MAIN JAIL CAPACITY TO MEET THE CONSENT DECREE REPORT

SACRAMENTO COUNTY

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By

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1.0 EXECUTIVE SUMMARY

The Question – and the Answer

Question: In April of 2021, Sacramento County General Services engaged Nacht & Lewis to study the question: **"how many inmates would have to be removed from the Main Jail in order to achieve compliance with the Mays Consent Decree?"**

Answer: after completing the study, the answer is: **"Even reducing the population very substantially, the Main Jail cannot achieve meaningful compliance with the consent decree."**

This report explains how the question was studied and how the answer was arrived at.

Background

Achieving substantial compliance in all areas of the consent decree would require changes to jail operations, medical and behavioral health services, increased staffing, and improvements to the jail's physical plant. The Main Jail, built in 1990 prior to ADA, HIPAA, and re-alignment, was not designed to meet current standards or best practices for the inmate populations it houses. While progress toward compliance is being made in some areas, the jail's hardened construction and inflexible configuration is a barrier to achieving compliance that cannot be overcome.

Study Team

Nacht & Lewis conducted the study with support from project team members including Jay Farbstein & Associates (correctional facility planners) and Falcon Inc. (correctional healthcare specialists). Firm and individual biographies are provided in the appendices.

Study Approach

To understand the jail population, the consultant team first collected data on the jail's special populations, specifically, the jail's population that are classified as Seriously Mentally Ill or needing medical detox or long-term medical care or are in Administrative Segregation. This group is the focus of the consent decree (though all detainees are "members of the class" that it covers) and comprises about 25% of the Main Jail's population.

The team then assessed how the Main Jail facility might be utilized to meet the most important needs of these special populations and how much the jail's capacity would have to be reduced to accommodate as many as possible of this group.

Finally, the team assessed the degree to which this achieves compliance with consent decree requirements.

Key Findings

Acute psychiatric and intensive outpatient (IOP) cohorts are resource-intensive and put the highest demand on infrastructure, staff, and services. The analysis shows that meeting the needs of this group **reduces the jail's capacity to 1,357 beds from its rated capacity of 2,397 –a loss of 1,040 beds** or nearly 44% reduction.

- This means that **306 lower acuity "outpatient" mental health population** (OPP) and **27 long term medical and medical detox** patients cannot be served and thus cannot be housed in the Main Jail.

- Additionally, **707 general population beds cannot be occupied**, because they are in units that must be dedicated solely to higher-need inmates.

- **Housing pods cannot be fully occupied**, the individuals of this cohort are most at risk of harming themselves or others. They cannot be housed with other populations. They cannot share a cell with another inmate and for safety, they must be located on the floor level not on a tier level. This results in housing pods that cannot be fully occupied when assigned to the highest acuity individuals. Leaving empty cells on the tier levels and an empty bunk in a cell that could house two inmates.

- **Group program rooms** must mostly be dedicated to the high acuity inmate-patients who meet in small therapy groups. Very little time is left for the general population who thus would be highly underserved.

- Most of these inmate-patients must recreate as individuals or in small groups and cannot recreate with other populations, **severely limiting the amount of recreation time** available to them and to other inmates.

Conclusion

The study shows that substantial compliance with all consent decree requirements is not possible within the Main Jail. Even major renovation projects would not solve the problems and in any case would not be possible technically, financially, or operationally.

2.0 INTRODUCTION

In April of 2021, Sacramento County General Services engaged Nacht & Lewis to study Facility Options for Consent Decree Compliance.

Purpose of the Study

A question was posed by Sacramento County General Services: "what level of the jail's population would need to be removed in order to use the existing areas of the Main Jail without renovation to meet the objectives of the Consent Decree?" After discussion with county staff, the question was reframed as, "what can be done in the Main Jail to meet the terms of the Consent Decree; which requirements can be successfully accomplished in this manner; and which requirements cannot be accomplished in this manner?" This simultaneously addresses the original question while providing more contextual information to better inform decisions

If the existing Main Jail cannot fully meet some requirements of the Consent Decree without renovation, it would raise the question of what would be the minimum renovation and/or addition needed to carry out full compliance. A phased approach has been developed in which Phase I would answer the original and reframed questions and, if warranted, the consultant team would continue in Phase II to address other options that would allow the county to meet the Consent Decree. The expectation is that the scope of work is to supply sufficient depth of analysis to inform later decision-making.

If Phase II of the analysis is authorized, it will consider the resources needed systemically, and to the extent necessary, taking into consideration the roles of the Main Jail, RCCC (Rio Consumes Correctional Center), and any proposed facilities viewed as playing inseparable roles in meeting requirements.

