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Sacramento County Correctional Facility Master Planning Services

Phase I/II Report: Functional Assessment and Projected Needs

Section 6.0 – Functional/Operational Assessment

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INTRODUCTION

This analysis of as-is conditions is provided to establish a baseline for planning in response to the requirements of Request for Qualification 81752 Correctional Facility Master Planning Services issued by Sacramento County. This RFQ was issued as basis for the development of this Master Planning study, resulting in a determination of the most appropriate long-term solution to addressing the agreed to conditions of the Mays Consent Decree related to five key areas of care and services which are under the purview of the County and administered by the Sacramento County Sheriff's Office (SSO), the County Department of Health Services, Adult Correctional Health Division (ACH) and Adult Correctional Mental Health Division (ACMH).

The five key areas addressed in the Consent Decree include:

1. Medical Care and Services
2. Mental Health Care and Services
3. Accessibility
4. Suicide Prevention
5. Restrictive Housing

Although facilities are not addressed in direct detail as part of the Consent Decree, each of these areas are affected, and subsequent Memoranda of Agreement (MOAs) refer to "remediation of physical plant deficiencies."[1] The County had been in the process of developing a proposal and possible RFP for construction of an Intake and Health Services Facility (IHSF) as an addition to the Main Jail (MJ). This effort was placed on hold to allow for a peer review of the proposal, which determined that the IHSF "did not adequately address several core Consent Decree requirements, including the provision of sufficient work, clinical, administrative, and treatment programming space for medical/mental health staff, the provision of sufficient outdoor recreation space, and other core facility needs."[2] As a result, the Second Memorandum of Agreement stipulates:

I. Unresolved Disputed Issue #1 re: Remediation of Physical Plant Deficiencies[3]

[1] Mays Consent Decree, First & Second Memorandums of Agreement

[2] Second Memorandum of Agreement

[3] Ibid

1. The County shall, by October 30, 2026, complete a Correctional Facility Master Plan, which shall provide a written report that details jail physical plant remediation options, with associated cost estimates, recommended project delivery methods, project timelines, and other relevant matters.
2. The Correctional Facility Master Plan shall include: (1) the inspection, assessment, inventory, and analysis of existing County facilities, (2) a detailed jail population analysis that includes assessment of the jail population's mental health care service, medical care service, and Americans with Disabilities Act (ADA)/Disability-related needs, (3) an operations assessment including compliance with the Consent Decree requirements for ADA/Disability accessibility, mental health care services, and health care services to meet the needs of the jail population, and (4) space planning and assessment.

In assessing any existing correctional facility, two primary aspects should be considered:

- The physical condition of existing facilities including deferred maintenance and potential critical issues related to the facility itself
- Functional/operational considerations related to spatial shortfalls or inadequacies based on standards and best practices as well as safety, security, and staffing/operational costs

These are of equal importance in terms of having a safe and effective environment. Overall physical conditions factor into decisions about whether to keep, remodel, or replace facilities based on the current conditions, deferred maintenance, and cost of repairs. In terms of driving remediation actions related to long-range planning options and decision-making, the operational assessment has more relevance than the physical condition assessment in terms of addressing identified challenges and critical deficiencies.

The RFQ for master planning addressed physical conditions in subsection 3.1 of the RFQ Scope of Work – Facilities Condition Assessment (FCA). This effort is documented in Section 7.0 of this report – Facility Conditions & Accessibility Assessment – Component 1.

For both the MJ and the Rio Cosumnes Correctional Center (RCCC) the FCA effort included:

- Physical assessment of current conditions of buildings and systems
- Accessibility assessment per the requirements of the ADA
- Assessment of security/detention construction (doors, locks, devices)
- Assessment of electronic security systems and controls
- Assessment of required upgrades to accommodate current technology

Refer to Section 7.0 and associated Appendixes in the Phase I/II Report for additional information.

The RFQ for master planning addressed functional and operational considerations in subsection 3.2 Population Analysis and Operational Assessment and 3.3 Space Planning & Assessment – Component 4.

Specific subsections related to the scope of this report include:

- 3.2.2. Operational Analysis of Current jail System: A complete system operational analysis should be conducted to determine future use of existing or new facilities to meet federal oversight compliance of the County jail system as a whole.
- 3.2.2.B. Transportation requirements between facilities including court appearance and how they impact staffing requirements, length of stay, and community reentry strategies.
- 3.2.2.G. Staffing Analysis 2. Custody staffing needs to meet the health care and safety needs of the inmate population.
- 3.3.4. Provide a gap analysis:
    - The consultant team shall identify gaps or misalignment between the existing jail system and the desired jail system based on the established goals and key objectives identified with the Committee and any input from internal and external stakeholders identified by the Committee. The gap analysis shall include:
        - Identification of all gaps relating to operation and functional requirements such as outdoor recreation space, population growth, and work, clinical, administrative, and treatment programming space for medical/mental health staff.

The primary goal of the functional/operational assessment, the subject of this section, is to understand current conditions and operations relative to current and future needs and what the existing resources are to accommodate those. All of this information serves as the basis for identifying misalignment between the existing jail system and the desired jail system and making specific recommendations for short- and long-term implementation in this "gap analysis."

In addressing current deficiencies affecting the delivery of care, this section also incorporates evidence-based best practices for modern detention systems from across the industry to reflect how Sacramento County could operate its desired jail system safely and effectively.

6.1 Summary Findings from the Functional and Operational Assessment

The functional and operational assessment focused first on issues under the five key areas of the Consent Decree as well as additional issues that are impacting day-to-day operations and are not reflective of best practices or the "implementation of modern detention facility management practices (direct supervision, strategic inmate management)" that would be

considered in defining the "desired jail system" for Sacramento County.[4] Findings are detailed in the body of this report with a general summary provided below.

Medical Clinic and Infirmary

The Medical Clinic and infirmary at the MJ are inadequate to serve the medical needs of the current population. A critical issue affecting the delivery of timely services is the fact that no holding or waiting areas are provided for inmate-patient staging, which reduces the efficiency of nursing and medical staff to provide services as a result of the increased downtime waiting for patients and affects delivery of medical services. Furthermore, the number of exam and treatment rooms is insufficient to maximize the number of patients that can be seen at this central location.

Planning should reflect best practices seen in free-world medical clinics—adequate waiting to stage patients, nursing station capable of supporting required staff, adequate exam rooms to stage and serve multiple inmate-patients concurrently, specialized facilities for telemedicine, and appropriate storage areas to avoid staging equipment in circulation corridors and treatment rooms.

Another key area of concern is the lack of a trauma room for the delivery of immediate treatment, which could also reduce off-site transport for services.

On the housing floors, a single medical exam room is provided to serve both the east and west pods in the core circulation area. No waiting is provided and access to services is affected by ongoing activities and movement from housing pods to treatment area. Housing level exam/treatment rooms located within each pod (east and west) would reduce waiting time between patients for medical staff, provide for queuing, and eliminate the need for escort or additional custody staff to monitor treatment rooms at housing, thereby increasing staffing effectiveness and timely access to care.

The infirmary also is inadequate, with no rooms sized to accommodate a hospital bed when mandated by treatment. Additionally, none of the infirmary rooms meets requirements for accessibility, a common need for both the infirmary and the clinic. Negative pressure rooms are inoperative, and the mixing of APU and medical rooms on the same area of the infirmary can

[4] *References are from Request for Qualification 8172 Correctional Facility Master Planning which established the scope for this planning effort.*

be disruptive to both. There are no out-of-cell or outdoor areas provided for infirmary patients. Also, there are no provisions for professional or social visiting at the infirmary.

At RCCC, medical facilities are duplicated in several locations—one for the newer higher security housing, one for the minimum-security barracks, and one for the female population, resulting in staffing inefficiencies. Clinical treatment space is limited relative to the capacity of the facility. The male infirmary consists of an open ward and several cells with bar grille fronts; no accessible cells are available.

Pharmacies at both locations are limited in space, a small basement room at MJ and small dedicated portion of maintenance building at RCCC.

Other sections of the report provide details on potential remedial actions and best practices for future planning. The Master Planning Team agrees that interim improvements may provide some improvement in facilities and access to care but will not fully resolve physical deficiencies relative to requirements of the Consent Decree for improved access to healthcare, ultimately requiring major renovation/expansion or new construction.

Mental Health Housing and Program Support

The Mental Health treatment program includes services identified in four levels of care: an Acute Psychiatric Unit (APU), an Intensive Outpatient Program (IOP), an Enhanced Outpatient Program (EOP), and Mental Health – General Population (MH-GP).

The APU on the second floor, as originally designed, provided seven dedicated cells for individuals clinically assessed as in need of psychiatric acute care. Over time, as the need for additional APU beds increased, 10 cells in the adjacent infirmary were assigned for APU inmate-patients, which is disruptive to the medical infirmary inmate-patients. Limited program space is available and access to outdoor recreation for the APU population requires escorting residents to one of the three shared recreation areas.

Note that none of the beds on the second floor meets requirements for accessible cells. Recently, Pod 200 East on the third floor was adapted to provide additional APU capacity including accessible cells. While this provides an interim solution, two-tier housing is generally not recommended for mental health treatment, both in terms of the risk of injury to inmate-patients or staff and the fact that it places a portion of the population more remotely from the treatment staff. There is also generally a lack of appropriate individual and group treatment space available for the APU population. The population is effectively split into three areas - originally APU, beds in the infirmary, and the new third floor unit - which results in staffing inefficiencies.

While the 167 beds dedicated to IOP housing are considered designated Mental Health beds, they are not purpose-built housing units. They are essentially existing general population beds, most with two beds, which formerly housed general population inmates and, in most cases, sub-units of general population housing. EOP and MH-GP inmate-patients are not housed in treatment cohorts and are generally spread throughout the general population.

Per the Second Memorandum of Agreement, the County agreed to and has provided 167 beds dedicated to housing people clinically assessed as requiring placement in the IOP. These beds are located in both the MJ and RCCC and are typically individual cells with capacity for double bunking via stacked bunks. All of the housing units are also tiered units and lack accessible cells and showers. Currently, most IOP housing units designate the lower tier for single-cell housing with additional provisions to mitigate suicide risk. The exception is Christopher Boone Facility (CBF) 200 at RCCC, which is 100% double-bunked. The EOP (34% projected single-cell need) and MH-GP populations are similarly housed at the MJ and RCCC.

A significant portion of the IOP population requires single-celling—projected at 66% per the population analysis presented in Section 3.0. As a result, a portion of the dedicated 167 beds is unavailable for those assigned to IOP. On average, based on information prepared for the projection model (Section 3 of this report) the IOP population, including the waiting list, involves 145 people, but as of April 2026 (Workshop 5) the actual population was only 136 due to required single-celling of a portion of the population.

Best practices would suggest that significant changes are needed to house this population—smaller housing units, single-level housing unit configuration, and if double-celling, both beds should be floor mounted rather than stacked vertically—and the IOP and EOP populations should be cohoused, rather than spread out, to support treatment goals and increase staff efficiencies and effectiveness.

Program and support facilities are also of concern. Multipurpose rooms must accommodate competing uses, including mental health treatment, education, community providers, and other functions. At the MJ, each pod of three housing units has a single multipurpose room. Additional program rooms were created on the third floor by displacing mental health staff to 711 G Street, which, as noted below, is also a problem in and of itself. It is believed that with extended scheduling the rooms available can meet the demand—but since the population is not cohoused, it may require escorted movement to assemble appropriate groups for group treatment. Multipurpose and individual interview/counseling rooms are extremely limited at RCCC based on the capacity of the campus. Limited facilities are available for Stewart Baird Facility (SBF), Christopher Boone Facility (CBF), Joseph Kievernagel Facility (JKF), and Kevin Blount Facility (KBF); the Honor Barracks have no unit facilities and use space in modular buildings; Sandra Larson Facility (SLF) has a program wing with classrooms/multipurpose rooms.

At the MJ, in an attempt to show compliance with the Consent Decree, the County has added glazed cubicles in the central core of each housing pod, but these cubicles are not enclosed at the top and do not provide confidential interview space, and as they are glazed to allow full view into adjacent housing units, they are in effect "fishbowls" for treatment counseling and interviews. Although recognized as a good faith effort, the lack of both aural and visual privacy has been cited as a deficiency. Additionally, the lack of conversational privacy is a Health Insurance Portability and Accountability Act (HIPAA) violation.

The relocation of mental health staff to 711 G Street also has had an impact on service delivery. Time is lost in moving from their offices to the MJ and back for report generation, etc.

Relative to best practices, treatment populations should be typically co-located, each housing unit should have a multipurpose room and individual interview room, and staff should be located near the population served.

Refer to the body of the report for additional details on potential remedial actions and best practices for future planning. It is the opinion of the Master Planning Team that interim improvements may provide some improvement in facilities and access to care but will not fully resolve physical deficiencies relative to requirements of the Consent Decree for improved delivery of mental health care, ultimately requiring major renovation/expansion or new construction.

Intake/Transfer/Release

While not directly cited in the Consent Decree as a key area of concern, the activities in this area are directly impacted by the cited concerns related to medical services, mental health services and accessibility issues.

Upon arrival at the MJ, medical screening included historically of having the arrestee respond to a list of standard questions unless there was a question about whether the jail would accept the individual. As the arrestee population has exhibited greater degrees of medical and mental health acuity, SSO in conjunction with ACH expanded their process and every person must now undergo a two-phase "receiving health screening." Individuals must pass both screening phases before they are accepted into custody.

Screenings are primarily conducted by intake nurses. Note that the intake process and booking area continue to be an area of focus of the plaintiffs and the SMEs for Medical and Mental Health who monitor and adjudge compliance with the provisions of the Consent Decree. ACMH recently assigned a mental health clinician to the intake area to direct traffic flow and information, provide an initial mental health assessment in booking, and prioritize patients based on acuity.

Phase 1 screening is an initial “fit for custody” evaluation. It is performed prior to acceptance to determine fitness for confinement and to assign an “acuity priority” to the patient. It involves a review of the arresting officer's observations, a full set of vital signs, and an assessment to ensure that the patient has no injuries or acute medical conditions requiring transfer to an outside hospital for further evaluation. The identification of a person with a developmental disability also begins at this stage and continues throughout incarceration.

Individuals who will be staying in jail receive a second, more comprehensive Phase 2 screening. Phase 2 screening involves an in-depth review of the patient’s medical history before formal booking. During Phase 2, nurses determine the acuity level of the person, placing color-coded wristbands on the patients to indicate their level of priority for triage as follows:

- Patients who are high-priority receive a red wristband
- Patients who are medium-priority receive a yellow wristband
- Patients who are low-priority receive a green wristband

Procedures are in place to prioritize and expedite intake for patients with acute medical or mental health needs (red wrist band).

The prebooking area is severely congested. Crowding of report workstations limits privacy for the arrestee when responding to questions and access to individual interview rooms is a major limitation to efficient processing.

Crowding is exacerbated during peak periods due to a lack of flex space to provide surge capacity. Additional interview rooms are needed for Phase 1 and Phase 2 Medical and Mental Health interviews and to allow additional staff to be assigned when necessary. The lack of adequate capacity not only slows intake processing and increases stress levels for all but also affects the efficiency and effectiveness of law enforcement personnel because they cannot return to the street until the Phase 2 interview is complete and SSO accepts custody.

Temporary holding facilities are inadequate and do not meet accessibility standards. Moreover, classification interviews occur in group holding cells, providing no privacy for arrestees while they respond to questions.

Similar processes are in place at RCCC, but the facilities are inadequate to support the operation. Medical screening, for example, occurs in a converted semi-trailer, and support facilities are virtually nonexistent.

The existing facilities as planned are ineffective and inefficient to accommodate operational flows or provide effective safety and security for staff. The intake/transfer/release component of the current facilities does not reflect a trauma responsive environment—proven critical to reducing stress, anxiety, and aggressive responses in arrestees

A process driven, purpose-built solution is required that can respond to day-to-day needs as well as peak needs. The process should be a "future-driven reengineering effort" in anticipation of potential changes, such as greater pretrial services involvement, earlier intervention by the public defender, opportunities for community diversion—none of which can be accommodated within the existing confines of the ITR area.

Accessibility

A separate report was undertaken as part of the FCA. This report documents 499 deficiencies in the MJ and 1,544 deficiencies at RCCC—many of which are repetitive across the facilities. One of two critical issues identified is the lack of accessible housing, showers, and toilets at both facilities. Typically, today, in new facilities provisions for accessibility are made in every housing unit in order to provide flexibility in housing assignments based on classification and assure that the availability of accessible housing is not limiting where a person in custody can be housed. Segregating people based on a disability has been found to be unacceptable.

The second critical issue—and one that has been key to the Consent Decree—is the inaccessibility of visiting space in the MJ. Visiting at the MJ is on the mezzanine level, which is inaccessible to individuals with certain physical disabilities. The County has made provisions for accessible visiting on the second floor as an interim measure, but Class Counsel does not view this as a long-term solution.

Suicide Prevention

The County, SSO, and ACMH have addressed this issue by increasing screening and assessment and designating additional Suicidal Inmate Temporary Housing Units with regular welfare checks.

Restricted Housing

SSO has drastically reduced the use of restricted housing in direct response to the issues raised in the Consent Decree. Future planning should consider a purpose-built unit that would provide better access to indoor and outdoor recreation for the limited out-of-cell time allowed.

Refer to Section 6.0 for a more extensive and detailed review of the findings of the functional assessment.

6.2 Functional/Operational Assessment, Gap Analysis, Recommended Remedial, and Future Planning Actions

Assessment Approach and Methodology

The consultant team conducted an analysis of the site, buildings and existing departmental areas contained within the MJ and the RCCC. Consultant team members toured each site on several occasions between October 2025 and January 2026 to observe physical conditions, current operations, and the quantity and quality of spaces. The visits provided an opportunity to observe current practices, processes, and activities firsthand, discuss strengths, security issues and functional challenges posed by the existing buildings age and configuration.

Observations gleaned during the site visits were supplemented by consultations with facility staff and fact-finding interviews with key stakeholders about their vision and expectations for the future. Additionally, the consultant team reviewed existing floor plans, surveys, and other documents provided by the County. Color-coded diagrams were generated (see Appendix A) as the basis for documenting and updating existing space allocation and utilization by floor and currently occupied square footage by major departmental component (spatial utilization analysis).

For each facility, the assessment was conducted against the following three main parameters:

1. Appropriateness and adequacy of space to perform daily activities effectively and safely, focusing on adjacencies and operational affinities, and space deficits or surpluses.
2. Adaptive reuse and flexibility of existing spaces for new functions through renovation and limited additions to mitigate shortfalls.
3. Responsiveness of each existing departmental area to support a dignified and professional work environment, an environment of care, and a humane and safe living environment.

Given the focus of the Consent Decree, the First and Second MOAs and multiple Subject Matter Expert (SME) monitoring reports produced between 2021 and 2026, the following key departmental areas were assessed as part of this project to address long-standing medical and mental health care deficiencies and standards for HIPAA, ADA, and PREA compliance:

- Housing
- Intake/Transports/Release
- Mental Health Services
- Medical Services

In addition, the following departmental components were assessed to identify space needs in other areas of the facility that are critical for improving staffing working conditions and operational safety, increasing in-custody population engagement, and providing mandatory out-of-cell time.

- Administration
- Staff services
- Program space and in-custody services, including indoor and outdoor recreation
- Building support services

In addition to considering gaps related to specific standards, the assessment also focused on best practices especially related to medical and mental health care and functional and operational considerations. During Workshop 3 with the Stakeholders and Executive Committee the Master Planning Team outlined best practices for general familiarity and consideration as benchmarks for defining the desired jail system of the future. These best practices were considered as part of the assessment and, in Workshop 4 - which presented the findings of the assessment - were the basis for recommendations for the development of alternative approaches for the future. Note that these best practices integrate operations, service delivery, and level of care as the basis for recommended actions to mitigate defined physical deficiencies.

The findings of the functional and operational assessment are presented below accompanied by a series of suggested recommendations to close the gaps between the existing and the desired jail system to address compliance with the agreed conditions of the Consent Decree. In addition to documenting recommended best practices for planning approaches for the future, Subsection 6.6 of this report outlines some interim measures that could be considered to remediate some of the more critical physical plant deficiencies impacting compliance with the Consent Decree at the two facilities.

Ultimately, the findings from this analysis will be considered in conjunction with the findings from the physical facilities conditions assessment as the foundation for further analysis and development of long-range systemic approaches for enhancing the functionality of the County's jail system and improving justice system outcomes in consideration of available financial options.

Housing – Assessment, Gaps, Remedial and Future Planning Recommendations

Main Jail

At the MJ, the housing component is distributed on seven floors (two through eight). The second floor is composed of single-level housing units, while housing units on the third through eighth floors have two levels of stacked cells (two-tier housing). All housing units are designed

as pods, with cells opening to a central dayroom. Each housing unit comprises three to four pods. Bed type accommodation consists primarily of single and double cells.

Findings

The rated capacity of the MJ is 2,400 beds. Using point in time data, as of January 27,2026, the facility housed 1,743 individuals, including 1,558 males and 185 females, and 23 non-rated beds in acute medical and psychiatric housing. Despite the vacancy rate, the MJ could never safely operate utilizing all available beds.

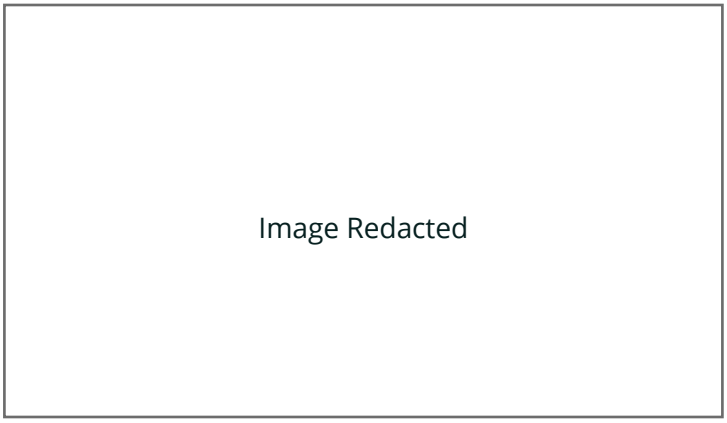
The need to safely and appropriately separate housed individuals with diverse classification levels and complex criminal histories, medical and mental health needs, reduces significantly the MJ's actual usable capacity. Matching individuals to the right type of bed consumes space, with proper separation of populations by risk and need categories being particularly challenging in the large pods (of 64 and 80 beds). This situation leads to bed space inefficiencies, and potential overcrowding in certain housing areas (above 90%), even with some beds available throughout the facility.

In addition to difficulties finding people of the same classification level who can be housed together, the two-tier configuration of the housing pods significantly affects where an individual can be safely housed. For example, on the 6th floor – East, used for detoxification/medication assisted treatment purposes, only the 16 cells located at the bottom of each of three pods can be used as single cells, rendering a total of 48 double occupancy cells (or a total of 96 beds) on the upper tier unusable. This challenge also applies the housing of individuals with mental health needs.

The following key issues were identified as critical gaps relative to the requirements of the Consent Decree, accepted standards, and functional/operational best practices.

- The large capacity of the existing housing pods (at 64- and 80-beds) does not align with current separation and classification requirements, rendering certain pods unusable for specific populations and leading to operational overcrowding even when physical beds are available.
- Providing adequate out-of-cell time is also a challenge in these large units with mixed classifications as certain populations cannot be programmed together. Note that this has also increased the historic utilization factor as not all beds in a unit can be used without mixing dissimilar classifications.

Image 6.2.1. Main Jail Typical Housing Unit



Remediation Recommendations

Existing Housing Units:

- Consider subdividing housing units to create smaller units or add subdivisions/sub-dayrooms to accommodate varying classifications and allow increase in out-of-cell time.

Future Planning:

- Consider planning based on smaller housing units or larger units with sub-dayrooms for staffing efficiency.

No accessible cells showers or seating are provided on any typical housing pod. Individuals requiring "medical accommodations" are housed in pods 200 and 300 with accessibility accommodations; however, these are noncompliant with ADA and state standards.

The ADA[5] mandates that correctional facilities—including local jails and state/federal prisons—provide accessible housing and equal access to all programs for incarcerated people with disabilities. In both new constructions and alterations, at least 3% of the total cells must be accessible for individuals who use wheelchairs or other mobility aids.

[5] Title II of the ADA, 42 U.S.C. §§ 12131-12134; ADA/Section 504 Design Guide: Accessible Cells in Correctional Facilities
Mobility Accessibility: At least 3% of total cells and rooms in jails, prisons, and detention facilities must be accessible.
Dispersion by Classification: Accessible cells must be distributed across each security classification and program level.
Communication Features: At least 2% of general holding and housing cells must include communication features.
Integrated Settings: Inmates with disabilities must be placed in the most integrated setting appropriate to their needs.
Medical Area Restrictions: Inmates who are not ill or injured should not be housed in medical units.
Program Access: Accessible housing units must provide equal physical access to dining, recreation, visitation, educational programs, and religious services.

Note that the ADA regulations also stipulate that incarcerated people with disabilities must not be excluded from programs, services, or activities on the same basis as non-disabled people and that specifically, people in custody be placed in housing related to their security classification rather than being forced into medical or distant facilities just because of a lack of accessible cells.

Best practices suggest that each housing unit should accommodate accessible cells or beds to respond to security and programmatic needs across the spectrum of the jail population.

Remediation Recommendations

Existing facilities:

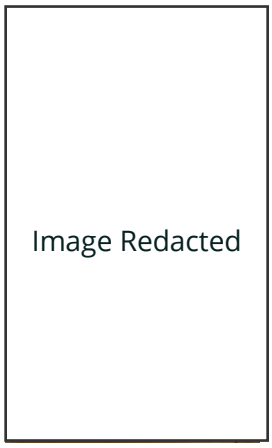
- Combine two cells to provide one accessible cell and shower per housing unit, resulting in a net loss of two beds per unit (currently being provided in two units on the third floor for special populations). (See Section 6.6 for initial concepts.)

Future planning:

- Plan for at least one accessible cell and shower per general housing unit and increase the ratio in medical and special needs housing.@

Double-bunked cells only have seating for one at the desk using the lower bunk—an issue raised by both the Consent Decree plaintiffs and SMEs. This layout requires the person assigned to the upper bunk to step on the lower bunk and table to reach the upper bunk. *Note that CA Board of State and Community Corrections (BSCC) standards only require one desk and one seat in a double-bunked cell*.

Image 6.2.2. Main Jail Typical Cell



Remediation Recommendations

Existing facilities:

- Provide a fixed stool in addition to the seat on bunk, which can also be used to reach upper bunk.

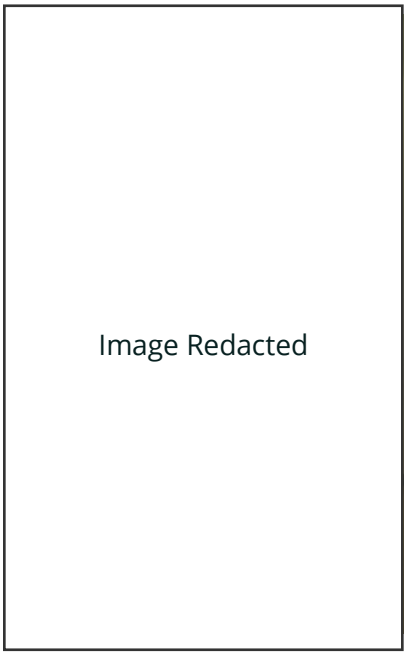
Future planning:

- Best practice for double occupancy cells is to provide two desks and stools per cell; additionally, if double-celled, all bunks should be on the floor; mandatory for special needs, medical, and geriatric detainees, and recommended for the general population

Given the limited availability of specialized beds, some general population housing units are used for the housing of special needs population groups and programs:

- Suicidal Inmate Temporary Housing Unit (SITHU)
- Critical Needs Assessment Program (CNAP)
- IOP
- Developmentally Disabled (DD)
- Detox/Medically Assisted Treatment (MAT)

Image 6.2.3. Main Jail
Typical Stair to Mezzanine Cells



The use of general housing for special needs populations presents significant barriers to effective treatment and safety. These large-format units lack the dedicated confidential treatment and programming spaces and small-scale therapeutic environment critical to support specialized and individualized clinical needs. Additionally, the two-tier configuration of the pods significantly impacts where someone can be safely housed. Fortunately, the County has provided barriers at the mezzanine level to prevent jumping and self-harm of individuals with mental health issues housed on the upper tier.

Remediation Recommendations

Existing facilities:

- Existing facilities: Limit housing of special populations to lower tier unless housing on upper tier approved by treatment staff.

Future planning:

- All mental health levels of care other than Enhanced EOP and MH-GP should be housed in smaller housing units or sub-dayrooms as part of larger units, of single-level configurations and accommodated in single cells.

Non-contact visiting (also used for non-contact treatment interviews and counseling) on the mezzanine level is inaccessible for people with disabilities, which is identified as a physical deficiency in the Consent Decree. The County has provided an alternate accessible area on the second floor, but this is not considered the same as providing equal access under the requirements of ADA and the Consent Decree.

Image 6.2.4. Non-Contact Visiting and Interview, Mezzanine Level and Access Stair



Remediation Recommendations

Existing facilities:

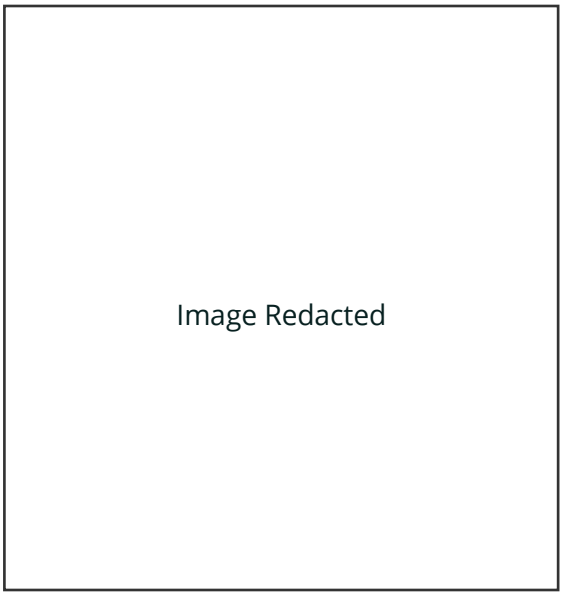
- Add visitor elevator stop at main floor; reconfigure multi-purpose room to provide non-contact visiting and confidential interview space; reconstruct group room adjacent unit 100. (See Section 6.6 for initial concepts)

Future planning:

- Provide accessible visiting at all housing units.

