Sacramento County Correctional Facility Master Planning Services

Phase I/II Report: Functional Assessment and Projected Needs

Section 4.0 - Mental Health Care Needs Assessment Report

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EXECUTIVE SUMMARY

Sacramento County is at a critical planning and compliance inflection point: its correctional health system must align staffing, treatment capacity, housing, facility design, and community-based alternatives with a jail population that has substantial, complex, and often urgent behavioral health needs.

Developed as part of Sacramento County's correctional facility master planning effort and in response to the Second Memorandum of Agreement, Mental Health Care Remedial Measures Implementation, this report provides an integrated assessment of mental health service delivery, capacity, and facility constraints across the Main Jail and Rio Cosumnes Correctional Center. The findings are intended to inform near-term operational improvements and longer-term capital and system redesign decisions.

The central finding is that Sacramento County has made meaningful progress, but current conditions continue to cause delays in access to care, overreliance on interim or lower levels of care, and inconsistent service delivery. Waitlists, short lengths of stay, staffing constraints, and space limitations create a system in which clinical need is often identified but not consistently translated into timely treatment, step-down care, or custody-to-community linkage.

At the same time, the County has a strong foundation for reform, including increased transparency and stakeholder collaboration, ongoing expansion of Intensive Outpatient Program (IOP) and Acute Psychiatric Unit (APU) capacity, initial investments in program development, and cross-sector coordination.

These efforts are essential building blocks, but sustainable Mays Consent Decree compliance will require more than additional resources. Sacramento County will need reliable operating systems that support timely access, real-time visibility into need, consistent level of care decisions, sufficient treatment space, and accountability for outcomes across custody and community settings.

Priority Actions

- Expand capacity across the mental health continuum, including acute psychiatric care, intensive outpatient treatment, enhanced outpatient services, routine outpatient care, crisis response, and reentry planning.
- Strengthen real-time tracking of referrals, waitlists, level of care status, service delivery, and release before placement outcomes so operational decisions are driven by current need.
- Align treatment space, housing design, and multidisciplinary staffing with the clinical acuity and functional needs of the population.

- Build a stronger custody-to-community bridge through earlier release planning, warm handoffs, medication continuity, benefits linkage, housing navigation, and community behavioral health access.

With focused execution and continued cross-sector collaboration, Sacramento County can move from planning and partial implementation toward a behavioral health system that delivers timely, clinically appropriate care and supports sustained compliance with the Mays Consent Decree.

Table of Contents

Executive Summary 2
Priority Actions 2
Acknowledgments 7
Introduction 8
Background 11
California Legislative Landscape 12
Proposition 36 12
AB 46 13
Proposition 1 14
CalAIM 15
CARE Act and Assisted Outpatient Treatment 15
BH-CONNECT 16
Overall Implications for Sacramento County 16
Mental Health Levels of Care 17
Acute Psychiatric Unit 17
Suicidal Inmate Temporary Housing Unit 17
Jail-Based Competency Treatment 17
Early Access and Stabilization Services 18
Critical Needs Assessment Program 18
Intensive Outpatient Program 18
Enhanced Outpatient Program 18
Mental Health – General Population 19
DD Housing 19
Approach and Scope 21
Overview 21
Key Documents Reviewed and Report Limitations 21
Data Collection and System Review 22
Prevalence, Acuity, and System Demand 22

Treatment Programming & Operational Planning....23
Site Visits....23
Workshops....23
Community Engagement Sessions....24
Patient Interviews and Chart Reviews....24
Key Informant Interviews....24
Population Projections and Future Capacity Requirements....26
Approach and Methodology....26
Data Sources and Period Covered....27
Model Selection and Validation....27
Overall ADP Projections....28
Bed Space Capacity Projections....29
Capacity Forecast Qualifiers: Consideration of the Jail Population Reduction Plans....32
Current Legal Landscape and Limitations of the O'Connell Study....32
Review of Diversion and Deflection Programming and Reentry Opportunities....34
Levels of Care Analysis and Bed Space Distribution....38
Methodology: Basis for Determination....39
Mental Health Staffing Evaluation....53
Staffing Analysis....53
Findings and Recommendations....55
Finding 1: APU staffing figures require careful interpretation....55
Finding 2: Housing designations like SITHU and I/DD create workload even when they are not separately staffed programs....56
Finding 3: IOP staffing is weakened by routine reassignment....56
Finding 4: Outpatient mental health staffing is the largest driver of future staffing need. 57
Finding 5: Intake and float capacity are necessary to make staffing operationally reliable. 57
Finding 6: Workforce shortages among licensed behavioral health professionals may limit the County's ability to fully implement future staffing recommendations....58
Finding 7: Housing plan assumptions affect how staffing should be deployed....59

System Assessment Themes and Recommendations....66
Clinical Themes....66
Mental Health Demand and Service Implications....70
Length of Stay....71
Waitlists and Access to Care....75
Additional QA Capacity Is Needed to Support Ongoing Consent Decree Compliance and System Expansion....77
Programming and Housing Challenges Within Current Space....78
Clear Accountability and Clinical Independence Are Important Components of Effective Correctional Health Systems....80
Deflection and Diversion....81
Cross-System Coordination Remains Essential to Reducing Reliance on Jail-Based Mental Health Treatment....82
Appendix A. Key Resources....84
Appendix B. ACMH Table of Organization....86
Appendix C. LPS FTE Staff-to-Patient Census Ratio Requirements....87

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INTRODUCTION

This report has been developed in the context of the Mays Consent Decree and subsequent implementation agreements, including the Second Memorandum of Agreement (MOA), Mental Health Care Remedial Measures Implementation, which address concerns about mental health care, staffing, treatment space, and continuity of care.

Health Management Associates, Inc. (HMA), in partnership with DLR Group, was engaged to support Sacramento County's correctional facility master planning process by assessing mental health service delivery, capacity, and facility implications across the Main Jail and Rio Cosumnes Correctional Center (RCCC). This report is intended to inform both near-term operational improvements and longer-term planning decisions by integrating site observations, stakeholder input, and key source documents, including the Mays Consent Decree materials, related memoranda of agreement, jail population reduction planning documents, and county population analyses.

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

The resource documents reviewed for this report show that Sacramento County has made important policy changes in recent years, including implementation of an Enhanced Outpatient Program (EOP), and interim measures to improve confidentiality and observation practices. At the same time, core compliance issues remain unresolved in several areas that are central to this report: physical plant deficiencies, inadequate mental health staffing, and insufficient Acute Psychiatric Unit (APU) and Intensive Outpatient (IOP) capacity.

This report's findings are consistent with the Mays Consent Decree Mental Health report's emphasis that Sacramento County's compliance challenges reflect the interaction of treatment capacity, staffing, physical plant limitations, and the need for timely access to clinically appropriate levels of care. More recent agreement materials, including the 2025 Second Memorandum of Agreement, also indicate that current need may be significantly underestimated and that the jail system remains under-resourced relative to the acuity of the population.

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

- **Background:** Summarizes the Main Jail and RCCC context, including the legal, policy, and operational developments shaping the current system
- **Approach and Scope:** Describes the multi-phase assessment process, including reports, data and documents reviewed, site visits, stakeholder engagement, and best-practice analysis
- **Mental Health Capacity and Projections:** Repeated here from Section 3.0 of the Master Planning Services Phase I/II report, this portion utilizes Sacramento County's demographics and population trends, crime trends, jail population trends, current developments, specifics on the Sacramento County's utilization, and other factors to develop population projections and future capacity requirements
- **Staffing and Capacity:** Identifies the staffing, treatment capacity, and housing implications needed to support timely access to clinically appropriate care
- **Findings and Recommendations:** Presents key observations about service delivery, system pressures, operational gaps, and practical steps to improve access, facility alignment, and performance
- **Appendix:** Provides supporting reference materials

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

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

Many individuals with behavioral health needs cycle repeatedly through jail, emergency, homelessness, crisis, and community systems without sustained engagement in treatment. The planning and compliance documents reviewed for this report demonstrate that jail population reduction, diversion, treatment alternatives, and coordinated reentry are compatible with, even essential to, Mays Consent Decree compliance. They both focus on strengthening pre-release care coordination, improving connections to community treatment and housing, reducing failures to appear and warrant-driven returns to custody when clinically appropriate, and aligning in-custody treatment with community-based behavioral health pathways.

Finally, the County needs to ensure adequate bed space capacity is available for incarcerated individuals and improve continuity of care provided in the jail setting through intensive treatment and outpatient services. Currently, existing mental health resources do not appear sufficient to meet current demand, as reflected in waitlists, delays in access to levels of care, and continued reliance on crisis-driven interventions. Expanding program capacity, treatment space, and clinically appropriate housing is necessary to align services with both current demand and need.

This assessment is also consistent with the Mays Consent Decree Mental Health subject matter experts' findings that staffing shortages remain one of the primary barriers to timely access, continuity of care, treatment delivery, and sustained compliance. Across interviews, site visits, document review, and operational data, staffing limitations emerged as a recurring determinant of assessment capacity, program access, waitlist management, release planning, and the delivery of clinically appropriate levels of care.

Although facility design and treatment space are critical considerations, sufficient mental health staffing remains foundational to effective system performance. For a more in-depth discussion of physical plant and infrastructure-related deficiencies that affect delivery of adequate mental health services to the in-custody population, see Section 6.0, Functional/Operational Assessment of the Phase I/II Report: Functional Assessment and Projected Needs.

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

The system requires a fully developed step-down approach within housing units to support individuals with moderate and serious mental health needs who do not require acute care but need dedicated housing and ongoing services as they transition to general population housing. Operationally, this approach includes regular clinical contact, group programming, medication management, and case management. From a design perspective, delivering these services in housing units equipped with program and staff office space where custody and clinician personnel work together in the same space remains an essential consideration for improving access to services and reducing operational barriers.

For clarity, this report uses "behavioral health" and "mental health" interchangeably when discussing symptoms, clinical presentation, and service needs.

BACKGROUND

Sacramento County manages two primary correctional facilities - the Main Jail in downtown Sacramento and the RCCC in Elk Grove. Both sites detain pretrial detainees and individuals sentenced by the Sacramento County Courts.

In recent years, Sacramento County's correctional system has experienced significant operational and legal changes, along with shifts in the behavioral health needs of its jail population. One important trend is the growth in the number of people in custody with complex trauma histories and serious mental illness. This upward trajectory has increased the jail's role as a major provider of mental health services in the County. Patient interviews - including those with individuals who have extensive psychiatric histories, co-occurring stimulant use, and active psychotic symptoms at the time of custody - reflected this same situation, underscoring the rising clinical complexity of the population.

In Sacramento County, ACH, a division of the Sacramento County Department of Health Services, provides medical and mental health treatment services including physical health, dental, pharmaceutical services, medication for opioid use disorder (MOUD), and ancillary healthcare services.

Since 1978, ACH has contracted with the University of California, Davis, department of psychiatry and behavioral sciences, to provide mental health services. Services are provided by a multidisciplinary team and include an Acute Psychiatric Unit (APU), Intensive Outpatient Program (IOP), Outpatient Program / Enhanced Outpatient Program, Jail-Based Competency Treatment (JBCT), and Early Access and Stabilization Services (EASS).

The current mental health service model within Sacramento County's correctional facilities is under significant strain. Across the Main Jail and RCCC, the County is managing a population with substantial behavioral health needs while relying on a service continuum that is still evolving in response to legal requirements, operational constraints, and changing clinical demand. Waitlists, space limitations, staffing constraints, and inconsistent access to treatment all affect the system's ability to deliver timely assessments and clinically appropriate care.

At the same time, Sacramento County has made important structural changes. Recent compliance and planning documents show movement away from an outdated framework and toward a more clinically grounded continuum built around acute psychiatric care, intensive outpatient treatment, enhanced outpatient services, and routine outpatient care. That shift is important because it better aligns treatment decisions with clinical acuity and population needs.

Documented by oversight agencies and court-appointed monitors, Sacramento County has faced long-standing challenges, including jail crowding, staffing shortages across key

disciplines, and inadequate program and treatment space. These conditions have limited access to services and disrupted continuity of care. In response, Sacramento County has implemented initiatives such as enhanced Sacramento Sheriff's Office (SSO) training and expanded clinical programming.

Together, these realities underscore a correctional system that is balancing traditional custody functions with an expanding role as a de facto mental health care provider. While Sacramento County has taken important steps to address overcrowding, staffing constraints, and gaps in continuity of care through training, program expansion, and community partnerships, sustained attention to capacity, clinical infrastructure, and oversight will be essential to ensure safe operations and improved outcomes for individuals in custody.

Sacramento County's broader planning environment includes a formal jail population reduction framework that tracks bookings, length of stay, returns to custody, and implementation of cross-system strategies intended to reduce pressure on the jail while improving outcomes for individuals with behavioral health needs.

California Legislative Landscape

Proposition 36

California's Proposition 36, approved by voters in 2024, changes how certain drug and theft offenses are charged and sentenced. The measure increases penalties for some repeat theft and drug offenses and creates a treatment-mandated pathway for certain felony drug possession cases.

For Sacramento County, the practical significance is that Proposition 36 may increase pressure on jail operations and mental health services if it leads to more felony filings, longer case processing times, or longer lengths of stay for people with behavioral health needs. At the same time, Proposition 36 includes a treatment-oriented component that could create opportunities if implementation is aligned with strong diversion, treatment, and reentry planning.

Early data suggest that Proposition 36 is generating some measurable activity in the jail system, although its direct effect on overall jail growth remains difficult to isolate. The County has begun tracking local Proposition 36-related bookings and filings, which provides an important baseline for monitoring future jail, court, and treatment impacts. SSO's weekly tracking from late March through mid-November 2025 showed roughly 66 Proposition 36-related bookings per week (~10% of total jail bookings when compared with average monthly bookings during this time period); however, many individuals booked on Proposition 36 charges are also detained for other offenses. Hence, these figures should be interpreted as Proposition 36-associated activity rather than a direct measure of additional jail admissions.

Because Proposition 36 was only approved in 2024 and implementation is still relatively recent, available data should be treated as inconclusive. This caution is consistent with state-level experience. California Department of Corrections and Rehabilitation (CDCR) substantially reduced its estimated Proposition 36 population impact between its spring and fall 2025 projections, cutting the projected impact by roughly two-thirds. CDCR attributed the downward revision to slower local implementation, fewer qualifying offenses than initially assumed, and shorter lengths of stay.

This underscores the need to treat the impacts of Proposition 36 as evolving and scenario-based, rather than fixed point estimates. The more immediate operational effects may appear at intake, assessment, and treatment linkage points, rather than solely through changes in the jail population.

The court pathway is also important context, as misdemeanor Proposition 36 cases may be less likely to result in extended jail stays, while felony cases may involve a range of outcomes, including treatment-oriented plea options, refusal of treatment, jail/probation alternatives, or diversion requests. For this reason, the measure's jail impact is likely shaped by factors such as charging decisions, case processing timelines, treatment availability, and the extent to which eligible individuals are connected to appropriate services.

Proposition 36 introduces both risks and opportunities for Sacramento County. Without corresponding investments in diversion, treatment infrastructure, and jail-based service capacity, the measure may exacerbate existing system pressures and complicate compliance with the Mays Consent Decree. Conversely, if leveraged strategically to expand treatment pathways and reduce reliance on custody, Proposition 36 could support Sacramento County’s longer-term goals of improving behavioral health outcomes and advancing sustainable compliance.

AB 46

Assembly Bill 46 (AB 46) is relevant to Sacramento County because it addresses a key issue at the intersection of jail population management and mental health diversion: the extent to which courts can use mental health diversion in cases involving more serious public safety concerns. Now enacted, AB 46 is expected to narrow or more clearly define eligibility for diversion in some cases by restoring greater judicial discretion and increasing the role of prosecutors in diversion decisions.

