 2024, in which 486 individuals enrolled from July through December 2025[24]
- Revised probation supervision practices

These are County-reported developments, and their effects on return to custody patterns are not yet observable in the data analyzed here.

Short-Term Releases, Service Delivery Timing, and Disproportionate Capacity Drivers

This analysis examines how the timing of releases and of in-custody services interacts with bed demand. It draws on three sets of County-provided records: booking and release records from January 2022 to July 21, 2025; mental health program and waitlist records; and custody and movement records for bookings linked to an IST determination from January 2022 through July 21, 2025 (see **Appendix 3**).

Findings

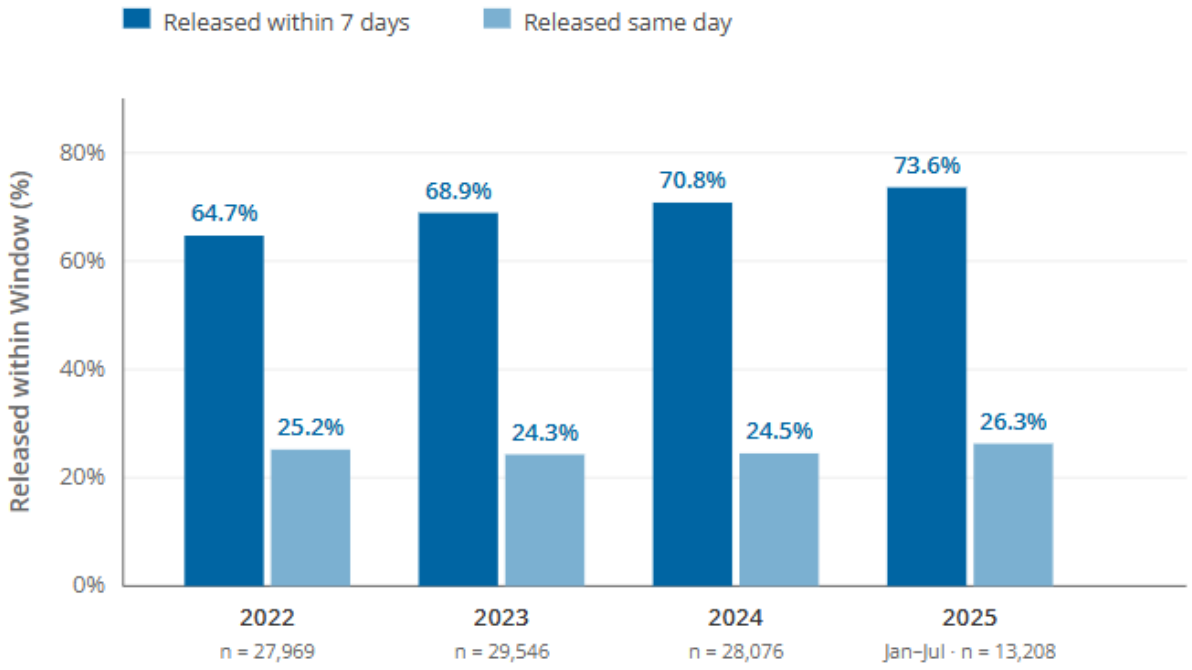
Short-Term Release Trends

The pretrial statistics in the section above describe the study period as a whole. A different pattern emerges when viewing month by month. The jail is processing people more quickly, but the population is getting no smaller. Between January 2022 and July 2025, the share of all bookings[25] released within seven days rose from 64.7% to 73.6%, yet ADP remained relatively stable.

[24] California Board of State and Community Corrections, ROAR Program Local Evaluation Plan, June 2025. bscc.ca.gov/wp-content/uploads/2025/06/Local-Evaluation-Plan-Sacramento-County.pdf (accessed July 2026). Enrollment figure per the JPRP status report, corrected to 486 per the ROAR team

[25] i.e., not just limited to pretrial bookings

Figure 3. Share of Bookings Released within Seven Days and on the Same Day, by Year (2022– July 21, 2025)



This finding is consistent with the pattern described above: because short-stay individuals occupy a bed only briefly, moving them through faster changes how many people pass through the jail without necessarily changing how many beds are filled on a given day. The same logic runs in the other direction: reducing short-stay bookings further could lower the number of individuals processed through the jail but would not substantially reduce the average number of beds occupied. It could, however, meaningfully relieve intake, holding, and health screening capacity, including the medical and mental health screening attached to every booking, which the constant flow of bookings and releases keeps in continuous use.

Separately, some individuals arrive at the jail in acute medical or mental health crisis; admission acceptance criteria are a clinical and policy determination that the data provided do not allow this report to evaluate, and this area may warrant further analysis by the County, which reported that changes to policy and practice for these arrivals are in process.

Mental Health Specialized Beds and Population Flow

This pattern of fast processing has direct consequences for mental health programming delivered inside the jail. Between June 2024 and June 2025, 1,054 individuals were placed on a mental health program waitlist; 793 of them (75.2%) were released with no recorded entry into any mental health programming.[26] Timing appears to be a central driver. Getting from the waitlist into a specialized mental health bed and completing programming takes longer at every

[26] The program records examine capture enrollment in specialized programs and their corresponding waitlists, not all mental health contacts in custody.

level of care than the length of custody for 75% of the jail population. Most waitlisted individuals are released from custody before a recorded placement can occur.

Waitlist counts therefore are best interpreted as a measure of identified need, and program placements as a measure of programming usage, and the two should not be read interchangeably. In-custody services primarily reach the small subset of people who stay in jail long enough to receive them. The handling of waitlist records, including their known limitations as a demand measure, is described in **Appendix 3**.

Incompetent to Stand Trial Determinations

At the opposite end of the length-of-stay distribution, individuals found IST are a small population with a disproportionate claim on bed capacity. Based on County-provided data for January 2022 through July 21, 2025, 366 bookings were linked to an IST determination, representing 0.3% of the 106,466 total bookings during this period. Yet these bookings had a median of 279 jail bed days per custody episode, compared with a median of three days for all other bookings.[27]

People who have had an IST determination enroll in or wait for specialized mental health programs at rates far higher than other bookings (**Figure 4**). A custody episode is a person's full period in custody from booking to final release; the 279-day figure counts only the time spent physically in county jail within it. Where movement records showed time at a state hospital or other outside facility, that time was subtracted (the unadjusted episode median was 374 days), making the figure deliberately conservative for jail capacity purposes.

Phases of the custody episode are reported separately, as medians for each disposition pathway (the route a case takes); for example, restoration in jail versus commitment to a state hospital. Because these are separate medians, they do not sum to the totals reported. A median of 108 to 128 days elapses between booking and any treatment placement, depending on pathway.

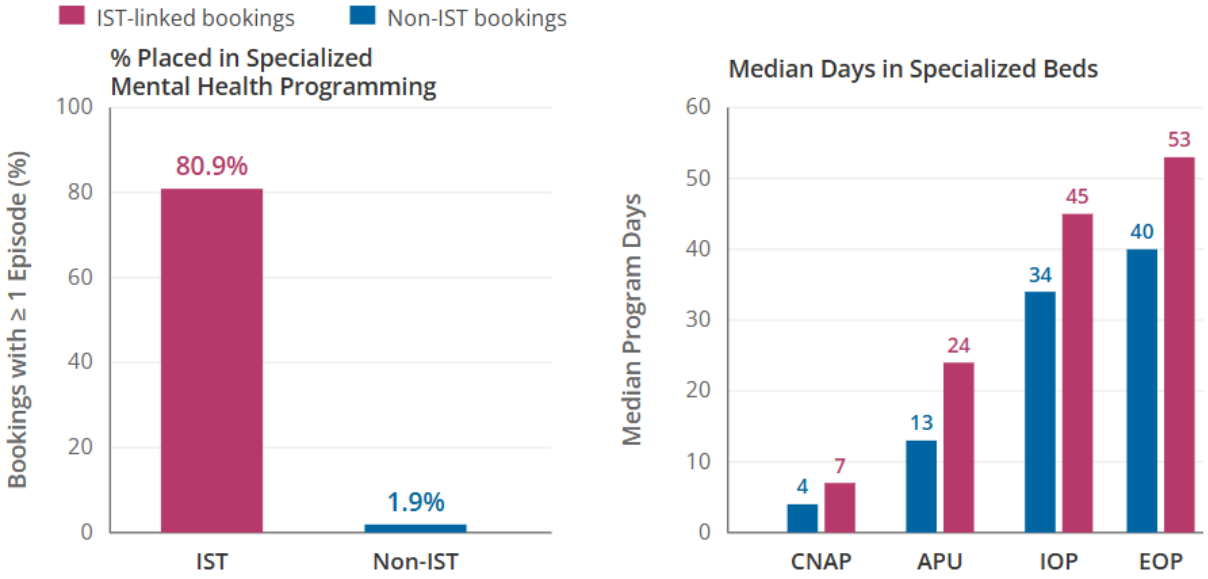
For individuals committed to the Department of State Hospitals (DSH), the wait for a treatment bed is a median of 107 days, and the DSH stay itself is a median of 161 days. Nearly half of those who were committed returned to county jail afterward, adding a median of 58 more days in custody (**Figure 5**). Even individuals who had their competency restored without any state hospital placement had a median custody episode of 223 days.