Image 6.2.5. Glazed Interview/Treatment Rooms

In an attempt to show compliance with the Consent Decree, the County has added glazed cubicles in the central core of each housing pod, but these cubicles are open to above and do not provide confidential interview space and, as they are glazed to allow full view into adjacent housing units, they are in effect "fishbowls" for treatment counseling and interviews. While recognized as a good faith effort, the lack of both auditory and visual privacy has been cited as a deficiency by the plaintiffs. Additionally, the lack of auditory privacy does not meet HIPAA requirements.



Remediation Recommendations

Existing facilities:

- Add confidential interview space as described above regarding visiting. (See Section 6.6 for initial concepts)

Future planning:

- Provide a minimum of one confidential interview room at each housing unit observable from the officer station with limited visibility from occupied areas by people in custody.

Limited-service delivery available on housing units, requiring daily movement of population:

- Available program space is limited to one (1) multipurpose room per housing floor (servicing up to 288 individuals). These rooms are poorly ventilated and not large enough for the delivery of group therapy.
- Outdoor recreation is provided on three partially enclosed recreation decks located at the mezzanine levels serving floor above and below. Access is via stairs and one deck is accessible via elevator to accommodate the physically challenged.

Remediation Recommendations

Existing facilities:

- Consider adapting a housing unit on each floor serving the special needs population as mandated by the Consent Decree with individual and group treatment rooms, interview rooms, and office space.

Future planning:

- Maximize service delivery on the housing unit for staffing efficiency, safety, and security, as well as for increased access to programs and services; provide interview, multipurpose group rooms, medical triage, recreation, and accessible visiting space at each housing unit.

A medical screening/triage room is available on each floor outside of the housing units in the central core adjacent to the elevators. This arrangement requires additional staff to escort detainees in and out of the housing units as well as for supervision when the room is in use. Additionally, no space is available for staging and waiting, which affects operational efficiency, efficacy, and delivery of services.

Remediation Recommendations

Existing facilities:

- Consider providing a bench and assigning staff for waiting and staging in the hall adjacent to the medical triage room; if necessary, based on classification/behavior provisions can be made for restraints.

Future planning:

- Locate medical triage on the housing unit to reduce escort movement and need for additional staffing, as well as to enhance efficiency (security by housing staff) and delivery of services. The space can also function as second interview room when not in use, with lockable storage.

Housing Pods “100” on all floors and both East and West towers are not visible from the floor officer position. They are only visible from the raised control room which is responsible for three pods.

Remediation Recommendations

Existing facilities:

- Consider staffing pod 100 in direct supervision mode; consider revising controls to provide floor officer with control panel that can be shut down in emergency by officer or remotely with primary control moved to housing post; consider consolidating housing control rooms/positions to cover multiple housing units freeing up staff for other direct inmate management duties. Alternatively, Pod 100 could be adapted as program and staff space to serve floors housing special needs populations.

Future planning:

- Base design on direct or hybrid direct supervision of sub-dayrooms for smaller special needs housing; housing staff responsible for all door operations, cameras, etc., inside housing unit with ingress/egress controlled by remote control room that has responsibility for multiple units.

Though not a directly measurable or quantifiable standard, environment is a critical element in creating a treatment-based facility. The provision of natural light, outside views, acoustic and temperature comfort, and incorporation of biophilic design features reminiscent of nature and natural based colors or murals are important elements in creating a humane, healing, and wellness-based environment. Additionally, modern lighting that allows for differing temperatures and color as well as mimicking the circadian rhythms of the body are all important considerations in developing a calming environment supportive of mental wellness for incarcerated people and staff alike.

Remediation Recommendations

Existing facilities:

- Any major renovation or repair/reconditioning effort should take these principles into account in the selection of colors, systems, and furnishings.

Future planning:

- Principles as outlined above should be the underlying driver of creating therapeutic healing, wellness-based environments for staff and people in custody alike.

Housing: Assessment, Gaps, Remedial, and Future Planning Recommendations (cont'd)

Rio Cosumnes Correctional Center

At the RCCC, the housing component is a combination of barracks/open dormitories dating back to the 1960s, linear-style units, and two-tier pods with cells or dormitories opening onto a

dayroom observed by a raised control room dating to the 1990s. The facility is basically subdivided into four separate sub-campuses:

- The female campus consisting of the SLF for women constructed circa 1973
- The minimum/medium security campus consisting of the original Honor Barracks, constructed circa 1959
- The higher security campus consisting of the double-celled, pod-remote operation buildings, the Christopher Boone (CBF) and Stewart Baird (SBF) facilities respectively constructed circa 1988 and 1991, and the pod-remote dormitory buildings, the Kevin Blount (KBF) and Joseph Kievernagel (JKF) facilities, constructed circa 1995
- An additional building, the Roger Bauman Facility (RBF) consisting primarily of multi-occupancy cells and of intermittent supervision, was vacant at the time of our assessment but has since been renovated for potential re-occupancy

The SLF is a self-contained women's campus with program space provided by converting a former dorm (Sutter), serving kitchen and multipurpose dining/recreation room, visiting, intake/booking and medical/mental health offices and treatment space. The SLF women's facility has four pods—three dormitory-style pods and one wing of cells, each with its own dayroom and recreation yard:

- Kinya (92 beds, minimum security)
- Golden Poppy (66 beds, minimum security)
- Camelia (70 beds, medium security)
- At the time of this report, Ramona Hall (rated capacity 24 beds/operational capacity 40 beds), had been decommissioned

The male population is divided into two separate compounds, one for low-security and one for high-security males. Housing units are a combination of newer pod-based buildings and older open barracks or dormitories.

- Minimum security inmates are all housed in Honors Facility dorms and in the A barrack.
- Medium security inmates are housed in the B, J, and K barracks as well as SBF, JKF, and RBF facilities, which provide a combination of single- and double occupancy cells, and open dorms in a two-tier configuration.
- Maximum security detainees are housed in Christopher Boone Facility (CBF) 200 pod, and in SBF 100, 300–600 pods.

Findings and Remediation Recommendations

The rated capacity[6] of the RCCC is 1,625 beds, however the SSO operational capacity at 2,224 beds significantly exceeds this number. Key areas where the rated capacity is exceeded on a regular basis include:

- SLF for women.
- The Stewart Baird (SBF) and CBF are equipped for 100% double-celled, but capacity is limited by Board of State and Community Corrections (BSCC) Standards. Additionally, these facilities at times house classifications and levels of mental health treatment that require single-celling.
- Kevin Blount (KBF) and Joseph Kievernagel (JKF) dormitory facilities have had beds added, increasing bed capacity on average to 130% of rated capacity.
- Barracks with added bed capacity operate on average at 145% of their rated capacity and in the worst cases over 200% of rated capacity.

Moreover, the rated capacity of several of the barracks—C,D,G,H, and M are "grandfathered" to standards in effect at the time of construction (1963), which are substantially less stringent that current standards. They have a rated capacity of 82 beds, which leaves limited space for a dayroom. As a comparison, similar barracks rated against 1980 standards have a rated capacity of only 37 beds.

A more critical issue is the change in the population profile that has occurred over time, affecting the type of accommodation where individuals can be housed. Overall, there is a misalignment between available low-security beds and the increasing security requirements of the inmate population. Over the past several years, RCCC has evolved from primarily a local facility for sentenced misdemeanants and low-level felons, to house primarily a pretrial population of all classification levels as well as felony offenders diverted to local facilities by AB 109. Currently, about 17% of the rated capacity is in-cell housing (CBF/SBF) based on 100% double-celling which equates to less than 14% of the current SSO operating capacity. The 1963 and 1980 barracks do not provide suitable secure housing for higher risk individuals, which has led to the crowding of the more secure dormitories (JKF/KBF) due to the changing profile of the population.

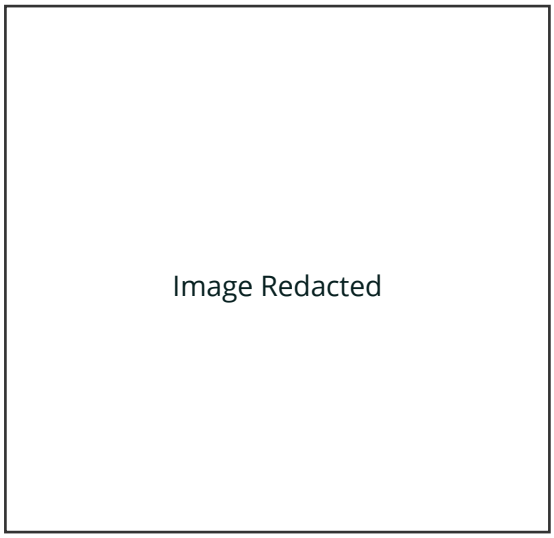
[6] Rated capacity is determined by the Board of State and Community Corrections (BSCC) based upon the facility standards in force at the time of construction or subsequent major renovation; SSO Operational Capacity reflects the actual number of beds in-place at the time of the current housing plan survey.

The following key issues were identified as critical gaps relative to the requirements of the Consent Decree, accepted standards, and functional/operational best practices.

Image 6.2.6. Sandra Larson Facility Women's Housing

SLF operates over design capacity. Only the dormitories are used due to the condition of the Ramona cell wing.

- Kinya dormitory has a rated capacity of eight beds but is furnished to accommodate 23 beds.
- Golden Poppy and Camellia dormitories have a rated capacity of 32 beds but are furnished to accommodate 72 beds.



- Ramona (vacant at the time of our assessment) has a rated capacity of 24 beds, with 21 cells furnished for double-celling for a total operational capacity of 45 beds.
- Renovations are underway to provide for accessibility.
- No small housing units are available to accommodate women with special needs.
- There is a general lack of program space and limited opportunities for programming.
- While not directly measurable or quantifiable as a standard, quality of environment is a critical function in creating a treatment-based wellness environment, natural light, views, acoustics, and incorporation of biophilic design principles related to nature and natural based colors or murals are important elements in creating a humane, healing and wellness-based environment. Additionally, modern lighting that allows for differing temperatures and color as well as mimicking the circadian rhythms of the body are all important considerations in developing a calming environment supportive of positive mental health for inmates and staff alike.

Remediation Recommendations

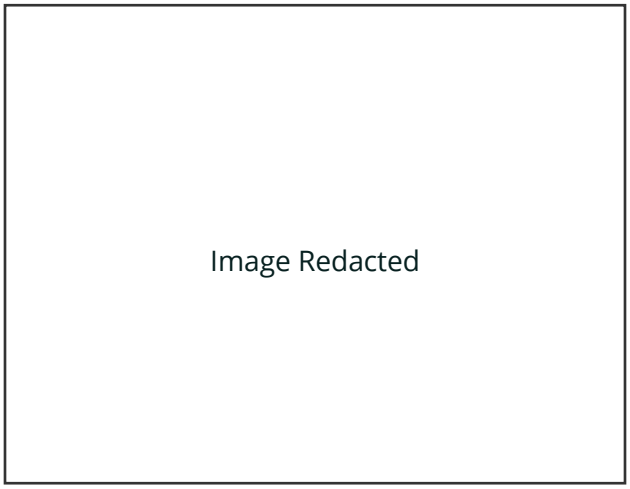
Existing facilities:

- Reduce the operating capacity to or closer to rated capacity and identify alternative housing for women.

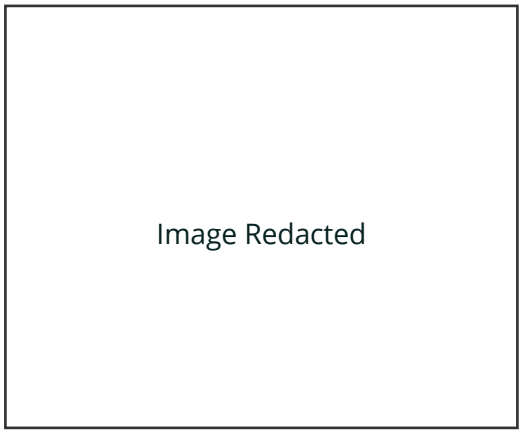
Future planning:

- Consider replacing and expanding Women's Housing. A mix of cells and dormitories may be appropriate; however, current best practice is to place all beds on the floor and in the case of dormitories to provide smaller cubicle groupings to enhance individual agency and provide a sense of privacy and personal space. As outlined above for the MJ, housing units maximize service delivery on the housing unit for staffing efficiency, safety, and security, as well as for increased access to programs and services; provide interview, group multipurpose, medical triage, and recreation at each housing unit.

Images 6.2.7. Typical 1963/1980 Barracks



The Barracks, dating to circa 1963 and 1980, were built primarily to house people sentenced to minimum security. As noted above, both the population profile and the mission of the facility have changed drastically over the past several years from a low-security sentenced population to a higher-security pretrial population across the spectrum of classifications. Key deficiencies noted:



- All barracks exceed Board of State and Community Corrections (BSCC)-rated capacity, and even the rated capacity is excessive for space available for the barracks "grandfathered" to the 1963 standards.
- Stacked dense bunks limit clear line of sight for maintaining safety and security.
- Toilet and shower cores are open with no privacy dividers and no provisions for accessibility, in violation of both PREA and ADA requirements.
- Dormitories are operated primarily on an indirect supervision model from an enclosed control area adjacent to the wet core.
- No individual and group programming space is provided in the barracks buildings.

- As noted above, the barracks are effectively a separate sub-campus with access to medical services/the infirmary and various program buildings.
- See comments above relative to the importance of quality of environment.
- Positive is direct access to the outdoors and availability of fenced recreation areas.

Remediation Recommendations

Existing facilities:

- Reduce capacity to or closer to rated capacity; reconstruct wet cores to provide for accessibility and comply with PREA; consider moving officer station to floor and adjusting furnishings to provide day space and locating double bunks along exterior walls and single bunks in the center for improved visibility.

Future planning:

- Determine percentage of beds in dormitories appropriate for projected population profile
- Consider replanning barracks for reduced capacity to meet BSCC standards rather than outmoded 1963/1980 standards
- Add program core to support EOP Enhanced and MH-GP mental health treatment for persons housed in the general population (see Section 6.6 for initial concepts)

Facilities—CBF, SBF, KBF, and JKF—form another self-contained sub-campus for high-medium and maximum-security inmates. The sub-campus includes a range of support services - serving kitchen multipurpose program space, visiting, and medical/mental health offices and treatment space. Each facility has an outdoor recreation court shared by six housing pods. Key deficiencies noted:

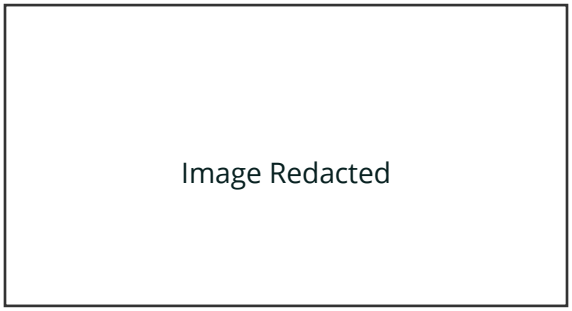
Image 6.2.8. Christopher Boone (CBF) and Stewart Baird (SBF) Facilities

- Only two pods have been adapted to accommodate accessibility needs.
- CBF, as the first of the new modules constructed in 1988, was based on single-cell occupancy and hence only one shower was provided for 16 cells. While all the cells are equipped for double bunking, BSCC standards base the rated capacity on the shower ratio and have capped capacity at 20 beds rather than the 32 actual beds.

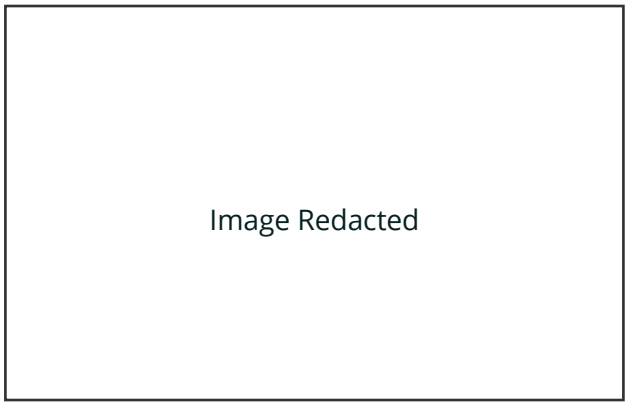


Image 6.2.9. Kevin Blount (KFB) and Joseph Kievernagel (JKF) Facilities

- KBF and JKF exceed rated capacity by over 130% based on actual beds provided, exceeding both BSCC sleeping and area requirements and required ratios for toilets, sinks, and showers (see bunk plan and density in background of control room image in **Image 6.2.9**). This increase in operational capacity results in an extremely crowded and noisy environment, and in addition to the standards shortfalls noted also puts a strain on acoustics and ventilation.



- CBF was also modified to provide expanded IOP capacity as agreed in the Second Memorandum of Agreement. This amendment raised the capacity to 167 beds. However, in responding to the demand, it was assumed that the majority of this capacity would be double-celled. As of April 2026 (Workshop 5), the actual service cohort was only 136 beds due to required single-celling base on classification and clinical assessment.



- The first-floor corridor is used for secure circulation, and the second-floor corridor accommodates visitor access to the housing units.
- While the sub-campus is self-contained, services are not provided at each facility or housing unit. Visiting for example is provided on the mezzanine level at CBF/SBF and a shared visiting room is provided for KBF/JKF cluster of housing units—however only the KBF/JKF visiting room is accessible via an elevator, requiring movement from one cluster to the other for accessible access. Note that while KBF/JKF has 50% of the visiting capacity of CBF/SBF, its rated capacity exceeds CBF/SBF by 167% and its SSO operational capacity exceeds CBF/SBF by 257%.
- Similarly, multipurpose program rooms are provided for each cluster one each for CBF/SBF and a shared one for KBF/JKF. The multipurpose program room in the KBF/JKF visiting room is accessible via an elevator requiring movement from one cluster to the other for accessible access.
- Medical and dental facilities are located on the lower level of both CBF and SBF with little or no waiting, requiring additional movement and escort for medical and dental visits for inmates housed in KBF/JKF.
- Office, interview, and group treatment space are in limited supply given other competing program requirements. IOP/Jail-Based Competency Treatment (JBCT) office for competency restoration custody staff is severely crowded, and most mental health clinicians are housed in a modular building adjacent to the administration portion of the sub-campus.
- See comments above regarding the importance of quality of environment.

- Positive is direct access to the recreation courtyards with supervision by housing staff providing opportunities for greater out-of-cell time.

Remediation Recommendations

Existing facilities:

- Expand IOP capacity to include higher percentage of single cells to meet the commitment to serve a cohort of 167 beds or the actual current and projected demand whichever is greater.
- Consider consolidating the IOP population with other subacute and acute populations to enhance access to care and efficiency in staffing and operations through shared staff and contract services.
- Consider adapting all housing units to accommodate accessible housing to better facilitate classification including adding a shower to CBF to meet BSCC-rated capacity for 1,005 double-celling. (See Section 6.6 for initial concepts).
- Provide additional individual and group treatment rooms if these facilities house inmates clinically assessed as IOP, EOP Enhanced or MH-GP.
- Reduce dormitory capacity to or closer to rated capacity to alleviate crowding.

Future planning:

- Determine percentage of beds in dormitories appropriate for projected population profile.
- As outlined previously, provide all services at each housing unit to increase access to programs and services while reducing movement and escort staffing.

Representative Housing Imagery

The images on the following pages (as well as others) were shared with the Stakeholders and Executive Committee at Workshops 2 and 4 as illustrations of some of the recommended concepts. Some County Stakeholders toured the Contra Costa West Facility to get a representative understanding of contemporary facility planning and design.

- **Images 6.2.10 through 6.2.12** illustrate a contemporary approach to housing design with space for programs and services provided at the housing unit to reduce movement and escort requirements. Additionally, the unit is operated as a direct supervision unit and as evidenced by quality of the environment—natural light, acoustics, color, and texture were important design considerations.
- **Images 6.2.13 and 6.2.14** illustrate subdividing a larger unit into sub-dayrooms. This allows for greater staffing efficiency while also providing each sub-group with out-of-cell time.

- **Image 6.2.15** illustrates a contemporary approach to the dormitory housing module, with all beds on the floor and low partitions creating smaller groupings to increase individual agency and sense of personal space.

Image 6.2.10. Contra Costa County CA, West Facility Expansion Typical Housing Unit

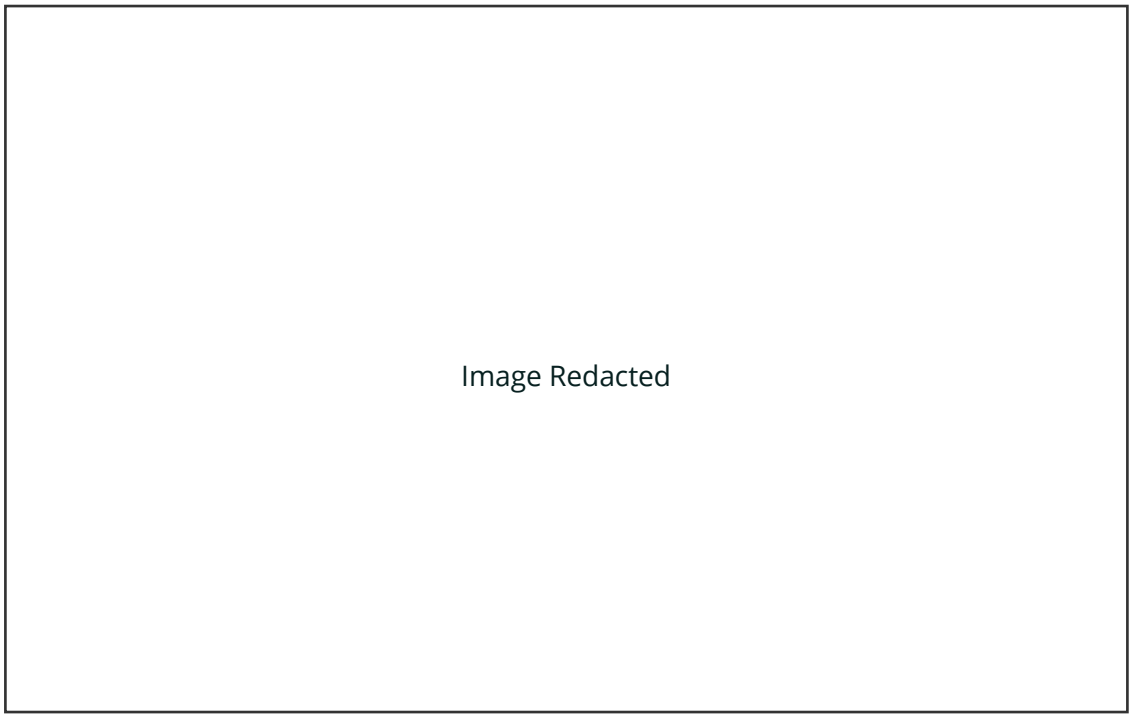


Image 6.2.11. Contra County CA, West Facility Expansion, Multipurpose Program Room on Each Housing Unit

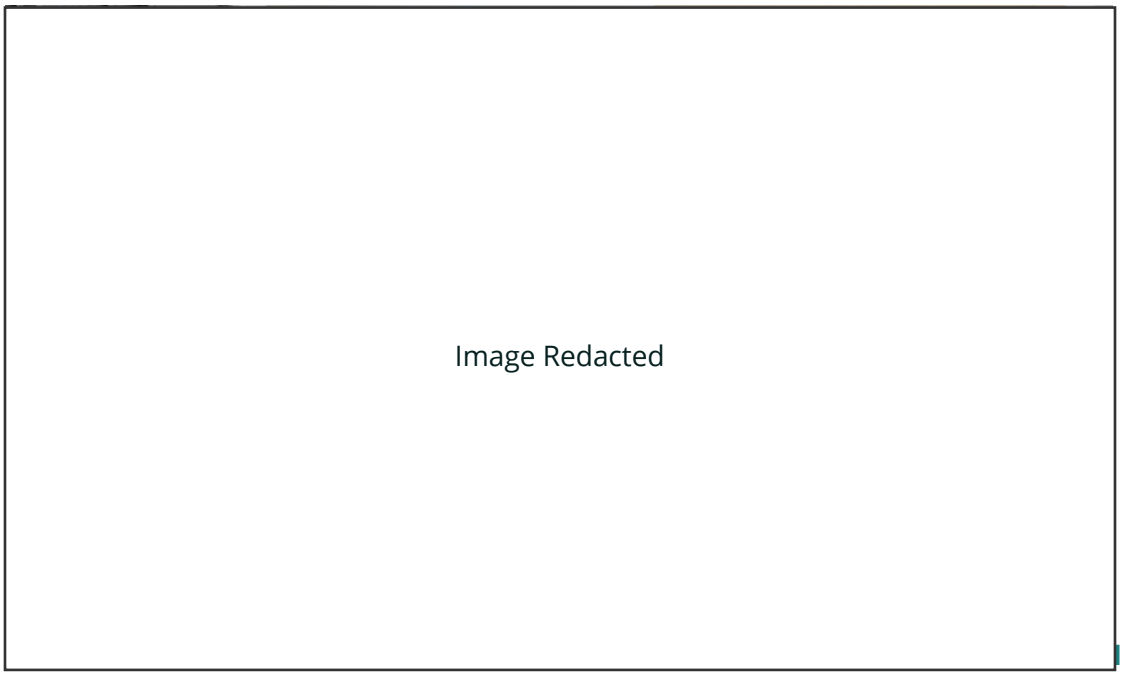


Image 6.2.12. Contra County CA, West Facility Expansion, Outdoor Recreation on Each Housing Unit as Extension of Dayroom

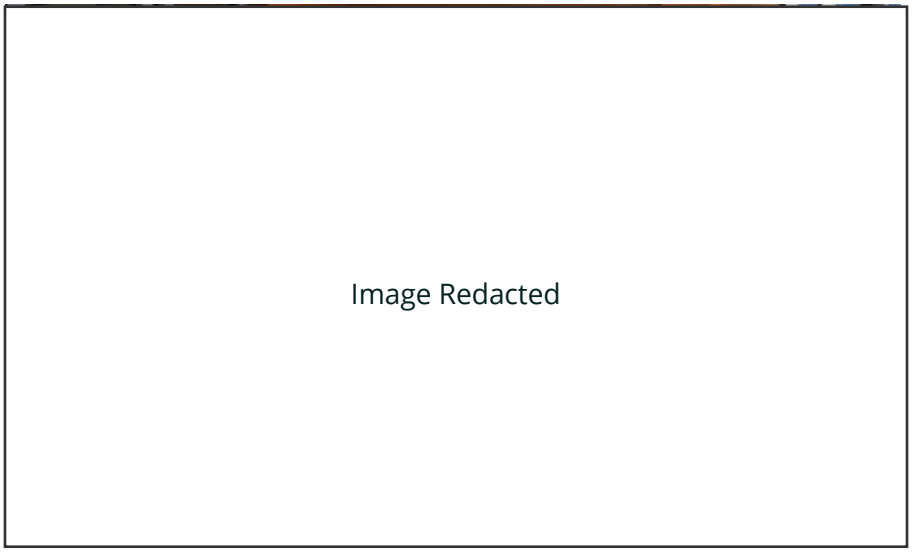


Image 6.2.13. Yavapai County AZ Justice Center, Housing Unit with Sub-Dayrooms (Larger Unit Accommodating Multiple Classifications)

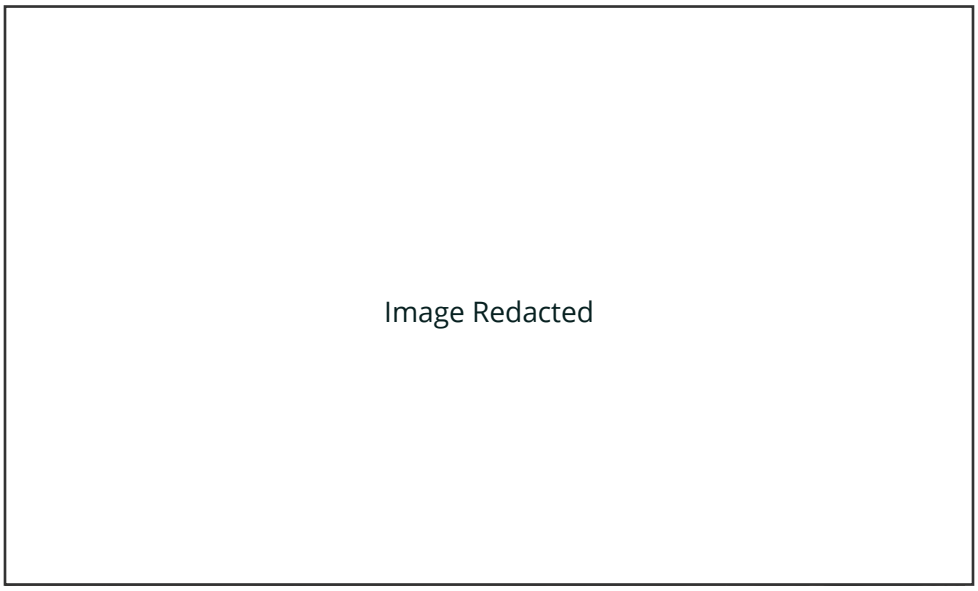


Image 6.2.14. Yavapai County AZ Justice Center, Sub-Dayrooms (Larger Unit Accommodating Multiple Classifications)