Scope of Work

This study focuses on Phase I as follows:

- What can be achieved in the Main Jail, to comply with the Consent Decree, without making physical improvements to the jail
- How many inmates would have to be released?
- What requirements would be met?
- What requirements would not be met or would not be fully met?

The analysis relies on as-built facility drawings, facility tours, documentation from earlier facilities studies and programming workshops, and meetings with project stakeholders.

Study Team

Nacht & Lewis conducted the study with support from project team members with Jay Farbstein and Associates and Falcon Inc. Firm Biographies are supplied for reference in the appendices.

Background relevant to the Study

The original mission of the Main Jail facility was primarily the detention of short-term general population inmates. The jail is two blocks from the County Courthouse, making it convenient for holding pre-trial inmates. The building replaced the original central jail facility at the corner of 6th and H. Other key facts:

- The existing Main Jail tower was designed in the mid-1980s under the 1988 Uniform Building Code and completed in 1989.
- The adjacent "bark lot" (named for the bark ground cover surface on the lot) was reserved for a future tower addition with anticipation of a population increase. Crime trends showed there would be a need to expand by the mid-1990s. However, 30 years later, the jail has not been expanded.
- Sacramento County's population has grown from 1.0M in 1989 to over 1.58M in 2021; the population is expected to grow at 1.5% per year to 1.8M in 2030.
- Originally the cells were single bunked, but secondary bunks were added over the years, and the current population cap is 2,432.
- The jail was designed with three large recreation yards (with a capacity for 50 inmates per yard), each serving two floors/twelve pods. This group of inmates is too large to recreate together.
- In the 1990s, a more significant percentage of inmates could mix for out-of-cell time in dayrooms and yards; this is no longer possible.
- Because the jail was never expanded, it was already overcrowded by the 1990s, affecting operations, staffing, and safety. In addition, it now houses more than double the inmate population that it was designed for.
- The jail does not function safely at the current density and is challenging to manage; this is the cause of many operational and safety issues documented.
- It requires far more staff than the building was designed to accommodate.
- It cannot provide the services that are now required by evolving needs and a paradigm shift in jail missions.

The needs of jails and inmates have changed over the last three decades and there has been growing support to act on the body of research that describes today's jail populations in recent years. Most have a behavioral health condition, with about 1 in 4 of those detained in jail having a Serious Mental Illness. The criminalization of behavioral health crises has resulted in exponential increases in the rates of those with psychiatric and substance use disorders who

become justice-involved. More recently, jurisdictions have pivoted to action orientation, recognizing that a fundamental shift in how we conceptualize justice-involved offenders is critical to improving outcomes, reducing recidivism, providing humane treatment, and ultimately improving public health and public safety.

Individuals who access jails in the United States are the same who are the super-utilizers of emergency room services, public assistance programs, and generally the most marginalized populations living on the fringes of society. The role of the jail must change. A complete paradigm shift is necessary to ensure that the built environment's public health and public safety purposes are realized, and that clinical and criminogenic needs are responsibly and effectively met. Fundamental to this paradigm shift is the inversion of the current criminal justice system from one that prioritizes incapacitation and punishment to one that recognizes the clinical and criminogenic need, works to meet those unmet needs, and upholds core pillars of treatment-centric design for restorative justice.

Purpose-built design means healthcare operations are prioritized, and before discussing a building at all, the operational components must be understood. For example, today's jail requires immediate and private healthcare screening, referral for assessments, development of clinical treatment plans, appropriate housing for special populations (i.e., Serious Mental Illness, those with chronic medical conditions), the provision of intensive medical, mental health, dental, substance use disorder, and specialty care, collaboration with community providers, discharge planning, and all other components of a healthcare delivery system. Functionally, today's jail behaves more like a hospital or clinic than like the jails of yesterday.

The Main Jail facility was considered state-of-the-art in 1989. However, because of its age and the evolving needs of inmates, the facility can no longer meet the mission requirements of a modern county jail system. Best practices and a variety of other standards defined by recent legislation and litigation require significant renovations or additions. A list of challenges to the outdated design are:

- compliance with the Americans with Disability Act (ADA established in 1991)
- HIPAA (specifically Health Information Privacy, established in 1996)
- longer-term inmates (driven by AB 109 legislation) and the related chronic medical conditions
- the increase in inmates with mental health issues
- new thinking relative to early classification and identification of programs to aid in rehabilitation
- the higher percentage of violent inmates who cannot be housed together or receive out-of-cell dayroom or yard time with others
- the increased staff and infrastructure related to a doubling of the population
- impacts from infectious diseases such as Norovirus or Covid

The following sections of this report lay out the study method and approach, the assumptions used for analysis, the results of the analysis and conclusions.