Restoration-related treatment happens in separate blocks of time rather than continuously across a person's detention, and stakeholders and the record in Mays v. County of Sacramento document concerns about clinical decompensation (a deterioration in mental health) among individuals awaiting and following restoration. The County's JPRP status reports document ongoing IST management efforts, including performance under the IST Growth Cap established

[27] This figure and the ~6-month figure reported in the 2022 O'Connell study measure different intervals: O'Connell's measures booking to case disposition, while the figure reported here covers the full custody episode from booking to release, including post-disposition restoration and case processing. The two are complementary rather than conflicting. O'Connell's Figure 25 (approximately 56% of IST individuals in custody 200 or more days) is consistent with the episode lengths reported here.

by DSH;[28] despite these efforts, IST-linked bookings remain a disproportionate consumer of jail capacity.

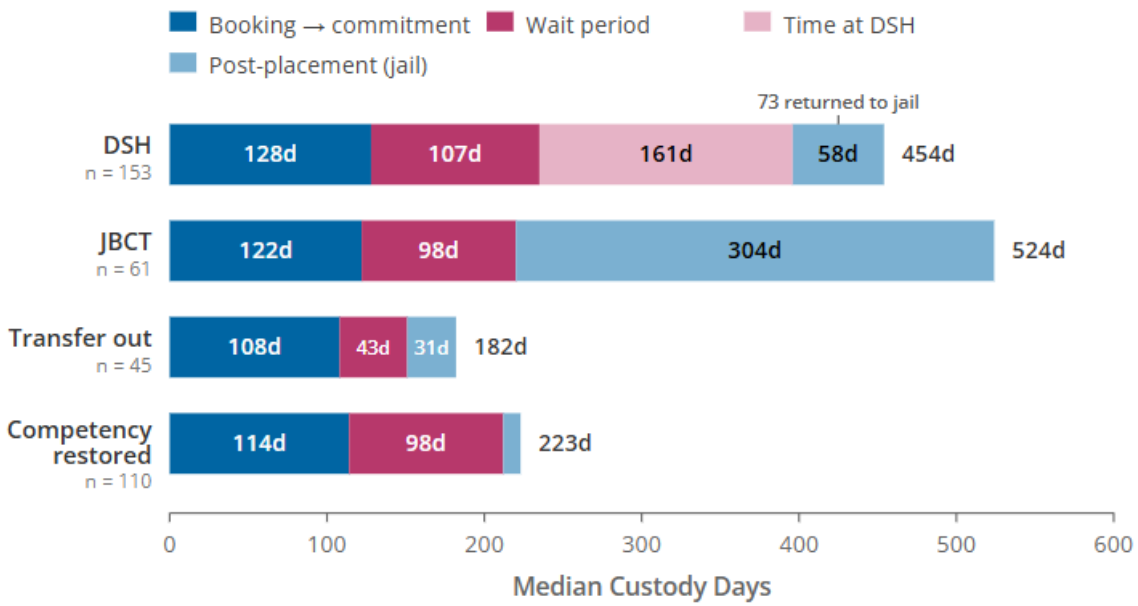
Figure 4. Specialized Mental Health Programming, Utilization and Length of Stay by IST Status (January 2022–July 2025)



Note. *Figures are derived from caseload data for four specialized mental health programs: CNAP, APU, IOP, and EOP. The 1.9% rate among non-IST bookings reflects the share of those bookings appearing in these records. It should not be read to mean that the remaining individuals on non-IST bookings received no mental health care. Individuals may have been seen or evaluated through other channels without being enrolled in these programs, and such contacts would not appear in the data underlying these charts.*

[28] Sacramento County Office of the County Executive, Jail Population Reduction Plans Status Report (July–December 2025), draft dated March 20, 2026 (provided by Sacramento County)

Figure 3. Outcomes and Median Days per Phase for IST-Linked Bookings (January 2022–July 2025)



Note: Bars show median days per phase of the custody episode: each IST determination was linked to exactly one booking, and all phase boundaries (commitment, placement, movement, release dates) were verified to fall within that episode. Medians are computed for each phase across bookings; stacked bar lengths represent the sum of phase medians and are illustrative. As medians are not additive, they differ slightly from the median total episode length reported in text.

Supervision Violations and Returns to Custody: Disaggregating State and County Supervision

Supervision violations (bookings in which someone is held for violating the terms of their parole or probation, rather than for a new crime) proved to be central to two of the problems described above. They were the single largest reason for stays in the 5–20-day range and had the highest overall rate of return to custody. That finding prompted a closer look at what is driving this category: specifically, how much it is steered by state authorities, such as state parole, or by County-run supervision programs like probation.

Bookings from January 1, 2022, through June 30, 2025, were classified into five categories based on which Penal Code statute was recorded as the primary charge, such as State parole holds (PC 3056), PRCS flash incarcerations (PC 3455), PRCS revocations (PC 3454), traditional probation violations (PC 1203.2), and drug-condition violations (PC 1203.35). Bookings in which a new offense was the primary charge are counted under the new offense, so these figures conservatively represent custody driven by the supervision process itself (full analysis: Appendix 3, Supervision Violations and Returns to Custody).

Findings

Booking Volumes and Bed Space Impact

Approximately 5,650 supervision violation bookings occurred from 2022 through mid-2025, dominated by PRCS flash incarcerations and state parole holds. These two categories affect jail capacity in different ways. Flash incarcerations are designed to impose brief custody (a median of 6 days), while state parole holds are far longer (median 14 days, with a quarter exceeding 45). Translated into beds, supervision violations account for an estimated 89 beds of the County's ADP.[29]

State parole holds are the single largest contributor, at roughly 46 beds, because each hold lasts much longer than the other categories. The remaining categories, all under County control, together account for 43 beds, most of which (33), are flash incarcerations. Even though flash incarceration is brief by design, there are enough of them that the category still accounts for a meaningful share of jail capacity.

Parole Hold Duration

The median completed parole hold stay rose from 6.5 days in 2022 to between 18 and 28 days in 2023 through mid-2025, while monthly parole booking volumes remained stable (32–72 per month), indicating that the growth in this population reflects longer, not more, holds. The timing coincides with the February 2023 expiration of California's COVID-19 state of emergency and the return to standard revocation processing. A one-day snapshot count at the close of the data period (July 21, 2025) found 159 individuals held on supervision violation statutes—79 of whom were state parole holds that the County cannot release.

The practical implication is that the persistent share of supervision violation bed demand (the part not made up of brief stays) is controlled largely by state processes (parole hold duration and revocation timelines) rather than by County policy, a distinction directly relevant to evaluating population reduction goals that are scoped to populations the County controls. Caveats about how bookings were classified, including sparse pre-2023 probation violation counts, are detailed in **Appendix 3**.

Summary of Analyses

Taken together, these analyses indicate a jail population split into two distinct groups. A high-volume, short-stay majority churns through booking and release, consuming intake and screening capacity but few beds, and cycles through too quickly to receive in-custody services. A smaller longer-stay population, comprising felony-charged individuals, IST-linked individuals, and state parole holds, occupies most beds, and the timelines that govern its length of stay (court case processing, DSH placement, parole revocation) are substantially outside County control.

[29] These bed figures are flow-based estimates intended to show the relative magnitude of each category, not counts from a facility census.

The County's average daily population has stayed within a narrow range in recent years (monthly ADP between 3,074 to 3,373 in 2024–2025). That stability does not mean these forces are absent but instead suggests they are offsetting one another. Rising turnover and expanded pretrial release are pulling the population down, while lengthening timelines for the longer-stay populations (felony case processing, IST placement and restoration, and state parole holds) are pushing it up. The projections presented below should therefore be read with this structure in mind: projected totals reflect the balance of these underlying components rather than the behavior of a single, uniform population.

Population Management Implications

The three analyses point to different levers for different populations as well as to different degrees of County control over each:

- **For same-day and short-stay bookings**, the available levers reduce processing volume without substantially reducing beds. Expanded citation practices, pre-arrest deflection, and behavioral health crisis response would relieve the intake, holding, and screening workload described above without substantially lowering the average number of beds occupied. The County reports sustained efforts along these lines, including engagement with law enforcement agencies on citation policies and expansion of crisis response through the CWRT program, the County's mobile crisis response program.[30] Citation and arrest decisions in the field, however, are made by law enforcement agencies, many of which operate independently of the County Board of Supervisors, and further reductions depend on their voluntary adoption of expanded citation policies, an effort the County reports having pursued for an extended period.
- **For the longer-stay population**, which accounts for a disproportionate share of bed days, reducing ADP depends on bail determinations, pretrial service availability, and case processing timelines. These levers rest substantially with the Sacramento Superior Court and with prosecution and defense counsel rather than with the County alone. The County reports that a pre-arraignment magistrate review process, operational since December 2023, is expected to complete reviews within 18 hours of booking and that the share of releases on own recognizance (release on a promise to appear, without bail), to pretrial monitoring, or on bond rose from 27% in 2023 to 43% in 2025. As of December 2, 2025, the County reported that 80.5% of pretrial monitoring participants had not incurred a new arrest.[31] Court-driven operational changes, including the elimination of night court and the transition to the new Tani Cantil-Sakauye Courthouse may affect arraignment timeliness and release processing but are likewise outside the County's direct

[30] Sacramento County Office of the County Executive, Jail Population Reduction Plans Status Report (July–December 2025), draft dated March 20, 2026 (provided by Sacramento County).
[31] Ibid.

operational control. Reinstating night or extended-hours court and expanding the use of virtual hearings are noted as actions for consideration by the County and the court.