The likely impact on jail census is mixed but potentially significant. In the near term, a more restrictive or more closely scrutinized diversion process could increase the number of individuals who remain in custody while courts evaluate eligibility, contest diversion, or proceed through more traditional criminal case processing. For Sacramento County, that change could contribute to higher pretrial census, longer lengths of stay, and increased

demands on jail-based mental health services, especially for individuals who previously might have been diverted earlier in the legal process.

At the same time, AB 46 could also push Sacramento County to strengthen the quality and structure of its community diversion pathways. As formal mental health diversion becomes more selective or more closely scrutinized, Sacramento County may need to rely more heavily on earlier deflection strategies, treatment court pathways, California's Community Assistance, Recovery and Empowerment (CARE) Court, Assisted Outpatient Treatment, crisis response, and other pre-booking or pretrial alternatives. In that sense, AB 46 may not eliminate diversion opportunities but could shift the emphasis toward building stronger frontend screening, more clinically robust diversion proposals, and better coordination between courts, prosecutors, defense counsel, mental health providers, and community-based organizations (CBOs).

For this report, the practical implication is that AB 46 could increase the importance of having a well-developed continuum outside the jail. If fewer people are diverted through traditional mental health diversion, or if diversion takes inordinately long, Sacramento County may experience additional pressure on jail census and in-custody treatment demand. Conversely, if the County responds by strengthening community-based services, some of that pressure could be offset. The enacted legislation, therefore, highlights the broader point that jail reduction and diversion outcomes are highly sensitive to state policy changes and to the County's local implementation capacity.

Proposition 1

California's Proposition 1, approved in March 2024, transforms the former Mental Health Services Act (MHSA) into the Behavioral Health Services Act (BHSA) and authorizes substantial bond funding to expand behavioral health treatment settings, supportive housing, and related infrastructure.

Proposition 1 requires Sacramento County to organize BHSA funding into three main buckets: 30% for housing interventions, 35% for behavioral health services and supports, and 35% for full service partnerships that support intensive, ongoing treatment and wraparound services, including mental health and SUD treatment, medically assisted treatment (MAT), assertive community treatment (ACT), forensic ACT (FACT), supported employment, and housing-related supports. Housing funds must support people with the most significant behavioral health needs who are homeless or at risk of homelessness, with half of that allocation prioritized for chronic homelessness.

Proposition 1 is not a stand-alone solution. Its value for Sacramento County will depend on implementation, including whether Sacramento County can successfully align local planning,

behavioral health operations, housing partnerships, and justice system coordination with the new funding and policy framework.

For Sacramento County, Proposition 1 may address several of the structural conditions that contribute to jail reliance and poor continuity of care. Expanded treatment beds, crisis stabilization capacity, residential options, and housing-linked services would reduce avoidable incarceration of people whose primary needs are clinical and could improve discharge and reentry planning for individuals leaving custody.

CalAIM

The California Advancing and Innovating Medi-Cal (CalAIM) initiative presents an important opportunity to improve continuity of care for justice-involved individuals. Through the Justice-Involved Reentry Initiative, California has expanded the ability to provide targeted Medi-Cal covered services to eligible individuals in jails and other correctional settings up to 90 days prior to release.

For Sacramento County, CalAIM is especially relevant because it directly supports several of the same goals emphasized throughout this report: timely assessment, release planning, continuity of treatment from jail to community, medication access, and reduced reliance on emergency and inpatient care after release.

In practical terms, CalAIM creates a bridge between in-custody treatment and community-based behavioral health services. If implemented effectively, it can improve continuity of care and reduce the likelihood that people cycle back into custody because services were not in place.

Sacramento County has begun operationalizing key elements of CalAIM through its Behavioral Health Services Justice-Involved Initiative. The County reports using a mental health referral and linkage process for community reentry, with telehealth-based assessment, linkage, and coordination of care designed to connect eligible individuals leaving custody with behavioral health services and reduce gaps at release. The County describes this work as part of a broader effort to create a coordinated reentry process, support continuity of health coverage, and prevent avoidable use of emergency departments, inpatient psychiatric settings, and other high-acuity services after release.

CARE Act and Assisted Outpatient Treatment

California's Community Assistance, Recovery and Empowerment (CARE) Act invests vast resources and dollars into the creation and implementation of a civil court process to connect eligible adult Californians living with bipolar I disorder with psychotic features, schizophrenia spectrum disorder, or other psychotic disorders to community-based mental health services, housing resources, and ongoing support.

Assisted Outpatient Treatment (AOT), often referred to as Laura's Law, is another pathway toward court-linked outpatient care for individuals with serious mental illness who are inconsistently engaged in voluntary treatment. Together, CARE and AOT create additional diversion and reentry tools for counties seeking to reduce repeated cycling between jail, crisis settings, and the community.

For Sacramento County, the value of these programs lies in their potential to provide structured treatment pathways for people who might otherwise return repeatedly to custody, emergency settings, or psychiatric holds. Their effectiveness, however, depends on referral pathways, available treatment slots, housing resources, and sustained coordination across behavioral health, courts, and community providers.

BH-CONNECT

California's Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative is another major development with implications for Sacramento County's jail and behavioral health systems. It is designed to expand access to community-based behavioral health services, scale evidence-based practices, strengthen the workforce, and improve outcomes for Medi-Cal members with significant mental health needs.

Of relevance to Sacramento County are models such as ACT/FACT, coordinated specialty care for first episode psychosis (CSC), and community transition supports. These models are especially important for people with serious mental illness, frequent crisis-system use, justice involvement, or high needs at the point of reentry.

For Sacramento County, BH-CONNECT offers an opportunity to expand the community-based side of the continuum that this report identifies as essential. If local implementation is aligned with jail discharge planning, diversion efforts, and community provider capacity, these services could reduce jail utilization, shorten lengths of stay, and improve long-term stability for high-need individuals.

Overall Implications for Sacramento County

Together, Proposition 36, AB 46, Proposition 1, CalAIM, CARE, AOT, and BH-CONNECT create a policy environment that strongly supports a more treatment-oriented and coordinated behavioral health system, but only if Sacramento County has the operational capacity to use these resources effectively. Some policies may increase pressure on the jails and courts, while others may create new opportunities to reduce incarceration, improve care access, and strengthen reentry.

For this report, the key takeaway is that legislative change alone will not resolve the challenges facing Sacramento County's correctional mental health system. The County's progress will

depend on whether it can translate these state initiatives into workable local pathways for diversion, treatment, crisis response, continuity of care, and facility planning.

Mental Health Levels of Care

Acute Psychiatric Unit

The Acute Psychiatric Unit (APU) represents the highest level of mental health care available within the Sacramento County jail system and is intended for individuals who are experiencing acute psychiatric episodes that cannot be safely or effectively managed in less restrictive treatment settings. Patients admitted to the APU typically present with severe psychiatric symptoms, significant functional impairment, or conditions that require intensive psychiatric intervention, close observation, and frequent multidisciplinary treatment. The APU is designed to provide a therapeutic environment with enhanced psychiatric services, intensive nursing support, multidisciplinary treatment planning and structured treatment programming.

The APU is a Lanterman-Petris-Short (LPS)-designated inpatient psychiatric program, which means it functions differently from other jail-based mental health units in that it must meet requirements associated with involuntary psychiatric treatment, inpatient stabilization, and clinical oversight for individuals who meet LPS criteria. As a designated LPS program, the APU provides a higher level of psychiatric care for patients whose symptoms and safety needs require inpatient-level intervention, while also requiring close coordination between ACMH and custody operations to ensure timely admission, treatment, discharge planning, and step-down to the appropriate level of care.

Suicidal Inmate Temporary Housing Unit

The Suicidal Inmate Temporary Housing Unit (SITHU) is a specialized housing designation for individuals who require observation, safety monitoring, and rapid clinical reassessment. According to ACMH, SITHU is not a separately staffed mental health treatment program in the same way as APU, Intensive Outpatient Program (IOP), or EOP. Rather, mental health care for individuals housed in the SITHU is provided by staff assigned to other levels of care, including Critical Needs Assessment Program (CNAP), EOP, Mental Health-General Population (MH-GP), and IOP when clinically indicated. Even though SITHU is treated as a housing designation, it creates significant clinical and operational workload because patients require urgent assessment, frequent monitoring, crisis intervention, coordination with custody staff, and timely movement to other levels of care when symptoms stabilize or worsen.

Jail-Based Competency Treatment

Jail-Based Competency Treatment (JBCT) is a specialized treatment program that serves individuals who have been found incompetent to stand trial through a judicial process and who require competency restoration services. The program 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. While many JBCT participants have significant behavioral health needs, placement in JBCT is determined by legal status rather than solely by psychiatric needs.

Early Access and Stabilization Services

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

Critical Needs Assessment Program

The Critical Needs Assessment Program (CNAP) is a high-priority assessment and stabilization area for individuals whose mental health presentation requires close monitoring and short-term intervention. CNAP is designed for patients with recent crisis indicators, acute behavioral health symptoms, or uncertain level-of-care needs that call for rapid assessment and coordinated follow-up. CNAP helps 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 Intensive Outpatient Program (IOP) serves individuals with serious mental illness who need a highly structured treatment environment but do not require inpatient psychiatric care. Patients assigned to IOP generally require frequent intervention, multidisciplinary treatment planning, regular psychiatrist involvement, group therapy, and structured out-of-cell therapeutic programming to support stabilization and recovery. IOP functions as an intermediate level of care between the APU and lower-intensity treatment settings and is intended to reduce mental health decompensation while promoting functional improvement.

Enhanced Outpatient Program

The Enhanced Outpatient Program (EOP) - levels 1 through 3 at the time of the survey and now EOP and Mental Health-General Population (MH-GP) - was designed for individuals with serious mental illness who require more intensive treatment and monitoring than routine outpatient services but who have symptoms that are stable enough to be managed outside of an intensive treatment unit. Patients in EOP 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 as a critical step-down level of care for patients transitioning from higher-acuity

settings and as a step-up level of care for patients with symptoms that are too severe to be effectively managed through routine outpatient services.

Mental Health – General Population

Mental Health – General Population (MH-GP) services represent the least intensive level of mental health treatment within the jail and are intended for individuals whose behavioral health needs can be managed through routine clinical intervention. Patients receiving outpatient services may require psychiatric medication management, brief therapeutic interventions, crisis follow-up, referral services, mental health monitoring, or periodic reassessment but do not require the intensive structure associated with EOP, IOP, or APU placement.

MH-GP serves the largest portion of Sacramento County's mental health caseload and are intended to provide timely access to care while supporting symptom stabilization and treatment engagement. Patients may be moved to higher levels of care when symptoms worsen or transitioned to lower-intensity monitoring when their condition improves.

DD Housing

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

DD is not a separately staffed mental health treatment program in the same way as APU, IOP, or EOP. Rather, care for individuals living with a developmental disability or cognitive impairment is provided by staff assigned to other levels of care, including CNAP, outpatient services, and IOP when clinically indicated. DD housing provides a safer and 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.

Together, these levels of care form a mental health continuum designed to match treatment intensity with patient need. Patients should move between levels of care based on clinical need, with the APU providing the highest level of psychiatric intervention, followed by IOP, EOP, and MH-GP. This continuum is intended to ensure that individuals receive the least restrictive level of care capable of meeting their treatment needs while allowing for timely assessment and treatment when symptoms worsen and for 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.

APPROACH AND SCOPE

Overview

Given the legislative state priorities outlined above, the Mays Consent Decree, the Sacramento County jail reduction plans, and the County's investment in sequential intercept mapping, Health Management Associates' (HMA's) assessment was designed as a multi-phase, track-based process aligned with Sacramento County's correctional facility master planning effort. The approach combined quantitative analysis, service gap identification, facility and operational review, resource modeling, expert consultation, and structured stakeholder engagement to evaluate behavioral health needs across the Main Jail and RCCC.

The assessment also included a review of national best practices and applicable correctional health standards to ensure that the analysis and recommendations reflect evidence-based approaches and operationally feasible models. Key references include nationally recognized industry standards and guidance from the American Correctional Association (ACA), the National Commission on Correctional Health Care (NCCHC), the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Corrections (NIC), and California's Board of State and Community Corrections (BSCC Title 15).

These guidelines emphasize timely access to care, least restrictive housing for people with mental health needs, and integrated medical and behavioral health services. They further highlight a broader nationwide shift toward delivering clinical services and programming in or near housing units to reduce movement, improve access, and support continuity of care.

Key Documents Reviewed and Report Limitations

A comprehensive review of key documents and literature informed this assessment. Materials reviewed included jail operational data, historic facility evaluations, and subject matter expert reports on mental health, medical services, and related operational issues. We also reviewed the County's Sequential Intercept Model (SIM), which identifies key points at which individuals with serious mental illness, SUD, or co-occurring conditions can be connected to community services to reduce future justice system involvement.

Our document review also included key legal, operational, and planning materials that frame Sacramento County's compliance and system redesign work. These materials include remedial plans, the Memorandum of Agreement: Mental Health and Suicide Prevention Remedial Measures Implementation, and the Second Memorandum of Agreement: Mental Health Care Remedial Measures Implementation. Both MOAs identify foundational compliance requirements and unresolved issues related to staffing, treatment capacity, and physical plant limitations.

The review also incorporated jail population reduction planning materials and related Sacramento County analyses focused on reducing bookings, shortening lengths of stay, preventing returns to custody, and expanding community-based alternatives across the Sequential Intercept Model. Together, these documents reinforce that facility planning, behavioral health service design, and population management must be addressed as part of a single, coordinated strategy.

One limitation of this report is that, although the document review was extensive, it was not exhaustive and may not reflect every data source or record; the resources reviewed were nonetheless sufficient to have an accurate assessment of mental health services within the Main Jail and RCCC. In addition, some source materials represent point-in-time conditions that will evolve as Sacramento County implements housing and programmatic changes.

Data Collection and System Review

HMA reviewed available jail operations data, mental health and health service information, planning materials, and related analytical reports to understand current demand, service capacity, operational constraints, and population trends.

This review was informed by the broader context of the Mays Consent Decree, related implementation agreements, and Sacramento County's jail reduction planning efforts. Hence, the analysis considered not only the current behavioral health service model inside the jails, but also the County's larger goals of reducing unnecessary bookings, shortening lengths of stay, improving access to treatment, and strengthening community-based alternatives across the Sequential Intercept Model.

The approach also examined how Sacramento County's evolving crisis response system, community behavioral health continuum, and justice system diversion strategies interact with in-custody service delivery. This broader framework was important because the jail system's behavioral health must be weighed against the availability and responsiveness of upstream and downstream community services.

Prevalence, Acuity, and System Demand

The project team analyzed available data to estimate the prevalence of mental health needs within Sacramento County's jail system and to understand how those needs interact with population flow, length of stay, and service capacity. This review included short-stay releases, rapid turnover patterns, waitlists across levels of care, and demand for services across all levels of care.

The analysis considered both current and projected jail population trends, including mental health caseloads, acuity levels, treatment demand, service utilization, booking patterns, length of stay, and population movement through the system. Particular attention was given to two

distinct but related operational pressures: individuals who cycle through custody quickly while still presenting significant behavioral health needs, and individuals with longer stays and higher acuity who require structured treatment, stabilization, housing coordination, and discharge planning. For a more detailed discussion of population trends and projected capacity analyses, see Section 3.0 Current & Future Population Trends and Projected Capacity Requirements of the Phase I/II Report: Functional Assessment and Projected Needs report.

Patient interviews were consistent with these patterns. They reflected both high-acuity individuals who need structured services and a broader group of individuals with unmet behavioral health needs during short periods of custody. Together, the quantitative analysis, patient interviews, subject matter expert (SME) input, and stakeholder engagement were used to identify service gaps, operational risks, and planning implications for future capacity, staffing, housing, and treatment programming.