3.0 APPROACH AND METHODOLOGY

Overview

Work on the jail Main Jail capacity to meet the consent decree study followed a series of already-completed tasks. These tasks started with pre-programming discussions and tours of new jail facilities in other jurisdictions to set the planning goals. In mid-2020, the team identified new and expanded programs that could reduce the jail population and developed estimates of their potential impacts on the jail census. It should be noted that these estimates were examined more deeply by the Council of State Governments Justice Center concurrent with this jail study. Subsequent facility programming tasks identified the operational and design requirements to accommodate these populations in a proposed jail annex adjacent and connected to the existing Mail Jail.

In addition, tours of the Sacramento County's Main Jail and RCCC included observations of existing conditions and operations as well as inventories of facility resources available at both sites. Administrators, managers, clinicians, and line staff of the Sheriff's Correctional Services and Adult Correctional Health were interviewed. Data on inmate characteristics and program utilization were analyzed. The consulting team also met with *Mays v County* plaintiff's attorneys, monitors, and subject matter experts.

The consultant team worked closely with Adult Correctional Health and contracted providers of clinical services to gain an understanding of healthcare delivery and its challenges in existing spaces within the county jail system. Targeted workshops and interviews with healthcare administrators and service providers were supplemented by data and document requests, additional site visits, and analyses of healthcare data for the jail population that informed the requirements for adequate service delivery within the Main Jail. Additionally, a workshop with the court-appointed consent decree monitors allowed for discussion of their concerns that echoed those of the consultant team. This generated specific direction pertaining to critical needs assessment and forecasting information, such as the acceptable number of patients in a therapeutic group setting, in order to be substantially compliant with the remedial plan.

Overall, this study was grounded on a foundation of thorough knowledge and understanding of facility operations, the existing physical environment, the county's jail system and broader justice system, and the community system of care.

Assumptions

The capacity of the Main Jail to meet the housing, programming, and treatment requirements of the consent decree is influenced by a large number of factors, making the approach taken to achieve adherence a crucial component of this options study. To determine a discrete capacity, it was necessary to develop an agreed-upon set of assumptions with which to move forward for analysis. The assumptions used for the analysis and reasons for their selections are as follows:

Administrative Segregation

- It was clear from reading the placement notes that a leading cause of placement in administrative segregation was behavior associated with an SMI, and those inmates would be better managed in a treatment environment. Therefore, it was assumed that inmates with an SMI who had been assigned to administrative segregation should be placed in the appropriate acuity level mental health unit in lieu of restrictive housing. Those with a history of violence against staff or other inmates would be in a higher security treatment unit with escort of movements consistent with their administrative segregation level.
- Placement in administrative segregation would be behavior-based with the average length of stay in restrictive housing based on the number and type of incident write-ups and the review time for such placements per the consent decree. For example, an inmate with one serious write-up was assumed to spend 15 days in ADS1 and 30 days in ADS2 before, upon review, being returned to general population (note that these abbreviations are defined in the Approach section below).

Infirmary and Long-Term Medical

- Less information was available for medical services than for administrative segregation and mental health care, so the team leaned heavily on the knowledge of ACH medical staff for context and understanding of medical services at the Main Jail for use in this analysis.
- Long-term Medical is assumed not to require use of the program rooms on the JPS schedule.

Mental Health Housing

The ability to meet the consent decree's requirements for inmate-patients with an SMI is most heavily influenced by the limited availability of program rooms for group therapy, as well as by the JPS treatment schedule. The assumptions listed below addressed these factors:

- Housing unit dayrooms will not be used for group therapy due to the inability to provide the level of confidentiality required by current practice.
- Use of the program rooms for mental health treatment would give first priority to Acute Inpatient units, followed by the Intensive Outpatient Program, and lastly to the Outpatient Psychiatric Program; consistent with standard triage protocols.
- Patients in Acute Inpatient units will receive five 1-hour group sessions per week in groups of no more than four. The consent decree does not specifically spell out group treatment requirements for acute care, but discussions with the monitors and their subject matter experts showed they find group treatment at this acuity deficient and are watching this closely.
- Patients in IOP will receive 10 group sessions per week per the consent decree.
- Patients in OPP will receive 7 weekly group sessions per the consent decree.
- The use of program rooms for group sessions will follow the current JPS schedule with a slight modification: JPS currently operates Monday through Friday, 8 am to 4 pm, with one, 1-hour group session in the morning and one in the afternoon. JPS's operational hours on-site are assumed to remain the same, but with a split schedule alternating two groups of patients between group therapy and structured dayroom time in the morning and afternoon, resulting in two 1-hour therapy sessions in the morning and in the afternoon.
- Program rooms will be available for other uses for four hours after 4 pm on weekdays and for 11 hours on weekends. (As a result, general population inmates will have very limited access to these rooms for their programs.)
- Unless patients in group sessions have a concurrent administrative segregation classification, it was assumed they would be able to change groups using the program rooms with negligible impact on the schedule. Sessions for patients who were also identified for administrative segregation were allocated 90 minutes to allow for individual escort time into and out of the program room.
- To the extent possible, patients will attend groups sessions on the same floor as they are housed, minimizing the amount of escorted movement outside of their housing unit. Those in Acute and IOP housing will preferably attend sessions on the same side (East or West) of the floor on which they are housed.
- All Acute and most IOP patients will be housed in single cells on the main level of housing units (not upper tiers). They will generally not be mixed with other acuities or classifications, resulting in the upper tiers of those units remaining unavailable for housing.
- A small number of IOP patients can be assigned to a transitional unit with OPP patients in double cells.
- OPP patients can be housed in double cells and upper tiers.