- **For individuals found incompetent to stand trial**, key components of the custody episode are governed by state resources and court procedures. The DSH waitlist (median 107 days, nearly a quarter of the total custody episode for those committed to DSH) reflects DSH capacity and prioritization decisions, and the booking-to-placement phase adds a median of 108–128 days. The JBCT pathway allows detainees to avoid the DSH waitlist, shows even longer total custody episodes in the data—a pattern that may partly reflect how program boundaries are recorded rather than treatment duration alone.[32] The County's JPRP documents active management within its available levers, including three consecutive years without incurring penalties under the DSH-established IST Growth Cap, collaborative stakeholder workgroups, and programs such as JBCT, MHD, and EASS. The County also reports preliminary data suggesting a decline in returns among recent IST cohorts and a reduction of individuals under Murphy conservatorship held in jail to zero in recent months.[33] Even so, the IST-linked bookings consumed bed days far out of proportion to their number, and the factors that most extend their stays sit beyond County authority.
- **For returns to custody**, the recency of most County initiatives limits what the current data can show. The County reports substantial growth in felony MHD decisions (from 169 in 2022 to 1,392 in 2025) alongside the reentry and crisis response investments described earlier, and that the Probation Department has set a measurement goal of reducing bookings for technical violations low-risk individuals by 5% from a 2023 baseline.[34] The County's authority here extends only to the probation population. Parole violations and revocations are determined by the CDCR. State parole bookings showed no downward trend over the study period (monthly volumes of roughly 32 to 72, averaging about 50 per month from 2022 through 2024), and further reduction of supervision violation bed demand would require engaging CDCR on parole hold practices, which lies outside the scope of the County's JPRP.

[32] Time in JBCT was not provided as discrete program records. Entry into JBCT is inferred from movement dates and notes identifying JBCT. No program exit date is recorded in the data provided, so the duration shown runs from JBCT placement to release from custody and may include custody time following participation. This figure therefore reflects custody time attributed to the JBCT phase of the custody episode, not clinically confirmed treatment duration and is not directly comparable to the program's design goal of restoration of transfer within approximately 90 days. See Appendix 3 for the method.

[33] Sacramento County Office of the County Executive, Jail Population Reduction Plans Status Report (July–December 2025), draft dated March 20, 2026 (provided by Sacramento County).

[34] Ibid.

Implications for County Data Systems

The analyses in this section depended on linking custody, clinical, programmatic, and case processing records that the County, like most jurisdictions, maintains in separate systems built for daily operations rather than for analysis. Where those systems did not connect cleanly, information had to be inferred rather than measured directly, and information entered into them generally cannot be corrected retroactively at scale. The practical implication is forward-looking: the County's ability to monitor its own reduction strategies, answer the questions raised in this report, and support future planning cycles would be strengthened less by any new dataset than by more consistent recording practices and routine data quality checks across the systems it already operates.

POPULATION PROJECTIONS AND FUTURE CAPACITY REQUIREMENTS

These projections are the quantitative foundation for facility planning decisions that will commit public resources over decades, and no single forecasting method works across that span. In the near term, jail's own recent history is the best guide: month-to-month momentum and seasonal patterns are most informative. Over 20 years, those signals fade and the County's changing demographics become the dominant driver. Statistical forecasting tools, such as time-series models, are accurate over short horizons, but their uncertainty compounds quickly as the horizon extends; [35] demographic models are less precise in the near term but structurally sound over long ones.

Approach and Methodology

The projection framework here uses a two-stage design (full specification can be found in **Appendix 3**). The near term is forecast with a seasonal time-series model (SARIMAX) fitted to the County's monthly ADP history. The long-term applies age-specific incarceration rates (derived from the County's own booking data) to the California Department of Finance's projections of Sacramento County's population by single year of age. The long-term projection is anchored to the near-term forecast, producing one continuous trajectory through 2045, the 20-year horizon set by the Jail System Planning/Compliance Oversight Committee.

The near-term model forecasts the total jail population, including all segments housed in the facility, because that specification performed best when tested against data held back from the model. And, per Executive Board direction, the 100 federal and 44 state contract beds are held constant throughout the projection, with growth adjustments applied only to the non-contract population.

The age-specific approach was implemented because of who has been driving the County's growth. Sacramento County's projected population growth is concentrated disproportionately among residents ages 50 and older, whose incarceration rates (below 1.5 per 1,000 residents) are a fraction of the peak-booking group (aged 25–34; approximately 5.4-5.8 per 1,000). The 50 and older share of jail population is projected to rise from 15.4% in 2025 to 17.3% by 2040. Scaling the jail population up in step with total county growth would overstate future need; projecting each age group at its own rate captures this dampening effect automatically.

Data Sources and Period Covered

The projection models draw on two primary data sources. The near-term model is trained on the jail's monthly ADP from January 2022 through December 2025 (48 months). This window was chosen because it reflects the jail as it now operates, after the post-pandemic recovery trajectory and the stabilization of jail operations under current booking and release practices.[36]

[35] In diagnostic testing for this project, the uncertainty band around a forecast from the time-series model alone widened to roughly 98% of the projected value by the third forecast year, which is why that model is not relied on beyond the near term.
[36] The training window was itself a tested choice, not an assumption. Candidate models trained on both shorter and longer historical windows were evaluated against the same 12-month holdout.

The long-term projection is anchored to county-level population projections published by the California Department of Finance, which provide the structural basis for the 2045 horizon.

AB 1950, which capped most felony probation terms at two years and reduced the pool of probationers subject to violation-based booking,[37] took effect before the window begins. Its effect on the jail population is therefore built into the model's baseline, rather than measured separately, and the same is true of other policy changes from that period. The baseline reflects pandemic recovery and the concurrent policy shifts together and the available data do not allow their individual effects to be separated.

Model Selection and Validation

The final specification was selected through an iterative process where candidate specifications and models were evaluated against 12-month out-of-sample holdout periods. Several alternative specifications were tested, including frameworks that forecast subpopulations separately, models trained on shorter and longer historical windows, and models that incorporate various external variables, such as crime rates and booking volumes. To test the near-term model, the most recent 12 months of data were withheld, each model predicted those months unseen, and its predictions were compared with what actually occurred. The selected model's monthly estimate differed from the actual population by an average of 2.74%, about 84 people against a population of roughly 3,040. This measure—the mean absolute percentage error (MAPE)—describes how closely the model tracks the population over the coming year.

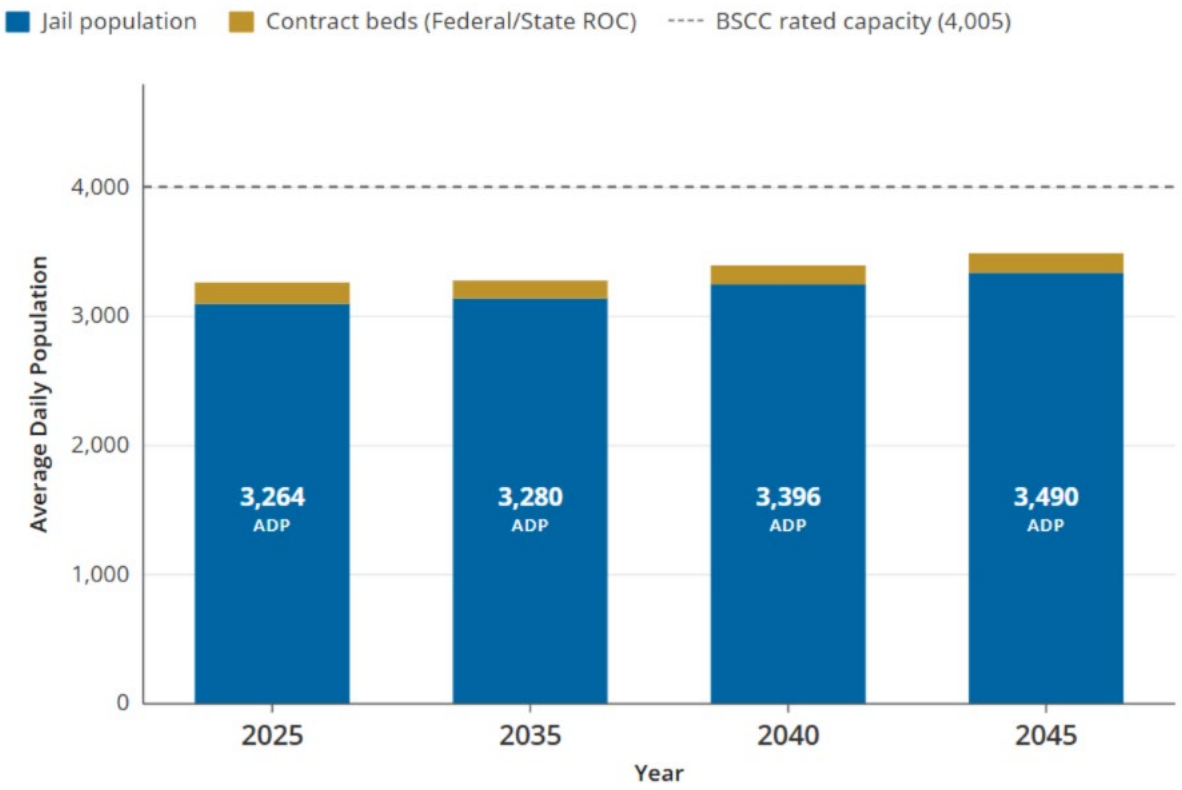
Two standard diagnostic checks were applied to the selected model. The first asked whether the model's errors still contain a predictable pattern that the model failed to capture. They do not. The second asked whether the errors follow the expected statistical distribution and indicates that they depart from it somewhat, reflecting a few unusually large month-to-month movements—a common feature in jail population data. This finding does not bias the forecast itself. Its only practical effect is that the confidence range around the forecast should be read as approximate and may understate how wide outcomes could be in unusual months.