Treatment Programming & Operational Planning

The assessment also examined existing treatment programming and service delivery models across both general population and specialized settings, including a review of mental health, medical, and operational workflows that affect access to care, movement, treatment participation, and continuity of services.

Site Visits

As part of the overall assessment, members of the project team conducted multiple in-person site visits to develop a grounded understanding of Sacramento County's correctional facilities, clinical operations, and day-to-day service delivery environment. These visits were structured to combine multidisciplinary expertise, direct observation, and stakeholder engagement.

The first site visit included the full project team to establish a shared baseline understanding of facility conditions and clinical operations. Subsequent site visits were more targeted and allowed for deeper clinical, operational, and leadership-focused follow-up, including direct observation of housing units, booking and intake areas, medical and mental health spaces, and program areas across both the Main Jail and RCCC.

These visits also included structured and informal discussions with custody staff, behavioral health staff, health services personnel, and Sacramento County leadership. Together, the site visits helped HMA validate findings from the document and data review, identify operational strengths and constraints, and ensure that the report's recommendations are grounded in the County's actual operating environment.

Workshops

The assessment approach also incorporated a series of structured, in-person workshops as a central part of stakeholder engagement and data validation. These workshops aligned with

the broader master planning work and provided recurring opportunities to review findings, validate assumptions, and refine the direction of the assessment with Sacramento County leadership, the Jail Planning Oversight Committee, the Sheriff's Office, and other stakeholders.

Workshops began with project initiation and work plan development, followed by sessions focused on population trends, standards and best practices, existing conditions, and planning alternatives. Later workshops supported review of preliminary recommendations, comparative evaluation of options, and refinement of the final framework. Collectively, these sessions ensured that the report reflects both analytical findings and operational realities.

Community Engagement Sessions

Members of the project team attended the Sacramento County Public Safety and Justice Agency Advisory Committee's in-person Jail System Master Planning Project community listening session and subsequent virtual webinar held later in the planning process. Participation in both sessions allowed the project team to hear community perspectives directly, including feedback related to the provision of healthcare, behavioral health services, reentry support, and broader questions about the future role and design of the jail system.

Patient Interviews and Chart Reviews

In December of 2025, a licensed psychologist and a double-board certified forensic psychiatrist from the HMA team conducted assessments of 26 incarcerated patients across the Main Jail and RCCC.

After participating in APU morning rounds, interviewers were given the names of detainees housed within IOP and EOP levels of care. A list of interviewees was selected, but ultimately participants were included based on their availability within the housing unit and on their interest in meeting with interviewers. Importantly, assessments were conducted without any previous knowledge of the person's clinical or legal history, and information was based solely on patient reports. To preserve confidentiality, individual patient details have been omitted from this report.

Key Informant Interviews

To complement the site observations and document review, the project team conducted key informant interviews with a cross section of stakeholders whose roles involve shaping policy, operations, and day-to-day service delivery within Sacramento County's correctional system. Interview participants included County leadership, judicial entities, ACMH leadership, ACMH clinical staff, SSO representatives, Class Counsel, Mays Consent Decree SMEs, community mental health and substance use treatment providers, and other stakeholders with direct knowledge of mental health system operations and service delivery. Individual names have been omitted from this report to protect privacy.

These interviews were used to gather perspectives on governance, clinical access, operational barriers, workflows, coordination across systems, and opportunities for improvement. The project team used a semi-structured format to maintain consistency while allowing participants to elevate emerging issues and provide details from their own operational context. Themes from the interviews were then considered in conjunction with site visit observations to inform findings and recommendations.

POPULATION PROJECTIONS AND FUTURE CAPACITY REQUIREMENTS

Note that the following information is excerpted from Section 3, Current & Future Population Trends and Projected 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, the 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 models such as time-series models are accurate over the short term, but their uncertainty compounds quickly as the horizon extends[1]. Demographic models are less precise in the near term but structurally sound over longer periods.

Approach and Methodology

This projection framework uses a two-stage design (full specification can be found in **Appendix C**). The near term is forecast based on a seasonal time-series model (SARIMAX) fitted to the County's monthly Average Daily Population (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. Further, 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 is 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 (ages 25–34; approximately 5.4–5.8 per 1,000). The age 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.

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[1] 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 used only for near-term estimates.

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.[2] 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,[3] took effect before the window opens. 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 in which candidate specifications and models were evaluated against 12-month out-of-sample holdout periods. Several alternative specifications were tested, including frameworks that forecast sub-populations separately, models trained shorter and longer historical windows, and models incorporating 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 asks whether the model's errors still contain a predictable pattern that the model failed to capture. They do not. The second asks whether the errors follow the expected statistical distribution. They depart from it somewhat, reflecting a few unusually large month-to-month movements, a common feature of jail population data. This incongruency 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.

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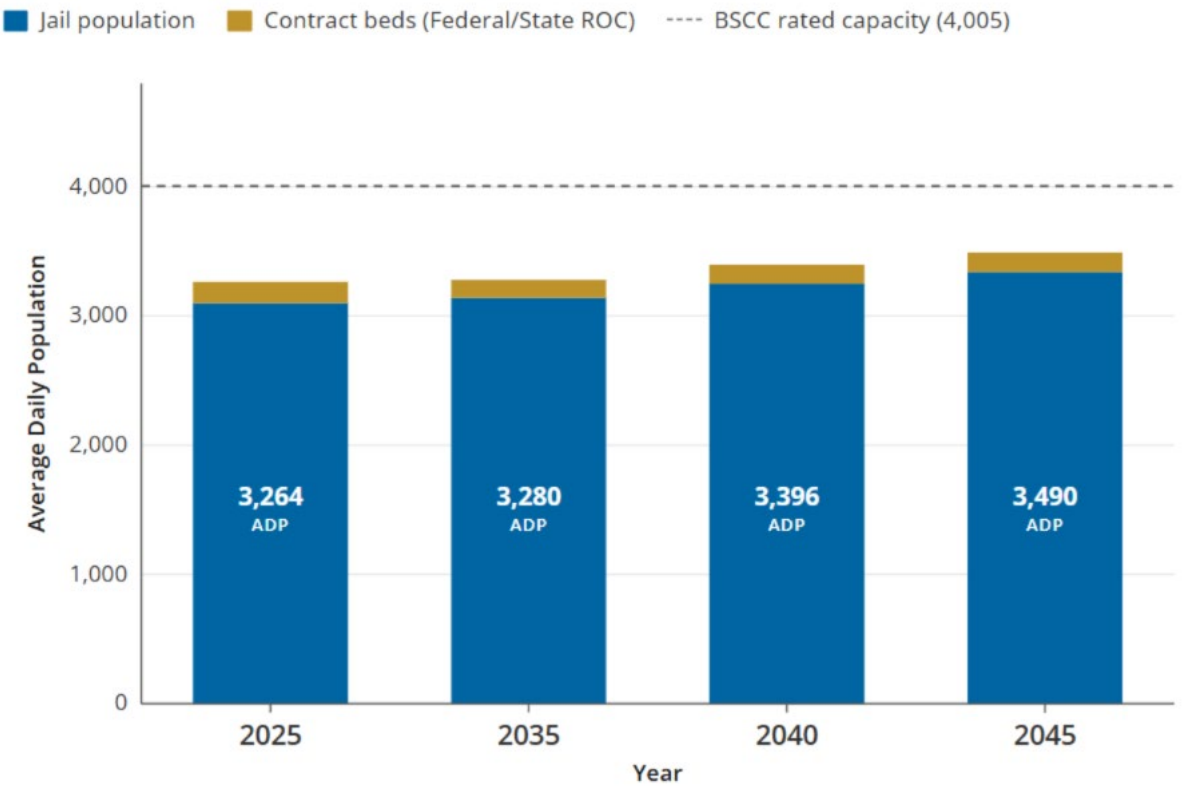
[2] The training window was itself a tested choice, not an assumption. Candidate models trained on both shorter and longer historical windows were evaluated against the same 12-month holdout.

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

Overall ADP Projections

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).

Figure 1. 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 throughout the first decade of the projection (3,280 ADP in 2035, a 0.5% increase from 2025) before rising between 2035 and 2045 (3,396 in 2040; 3,490 in 2045). This rate of jail population growth 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 the majority 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

Average daily population is, by definition, an average: it describes the typical number of people in custody, not the peak counts that occur above it on specific days or in particular 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: 1) population peaks above the average, and 2) 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 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 indicate 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 (about 6%) is sufficient to absorb ordinary peaks—reflecting 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 sufficient beds 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 of these factors in mind, three scenarios were carried forward and applied as multipliers[4] 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 bound driven by current operational constraints rather than an estimate of expected need

Three Decisions in This Analysis Reflect Direction from the Jail System Planning/Compliance Oversight Committee

First, the planning horizon: the projection was extended to 20 years through 2045. Second, the treatment of contract populations: the 100 federal (USMS) and 44 state contract beds remain 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. Consequently, a 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.

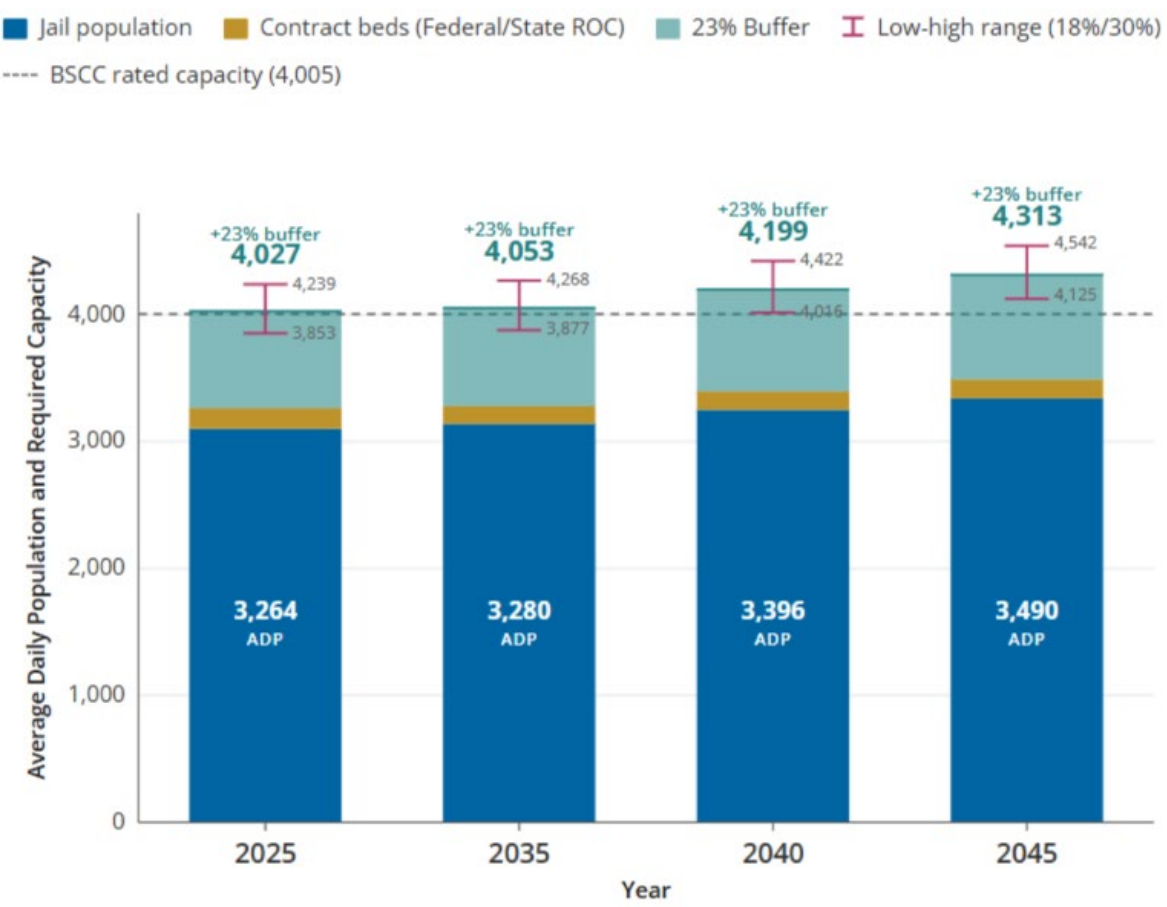
If the County's bed mix were brought into closer alignment with its population (i.e., if housing unit types that are currently undersupplied were added in appropriate proportion, and those of overrepresented types were reduced), that buffer could be reduced and the industry

[4] 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.

standard of ~18% would likely be adequate. In other words, the higher buffer figures 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 Mays 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 2 depicts projected demand alongside the County's current BSCC rated capacity of 4,005 beds and the three buffer-adjusted capacity scenarios discussed above.

Figure 2. 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 answer two questions: how much 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' average daily population. The resulting Sacramento County Jail Study (2022) made 10 recommendations, which 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 another 12–18 months to ramp up and reach full effect.

Under the Consent Decree, the County entered an MOA in 2022, requiring two plans:

1. A plan to remedy the physical plant deficiencies of its jail facilities that impact delivery of care
2. A plan for jail population reduction measures, including funding and an implementation schedule

The resulting Jail Population Reduction Plans (JPRP), 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 aimed at reducing jail admissions and expanding 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:

- Expanding behavioral health interventions before/during crisis
- Facilitating initial deflection and pre-arraignment release opportunities
- Reducing use of County jail for federal and out-of-county inmates
- Decreasing time spent in jail for individuals eligible for community release or alternative care
- Reducing admissions and returns to custody from warrants/violations
- Improving 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 magnitude is no longer considered achievable without a renewed, cohesive agreement among all criminal legal system partners.

Wendy Still, the conditions of detention expert retained by the County, peer reviewed the study and 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."[5]

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 outside the County's purview, including local law enforcement agencies, which account for most arrests and jail bookings, and the Sacramento Superior Court, which is 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 JPRPs continually and publishing semi-annual reports on progress toward implementation to manage current and projected use of jail beds. 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 one part 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 intended to do more than reduce the average daily population. It also is intended to reduce the number 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, SUD, and co-occurring conditions who continually cycle through jail, crisis, hospital, and community systems. For the jail system, the practical implication is that in-custody mental health planning is tied to 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, implementation of these approaches could result in strengthening

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[5] Still W. *Review of Nacht & Lewis Main Jail Capacity to Meet Consent Decree Report and Kevin O'Connell Sacramento Jail Study*. Prepared for Sacramento County. August 2022.

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, mental health diversion 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 repeatedly cycle through crisis settings before receiving sustained treatment.

Strengthening Opportunities for Diversion

The County actively aligns with the Sequential Intercept Model to intercept individuals at the booking stage (Intercept 2) and divert 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 pretrial 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, less time is 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 any new arrests. In addition, 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.[6]

However, as identified in this section, the number of people waiting in jail for a technical violation of probation while the disposition of their cases is pending remains an area of

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

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 sending someone back to jail. It also requires the assistance and shared support of the courts to expedite probation violation hearings.

Jail Diversion Treatment and Resource Center (JDTRC): 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 SUD. 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 mental health diversion calendars, with military diversion even higher.[7]

Together, mental health diversion 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 Prop 36 Court, which offers treatment in lieu of jail 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 for repeat offenders accused of felony drug-related offenses.

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 mental health diversion motions, which previously numbered over 1,300 in a single year within the County.

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

[7] Ray A. Trailblazers of Justice: Judges Lawrence G. Brown and Jennifer K. Rockwell Lead Sacramento's Collaborative Court Movement. *Sacramento Lawyer.* 2025; 2:9. Available at: https://www.saccourt.ca.gov/general/docs/scba-trailblazers-of-justice.pdf.

stay and review mechanisms to ensure the continued usage of diversionary options, the average daily population is expected to remain below the total capacity limits mandated by the BSCC. That said, if the County wishes 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). Through this intervention law enforcement and first responders 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 additional strain on already overburdened correctional and emergency response systems.