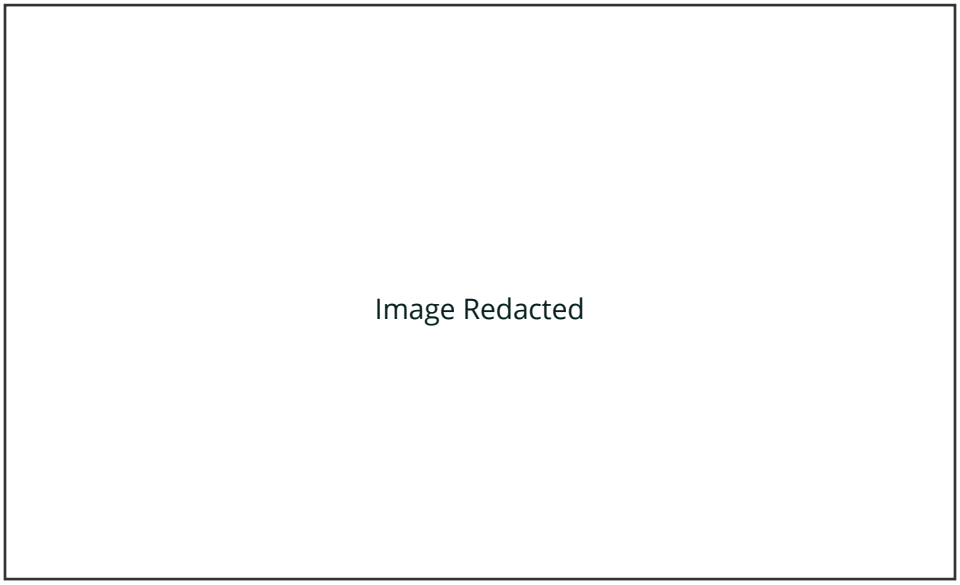
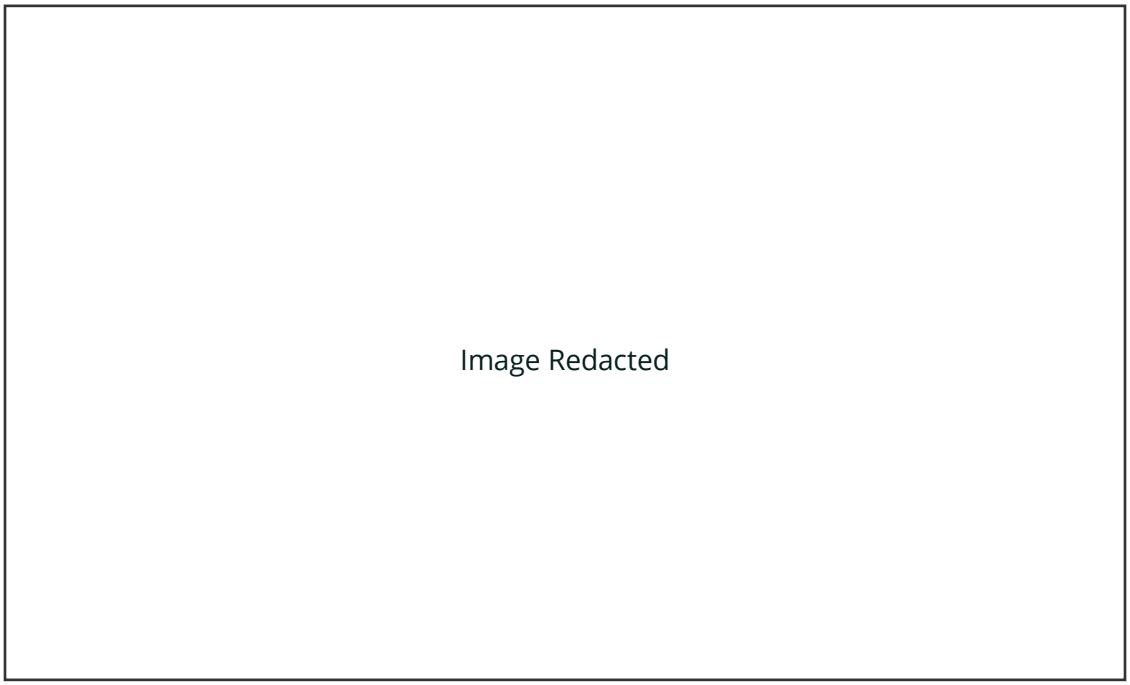


Image 6.2.15. Los Colinas, San Diego, CA, Women's Facility—Dormitories with Cubicles, Creating Personal Space



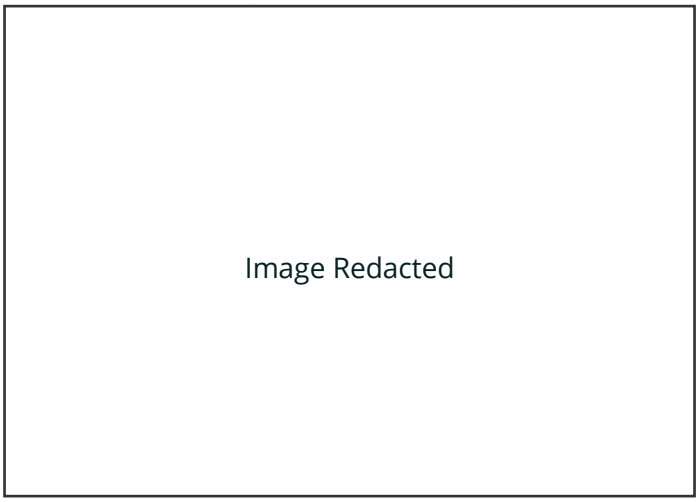
Intake, Transfer, and Release: Assessment, Gaps, Remedial, and Future Planning Recommendations

Main Jail

Most of the bookings performed by law enforcement agencies within Sacramento County occur at the MJ. Some limited bookings take place at the RCCC (2–3 per day), primarily from outlying jurisdictions. Both facilities accept newly arrested people 24 hours a day.

Intake Area: At the MJ, the intake area is located on the 1st floor and is adequately separated from release and transportation functions (facility transfers and agency pickups). Newly arrested individuals arrive at the facility by vehicle and are brought into the building via a dedicated drive-through vehicle sallyport. This enclosed garage is adequately sized to accommodate multiple transportation vehicles at a time and includes designated parking for patrol/fleet vehicles and judges. Narcotics/evidence lockers are also located in this area.

Figure 6.2.1. Main Jail Intake and Booking, Dedicated Area and Vehicle Garage

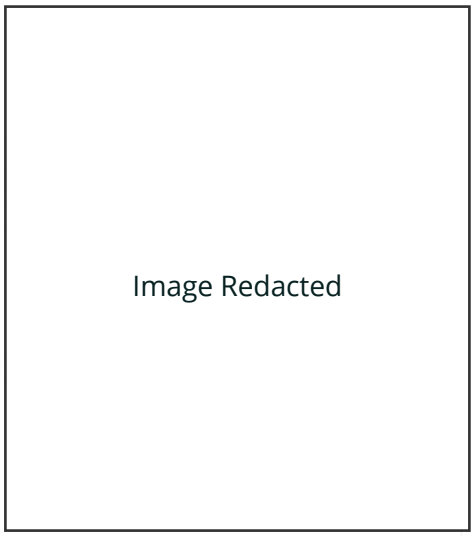


The jail was originally planned with a booking loop as illustrated in **Figure 6.2.1**. Arresting officers completed their basic arrest report; SSO received custody, and booking continued around the curve counter staffed by civilians. Advances in technology have allowed for greater efficiency, linking the arrest report to SSO booking eliminating duplicative data entry by civilian staff.

The process as it has evolved is as follows.

From the vehicular sallyport individuals are escorted by police officers into a dedicated Arresting Officers Report Room, used by law enforcement for initial arrest report writing and paperwork processing prior to bringing the person into the booking area. This open area comprises three rows of computer stations and benches.

Figure 6.2.2. Main Jail Intake and Booking, Original Booking Loop



Upon arrival at the facility, medical screening consisted historically of having the arrestee respond to a list of standard questions unless there was a question about whether the jail would accept the individual. As the arrestee population has exhibited greater degrees of medical and mental health acuity, SSO in conjunction with ACH expanded their process and every person must now undergo a two-phase "receiving health screening." Individuals must pass both screening phases before they are accepted into custody. Screenings are conducted by intake nurses. Note that the intake process and booking area continue to be an area of focus of the plaintiffs and the SMEs for Medical and Mental Health who monitor and judge compliance with the provisions of the Consent Decree.

Note: At the time of this report, ACMH was in the process of assigning a mental health clinician to the intake area to help direct traffic flow and information, assist with assessment for mental health in booking, and prioritize patients based on acuity level.

Phase 1 screening is an initial "fit for custody" evaluation. It is performed prior to acceptance to determine fitness for confinement and to assign an acuity priority to the patient. It involves a review of the arresting officer's observations, a full set of vital signs, and an assessment to ensure that the patient has no injuries or acute medical conditions requiring transfer to an outside hospital for further evaluation. The identification of a person with a developmental disability also begins at this stage and continues throughout incarceration, assuming the individual is accepted after Phase 2 screening and not released upon appearance.

After the arresting officer completes data entry related to the charge, a second, more comprehensive Phase 2 screening. Phase 2 screening involves an in-depth review of the patient's medical history before formal booking. During Phase 1, nurses determine the acuity level of the patient placing color-coded wristbands on the patients to indicate their level of priority for triage as follows: high-priority patients receive a red wrist band; medium-priority patients receive a yellow wrist band, and patients who are low-priority receive a green wrist band. Procedures are in place to prioritize and expedite intake for patients with acute medical or mental health needs (red wrist band).

Note that the arresting officer must remain at the facility and supervise the arrestee until the second screening is completed because the detainee may be declared unfit at Phase 2.

As previously noted, the intake area was originally planned with a booking loop, with separate areas for the processing of male and female detainees:

- The male intake area includes four group holding cells (all with combination toilet and lavatory fixtures (wet) with one of them reserved for protective custody cases); five individual cells (without toilet or lavatory fixtures (dry) to separate people by risk/need, two safety cells (dry), one sobering group holding tank and a medical observation group holding cell.

  Note: *At the time of this report SSO, in conjunction with ACH and ACMH, had adopted an approach to relocate those arrestees with withdrawal management symptoms to specialized treatment housing unit immediately upon completion of processing.*
- The female intake area includes a clothing exchange area, a sobering tank, two group holding cells, one single holding cell, and one safety cell.

SSO has implemented workaround practices related to space constraints including creating separate male and female processing flows with common support functions (e.g., ITR supervisory staff, property room, clothing issue, etc.).

Overall, changes in the booking and admissions process that have occurred over time have been accommodated within the confines of the original plan, by repurposing existing space:

- Additional arrest reporting stations have been added to accommodate the growth in volume—within the existing space available resulting in little or no privacy for arrestees during questioning.
- Toilet and holding rooms have been converted to interview/exam rooms; however, these rooms do not have glazed fronts resulting in doors being left open for safety and supervision, again impacting privacy during questioning and counter to HIPAA requirements.
- Additional staff have been assigned to the original intake Medical Area.
- Four total interview/exam rooms have been recently added to privately accommodate Phase 2 assessments.

Every one of these changes has resulted in additional crowding and congestion and the loss of other functionalities, making the current layout inadequate to effectively and efficiently accommodate operational flows or provide for effective safety and security of staff.

Transfer/Transport Area: Transfer at the MJ includes interfacility transfers, medical and special transports, transport to state facilities, court transport, and miscellaneous movement of the in-custody population.

Release Area: The MJ is the primary release point for all SSO inmates. Limited releases occur at RCCC, only with scheduled pickup.

Findings and Remediation Recommendations

As part of the gap analysis, it is impossible to recommend an overall solution for the ITR area. But given the need to maintain this mission critical component, it is likely that an operational responsive solution would require either: a) space equal to a full floor of the MJ for renovation while the ITR remains operational, or b) new construction. This component will be defined as part of the program planning and alternative approaches development phase.

The following observations provide a glimpse of gaps that must be addressed in planning.

Image 6.2.17. Main Jail Intake Vehicle Vestibule

Vehicular Vestibule

- Multi-functioning drive-through garage accommodating deliveries, trash removal, SSO parking, intake and transports and other agencies pickups.
- Trucks must back up to access loading dock/remove trash (tight maneuverability radius).
- Sections of the garage are used for storage purposes due to lack of storage space inside the Main Jail. For example, a section of the garage is used by the Emergency Response Team as a changing and locker area for the storage of their equipment.

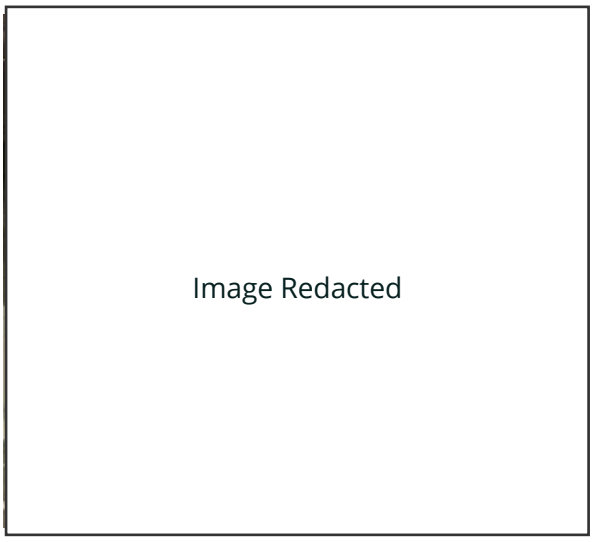
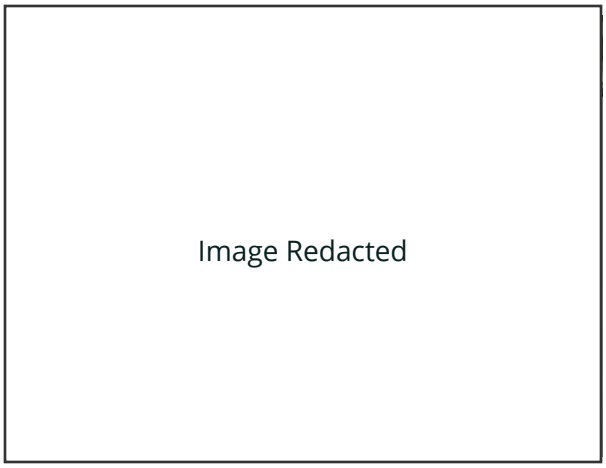


Image 6.2.18. ERT Lockers in Vehicle Vestibule



REMEDIATION RECOMMENDATIONS

Existing facilities:

- Remove unnecessary functions from the vehicle vestibule

Future planning:

- Vehicle sallyport should be dedicated to intake and transportation functions. All other functions should be accommodated elsewhere.

REMEDIATION RECOMMENDATIONS

Existing facilities:

- Remove unnecessary functions from the vehicle vestibule

Prebooking/arrest write-up area:

Image 6.2.19. Typical Arresting Officer Workstation

- Severely congested area during high-activity periods. Crowding of report workstations limits privacy for the arrestee when responding to questions.



- Crowding is exacerbated during peak periods due to a lack of flex space to provide surge capacity e.g., additional interview rooms, Phase I and Phase I/II Medical interview rooms, and Mental Health. This not only slows intake processing and increases stress levels for everyone, but it also impacts efficiency and effectiveness of law enforcement, as they cannot return to the street until the Phase I/II interview is complete and SSO accepts custody.
- Lack of support space—open waiting/staging areas; secure holding for the temporary separation of arrestees based on behavior and risk; arresting officers and arrestee's restrooms.
- Four rooms are available for Phase 1 and Phase 2 screening—one for Phase 1 and three for Phase 2. The room adapted for Phase 1 initial medical/mental health screening does not have fully glazed walls for safety and security, resulting in doors being left open when the room is occupied, impacting privacy and HIPAA compliance.

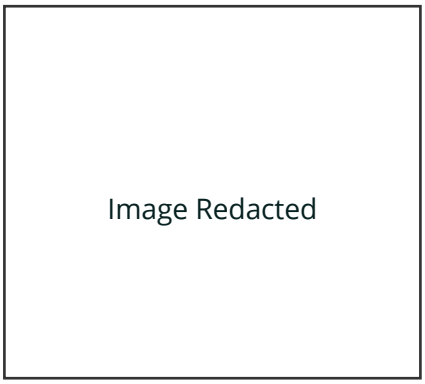
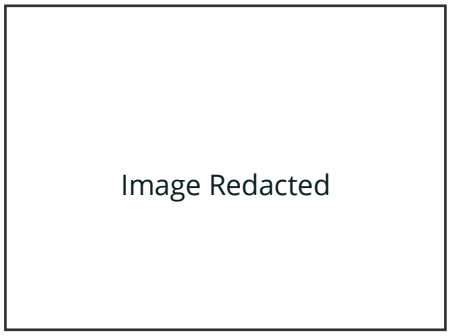


Image 6.2.21. Phase I/II Medical Interview Room

- Phase 2 screening consists of three rooms assigned to nurses, shared with medical supervisor (former open nurses' station are now used for storage purposes); with a narrow circulation corridor accommodating waiting/staging for both the arrestee and accompanying arresting officer.
- Overall the prebooking area is noncompliant with accessibility requirements due to initial construction, crowding, and adaptation of existing rooms for other purposes.



Remediation Recommendations

Existing facilities:

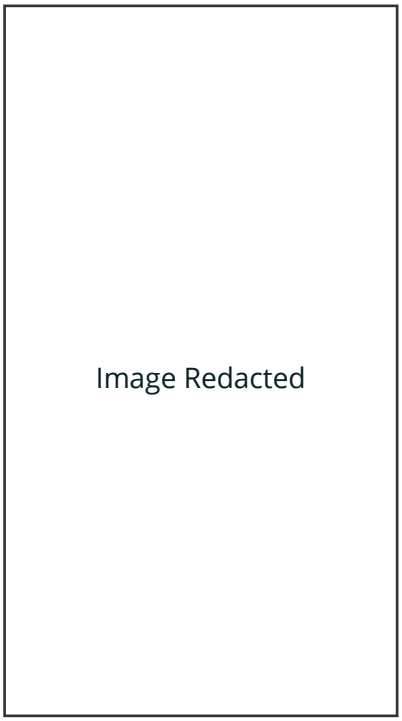
- Consider expanding the arrest reporting area to reflect current operating procedure and peak demands by extending to the west (see Section 6.6 for area identified for potential expansion).
- Improve acoustics, color finishes, and lighting to reflect a trauma-responsive environment to reduce stress for staff and arrestees alike.
- Arrest reporting: Low acoustically treated cubicles with adequate spacing for privacy.
- Initial medical/mental health offices on perimeter—glazed room fronts; adequate circulation separation from arrest reporting.
- Provide support facilities—secure individual/group holding, staff and arrestees' restrooms, and decontamination showers.
- Provide adequate space to accommodate peak demands with waiting for stage 2 medical/mental health evaluations.
- Review records to date to determine what percentage of arrestees are rejected at stage 2—if insignificant consider moving stage 2 to after acceptance, allowing arresting officer to exit the facility.
- Fully implement process for separating, processing and expediting arrestees determined as initial screening to be medically or mental health fragile or vulnerable and move them to safe prebooking/booking track.
- Provide formal area for the transfer of custody—valuable property, commitment paperwork review, arrestee screening, etc.

For future planning, see discussion at the end of this section.

Booking area: Workflow and spatial inefficiencies

- Organization of functions and space utilization is adaptive use of original design and is dysfunctional for current operational flow.
- No central officer's station is provided. Workstations are available only in the main circulation corridor.
- Does not reflect current operational procedure and does not provide for the smooth and efficient flow of people and processing activities, resulting in back-and-forth between the front and the back of the intake area while concurrent activities occur.
- Severely underutilized "inner loop." Booking counters are not currently used by clerical staff to conduct interviews. Incorporation of this space may provide some interim relief.
- Larger office space is needed for the classification officers, watch commanders, and the sergeants (the property conveyor is located above the Sergeant's Office with the noise it makes being very disruptive).

Image 6.2.22. Booking Loop, Holding Areas on Outer Edge, Support Functions on Inner Edge



Booking Area: Holding

- Primarily secure holding cells, both group and single; visibility, lighting, and acoustics are poor potentially contributing to anxiety and aggression inducing behavioral responses.
- Design (narrow windows) and location (single cells are located on a secondary corridor) presents challenges to meet 1:1 constant observation requirements; Inmates moved to 3 East as a workaround.
- Some arrestees, including a high proportion of those judged eligible for quick release (25% =/- of bookings), are kept in the booking area/sobering tank overnight, sleeping on benches or often on the floor. Their needs for safety, hygiene, and humane conditions should be more directly addressed by providing adequate sleeping accommodation.
- Contemporary facilities use open waiting both to create a less constricting environment and to establish a sense of the behavior anticipated in a modern correctional setting. All holding spaces at the MJ Booking Loop are secure, fully

Image 6.2.23. Booking Loop, Typical Holding Cells



enclosed cells. Additionally, the visibility, lighting, and acoustics of the primary secure holding cells - group and single -is poor, potentially contributing to anxiety and aggression-inducing behavioral responses.

- The limited number of safety cells available (two for males and one for females) to manage individuals experiencing a mental health crisis and those who need close supervision for potential suicidal behavior are poorly designed and inadequate in number. Their design (narrow windows) and location (on a secondary corridor) pose challenges to meet the one-on-one constant observation requirement for monitoring people on suicide watch.
- Overall, holding spaces do not reflect a trauma-responsive environment. This has proven critical to reducing stress, anxiety, and aggressive responses in arrestees.
- Class Counsel and SME's have expressed concerns regarding privacy in the booking area. Critically, medical/MH interview areas to not meet HIPPA requirements for privacy.
- Classification interviews are conducted from a non-contact area between holding cells:
    - Male booking track: The interview tank's stalls used by classification are placed back-to-back with no privacy partition. While serving two holding areas, only one interview can occur at a time; interviews are non-contact via phone receiver with arrestee in a group holding room, with questions limited to a yes/no answers due to a lack of auditory privacy or confidentiality.
    - Female booking track: Classification interviews and other assessments happen at the cell front or inside the cells, with no auditory privacy or confidentiality.

Except for a single attorney/client interview room, all spaces used to interview, meet, and assess newly booked individuals by different agencies and professionals lack auditory privacy. A second interview tank is now used as a breakroom for booking deputies.

Remediation Recommendations

Existing facilities:

- As noted previously, investigate expanding space available including expansion into the vehicular vestibule as well as the underutilized area of the central loop or possible 2nd floor are above if some administrative functions and staff support can be displaced to the adjacent County Administration Building.
- If additional space can be identified:
    - Replan facility to reflect current operating procedure and peak demands
    - Maintain separate tracks for male and female arrestees and fast-track, "safe booking" track for suicidal/constant watch, withdrawal management and

medically or mental health fragile/vulnerable population or provide for final booking at special needs housing unit
    - Consider using open waiting as primary approach to booking staging, with secure cells only for uncooperative population
    - Provide appropriate interview space for classification and other assessments—primarily contact with secure and confidential space for uncooperative population
    - Provide short-term housing unit for "quick release" and other overnight intake inmates with appropriate sleeping and hygiene facilities, reducing the workload and space needs for the intake and reception area
    - Provide adequate office and support space
    - Provide for accessibility and PREA requirements for both water closets and showers
    - Consider potential future needs such as greater pretrial services involvement, earlier intervention by the public defender, opportunities for community diversion
    - Enhance the physical environment to be reflective of trauma informed design tenets—materials, colors, acoustics, lighting etc.—to reduce anxiety, tension and aggressive reactions and an improved environment for staff

For future planning, see discussion at the end of this section.

Transfer, Transport and Release Area

- Separate holding facilities and dress-out areas for men and women, but in general support functions and circulation is common to both.
- The number of staging areas inadequate to ensure separate RCCC transfers, court transfers, and release activities, and to separate by gender.

Remediation Recommendations

Existing facilities:

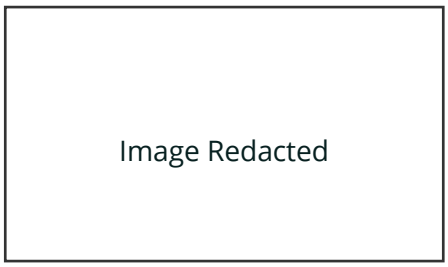
- Transfer, Transport and Release Area: Maintain separate flows for intake, transport and release; apply concepts outlined above for booking and intake including open waiting for non-disruptive individuals.

For future planning, see discussion at the end of this section.

Intake, Transfer, and Release (ITR): Assessment, Gaps, Remedial, and Future Planning Recommendations (cont'd)

Rio Cosumnes Correctional Center

Image 6.2.24.
RCCC Secure Intake Yard



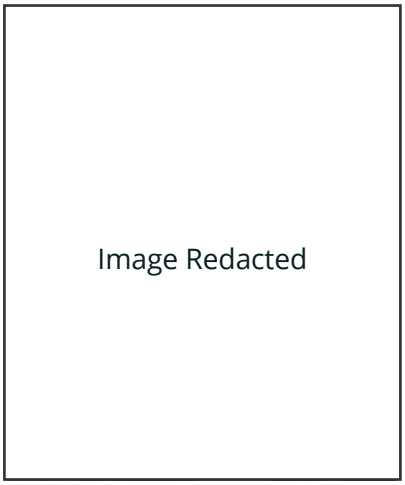
At the RCCC complex, newly arrested individuals arrive by vehicle, which is parked outside the designated male and female intake areas. Within limitations, RCCC has attempted to duplicate process improvements implemented at the MJ.

A medical trailer has been added adjacent to the male booking building to perform medical screenings to relieve pressure at the downtown jail, if needed.

- Small exterior fenced vehicle yard. Provides very limited parking space, with large buses forced to back up to intake entrance.
- The male booking area includes four service windows used by classification staff, three group holding cells, an open are with benches, and search/changing cubicles. The current area provides for minimal privacy if the nursing station is not in use.
    - The booking area is small; not originally sized for high volume booking activity, release processing and interfacility transfer functions.
    - Classification windows do not allow for auditory privacy or confidentiality.
    - The nursing station provided within is the size of a closet (6'0" +/-). Recently, a semi-trailer was positioned near booking and adapted to provide additional space for medical and mental health screening.
    - Small property storage room is not sized to store personal property long-term.
    - Original showers and toilets within this area are used for storage.
    - The existing facility also provides significant limitations on the transfer process/transport functions.

The dedicated intake area of SLF is reported as adequate for the volume of weekly female bookings and transfers (1 and approximately 10, respectively). It consists of two dry group holding cells, three search cubicles, and a contiguous small property room.

Image 6.2.25. RCCC Intake



Remediation Recommendation

Existing facilities:

- It is probable that full compliance with the Consent Decree based on the level of improvements and increased staffing implemented at the MJ will require either:
  - Complete remodel of the existing intake/transfer building
  - Replacement with new construction as previously recommended (See SB 863 Project and supporting documentation, circa 2015)
- As part of a two-facility solution (MJ + RCCC or possibly MJ + new remote annex) the potential of consolidating intake/release at a single location should be considered in terms of total cost of ownership − capital cost + staffing and operational cost.
- For future planning, see discussion at the end of this section.

Summary of Findings and Remediation Recommendations for Future Planning

- The MJ facility as planned does not effectively and efficiently accommodate operational flows nor provides for effective safety and security of staff.
- The intake/transfer/release component of the downtown jail does not reflect a trauma responsive environment, which has proven critical to reducing stress, anxiety, and aggressive responses in arrestees.
- A process driven, purpose-built solution that can respond to day-to-day needs as well as peak demands is needed.
- The process should be a "future-driven reengineering effort" anticipating potential changes such as greater pretrial services involvement, earlier intervention by the

public defender, opportunities for community diversion—none of which can be accommodated within the existing confines of the ITR area.

- Incorporate the concepts outlined above for consideration related to improving existing facilities.
    - Create an environment reflective of trauma-informed design tenets—purposively using normative materials, soothing colors, good acoustics, adequate lighting, etc., to reduce anxiety, tension and aggressive reactions and an improved environment for staff.
    - Given the need to maintain mission critical activities it is highly likely that an operational responsive solution would require either:
        - Space equals a full floor of the MJ for renovation while the existing ITR remains operational
        - New construction
    - It is impossible to recommend an overall solution as part of the gap analysis. This will be defined as part of program planning and alternative approaches development. The following observations provide a glimpse of gaps that must be addressed in planning. Additionally, the final development of approaches must address locational issues related to ITR.
        - Should a primary jail site fall within the area bounded by I-5, I-80, SR 50 & SR 99 or immediately adjacent thereto, then ITR can be a component of the primary jail facility.
        - Should a primary jail site fall outside these boundaries then consideration should be given to constructing the ITR with associated short-term 72-hour housing within this boundary to support the return of the highest percentage of law enforcement staff to the street in a timely manner and efficient access to the courts for first appearance.
        - Should a two-facility approach be considered a decision will need to be made on consolidating or duplicating ITR services including consideration of related staffing and operational costs.

Mental Health Facilities: Assessment, Gaps, Remedial & Future Planning Recommendations

Main Jail & Rio Cosumnes Correctional Center

The provision of healthcare for the jail population is under the authority of the Sacramento County Department of Health Services via Adult Correctional Health (ACH) and Adult Correctional Mental Health (ACMH).

- ACMH is a contract provider through the UC Davis Department of Psychiatry and Behavioral Sciences. UCD has been providing psychiatric and behavioral services in the county jails since 1978.
- ACMH provides a JBCT for competency restoration under County contract with the Department of State Hospitals. Individuals in the JBCT must be found incompetent to stand trial through a judicial process. The State has added a second program referred to as EASS (Early Access and Stabilization Services) program for all patients newly determined to be incompetent to stand trial. This program is a hybrid model of restoration services established through an early collaboration model between the Department of State Hospitals and the Sheriffs' office. These two state mental health programs for males are housed at the RCCC's CBF facility (pods 100 and 600 respectively) and females in the EASS program are housed in Unit 100 at KBF.

As outlined in Section 3, the applied levels of care have changed and have been adapted since the original Consent Decree. The Consent Decree, as approved by the Court, established specific requirements for mental health levels of care and stipulated performance requirements for ACH and ACMH. For a portion of the mental health population, the Consent Decree also stipulated anticipated capacity requirements.