Recreation Yards

The requirements for access to the recreation yards affects the entire Main Jail population, except for those inmates temporarily housed in the infirmary. Some assumptions were necessary regarding the nature and priority of use of recreation yards by certain groups that, in turn, affect the overall capacity of the Main Jail under the consent decree:

- All inmates will receive three hours of recreation yard time per week as required by Title 15 of the California Code of Regulations.
- All yard access will occur within the 11 hours per day, 7 days per week for inmate activities available in the custody schedule.
- General population inmates will share the recreation yards at their full capacity of 52 inmates. The following types of inmates will use the recreation yards at the following group sizes despite the yards' larger capacities:

Acute Inpatient	4
IOP	8
OPP	37
ADS1	1
ADS2	4

Mental health patients with a concurrent administrative segregation classification will recreate in the most restrictive group size.

- Men and women will continue to recreate separately.
- While the development of special management yards is feasible within the Main Jail, it was assumed the existing yards would be used as-is consistent with the direction given for this study.

Approach and Methodology for Estimating the Size of Each Population Group

Two strategic options were considered for testing the ability of the Main Jail to properly accommodate the populations covered by the consent decree (which, for some issues, consist of the entire jail populations as members of the class). The purpose was to understand each option's ability to comply with the consent decree fully or partially (and, if partially, to what extent) without making facility improvements to the Main Jail.

The consultant team considered two possible approaches or options:

Option 1: Meeting lower acuity needs
Option 2: Meeting highest acuity needs

("Acuity", as used here, refers to the degree of seriousness of the inmates'/patients' medical/mental healthcare needs and the resulting demands that are placed on the facility to accommodate those needs.)

The team took Option 1 to a certain level of completion before it was pointed out that accommodating lower acuity needs, while able to utilize more existing jail beds, performed very poorly in meeting consent decree requirements. In fact, it left the vast majority of the inmates/patients with more challenging requirements needing to be accommodated outside the existing facilities (in some combination of expanded jail beds and community placements).

Therefore, Option 1 was dropped from further consideration (and is not reported on below) so the team could focus on Option 2, which accommodates far more of the inmate/patients in the existing Main Jail and at least reduces the need for new jail or community solutions.

Once the team moved on to Option 2, the Main Jail's ability to accommodate various population groups was determined by comparing estimates of demand for groups of class members identified in the consent decree with the resources afforded by the Main Jail. Since the study was an examination of the Main Jail's ability to meet the requirements of the consent decree "as is," RCCC was not considered beyond the assumption that certain populations, such as those requiring restoration of competency, would continue to be served there.

The analysis began with snapshot profile data for a single day of inmates in the following classifications:

- administrative segregation (Ad Seg – further distinguished as ADS1 or ADS2)
- the three acuity levels of mental health treatment
  - Acute Inpatient (Acute)
  - Intensive Outpatient Program (IOP)
  - Outpatient Psychiatric Pods (OPP)
- infirmary patients
- long-term medical patients.

The approach for analysis of each segment of the population is described below.

Administrative Segregation

"Administrative segregation" refers to separation from the rest of the population and a reduction in privileges as the result of serious and/or repeated rule violations[1]. ADS1 is a restrictive housing assignment based on a major rule infraction; ADS2 is a restrictive housing assignment for either a minor rule infraction or as a transition between ADS1 and the general

[1] Sacramento County Sheriff's Department Correctional Services. Inmate Handbook, 2019, p. 17.

population. The administrative segregation data focused on factors that would indicate utilization of the placement in restrictive housing consistent with the terms of the consent decree, including:

- cell identification.
- classification (ADS1 versus ADS2);
- reason for placement (notes);
- most serious charge;
- number of in-custody incidents;
- number of serious incident write-ups;
- number of less serious incident write-ups;
- gender;
- active medical case;
- serious mental illness;
- substance use disorder;
- co-occurring disorder;
- date of jail intake;
- next court date;
- date assigned ADS1 classification;
- date moved out of ADS1;
- date assigned ADS2 classification; and
- date moved out of ADS2.