In Sacramento County, the political and operational appetite for case deflection by police is fragmented. Although there seems to be strong support for deflecting individuals experiencing mental health or substance use challenges into treatment, there is disagreement about how it should be executed and which agency should be responsible for the effort. At the same time, law enforcement may have inconsistent, outdated 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 not substantially reduce the average number of beds occupied, because short-stay individuals occupy a bed only briefly. It would, however, meaningfully relieve intake, holding, and health-screening capacity -including the 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 Community Wellness Response Team (CWRT) program. However, citation and arrest decisions in the field are made by law enforcement agencies, many of which operate independent 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 reportedly has encouraged.

HMA recommends investigating 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 underutilized and determine what can be done to enhance their use to ensure expansion in the future.

Levels of Care Analysis and Bed Space Distribution

A critical component of future planning is understanding the impact of future population need on the medical and mental health populations, which are two of the five core issues addressed in the Consent Decree. Throughout this process, the planning team collaborated with representatives of Sacramento County ACH who are 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 current 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 over and beyond the limited capacity requirements stipulated by the Consent Decree.

Several factors complicated our ability to define current need and project future expectations and requirements:

- Limited historic data on the utilization of special needs beds by cohort
- Changes in 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 SMEs as finally agreed upon by all parties - County, ACMH, SMEs and Class Counsel

To navigate this evolving 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 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 projections or ceilings. The Consent Decree was intended to promote an appropriate level of care to all inmate patients identified needs based on their clinical assessment, regardless of estimated capacity requirements. **Table 1** outlines special populations that were identified and the estimated capacity required to meet their clinical needs:

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

Cohort	Consent Decree Estimated Capacity Requirements
Acute Psychiatric Unit (APU)	18 beds[8]
Intensive Outpatient Program	85–120 beds

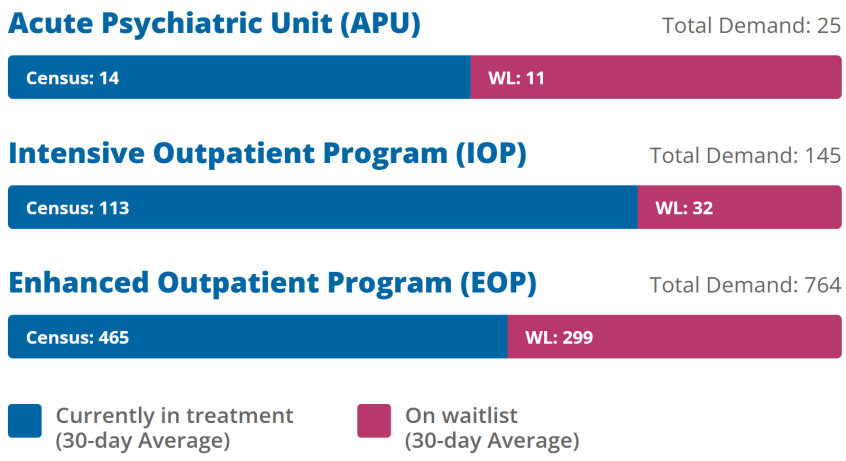
[8]Beds designated for short-term mental health confinement for observation and treatment in accordance with the provisions of the Lanterman-Petris-Short (LPS) Act, based on current capacity. Adjusted to 17 beds as a former double-bunked cell was converted back to a single cell as appropriate for APU care.

Outpatient Psychiatric Program	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. Because these were new levels of care, historical data on population distribution was unavailable.

During the development of the population projections, data was available only 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 more than one waiting list, individuals on multiple lists were only assigned and counted on the highest level of care waiting list on which their name appeared. As **Figure 3** 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 3. 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, which indicated that based on program placements and waitlists at that time, the capacity need for EOP 1 totaled 160 beds, and for EOP 2 it 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 was then used to project future needs.

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

Cohort	Current Need	Current Capacity
Acute Psychiatric Unit (APU)	ADP 33 Beds	41beds; including 7 step-down beds[9] per Second Memorandum of Agreement, including 24 Beds under Construction 3 East Pod 200 at time of study
Intensive Outpatient Program	ADP 145 Beds	167 beds[10] per Second Memorandum of Agreement
Outpatient Psychiatric Program	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	

[9] 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.
[10] 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.

Cohort	Current Need	Current Capacity
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 Need	Current Capacity
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 C**, data from all available sources were used to create a picture of current blended utilization, which yielded current need or utilization based on the 2025 ADP as illustrated in **Table 3.4.4.**

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 variations in peaking or variations in levels of care. A factor of 15% is an appropriate peaking factor for the population, as the recommended best practices for single-celling and smaller units will allow 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 alternatives 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 projections in **Table 3.4.4** were based on the levels of care in practice at the time of the analysis (i.e., with EOP subdivided into three levels of care). The planning team reviewed the current need/utilization analysis with ACMH and 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 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 estimate 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 when the projections were developed. 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 of acute, subacute, and general population treatment beds. Revised levels of care as adopted by the County and ACMH and agreed to with the SMEs, as well as recommended housing parameters, are outlined 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 in February 2026 assumed that 30% of IOP and 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 pattern (see detailed table in **Master Plan Report Appendix C**).

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 and 3), treatment beds in the general population were determined to be appropriate, with a distribution of 5% single and 95% double-celling. These ratios are consistent with current needs and best practices. For future flexibility, we recommend 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 are actually housing 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. Additionally, consideration should be given to removing the second bunk from cells for special needs inmates as it creates a potential safety risk (e.g., diving off the upper bunk resulting in trauma to the individual).

Preliminary Bed Space Distribution

Table 5 summarizes the current and projected capacity needs by category for mental health treatment capacity needs for planning. We anticipate that 1,295 beds will be needed to address diagnosed mental health treatment needs. Only 48 of these beds that are planned for APU are considered 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, 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 and a mix of single and double cells. A total of 939 beds are anticipated in the general population to accommodate the EOP and Mental Health Treatment–General Population 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

	Current (2025)		Projected (2045)	
Program/Level of Care	**Need Blended ADP**	**Capacity**	**Need ADP[11]**	**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				

[11] 2045 ADP based on percentage of total ADP by Cohort applied to projected total 2045 ADP

	Current (2025)		Projected (2045)	
Program/Level of Care	**Need Blended ADP**	**Capacity**	**Need ADP[11]**	**Capacity ADP + 15%**
Acute Psychiatric Unit (Non-Rated) LPS Designated & Licensed	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[12]
Jail-Based Competency Treatments	44	44	44	44
Subtotal Acute Care Beds	**141**	**129**	**147**	**163**

Subacute Care Beds

[12] Assumes DSH contract renewal at 12 beds, reflecting a two-bed planning margin for anticipated caseload growth.

	Current (2025)		Projected (2045)	
Program/Level of Care	**Need Blended ADP**	**Capacity**	**Need ADP[11]**	**Capacity ADP + 15%**
Intensive Outpatient Program[13]	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)[14]	160	467	171	197
Enhanced Outpatient Program (EOP2)[15] – MH-GP (Revised LOC)	390	Shared OP Roster	417	479

[13] **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.
[14] **EOP1 (EOP Intensive, revised LOC – OPP):** Blended ADP: email ACMH 1-22, 160 patients meeting criteria. Capacity: OPP Roster 1-22 indicated 467 beds.
[15] **EOP2 (MH-GP, revised LOC):** Blended ADP: email ACMH 1-22, 390 patients meeting criteria. Capacity: OPP Roster 1-22 indicated 467 beds.

	Current (2025)		Projected (2045)	
Program/Level of Care	Need Blended ADP	Capacity	Need ADP[11]	Capacity ADP + 15%
Enhanced Outpatient Program (EOP3)[16] – MH-GP (Revised LOC)	214	GP	229	263
Subtotal Treatment Beds, EOP, and MH-GP	**764**	**467**	**817**	**939**
TOTAL Psychiatric/MH/Special Needs Beds	**1,061**	**778**	**1,131**	**1,295**

In a best-case scenario, resolving facility deficiencies impacting compliance with the requirements of the Consent Decree is years in the future. To address immediate and interim needs, the County requested that the analysis of the special needs mental health population provide a review of current needs, including distribution of single- and double-bed requirements based on adopted best practices. The following table provides a summary of current and projected need and single vs. double bed capacity required. Note that this 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 C** for details on current and projected distribution of capacity by male and female cohorts.

[16] **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.

Table 6. Acute Care Mental Health Beds, Subacute Mental Health Beds

Cohort	Current Need			Projected Need 2045		
	Total	Single	Double	Total	Single	Double
APU	41	41		42	42	
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

Again, we recommend that if the County proceeds with an interim solution or one of the ranked approaches, implementation should include:

- 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

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

Cohort	Comments
Infirmary	Inpatient treatment/recovery (non-rated beds)
Chronic Medical/Long-Term Care	General population beds, rated capacity

Cohort	Comments
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 were 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 recommendation to add 76 beds in the general population, specifically to meet the needs of the geriatric population, for a total of 258 beds.

Only 48 of the beds planned for the infirmary, including isolation/negative-pressure cells, are considered non-rated beds. All other beds are considered part of the system's rated capacity.

Table 7 summarizes the projected need for medical beds. As indicated, 48 beds are projected for acute medical/infirmary care, including eight negative-pressure rooms. These beds are not part of the rated capacity as projected as they are temporary beds, 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 7. Recommended Scenario: Medical Beds

	Current Need	Current Capacity	Projected Capacity 2045
Total Capacity			
Average Daily Population	**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			**76**

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

Mental Health Staffing Evaluation

This section builds on the broader evaluation of mental health services at the Main Jail and RCCC and examines whether ACMH staffing is structured to meet clinical needs of detained patients, support daily operations, and sustain progress toward compliance with the Mays Consent Decree. Sufficient and competent staffing at the right level of care is essential for Sacramento County to provide adequate mental health services and to sustain progress toward compliance with the Consent Decree.

Looking at staffing across the jail system is more complicated than comparing budgeted position counts with a benchmark number. ACMH must cover multiple levels of care, respond to both routine and urgent referrals, support higher-acuity units, and work around shift differences and daily operational pressures. Because staffing needs change day by day, the picture depends not just on how many positions exist on paper, but on how staff are actually deployed.

Staff are frequently reassigned to cover lower acuity settings. This stopgap measure used by ACMH may help in the short term, but it reduces the delivery of routine services elsewhere. Staff are regularly pulled from EOP and reassigned to outpatient areas to support urgent and emergent referrals and intakes. As a result, routine follow-ups are delayed, causing pressure in other settings. In the context of the Consent Decree, the issue is whether required services are available in a timely and consistent manner across levels of care. If coverage in one area depends on reducing services in another, the treatment model fails.

The current model also relies heavily on per diem staffing and other flexible coverage arrangements to fill operational gaps. Although per diem staff play an important role in providing clinical coverage, dependence on this approach indicates that the baseline number of positions is insufficient. This is especially relevant in the Sacramento jail environment, where staffing needs are shaped not only by census, but also by acuity, housing configuration, intake volume, crisis activity, court movement, and the operational demands of a secure facility. For that reason, consideration should be given to increasing the number of funded positions to account for a realistic relief factor. The staffing model should include capacity to absorb routine vacancies, overnight coverage, leave, training, reassignment, and other predictable disruptions without compromising access to care.

Staffing Analysis

The existing mental health staffing of about 161 full-time equivalent employees (FTEs) is insufficient to provide consistent coverage across all required service areas. Under the Mays Consent Decree, a key question is whether each level of care has the capacity to support timely evaluation, ongoing treatment, crisis response, and continuity of care. Any staffing

discussion should focus not only on the total number of positions, but also on whether those positions are structured to support reliable daily operations.

Several assumptions and methodological limitations should be considered when interpreting the staffing analysis. The calculations rely on funded staff lines rather than filled positions, which may overstate the staffing actually available at any given time. Staffing attributed to the APU also excludes certain ACH-associated roles, including nursing staff, unlicensed behavioral health personnel, residents, fellows, and other trainees. Leadership positions were allocated proportionally across levels of care, a reasonable planning method that may not fully reflect how leadership time is used in daily operations. To better estimate the staffing needed for a more durable model, current ACMH-funded per diem positions - including 10 nurse practitioners and 10 licensed clinical social workers - were excluded from the comparative analysis. These assumptions do not undermine the analysis, but they underscore that actual service capacity may differ from what budgeted lines suggest. As of May 27, 2026, ACMH had a 19.8% vacancy rate, with most vacancies in Social Worker I/II and Licensed Clinical Social Worker positions.

The vacancy rate should be understood as both a staffing and service delivery risk. This assessment did not include a comprehensive recruitment and retention analysis, such as a labor market compensation review, employee engagement assessment, hiring pipeline review, time to fill analysis, or evaluation of leadership and supervision structures. Therefore, this report does not attribute the vacancy rate to a single cause. The available information, however, indicates that vacancies, reliance on per diem coverage, staff reassignment, and limited relief capacity reduce the stability of daily operations and may affect the timeliness and consistency of mental health services.

Because adding positions alone will not resolve staffing shortages if positions remain unfilled, Sacramento County should conduct a focused ACMH workforce stabilization analysis. That analysis should examine vacancy trends by classification, time to fill, turnover, compensation competitiveness, availability of licensed social workers and psychologists in the regional labor market, use of per diem staff, onboarding and retention barriers, workplace conditions, availability of clinical office and treatment space, and supervision and leadership structures. The results should inform a recruitment and retention plan that accompanies any recommended increase in funded positions.

Projecting 2045 staffing introduces additional complexity. Staff schedules vary considerably, with some personnel working eight-hour shifts across five days a week and others working 10- or 12-hour schedules across four days, which makes it challenging to translate headcount into consistent service capacity across a 24-hour operation. For that reason, planning should account not only for the number of positions, but also for the practical availability of staff

hours across shifts, levels of care, and sites. The recommendation to increase direct care staffing by 44.6 positions, before including additional quality assurance (QA) and training staff, intake staff, floaters (mental health personnel who are not assigned to a particular level of care and who respond to new and emergent needs), and SITHU staff reflects this reality and offers a more functional approach to coverage. **Table 8**, Comparison of Current Staffing to Mays Consent Decree Current and Projected shows our calculations.

Finally, projected beds/patients and FTE estimates do not yet fully reflect the implications and efficiencies of a future housing plan that includes smaller and differently configured units. As the housing model is refined, staffing needs may shift based on SSO visibility requirements, patient movement, and the location of treatment spaces. A more resilient staffing approach will require not only additional positions, but also a structure that reduces reallocation, strengthens coverage for intakes and urgent referrals, accounts for relief and shift variation, and aligns staffing deployment with both clinical need and operational realities. Together, these changes would improve the County's ability to meet required standards, support safer operations, and provide more consistent mental health care across all levels of custody.

These staffing pressures come into focus when the current model is compared with both Mays Consent Decree expectations and projected future needs.

Findings and Recommendations

The findings below interpret the staffing comparison shown in **Table 8** and identify the operational issues that should guide future staffing decisions. The analysis shows that closing the gap between current staffing, Consent Decree expectations, and projected demand will require more than adding direct care positions. Sacramento County will also need dedicated SITHU staff, intake capacity, float coverage, reduced reliance on staff reassignment, and explicit planning for workload generated by specialized housing designations.

Finding 1: APU staffing figures require careful interpretation.

At the highest acuity end of the continuum is the APU. **Table 8** shows 41 current APU beds with 20.5 current ACMH FTEs versus 8.0 FTEs, while the 2045 comparison lists 8.0 FTE for the projected 2045 volume of 48 beds. These APU staffing figures require careful explanation because the number is based on LPS regulatory staffing requirements (see **Appendix C**), not the Mays Consent Decree. The staff line is intentionally limited to ACMH-comparable staffing and does not include ACH staffing, residents, fellows, trainees, nursing staff, or unlicensed behavioral health staff that support inpatient operations but are not counted in ACMH staffing totals. In addition, this figure does not include ACMH-funded per diem positions. As a result, the APU figures are best understood as a staffing tool for ACMH-funded mental health staff rather than a complete census of every profession on the unit.