The following special populations were identified with specific capacity and program requirements noted:

Table 6.2.1. Special Population Capacity Requirements

Cohort	Consent Decree Estimated Capacity Requirements
Acute Psychiatric Unit (APU)	18 beds[7]
Intensive Outpatient Program	85–120 beds, adjusted to 167 beds[8]
Outpatient Psychiatric Program	200 beds
General Population Mental Health Caseload	No capacity estimate provided; caseload standards only

Subsequent to the Consent Decree, the Second MOA and the development of IHSF, ACMH initiated a program for revised levels of care. As these were new levels of care, historical data on population distribution was not available. As noted above, current capacity needs were based on estimates from ACMH, a population analysis completed as part of the base projections presented in Workshop 3, and an analysis of waiting lists to remove duplicate entries as follows:

Table 6.2.2. Special Population Needs

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

[8] Second Memorandum of Agreement, September 2025

Cohort	Current Need	Current Capacity
APU	ADP 33 Beds	41 Beds; includes 24 Beds under Construction 3 East Pod 200 completed June 2026
Intensive Outpatient Program	ADP 145 Beds	167 Beds[9] per Second Memorandum of Agreement
Outpatient Psychiatric Program	No longer level of Care; Housing Designation Only	467 beds identified as Outpatient Psychiatric Population (OPP) assumed to be EOP all levels; detailed housing assignment information not readily available.
Enhanced Outpatient Level 1	ADP 160 Beds	N/A
Enhanced Outpatient Level 2	ADP 390 Beds	N/A
Enhanced Outpatient Level 3	ADP 214 Beds	N/A

[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.

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

Table 6.2.3. Additional Cohort Needs

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

In the second quarter of 2026, 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. This resulted in some adjustments to the distribution in terms of acute, subacute, and general population treatment beds. Levels of care currently in place are summarized as follows:

Final Levels of Care as Defined for Planning

Acute Levels of Care

- APU
- SITHU
- CNAP
- EASS
- JBCT

Subacute Levels of Care

- IOP
- Developmentally Disabled

Treatment Beds, General Population

- EOP
- MH-GP

The Outpatient Psychiatric Population (OPP) was discontinued as level of care but is used by SSO to identify beds assigned in the General Population for Mental Health Treatment.

It is important to note that the assessment relative to specialized beds for mental health treatment was based solely on the Consent Decree defined levels of care as data was not specifically available by facility or housing unit on housing assignments based on the Interim Levels of Care and the final levels of care were only put in place as this phase of the Master Plan study ended.

- APU[10]
- IOP
- OPP

Within this framework and based on the interim levels of care, it was determined that the OPP population was directly related to the Interim levels of care EOP 1 through 3 and the final levels of care Enhanced EOP, MH-GP. No specific information was readily available related to specific facility, housing unit, or housing assignment (single-cell, double cell, or dormitory), so no breakdown was included in the assessment.[11]

Note that all initial observations and recommendations presented in Workshop 4 were based on these parameters. For the Phase I/II report, we have adjusted to better bridge to the final levels of care adopted toward the end of Phase I/II.

[10] Beds designated for short-term mental health confinement for observation & Treatment in accordance with the provisions of the Lanterman-Petris-Short (LPS) Act

[11] ACMH did provide projected breakdown for projections and future planning without housing assignments identified.

The program structure or levels of care used for the assessment consisted of the following levels:

- **Inpatient APU.** This program is located at the MJ and consists of a total of 41 Lanterman-Petris-Short (LPS) beds for involuntary (5150 hold) and voluntary inpatient psychiatric care. It provides 24/7 staffing coverage, emergency medication, therapeutic interventions, certification hearings, and daily physician evaluations.
- Initial bed capacity consisted of a small, seven-bed acute mental health unit located on the second floor. As the population increased, cells in the contiguous medical area have been captured to house acute mental health patients, increasing capacity to 17 beds. Most recently, 200 East pod on the 3rd Floor was renovated as an interim measure to provide an additional 31 beds—24 APU beds for a total capacity of 41 beds, and seven additional step-down beds.
- **IOP.** This program is a step up from general population and a step down from the APU inpatient unit. It services patients diagnosed with serious mental illness who require the structure of a therapeutic environment that is less restrictive than an APU setting.

IOP patients are now housed at both the MJ and RCCC in high-security cell housing as follows[12]:

[12] NB: Data as presented is based on a point in time and may vary.

Table 6.2.4. IOP Housing Distribution

Location	# of Cells	IOP Capacity	M/D	Single Cells	Double Cells	Lower Tier Only	Upper & Lower Tier
Main Jail							
3W 100	32	43	F	21	11		X
3W 300	40	20	M	20		X	
RCCC							
CBF 200	16	32	M		16		X
CBF 300	16	24	M	8	8		X
CBF 400	16	24	M	8	8		X
CBF 500	16	24	M	8	8		X
Total		**167**		**65**	**51**		

It should be noted that under the Second MOA, the County is to increase the IOP capacity to167 beds through renovations and reassignment of beds at both the MJ and RCCC. The work has been completed. However, the capacity has fallen short of the anticipated 167 beds due to requirements for single-celling IOP patients based on clinical determinations. On average, based on information prepared for the projection model (Section 3 of this report) the IOP population including the waiting list is 145 people, but as of April 2026 (Workshop 5) the actual population was only 136 due to single-celling a portion of the population.

- **EOP**. People with intellectual or developmental disabilities are mostly included in the EOP category. Per the current case management model, at the time of the facilities functional/operational assessment patients were assigned to one of three levels of care based on functional impairment and ability to independently manage mental health symptoms:
    - EOP Intensive (Level 1), if diagnosed with serious mental illness (SMI) and have significant impairment in their ability to manage activities of daily living.
    - EOP Moderate (Level 2), if diagnosed with SMI and a level of impairment that requires moderate support with activities of daily living.
    - EOP General Population (Level 3), if diagnosed with MH disorder and exhibit stabilization or partial remission of MH symptoms and the person can function independently.

These levels were subsequently replaced with two levels—EOP and MH-GP. See Section 3.0 for additional discussion on population projections and Section 4.0 for additional information on mental health treatment.

At the time of the functional/operational assessment, EOP patients (levels 1 through 3) are now housed at both the MJ and RCCC in various levels of security classifications as presented on the table below, and according to the following housing distribution:

- 73% of the EOP population are single or double-celled
- 27% are housed in dormitory housing

Table 6.2.5. OPP Housing Distribution Based on One-Day Snapshot

Location	# of Cells	OPP Capacity	M/F	Lower Tier Only	Upper & Lower Tier
Main Jail					
2E 100	5	1	M		
2E 200	16	5	M	X	
2E 300	18	3	M/F		
2 PSYCH	18		M/F		
3E 100	32	24	M	X	
3E 300	40	53	M		X
3W 100	32	1	F		X
3W 200	32	14	M		X
3W 300	40	6	M		X
4E 100	30	44	M		X

Location	# of Cells	OPP Capacity	M/F	Lower Tier Only	Upper & Lower Tier
4E 300	32	49	M		X
4W 100	32	45	M		X
4W 200	32	28	M		X
7W 100	32	20	F		X
7W 400	20	6	F	X	
8E 100	30	4	M	X	
8E 200	32	4	M	X	
RCCC					
B Barracks	80 beds	53	M		
JFK 400	52 beds	41	M		X
KBF 100	36 beds	1	F		
KBF 200	68 beds	31	F		

Location	# of Cells	OPP Capacity	M/F	Lower Tier Only	Upper & Lower Tier
SBF 200	16	7	M		X
SBF 200	18	27	M		X
Total		**467**			

Additionally, both facilities have dedicated cells within designated housing units set aside for individuals with intellectual and developmental disabilities and those who are in various mental health classifications that require high levels of mental health services and deemed unable to function in general population.

As part of the intake process, a referral is made and, depending on type of care needed, priorities are made to assign each person to the right level of care and corresponding housing unit placement. Generally, individuals are placed in designated mental health units at the discretion of mental health personnel, based on a clinical evaluation.

As noted in the several SME reports and by the many professionals interviewed for this study and the analysis of historical data performed as part of the planning phase, although the overall jail population has been decreasing over time, the proportion of patients with complex psychiatric needs and individuals receiving mental health services has continuously increased across both facilities. The jail system is serving as the de facto psychiatric facility and primary provider of behavioral health services in Sacramento County. Naturally, this arrangement has resulted in workload increases and a need to expand mental health staffing, specialized housing, evidence-based treatment offerings, and support space for the delivery of programs and services. Something the existing facilities are ill-prepared to accommodate because they were never envisioned as or planned to serve as purpose-built mental health treatment facilities and therefore lack appropriate housing and program/treatment support spaces.

With the advent of the Consent Decree, the gaps in housing, program space and staff facilities have been magnified exponentially based on agreed to levels of care, minima for staffing ratios and minimum performance criteria for individual and group treatment and unstructured out-of-cell time.

Remediation Recommendation

Existing facilities:

- Several opportunities for improvement are discussed in the assessment of each component below. It is probable that some improvements can be accommodated in existing facilities at least on an interim basis. However, as outlined under future planning, it is doubtful whether this would result in a longer-term Consent Decree compliant solution.

Future planning:

- It is doubtful that the specialized needs requirements can be met in existing facilities, potentially requiring the development of purpose-built therapeutic treatment facilities to meet the needs of the population and respond to physical plant issues raised in the Consent Decree litigation.

Acute Psychiatric Unit

- Initial construction included a small acute mental health unit of seven beds. As the population increased, cells in the medical area have been captured to house acute mental health patients, increasing capacity to 17 beds. Most recently, 200 East pod on the third floor was renovated as an interim measure to provide an additional 24 beds for a total capacity of 41 beds.
- While the expansion of APU beds provides some temporary relief, it is an incomplete response to the "remediation of physical deficiencies" as described in the Consent Decree.
- Even with the expanded capacity of the program, a waiting list for placement will remain based on 2045 projected needs.
- Housing APU patients in the general infirmary is disruptive to patients housed in adjacent cells for medical care.
- The original APU is deficient in the provision of on-unit individual and group treatment program rooms.
- The original APU on the 2nd floor has a small dayroom that is open to all cells.. Typically, in an APU a separate lockable dayroom is provided to allow treatment staff free

Image 6.2.26. Existing APU Cells, 2nd Floor Main Jail

Image Redacted

Figure 6.2.3. APU Expansion, 3rd Floor Main Jail 200 East

Image Redacted

movement without the need for a security escort when inmate-patients are provided out-of-cell time and limit access during out-of-cell time to other cell fronts. Outdoor recreation is limited to escorted movement to the common recreation decks. Again, typically in an APU this is a lockable courtyard again to allow unescorted treatment staff movement.

- The expanded APU on the 3rd floor has a much larger dayroom, but again it is open in front of the cells. Recreation is similarly provided via escort to the shared common recreation decks. Again, operationally separate lockable areas on the housing unit are recommended for safety, security, enhanced out-of-cell time and operational efficiency.
- Delivery of treatment services is further impaired by the lack of on-site offices for healthcare staff.

Remediation Recommendations

Existing facilities:

- Consider relocating all APU beds to the 3rd floor to eliminate conflicts with medical housing and increase staff effectiveness and efficiency.
- Consider consolidating all acute care housing in contiguous housing units—SITHU, CNAP, and gravely disabled patients—all currently mixed with other classifications; as well as JBCT and EASS housing units. Colocation should increase staffing efficiency and effectiveness for both ACH and ACMH staff as well as outside providers. This will also enhance the treatment/security team treatment approach envisioned in the Consent Decree.
- Identify both program (individual and group) and staff support space in proximity to acute care housing to enhance treatment.
- Provide accessible cells and showers in each housing unit.

Image 6.2.27. Contemporary APU Example, Thunder Bay Correctional Centre, ON, CN

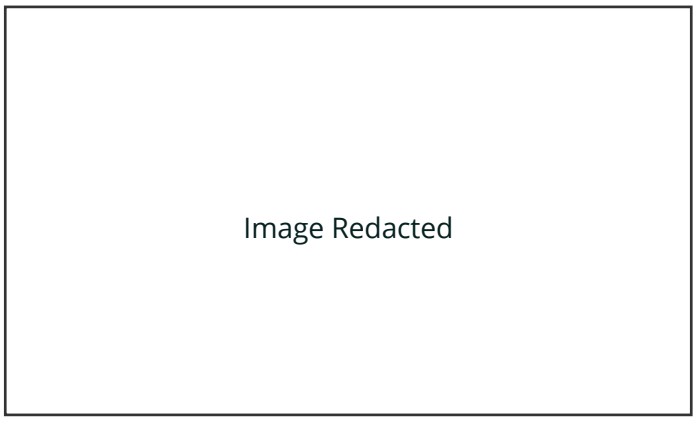
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Future planning:

The following comments should be considered relative to programming, alternative approaches development and ultimately facility planning, design and construction.

- Single-level housing units of 12–20 beds may form a larger unit with sub-dayrooms
- Single cells w/higher percentage of accessibility cells; fully glazed cell front
- Contact and non-contact interview rooms in each unit or sub-unit
- Securable group rooms in each unit or sub-unit
- Securable activity rooms in each unit or sub-unit
- Outdoor areas associated with each unit or sub-unit
- Nurses station on the unit or serving multiple small units
- Staff support/work area
- Units potentially twinned or a quad for reduced staffing
- Direct supervision with backup from remote control room

Image 6.2.28. Recently Completed APU, Contra Costa County, CA West



Intensive Outpatient Program

- Current housing utilizes single-celling for 31% of the IOP population and double-celling for 69% of the IOP population in stacked bunks.
- A portion of the IOP population is housed in pods of mixed classification (3W 300)—SITHU, CNAP, GD, intellectually/developmentally disabled.
- Population is housed at both the MJ and RCCC resulting in duplication of staffing and services.
- In both locations, staff facilities are remote from the population served—MJ, County office building on G Street two blocks away; RCCC, modular building near the main facility entry and administration.
- RCCC population is not in a direct sphere of influence for outside providers resulting in increased costs and time lost for commuting to/from the site.
- The Consent Decree requires two, one-hour group sessions per day, five days a week; seven hours of unstructured out-of-cell time; 1:1 confidential contact every seven days. Physical limitations at all housing locations related to availability of confidential treatment rooms and program space impacts meeting these minimums.
- Realignment of levels of care resulted in all IOP beds being considered as subacute beds, not general population.

Remediation Recommendations

Existing facilities:

- IOP should be co-located to increase staff utilization and effectiveness.
- To accommodate various security classifications, existing housing units should be subdivided.
- All housing units should include an accessible cell and shower.
- Provide both program (individual and group) and staff support space in proximity to IOP housing to enhance staff efficiency and treatment.
- Optimize use of existing program spaces via scheduling and potentially expanded hours.

Future planning (the following comments should be considered relative to programming, alternative approach development and ultimately facility planning, design and construction):

- Single-level housing units (12–20 beds) may form a larger unit with sub-dayrooms.
- 66% single cells, 34% double -cells w/higher percentage of accessibility cells; fully glazed cell front.
- 34% double cells with bunks on the floor (no stacking) and higher percentage of accessibility cells; fully glazed cell front.
- Contact and non-contact interview rooms in each unit or sub-unit.
- Securable group rooms in each unit or sub-unit.
- Securable activity rooms in each unit or sub-unit.
- Outdoor areas associated with each unit or sub-unit.
- Staff support/work area.
- Units potentially twinned or a quad for reduced staffing.
- Provide for future nurses' station for portion of unit to allow for variations in populations.
- Direct supervision with backup from remote control room.

Image 6.2.29. Contemporary IOP Examples, Thunder Bay Correctional Centre, ON, CN and Ventura County, CA

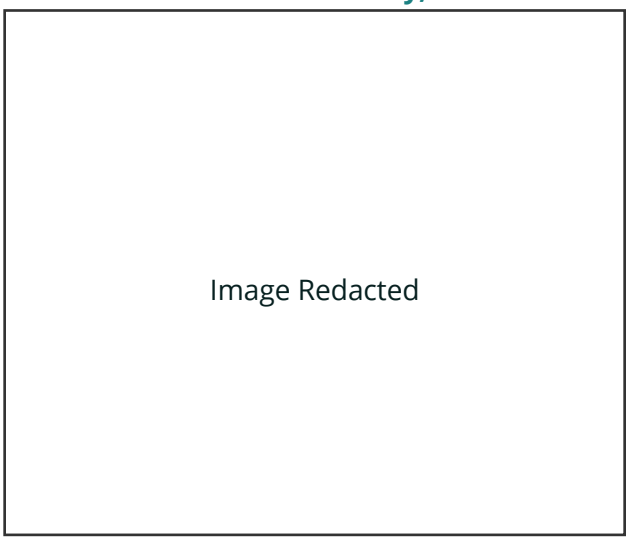
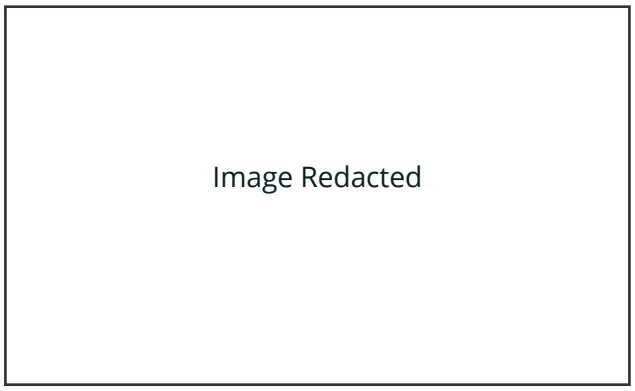


Image 6.2.30. Recently Completed IOP Housing, Contra Costa County, CA West



Enhanced Outpatient Program

- EOP patients (levels 1 through 3 at the time of the survey, now EOP and MH-GP) are now housed both in the OPP surveyed population and the general population in various levels of security classifications. A portion of the population is housed in mixed classification settings due to the large capacity of the housing units, which impacts unstructured out-of-cell time.
- Current assigned OPP beds (EOP 1 through 3) fall short of total demand by approximately 300 beds.
- Meeting the Consent Decree minima for treatment is affected by physical limitations of at all housing locations due to lack of appropriate individual interview/ treatment rooms, group program and treatment rooms and space for indoor and outdoor unstructured out-of-cell time.
- EOP Enhanced is considered as special needs beds within the general population.
- MH-GP is considered as general population beds that can be double-bunked unless clinical determination of need for special (single-cell) housing.

Remediation Recommendations

Existing facilities:

- Evaluate housing plan to house EOP Enhanced as a cohort for increased staffing efficiency and to enhance treatment.
- Identify both program (individual and group) and staff support space in proximity to EOP Enhanced housing.
- Provide accessible cells and showers in each housing unit.

Future planning (the following comments should be considered relative to programming, alternative approach development and ultimately facility planning, design and construction):

- EOP 1 (EOP Enhanced)
  - Special needs beds should be co-located as a cohort. Capacity distribution should be 34% single cells and 66% double cells.
  - Single-level housing is preferred, but two-tier housing is acceptable.
  - For double-celling, side-by-side beds on the floor (not stacked) is preferable.
  - Placement in upper tier or upper stacked bunk should be joint classification/security and clinical determination.
- EOP 2 & 3 (MH-GP)
  - General population beds that can be distributed based on classification.
  - Up to 5% single-celling projected based on clinical determination.
  - Two-tier housing is acceptable.
  - For double-celling, side-by-side beds on the floor (not stacked) is preferable but not required.
  - Placement in upper tier or upper stacked bunk should be based on joint classification/security and clinical determination.
- EOP 1 (EOP Enhanced) & EOP 2 & 3 (MH-GP)
  - Typical Housing units—32–48 beds acceptable
  - Contact interview rooms in each unit or sub-unit
  - Group rooms in each unit
  - Activity rooms in each unit
  - Outdoor areas associated with each unit
  - Staff support/work area
  - Units potentially twinned for reduced staffing
  - Direct supervision with backup from remote control room

Office and Staff Support Space

- Neither facility was planned nor designed to accommodate the growth experienced in the number of medical and mental health care staff, nor their wellbeing.

Consequently, there is too little space to accommodate the staffing growth that has occurred over time, which directly affect working conditions and results in inefficiencies and delays in providing services.

- Mental health personnel are scattered throughout the two facilities.
    - At the MJ, staff are scattered throughout in space available. Recently, ACMH staff at the downtown jail were relocated to the "G Street" office building two blocks from the MJ.
    - Mental health staff at the RCCC are in two modular trailers—one adjacent to the Administration Building, and one adjacent to the Sandra Larson Facility—remote from the populations served.
- On-site conference and work space is limited.
- In general, staff spaces are inadequate and shared by multiple personnel, providing limited privacy for confidential conversations. Shared offices are generally open areas with tables, with limited lay-down space for documents. Additionally, they do not represent a professional atmosphere focused on care.
- Limited respite space is provided for mental health professionals which is an evidence-based best practice to support better care.
- Poor or non-existent staff support facilities—lockers, storage etc.
- The lack of space and dispersal of locations significantly affects the provision of services as follows:
    - Time lost in moving from an office location to a service location
    - Limitations on interaction with medical and custody staff that are part of a treatment team as mandated by the Consent Decree
    - Impact on work efficiency—time spent with clients vs. treatment planning and recording outcomes
- An overarching issue of concern is also the impact of the work environment and working conditions on retention and recruitment.

Remediation Recommendations

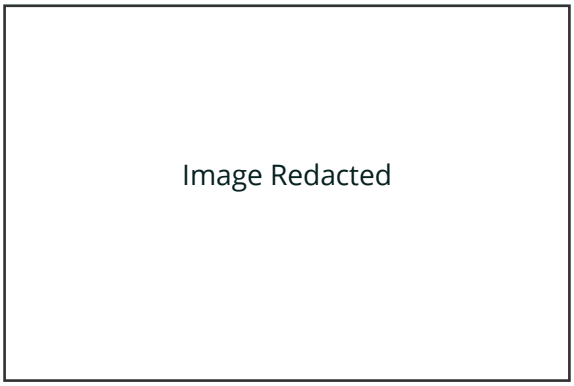
Existing facilities:

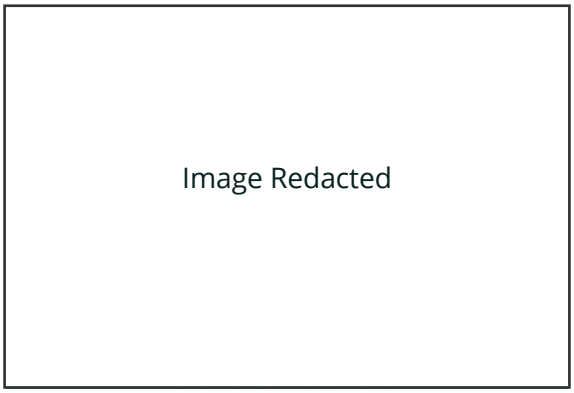
- Consider relocating some administrative functions and staff to the adjacent County Administration Building; investigate expanding space available in the MJ for mental health clinicians
- Optimize use of existing program spaces via scheduling and potentially expanded hours

Future planning:

- Staff should work in a professional environment.
- Administrative core personnel should be co-located with the major service population and ideally with medical administration.
- Clinicians and providers should be provided with work and office space in a separate zone in proximity to the population served.
- Space should be provided for group staff meetings and interdisciplinary teams.
- Confidential interview, counseling, and treatment rooms should be provided at each housing unit with surveillance from a security post without constant observation of activities by the incarcerated population.
- Group treatment rooms should be provided at each housing unit with surveillance from a security post.
- Mental health clinicians should have the opportunity to also use outdoor areas for treatment activities.
- Mental health (and medical) staff should be provided with adequate support facilities—lockers, lunchroom, break/respite areas, and similar supportive accoutrements.

Image 6.2.31. MH Unit Staff Workstations, Nebraska Receptions and Treatment Center





Medical Facilities: Assessment, Gaps, Remedial & Future Planning Recommendations

At both facilities, legally mandated health care services are provided by Adult Correctional Health (ACH), a program within the Department of Health Services (DHS), Primary Health Division, through County staff and contracted providers working in partnership with SSO.

Nurse sick calls are the primary point of patients' access to care. Services provided include primary care, women's health, behavioral health, pharmacy, ancillary, specialty, and hospital services. Most of the specialty services and all the hospital services are provided off-site.

Centralized Medical Clinics and Dental Services

At the Main Jail:

- Centralized clinics are located on the second floor. It has a holding cell for medical runs, a dialysis room (two chairs), a dental room (two chairs), and x-ray room. A mobile dental unit is also available to provide access to dental services at the housing unit level (multipurpose room).
- There are exam rooms available on floors 3–8, shared between East and West housing units on each floor, used by the medical team for sick call.
- Six East houses detox and MAT services. An adjacent room to the unit is used by medical personnel for clinical services. The original classroom on the sixth floor is used as a medical exam/treatment room.

At the RCCC medical and dental services are located at several locations across the campus:

- Residents of the Honors Housing (HF), M dorm, and A barrack go to the "M" Medical Housing Unit building for pill-call and medical appointments. Medical spaces available in this area include a lobby/waiting and reception room with two desks, a private office for the medical supervisor, two exam rooms, restroom with lockers for medical staff, a medication storage room, and storage spaces for medical supplies.
- B, J, and K residents go to the medical satellite clinic located in Stuart Baird, accessed from secure corridor. There is a waiting area next to the medical room; pill-call occurs at the cell door or in the case of dormitories, at the pod door.
- JFK and KBF share two exam rooms.
- SBF and CBF share two exam rooms.
- The entire campus population access dental services (two chairs) and X-rays in the SBF/CBF KBF/JFK complex.

Pharmacy Services

Pharmaceutical services at both facilities are provided by ACH/DHS each facility has a dedicated on-site pharmacy.

At the Main Jail, the pharmacy is located on the basement, in a space retrofitted about five years ago. The pharmacy is staffed by five pharmacists and four pharmacy technicians. At the RCCC, the pharmacy is located outside the main facility, close to the welding shop.

Medical Housing Units

Patients can be assigned to a medical housing unit for both intermediate and long-term care.

At the Main Jail:

- The medical infirmary (acute medical housing) is located on the 2nd floor (M2 West) and has 10 medical beds (M1-M10, single cells). It houses both males and females. Admissions and discharges are monitored daily by medical personnel to ensure that the patients' flow in and out of the infirmary is appropriate and timely.
- 2 East provides additional acute and subacute medical housing for males. 2 East has a medical office and an open station for medical personnel. In early 2025, a confidential booth was added to the 2 East indoor recreation area to support private visits with patients. This medical floor consists of three pods:
    - Pod 100 has five cells used as step-down/medical observation housing. The five cells and shower in the 100 Pod have ADA accessible features, however, they are not ADA-compliant.
    - Pods 200 and 300 house individuals requiring "medical accommodations," the primary limitations of which are mobility issues because none of the housing units on floors 3 through 8 have ADA-compliant in-cell accessible features, accessible showers, accessible visiting areas, and accessible access to outdoor recreation. More specifically, within these two pods there are cells set aside for handicapped people that have been prescribed a wheelchair, cane, or crutches, or need ADA accessible housing.
    - No ADA accessible housing is available for women with disabilities in the designated female housing units. If a female requires ADA accessible housing or in-cell ADA accessible features, she is housed in 2M (medical unit) or on the upper floors without the required accommodations.
- **6 East is another medical floor.** It is also the designated substance use detoxification unit and houses patients needing withdrawal treatment and monitoring, with Pod 100 housing females and Pods 200 and 300 males. This unit also houses induction to the MAT program, which continues to expand. There are designated medical staff located on 6 East 24/7.

At the RCCC, adult males with medical needs are housed in a designated Medical Housing Unit referred to as MHU. Within the MHU, there is a dialysis room, a nurse station (two desks for nurses and one deputy), and a general medical office with five stations. A yard is available adjacent to the unit providing patients relatively free access to use it. This 21-bed unit includes 13 medical beds for minimum security inmates in an open ward and six cells (labeled #35 through #40) of the following capacity:

Cell #35	Double occupancy (bunk bed); wet
Cell #36	Single occupancy; wet; negative pressure
Cell #37	Single occupancy; wet
Cell #38	Single occupancy; wet
Cell #39	Single occupancy; wet
Cell #40	Double occupancy (bunk bed); wet

Additionally, the "M" Dorm, KBF 100 Pod, and JFK 100 Pod are used to house handicapped individuals who have been prescribed assistive devices (an HCA/AD/DME) in the RCCC. There are no medical beds available to the female population. Female patients housed at RCCC that are acutely ill and require infirmary level of care are said to be transported to the MJ.

There is no accessible housing for full-time wheelchair users at RCCC (male or female) except in the MHU and "M" Dorm, which houses males. The only housing unit with some ADA accessible features for females with impaired mobility and who do not require wheelchair accessible housing is Kinya at SLF, which is a minimum-security housing unit. If a medium security female requires ADA accessible housing, staff would have to allow the person to be housed in Kinya on a classification override. If a maximum-security female at SLF requires ADA accessible housing, she would have to be housed in the non-ADA-accessible housing (Ramona) or be transferred to the medical housing unit at the MJ.

Main Jail

Medical Clinic and Staff Support

- The medical clinic shares a common space with APU, infirmary and Offices.
- Significantly undersized for population served.

- Over time, staffing has substantially increased without a corresponding increase in offices and support space. Medical and custody personnel are currently cramped in office space, with the current work environment potentially impacting on retention and recruitment.
- Limited waiting including use of clinic/infirmary circulation common waiting area for male and female patients. This lack of waiting/staging areas severely impacts efficiency of medical staff and hence the delivery of services.
- All rooms serve multiple functions.
- Common treatment and exam areas servicing male and female patients:
    - Insufficient number of medical exam rooms (only 2).
    - Limited treatment and space for specialized clinical services and for outside providers, potentially contributing to increased transportation.
    - No emergency/trauma treatment facilities, potentially contributing to extent of emergency transportation.
    - Dental theater provided with two chairs only (a mobile unit is also available), resulting in a 3-month waiting list to access dental services.
    - Although medical screening/triage is provided on floor, this occurs outside of the housing units which require additional staff; no waiting area is provided, impacting operational efficiency, efficacy, and delivery of services.
- General lack of storage space - medical supplies, equipment and devices are stored in hallways and circulation corridors. Areas originally designated as storage have been repurposed as offices.
- Low ceilings, narrow corridors, and doorways. Signs of wear and tear.