Overall ADP Projections

Applying this methodology yields a central projection of **3,490 total ADP in 2045,** compared with the 2025 average of 3,264. This represents a 6.9% increase over the 20-year horizon (approximately 0.34% per year).

[37] For the corresponding effect on the supervision violation population, see Appendix 3, Caveats and Limitations.

Figure 4. Sacramento County Jails Projected Average Daily Population Through 2045



Note: *Contract beds were held constant at 100 federal beds and 44 state contract beds.*

The trajectory is essentially flat through the first decade of the projection (3,280 ADP in 2035, a 0.5% increase from 2025) before rising more visibly between 2035 and 2045 (3,396 in 2040; 3,490 in 2045). This rate of growth in the jail population is below the projected rate of total county population growth over the same period. The mechanism is the demographic composition shift described in earlier sections: the working-age population segments from which the jail draws most of its bookings are projected to grow more slowly than the county overall, while the older age segments, which book at substantially lower rates, are projected to grow more quickly.

Bed Space Capacity Projections

ADP is, by definition, an average: it describes the typical number of people in custody, not the peak counts that occur above it on particular days or in certain seasons. The projection model captures trend and month-to-month movement in that average. No forecast of an average, however accurate, describes the daily peaks a facility must be able to absorb. Facility capacity planning, therefore, requires converting projected ADP into bed space by applying a multiplier that accounts for two things: population peaks above the average, and the share of rated capacity that must be held in reserve because operational constraints such as classification separation requirements prevent a jail from using every bed at its nominal count.

Following the framework in the National Institute of Corrections (NIC) Jail Capacity Planning Guide, the composite multiplier is the product of a peaking factor and an operational (classification) buffer.

Peaking Factor

The peaking factor adds capacity for seasonal or daily fluctuations above the monthly average, so that ordinary peaks do not push the facility toward forced releases. Sacramento County's historical data indicates that this component is modest: day-to-day variation in the jail population is typically 2.6%, around its monthly average, and a peaking allowance set at the 95th percentile of that variation (approximately about 6%) can absorb ordinary peaks. This reflects a relatively stable pattern of intakes and releases without the seasonal or event-driven spikes seen in some jurisdictions.

Operational (Classification) Buffer Factor

The operational (classification) buffer ensures that enough are available at any given time to accommodate changes in custody classification and levels of care. This includes maintaining vacancies across housing units by sex, custody level, level of care, administrative holds, legal status, etc., as well as allowing for routine maintenance and a margin for population-driven changes (such as intake surges, Prop 36, or other legislative shifts) that may increase the population above the demographic baseline.

A commonly cited planning rule of thumb is that jails should operate at roughly 80–85% of their rated capacity, but the appropriate figure depends on each facility's configuration and population composition, rather than a uniform standard. The figures used here are derived from the County's data rather than adopted from a fixed benchmark.

With both these factors in mind, three scenarios were carried forward and applied as multipliers[38] to the projected ADP:

- **Low, +18%** (operating at about 85% of capacity): Appropriate for a facility whose bed types are well matched to its population composition; provides margin for specialized housing needs
- **Base, +23%** (operating at about 81% of capacity): Within commonly cited practice; adds margin for the elevated buffer the current facility requires (explained below), and for routine contingencies
- **High, +30%** (operating at about 77% of capacity): An explicit allowance for rare adverse events, including flood conditions or a future public health emergency with operational effects comparable to COVID-19; an upper limit driven by current operational constraints rather than an estimate of expected need

[38] The percentages shown (+18%, +23%, +30%) are composite multipliers, rather than single-step markups. Each combines a peak-to-average factor with an operational buffer. The percentages in text are rounded to the nearest whole percentage for readability.

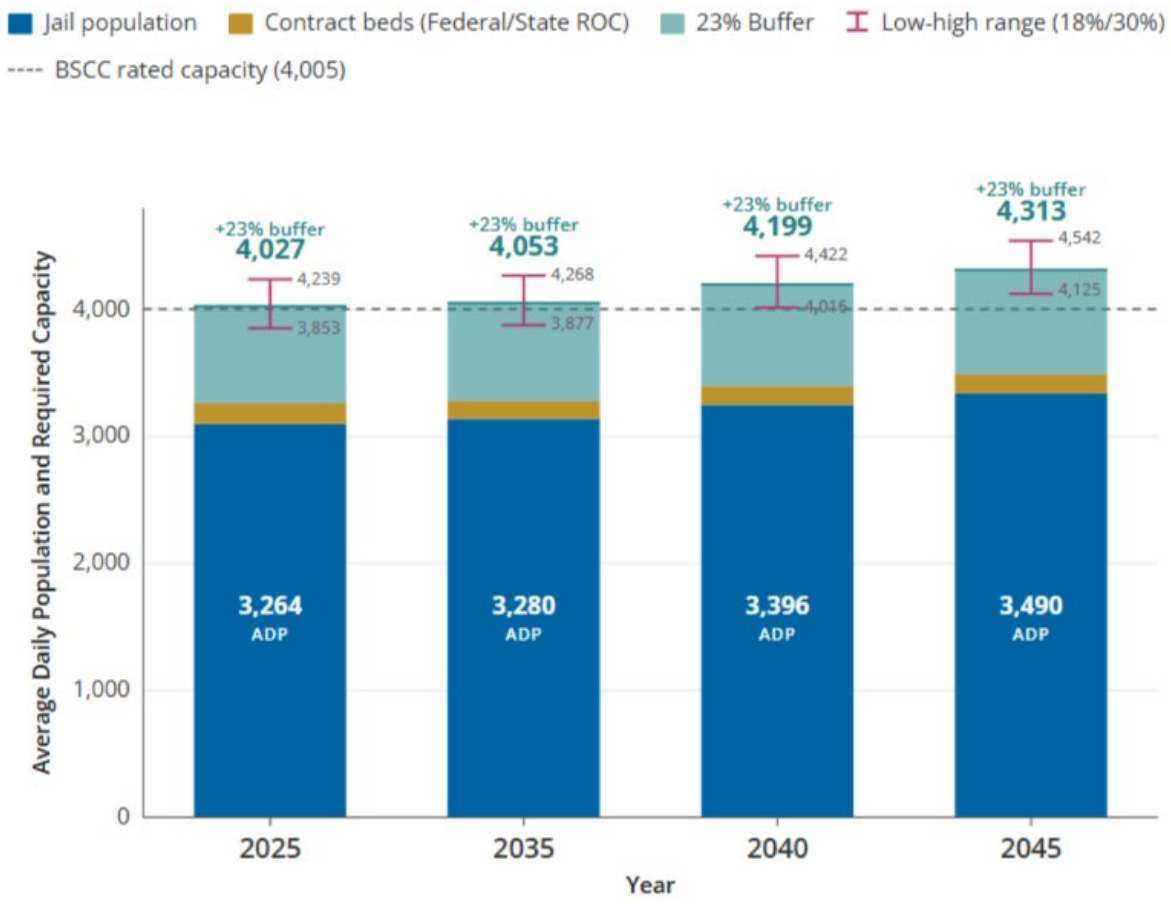
Three decisions in this analysis reflect direction from the County's Jail System Planning/Compliance Oversight Committee rather than determinations derived from the data. First, the planning horizon: the projection was extended to 20 years through 2045. Second, the treatment of contract populations: the 100 federal (US Marshals Service; USMS) and 44 state (restoration of competency; ROC) contract beds are held constant throughout the projection, with growth adjustments applied only to the locally driven population. Third, the +23% case was selected as a conservative planning case, rather than as a point estimate of expected buffer requirements. Applied to the projected 2045 ADP, the +23% base case yields a forecast need of 4,313 beds.