Recommendation

The County has started to and should continue to distinguish ACMH-funded mental health staffing from ACH, nursing, trainee, and other unit-based staffing when using the APU figures for planning. This distinction is important so that staffing comparisons do not understate the full operational workforce required to support inpatient-level care.

Finding 2: Housing designations like SITHU and I/DD create workload even when they are not separately staffed programs.

In **Table 8**, SITHU is listed separately, but staffing is not calculated. **Table 8** shows 16 current SITHU beds and 20 projected beds, with staffing marked N/A (not available) in both periods, because SITHU is a housing designation and care is delivered by staff already counted in other levels of care (e.g., CNAP, outpatient, and IOP) when relevant. Even so, SITHU increases operational demand because suicide-related monitoring, urgent assessments, and rapid changes in patient conditions require staff time that must come from other programs.

I/DD, like SITHU, is treated as a housing designation rather than a separately staffed mental health program. The table shows 11 current I/DD beds/patients and 14 projected beds/patients, with staffing listed as N/A (not available) because the staffing needed to serve those patients is embedded in other levels of care. The same planning caution applies here as with SITHU: the absence of a separate FTE line does not equate to absence of workload. These housing designations create recurring demands for clinical judgment, custody coordination, and timely reassessment, particularly when a person's risk, functioning, or level of care needs change. Without explicitly accounting for this embedded workload, the staffing model may understate the amount of staff time needed to maintain safety, support accommodations, and preserve timely access to treatment across the continuum.

Recommendation

The County should account for SITHU and I/DD workload in operational staffing plans, even though these categories are not assigned separate FTE lines. Planning should recognize that patients in these housing designations require clinical monitoring, reassessment, crisis response, and coordination that draw staff time from other levels of care. Recommendations for dedicated SITHU staffing can be found in **Table 8**. Sacramento County should revisit these staffing assumptions as the future housing and treatment model is finalized. Where the Consent Decree does not specifies a ratio, the County should validate whether current staffing patterns are adequate for projected census, acuity, movement, and treatment demands.

Finding 3: IOP staffing is weakened by routine reassignment.

IOP is one of the largest ACMH programs based on beds and assigned staff. IOP has 145 current beds/patients with 40.5 current FTEs and a benchmark of 27.7 FTE for current volume. In 2045, it rises to 179 beds/patients and 34.2 benchmark FTEs. Although the benchmark figure is below the current assigned staffing, that does not mean the program is overstaffed.

In practice, IOP staff are routinely reassigned to higher priority demands and other urgent clinical needs. As a result, the staffing number may appear sufficient on paper even when available program staffing is not stable.

Recommendation

ACMH should reduce reliance on IOP staff as a standing source of cross-coverage. Dedicated intake and float capacity should be used to absorb urgent demand so that IOP services remain consistently available.

Finding 4: Outpatient mental health staffing is the largest driver of future staffing need.

EOP and Mental Health - GP are the categories that most clearly explain why the 2045 staffing recommendation increases significantly. EOP shows 160 current beds/patients with 26.4 current FTEs, compared with 20.9 benchmark FTEs for current volume; in 2045 it increases to 197 beds/patients and 25.8 benchmark FTEs. At the time of this analysis (and at the time of Mays Consent Decree) EOP was not yet operationalized. Benchmark FTE calculations for EOP are based on the Outpatient Psychiatric Pod staffing ratios specified in Mays. Mental Health - GP shows 604 current beds/patients with 35.5 current FTEs, compared with a benchmark of 75.7 FTEs for current need; by 2045 it rises to 742 beds/patients and 93.0 benchmark FTEs. This outpatient category is the single largest numeric driver of projected staffing need. Outpatient numbers are especially important because outpatient staff are relied upon to manage urgent and emergent referrals, not only scheduled follow-up care. In addition, staff are routinely pulled from IOP and reassigned into outpatient for new or urgent referrals. This reallocation can make higher-acuity units appear stable while creating noncompliance elsewhere. As a result, the current staffing picture may appear more stable than it is operationally.

Recommendation

The County should prioritize outpatient mental health staffing in the 2045 model, including sufficient EOP and MH-GP capacity to support scheduled follow-up, urgent referrals, and emergent clinical needs without pulling staff away from other levels of care.

Finding 5: Intake and float capacity are necessary to make staffing operationally reliable.

Maintaining staffing ratios requires more than meeting benchmark caseload formulas. The staffing model must also account for routine leave, vacancies, training, urgent referrals, new intakes, suicide risk concerns, and other predictable disruptions in a jail environment. Without dedicated intake and float capacity, ACMH must pull staff from existing programs to respond to immediate needs, which reduces the reliability of scheduled services across the continuum.

Recommendations

Sacramento County should establish dedicated intake staffing sufficient to support 24/7 operations and create an outpatient float pool to cover predictable absences, vacancies,

training, and urgent clinical demand. This structure would reduce the need to move staff between programs and would help preserve continuity of care across levels of care. **Table 8** illustrates the recommendation to add 8.4 FTE for intake, 9.5 FTE for outpatient floaters. The intake recommendation reflects the need for additional around-the-clock intake coverage, and floaters are recommended to create a relief factor for paid time off, sick leave, family medical leave of absence (FMLA), vacancies, and other predictable absences. This is particularly important in a setting that relies on per diem support and has wide variation in staffing hours and schedules. Some staff work 8-hour shifts, others work 10- or 12-hour shifts, and some are full-time while others are part-time. These variations make it difficult to translate FTE counts directly into always-available coverage without a relief factor built into the model.

Sacramento County should pair any increase in ACMH-funded positions with a targeted workforce stabilization plan. The plan should identify the drivers of vacancies and turnover, assess whether compensation and job classifications are competitive and equitable for licensed mental health professionals, evaluate the impact of jail-based working conditions and available office and treatment space on recruitment and retention, and establish measurable strategies for filling and retaining positions. This should include monitoring vacancy rate, time to fill, turnover, per diem utilization, leave coverage, reassignment frequency, and the effect of vacancies on timely access to care.

Finding 6: Workforce shortages among licensed behavioral health professionals may limit the County's ability to fully implement future staffing recommendations.

Sacramento County's current mental health staffing challenges should be considered within the broader context of statewide and national shortages affecting licensed behavioral health professionals. As noted elsewhere in this report, ACMH reported a 19.8% vacancy rate, with many vacancies occurring in Social Worker I/II and Licensed Clinical Social Worker positions. While additional staffing positions may be necessary to meet current and projected service demands, expansion of funded positions alone is no guarantee of improved service capacity, especially if no qualified candidates are available to fill them. Workforce shortages affecting licensed clinical social workers, psychologists, and other behavioral health professionals have been well documented and may continue to affect the County's ability to recruit and retain staff in a highly competitive labor market. The operational impact of these vacancies is reflected in the need for staff reassignment and reliance on per diem coverage, both of which may affect continuity of care and timely access to services.

Recommendations

Broadening the pool of eligible licensed behavioral health professionals would provide ACMH with additional workforce flexibility while maintaining clinically appropriate care. Many licensed marriage and family therapists (LMFTs), licensed professional clinical counselors (LPCCs), and other qualified master's-level behavioral health professionals possess training

and expertise in screening, assessment, crisis intervention, treatment planning, and treatment services that may be appropriate for many correctional behavioral health functions. Where permitted by scope of practice, contractual requirements, and applicable regulations, expanding the use of these licensed disciplines could improve recruitment opportunities, reduce vacancy-related service disruptions, and strengthen the County's ability to sustain mental health service delivery in the Main Jail and RCCC.

The County should evaluate opportunities within its contract with the University of California, Davis, Department of Psychiatry and Behavioral Sciences to expand the range of licensed behavioral health professionals eligible for correctional mental health positions, including LMFTs and LPCCs where appropriate and permissible under Consent Decree standards. Expanding the pool of eligible licensed clinicians may improve recruitment and retention, reduce the operational impact of vacancies, and provide greater workforce flexibility while preserving the County's ability to deliver timely, clinically appropriate mental health services.

Finding 7: Housing plan assumptions affect how staffing should be deployed.

Projected beds and the projected FTEs do not yet reflect a finalized housing plan based on smaller units. Once the housing plan is completed, the County may find that the total staffing need remains similar overall although the distribution of FTE across programs, posts, and shifts may change.

Recommendation

Sacramento County should finalize the future housing plan before translating projected FTE requirements into specific posts, shifts, and program assignments. As the County moves toward smaller, treatment-oriented housing units, staffing deployment should be modeled against the actual location of patients, clinical work areas, program space, SSO visibility requirements, and movement patterns. The County should use this finalized housing model to determine where direct care staff, supervisors, intake staff, float staff, SITHU coverage, QA and training staff, and reentry personnel should be assigned across the Main Jail and RCCC. This process should preserve the overall staffing assumptions reflected in the 2045 model while refining the distribution of staff so that coverage is operationally reliable, clinically responsive, and aligned with the physical design of the future system.

In summary, the comparison shows 161.2 FTE currently assigned across the levels of care, in comparison with 170.6 benchmark and a projected 2045 benchmark that rises to 205.8 FTE before intake, relief, additional QA & Training staff and additional SITHU staff are added. The staffing recommendation therefore is more than a response to larger population numbers. It is also a response to the realities of cross-coverage, urgent referrals, reliance on per diem, vacancy pressure, and uneven shift structures. Read together, the current and projected figures present a detailed planning narrative: ACMH can maintain the present system only

through frequent staff reallocation, but a more durable 2045 model requires both higher benchmark staffing and deliberate capacity to keep services reliable across all levels of care.

Table 8. Comparison of Current Staffing to Mays Consent Decree Current and Projected Staffing

	Current			Projected (2045)	
Level of Care	*Beds/Patients* [a]	Current FTEs [b]	Required FTEs [c]	*Beds/Patients*	Required FTEs [c]
Acute Psychiatric Unit (APU) [d]	*41*	20.5	8.0	*48*	8.0
Suicidal Inmate Temporary Housing Unit (SITHU) [e]	*16*	*n/a*	*n/a*	*20*	*n/a*
Critical Needs Assessment Program (CNAP) [f]	*32*	8.9	8.9	*39*	10.8
Early Access and Stabilization Services (EASS) [f]	*10*	5.6	5.6	*12*	6.8
Jail Based Competency Treatment (JBCT) [f]	*44*	8.4	8.4	*44*	8.4
Intensive Outpatient Program (IOP)	*145*	40.5	27.7	*179*	34.2
Developmentally Disabled (DD) [e]	*11*	*n/a*	*n/a*	*14*	*n/a*
Enhanced Outpatient Program (EOP) [g]	*160*	26.4	20.9	*197*	25.8
Mental Health - General Population (MH-GP) [g]	*604*	35.5	75.7	*742*	93.0
Subtotal	*1,063*	145.9	155.3	*1,295*	187.0
Administrative Staff					
MH RVR & ADSEG [h]	-	11.8	11.8	-	14.6
QA & Training [i]	-	3.5	3.5	-	4.2
Subtotal	-	15.3	15.3	-	18.8
Total	*1,063*	161.2	170.6	*1,295*	205.8
Staffing Gap [j]			**9.4**		**44.6**

Recommendation:			
	Additional Staff		*Additional Staff*
Intake [k]	*8.4*		*8.4*
Floaters [l]	*9.5*		*9.5*
SITHU [m]	*4.4*		*5.6*
QA & Training [n]	*2.0*		*2.0*
Subtotal	*24.3*		*25.5*
Total Additional Staffing [o]	***33.8***		***70.1***

Table 8 Notes:

a) *Based on current capacity for APU and EASS as they are designated/contracted services (respectively) and based on current need for all other levels of care. In addition, EOP and MH-GP levels of care have not yet been operationalized by ACMH, therefore capacity has not yet been established.* See Section 3.0 for description of determination and methodology.

b) *Based on ACMH organizational chart as of May 29, 2026 (see Appendix B Adult Correctional Mental Health (ACMH) Organizational Chart). FTE counts reflect allocations across multiple levels of care for positions with supervisory or oversight roles or when staff may serve multiple levels of care (see Table 9 ACMH Organizational Chart Mapping and Allocation to Level of Care). Currently designated Outpatient Program FTEs are represented as MH-GP current FTEs. In addition, current ACMH-funded per diem positions are not included in FTE calculations.*

c) *Calculated using staffing ratios specified in Lanterman-Petris-Short Act (LPS) Interim Regulations for APU, Mays Consent Decree for IOP, EOP, MH-GP, and current FTE counts for CNAP, EASS, JBCT, MH RVR & ADSEG, QA & Training which do not have LPS or Consent Decree specified staffing.*

d) *APU current required staffing levels based on LPS staff requirements (note Appendix 3) for 41 beds of three behavioral health physicians (psychiatrists), and five behavioral health professionals); and projection of 48 beds results in three behavioral health physicians (psychiatrists), and five behavioral health professionals). The following LPS specified staff are not included for the comparison to ACMH staff: 10 Licensed Nursing Staff (because they are currently provided/funded by ACH) and 13 Behavioral Health Personnel (because they are provided/funded by custody and include certified nursing assistants). See Appendix C, LPS FTE Staff-to-Patient Census Ratio Requirements.*

e) *SITHU and I/DD are housing designations, and mental health services are provided by staff associated with (and counted in) other levels of care. ACMH does not currently designate or track SITHU or I/DD staffing, and Mays Consent Decree does not specify staffing for housing. Therefore, no staff members are represented on this line item; however, HMA recommends dedicated SITHU staff. See Recommendation and footnote "m."*

f) *Neither the Consent Decree nor LPS specifies staffing levels for CNAP, EASS, or JBCT levels of care. Therefore, required FTEs are based on current FTE assignments.*

g) *EOP and MH-GP beds/patient are based on current need (as opposed to current capacity), because redefined EOP and MH-GP levels of care have not yet been operationalized as separate levels of care by ACMH. EOP current FTEs represent current EOP designated staff, and MH-GP current FTEs represent the 35.5 FTEs currently designated as Outpatient Program FTEs, which cover multiple levels of care and are not counted on other line items. Benchmark EOP staffing levels are calculated using the Outpatient Psychiatric Pod specified in Mays Consent Decree.*

h) *The Consent Decree did not designate staffing level requirements for MHRVR & ADSEG administrative functions. Therefore, current Required FTEs is based on Current FTEs, and 2045 FTEs is proportionately increased based on the aggregate increase in beds/patients from current to 2045*

i) *Mays Consent Decree did not designate staffing level requirements for QA & Training administrative functions. Therefore, current Required FTEs is based on Current FTEs, and 2045 FTEs is proportionately increased based on the aggregate of total patient/beds increase.*

j) *Current staffing gap is the calculated difference between existing ACMH FTEs and calculated Required FTEs. Projected Staffing Gap is the calculated difference between existing ACMH FTEs and staffing required for projected beds/patients.*

k) *Additional Intake FTE calculation is based on coverage of two additional people, covering 24 hours per day, 7 days per week.*

l) *Outpatient Floaters are recommended in order to provide relief staffing for personal time off (PTO), sick days, FMLA, etc. It is calculated as 5.25 times 1.6 which is then rounded up to 9.5 in order to provide reliable operational coverage.*

m) *The Consent Decree does not specify SITHU staff, however dedicated SITHU staff are recommended. SITHU staff are calculated using the CNAP staff-to-patient ratio as a proxy.*

n) *Additional recommended QA & Training is for two additional FTEs to support current QA functions.*

o) *Total Additional Staffing is the sum of staffing gap and the recommendation for additional staff.*