Image 6.2.32. Main Jail Staff Workstations

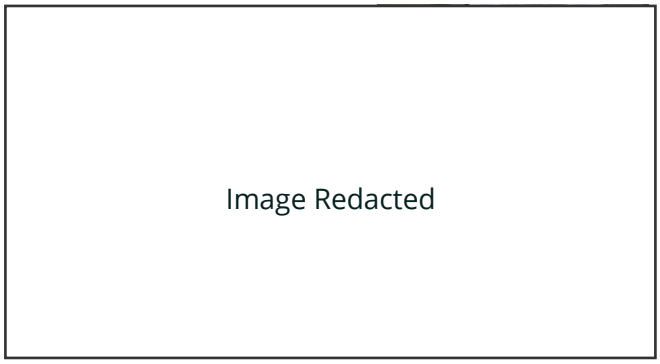
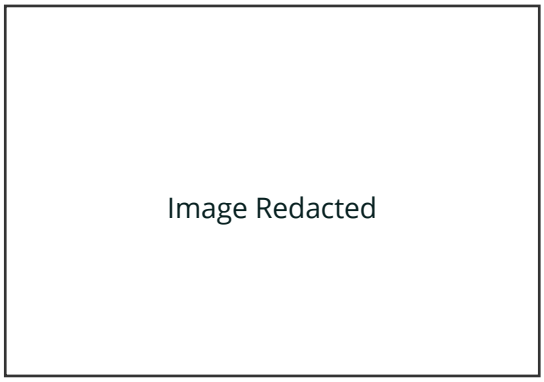


Image 6.2.33. Main Jail, Typical Exam Room, Equipment Storage in Hallway

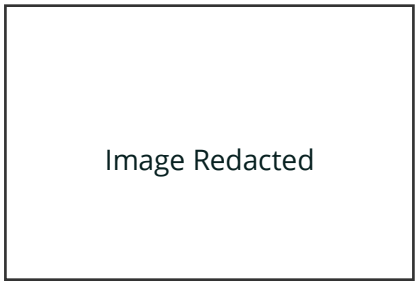


Remediation Recommendations

Existing facilities:

- Consider relocating APU as previously discussed to consolidate APU and eliminate conflict with clinic/infirmary
- Consider relocating some administrative functions, and staff support spaces to the adjacent County Administration Building investigate to expanding space available in the Main Jail for clinical services, waiting/staging, and support space.

Image 6.2.34. Typical Nurses Station w/ Exam Room in Background



Future planning:

- Interim improvements will not fully resolve requirements of the Consent Decree. Ultimately, this will require major renovation /expansion or new construction. Key planning tenets include:
    - Physically differentiated areas in proximity to each other—clinic with adjacent infirmary and separate back-of-house support offices; APU as discrete separate component.
    - Provide separate waiting and treatment areas for male and female patients, with shared specialized clinical services; incoming open waiting & holding with separate waiting for patients returning to housing.
    - Provide appropriately sized nurse's station and separate administrative/office space for medical staff and providers.
    - Provide a range of services including space for telemedicine; exam rooms like community clinics to increase efficiency and effectiveness of medical

staff and access to care. Based on benchmark facilities 4–6 treatment rooms should be provided.

- Provide an emergency treatment room.
- Provide dental chairs based on demand—three to four recommended.
- To reduce escort requirements and the need for additional staffing, provide exam rooms at the housing unit level to accommodate triage and medication distribution services.
- All corridors and doors should be sized for hospital bed or gurney with space for a person to walk beside it.
- Provide secure storage areas.

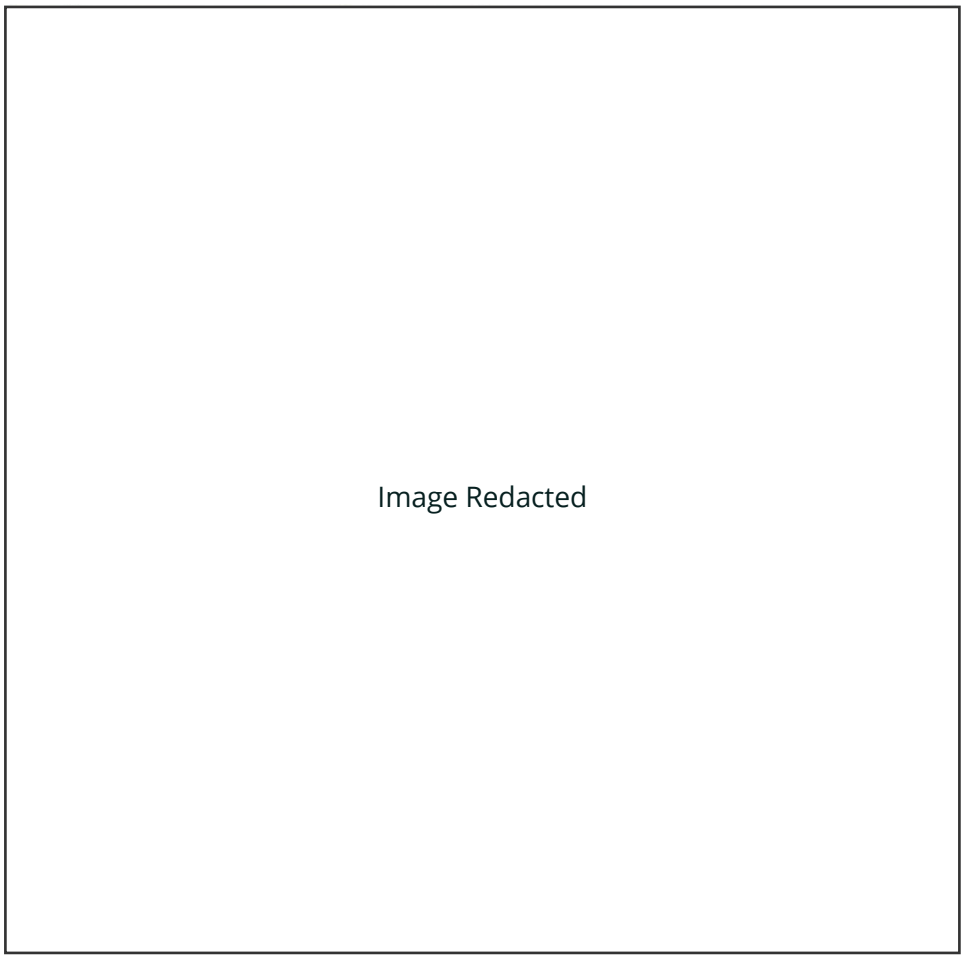
Image 6.2.35. Typical Waiting/Staging Area with Open Seating and Secure Cells



Image 6.2.36. Typical Reception Alcove for Vitals



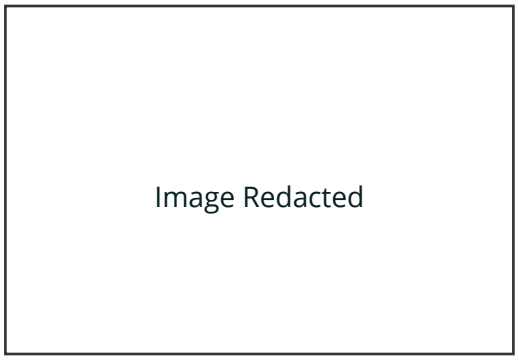
Image 6.2.37.
Specialized
Treatment Areas



Medical Infirmary (2M)

- Infirmary is in common space with APU, clinic, and offices.
- Significantly undersized for population served.
- Limited number of infirmary beds (10). 2 East 100 Pod used for medical overflow providing an additional five step-down/observation beds.
    - Main infirmary beds are typical cells; of particular concern is the adjacency of P18/M1 beds, disruptive of patients recovering.
    - Rooms do not provide for accessibility or adequate room for bedridden treatment.
    - Overflow beds have accessibility features but do not meet minimum code requirements; all doors are too narrow for hospital beds or gurneys with staff walking beside.
    - The two rooms originally provided as negative pressure rooms are inoperable and do not meet current design standards (no anteroom).

Image 6.2.38. Main Jail – Typical Infirmary Room



- Nurse's station does not have observation of all infirmary cells. The overflow cells are especially remote from nurse's station.
- Highly institutional environment; visually dark, depressing, and unfriendly. Does not reflect an environment supportive of healing and recovery.
- Lack of dayroom. Not equipped with "pod" phones.
- Lack of recreational space and contiguous exercise yard.
- Deficient in treatment space, staff work areas & storage for equipment.

Remediation Recommendations

Existing facilities:

- Consider relocating APU as previously discussed to consolidate APU and eliminate conflict with clinic/infirmary and capture beds and dayroom as part of infirmary.
- If some administrative functions and staff support can be relocated to the adjacent County Administration Building investigate replanning existing and added space to meet needs of clinic and infirmary jointly.

Future planning (again, interim improvements will not fully resolve requirements of the Consent Decree and ultimately will require major renovation/expansion or new construction) key planning tenets include:

- Differentiate areas physically but located in proximity to each other. Clinic with adjacent infirmary and separate back-of-house support offices, with APU as discrete separate component.
- Provide additional medical beds (typically representing 1%+/- of the total facility bed space capacity).
    - The Projected Need calls for 40 Beds (32 male beds, 11 female beds, and 8 medical isolation beds).
    - These beds should provide a mix of singles, doubles, and quad rooms w/toilet alcove; glazed cell fronts; they should all be sized to hospital/CTC standards; provide negative. pressure/infectious control rooms.
- Plan for visibility of all cell fronts.
    - Rooms should be planned for: treatment similar to hospital room—three-sided access to bed
    - All rooms should accommodate accessibility requirements
    - Suggest Title 24 Correctional Treatment Center standards as guideline even if not licensed, minimum room size 120 square foot
- Provide securable dayroom/activity room, multipurpose room
- Provide passive outdoor area.
- Provide a minimum of one accessible cell & shower per housing unit; consider full hygienic facilities in-suite.
- Provide air-borne infectious isolation room with anteroom.

Image 6.2.39. Typical Full Hospital Room

Image Redacted

Image 6.2.40. Typical Step-Down Infirmary Room

Image Redacted

Image 6.2.41. Hospital Ward, Cells to left in Photo

Image Redacted

Subacute Medical Housing

- 2 East Pods 200 and 300 house inmates requiring "medical accommodations," whose primary limitations are mobility issues. These pods provide accessibility accommodation but are not code compliant.
- 2 East deputies have to escort 2 East inmates to outdoor recreation on the 3rd Floor via an elevator to a wheelchair accessible outdoor area. Due to facility limitations, mobility limited inmates require additional planning and resources to safely facilitate outdoor time.

Withdrawal Management

- Patients in need of withdrawal treatment and monitoring are housed at an existing general population housing unit (6th floor East, pods 100, 200 and 300), adapted for Medical Detox/MAT/MOUD induction.
- All of the pods are two-tiers. Preference is to use lower tier cells for immediate access by medical personnel—upper tier cells are by their nature more remote from nursing staff. Volume of need, however, requires that day-to-day, a portion of the upper tier cells are used for MAT.

Geriatric/Medically Fragile

There is no specialized housing provided for long-term chronic care or for accommodating the geriatric population in proximity to the infirmary.

Remediation Recommendations

Existing facilities:

- Continue current MAT Cohort program.
- Consider adapting a dorm(s) at RCCC for geriatric/medically fragile individuals.

Future planning:

- Provide specialized housing for MAT & Geriatric/Medically Fragile in proximity to medical clinics and the infirmary; consider mix of cells & open ward beds.

Image 6.2.42. Housing Options - Geriatric/Medically Fragile



Pharmacy

- Duplication of services MJ & RCCC; Best Practice – Central Pharmacy capable of packaging specific prescriptions.
- Supply deliveries are to off-site location (G Street); Best Practice, central secure delivery site.
- Current Condition – Significant gap in space available vs. space needed.
    - Lacks office space. At the Main Jail the staffing includes five pharmacists and four technicians in an area of 537 sf +/-, a very cramped and inefficient layout. Similarly, at RCCC the pharmacy housed three pharmacists and two technicians in equally cramped space.
    - Reports of flooding.
    - No IV capability, no hood, sterile; Premix bags are used for IV delivery; also nursing staff mix at bed for immediate delivery to inmate-patient.
    - Conduit space limited, full, crushed.
    - No room for future expansion. Significant shortfall in support, office, and storage space to process and fill all inpatient, outpatient and keep on person (LTC) prescriptions.
- Significantly undersized; current area allocation 886 SF +/-, vs. 3,500 SF typical of facilities this size; IHSF program, 1,931sf; 2015 RCCC Program 1,362

Remediation Recommendation

Existing facilities:

- Identify space available to enlarge and provide adequate facilities

Future planning:

- Provide new pharmacy space.
- Consider impact on staffing and operations of operating bifurcated pharmacy for two locations.

Rio Cosumnes Correctional Center

Medical Clinic/Dental/Pharmacy

- Clinical treatment and office support space are limited in all areas.
- Only specialized treatment space provided is dialysis, located in Building “MHU.”
- The Pharmacy is in adapted space (in the welding vocational tech building) and is overcrowded and not in proximity to other medical services.

Infirmary

- Individuals requiring "medical accommodations" (primarily mobility challenged) are housed in the south wing of Building "MHU;" accessibility accommodations are provided but may not be fully code compliant.
- Center element of Building "MHU" houses clinical spaces are limited; recently, a storage area was converted to a dialysis treatment room accessed from the infirmary, not the clinic.
- Within the infirmary, the cells are open bar grille and not sized to accommodate access to beds on three sides.
- Support, storage, interview and program space is limited or non-existent.

Remediation Recommendation

Existing facilities:

- Additional space is required at both facilities to provide adequate space to meet treatment needs in a timely manner and reduce and hopefully avoid continued backlogs for service.

Future planning:

- While interim improvements may provide some relief, it is believed that major renovations of new construction will be required to provide facilities that will support the desired standard of care.
- Consider impact on staffing and operations of operating bifurcated pharmacy for two locations.

Administration – Assessment, Gaps, Remedial & Future Planning Recommendations

Main Jail & Rio Cosumnes Correctional Center

Since their initial construction, both the MJ and the Rio Cosumnes Correctional Center (RCCC) have seen significant increases in administrative, custody, programs, and support staff to manage a growing inmate population. Furthermore, compliance with and monitoring the conditions of the Consent Decree has mandated additional functions, driving an increase in medical and mental health personnel.

Despite these increases, upgrading spaces for administrative and security staff have not kept pace. At both facilities, particularly at the MJ, space available for staff is very limited. This has forced to relocate staff where "space is available," including the basement at the MJ, and trailers and modular facilities at RCCC.

- The provision of adequate number of staff offices and office support space is critical to ensure efficient daily operations.
    - At both facilities, staff are not optimally placed. At the MJ in particular, a facility originally built for far fewer people, staff are cramped in offices or operating off-site, forcing staff to operate in unsuitable or highly fragmented areas.
    - The scattered location of administrative and custody personnel where "space is available" results in critical staffing logistics and a fractured command and control structure.
- The lack of dedicated space has similarly impacted on Custody Administration in terms of specialized teams and services (ERT, IOP) and unit management throughout both facilities.
- A key deficiency is the lack of physical adjacency of facility command staff and ACH and ACMH leadership.

Remediation Recommendations

Existing facilities:

- Explore relocation of Administrative and non-direct facility operations (e.g., transportation) to available space in adjacent County Administration Building both to provide adequate office and support areas and to free space for adaptive use for programs and services.

Future planning:

- Main Jail: Reuse planning for existing jail will either require relocation of some functions to available space or new construction as part of an Annex.
- RCCC: Construction of expanded administrative space will be required, possibly as part of new building at perimeter housing administration, visiting & staff services.
- Approaches that include replacement facilities should provide adequate space inside and outside the perimeter for administrative functions.
- In both cases, adequate number of offices and support spaces should be provided at both facilities for Administration, Custody Administration, ACH, and ACMH management, ideally in proximate location to foster a stronger team approach to population.
- A space program will be developed quantifying the need for administrative space outside and inside the perimeter.

Staff Services: Assessment, Gaps, Remedial & Future Planning Recommendations

Main Jail & Rio Cosumnes Correctional Center

The SSO is committed to creating a professional and safe working environment. Though not strictly mandated by the decree, the need to upgrade and expand staff facilities is seen as essential for staff wellbeing in high-stress environments, as well as for improving overall jail conditions. Enhanced staff areas contribute to better working conditions, potentially helping with retention and recruitment efforts.

- Providing specialized resources and dedicated on-site facilities is essential to improve morale, reduce stress and burn out.
- The increased staffing requirements to meet the federal Consent Decree mandates has resulted in significant shortfalls, creating challenging environments for personnel.
- All staff support services—parking, lockers (currently located in hallways), briefing/conferencing, in-service training, showers, washrooms, fitness, and wellness rooms, are crowded and physically do not meet current need.
    - At the Main Jail, although some staff training rooms are available on the second floor, there is no space provided to train staff in situational inmate control using simulated environments.
- Existing spaces and amenities for decompressing are non-existent or makeshift at best. The importance of providing staff respite areas cannot be minimized. They promote staff wellness and enhance service delivery by allowing staff to decompress before returning to their assignments in a better frame of mind.

Remediation Recommendations

Existing facilities:

- Main Jail: Explore relocation and expansion of Staff Services in available space in adjacent County Administration Building both to provide adequate office and support areas and to free space for adaptive use for programs and services.
- Main Jail: Explore options to provide additional parking to address current shortfall.
- RCCC: Construction of expanded staff services space will be required, possibly as part of new building at perimeter housing administration, visiting & staff services.

Future planning:

- Main Jail: Reuse planning for existing jail will either require relocation staff service, expansion in place if space is available, or new construction as part of an Annex.
- Main Jail: A solution to parking to address current shortfall and additional demand required by expansion will be required.

- RCCC: Construction of expanded staff services space will be required, possibly as part of new building at perimeter housing administration, visiting & staff services.
- RCCC: A comprehensive Master Plan will be needed including asking the question, "Should parking continue inside the fenceline or be located outside the fence?"
- At both facilities through renovation, expansion, or new construction and for facility replacement approaches, adequate facilities should be provided for both sworn and non-sworn staff including lockers, showers, fitness, training, and break rooms outside the perimeter and staff dining and respite/break rooms inside the perimeter.
- A space program will be developed quantifying the need for and type of lockers, briefing/conferencing, in-service training, showers, washrooms, fitness, and wellness space including respite space for the projected staff complement, both sworn and non-sworn.
- Parking will be addressed based on accommodating shift change for the two largest shifts.

Programs: Assessment, Gaps, Remedial & Future Planning Recommendations

Main Jail & Rio Cosumnes Correctional Center

As supplied by the SSO, the following programs are offered to the inmate population to equip those incarcerated with the skills and tools for successful reentry into the community:

- Educational programs
- Vocational courses (like welding, culinary arts, automotive, construction, barista training, custodial training, landscaping, and gardening, sign making and engraving, all of them offered at the RCCC)
- Substance Use Disorder counseling provided by ACH as well as community providers (AA/NA)[13]
- Reentry and employment assistance services
- Library/Law library services
- Recreation

[13] It should be noted that the use of community providers has been significantly curtailed, as Class Counsel has taken the position that if provided, they must be offered to all. This is not typical of detention and correctional settings where the capacity of programs is limited both by providers custody staff availability; access to a program is based on placement specifically as part of planned treatment program rather than opened to all on a "sign-up" basis.

Although there are a variety of programs in place, there is a general lack of program space, particularly at the MJ. In addition to education, substance abuse and other volunteer services, the program rooms must also accommodate treatment and group counseling sessions required by the Consent Decree.

There are many community resources and interest in involvement from organizations and volunteers but a lack of adequate space/hoteling stations to accommodate them.

Program space is also functionally inadequate.

- Additional and bigger classrooms are needed to accommodate large group activities.
- There is a need for additional small rooms for one-on-one interviews and counseling at the MJ. The interview rooms added as interim measure for confidential contacts do not meet HIPAA or functional requirements as they are "fishbowls." Additionally, physical space constraints in the MJ impact the provision of out-of-cell time, rehabilitative programs and general assistance services offered to the population.
- At the RCCC there is a limited number of interview rooms on CBF, SBF, KBF and SLF units; none is available on the barracks.

Without considering other programs and assuming inpatient programs are developed to meet program needs in new construction, Consent Decree compliance alone would require 29 group rooms in use full-time, based on the projected capacity needs by level-of-service, number of group sessions required at an average of 10 participants and assuming all are accommodated within an eight-hour shift, based on six hours of actual program time based on meals, counts and escorted movement.

Recreation is another key program of concern.

- The MJ has three recreation areas to accommodate populations housed in 39 separate units, with many of these units including individuals of varying classifications that cannot mix.
- SSO has developed a complex schedule to ensure a minimum recreation time is met; this is a management burden and does not support best practices of daily outdoor recreation.
- RCCC—CBF, SBF, KBF and JKF—each have a single recreation yard shared by six units allowing for daily outdoor recreation time for each unit. Barracks and SFL have access to fenced natural recreation areas.

Remediation Recommendations

Existing facilities:

- Main Jail & RCCC: Make greater use of technology and tablets to expand/enhance programs.
- Main Jail & RCCC: Optimize use of existing space via scheduling and extending treatment and program hours.
- Main Jail & RCCC: Investigate options for increasing individual and group treatment space (See Section 6.6 for initial concepts).
- Main Jail: Consider splitting large recreation decks into two separate areas to double available outdoor recreation spaces. (See Section 6.6 for initial concepts).

Future planning:

- Main Jail& RCCC: Continue existing facility options above.
- All new housing should include program areas—adequate dayrooms, multipurpose group rooms, individual interview/counseling rooms, outdoor recreation to enhance program delivery, reduce movement and escort staffing and enhance safety and security.
- The ability to accommodate programs and associate support space in existing or repurposed space should be a key consideration in developing and analyzing approaches relative to continued use of existing facility resources.

Support Services – Assessment, Gaps, Remedial & Future Planning Recommendations

Main Jail & Rio Cosumnes Correctional Center

Food service

- Food service was evaluated in detail in the Marshall Associated, Inc Report, April 20, 2021. This report identified all the physical condition deficiencies along with demand for special diets.
- The inadequacy of the kitchen was also identified in prior studies and the 2016 plan for reconstruction of portions of RCCC included a new central chill kitchen and associated warehouse.

Laundry

- Prior studies identified laundry condition and capacity as continuing CIP issue.
- The 2016 plan proposed a combined central laundry at RCCC.

Support services

- Maintenance – On-site maintenance facilities are limited to what is required to support day-to-day repairs.
- Central plant – hot and chilled water is provided by the County's Central Plant from the adjacent County Administration Building site.

Remediation Recommendations

Existing facilities:

- None identified.

Future planning:

- Explore potential for centralized services – Food service cook/chill/retherm, warehousing and larger system maintenance facilities as suggested by the 2016 plan for RCCC expansion.

6.3. MAIN JAIL AND RCCC STAFFING ASSESSMENT

The staffing assessment of Correctional Services Division of the Sacramento County Sheriff's Office (SSO) provides an initial understanding of current operations, service levels and management, staffing coverage, scheduling of employees, and workplace environment.

This preliminary assessment of staffing and operations represents the as-is state of the County's adult correctional system. The primary aim of developing this descriptive is to provide a foundation for subsequent analysis of staffing needs, with the general observations being valuable to look for opportunities to improve effectiveness and, where possible, operational efficiency.

This assessment is based on a tour of the existing facilities, information and data gathered from the County and review of existing reports, documents, and policies and procedures supplemented with the input received from first line staff and service providers encountered during the facility tours at both facilities.

6.3.1. Office of the Sheriff's Overview

The SSO operates as a constitutional office and part of the executive branch of government, providing law enforcement, court security, and jail operations.

Within the SSO, the Correctional Services Division is responsible for the secure management, custody, and safety of the in-custody population, remaining an essential partner in facilitating and ensuring people in custody access to care and essential services.

In addition, the SSO's Reentry Services Unit provides reentry programming and rehabilitative services to the in-custody population with the goal of reducing recidivism by preparing individuals for successful community reintegration.

Corrections Services is responsible for the provision of custodial and security services for incarcerated and detained individuals under the jurisdiction of the Sacramento County Court System and other outside agencies. The SSO contracts with the U. S. Government to house federal inmates and with the State of California to house some State parole violators. Through the provision of resource-sensitive services and care from arraignment of the individual to release, Correctional Services strives to promote a safe, secure, and healthy environment that supports successful reintegration into the community.

The mission of the **Reentry Services Unit**, located at the RCCC, is to enhance public safety with the reduction of recidivism. As part of Reentry Services, social workers coordinate with various county agencies and private community partners to link services before and upon release from custody. The Unit utilizes effective program approaches and research-informed vocational, educational and treatment programs to equip incarcerated people with the skills and tools necessary for successful reintegration into the community.

6.3.2. Review of Current Operations

In order to assess current number of personnel, the consultant team reviewed Facility Staffing Roster and Shift Staffing Rosters for both facilities. A "shift staffing roster" identifies the authorized number of personnel assigned to a shift, the actual number assigned to each shift, and the number of vacancies. It is also the foundation for operations and for developing a "Staffing Plan" establishing the minimum number of staff to cover each shift (post requirements) based on the current census population and distribution of beds across the two facilities.

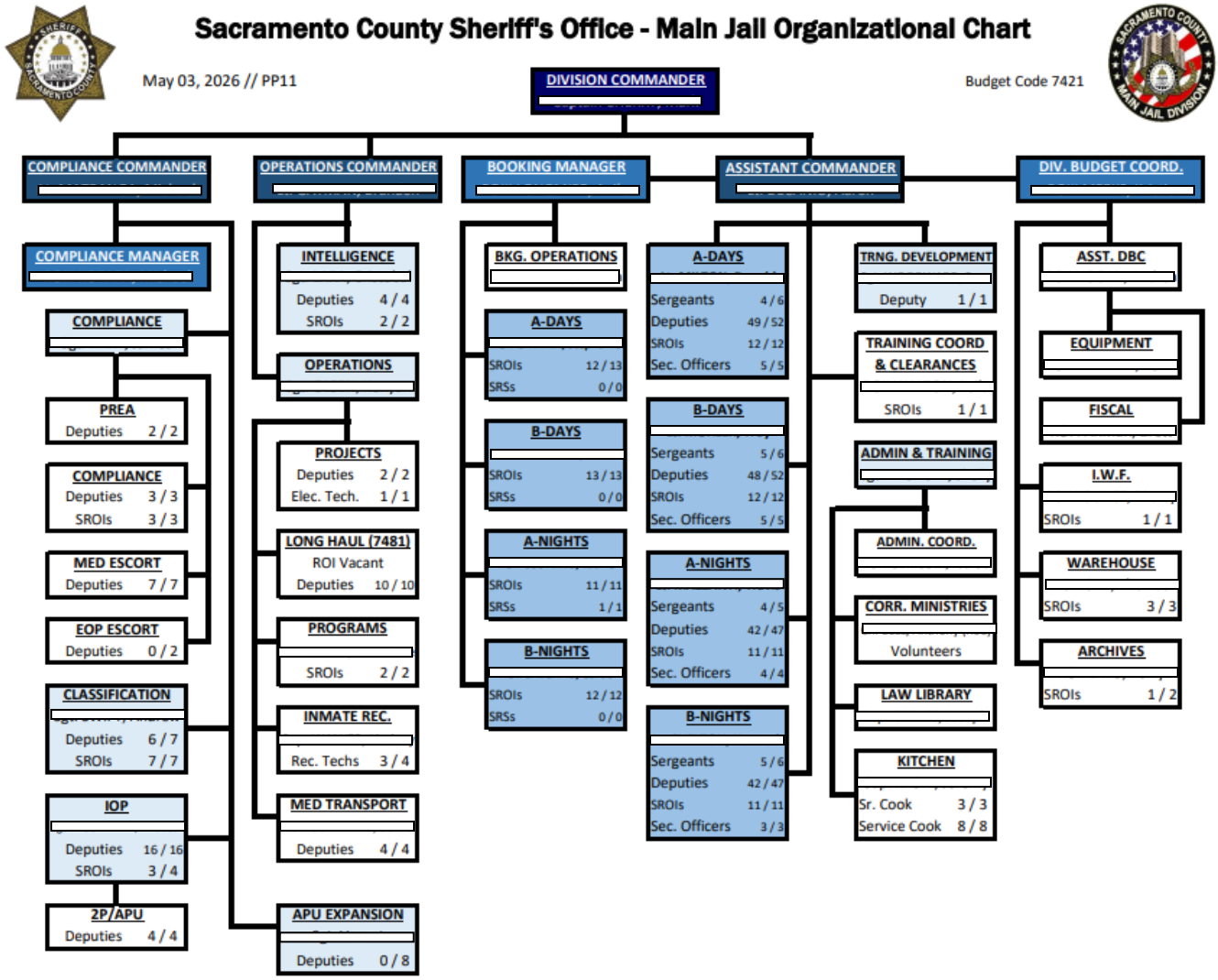
The review and analysis of current staffing and shift rosters was conducted to account for the applicable local laws and state regulations and standards governing staffing requirements. Based on the physical layout, bed space capacity and other factors, every post at the detention facilities is either required by the United States Department of Justice ("DOJ"), the California Code of Regulations, the BSCC, the Sacramento Sheriff's Office Custody Policy Manual (SSOCPM, Minimum Staffing Requirements) or has been added as the result of policy decisions made by the Sheriff. Additionally, the Prison Rape Elimination Act of 2013, also known as PREA, and the American Correctional Association (ACA) provide standards that, albeit not binding, are recognized by most as best practice industry standards.

Each facility is overseen by a Division Commander (Captain) who is responsible for oversight of daily facility operations. Facilities are staffed by both sworn officers and civilian personnel (non-

sworn), including building maintenance and food services staff, vendors, social workers, recreation specialists and other occupations necessary to operate the facility.

Sworn staff are required to complete 24 hours of Standards and Training for Corrections (STC) approved training each year, which includes Peace Officers Standards and Training (POST) mandated courses. Training addresses a wide range of key operational areas from Officer Safety to the Jail Inmate Management System. Additional training addresses suicide prevention and other mental health management issues. Additionally, custody staff receive periodic training on the identification of symptoms of mental illness. Non-sworn staff complete mandated annual training in various policy and computer related areas.