The sample yielded 99 records: 94 in the Main Jail and five at RCCC. Inspection of the data quickly revealed that inmate-patients diagnosed with Serious Mental Illness (SMI) were heavily represented in the sample.

The architectural and mental health team members collaboratively reviewed the charges, reasons for classification, mental health history (discussed in the following section), progress in the court process, and institutional misconduct. Recognizing that it would better serve the patients, the consultants decided to assume all 64 individuals housed at the Main Jail in administrative segregation with a diagnosed SMI should be placed in a treatment unit, greatly reducing the need for administrative segregation. These cases were separated from the balance of administrative segregation cases and further analyzed in context of mental health treatment need. Cases at RCCC were determined to be appropriately placed and omitted from further analysis.

A formula was developed for the remaining 30 non-SMI cases to determine the average daily population (ADP) each inmate would contribute to the jail if consent decree review periods were strictly adhered to, which would typically result in a transition back to general population. The formula was applied using the following steps:

Step 1:

- Each serious write-up would result in 15 days in ADS1 and 30 days in ADS2 followed by a return to general population.
- Each less serious write-up would result in 30 days in ADS2 followed by a return to general population.

Step 2: Days in ADS1 and ADS2 were divided by total days in-custody to determine each inmate's contribution to daily population in administrative segregation[2]. By the time the analysis was conducted, a majority of release dates were known; for the few unknown release dates, the date of the sample was used.

Step 3: The contribution to bed needs was determined by multiplying projected daily population by 1.15, the default peaking and management flexibility factor used by the BSCC.

Step 4: Bed needs were summed for four categories:

- Male ADS1
- Male ADS2
- Female ADS1
- Female ADS2. The bed needs for females were so small that a minimum of one each was used for women in ADS1 and ADS2.

The bed needs for administrative segregation under the consent decree were allocated toward the resources available in the Main Jail as described at the end of this chapter.

Medical and Mental Health

The team obtained the health record for every incarcerated person in the facility who was identified as meeting criteria for a chronic medical, psychiatric, substance use, or co-occurring disorder. These data were drawn from the same date as the Ad Seg sample, enabling prevalence rates of each to be tabulated and cross-referenced with those identified in administrative segregation and other housing, demographic, and custodial categories. This cross-sectional data was gathered for two additional points in time at approximately three-month intervals to create a more robust sample for analysis.

For the mental health populations, cross-sectional data sets were disaggregated by housing unit and level of care (i.e., Acute, IOP, and OPP). Each usable clinical data point was then cross-

[2] This step was adapted from the typical formula for average daily population: *number of intakes x average length of stay / 365*. In the adapted formula, each case constitutes one Intake, and each individual's length of stay is used in place of 365 days per year.

referenced with publicly-available criminal justice information to examine the details of justice-involvement (for example, bail schedules) for those identified as requiring Acute, IOP, and OPP levels of mental health care inside the facility.

Ultimately, the consultant team was able to:

- disaggregate the clinical population by total clinical demand for Acute, IOP, and OPP beds;
- study the same population by lead charge, seriousness of lead charge, administrative status (e.g. State Hospital hold), bail status, and other information pertaining to reason for detention;
- determine the number of spaces necessary to meet the group therapy demands contemplated in the remedial plan of the consent decree; and
- compare all of those demands and requirements to the availability of housing and treatment spaces to accommodate the identified needs.

To assess the medical needs and the population of those requiring acute, chronic, and routine healthcare, the subject matter experts followed similar methodology and procedures to obtain information from Adult Correctional Health (ACH) and the County's contracted providers of medical, dental, pharmacy, and ancillary services. Workshops were held focusing on all aspects of service delivery, and to the extent available, data and documents were requested (and received) to allow the team to assess utilization of healthcare services by those who are detained in the Main Jail.

As mentioned earlier in this Chapter, relative to available data for the populations enumerated in the consent decree's remedial plan for mental health, significantly less information was available with respect to utilization of medical services and somatic healthcare operations. This is a function of the remedial plan for medical services being far broader, applicable to every person detained in the Main Jail, and not specific to levels of care as outlined in the mental health remedial plan. However, ACH nursing staff were extremely knowledgeable about their operations and assisted with educating the consultant team, aiding in gaining a deep understanding of the operations, the needs of the population and staff, and the issues surrounding the built environment and challenges it presents.

The next Chapter details the results of these analyses and the team's findings on the degree to which the Main Jail can meet the needs of the highest acuity individuals in accordance with consent decree requirements.