Table 9. ACMH Organizational Chart [(a)] Mapping and Allocation to Level of Care

Level of Care	Org Chart Mapping	MDs	Leadership /Oversight	BH Psych Supervisor	Hospital Unit Svs Coord	Program NP	Social Worker Supervisor	Clinical Licensed Social Workers	Social Worker	Psychol-ogist	Asst Clin Ops Supv (SW)	Clin Ops Mgs Sup	NP II/III	Total
Acute Psychiatric Unit (APU)	Main Jail - APU #2	2.1	0.2	0.3	0.3	0.9	1.0	4.0	-	-	-	-	-	8.8
	Main Jail - APU #3	2.1	0.2	0.3	0.3	0.9	1.0	6.0	-	1.0	-	-	-	11.8
	Subtotal	4.1	0.3	0.7	0.7	1.8	2.0	10.0	-	1.0	-	-	-	20.5
Suicidal Inmate Temporary Housing Unit (SITHU)							***Housing*** [(a)]							
Critical Needs Assessment Program (CNAP)	Mail Jail	-	0.2	-	0.3	0.9	2.0	1.0	4.0	-	0.3	0.3	-	8.9
Early Access and Stabilization Services (EASS)	RCCC	-	0.2	-	0.3	0.9	0.5	-	2.0	1.0	-	0.3	0.5	5.6
Jail Based Competency Treatment (JBCT)	RCCC	1.3	0.2	-	0.3	0.9	0.5	3.0	-	2.0	-	0.3	-	8.4
Intensive Outpatient Program (IOP)	Main Jail	-	0.2	-	0.3	0.9	2.0	7.0	7.0	-	0.3	0.3	-	17.9
	RCCC	-	0.2	-	0.3	0.9	3.0	6.0	11.0	1.0	-	0.3	-	22.6
	Subtotal	-	0.3	-	0.7	1.8	5.0	13.0	18.0	1.0	0.3	0.5	-	40.5
Developmentally Disabled (DD)							***Housing*** [(a)]							
Enhanced Outpatient Program (EOP)	Main Jail	-	0.2	-	0.3	0.9	3.0	7.0	14.5	-	0.3	0.3	-	26.4
Mental Health - General Population (MH-GP)	Not Operationalized													-
Outpatient Program	*Main Jail - Outpatient Program*	-	*0.2*	-	0.3	*0.9*	*2.0*	*18.0*	*4.0*	-	*0.3*	*0.3*	-	*25.9*
	RCCC - Outpatient Program	-	*0.2*	-	0.3	*0.9*	*1.0*	*4.0*	*3.0*	-	-	*0.3*	-	*9.6*
	Subtotal	-	*0.3*	-	*0.7*	*1.8*	*3.0*	*22.0*	*7.0*	-	*0.3*	*0.5*	-	*35.5*
MH RVR & ADSEG Reviews	Main Jail & RCCC	-	0.2	0.3	0.3	-	1.0	5.0	5.0	-	-	-	-	11.8
Quality Assurance & Training	Administrative	-	3.2	-	0.3	-	-	-	-	-	-	-	-	3.5
Total		5.4	4.8	1.0	4.0	9.0	17.0	61.0	50.5	5.0	1.0	2.0	0.5	161.2

Table 9 note: See **Appendix B** for the Adult Correctional Mental Health (ACMH) Organizational Chart as of May 29, 2026

Table 10. Calculation of Required FTEs by Level of Care

Level of Care	Current						Projected (2045)			
	Beds / Patients [a]	Clinician Caseload Ratio	Calculated Clinician FTEs	MD/NP Caseload Ratio	Calculated MD/NP FTEs	Required FTEs	*Beds / Patients* [a]	Calculated Clinician FTEs	Calculated MD/NP FTEs	Required FTEs
Acute Psychiatric Unit (APU) [b]	*41*	*LPS* [b]	5.0	*LPS* [b]	3.0	8.0	*48*	5.0	3.0	8.0
Suicidal Inmate Temporary Housing Unit (SITHU) [c]	*16*					n/a	*20*			n/a
Critical Needs Assessment Program (CNAP) [d]	*32*					8.9	*39*			10.8
Early Access and Stabilization Services (EASS) [d]	*10*					5.6	*12*			6.8
Jail Based Competency Treatment (JBCT) [d]	*44*					8.4	*44*			8.4
Intensive Outpatient Program (IOP)	*145*	10.00	14.5	11.00	13.2	27.7	*179*	17.9	16.3	34.2
Developmentally Disabled (DD) [c]	*11*					n/a	*14*			n/a
Enhanced Outpatient Program (EOP) [e]	*160*	25.00	6.4	11.00	14.5	20.9	*197*	7.9	17.9	25.8
Mental Health - General Population (MH-GP) [e]	*604*	29.00	20.8	11.00	54.9	75.7	*742*	25.6	67.5	93.0
Subtotal	*1,063*					155.3	*1,295*			187.0
Administrative										
MH RVR & ADSEG [f]	-					11.8	-			14.6
QA & Training [g]	-					3.5	-			4.2
Subtotal	-					15.3	-			18.8
Total	***1,063***					**170.6**	***1,295***			**205.8**

Table 10 notes:

a) *Based on current capacity for APU and EASS as they are designated/contracted services (respectively) and based on current need for all other levels of care. In addition, EOP and MH-GP levels of care have not yet been operationalized by ACMH, therefore capacity has not yet been established. See Section 3.0 for description of determination and methodology.*

b) *APU current required staffing levels based on LPS staff requirements (note Appendix 3) for 41 beds of three behavioral health physicians (psychiatrists), and five behavioral health professionals); and projection for 48 beds of three behavioral health physicians (psychiatrists), and five behavioral health professionals (licensed clinical social workers, licensed psychologists). The following LPS specified staff are not included for the comparison to ACMH staff: 10 Licensed Nursing Staff (because they are provided/funded by ACH) and 13 behavioral health personnel (because they are provided/funded by custody and include certified nursing assistants). See Appendix C, LPS FTE Staff-to-Patient Census Ratio Requirements.*

c) *SITHU and DD are housing designations, and mental health care is provided by staff associated with (and counted in) other levels of care. Therefore, additional staffing is not calculated.*

d) *The Mays Consent Decree did not designate staffing levels for CNAP, EASS or JBCT levels of care. Therefore, current required FTEs is based on current FTEs, and 2045 FTEs is proportionately increased based on the patient/beds increase.*

e) *EOP and MH-GP beds/patients are based on current need (as determined in Section 3.0), because redefined EOP and MH-GP levels of care have not yet been operationalized as separate levels of care by ACMH.*

f) *The Consent Decree did not designate staffing level requirements for MHRVR & ADSEG administrative functions. Therefore, current required FTEs is based on current FTEs, and 2045 FTEs is proportionately increased based on the aggregate of the levels of care primarily served by MHRVR & ADSEG (IOP, CNAP and EOP) patient/beds increase.*

g) *The Mays Consent Decree did not designate staffing level requirements for QA & Training administrative functions. Therefore, current Required FTEs is based on Current FTEs, and 2045 FTEs is proportionately increased based on the aggregate of total patient/beds increase*

In short, the current staffing model does not ensure stable coverage across levels of care. The issue is not just the number of positions, but also the extent to which day-to-day coverage depends on moving staff between programs and relying on limited relief capacity. This report highlights the gap between current staffing, Mays Consent Decree expectations, and projected future need. Closing that gap will require additional positions and enough intake and float coverage to manage routine vacancies and urgent demand without reducing and disrupting

care elsewhere in the system. Without those changes, it will be difficult to build a staffing model that is stable enough to support both daily operations and sustained Consent Decree compliance.

SYSTEM ASSESSMENT THEMES AND RECOMMENDATIONS

The observations summarized below are not intended to attribute causality; rather, they identify patterns that may merit further review, with the goal of supporting clinical integrity, more consistent levels of care pathways, and more reliable access and follow-up processes for patients with complex psychiatric and substance use needs.

Clinical Themes

Across our interviews and corresponding chart reviews, HMA clinical SMEs observed recurring inconsistencies between information presented in electronic health records (EHR) and information documented in clinical notes or reported by patients. In multiple records, chart notes appeared to function as a high-level snapshot of diagnoses, medication lists, and level of care status but unreliable in capturing the clinical narrative needed to interpret symptomatology, properly diagnose, follow longitudinal course, or provide the rationale for clinical decisions.

The EHR itself was difficult to navigate, creating difficulties in establishing an easy chronology of clinical findings, decision-making, or planning. There were challenges in establishing a clear picture of treatment over time. Its outdated interface creates avoidable issues and adds unnecessary complications when examining a patient's medical history. The interface initially appears as though it would be easy to obtain information, but ultimately it is difficult to locate specific information a clinician may need. Information is split up into different categories within the EHR, which creates a disjointed and difficult experience when attempting to glean information on a client's overall presentation. It makes it unnecessarily difficult to gain a comprehensive understanding of a patient's history and current presentation. This can cause clinicians' notes to contradict each other, resulting from clinicians' inability to track a patient's progress which increases the likelihood of misdiagnoses and lack of integration of a treatment plan.

In some cases, the EHR reflected diagnoses, risks, or service intensity that were not readily supported by chart notes, whereas in others, clinically salient information documented in the notes was missing from the chart. This misalignment can reduce the use of the EHR as a resource for clinicians, reviewers, and other stakeholders, particularly when attempting to quickly understand acuity, risk, and treatment needs.

One area where documentation gaps were most apparent involved significant risk indicators or designations, including being a danger to self, being a danger to others, serious mental illness (SMI), and movement into or across higher or lower levels of care (APU, CNAP, IOP, EOP, OPP). Across records, we observed instances in which clinicians and prescribers indicated risks within chart notes but did not clearly describe the specific behavioral observations that would support the designation.

Alternatively, we observed situations in which clinically relevant risk information appeared in notes (e.g., statements or behaviors suggestive of self-harm or threats toward others) but were inconsistently used in treatment planning. Additionally, diagnostic formulations and medication histories sometimes differed across notes, or appeared to change without clearly documented assessment findings or diagnostic reasoning for the change. Together, these patterns suggest that EHR may inconsistently reflect a reconciled or clinically coherent picture of risk, diagnosis, and treatment planning over time.

We also observed frequent use of multiple concurrent waitlists (most commonly IOP and EOP, and at times APU Pre-Admit), including prolonged periods on waitlists while individuals were actively receiving another level of service. For example, Patient 16's chart reflected movement across outpatient, EOP, IOP, APU Pre-Admit, and CNAP, with repeated danger to self designations and overlapping waitlist activity, illustrating how difficult it can be to identify a single, clearly documented treatment pathway over time. In several instances, individuals appeared to remain on an earlier waitlist after moving to a different level of care, without clear documentation of whether the prior referral was intentionally maintained, administratively closed, or clinically superseded.

Notes and interviews also suggested that individuals could decline placement yet remain waitlisted, and that reassessment of ongoing waitlist necessity was not consistently documented at regular intervals. From a clinical operations perspective, this pattern may increase administrative complexity, obscure the current plan of care, and make it more difficult to determine whether waitlists are being used primarily for clinical need, to secure future step-up/step-down capacity, or to manage limited program availability.

Several patients reported limited continuity of care, including seeing different clinicians across visits and uncertainty about who was prescribing medications. Across interviews, patients frequently described uncertainty about who was responsible for their treatment, medication management, or follow-up care, suggesting that continuity of provider relationships remains difficult to maintain within existing clinical and operational structures. Patients also described differences between RCCC and the Main Jail in both program access and interactions with custody staff; while experiences varied, the overall pattern suggested that local staffing, space constraints, and unit culture may contribute to uneven delivery of similar levels of care across the Main Jail and RCCC.

Interviewees also expressed concerns about access to care processes and basic communication mechanisms. Patient 14 reported that "kite" (handwritten notes used by people in custody to request services from jail staff) responses could take three to four weeks, while Patient 20 stated that in some housing areas, officers would deny all kite requests. Patients described variable response times to kites and call-button requests, ranging from

same-day responses to delays of weeks, including delays for concerns related to mental health symptoms, medication side effects, and requests for support.

In addition, group programming was described as interrupted or constrained by operational demands (e.g., pill call) and physical space limitations (e.g., availability of classrooms/treatment rooms), with notes indicating that some higher acuity areas provide strong clinical engagement but lack adequate program and counseling space. Collectively, these factors contribute to inconsistent treatment engagement and may reduce the effectiveness of outpatient levels of care that are reliant on predictable access and follow-up.

Medication management issues emerged across several records and interviews. Several patients described significant sedation and in a subset of cases in the clinical narrative raised questions about whether medication efficacy and side effects were being routinely monitored. Medication lists and prior trials were extensive in some charts, and, at times, difficult to reconcile across note types, raising the possibility of incomplete medication reconciliation or inconsistent documentation of regimens.

Patients also raised operational concerns related to medication timing (e.g., late-night administration) and the impact of medication on sleep and participation in programming. In addition, patients described diversion and hoarding of medications, particularly buprenorphine, as ongoing concerns. Implications for patient safety (e.g., overdose risk, coercion, secondary use) and the integrity of treatment for opioid use disorder must be considered. These themes suggest the need for clear documentation of medication indications, response, side effects, adherence, and risk mitigation strategies within the constraints of the custodial environment.

Substance use, particularly methamphetamine, was prevalent across the patients and was frequently identified as a contributor to psychiatric symptoms, behavioral dysregulation, and cycling between systems of care. Several patients described long histories of stimulant use and reported that hallucinations, paranoid delusions, or mood symptoms worsened with use; patients and EHR notes also reflected co-occurring opioid use disorder in some cases. Nonetheless, both chart review and interviews suggested limited availability of specific, structured interventions tailored to stimulant use disorder, beyond general counseling, safety monitoring, and in some cases medication treatment for opioid use disorder.

Where substance use was central to the presenting problems, the documentation did not consistently clarify whether symptom presentations were conceptualized as primary psychotic/mood disorders, substance-induced conditions, or mixed presentations, nor did it consistently articulate how that formulation informed level of care decisions and treatment planning.

In summary, the themes highlighted across interviews and chart reviews converge on a combination of the following:

- Clarity and consistency of documentation (including risk, diagnosis, SMI designation, and level-of-care rationale)
- Transparency and reassessment in waitlist and level of care pathways
- Operational constraints that affect access, continuity, programming, and medication management

These themes appear interrelated. When staffing and space limitations constrain service delivery, clear documentation and reliable communication mechanisms become increasingly important to support continuity and safe transitions. The purpose of highlighting these themes is to identify areas that may warrant further review and targeted process improvements, with attention to feasibility within the custodial environment.

Recommendations

Sacramento County should continue make targeted investments in an information infrastructure that allows clinicians and system leaders to see a coherent longitudinal picture of each patient's care. A more functional EHR should support medication reconciliation, diagnostic history, risk designations, level-of-care status, referral history, waitlist activity, treatment plan changes, and discharge planning across facilities. These improvements are not simply administrative; they are necessary to reduce documentation inconsistency, support accurate clinical decision-making, and help staff better respond to changing risk and acuity.

The County should also strengthen documentation and treatment plan integrity by establishing clearer expectations for recording diagnostic rationale, medication changes, danger to self or others designations, serious mental illness status, and the reasons for movement between levels of care. When individuals remain on multiple waitlists or move between outpatient, enhanced outpatient, intensive outpatient, crisis observation, and acute psychiatric settings, the record should clearly indicate whether earlier referrals remain clinically necessary, have been superseded, or should be closed. This would improve continuity, reduce administrative ambiguity, and make the current plan of care easier for clinicians, custody partners, and reviewers to understand.

Finally, Sacramento County should improve access to care workflows and patient communication. Kite response, call-button response, medication follow-up, and mental health follow-up requests should continue to be monitored more consistently, with clearer expectations for response times and escalation. Patients should also receive more consistent information about who is providing care, the level of care they are receiving, which medications are being prescribed, and next steps in treatment. These process improvements would mitigate the effects, space constraints, and staffing variability on continuity of care.