Figure 6.3.1. Main Jail Current Staffing



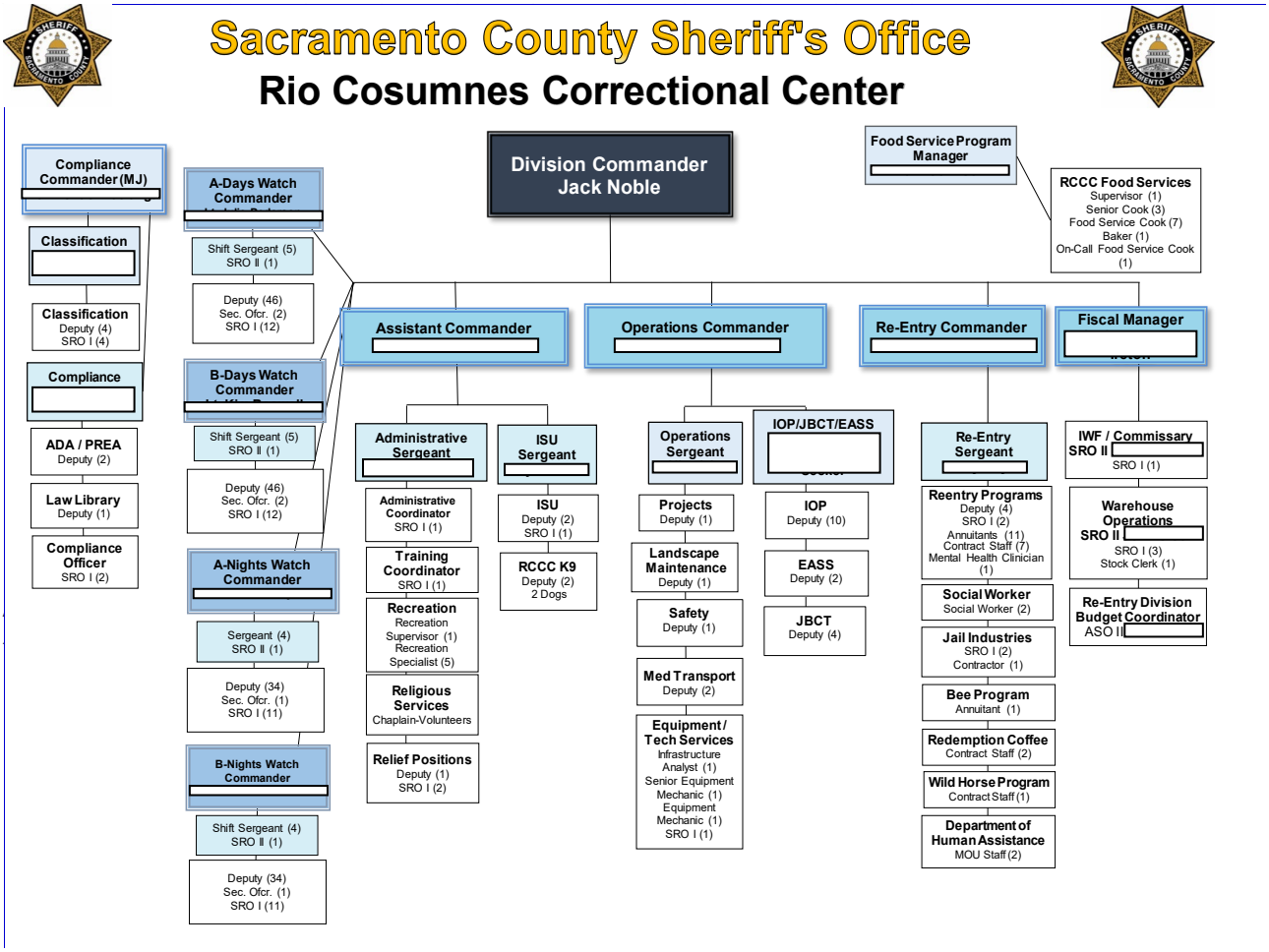
As of May 2026, there were 484 authorized positions in the Main Jail with 445 positions currently filled to support the daily operation of the jail. The breakdown of authorized positions was as follows:

- Sworn officers – 308 (64%)
- Non-sworn personnel – 176 (36%)

The 39 vacant positions represent an overall total staff vacancy rate of 8% of authorized positions, with the bulk of vacancies (34) in the sworn "line ranks." The overall adjusted vacancy rate (which accounts for people who are taking admin leave, sick time, time off, etc.) at about

14% is much higher. More specifically, it is particularly high among sergeants (26%) and deputies (18%). This situation translates into daily staffing shortages, sometimes in the range of 30 to 70 personnel, particularly during the B shifts of the week. The minimum number of deputies required during the day shift is 38. To get to this minimum staffing numbers, vacancies are filled using personnel on overtime.

Figure 6.3.2. RCCC Current Staffing



As shown by the staffing data, there were 30 vacant positions representing **an overall 9% vacancy rate, with an adjusted vacancy rate of 13%**. Like at the MJ, the bulk of vacancies (26) are in the sworn professional staff categories, deputies in particular (15%), with most staffing shortages occurring during the A and B Night shifts.

While any vacancy in a correctional facility makes operations more difficult, compared to national averages, an 8–9% vacancy rate is often considered low. However, adjusted vacancy

rates between 20% and 30% are more critical and are contributing to persistent challenges, potentially leading to unit lock-downs and reduced out-of-cell time.

Beyond maintaining safety and order, custody staff also have a tremendous impact on access to healthcare services. Custody staff serve as the primary link between people in custody and clinical services, and their actions directly influence whether incarcerated individuals receive timely and necessary mental health and medical services.

Sacramento County Staffing Response to Complying with Conditions of the Consent Decree

Over time, to comply with the Consent Decree and improve access to medical and mental health services - including timely delivery and administration of medication, the Sacramento County Board of Supervisors has approved several budget appropriations to fund new Deputy Sheriff positions (custody posts) for the purposes of health care escorts.

- In Fiscal Year 2024–2025, the Board authorized $900,000 to fund four new Deputy Sheriff positions responsible for escorting both inmates and medical staff to health appointments.
- Most recently in Fiscal Year 2025-26, the Board approved $600,000 for three full-time equivalent (FTE) Deputy Sheriff positions to escort inmates to medical and dental appointments.
- Additionally, $500,000 was allocated for one sergeant and four deputy sheriff positions to support the expansion of the IOP.

These positions are essential to the Remedial Plan mandated by the Consent Decree which requires the County to provide timely access to medical and mental health services.

Working Schedules

Most command staff, specific administrative services and divisions typical operations are Monday through Friday, during the standard business shift of 7:00 a.m.–4:00 p.m.

Custody staff operate on a day and night (A and B shifts) schedule, commonly a 12-hour shift. The staffing plan specifies that, in the MJ, 51 deputies are assigned to the day shift and 47 deputies are assigned to the night shift. At the RCCC, 46 deputies are assigned to the day shift and 34 deputies are assigned to the night shift.

During the day shift, there is a higher level of internal movement due to programs, court proceedings, medical appointments, job training, etc.; therefore, the staffing plan calls for increased personnel to augment standard custody staffing assigned to specific control points.

6.3.3. Current State Observations and Future Impact

The following section lists a variety of observations related to interview outcomes, data review, and facility tours that could prove influential in the future operations of the detention system in Sacramento County. These observations are mostly qualitative though potentially impactful.

- Current budget:
    - The budget for the Sheriff's office was cut last year, but funds were restored at the recent June 4, 2026, Board of Supervisors approval of the $8.9 billion Recommended Budget for Fiscal Year (FY) 2025–2026. The approximate budget history (exclusive of federal grants) is as follows:
        - FY 2023–2024: $695.3 million
        - FY 2024–2025: $681 million
        - FY 2025–2026: $700 million

      Despite fiscal challenges, the Board sought to balance "fiscal responsibility with meeting the needs of our community." It included restoring services provided by the Sheriff's office and a new Behavioral Health Urgent Care Center to support the Consent Decree.

    - Operating two correctional facilities creates duplication of services (e.g., kitchen operations, laundry services, maintenance and supplies, medical and mental health staff, etc.). This has created additional operational and maintenance costs associated with duplicative systems and equipment.

    - Inefficient design also wastes money. Compared to other jail designs, the county jail system requires more staff for basic operations in supervision, security, and movement, particularly at MJ.

    - A newly designed and constructed facility could result in reduced operational and staffing costs, if modern design principles and best practices are incorporated into the new design. A single facility could reduce staffing operations and maintenance costs for systems and equipment deployed. A new correctional facility would create an effective staffing model to better serve the jail population.

- Current staffing coverage:

Overall, although the current staffing plans for custody staff are reported as being generally sufficient to meet the minimum staffing numbers, staffing levels are impacted by several factors and changes that have occurred over time. The following main

factors are working against staffing efficiency, making staffing requirements more complex and extensive, particularly at the MJ:

- Changes in the profile and needs of the jail population (more complex histories of trauma and abuse, more violence, more gangs, increase in substance use, mental health problems and co-occurring disorders) resulting in the proliferation of different levels of care and security classification sub-categories as well as the expansion of specialized housing units.
- Requirements to keep different people in custody strictly apart for safety and security reasons (e.g., by security level, gang affiliation, protective custody, etc.), requiring increased security staffing on high-security floors, which also house most of the administrative segregation and individuals classified as "keep-separate" (total separation).
- Changes in program needs, enhancement of services and extended range of services provided necessitating additional staffing positions. The challenge is for SSO to ensure that there is sufficient custody staff present in specialized housing units as well as to support access to programs and extended service hours and days to facilitate confidential contacts:
    - In the APU, to increase access to treatment, staffing allocation has changed to provide two full-time deputies. In the IOP units, there is a designated IOP team of specifically trained deputies (20 deputies and one sergeant) doing exclusively IOP programming. Prioritizing staffing assignments and custody escorts in these critical programs often results in having insufficient staff in other areas of the MJ (i.e., booking through the 8th floor). Reportedly, there are insufficient deputies to supervise out-of-cell activities for people in the general population.
    - Augmented custody staff to monitor and escort patients is reported during the primary service hours and on shifts where there is increased activity and treatment groups requiring inmate movement.
    - Moving forward, as APU, IOP and EOP programming continue to expand, additional custody staffing will be necessary at both facilities to allow these efforts to be successful.
    - Although some improvements in equipment and technology have proven helpful and, in some instances, have reduced staffing pressures, a modern jail design would allow for seamless integration of new and pending security-related technologies to help improve operational and staffing efficiencies (RFID bracelets, tablets controlling cell ingress/egress, etc.).

- The outdated physical plant and layout configuration of the facilities are also impacting staffing levels and service delivery.
    - Extra officers are required to maintain a safe line of sight in the housing units at the MJ and at the RCCC dormitory-style units, and to manage movement throughout the facilities.
    - At the RCCC, due to the challenges for custody staff to be able to observe the clinicians and patients in dedicated programs and treatment rooms (particularly groups occurring in the IOP classroom), a deputy needs to be present inside or sit outside the room.
    - Additionally, daily inmate movement at the RCCC is uniquely spread out due to the expansive, campus-style layout.
    - The greatest impact on staffing comes from "send outs" - the process of transporting people in custody to a local hospital or medical provider for medical treatment. These medical runs significantly strain correctional facility resources by pulling officers away (10 to 12 on average) from their primary duties and driving up overtime costs. Send outs require two deputies per run/hospitalized person, with the number and frequency resulting in reduced shift staffing and modified operations.
- Current workplace limitations:
    - Over the past decade, the SSO has had around 100 vacancies driven by a high-rate attrition, retirements, and difficulty in recruiting new talent. The SSO is strongly committed to continuing to address the challenge of filling vacant positions. Leadership staff notes that employee retention is difficult because of the conditions at the current facilities, especially at the MJ.
    - It was repeatedly observed that parking is a necessity for facility employees as the current state related to downtown parking is untenable. It was noted that parking is particularly relevant as a future incentive (recruitment tool) for potential new recruits. Based on current staffing patterns, about 450 parking spaces would be needed for the Main Jail for sworn custody staff and civilian staff, and about 375 spaces would be needed at RCCC. Note that the parking numbers need to cover shift change for two shifts (staff arriving/staff departing, command staff and staff working an eight-hour shift non-relieved.
    - An overarching issue of concern is the impact of the work environment on retention and recruitment. Staff should be provided with a professional work environment. Notoriously at the MJ, there is not enough space to adequately accommodate the staffing growth that has occurred overtime

with the expansion/implementation of new programs and the addition of the new medical escort team.

- To help with staff turnover and bolster recruitment and retention, space should be devised such that personnel are provided with adequate office space and support facilities (employee cafeteria, resource center, lactation and quiet rooms, external entrance to employee gym for off-hours workout, etc.). These amenities are poor or lacking in the current facilities.

6.4. Review of Transportation and Inmate Movement Coverage

Transportation represents a critical operational component of the County's jail system. Transports account for a large portion of staff time and overall costs. As such, an assessment of transportation staffing and operations is critical as these units consume significant staff resources and can result in officer downtime, increasing overtime and operational costs.

To examine what is currently working well and what changes could be made in the future that might improve processes/reduce costs, the consultant team conducted online interviews with relevant staff to gather information about current operations and future needs, including potential growth of staff, vehicles, and office needs. With the goal of assessing transportation activity and demands and their impact on operations, staffing and costs, the team examined available transport data provided by the County for a three-month period (November 2025 through January 2026). This data covered information related to documentation of transport trips and costs, including but not limited to mileage, fuel, and purchase and maintenance of vehicles.

6.4.1. Current Transportation Operations

MJ is the main transportation hub for the SSO's Correctional Services Division, also having the primary mission of housing medical and mental health individuals. Given the proximity to the courts and where the court hearings are scheduled, all court transports are operated from the MJ through the SSO's Court Security Division. At the MJ, there are a total of 12 vehicles used for transportation purposes, six of which are assigned to medical runs and the other six to the long-haul unit.

With few exceptions, most releases also occur from MJ. Unless individuals released from RCCC have pickup arrangements, all individuals are transported downtown for releases. Individuals released from RCCC who lack transportation are transported to the MJ via a Sheriff's Office bus.

Sworn officers at the MJ and RCCC manage all aspects of in-custody movement and transportation, ensuring the security and custody of individuals being transported for a variety of reasons. These include transports to court, medical appointments, emergency transports,

and interfacility transfers which include movement related to available bed space, specialized units and program needs, and separation orders. For the protection of the staff, a minimum of two officers is generally assigned to any transportation assignment. These transports may be scheduled or unscheduled.

At the MJ there are 12 Ford Transit 350 vans available to service the daily transport needs of the facility. At the RCCC, in addition to the buses, there are four vans available for medical transports.

Transportation Units and Cost Estimates

Most scheduled transports are conducted by the Long-Haul Transportation Unit, the Court Security Unit, the Medical Transportation Units, and the RCCC Facility Transportation Bus Details.

The Long-Haul Transportation Unit is a specialized team responsible for securely moving individuals across the state, including transfers of in-custody individuals to state correctional facilities, state hospitals, other law enforcement agencies, and warrant pickups from other jurisdictions. Operating from the MJ, the unit is staffed by 10 sworn deputies working on the day shift. A Records Officer is assigned to the unit for scheduling purposes. The entire operations are overseeing by a Sergeant.

Medical Transport Units have designated personnel that are responsible for transporting people in-custody to and from pre-scheduled medical appointments. These appointments are coordinated by the Units' Record Officers (scheduling supervisors) in conjunction with ACH.

Individuals are transported to appointments one at a time, with every appointment and hospital run requiring two deputies. There are two dedicated teams at the MJ and one team at RCCC for pre-scheduled appointments. At each facility, the teams are supported by a Records Officer (scheduling supervisor) and overseen by one Sergeant.

- The Medical Transportation Team at the MJ consists of two teams with two full-time deputies, for a total of four deputies assigned to the day shift. This team uses six multi-passenger vans, two of which are ADA vans equipped to carry wheelchair bound individuals.
- The Medical Transportation Team at RCCC consists of one team of two full-time deputies assigned to the day shift.

As reported by staff, medical runs vary in length, taking between an average of four to six hours if within the County, or six to 12 hours if outside of Sacramento. It should be noted that the escorting of individuals to dentist, nursing or doctor appointments within the facilities is handled by a dedicated healthcare escort team created in 2024 of nine full-time authorized

positions at the MJ to facilitate access to mental health care and medical appointments, allowing unit deputies to focus on other duties.

The table below summarizes the total number of medical runs performed in a month, which translates into an average of approximately six medical runs a day, with up to 15 med runs on a single day.

Table 6.4.1. Medical Transportation Units - Monthly Number of Scheduled Visits

	MJ	RCCC
Nov 2025	32	23
Dec 2025	37	32
Jan 2026	31	34
Med Transport Estimates	**$55,877.39**	**$88,709.50**

For that three-month time period, the cost for the deputies responsible for transporting incarcerated individuals from the MJ to outside medical appointments (based on regular hourly deputy pay estimates) was $55,877.39, and $88,709.50 at the RCCC. This figure includes all of their payroll costs.

Unscheduled Emergency Transportation Runs. At both facilities, there are unscheduled emergency medical runs which require two deputies per run, with each run done individually. There is no dedicated team for unscheduled runs. Staff are pulled from their duties to assist, as needed.

As reported by staff, unscheduled runs vary in length, with medical runs taking between an average of six to 12 hours. Any available medical transportation van is utilized for unscheduled medical runs or, if officers are relieving others, they may come from home and are reimbursed for the parking expenses.

The emergency medical runs are calculated on hourly overtime rates, two deputies per run, varying between six to 12 hours; some on-call regular hours are included.

Table 6.4.2. Unscheduled Medical Runs Overtime Estimates (Nov. 2025–Jan. 2026)

	OT Estimates
MJ	$56,998.74
RCCC	$84,990.09

Court-related Transports. MJ serves as the central hub for daily scheduled pickup transports to the various Courthouse locations. Court operations are under the SSO's Court Security Division which, pertinent to people in custody, is located at the basement of the MJ.

Table 6.4.3. Court Security Division

Staffing Authorization		
Auth.	**Classification**	**Filled**
1	Captain	1
2	Lieutenant	2
7	Sergeant	7
110	Deputy	99
28	Security Officer	28
1	ASOI	1
1	RO I	1
150	**Total**	**139**

The Court Security Division operating out of the MJ is staffed with one sergeant, two control security officers, four tank deputies, and 10 deputies who are assigned as either bailiffs or who roam between the courtrooms and the basement. Deputies also manage the security of the courtrooms and are responsible for delivering all in-custody defendants to and from the several courthouse buildings in a safe and secure manner. Additionally, the Short Haul Transportation

Unit, a subdivision of the Court Security Division, has one sergeant and five deputies assigned to the holding tanks, helping with loading and unloading.

The unit uses two Ford F550 vans (each holds 30 inmates). As a way of reference, the unit makes about 12 to 20 trips per day. Since the opening of the new Sacramento County Superior Courthouse, the volume of daily transport has remained at similar levels.

Effective April 27, 2026, the Sacramento Superior Court transitions all first-time arraignments from evening hours to daytime calendars as part of a move to streamline court operations, eliminate the practice of "middle-of-the-night" releases from the downtown jail, and improve access to social services by processing individuals during regular business hours.

Movement for court appointments from RCCC to the downtown jail are scheduled twice daily—once in the morning and once in the afternoon through the RCCC Transportation Bus(es) (branch bus) Unit. The **Transportation Bus(es) (branch bus) Unit** operates out of RCCC. The Unit is supervised by on duty RCCC shift supervisors. It consists of two teams operating on the A-day shift, with a total of four deputies. On average, each team runs two court runs. As a frame of reference, there are about 30 to 35 people going to court in the morning, and 20 to 25 in the afternoon.

In addition to movement for court appointments, movement of in-custody people between facilities occurs several times per day for transfer (housing moves) and releases. On average, as a relief valve to the MJ, RCCC receives about 25 to 35 transfers every morning.

There are four buses available for movement between the two facilities. Each bus can hold about 50 people. They are outfitted with compartments (holding tanks) that allow to separate males and females and transport individuals of different classifications together, for increased transport efficiencies.

6.4.2. Current State Observations and Future Impact

- Workplace environment:
    - The MJ is the main release and transportation hub for the SSO's correctional services division. Yet, due to the overall shortage of office space inside the jail, workforce is squeezed into small spaces. The Long-Haul team is cramped into a 250 sf +/- room on the public side of the perimeter. This room only has two desks shared by 10 officers. They also lack dedicated lockers for transportation equipment. The Court Security Division has also limited office and staff working/breakroom space at the basement.
- Transportation challenges:
    - The amount of daily movement conducted - between correctional facilities, to court, to hospitals, and other appointments - is significant and costly.

    - Additionally, there is a considerable amount of coordination that needs to be performed to facilitate these transports, with some delays experienced when the facility is running short on staff.
- Medical/MH transportation:
    - Medical operations significantly impact custody staff in many different areas of facility operations but significantly impact transportation staffing.
    - Medical transportation and the coverage of people on inpatient status at outside locations consumes significant officers' time and results in significant expenditures from having to supervise individuals admitted to outside hospitals.
    - The transport of individuals with mental illness is particularly challenging.
- Daily transport requires careful planning, coordination, and resources. It is a time-consuming and costly activity for SSO. Additionally, there are safety risks related to transport for all who are involved in the processes. Any strategy that could be implemented to reduce the total amount of transports would create efficiencies, reduce costs, and have a positive impact both on those in the custody of SSO as well as the staff who conduct these transports.
    - Utilization of telemedicine can reduce the large amount of transportation for trips to special medical clinics and hospitals. It can also potentially reduce hospitalizations and both the costs and the strain on staff resources.
    - Having an emergency trauma room on-site could also help reduce/eliminate emergency runs.
    - Increased use of technology to facilitate video arraignments should be considered to increase efficiency and reduce the overall costs associated with court transport specific to arraignments. Additionally, as attorney and client meetings are regularly occurring as part of the court transfer process, and those meetings may impact the daily schedule of transports and hearings, using video conferencing solutions for attorney-client communications may also be an option. This would require a secure room at the court with video capability that provides privacy for attorney-client meetings, being done with those in custody using tablets/laptops equipped with a camera.
    - As a long-term strategy that would improve staffing efficiencies and achieve cost savings is the construction of a new consolidated detention facility.
        - Housing the entire in-custody population on one site would allow SSO to more efficiently manage where inmates are housed and eliminate daily transport between facilities, free up transport staff, and likely result in decreased overtime costs.
        - This framework will also create opportunities to design for the needs of the current population and the overall requirements of a more

modern correctional facility. While challenges related to transport would continue, a new facility design would account for video processes and ensure the availability of private rooms to conduct judicial proceedings.

- In a modern correctional facility, the medical services component would also be designed to limit the internal movement of offenders in need of medical or mental health attention and minimize the need to transport inmates to an emergency room upon release or to a hospital facility.

6.5. Detention Facility Management Best Practices

Modern correctional planning and design is built on several key operational strategies and design features known to promote security, safety, functionality, healing, and rehabilitation.

Across diverse jurisdictions, implementing these frameworks and practices is associated with safer, more supportive conditions that better support rehabilitation and reintegration. Available evidence shows consistent association between architectural interventions prioritizing smaller housing units, direct supervision, and supportive environments with measurable improvements in wellness, living conditions and staff outcomes, as well as in lowering recidivism while optimizing operations and the nonnegotiable factor of safety.

This section provides a more detailed description of evidence-based frameworks, design best practices and evidence from prison-environment literature related to unit management and supervision, housing units, and the location of programs and support spaces in relationship to housing. These best practice concepts introduced earlier in this section (Section 6.1) respond in the broadest sense to the Consent Decree issues and the operational and architectural challenges impacting the existing facilities today. Where applicable, a discussion of best practices is accompanied by graphic resources to illustrate some of the concepts.

6.5.1. Unit Management and Supervision Best Practices

The management of people in custody in an appropriate manner to meet the security, safety, custody level, rehabilitation, and medical and mental health needs is critical to efficient operations as well as the reduction of recidivism.

Currently, the existing facilities deploy a combination of management approaches with most housing units set in an indirect supervision environment. Housing units comprised of several “pods” have staff located inside the unit to provide hands-on management of people within each pod, as needed, while control stations provide remote surveillance. This approach is a hybrid of direct and indirect supervision and is staff-intensive.

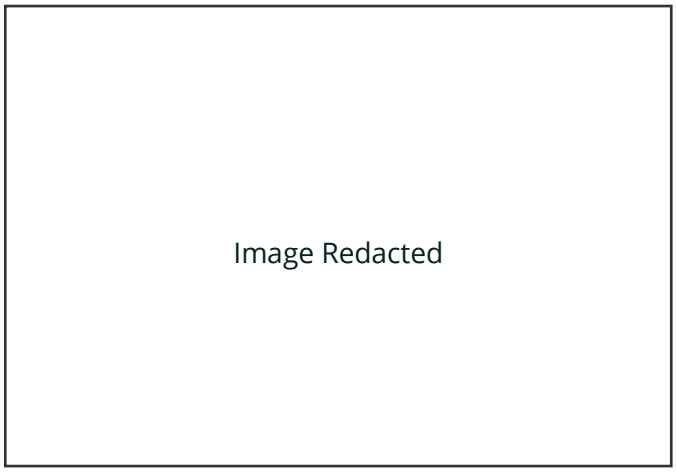
Best practices for unit management emphasize decentralizing supervision and integrating staff directly within living areas for proactive staff-inmate interaction. This proactive, hands-on approach builds rapport and creates a safer, more predictable environment that benefits both staff and individuals in custody and improves their wellbeing by fostering a higher perception of safety and respect.

The core tenets of this management approach are:

- **Risk-Need-Responsivity Alignment:** Supervision, programming and treatment plans are tailored to the specific criminogenic needs and risk levels of the individuals.
- **Manageable Housing Units:** Facilities are subdivided into smaller, self-contained, and autonomous units (typically housing no more than 48 individuals) to foster a sense of community and more predictable environment.
- **Staff Integration:** Officers are stationed directly within the unit to maintain constant communication and interaction with people in custody, playing a critical role in modeling pro-social behavior and managing negative behavior rather than relying on reactive remote surveillance. Where implemented, this relationship approach has proven to increase human interactions, improve the attitude of people in custody and increase their engagement and participation in programs and treatment.
- **Direct Supervision Model:** Often credited for improving the health and wellness of the environment through decreased trauma or negative exposures, state-of-the-art facilities primarily operate under a direct supervision management model and design approach. As a management strategy, direct supervision requires staff to have more frequent engagement with the population and thus encourages closer contact or interactions to build rapport and foster appropriate professional relationships. Under a direct supervision model, officers are posted within the housing units where they directly observe and interact with the residents of that housing unit. Direct supervision affords the officer the opportunity to be proactive in managing the residents under their care—addressing issues and diffusing potentially problematic situations before they occur.

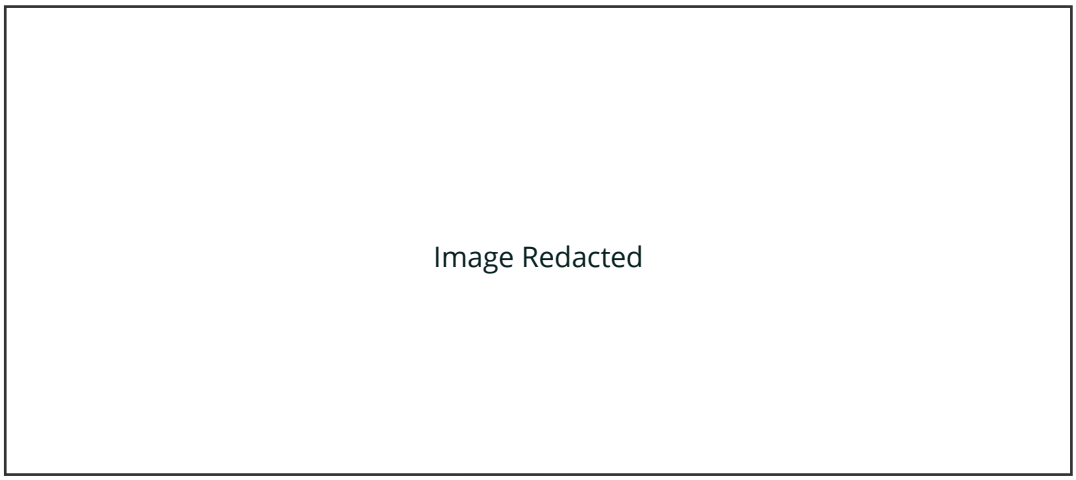
  Staff interaction with residents in a direct one-to-one environment increases security and management effectiveness. The physical design of the jail supports this model by reducing physical barriers that impede interaction between staff and in-custody people, by ensuring there are clear sightlines into all areas of the housing units, and by incorporating design elements, fixtures, and furnishings that promote positive and respectful behavior.

Image 6.5.1. Direct Supervision Example



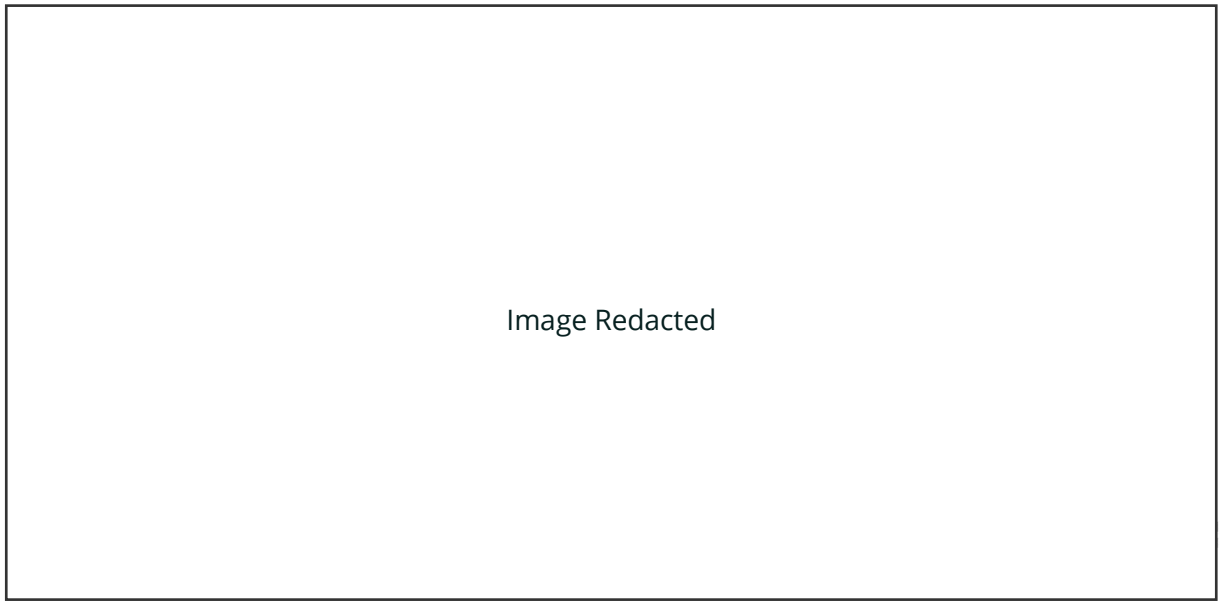
- **Modified direct supervision** is planned for certain designated units where the small number of individuals fitting any one classification category makes discrete units operationally unviable. In these instances, the unit is designed to provide for physical separation of different classification categories within, under the supervision of one officer. Units operated under "modified" direct supervision are designed to feature sub-dayrooms providing flexibility to potentially transform these units into direct supervision units. Sub-dayrooms can operate independent of the primary unit dayroom providing the flexibility needed to manage several population sub-groups and adjust to inevitable swings in population.
    - The principles of direct supervision can be implemented even in sub-day rooms when there is a well-trained staff. In a modified direct supervision configuration, the officer has good lines of sight into each sub-component, but the station is typically enclosed, and outside of the housing unit.
    - Depending upon the populations housed within a modified direct supervision housing unit, it is possible to have the officer station in the dayroom area of most of the cells, functioning as a typical direct supervision unit, with only a smaller sub-set of the population placed together in a sub-dayroom.
    - From a design perspective, walls dividing sub-dayrooms should be angled toward the housing workstation. Walls between the sub-dayroom and dayroom should be partially glazed to increase visibility.