4.0 RESULTS

Overview

This chapter first reviews the profiles and expected numbers of each of the population groups that require special accommodations according to the consent decree. It then outlines the constraints imposed by the configuration of the Main Jail that limit the numbers of each population group that can be accommodated. Finally, it compares these two factors to establish the number of existing beds that can be utilized and the (limited) degree to which this satisfies the consent decree.

This chapter of the report, therefore, describes the degree to which the Main Jail can meet the consent decree's requirements for the highest acuity inmate patients. It begins with population profiles and projections of the number of beds that are needed for each category. It then moves to considering how existing housing units can (or cannot) accommodate the needed beds. Finally, it considers other requirements such as providing confidentiality at Intake and meeting ADA standards.

The underlying assumptions for the analyses are described in Chapter 3.0.

Population Profiles

Capacity demands for special populations covered under the consent decree were determined based on their actual census on the day the sample was taken, their profile characteristics, and unmet demand indicated by waiting lists. Sufficient information was supplied to provide useful profile information on administrative segregation and three acuities of mental health patients. Information pertaining to medical housing in the infirmary and long-term medical units was provided via interviews, workshops, review of limited utilization data, and reliance on the experience of the consultant team.

Administrative Segregation

In reviewing this population's characteristics, it was striking how large a proportion of these inmates had SMIs: sixty-eight percent, or 64 of the 94 inmates in administrative segregation had an SMI. A review of the classification notes showed that, in many cases, behavior related to their SMI was the reason for their placement in administrative segregation. In essence, this restrictive classification was being used as a means to manage inmates who were much too difficult to manage in other available housing settings.

A deeper evaluation of these inmates revealed a number of constraints that limited other options for their release from jail. Most were charged with serious felonies and their bail amounts indicated judges intended for them to remain in custody. Many were on hold awaiting

placement in a state hospital. These were not cases amenable to release to community-based programs, rather they were cases whose symptoms were likely to be exacerbated by the jail setting itself and restrictive housing in particular. Most of these inmates should be treated as acutely mentally ill (see next paragraph) rather than being placed in restrictive housing (and are treated as such in the Estimated Bed Needs section below).

Mental Health

Clinical data for the Acute, IOP, and OPP populations revealed that the demand for housing in each of the three levels of care far exceeded what was available in the Main Jail.

The contracted provider of mental health services had identified 34 unique individuals who required an Acute level of care, yet only 17 Acute housing beds were available. The remaining 17 individuals were temporarily housed in a designated area of an IOP unit, where they awaited bedspace availability in the Acute unit in suicide-resistant cells called the Suicidal Inmate Temporary Housing Unit (SITHU). The acute unit is described as a "psychiatric emergency room" with approximately 95% of the population involuntarily committed as Lanterman-Petris-Short (LPS) patients and approximately 40% on court-ordered involuntary psychotropic medication. Approximately 50% of the acute population is Incompetent to Stand Trial (IST) or awaiting placement in Department of State Hospital facilities. Data for the Acute population revealed very few misdemeanor charges, and all of those with misdemeanor charges were held pending hospital transfer. The Acute population included 74% with violent charges and 58% with No Bail status. The average bail for the remaining 42% of the Acute population was $208,658 (median = $51,000; mode = $50,000; range = $30,500 – $1,000,000).

Within the IOP population, the contracted provider of mental health services had identified 78 individuals who met the criteria for this level of care, yet only 59 were able to be housed in the IOP units. Within the IOP population, 88% of individuals had violent lead charges and 33% had No Bail status. The average bail for the remaining two-thirds of the population was $156,203 (median = $50,000; mode = $50,000; range = $10,500 - $1,000,000).

Lastly, within the OPP population, the contracted provider of mental health services had identified 318 individuals who required that level of care, but at that time, there was not an officially designated OPP housing area to meet those clinical needs. Rather, the OPP was a target population to be housed in the proposed Main Jail Annex, also known as the Correctional Health and Mental Health Services Facility (CHMHSF). Of those identified as needing OPP level of care, 78% reflected lead charges that are considered violent, and 46% were held with No Bail status. Of the remaining 54%, the average bail was set at $278,616 (median = $50,100; mode = $50,000; range = $1,500 - $3,000,000).

In addition to the Acute, IOP, and OPP populations, two sub-populations emerged which are known proxies for psychotic disorders, neurodevelopmental disorders, and other SMIs. As of the

population sample date, there were 84 individuals awaiting bed space in Department of State Hospital (DSH) facilities, with another 3 awaiting placement in a suitable county or state facility due to their status as Murphy's Conservatees.[i] In sum, the survey found 97 additional individuals who were awaiting placement but had been clinically and legally assessed as needing an inpatient civil or forensic psychiatric hospital setting and yet were housed in the Main Jail. Some individuals are held in this status for up to two years. This population is described by healthcare and custody staff as being some of the most challenging individuals to manage in this setting.