Mental Health Demand and Service Implications

The analysis of available data sources, planning documents, and stakeholder input indicates that Sacramento County's correctional system is managing a population with substantial and complex behavioral health needs. Across both the Main Jail and RCCC, mental health and substance use concerns extend beyond a small subset of individuals; rather, they are central drivers of service demand, operational pressure, and facility planning needs. This includes people with serious mental illness, co-occurring SUDs, I/DD, trauma histories, and repeated cycling between custody, crisis, hospital, and community systems.

Patient interviews and chart reviews reinforced the prevalence of co-occurring mental illness and SUD, particularly methamphetamine use, with many individuals describing psychiatric symptoms, repeated hospitalizations, homelessness, and recurring contact with both behavioral health and criminal legal systems.

Behavioral health needs are often identified at the earliest point of contact with the detention system. Intake screening and early clinical review must therefore serve multiple purposes at once: identifying suicide risk, determining immediate treatment need, recognizing withdrawal or intoxication, distinguishing short-term crisis from longer-term care needs, and guiding level of care placement. In a system with both high acuity and rapid turnover, this creates sustained pressure on intake, stabilization, and assessment functions.

Planning documents reviewed for this report also suggest that jail population pressure cannot be understood solely through ADP. Sacramento County must also account for who is entering custody, why they are entering, how long they remain, and what behavioral health needs they present while in jail. In practice, people booked with warrants, people experiencing behavioral health crises, people with frequent prior system contact, and people whose release is delayed by service or housing gaps can all contribute to elevated demand on jail-based mental health services.

Several themes emerged consistently across the data reviewed for this assessment:

- High prevalence of behavioral health needs at intake, including mental illness, SUD, and co-occurring conditions
- Sustained demand for crisis response, suicide prevention, and early stabilization, especially during the first days of custody
- Ongoing need for treatment capacity across multiple levels of care, including outpatient, enhanced outpatient, intensive outpatient, and acute psychiatric services
- Disproportionate resource utilization among individuals with serious mental illness and repeated system involvement

- Operational strain created by the combination of rapid turnover, waitlists, classification levels, and higher-acuity patients who require structured treatment and housing support

At the same time, interviews suggested that individuals who successfully accessed structured treatment settings such as IOP often reported strong therapeutic engagement, more frequent clinical contact, and greater satisfaction with services, suggesting the potential benefits of treatment-oriented environments when capacity is available.

Recommendations

Sacramento County should plan for behavioral health acuity, not only for average daily population. Population and facility planning should account for serious mental illness, co-occurring substance use, I/DD, trauma histories, repeated system involvement, and the high volume of individuals whose short jail stays still require screening, medication review, stabilization, and linkage to care. This means that behavioral health demand should be treated as a central driver of staffing, housing, programming, intake, and facility design decisions.

The County should continue expanding the full behavioral health continuum, including acute psychiatric care, intensive outpatient treatment, enhanced outpatient services, routine outpatient care, crisis response, reentry planning, and community-based alternatives. Expansion should include increased treatment slots, sufficient clinical space, clearer and more seamless operational workflows, and more robust staffing support so that each level of care can function as intended and to ensure individuals can graduate to the next level rather than getting stuck.

Sacramento County should also use behavioral health data as an ongoing management tool. Data on acuity, length of stay, release before placement rates, service utilization, and repeat system contact should inform staffing models, housing plans, clinical capacity, diversion planning, and future capital investments. Without this type of data-informed planning, the system risks continuing to respond to behavioral health demand reactively rather than building capacity around the actual needs of the population.

Length of Stay

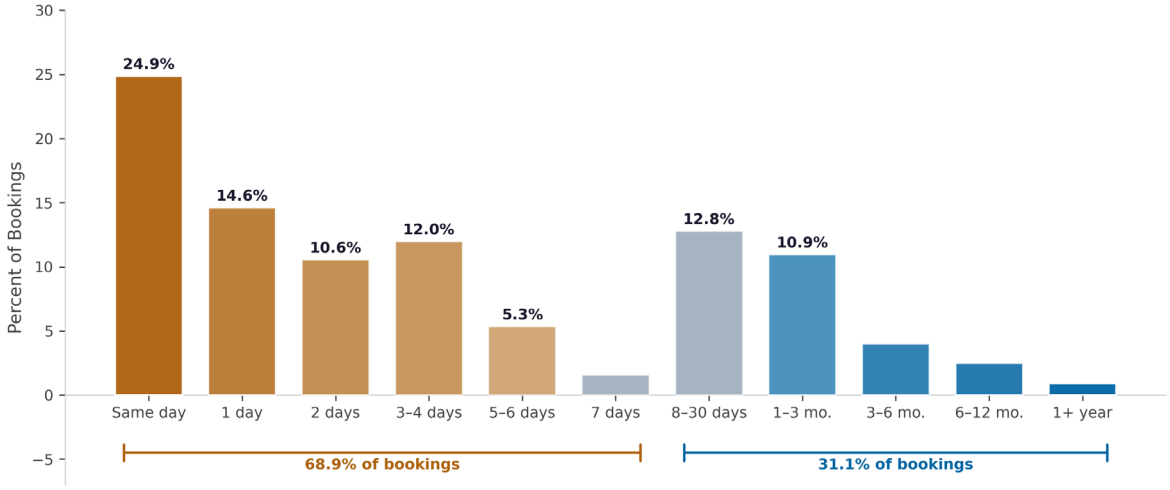
Length of stay is a major factor shaping access to and demand for mental health services within Sacramento County jails. Individuals with very short stays (i.e., “Quicks”) may require screening, stabilization, medication review, and discharge coordination within a narrow time window. In contrast, individuals with longer stays, particularly those with serious mental illness or complex medical and psychiatric needs, require ongoing treatment, case management, housing coordination, and structured programming. This combination of high-

volume, short stays and smaller numbers of higher acuity patients with longer stays places pressure on every part of the clinical continuum.

As **Figure 4** illustrates, nearly 69% of people booked into Sacramento County's jail system – across pretrial, sentenced and hold/violation admissions - are released within the first seven days of custody, which means that, for the majority of the jail population, the period available for meaningful clinical engagement is extremely short. During that narrow window, clinical staff need to complete intake screening, identify suicide risk, assess for acute psychiatric symptoms, review current and prior medications, evaluate for substance withdrawal, determine the appropriate mental health level of care, and potentially begin planning for release. In a system serving many individuals with complex behavioral health needs, that pace creates considerable pressure on intake, nursing, psychiatry, mental health triage, and classification. By the time a person is fully assessed, referred, or placed on a waitlist, they may already be close to release.

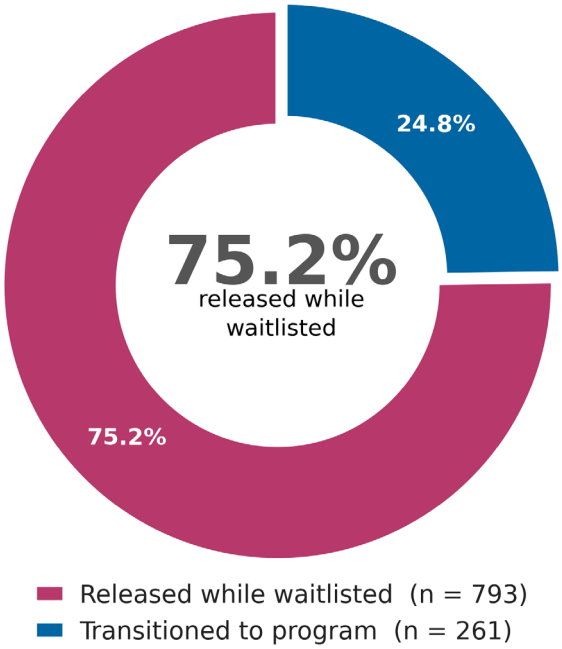
In practical terms, the County's mental health system must be designed not only for people with serious and longer-term needs within custody, but also for a high number of people who are in jail briefly. This pattern has direct implications for staffing, workflows, and facility planning. It underscores the need for rapid frontend assessment capacity, EHR integrity, timely medication continuity, immediate access to stabilization services, and strong reentry linkages that can begin almost as soon as a person enters custody. Without those capabilities, the jail is challenged to manage high behavioral health needs within a timeframe that often is too short for referral and treatment processes to function effectively.

Figure 4. Distribution of Length of Stay Across All Bookings (Jan 2022 – Jul 2025)



Note: Nearly one in four people who are booked are released the same day; only 6.4% stay more than three months.

Figure 5. Outcomes for Individuals Placed on Mental Health Program Waitlists



N = 1,054 unique individuals | June 2024–June 2025

As noted in **Figure 5**, approximately 75% of people identified as needing a mental health program level of care were released while still waitlisted for that care. This finding is significant because it suggests that, even when clinical need is recognized, many individuals are in custody too briefly to reach the service level that has been determined to be appropriate.

Put differently, identification of need does not necessarily translate into timely access to treatment. Instead, people may be screened, referred, and placed on a waitlist, but then leave custody before placement occurs. For Sacramento County, this dynamic points to a combined challenge of rapid turnover and limited program capacity.

The waitlist is a measure of the gap between identified need and actual treatment access. When people are released before entering the level of care they need, the likely result is that their psychiatric and substance use symptoms remain unaddressed. That can weaken continuity of care at release and increase the risk of return to crisis settings, hospitalization, homelessness, or future justice involvement.

The chart therefore supports a broader conclusion of this report: Sacramento County needs a mental health service continuum that can respond more quickly to identified need and a stronger bridge between custody and community-based care for those who will be released before in-custody treatment can be fully delivered. In that sense, the issue is not only about waitlists, but rather the degree to which the current system struggles to match clinical need with timely intervention in a jail population that turns over too quickly for conventional treatment pathways to keep pace.

Recommendations

Sacramento County should strengthen intake and early stabilization capacity so the system can respond effectively during the short period that most people are in custody. This entails providing adequate staffing, confidential assessment space, timely suicide risk assessment, substance use screening, medication review, rapid connection to the appropriate level of care, and immediate release planning. Because many people leave custody within days, the County should build discharge planning and community linkage into the front end of the custody process rather than waiting until release.

The County should also improve the speed from identification of need to intervention. Referral, waitlist placement, program admission, release, and community linkage should be tracked as part of routine performance management. For individuals released before receiving the level of care indicated, the system should ensure direct linkage to outpatient treatment, medication support, crisis follow-up, housing navigation, transportation assistance, and benefits activation or reinstatement.

Sacramento County should provide peer support services within the jail as part of its behavioral health and reentry continuum. Trained peer support specialists with lived experience of mental health challenges, substance use recovery, homelessness, or justice system involvement can build trust, improve engagement in treatment, support motivation for recovery, and strengthen release planning.

Peer services should be integrated into multidisciplinary teams and available across intake, housing-based programming, discharge planning, and reentry workflows, with clear role expectations, supervision, confidentiality protocols, and coordination with ACMH, ACH, SSO, and community-based providers. Incorporating peer services would add a recovery-oriented and culturally responsive component to the jail mental health continuum and improve the likelihood that individuals leave custody connected to treatment, benefits, housing supports, and other community resources.

More broadly, Sacramento County should use short-stay data to design mental health service capacity. Staffing, intake space, stabilization capacity, and community handoff processes should be sized for the reality that many people with serious behavioral health needs will be in custody too briefly for traditional waitlist-based treatment pathways to work. A stronger custody-to-community bridge is, therefore, an essential part of the jail mental health continuum, not an ancillary service.

Waitlists and Access to Care

Waitlists are one of the clearest indicators that Sacramento County's current mental health service continuum is not fully aligned with the volume, acuity, and pace of need within the jail system. Available data, chart reviews, and stakeholder feedback all suggest that waitlists are functioning not merely as an administrative tool, but as a sign of a larger mismatch between clinical need and the system's ability to deliver timely access to treatment.

Intensifying this challenge is the high turnover of the jail population itself. As the preceding figures show, many people leave custody within days, and a large share of those identified as needing a mental health program level of care are released before they reach that level of service.

As a result, the system is often trying to assess, prioritize, and move people into care within a time frame that is shorter than the referral and placement process itself. The result is a recurring pattern in which need is recognized, but treatment is delayed or never fully initiated before release. At the same time, individuals with longer stays and greater acuity may remain on waitlists for movement into more clinically appropriate settings, creating additional strain on outpatient units, crisis observation, and other parts of the service continuum.

Waitlists also raise questions about continuity, level of care integrity, and the operational meaning of referral status. Chart reviews for this report showed that some individuals were carried on multiple waitlists over time, at times while already receiving another level of service, without consistent documentation of whether a prior referral remained clinically necessary, had been superseded, or was being held in place because future capacity was uncertain. This situation can make it difficult to determine whether waitlists are being used primarily to indicate clinical need, preserve access to treatment slots, or manage the practical limitations of bed and program availability.

Regardless of the reason, the broader implication is that Sacramento County needs stronger real-time visibility into referral status, clearer criteria for waitlist management, and enough treatment capacity across levels of care to ensure that identification of need leads to timely intervention.

Patient statements echoed this ambiguity, with some individuals reporting that they were on multiple waitlists, unsure why they had not been moved, or unclear whether prior referrals remained active after their level of care changed.

For this report, waitlists should therefore be understood not as a narrow scheduling issue, but as a system-level signal. They reflect the combined effects of rapid turnover, limited program capacity, documentation and tracking challenges, and gaps between custody-based treatment and community-based follow-up. Addressing them will require both near-term operational improvements, such as better referral tracking, reassessment practices, and release coordination, and longer-term investments in staffing, treatment space, housing design, and community linkage pathways so that Sacramento County can move people into the right level of care more quickly and more consistently.

This assessment is also consistent with the Mental Health Monitors' findings that staffing shortages remain one of the primary barriers to timely access, continuity of care, treatment delivery, and sustained compliance. Across interviews, site visits, document review, and operational data, staffing limitations emerged as a recurring factor affecting assessment capacity, program access, waitlist management, discharge planning, and the delivery of clinically appropriate levels of care. While facility design and treatment space are critical considerations, sufficient behavioral health staffing remains foundational to effective system performance.

Recommendations

Sacramento County should treat waitlists as a system management indicator rather than as a scheduling tool. Waitlist volume, wait time, release before placement, multiple concurrent referrals, and movement across levels of care should be tracked and reviewed regularly by

clinical and custody leadership. These data should be used to determine where treatment capacity, staffing, housing, and programming space should be expanded.

The County should also establish clearer criteria for maintaining, closing, or superseding referrals and should require periodic reassessment of active waitlist status. Clinical teams should be able to determine who is waiting, for what service, for how long, whether the person is receiving another level of care, and whether the current referral still reflects the individual's clinical needs. This would improve level of care integrity and reduce the risk of waitlist status leading to a disconnect from the ongoing treatment plan.

In addition, Sacramento County should use waitlist trends to guide near-term and long-term planning. Persistent waitlists should inform decisions about staffing, bed capacity, program space, housing design, and community-based alternatives. The goal should be a system in which identified need leads to timely intervention, and when in-custody treatment cannot be delivered before release, an active and documented handoff to community-based care should occur.

Additional QA Capacity Is Needed to Support Ongoing Consent Decree Compliance and System Expansion

Sacramento County's correctional behavioral health system has become increasingly complex as ACMH has expanded treatment capacity, developed specialized levels of care, implemented multidisciplinary treatment processes, and continued efforts to comply with the Mays Consent Decree. The system now includes multiple treatment levels and specialized programs, including the APU, IOP, EOP, JBCT, EASS, the CNAP, and outpatient mental health services. Each level of care carries unique treatment expectations, monitoring requirements, reporting needs, and compliance obligations.

Sustained compliance with the Mays Consent Decree requires the ability to demonstrate, through reliable performance data and routine monitoring activities, that patients receive timely assessments, appropriate placement, required treatment contacts, multidisciplinary treatment planning, structured therapeutic activity, and timely movement throughout the continuum of care.