Image 6.5.2. Sub-dayroom Examples



- **Hybrid Supervision Approach:** Ability to vary operational approach based on behavior or classification needs.

Image 6.5.3. Hybrid Direct/Indirect Supervision



- **Collaborative Unit Multidisciplinary Teams:** Especially related to the housing of the medical and acute, subacute and chronic mental health populations, unit managers, custody, and clinician personnel work as an integrated team within the same physical footprint coordinating individualized care plans and streamlining program delivery.

6.5.2. Housing Unit Best Practices

Housing unit design best practices emphasize reducing spatial density and small unit scale as key strategies to enhance staff-inmates interaction, minimize staff fatigue and create normalized, therapeutic environments that facilitate healing and recovery.

Modern guidelines recommend limiting housing capacity to 32 to 48 individuals, with some specialized units capped at 16 to 24 people to ensure individualized treatment, higher staff-to-patient ratios, and quieter, less stimulating environments. Small unit sizes provide flexibility to accommodate different sub-population classifications and changes in the profile of the population that may occur over time. In turn, this small unit configuration helps to foster a sense of community, support positive and routine engagement between people in custody and staff, making for easier management while limiting the institutional feel.

Best practices in housing unit design focus on the following core principles:

- Housing people in custody in the least restrictive care and intrusive environment.
- Flexibly designed “community-style” housing units allowing for group size to be adjusted in response to diverse custody classifications, levels of care, needs, and group dynamics.
- Provision of a variety of accommodations (single vs. double cells and multiple-occupancy cubicles).
- Maximizing staff-resident interaction and social contact by locating staff directly in the units rather than isolated behind control desks (direct supervision approach) to create an ordered and more natural living environment through design layouts that encourage cooperation and connection with users, rather than isolation or detachment.
- Utilizing straight-line designs and strategic sightlines that remove blind spots from the officers' field of vision in support of staff observation without constant threat cues.
- Normalizing the environment by incorporating non-institutional fixtures (e.g., wood-look finishes, access to natural daylight, soothing colors, and varied furniture arrangements in dayrooms), where possible. Using thoughtful acoustic treatments to reduce ambient noise, which significantly lowers agitation and stress. Normalized environments promote human dignity and typically lead to less stress, less destruction, and improved outcomes.
- Providing physical options for separation and temporary removal, as opposed to isolation.
- Providing access to semi-private spaces (e.g., quiet rooms, secure outdoor spaces, low-stimulus, sensory rooms, etc.) that enable relaxation and effective containment and allow residents to self-regulate and manage their behaviors and emotions safely.

- Following a “progression” approach that allows people in custody to move through progressively less restrictive settings as their behavior and treatment goals are successfully met. Individuals classified as lower custody have more personal responsibilities and accountability for making decisions regarding their daily activities, but with constant monitoring by unit officers, case managers, counselors and other programs and custody personnel. If setbacks occur, the model allows residents to "step up" to more intensive care temporarily. As custody levels increase, and for special circumstances, individuals gradually have more direct and restrictive requirements but still have access to programs and treatment. The objective of this management approach is for people to progress to lower custody levels and more autonomy and independence in preparation for release.

Additionally, the following core principles are applicable to specialized housing units dedicated to specialty populations (i.e., individuals presenting complex medical, mental health, and behavioral histories, individuals struggling with addiction, neurodivergent and medically fragile population, etc.):

- Dedicated special needs housing units purpose-built to meet the unique physical, health, and psychological requirements of specialty populations rather than relying on retrofitted standard spaces. For many of these populations, general population housing environments, bunk beds, and dormitory-style accommodations are not suitable.
- Small treatment and peer groups to facilitate targeted therapy and a secure environment.
- Staffing levels and group sizes geared to levels of acuity for health and mental health residents so that appropriate treatment can be provided (dynamic ratios).
    - Staffing levels must fluctuate with the severity of residents’ medical, psychological, and behavioral needs. Aligning staffing levels to resident acuity ensures that health and mental health needs are safely met.
    - Higher acuity requires smaller group sizes and lower staff-to-resident ratios to ensure a safe, therapeutic environment.
- Multidisciplinary team approach - Therapeutic "alliance" between custody and clinical staff.
- In-unit programming spaces.
- Dedicated housing units for the mentally ill should be of single level and have a built environment that is as therapeutic as possible, enriches and nurturing, with access to fresh air and outdoor sunlight with finish colors that express calmness instead of sterility. These dedicated units should be located in the appropriate areas (not mixed with other populations), with calm and peaceful ambience and space conducive to continuous monitoring.

- Dedicated housing units for medical assisted detoxification and induction of MAT, medically monitored and with comfort measures.
- Rather than general population housing units, dedicated "holding" housing units should be provided for individuals identified as "quicks" who will be booked and released within hours. These holding areas ensure that individuals remain secure without tying up general population resources. Typically, these areas are reduced to the essentials to discourage extended stays and promote rapid processing and release. Therefore, they are equipped with less infrastructure (such as communal spaces), but feature a continuous, flat surface (benches) to safely accommodate overnight stays, if needed.
- Following a step-down approach to moving patients from highly specialized and treatment-intensive housing into more programmatically structured interventions and less restrictive environments. This progression approach aligns with best practice "secure detention to community transition" continuum of care models.

6.5.3. Spatial Relationship of Programs and Services Best Practices

Escorting the in-custody population to centralized programs and services areas is not only staff-intensive, but it increases risks to security and safety for staff, and the population alike and significantly reduces efficiency and effectiveness of access to services.

Best practices in programs and services focus on limiting the movement of people in custody by optimizing service delivery at the housing unit. Operationally, this is accomplished by moving staff to the population and bringing programs and services within or immediately adjacent to the housing units in a way that allows for movement in and out to be easily observed by staff.

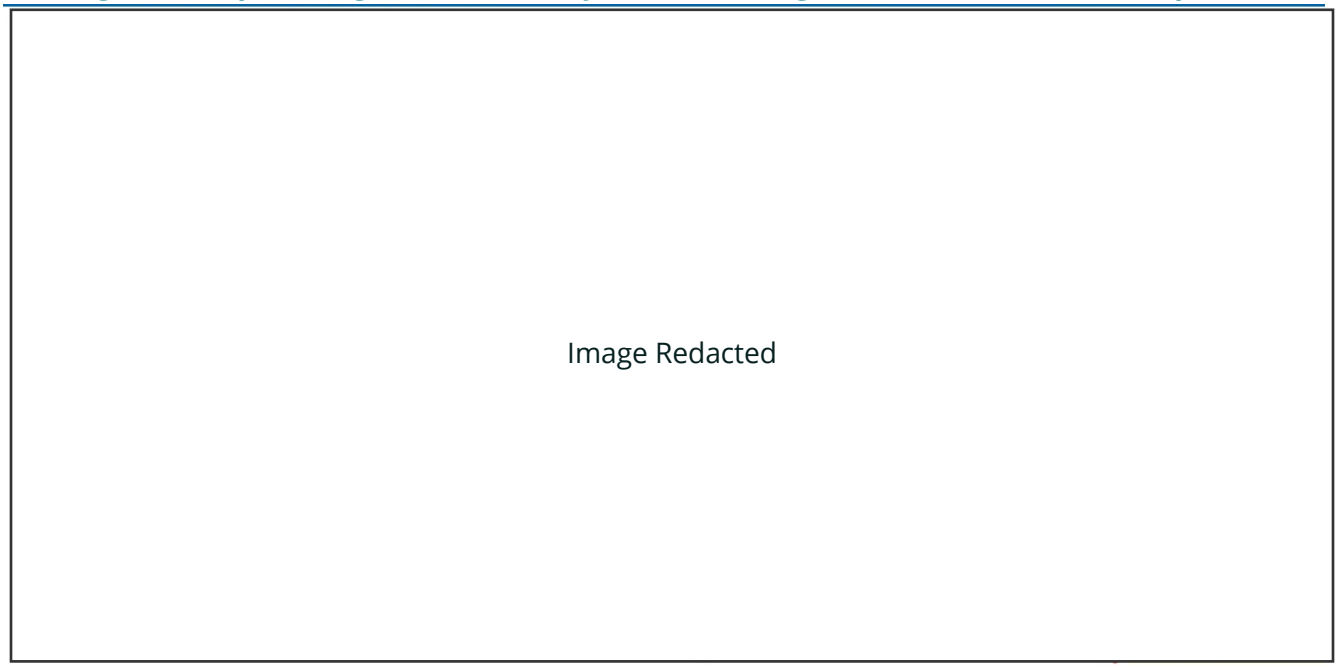
This decentralized program delivery arrangement allows for a greater concentration of participants and introduces efficiency by making more multipurpose spaces available for several housing units to share. This minimizes disruption to individuals accessing services and keeps interactions contained to the specific management unit. It also increases operational efficiency by eliminating delays associated with availability of escort staff. However, it does result in duplication of spaces and increased overall area per occupant.

Design-wise, this is accomplished through design by:

- Integrating dedicated facilities/spaces for service providers (e.g., medical triage rooms, private and group treatment areas, etc.) strategically located within or immediately adjacent to the housing unit.
- Having "off-stage" areas to support staff duties and responsibilities is also important through a combination of professional offices, respite areas, and staff support spaces.

- Providing built-in physical/recreational activity space in each housing unit so that residents can recreate regularly without having to compete for access with residents from other housing units.
- Organizing housing units in clusters grouped together given their affinity in mission or population served, with a typical cluster consisting of about four housing units and providing a range of flexible program shared space in the cluster core adjoined to each unit to increase opportunities for purposeful daily activity while reducing the need for movement around the facility.

Image 6.5.4. Optimizing Service Delivery at the Housing Unit Best Practices (Example)



In order to inform this exercise as part of the evaluation of "as-is" conditions, the Planning Team also undertook an evaluation of the IHSF proposal as previously documented including the draft program dated August 15, 2023, and Conceptual Drawings dated October 10, 2023. This information was reviewed with the Stakeholders and Executive Committee as part of the Workshop 4 in February of 2026.

Key findings related to the Planning Team's assessment of the IHSF proposal, which serves as a basis for the continued analysis of future approaches as a deliverable of this master planning study, are summarized below and illustrated on the diagrams following the text.

- **The IHSF proposal is not a systemic solution to the conditions of the Consent Decree.** The IHSF proposal only addresses housing for the special needs populations (medical and mental health) at the Main Jail. It does not address issues identified under the Consent Decree at RCCC, and as a result, does not constitute a comprehensive solution capable of achieving relief from continued oversight by the

court and the plaintiff's agreed-upon Subject Matter Experts across the five critical areas of the Consent Decree. Additionally, while there were several other studies of related Consent Decree compliance issues (e.g., Accessibility Requirements), it is not apparent if the overall solution will address the Consent Decree issues holistically other than the provision of special needs beds and a new Intake/Transfer/Release Center.

- **Planned capacity under IHSF falls short of currently projected capacity needs.** As illustrated in Table 6.6.1, the total need for treatment beds is more than double the planned capacity under the IHSF. Moreover, the recommended new construction capacity, based on best practices for smaller, single-level units for acute and subacute treatment, increases from 300 beds in the IHSF proposal to a current projected need for 462 beds (assuming that Geriatric/Medical Fragile Housing can be accommodated in existing facilities such as the dormitories at RCCC). There are several possible reasons for this variance:
    - It was determined during the course of the study that projection of required system capacity for all populations should extend through 2045.
    - Several additional population cohorts were identified as critical to planning—SITHU, Critical Needs Assessment Program (CNAP), EASS and JBCT. These were incorporated into the acute treatment mental health cohort as part of operational planning for increased staffing efficiency, since the treatment programs, while varied, rely on the same staff and outside professional resources.
    - ACH has seen a significant increase in the demand for detox/MAT, which resulted in an increase in planned capacity.

Table 6.6.1. Planned IHSF Capacity vs. Current Projected Capacity

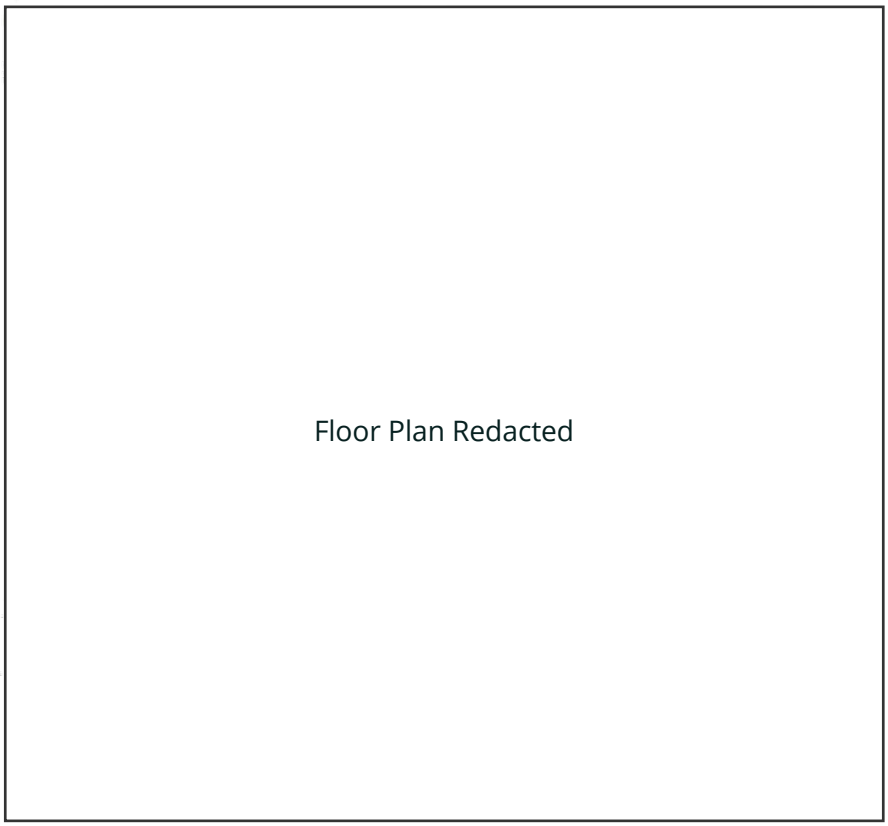
	IHSF	Current Projections
Acute Medical Beds	26	40
Isolation/Negative Pressure Beds	4	8
Chronic Medical/Long-Term Care	32	55

	IHSF	Current Projections
Detox/MAT	48	79
Geriatric/Medical Fragile Housing	Not Identified	76
Total Medical Treatment Beds	**110**	**182**
APU	60	48
SITHU	Not Identified	20
CNAP	Not Identified	39
EASS	Not Identified	12
JBCT	Not Identified	44
Total Mental Health Beds	**620**	**1,295**
Mental Health Beds – Acute Care	**60**	**163**
Intensive Outpatient Program (IOP)	160	179
Developmentally Disabled (DD)	Inc. above	14

	IHSF	Current Projections
Mental Health Beds – Subacute Care	**160**	**193**
OPP	400	Superseded
Enhanced Outpatient Program (EOP)	Revised level of care	197
Mental Health Treatment – General Population (MH-GP)	Revised level of care	742
Treatment Beds – General Population	**400**	**939**
Total Special Needs Beds	**730**	**1,477**

- Sheriff Department Security Staffing as illustrated in **Figure 6.6.1** appears to be staff intensive.
    - Housing is appropriately based on small units of 12–20 beds, however, providing a secure control room for every two units results in staff-intensive ratios of security staff to inmate-patients (e.g., 1:24 or 1:20).
    - Total of 20 housing units or 10 pairs are projected. If each pair is staffed control plus one per housing unit on the day shift and control + ½ per housing unit on the night shift, then five positions are required per pair daily, or 10 per floor.
    - Five floors = 50 staff or 120 staff +/- with relief for 24/7 365 days for housing only (excludes escort, rovers, shift leadership).

Figure 6.6.1. Project SSO Staff, Typical IHSF Floor Plan

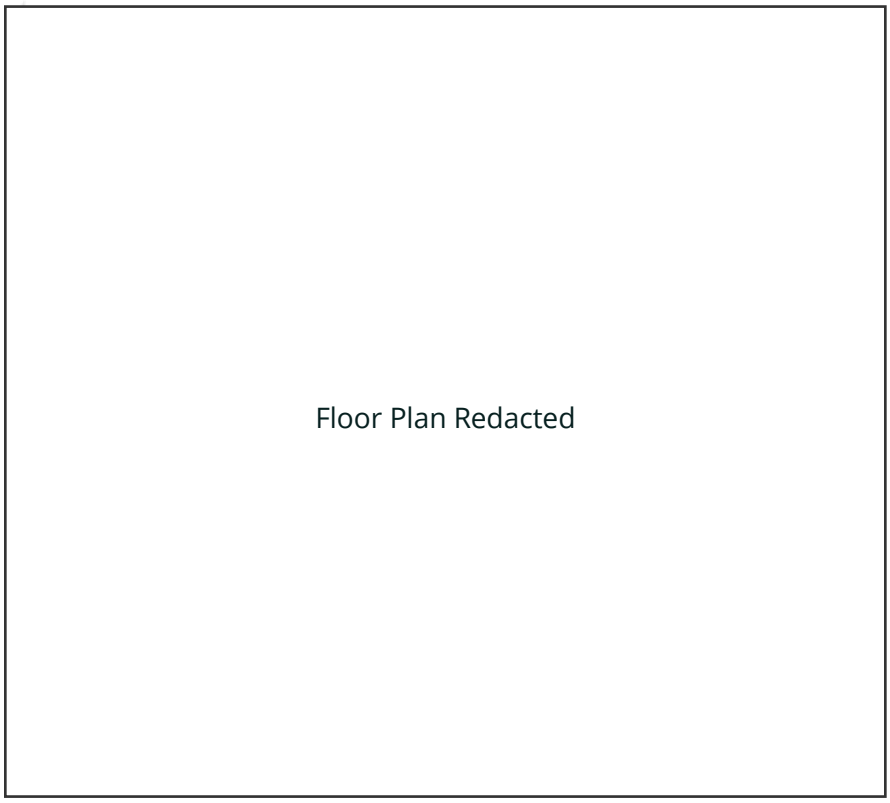


Small housing units are, in fact, best practices and should continue to be considered as part of master planning and future design and construction; however, as noted, they can be staff-intensive. As presented in Workshops 3 and 4, one way to provide for smaller housing units in a staff-efficient manner is to develop larger units with smaller sub-units/sub-dayrooms. Using the IHSF as a baseline, units could be 48 (four sub-units of 12) or 80 (four sub-units of 20). A single, open, direct supervision desk could then be provided to accommodate multiple security staff, one responsible for door operations and video monitoring and several during the day for on-unit activities, escorting etc., with staffing reduced at night, significantly reducing overall staffing requirements.

- Similarly, ACH Staffing as illustrated in **Figure 6.6.2** appears to be staff intensive.
    - All housing units show a nurse's station even though that is not defined in the program as required for IOP, therefore, in terms of staffing, it is assumed that for IOP these stations are not staffed 24/7 and are used for medication distribution only. Provision of the staffing station, however, does provide for flexibility in use should additional acute care beds be needed in the future.

- Location of the nurses' stations limits the ability to have a single position cover two housing units.
- For the Acute Psychiatric Program, infirmary, Long-Term Care, Withdrawal/MAT population a total of 12 nurses are provided.
- As planned, each would require a minimum of one full-time position with relief, equating to 61 nurses for housing full-time plus additional treatment staff assigned during the day shift.

Figure 6.6.2. Project ACH Staff, Typical IHSF Floor Plan

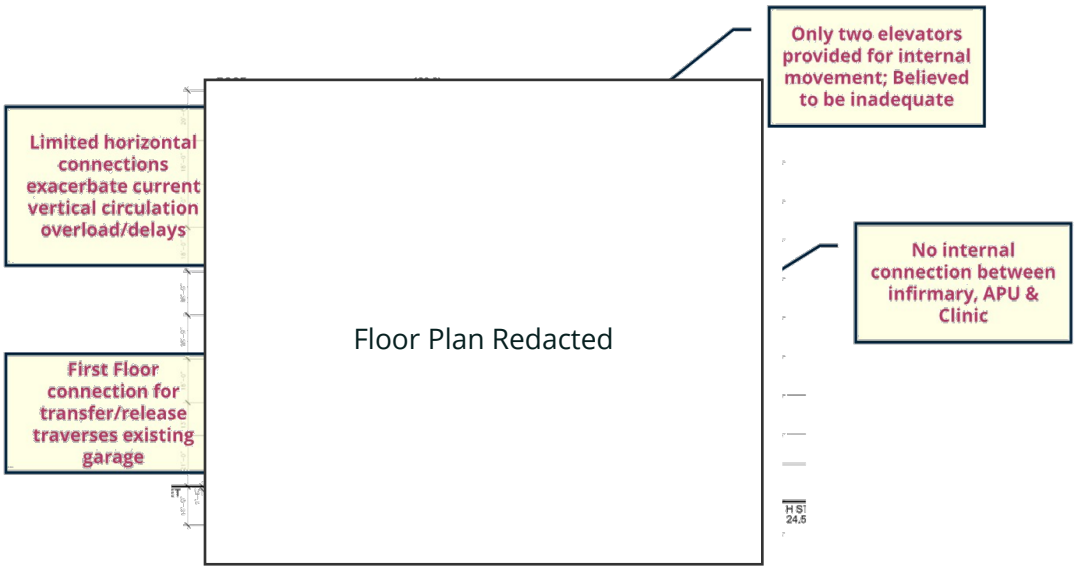


As noted above, small housing units are in fact best practices and should continue to be considered as part of Master Planning and future design and construction. However, as noted, they can be staff intensive. Again, as presented in Workshops 3 and 4, one way to provide for smaller housing units in a staff-efficient manner is to develop larger units with smaller sub-units/sub-dayrooms. Using the IHSF as a baseline, units could be 48 (four sub-units of 12) or 80 (four sub-units of 20). Units could be better "twinned" to allow a single nurse's station to observe and serve two units, or centralized to see four sub-units, as described for security staffing. It should be noted that current practice at both the second floor APU and the APU expansion currently under construction on the third floor provide a physical separation

between the nurse's station and the housing unit. Nurses' stations in the infirmary, however, are open as is typical of medical housing.

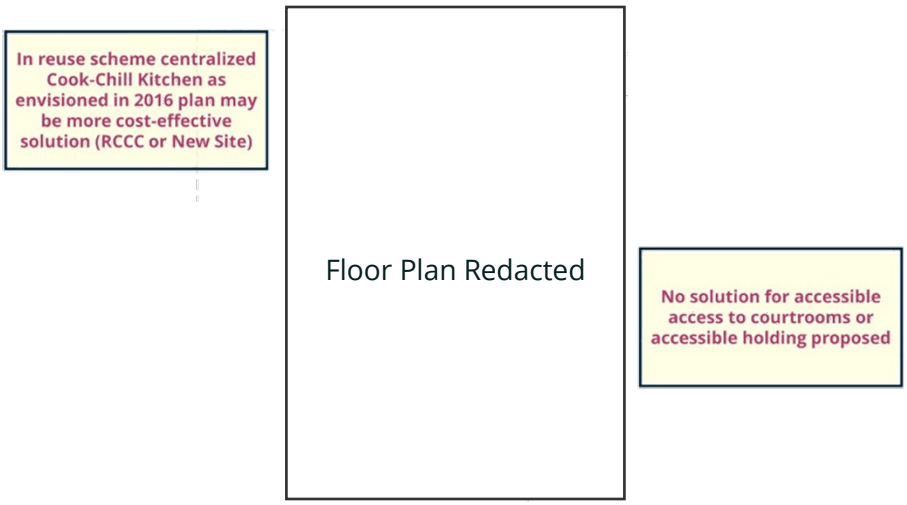
- As noted in **Figure 6.6.3**, there are multiple concerns regarding vertical and horizontal connections between the Main Jail and the IHSF as proposed.
    - There are limited horizontal connections between the two buildings, exacerbating the current delays in vertical movement in the Main Jail. This also increases response time between the two facilities in case of an emergency.
    - Questionable if two elevators in the IHSF are adequate to handle vertical movement.
    - Ideally, an internal vertical connection would be provided between the Clinic and acute and subacute housing floors, separate from inmate and security staff movement.
    - First floor connection between the two facilities traverses the existing sallyport/official vehicle garage which appears from the conceptual diagrams will continue to accommodate transfer movement to the courts and other facilities.

Figure 6.6.3. Horizontal and Vertical Connection, IHSF Section Relationship to Existing Jail



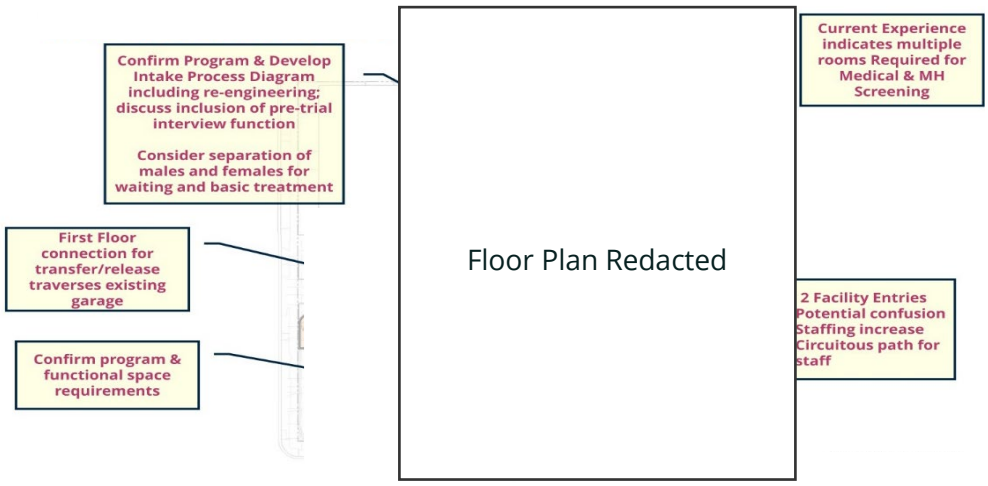
Per the observations noted in **Figure 6.6.4**, the need to replace the kitchen on-site should be evaluated further vs. remodeling the existing kitchen or constructing a cook-chill facility and converting the existing kitchen to a retherm kitchen. Additionally, there is no solution for accessible access to courtrooms or accessible holding and attorney/client visiting facilities.

Figure 6.6.4. Lower-Level IHSF Observations



- Per the observations in **Figure 6.6.5**, there are several areas of concern regarding the first floor conceptual layout:
    - Again, connection between the two facilities traverses the garage
    - Two entries potentially creates confusion for the public and visitors
    - Space program should be confirmed, especially related to accommodating peak flows, including medical and mental health interviews

Figure 6.6.5. First Floor IHSF Observations



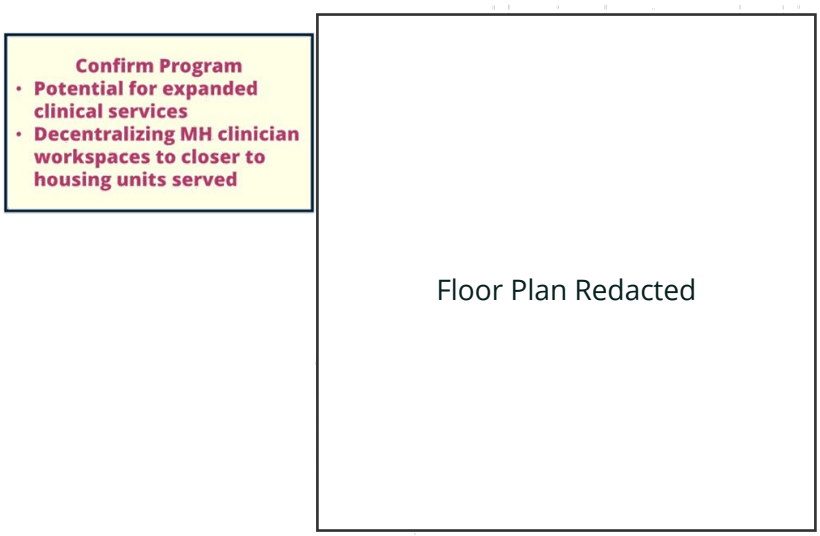
- As illustrated in **Figure 6.6.6**, the area of concern with the IHSF Mezzanine Level is splitting functions (Administration and Staff Services), multiple entries and limited interconnection of the two buildings.