The base scenario lands at the higher end of the commonly cited operating range mainly because of a mismatch between the jail's current bed types and the population it holds. Some housing unit types are undersupplied relative to the population segments requiring them, and the gap between physical bed count and operationally usable beds is larger than would be expected in a facility with a mix matched to its population. As a result, larger portion of the jail's rated capacity must be held in reserve to accommodate classification moves, transfers, and segregation requirements. This is a feature of the facility's present configuration, rather than a permanent property of the jail system.

If the County's bed mix were brought into closer alignment with its population (i.e., if housing unit types that are undersupplied were added in appropriate proportion, and those of overrepresented types were reduced), that buffer could be reduced and the industry standard of ~18% would likely be adequate. In other words, the higher buffer figures carried forward in this report therefore reflect as-is facility conditions rather than a structural feature of the Sacramento County jail system that cannot be addressed through facility design. This distinction is consistent with the Consent Decree framework's emphasis on population management and the efficient use of existing capacity and has been discussed with County stakeholders as part of the planning process.

Figure 7 depicts projected demand alongside the County's current Board of State and Community Corrections (BSCC) rated capacity of 4,005 beds and the three buffer-adjusted capacity scenarios discussed above.

Figure 5. Sacramento County Jail Projected ADP with Buffers (Beds Required)



Note: *Design capacity is calculated as (Total ADP – State ROC) x (peak factor x operational buffer) + State ROC. State ROC contract beds (44) represent a fixed contractual capacity for the JBCT program and are added at contract value rather than buffered.*

Like any long-range forecast, the projections in this report are subject to structural uncertainty that exceeds what can be captured by statistical confidence intervals. The forecast does not and cannot account for future legislative or judicial action, Consent Decree modifications or compliance orders, changes in federal immigration policy affecting the contract populations, County budget constraints that may alter operational capacity or programming, economic shocks, labor market shifts, changes in mental health treatment capacity or diversion eligibility, modifications to the realignment framework, and demographic shifts not captured in the county population projections (migration, displacement events, or other disruptions). The forecast should accordingly be interpreted as a conditional projection under current institutional and policy arrangements, rather than as an unconditional prediction.

Capacity Forecast Qualifiers: Consideration of the Jail Population Reduction Plans

The capacity forecast must be read alongside the County's active efforts to reduce its jail population. This section describes those efforts and describes how they were taken into consideration in the planning process.

Current Legal Landscape and Limitations of the O'Connell Study

In 2020, seeking to reduce its jail population, Sacramento County commissioned subject matter expert Kevin O'Connell to determine how much could the jail population could be reduced through diversion or release programs and which programs were reasonable to implement and most likely to reduce the jails' ADP. The resulting Sacramento County Jail Study (2022) made 10 recommendations, which Mr. O'Connell estimated the County could reduce the jail's ADP by up to roughly 600 if implemented over the following two to three years, with each program requiring an additional 12–18 months to ramp up and reach full effect.

Under the Consent Decree, the County entered a Memorandum of Agreement in 2022, requiring two plans: one to remedy the physical plant deficiencies of its jail facilities that impact delivery of care and one for jail population reduction measures, including funding and an implementation schedule.

The resulting JPRPs, built on the O'Connell recommendations and developed with input from community stakeholders, data experts, and criminal justice system partners, were submitted to Class Counsel and published in draft form in October 2022, then refined and approved by the Board of Supervisors on December 8, 2022. As approved, the plans contained 33 initiatives designed to reduce jail admissions and expand options for justice-involved individuals to be released safely into the community.

In April 2024, the plans were revised again, consolidating the 33 efforts into six strategies designed to reduce bookings, lengths of stay, and returns to custody:

1. Expand behavioral health interventions before/during crisis
2. Facilitate initial deflection and pre-arraignment release opportunities
3. Reduce use of county jail for federal and out of county inmates
4. Decrease jail times for individuals eligible for community release or alternative care
5. Reduce admissions and returns to custody from warrants/violations
6. Improve programming, support services, and linkages before and after release

Progress is monitored through semi-annual JPRP status reports, which the consultant team reviewed for their potential impact on future capacity requirements.

Two limitations prevent the estimated 600-bed reduction from serving as a reliable planning target today. First, the study relied on data from 2021, a period when the jail population was intentionally held low during the COVID-19 pandemic for safety reasons, so its estimate describes a starting point that no longer exists.

Second, as reported in the most recent JPRP status report (July through December 2025), subsequent changes in law and policy, together with changes in operations outside of County

control such as courts, parole, probation, have made several of the original strategies difficult to implement and have altered the study's expected outcomes. A reduction of that size is no longer considered achievable without a renewed, cohesive agreement among all criminal legal system partners.

The study was peer-reviewed by Wendy Still, the conditions-of-detention expert retained by the County, who concurred with its findings with the following caution:

> *"The implementation of these ten strategies will take extraordinary efforts and strong collaboration on the part of the County's Administration, Justice, Health, and Social Service partners. Additionally, culture change will be required within the County with these same partners. Rehabilitative programming and diversion programs are only effective when implemented correctly, and staff are sufficiently trained. Also, the successful implementation of these strategies will take strong leadership, adequate fiscal resources, planning, collaboration, and a commitment by the County to overcome barriers to implementation. Data sharing and information system interoperability will also be an extremely essential element for success of the jail population reduction strategy."*[39]

Given the complexity of multiagency coordination and additional funds necessary to implement all recommended program and service expansion plans, full implementation is expected to take several years and depends on partners the County does not control, including local law enforcement agencies, which account for most arrests and jail bookings, and the Sacramento Superior Court, who are responsible for most release decisions. These external partners are not County entities and are not subject to the Consent Decree.

For these reasons, the Jail System Planning/Compliance Oversight Committee decided to proceed with the projected 2045 capacity need of 4,313 beds as the planning baseline, without assuming reductions that have yet to occur. This decision reflects a planning posture, not an expectation about the outcome of the reduction efforts. The County's Public Safety and Justice Agency is committed to updating the Jail Population Reduction Plans continually and publishing semi-annual reports on progress made toward implementation to help manage current and projected use of jail beds, and as population reductions are realized, the projection and capacity for planning will be adjusted over the several years required to fund, design and eventually implement the recommendations in this report.

Review of Diversion and Deflection Programming and Reentry Opportunities

As previously acknowledged, realizing actual jail population reduction necessitates systemwide collaboration and commitment from several agencies and county partners. No single component of the criminal justice system can implement and obtain results unilaterally.

The jail reduction materials reviewed for this report underscore that Sacramento County's strategy is designed to do more than reduce the ADP; it is also intended to reduce the number

[39] Wendy Still, *Review of Nacht & Lewis Main Jail Capacity to Meet Consent Decree Report and Kevin O'Connell Sacramento Jail Study* (August 2022), prepared for Sacramento County.

of people whose health needs escalate because treatment and support were unavailable early enough. As a result, Sacramento County faces a persistent challenge in responding to the needs of people with serious mental illness, substance use disorders, and co-occurring conditions who continue to cycle through jail, crisis, hospital, and community systems. For the jail system, the practical implication is that in-custody mental health planning cannot be separated from the availability, responsiveness, and coordination of community-based behavioral health services.

Effective jail reduction strategies begin with early identification and intervention for individuals with mental health, substance use, and co-occurring treatment needs. For Sacramento County, that means strengthening deflection and diversion opportunities before booking, at booking, and early in the court process so that eligible people with treatable behavioral health conditions are connected to care as early as possible and in the least restrictive setting.

Sacramento County has established many of the core elements of a deflection and diversion framework, including crisis response resources, urgent care access points, treatment court pathways, MHD options, and a growing community behavioral health continuum. Stakeholder interviews, however, suggest that these services do not yet operate as a seamless alternative to justice involvement. One community-based provider, who preferred to remain anonymous, described the current system as having a "fail first" dynamic, in which individuals often must deteriorate, be arrested, or cycle repeatedly through crisis settings before receiving sustained treatment.

Strengthening Opportunities for Diversion

The County actively aligns with the Sequential Intercept Model to divert individuals at the booking stage (Intercept 2) and reroute them into community-based mental health and substance use programs. As studied at length and reported in previous jail studies, pretrial release programs and collaborative (problem-solving) courts have played a key role in serving as accountable diversion programs to reduce admissions to the jail system and improve jail population management.

Probation Pretrial Diversion

Since the Sacramento County Probation Department created the Pretrial Unit in 2019, the program has offered some detainees greater access to pretrial release on a case-by-case basis. The County has continued to improve operations at the courts and monitoring in the community to safely keep low-risk individuals in the community. It has also improved and expedited the pretrial release assessment process so that, upon arrest and booking, there is less time spent in jail for the accused. Since December 2023, reviews for pretrial release eligibility are expected to be completed within approximately 18 hours of booking.