The other critical sub-group was those found incompetent to stand trial (IST) and assigned to the Jail-Based Competency Treatment (JBCT) program, a distinct population from those awaiting placement in DSH facilities. These individuals have been found IST by a criminal court and cannot proceed with the resolution of their cases until competency is restored. Incompetence to stand trial serves as a proxy for Serious Mental Illness because severe psychotic symptoms, intellectual disabilities, and other symptoms of severe disorders are strong predictors of findings of incompetence. Those engaged in the JBCT program are housed and treated at RCCC, while the vast majority of those on the waitlist are housed in the Main Jail among the Acute, IOP, and OPP populations. The capacity of the JBCT program to engage individuals who are IST and charged with felonies includes 44 beds on the treatment unit. At the time of the survey, there were 44 engaged in the JBCT felony program with 102 on the felony waitlist. Additionally, the JBCT program has 8 spaces for individuals who are IST and facing misdemeanor charges. At the time of the data collection, there were 8 individuals engaged in the JBCT misdemeanor program with 5 on the waitlist. Aggregated, there were 52 beds in the total JBCT program, yet there were 146 incompetent defendants in the jail system who had been ordered into JBCT, with most housed at the Main Jail. These are individuals with serious mental health needs, corresponding behavioral challenges, and no prospect for progressing through the criminal justice system unless and until they are restored to competency through the JBCT program.

[1] Murphy Conservatorships are court-ordered appointments of guardians for those unable to handle basic needs for themselves, and who are incompetent to stand trial, have outstanding felony charges causing great physical injury or death, are gravely disabled with a psychiatric disorder, and who pose a threat to self and/or others.

Estimated Bed Needs

Using the assumptions and methods described in Chapter 3.00, the bed needs for each special population were estimated and the remaining beds available for general population inmates were determined. The original intent was to adjust bed demand for the 2,397-bed maximum capacity of the Mail Jail. However, it eventually became clear that limitations in program rooms for group therapy and recreation yards would limit the capacity of the Main Jail to a number comparable to the census the day of the sample, so the bed needs estimated using the sample were used to evaluate the capacity the jail could support under the consent decree.

Administrative Segregation

After shifting inmates with SMI to the mental health treatment group and adjusting the resulting sample to conform to the consent decree, the remaining ADP for administrative segregation was greatly reduced, as shown in the table below:

Table 4.01: Administrative Segregation Bed Needs Under the Consent Decree

	Bed Need	
Housing Type	**Male**	**Female**
Administrative Segregation		
ADS1	6	1
ADS2	10	1

Due to the low number of women in administrative segregation, both in the sample and results, it was decided to assume that women classified as administrative segregation would be housed together with high security women and be managed with additional operational restrictions as needed.

Mental Health

Beds needed for SMI populations were largely driven by their representation in the sample population, moving inmates with SMIs from administrative segregation to treatment, and waiting lists for treatment beds at the time of the sample. Those inmates with histories of assaults on staff or other inmates were broken out for higher security housing within their acuity level. Table 4.02 summarizes the resulting bed needs.

Table 4.02: Mental Health Bed Needs

	Bed Need	
Housing Type	**Male**	**Female**
SMI Populations		
Acute Inpatient	27	4
Acute Inpatient/ADS1	3	<1
IOP	103	13
IOP/ADS1	4	<1
OPP	295	37
OPP/ADS1	10	2

Medical

Although the consultant team recognized substantial improvement in data collection methodology for utilization review going forward, census data on existing medical populations was not recorded in a way that would support a reliable determination of bed needs. Table 4.03 below presents the breakdown of medical beds from the draft program for the proposed Jail Annex, developed through numerous meetings between medical providers and the consultant team, review of chronic care clinics, withdrawal management protocols, infirmary bed utilization, and comparison with national models and trends. While not finalized, they are the product of medical managers' knowledge of their workload and have been vetted at a draft level by medical administrators and consultant team subject matter experts.

Table 4.03 Medical Bed Needs

	Bed Need	
Housing Type	**Male**	**Female**
Rated Medical Beds		
Long-Term Medical	32	4
Medical Detox	38	5
Infirmary (not rated)	20	10

Total Special Populations

These special populations require a total of 595 beds to meet their needs, as shown in Table 4.04 below.