As treatment capacity continues to expand and reporting expectations increase, QA activities become increasingly important to ensure that system improvements are producing measurable operational and clinical outcomes. Additional QA capacity would strengthen ACMH's ability to conduct routine audits, validate performance data, monitor trends, evaluate corrective actions, and provide ongoing proof-of-practice documentation associated with Consent Decree compliance requirements.

Recommendations

Sacramento County should increase dedicated mental health QA capacity within ACMH to support ongoing Mays Consent Decree compliance, performance monitoring, and continuous quality improvement activities. Additional QA resources should support routine clinical audits, proof-of-practice reviews, performance reporting, data validation, corrective action monitoring, and evaluation of treatment outcomes across all levels of care.

A reasonable long-term structure would include a designated QA lead, supervisor, or director responsible for coordinating QA activities, establishing performance measures, supervising compliance reporting, and ensuring that findings are translated into operational improvements. Supporting staff could focus on two primary functions: 1) clinical quality review and proof-of-practice auditing, including assessments, treatment plans, level-of-care determinations, medication follow-up, discharge planning, and continuity of care processes; and 2) performance reporting and data analytics, including monitoring waitlists, access to care measures, structured therapeutic activity, treatment participation, level of care movement, and other Consent Decree related performance indicators.

Strengthening QA capacity would allow Sacramento County to more effectively evaluate whether expanded treatment services are reducing waitlists, improving timely placement into appropriate levels of care, increasing access to structured treatment, and supporting sustained compliance with the Mays Consent Decree over time.

Programming and Housing Challenges Within Current Space

The intake process plays a critical role in identifying mental health, medical, and substance use treatment needs. Sacramento County should ensure adequate space and staffing for comprehensive intake, including behavioral health assessment, medical evaluation, suicide risk assessment, and SUD screening.

In addition to broader assessment and treatment space limitations, most mental health staff lack dedicated office space or consistent locations to provide services within the jail. Clinicians frequently rely on shared, temporary, or multipurpose spaces, which can limit privacy, create scheduling conflicts, burden SSO escorts, and reduce the efficiency of treatment delivery.

The absence of dedicated clinical work areas also creates challenges for documentation, confidential patient consultations, and multidisciplinary collaboration. These operational constraints reduce the amount of time clinicians can devote to direct patient care and contribute to delays in assessments and treatment. The current footprints limit Sacramento County's ability to create smaller, treatment-oriented housing environments and to consistently deliver programming within or adjacent to housing units.

Multiple patients describe treatment interruptions associated with pill call, limited program space, housing-related stress, and restricted access to therapeutic activities, reinforcing

stakeholder concerns that the physical space continues to constrain delivery of mental health services.

There is a general lack of dedicated housing to meet the unique physical, health, and mental health requirements of specialty populations. For many of these populations, two-tiered general population housing environments, bunk beds and dormitory-style accommodations are unsuitable.

Recommendations:
Sacramento County should align facility design with clinical and operational needs by prioritizing intake and early stabilization space, housing-based treatment space, distributed clinical capacity, and staff co-location. Facility planning should support timely, confidential, and therapeutically appropriate service delivery, particularly for individuals with serious mental illness, intellectual and developmental disabilities, mobility limitations, trauma histories, and other clinical needs that are poorly served in traditional two-tiered or dormitory-style housing.

The County should continue moving toward a housing unit-based service delivery model in which clinical services, case management, medication support, and therapeutic programming are provided closer to where people live. Program rooms, counseling rooms, consultation space, telehealth rooms, and medication support areas should be located within or adjacent to housing units where possible. This approach will reduce escort-related barriers, improve participation, and make treatment more consistent for individuals who require regular clinical contact but do not need acute psychiatric care.

Sacramento County should increase the availability of dedicated office space, interview rooms, and treatment areas for behavioral health personnel. Mental health staff should have access to secure and confidential workspaces located in or near the housing units and treatment programs they support. Future facility planning efforts should incorporate sufficient clinician offices, private assessment rooms, multidisciplinary team areas, and treatment space to support efficient service delivery and reduce operational barriers to care.

Sacramento County should also support multidisciplinary unit-based teams. Housing-based care should include coordinated participation by custody, mental health, medical, nursing, case management, and reentry staff. Co-location and regular team-based communication would improve awareness of patient behavior, support earlier intervention during mental health crises, and reduce operational barriers that interfere with treatment delivery.

Facility design, in turn, will inform specific staffing needs and the distribution of staff across the hours of operation, including overnight shifts.

Clear Accountability and Clinical Independence Are Important Components of Effective Correctional Health Systems

National standards and best practices consistently emphasize the importance of maintaining clinical independence in correctional health services, including both medical and mental health care. Organizations such as the NCCHC and the American Public Health Association (APHA) emphasize that correctional health services should operate under governance structures that preserve clinical independence and align with community standards of care. APHA specifically notes that health professionals in correctional settings should function as independent providers, while NCCHC standards require systems of governance and administration that support appropriate and accountable delivery of care.

Medical, mental health, and custody staff should function as interdependent partners with clearly defined roles: healthcare staff retain clinical decision-making authority, oversight and autonomy, while custody supports safe access to care. This partnership can be reinforced through joint policies, routine multidisciplinary meetings, shared quality improvement review, cross-training, and clear communication protocols that protect confidentiality while ensuring custody has the information needed to maintain safety and support treatment plans. The goal is not to merge or overlap clinical and custody functions, but to align them so that individuals have timely access to services and custody operations are informed by appropriate health care guidance. This approach is consistent with NCCHC's emphasis on organized health services and responsible health authority oversight, and ACA's focus on safe and secure facility operations that provide access to necessary medical and behavioral health.

At the same time, effective systems require strong operational coordination between custody and clinical teams. For Sacramento County, retaining mental health and medical services within the County health department aligns with these national standards and supports continuity of care across custody and community systems, particularly given the County's investments in CalAIM, BH-CONNECT, and community-based mental health infrastructure.

Regardless of governance or leadership structure, the critical success factor is not who holds the contract, but whether the model ensures collaboration, clinical independence, and clear accountability for outcomes.

Recommendations

Sacramento County should continue to structure correctional mental health and medical services in a manner that preserves clinical independence, establishes clear accountability for outcomes, and promotes effective collaboration between SSO, ACMH and ACH. The County should support processes that reinforce interdisciplinary communication, joint problem-solving, coordinated quality improvement activities, and clearly defined decision-making

authority. Future planning and service delivery models should ensure that clinical decisions remain the responsibility of appropriately qualified healthcare professionals.

Deflection and Diversion

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.

Even when individuals are successfully deflected or diverted to crisis or urgent care settings, significant barriers may remain. Additional screening, authorization, and referral requirements can delay connection to ongoing community-based treatment, disrupting stabilization and increasing the likelihood of repeated crises and return to custody.

These challenges often persist beyond the point of diversion or release. Individuals leaving jail, or transitioning from crisis, urgent care, or diversion settings, may still face substantial delays in accessing follow-up mental health, substance use, or medication management services in the community. Such gaps will undermine continuity of care and weaken the effectiveness of both diversion and reentry efforts.

At the same time, law enforcement may have inconsistent, outdated information about the scope, eligibility criteria, and availability of community-based behavioral health services that could support effective deflection or diversion. As a result, opportunities to connect individuals to appropriate treatment in the least restrictive setting may be missed.

Recommendations

Sacramento County should continue to strengthen deflection and diversion pathways that connect eligible individuals to community-based services as early as possible and in the least restrictive setting. This includes stronger use of the Community Wellness Response Team, crisis response resources, Crisis Receiving for Behavioral Health (CRBH), Mental Health Urgent Care Center, 988, treatment courts, CARE Court, Assisted Outpatient Treatment, and other alternatives to incarceration.

The County should also enhance cross-sector collaboration among law enforcement, behavioral health agencies, courts, correctional health, housing partners, crisis providers, and community-based providers so that diversion, in-custody treatment, and reentry operate as one coordinated system. Regular cross-sector forums should review barriers, referral pathways, service capacity, high-utilizer trends, and outcomes. These forums should support

shared problem-solving and help ensure that people do not have to deteriorate, be arrested, or cycle repeatedly through crisis settings before receiving sustained treatment.

Sacramento County should ease access to community-based services by creating more direct pathways from custody, crisis response, and diversion settings to ongoing treatment. Referrals from jail and crisis programs should be treated as urgent transitions requiring active follow-up, warm handoffs, and direct scheduling where possible. CalAIM, BH-CONNECT, CARE Court, AOT, treatment courts, and CCBHC pathways should be aligned with release and diversion workflows so that individuals are not left to navigate complex referral systems on their own.

Finally, Sacramento County should improve outcome measurement and reporting across crisis response, deflection, diversion, treatment access, jail reduction, and reentry. Practical measures should include time to first appointment, referral completion, treatment engagement, medication continuity, release planning completion, rebooking, crisis-system use, and connection to housing or benefits. Stronger data-sharing agreements between silos of community, correctional, and law enforcement agencies and shared workflows would help identify frequent system users, track transitions, and support coordinated interventions.

Cross-System Coordination Remains Essential to Reducing Reliance on Jail-Based Mental Health Treatment

Sacramento County faces a persistent challenge in responding to the needs of people with serious mental illness, SUDs, and co-occurring conditions who continue to cycle through jail, crisis, homelessness, hospital, and community systems. Jail remains a frequent point of intervention for individuals whose primary needs are clinical or service-driven rather than custodial. Reducing the reliance on treatment afforded in the jail will require stronger coordination across the jail, County Department of Health Services (in particular the Division of Behavioral Health Services), SSO, the courts, correctional health, community-based providers, and reentry partners.

Sacramento County already has invested in a broad community-based mental health continuum, including urgent care, crisis response, diversion pathways, specialty treatment courts, and community treatment options. Although those investments create an important foundation, stakeholder interviews, however, suggest that Sacramento County services do not yet operate as a seamless alternative to justice involvement.

One community-based provider 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. The County still has important opportunities to intervene earlier, strengthen service handoffs, and improve coordination across the Sequential Intercept Model.

The jail reduction materials reviewed for this report underscore that Sacramento County's strategy is not limited to reducing the average daily population; it is also intended to reduce the number of people whose health needs escalate because treatment and support were not available early enough. In practical terms, this means aligning community-based supports within the jail, prevention, deflection, diversion mechanisms, in-custody treatment, and reentry supports as part of one coordinated system rather than treating them as separate efforts.

Successful cross-sector collaboration will produce lower jail utilization, improved mental health outcomes, better continuity of care, more efficient use of public resources, and improved public safety outcomes.

Recommendations

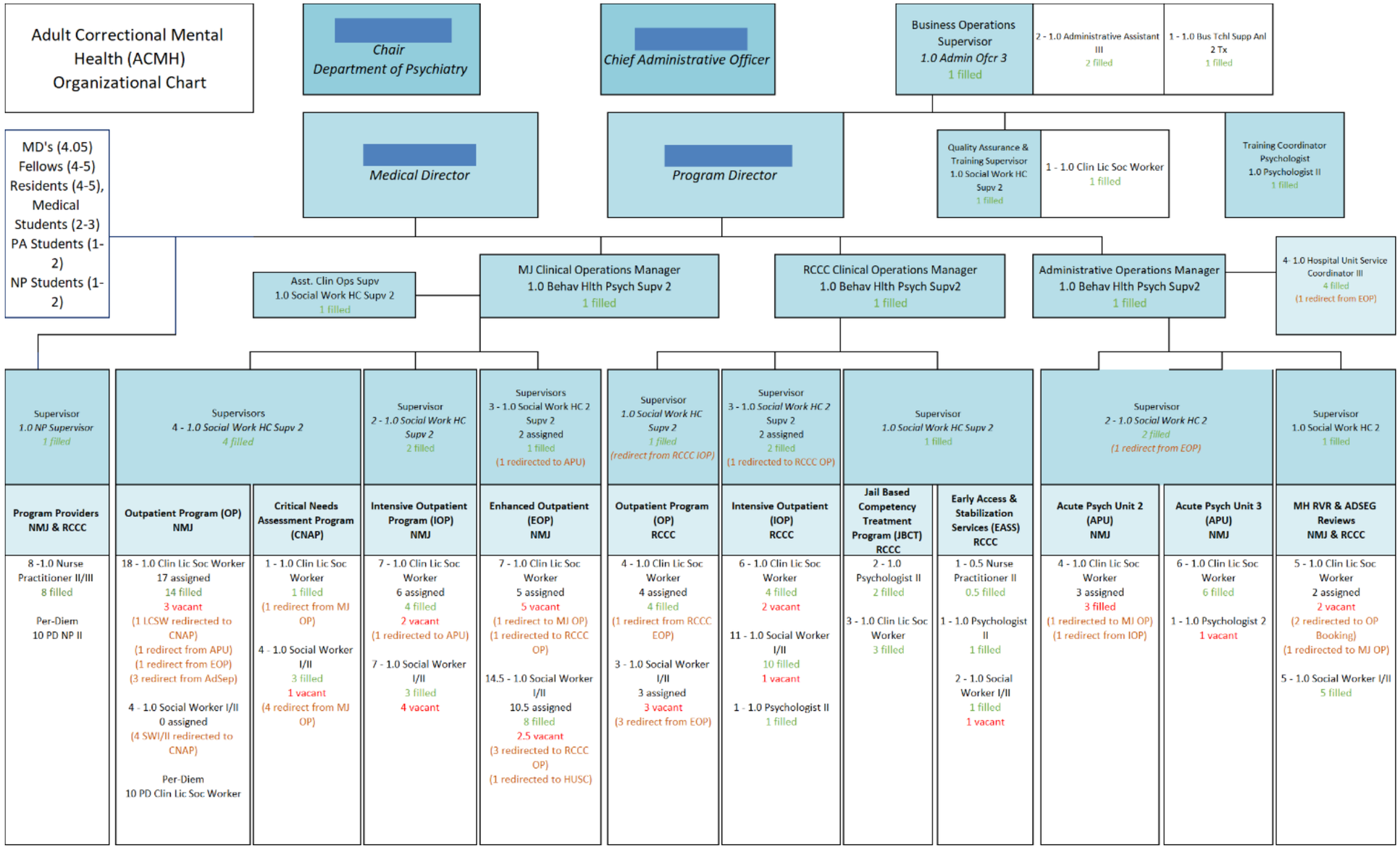
Sacramento County should continue to strengthen cross-sector collaboration among the jail, County Department of Health Services, SSO, courts, community-based behavioral health providers, and reentry organizations to reduce reliance on jail-based treatment and improve continuity of care. Future planning efforts should emphasize coordinated care pathways, stronger transitions between systems, expanded diversion and deflection opportunities where clinically appropriate, and shared accountability for outcomes across the behavioral health continuum. The County should continue using the Sequential Intercept Model as an organizing framework to identify service gaps, improve coordination, and prioritize investments that support intervention earlier in the behavioral health and justice continuum.

APPENDIX A. KEY RESOURCES

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- *Second memorandum of agreement* (Doc 225-1). (2025, September 16). View document

APPENDIX B. ACMH TABLE OF ORGANIZATION



APPENDIX C. LPS FTE STAFF-TO-PATIENT CENSUS RATIO REQUIREMENTS

	Minimum Number of Required Full-Time Equivalent Staff									
Patient Census	**1–10**	**11–20**	**21–30**	**31–40**	**41–50**	**51–60**	**61–70**	**71–80**	**81–90**	**91–100**
Behavioral Health Physicians	1	1	2	2	**3**	3	4	4	5	5
Behavioral Health Professionals	1	2	3	4	**5**	6	7	8	9	10
Licensed Nursing Staff	4	5	6	8	**10**	12	14	16	18	20
Behavioral Health Personnel	3	5	8	10	**13**	15	18	20	23	25
Totals	9	13	19	24	31	36	43	48	55	60

Legend: **ACMH Staff** | **ACH Staff**