Figure 6.6.6. IHSF Mezzanine Level Observations



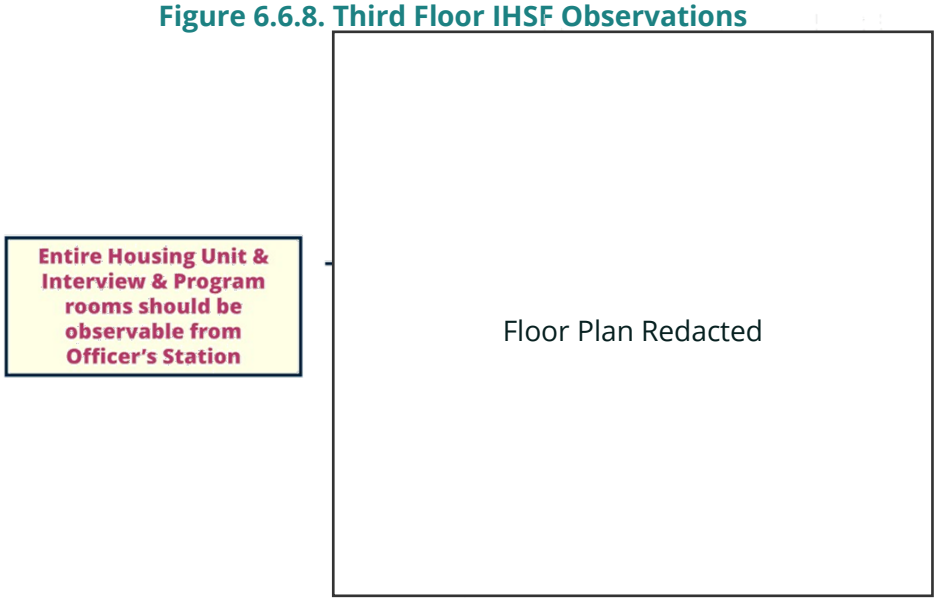
- As illustrated in **Figure 6.6.7**, the primary area of concern with the 2nd floor is confirming the adequacy of the program for expanded services to reduce transportation and a suggestion that clinician space be distributed throughout the facility in proximity to the treatment population rather than centralized

Figure 6.6.7. Second Floor IHSF Observations



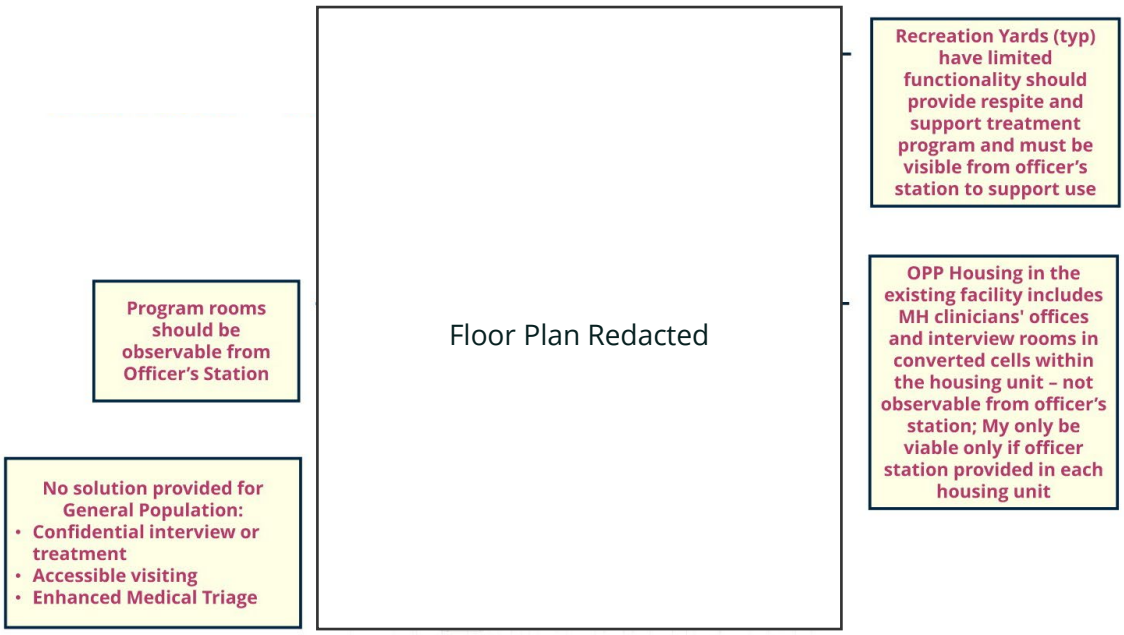
- Relative to the third floor conceptual plan, and in addition to the overarching concerns regarding staff efficiency, a key consideration is locating security stations to have line-of-sight views with all housing and treatment areas, including interview and group rooms, in order to maintain a safe and secure environment for treatment activities and interaction with the inmate-patient population by staff.

Figure 6.6.8. Third Floor IHSF Observations



- **Figure 6.6.9** illustrates a typical treatment level floor for the APU and IOP treatment cohorts. In addition to the relatively high staffing requirements, the following observations were made relative to future planning:
    - In the IHSF treatment housing, the entire housing unit, including interview and program rooms, should be observable from Officer's Station.
    - In the IHSF treatment housing, recreation yards are quite small and have limited functionality; they should provide respite and support treatment programming and must be visible from officer's station to support use.
    - OPP Housing in the existing facility includes MH clinicians' offices and interview rooms in converted cells within the housing unit—not observable from Officer's Station; may be viable only if Officer Station is provided in each housing unit.
    - No solution provided for EOP or MH-GP:
        - Confidential interview or treatment
        - Accessible visiting
        - Enhanced Medical Triage

Figure 6.6.9. Typical IHSF Treatment Floor Observations



6.7. OPTIONS FOR MITIGATING PHYSICAL PLANT DEFICIENCIES

As a parallel track to completing the "as-is" physical and functional evaluation of existing facilities, the Planning Team also focused on identifying potential approaches to mitigating the physical plant deficiencies in existing facilities, which are an underlying theme of both the Consent Decree and associated MOAs.

It should be noted that at this point in the study effort these are conceptual ideas that still need to be tested in terms of constructability and costs as part of approach development related to effective reuse of existing facilities in compliance with the Consent Decree and creating the "desired Jail system" of the future.

The following concepts were reviewed with the Stakeholders and the Executive Committee as a topic in Workshop #4, as a basis for the development of approaches that may include the continued use of existing facilities. Additionally, recognizing that the development of a full solution may require a significant time period for funding, planning, design, construction and activation, it was thought that the concepts outlined may provide a path for interim improvements in response to both the provisions of the Consent Decree and day-to-day operational challenges.

- **Figure 6.7.1** illustrates an approach to adapting existing housing units in the Main Jail to provide housing for physically challenged inmates. The Americans with Disabilities Act (ADA) mandates that correctional facilities—including local jails and state/federal prisons—must provide accessible housing and equal access to all programs for inmates with disabilities. In both new constructions and alterations, at least 3% of the total cells must be accessible for individuals who use wheelchairs or mobility aids.
- Note that the ADA regulations also stipulate that inmates with disabilities must not be excluded from programs, services, or activities on the same basis as non-disabled inmates and that specifically, inmate be placed in housing related to their security classification rather than being forced into medical or distant facilities just because of a lack of accessible cells.
- Best practices suggest that every housing unit should accommodate accessible cells or beds to respond to security and programmatic needs across the spectrum of the inmate population.
- As illustrated in **Figure 6.7.1**, the anticipated approach is to convert two cells in the corner of each housing unit at the Main Jail to an accessible cell and shower, similar to the renovation currently underway for 300 West to provide expanded APU capacity. This will reduce the capacity of each housing unit by two beds, assuming that the accessible cell continues to be double-bunked. The current Board of State

& Community Corrections (BSCC) approved rated capacity would be reduced from 2,512 beds to 2,438 beds or a reduction in capacity of the Main Jail of 74 beds.

Figure 6.7.1. Main Jail: Accessibility Improvements (Add Accessible Cell and Shower to Each Housing Unit)

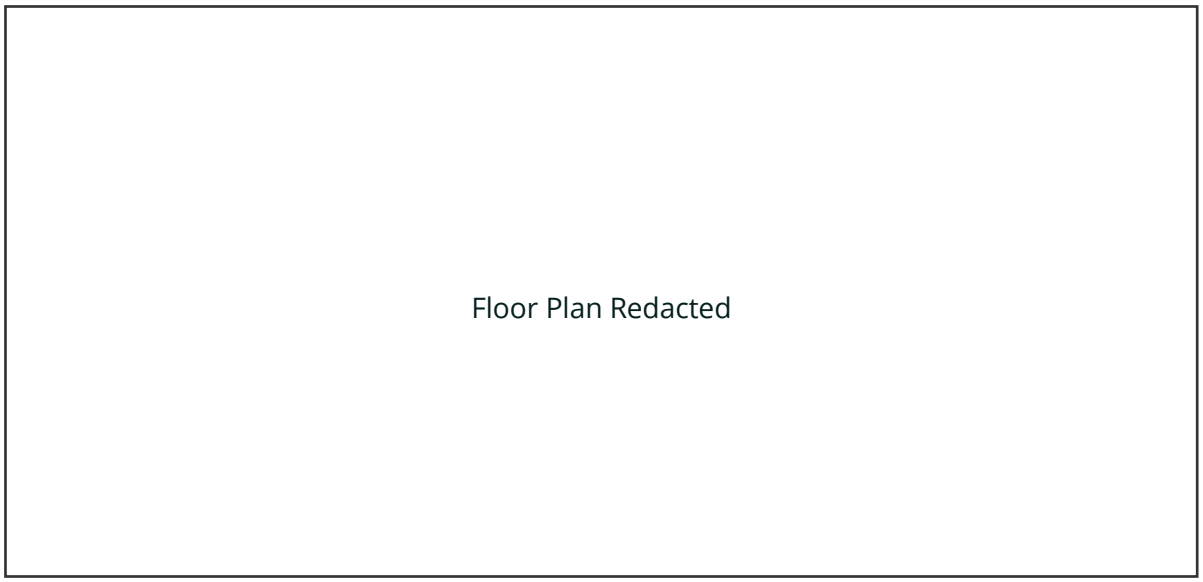


Figure 6.7.2 illustrates an approach to providing accessible visiting on each floor and interview rooms which provide increased privacy for mental health treatment. These improvements specifically respond to the Consent Decree stipulations. Currently, non-contact visiting areas are on the mezzanine and are not accessible for physically challenged inmates. A single accessible visiting room has been provided on the second floor but requires escorted movement and is not comparable to visiting opportunities provided to non-physically challenged inmates. In an attempt to show compliance with the Consent Decree, the County has added glazed cubicles in the central core of each housing pod, but these cubicles are open to above and do not provide confidential interview space and as they are glazed to allow full view into adjacent housing units they are in effect "fishbowls" for treatment counseling and interviews. While recognized as a good faith effort, the lack of privacy both audial and visual has been cited as a deficiency by the plaintiffs.

The mezzanine non-contact visiting area is accessed via two elevators and an emergency egress stair from the public lobby on the non-secure side. As illustrated in **Figure 6.7.2**, a review of the drawings and field conditions indicated that additional stops for the elevators and an egress door to the stair could be provided on the main floor, allowing the existing group room to be converted to an accessible non-contact visiting room and two private interview rooms. The existing group room would be relocated to space adjacent to the 100 unit in both the east and west sides of each housing floor.

A seismic assessment was completed which indicated that the building meets current codes for seismic resistance in terms of life safety, but that is may not be immediately habitable if a design level seismic event occurs. Minimal upgrades to transfer girders, flooring and pile footings are recommended to allow for continued habitability in the event of a design level event.

Figure 6.7.2. Main Jail: Accessibility Improvements (Add Accessible Non-Contact Visiting; HIPAA-Compliant Interview Rooms; Program and Medical Room Internal to East and West Tower)



Figure 6.7.3 illustrates an approach to providing smaller housing units to accommodate differing classifications and allowing for increased out-of-cell time. An underlying concern of the Consent Decree is out-of-cell time. While specifically addressed only for restricted housing, it is also part of effective treatment and wellbeing for the inmate population. Currently, housing unit capacities are typically 64 beds and 300 East is 80 beds, double-celled. As a result, in many instances these units house multiple classifications with out-of-cell time limited to like classifications at any one time.

As illustrated in **Figure 6.7.3**, the conceptual approach is to subdivide the 200 and 300 units while maintaining lines of sight from both the floor position in the center area of each housing wing and the raised control room. 100 level units are left as single units as a subdividing partition would block views from the raised control room. Subdivision would also result in additional renovations to provide an accessible cell in each resulting housing unit.

Typical 64-bed units as subdivided would provide units of 17 and 13 cells (34 & 26 beds) respectively, and the 300 east unit would provide two units of 19 cells each (38 beds/unit). This will further reduce the BSCC approved rated capacity as additional cells will be removed to provide an accessible cell and shower in the subdivided units. Rated capacity would be reduced from 2,512 beds to 2,376 beds or a reduction in capacity of the MJ of 136 beds.

Figure 6.7.3. Main Jail: Enhance Utilization by Creating Smaller Housing Units (Subdivide All or a Portion of Units 200 and 300)

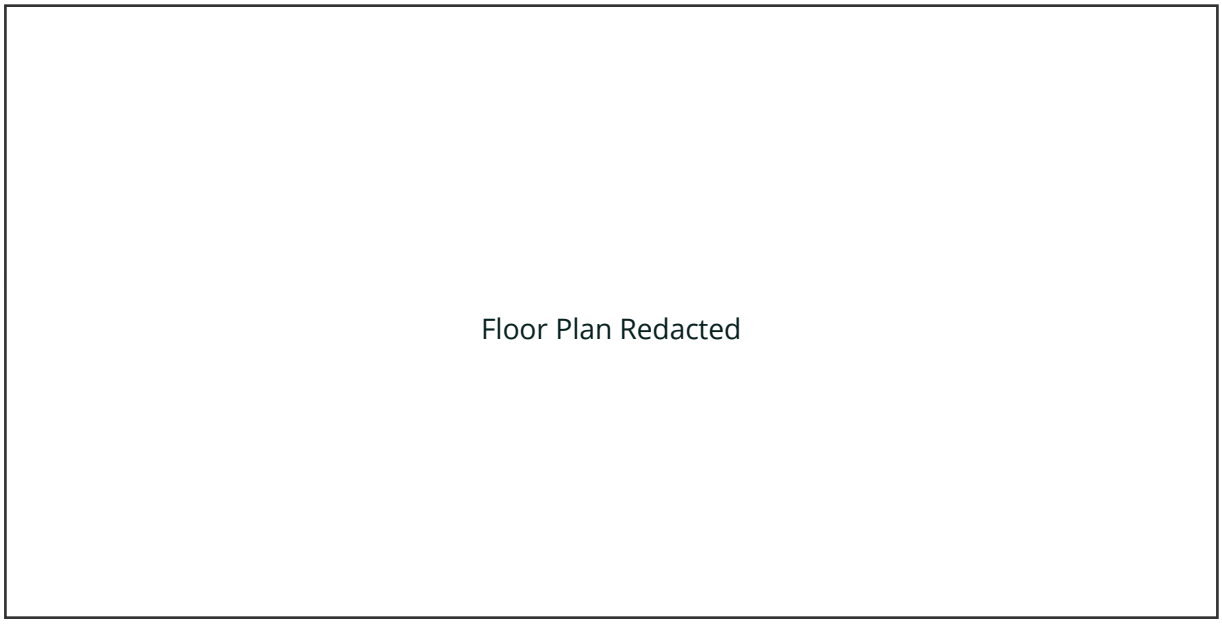


Figure 6.7.4 illustrates an approach to **increasing access to recreation by subdividing the recreation yards into two separate recreation areas.** Access to recreation and out-of-cell time is a Consent Decree compliance issue. Limitations on space available and required separations by classification requires the custody staff to schedule and monitor access to recreation carefully. Their current schedule is extremely tight and does not provide flexibility in day-to-day operations or any ability to provide recreation above minimum required standards.

As illustrated in **Figure 6.7.4**, this conceptual approach would subdivide each recreation deck into two separate spaces, doubling available spaces from three to six. It should be noted that the County considered this before but did not move forward due to potential structural limitations. The intent of this plan is to construct a partition of stud and abuse resistant drywall with embedded mesh to a height of 12 feet with open mesh above for improved ventilation. This approach will substantially reduce any structural impact. (This is currently under review as part of the structural/seismic assessment.) Note that a toilet and water fountain will be provided in the subdivided recreation yard.

Figure 6.7.4. Main Jail: Increase Access to Recreation (Subdivide Recreation Decks to Increase Recreation Areas)



Figure 6.7.5 illustrates an approach to **increasing program and support areas for mental health treatment in the MJ.** The Consent Decree includes specific requirements for individual and group treatment for the various levels of care identified in the Consent Decree. As part of the initial functional assessment of the existing facilities, several deficiencies were identified relative to support facilities—number and quality of individual interview/counseling rooms, group rooms and collocating office space on housing unit floors for mental health staff.

As illustrated in **Figure 6.7.5**, an option identified to resolve the physical deficiencies would be to adapt unit 100 East as a program, services, and office core on any floor(s) used to house the outpatient mental health treatment cohort. This would provide office space, group rooms, individual interview and counseling rooms and group treatment rooms. This would also accommodate improved medical treatment facilities as well.

Note that subsequent to this effort, the County and Sheriff's Office quantified available treatment space and determined that adequate space appears to be available based on actual scheduling and that extended treatment hours would also increase utilization of available space. However, the Planning Team does believe that increasing space on the floor including co-locating treatment providers with the population served will enhance the delivery of services.

Figure 6.7.5. Main Jail: Increase Program, Support & Office Space (Add Program Floors Within Recreation Deck Envelope on Fifth and Seventh Floors)



Figures 6.7.6 and 6.7.7 illustrate alternate approach to **improving vertical circulation in the MJ**. Discussions with the Sheriff's staff indicated that vertical circulation in the jail was challenging and impacted movement and the delivery of services due to conflicts among various services—food service delivery and pickup, laundry delivery and pickup, court movement, movement to medical and program space, large group movement to recreation, etc.

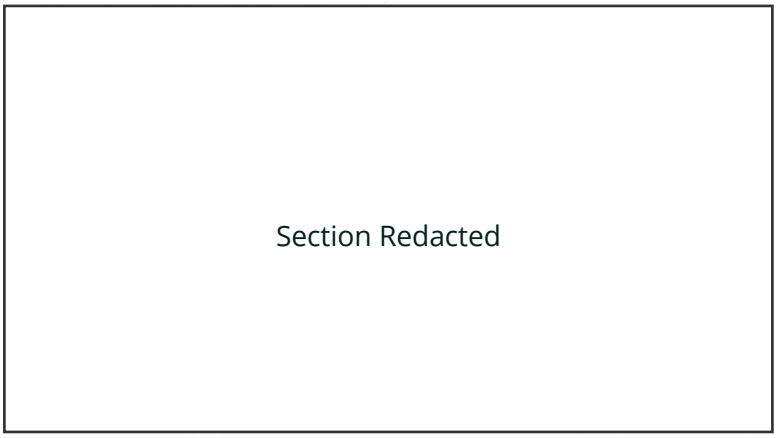
As illustrated in **Figure 6.7.6**, additional elevators would be added opposite the existing elevator core. These elevators could be designated as service elevators as they can connect directly to the basement kitchen and laundry areas and potentially could be oversized.

Figure 6.7.7 suggests that if an annex is constructed to the north of the existing jail that multiple horizontal connections be provided to allow the two elevator cores to serve both buildings jointly.

Figure 6.7.6. Main Jail: Improve Vertical Circulation (Add Elevators Across Corridor from Existing Elevator Core)



Figure 6.7.7. Main Jail: Improve Vertical Circulation (Provide Horizontal Connections at Multiple Floors to New Annex if Adjacent to the Main Jail)



Figures 6.7.8 and 6.7.9 illustrate solutions to **accessibility improvements for the courtrooms & court holding components.** This is part of responding to the accessibility requirements of the Consent Decree.

As illustrated in **Figure 6.7.8**, cells and adjacent interview areas in the basement will be reconfigured to accommodate accessibility, and **Figure 6.7.9** illustrates a change on the main floor to remove a clerk's office and provide a direct connection on the first floor between the secure area of the jail and the courts.

Figure 6.7.8. Main Jail: Accessibility Improvements (Accessible Court Holding, Attorney Interview and Path Court Appearance)



Figure 6.7.9. Main Jail: Accessibility Improvements (Accessible Court Holding, Attorney Interview and Path to Court Appearance)



Figure 6.7.10 illustrates **potential space available for adaptive use based on the current IHSF proposal**. Note that subsequent to Workshop 4, space was identified in the adjacent County Administration Building that could potentially vacate additional space for adaptive use. While programming will be completed in the next phase, it is probable that any reuse approach focused on the MJ will require additional space for critical functions, which may require the displacement of some support functions. This will continue to be studied as part of alternative approach development.

Figure 6.7.10. Main Jail: Reuse of Vacated Space



Figure 6.7.11 illustrates accessibility improvements to the SBF and CBF, and **Figure 6.7.12** illustrates accessibility improvements to the KBF and JKF. This is part of responding to the accessibility requirements of the Consent Decree. Note that while the Workshop 4 effort focused primarily on housing as part of understanding the impact of improvements on rated capacity, at RCCC the larger issue, in addition to program and support buildings, is overall site accessibility, which will be addressed as part of alternative approaches analysis.

As illustrated in **Figure 6.7.11** an accessible cell and shower will be provided at each housing unit in SBF & CBF. This results in a reduction in BSCC-rated capacity at SBF from 148 to 136 beds, but an increase in BSCC-rated capacity at CBF from 120 to 136 beds as double-celling capacity was impacted by the shower ratio per standards. Total rated capacity for the combined units increases from 268 to 272 beds.

Figure 6.7.11. RCCC: Accessibility Improvements (SBF/CBF – Add Accessible Cell and Shower to Each Housing Pod)



As illustrated in **Figure 6.7.12**, a shower will be provided at each unit at KBF & JKF. There is no impact on current BSCC-rated capacity of 448 beds. It should be noted, however, that the Sheriff's operational capacity exceeds BSCC-rated capacity with a total operational capacity of 688 Beds.

Figure 6.7.12. RCCC: Accessibility Improvements (KBF/JFK – Reconfigure Wet Core to Add Accessible Toilet, Shower, and Comply with PREA at Each Housing Pod)



Figures 6.7.13 through 6.7.15 illustrate three alternative configurations for accessibility & PREA compliance improvements and program delivery expansion to the Honor Barracks at RCCC. Again, these improvements are intended to ensure compliance with the letter and the intent of the Consent Decree. The three alternative configurations are intended to inform a decision on how best to utilize the Honor Barracks for development of Master Plan approaches.

Figure 6.7.13 illustrates a conceptual plan to reconfigure the toilet and shower core to provide accessible facilities, construct a program addition to accommodate group and individual

treatment and replan the furniture layout for better visibility. The replanning is based on direct supervision with an officer station located for direct line of sight to all areas. Beds along the exterior are stacked double bunks and are single-level in the center to allow for clear sight lines of the sleeping area. Capacity is based on 1983 standards as "grandfathered" by BSCC. As a result, day space is limited. The revised plan does, however, reduce the capacity of each side from the current rated capacity of 82 beds to 73 beds or a total loss of capacity per building of 18 beds. There are four honor dormitories within two buildings for a total reduction of 36 beds.

Figure 6.7.13. RCCC: Accessibility Improvements (Barracks – Reconfigure Wet Core to Add Accessible Toilet and Shower to Comply with PREA; Capacity Based on BSCC Grandfathered 1963 Standards)



Figure 6.7.14 similarly illustrates a conceptual plan to reconfigure the toilet and shower core to provide accessible facilities, construct a program addition to accommodate group and individual treatment and replan the furniture layout for better visibility as noted above. However, capacity is based on current BSCC Standards. As a result, day space is provided and the capacity of each side is reduced from the current rated capacity of 82 beds to 48 beds or a total loss of capacity per building of 68 beds or a total of 272 beds for all four honor dormitories.

Figure 6.7.14. RCCC: Accessibility Improvements (Barracks – Reconfigure Wet Core to Add Accessible Toilet and Shower to Comply with PREA; Capacity Based on Current BSCC Standards)



Figure 6.7.15 similarly illustrates a conceptual plan to reconfigure the toilet shower core to provide accessible facilities, construct a program addition to accommodate group and individual treatment and replan the furniture layout for better visibility as noted above. Space Planning is based on a best practice concept for dormitories that creates small group sleeping cubicles in lieu of an open dayroom plan. Double bunks are again placed on the outer walls while single bunks are planned toward the center of the room for improved sight lines. The capacity of each side is reduced from the current rated capacity of 82 beds to 43 beds or a total loss of capacity per building of 78 beds or a total of 312 beds for all four honor dormitories. This could be a viable solution for the geriatric population with the upper bunks assigned to inmate orderly helpers.

Figure 6.7.15. RCCC: Accessibility Improvements (Barracks – Reconfigure Wet Core to Add Accessible Toilet and Shower to Comply with PREA; Capacity Based on Providing Six-Bed Privacy Cubicles to Create a Therapeutic Environment)



Figures 6.7.16 and 6.7.17 provide an initial assessment of recommended new construction for special needs, medical and mental health beds and support components and the resulting impact on available capacity vs. projected need.

Figure 6.7.16 indicates a potential need for construction of 614 new special purpose beds, or perhaps 538 beds if Honor Barracks at RCCC are modified for the Geriatric/Medical Fragile cohort. In all cases, this is based on known best practices for constructing treatment-focused housing—smaller housing units, single-level housing (no tiers or mezzanines, high percentage of single cells, where double-celling is included all bunks are placed on the floor (not stacked), and colocation of custody and treatment staff as a treatment-based team, which is a Consent Decree stipulation. Generally, all of current housing, with the exception of the second floor of the MJ, are two-tier housing units with stacked bunks for double-celling, hence the initial observation of required construction of new beds.

Preliminarily, it is also believed that at a minimum a new and expanded medical clinic will be required, along with medical/mental health administrative and staff facilities, central pharmacy and intake/reception/transfer/release facilities in order to comply with the Consent Decree. There are some additional program and support components to be considered as well, which may have unique solutions based on various approaches to be considered.

Figure 6.7.16. Highest & Best Use – New Construction (Preliminary Assessment Minimum New Construction – As Part of Reuse Approach)

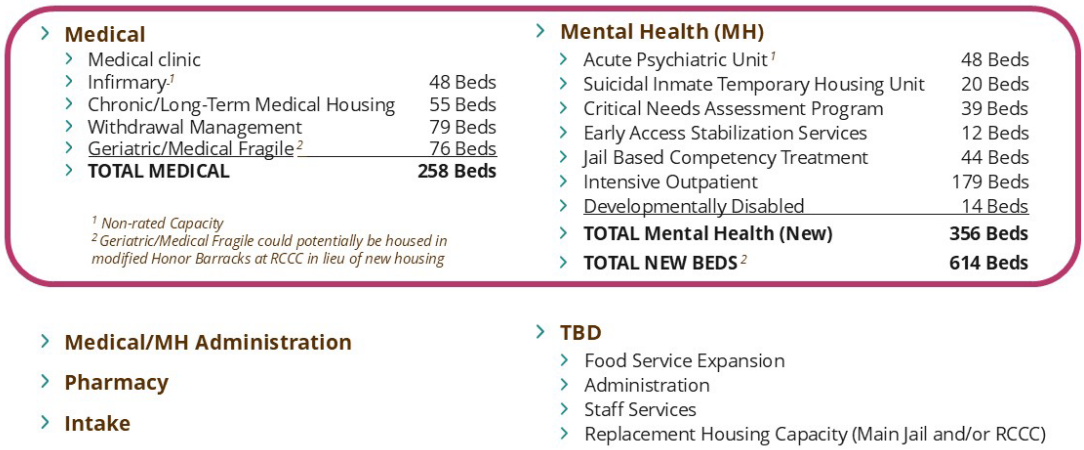


Figure 6.7.17 provides a preliminary analysis of total capacity requirements, assuming that all but the non-rated beds for the Medical Infirmary (48) and the APU (48) identified as potential new construction are added to the system. Existing capacity is also impacted by the planned partial single-celling (64%) of the EOP treatment cohort in existing beds as well as partial single-celling (5%) of the Mental Health Treatment – General Population (MH-GP) treatment cohort in existing beds.

With these considerations, total available capacity is estimated at 4,201 beds for the general population vs. a projected need for 4,313 beds resulting in a potential shortfall of 112 beds for the general population. If the Geriatric/Medical Fragile population is housed in modified Honor Barracks rather than new construction, the total shortfall will increase to 188 beds.

Figure 6.7.17. Highest and Best Use – Existing Facilities Capacity (Impact of Special Needs Population Single-Celling on Total Rated Capacity)

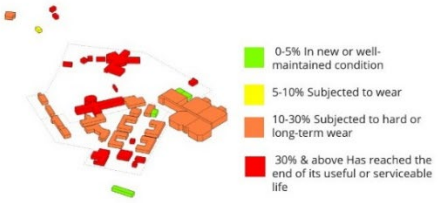
Main Jail Rated Capacity after ADA Compliance	2,438 Beds
RCCC Rated Capacity after ADA Compliance & Barracks Adaptation	1,412 Beds
Rated Capacity Special Needs Beds (Assumed New Construction)	518 Beds
TOTAL Rated Capacity	**4,368 Beds**
Anticipated Special Needs Single Celling Required	
Enhanced Outpatient Program (EOP)	130 Beds
Mental Health Treatment – General Population (MH-GP	37 Beds
TOTAL Projected Single Cell Capacity Required	**167 Beds**
Resulting Rated Capacity	**4,201 Beds**
Projected Need 2045	**4,313 Beds**
Delta (Shortfall in Projected Future Capacity Needs)	**(112) Beds**

Figure 6.7.18 illustrates the impact of physical conditions as documented in the Facility Condition Assessment for RCCC regarding adaptive use and the development of approaches**.** As indicated, a significant portion of the existing physical plant is rated as having reached or is approaching the end of its useful life. This information was developed for Workshop 4 to begin to inform the development of approaches relative to defining the level of resources provided by RCCC. This will continue to be investigated as part of developing approaches that include RCCC as a planning resource.

Figure 6.7.18. Highest and Best Use – RCCC (Potential Replacement Construction)

Potential Demolition

- Roger Bauman Facility (RBF)
- Sandra Larson Facility
- Miscellaneous Trailers & Modulars
- Clinic/infirmary
- Intake/visiting
- Kitchen
- Laundry



Potential New Construction/Renovation

- Clinic/infirmary
- Intake/visiting
- Kitchen
- Laundry
- Programs Building (s)
- Office Space ACH & ACMH
- Female Housing
- Expand Administration
- Expand Staff Services
- Re-imagine Barracks
- Replacement/Added Capacity



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