The Pretrial Unit has replaced the old system of imposing unrealistic and overly burdensome requirements with direct monitoring and court date reminders to help participants make it to their court appointment and avoid new arrests. Additionally, individuals access critical support

systems and receive treatment and counseling services. As reported by the Probation Department, approximately 81% of participants on pretrial monitoring avoid new arrests.[40]

However, as identified in this section, the number of people waiting in jail for a technical violation of probation pending the disposition of their cases, remains an area of concern. Incarcerating people for technical violations drives up the County's total daily jail population, leading to worse outcomes and consuming valuable resources. Reducing bookings and returns to custody from technical violations of probation (no new crimes) requires establishing a swift, graduated response matrix of intermediate/step-up sanctions (e.g., modified supervision conditions, greater use of electronic monitoring, adult day reporting centers, etc.) before returning someone to jail. It also requires the assistance and shared support of the Courts to expedite probation violation hearings.

Jail Diversion Treatment and Resource Center

Located near the Main Jail at 711 G Street, this center serves participants in the Misdemeanor Mental Health Diversion Court who are dealing with mental illness, trauma, or substance use disorders. It functions as a centralized hub providing prompt clinical assessments, therapeutic classes, and direct connections to community service providers.

Problem-solving Diversion Courts

The County operates several collaborative justice courts, with the first mental health court in operation since 2013. The County's Mental Health and Veterans treatment courts register high success rates (measured by program completion and connection to long-term treatment and the community). Court leadership reports success rates above 75% for the MHD calendars, with military diversion even higher.[41]

Together, MHD specialized tracks for both misdemeanor and felony cases have continued to grow, with court calendars further expanded in 2025 to meet demand. In response to Prop 36, the Superior Court started a court dedicated to offering treatment in lieu of jail time for drug possession charges. The Sacramento Probation Department monitors Prop 36 for drug/alcohol/mental health screening and treatment referral, creating an additional diversion pathway and treatment opportunity regarding repeat offenders accused of felony drug-related offenses.

Most recently, at the end of 2025, new Mental Health Compliance Counters were added and a full-time mental health court created (Dept. 3) exclusively dedicated to reviewing and managing Penal Code 1001.36 mental health misdemeanor and felony diversion applications. These initiatives streamline the evaluation of MHD motions, which previously numbered over 1,300 in a single year within the County.

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[40] Source: Draft Jail Population Reduction Plans Status Report (July – Dec 2025), page 2.

[41] Angelina Ray, "Trailblazers of Justice: Judges Lawrence G. Brown and Jennifer K. Rockwell Lead Sacramento's Collaborative Court Movement," *Sacramento Lawyer*, Vol. 2 (2025): 9, https://www.saccourt.ca.gov/general/docs/scba-trailblazers-of-justice.pdf.

These concerted diversion efforts are reflected in the historical jail population downward trend. And moving forward, with some additional process adjustments to reduce length of stay and review mechanisms to ensure the continued usage of diversionary options, the ADP is expected to remain below the total capacity limits mandated by the BSCC. That said, if the County intends to influence these estimates even further by expanding diversion opportunities, there needs to be a systematic alignment at the judicial and prosecutorial level. Defense counsel must become more familiar with the eligibility and referral process for these programs, and prosecutors must triage and prioritize appropriate cases for collaborative courts.

Strengthening Opportunities for Deflection

An area suggested for further exploration is deflection (also known as pre-arrest diversion), which is an intervention law enforcement and first responders use to redirect individuals—typically those struggling with substance use or mental health challenges—into community-based treatment or supportive services instead of arresting them.

A substantial share of individuals who come into contact with law enforcement or other public safety personnel have significant behavioral health needs that are better addressed through timely access to community-based behavioral health services than through arrest, booking, or detention. When the justice system becomes the default response to unmet behavioral health needs, it not only drives unnecessary system involvement and avoidable incarceration, but also delays appropriate treatment, exacerbates clinical instability, and places added strain on already overburdened correctional and emergency response systems.

In Sacramento County, the political and operational appetite for case deflection by police is fragmented. While there seems to be strong support for deflecting individuals experiencing mental health or substance use issues into treatment, there is disagreement on how and who should be the frontline agency executing it. At the same time, law enforcement may lack consistent, up-to-date information about the scope, eligibility criteria, and availability of community-based options that could support effective deflection. As a result, opportunities to connect individuals to appropriate treatment in the least restrictive setting are missed.

Increasing deflection opportunities is therefore a viable option for consideration that could help manage future detention capacity needs.

As previously discussed in this section, same-day releases and short stays account for about 62% of all pretrial bookings. Most of the people entering and leaving jail within 24 hours are booked under California Penal Code Section 853.6, which grants law enforcement officers the discretion to book individuals facing misdemeanor charges in jail for processing, rather than citing and releasing them (non-release exceptions). Processing these individuals causes severe resource inefficiencies, even if they are not assigned a bed.

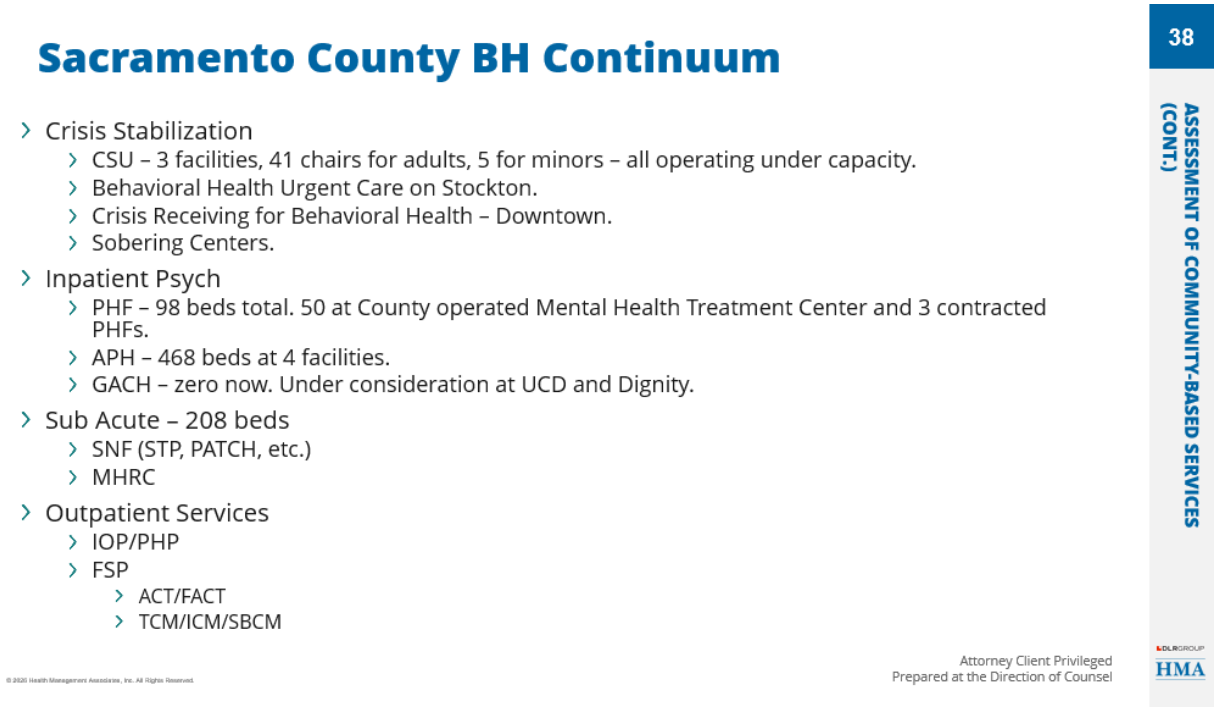
Reducing same-day and short-stay bookings through expanded citation practices, pre-arrest deflection, or behavioral health crisis response would reduce the number of individuals processed through the jail but would have limited impact on the average number of housing beds occupied because short-stay individuals hold a bed only briefly. It would, however,

meaningfully relieve intake, holding, and health screening capacity—including medical and mental health screenings that attach to every booking—which high booking turnover keeps continuously in use.

The County reports that it has pursued efforts along these lines, including engagement with law enforcement agencies on citation policies and expansion of behavioral health crisis response through the CWRT program. Citation and arrest decisions in the field, however, are made by law enforcement agencies, many of which operate independently of the County Board of Supervisors. The County notes that achieving further reductions in short-stay bookings depends on voluntary adoption of expanded citation policies by law enforcement partners, an effort the County reports having encouraged.

As part of this study, the recommendation is made to investigate why any of the existing non-carceral, community-based programs designed to serve clients with specialized needs (e.g., crisis stabilization, sobriety, mental health, substance abuse, and co-occurring issues) are currently underutilized and determine what can be done to enhance utilization of existing community-based resources as a basis for considering expansion in the future.

Image 3.4-1 (Excerpted from Workshop 4)



Strengthening Community Linkages and Support Services upon Release

The County's 2025–2026 Recommended Budget, approved by the Board of Supervisors, identified $4.3 million in funding for Homeless Services and Housing, of which $3.1 million supports the Watt Safe Stay Campus's shelter, operational, and facilities costs. This funding is

drawn in part from State Homeless Housing and Prevention (HHAP) funding and Behavior Health Bridge Housing (BHBH) reimbursement from Health Services.[42]

Note that as part of Workshop 4, HMA interfaced with County Mental Health regarding available programs and capacity as well as opportunities for expanding programs as a county-funded agency to support diversion or deflection both before and after arrest and as part of a continuum of services for reentry. The Planning Team would recommend that the County continue to pursue this partnership with County Mental Health.

Levels of Care Analysis and Bed Space Distribution

A critical component of planning for the future is understanding the impact of future population needs on the medical and mental health populations, which are two of the five core issues of the Consent Decree. Throughout this process the Planning Team collaborated with representatives of Sacramento County Adult Correctional Health (ACH), responsible for medical care and nursing care in the APU and ACMH, responsible for mental health assessment and delivery of treatment services for both inpatient and outpatient levels of care in the jail setting.

To determine future medical and mental health bed needs, a baseline of need was first established based on ADP numbers for these groups. The calculated percentage that these populations represent from 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 historic data related to the changing levels of care.

Current capacity needs were based on 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 above and beyond the limited capacity requirements stipulated by the Consent Decree.

Defining current need and projecting future need and capacity requirements was complicated by several factors:

- Limited historic data on the utilization of special needs beds by cohort
- Changes to the defined levels of care from the cohorts identified in the Consent Decree, to an expanded number of cohorts at the beginning of the analysis, to the final levels of care developed in concert with the subject matter experts (SMEs) as finally agreed to by all parties – County, ACMH, SMEs and Class Counsel.

[42] Sacramento County, "2025-26 Recommended Budget Approved," Sacramento County News, 2025, https://www.saccounty.gov/us/en/articles/2025-articles/2025-26recommendedbudgetapproved.html.

To navigate this changing landscape, the Planning Team collaborated with ACMH to refine the population distribution as well as recommended best practices for housing each cohort as the levels of care evolved over the course of the analysis.

Methodology: Basis for Determination

Special Needs Mental Health Bed Capacity Projections

The Consent Decree, as approved by the Court, 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. Special need populations were identified with estimated capacity requirements as noted in **Table 1**.

Table 1. Specialized Mental Health Programming and Consent Decree Estimated Capacity Requirements

Cohort	Consent Decree Estimated Capacity Requirements
Acute Psychiatric Unit (APU)	18 beds[43]
Intensive Outpatient Program (IOP)	85–120 beds
Outpatient Psychiatric Program (OPP)	200 beds
General Population Mental Health Caseload	No capacity estimate provided; caseload standards only

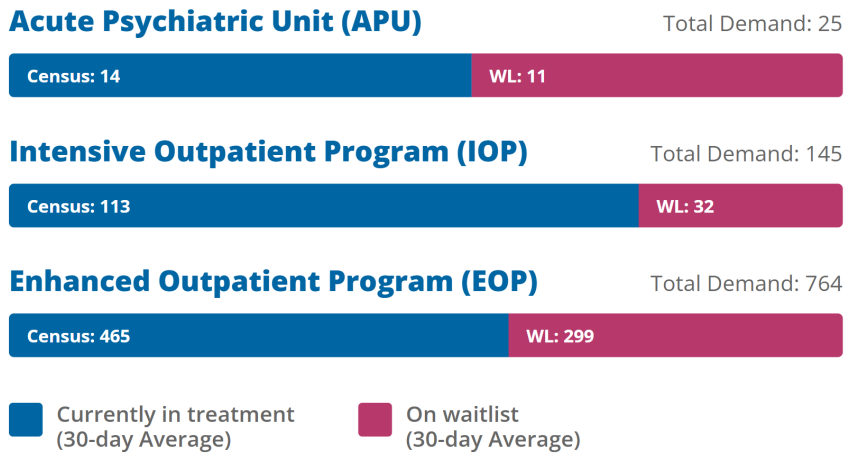
Subsequent to the Consent Decree, ACMH initiated a program for revised levels of care. APU and IOP continued as levels of care, with the introduction of three levels of the EOP identified as EOP 1 Intensive, EOP-2 Moderate and EOP-3, General Population (GP). As part of the evolution of these levels of care, Outpatient Psychiatric Program in the Consent Decree became a housing classification—not a defined level of care. As these were new levels of care, historical data on population distribution was not available.

During the development of the population projections, data was only available for the APU, IOP and total EOP cohorts and OPP housing assignments. The Planning Team undertook an analysis of a 30-day sample of the daily population census, covering individuals assigned to these levels of care or on a waiting list for entry to the treatment program. Because it was common for an individual to be on multiple waiting lists, these individuals were only assigned and counted on

[43]Beds designated for short-term mental health confinement for observation and 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.

the highest level of care waiting list. As Figure 8 illustrates, combining the average daily census with the average daily waiting list resulted in a total demand for 25 beds for the APU, 145 beds for the IOP, and 764 beds across the three levels of EOP.

Figure 6. APU, IOP, and EOP 30-Day Average Demand, 30-day Average Snapshot (August–September 2025)



To further refine the breakdown based on the three levels of care, the Planning Team obtained additional data from ACMH that indicated that based on then current program placements and waitlists, the capacity need for EOP 1 totaled 160 beds and for EOP 2 totaled 390 beds. Based on the identified total demand for 764 beds for all EOP categories the resulting capacity for EOP-GP was determined to be 214 beds.

Current capacity needed and capacity available are summarized in **Table 2**. Current capacity needs as a percentage of current ADP were then used to project future needs.

Table 2. Specialized Mental Health Designations and Current Need and Capacity

Cohort	Current Capacity Needed	Current Capacity Available
Acute Psychiatric Unit (APU)	ADP 33 beds	41 beds; including 7 step-down beds[44] per Second Memorandum of Agreement, including 24 beds under construction 3 East Pod 200 at time of study

[44] 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.

Intensive Outpatient Program (IOP)	ADP 145 beds	167 beds[45] per Second Memorandum of Agreement
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	

In addition, further discussion with ACMH and workshop participants indicated that the following additional cohorts should be considered in analyzing special housing needs.

Table 3. Specialized Housing Cohorts and Current Need and Capacity

Cohort	Current Capacity Needed	Current Capacity Available
Gravely Disabled	ADP 6 beds	6 beds, ultimately combined with APU beds
SITHU	ADP 16 beds	28 beds, varies with CNAP
CNAP	ADP 32 beds	20-bed capacity, varies with SITHU
EASS	Contract limit: 10 beds	10 beds
JBCT	Contract limit: 44 beds	44 beds

As outlined in **Appendix 3**, data from all available sources were used to create a picture of current blended utilization, which resulted in the data related to current need or utilization based on the 2025 ADP as illustrated in **Appendix 3 Table 9**, column titled "Adjusted Historic Utilization & % of 2025 ADP; M/F Distribution."

[45] 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.

These percentages were then applied to the 2045 ADP projection as determined by the Jail System Planning Committee to arrive at the projected special needs mental health ADP by category for the year 2045. This number in turn was increased by a factor of 15% to accommodate peaking/variations in levels of care numbers. A factor of 15% is an appropriate peaking factor for the population as the recommended best practices for single celling and smaller unit will allow the Sacramento Sheriff's Office (SSO) and ACMH to accommodate different classifications and difference in treatment needs without a larger buffer. To mitigate future variations in numbers by cohort or changes to level of care, as part of developing a future housing plan and program for alternative approaches analysis and master planning, acute and subacute housing units will be standardized to the greatest extent possible for future flexibility as needs change.

It should be noted that the referenced **Appendix 3 Table 9** for projections of future need was based on the levels of care in practice at the time of the analysis—that is with EOP subdivided into three levels of care. The Planning Team reviewed the current need/utilization analysis with ACMH, and it was determined that for planning purposes, the cohort defined as EOP 1 should be considered to be the revised level of care cohort EOP Enhanced and that EOP levels 2 and 3 as analyzed should be considered to be MH–GP.

In addition, the initial analysis assumed that IOP and EOP 1 beds would be split between specialized subacute beds (30%) and treatment-based general population beds (70%) for both cohorts. Based on the revised levels of care this was also adjusted to place all IOP beds in the subacute category and all EOP beds—both EOP Enhanced and MH–GP in treatment based general population beds. Finally, based on best practices, the need for single versus double cells and preferred housing unit configuration was defined for each cohort as outlined in **Table 4**.

Future capacity needs for dedicated mental health treatment are projected at 1,295 beds. As noted, the initial analysis reflected levels of care in place at the time of the development of the projections, ongoing discussions among the County, ACMH and the SMEs retained under the Consent Decree for compliance tracking determined that the adjusted levels of care in place at the time of the analysis were more complex than needed for effective treatment. As a result, some adjustments were made to the distribution in terms of acute, subacute, and general population treatment beds. Revised levels of care as adopted by the County, ACMH and agreed to with the SMEs as well as recommended housing parameters are described in Table 4.

Table 4. Specialized Housing Broken Down by Type and Parameters

Level of Care	Cohort	Housing Parameters / Comments
Acute Levels of Care	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.

	SITHU	Single-cell, smaller units, one level, no tiered housing.
	CNAP	Single-cell, smaller units, one level, no tiered housing.
	EASS	Single-cell, smaller units, one level, no tiered housing.
	JBCT	Single-cell, smaller units, one level, no tiered housing.
Subacute Levels of Care	IOP and I/DD	66% single cells / 34% double cells; one level, no tiered housing; double cells with both bunks on the floor; no stacked bunks.
Treatment Beds, General Population	EOP	34% single cells / 66% double cells; may be tiered with stacked bunks in existing housing.
	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 comparable facilities in mission and purpose. The initial analysis presented at Workshop 4 (February 2026) assumed that 30% of IOP and the then current 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 were also revised. All IOP individuals were assigned to the subacute cohort, along with the developmentally disabled, when deemed clinically appropriate. Within this cohort, the bed distribution is 66% in single cells and 34% in double cells 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 if consistent with clinical recommendations utilize stacked bunks. For the revised MH–GP level of care (formerly EOP 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. Additionally, for future flexibility it is recommended that all single-cell beds for both the EOP and MH–GP 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 actually are allocated to 136 inmates based on 60% requiring single celling and 40% appropriate for double-celling, current housing utilization (as specifically defined for IOP and data gathered from OPP housing assignment data) does not support the current distribution of bed needs. Additional consideration should be given to removing the second bunk from cells utilized for

special needs inmates as it creates a potential safety risk re: diving off the upper bunk resulting in trauma to the individual.

Preliminary Bed Space Distribution

Table 5 (overleaf) summarizes the current and projected capacity needs by category for mental health treatment capacity needs for planning. It is anticipated that 1,295 beds will be needed to address diagnosed mental health treatment needs. Only 48 of these beds planned for APU are considered as non-rated beds. All other beds would be considered part of the rated capacity of the system.

Of these, 163 beds are projected for acute care and 193 beds for subacute care. As described above in terms of best practices for mental health treatment housing, this indicates a need for construction of a total of 356 new beds planned and designed specifically to reflect a treatment-oriented environment: single-level, smaller housing units, a mix of single and double cells.

A total of 939 beds is anticipated in the general population to accommodate the EOP and MH–GP levels of care in existing housing.

As part of further detailed programming, housing units, especially for acute and subacute bed needs, will be planned to allow flexibility in utilization as the population ebbs and flows over time. Planning should also consider co-locating the EOP population with smaller housing groupings to support classification requirements.

Table 5. Recommended Scenario Acute Beds, Subacute Mental Health Beds, Treatment Beds in the General Population

Program / Level of Care	Current - 2025 Need (Blended ADP)	Current - 2025 Capacity	Projected - 2045 Need (2045 ADP x 2025%)	Projected - 2045 Capacity (ADP + 15%)
Total Capacity – All Beds				
Average Daily Population	3,264	—	3,490	—
BSCC Rated Capacity	—	4,005	—	4,313
SSO Operational Capacity (actual number of beds)	—	4,901	—	4,313
Non-Rated Beds, Med / Psych (excluding temporary holding)	—	77	—	96
Psychiatric / Mental Health / Special Needs Beds				
Acute Care Beds				
APU (Non-Rated) LPS[46] Designated	39	41	42	48
Suicidal Inmate Temporary Housing Unit	16	28	17	20
Critical Needs Assessment Program	32	20	34	39
Early Access and Stabilization Services	10	10	10	12[47]
Jail-Based Competency Treatment	44	44	44	44
Subtotal – Acute Care Beds	**141**	**129**	**147**	**163**
Subacute Care Beds				
IOP[48]	145	167	156	179
Developmentally Disabled	11	15	12	14
Subtotal – Subacute Care Beds	**156**	**182**	**168**	**193**
Treatment Beds – OPP and General Population				
Enhanced Outpatient Program (EOP1)[49] – EOP Intensive (Revised LOC)	160	467 Shared OPP roster	171	197
Enhanced Outpatient Program (EOP2)[50] - MH–GP (Revised LOC)	390		417	479
Enhanced Outpatient Program (EOP3)[51] - MH–GP (Revised LOC)	214	GP	229	263
Subtotal – Treatment Beds, EOP & MH–GP	**764**	**467**	**817**	**939**
TOTAL – Psychiatric / MH / Special Needs Beds	**1,061**	**778**	**1,131**	**1,295**

[46] The APU is a Lanterman-Petris-Short (LPS)-designated inpatient psychiatric program, meeting the requirements associated with involuntary psychiatric treatment, inpatient stabilization, and clinical oversight for individuals who meet LPS criteria.
[47] Assumes DSH contract renewal at 12 beds, reflecting a two-bed planning margin for anticipated caseload growth.
[48] Intensive Outpatient Program. Blended ADP: DLR Group Population Analysis Workshop 3 (historic utilization + waitlist); Capacity: 2nd MOA actual confirmed by DGS. Figure is rated capacity; functional capacity is limited due to need for single celling – actual functional capacity at publication was 136 beds
[49] EOP1 (EOP Intensive, revised LOC – OPP). Blended ADP: email ACMH 1-22, 160 patients meeting criteria; Capacity: OPP Roster 1-22 indicated 467 beds.
[50] EOP2 (MH GP, revised LOC). Blended ADP: email ACMH 1-22, 390 patients meeting criteria; Capacity: OPP Roster 1-22 indicated 467 beds.
[51] EOP3 (MH GP, revised LOC). Blended ADP: DLR group total waiting list, Workshop 3, less EOP 1&2. Capacity: OPP Roster 1–22 indicated 467 beds. Per revised levels of care, this population may be housed in GP unless OPP placement is clinically indicated

In a best case scenario, resolving facility deficiencies that affect compliance with the requirements of the Consent Decree is years in the future. As a basis for addressing immediate and interim needs, the County requested that the analysis of the special needs mental health population include a review of current needs including distribution of single and double bed requirements based on adopted best practices. **Table 6** provides a summary of current and projected need and single versus double bed capacity required. Note that summary is based only on the projected number of beds needed as the minimum requirement for capacity and excludes the 15% peaking factor discussed above. Refer to **Appendix 3** for information on current and projected distribution of capacity by male and female cohorts.

Table 6. Acute Care Mental Health Beds, Subacute Mental Health Beds
Treatment Beds in the General Population
Current Need - Single & Double Bed Needs excluding 15% Peaking Factor

Cohort	Current Need			Projected Need 2045		
	Total	Single	Double	Total	Single	Double
APU	41	41	N/A	42	42	N/A
IOP, including I/DD	156	104	52	168	110	58
EOP, including I/DD	160	54	106	171	59	112
MH–GP	604	30	574	645	33	612

We again recommend that if the County proceeds with an interim solution or one of the ranked approaches that implementation includes:

- A reassessment of the underlying statistical data to confirm need by cohort as a prelude to final architectural programming and design
- As outlined above, every effort will be made to standardize to the greatest extent possible acute and subacute housing units for future flexibility to accommodate variations in numbers by cohort or changes to level of care.

Special Needs Medical Bed Capacity Projections

While 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. A similar analysis was undertaken to quantify the projected need for medical beds. The following cohorts were identified as the basis for planning medical bed capacity needs for the future:

Table 7. Medical Beds

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

The projected need for medical beds was developed using the same methodology as 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. **Future capacity needs for dedicated medical care are projected at 182 beds plus a recommended additional 76 beds in the general population specifically planned for the needs of the geriatric population for a total of 258 Beds.**

Only 48 of these beds planned for the infirmary including Isolation/negative pressure cells are considered as non-rated beds. All other beds would be considered part of the rated capacity of the system.

Table 8 summarizes the projected need for medical beds. As indicated, a total of 48 beds is projected for acute medical/infirmary care including eight negative pressure rooms. *These beds are not part of the rated capacity as projected because they are temporary beds and not intended to be occupied as permanent housing assignments.* Chronic medical capacity is projected at 55 beds, and MAT capacity is projected at 79 beds based on most recent experience. Note that the analysis of the MAT cohort was revised to increase capacity after review with the stakeholders at Workshop 3. Finally, 76 beds are projected for the geriatric in-custody population.

Table 8. Recommended Scenario - Medical Beds

	Current Need	Current Capacity	Projected Capacity 2045
Total Capacity			
ADP	**3,264**		
BSCC Rated Capacity		**4,005**	**4,313**
SSO Operational Capacity (Actual number of beds)		**4,901**	**4,313**
Non-Rated Beds Med/Psych (excl. Temp Holding)		**77**	**96**
Medical Beds			
Infirmary (Non-rated)		34	40
Isolation/Negative Pressure (Non-Rated)		2	8
Chronic Medical/Long-Term Care		32	55
Detox/MAT		73	79
Total Medical Care Beds		**141**	**182**
Geriatric/Medically Fragile Housing		**N/A**	**76**

Note. *Please refer to Appendix 3 for additional details on the development of projected future capacity needs for mental health and medical treatment.*