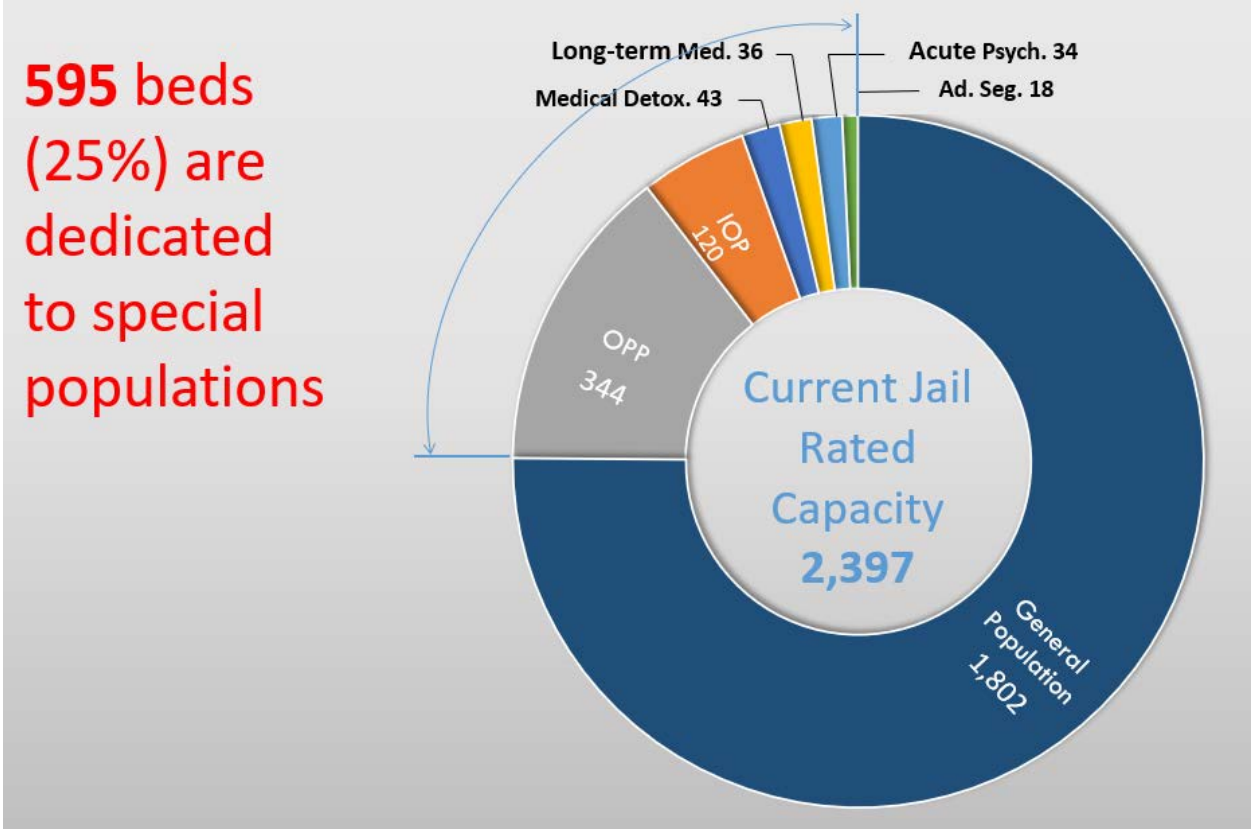
Table 4.04: Combined Special Population Bed Needs

	Bed Need	
Housing Type	**Male**	**Female**
SMI Populations		
Acute Inpatient	27	4
Acute Inpatient/ADS1	3	<1
IOP	103	13
IOP/ADS1	4	<1
OPP	295	37
OPP/ADS1	10	2
Rated Medical Beds		
Long-Term Medical	32	4
Medical Detox	38	5
Administrative Segregation		
ADS1	6	1
ADS2	10	1
Total Special Rated Beds	528	67
	595	
Infirmary*	20	10

*Infirmary capacity is scoped for the study but is not counted in the rated capacity, and thus not included in this table.

This represents approximately 25% of the inmates housed in the Main Jail just after midnight on the day the sample was taken. It does not include inmates in the Intake area. The relationship is shown graphically in Figure 4.01 below.

Figure 4.01 Special Population Bed Needs



Mental health treatment programs have the greatest deficit in available beds. There are currently 248 beds allocated for the 498 inmates with SMIs. Assignments to administrative segregation are over-utilized with 147 beds allocated; ideally, this is closer to 18 beds if consent decree requirements were followed. Unfortunately, the lack of mental health treatment housing cannot be solved by simply reallocating beds, as other needed resources are also extremely inadequate.

Facility Resources and Constraints

Intake Area

While not a bed capacity issue, the intake area is also covered in the consent decree – and it impacts every detainee who is brought to jail for possible booking. This is where inmates are initially assessed and assigned to specific populations.

The intake area of a busy urban jail provides arguably the most critical clinical contact throughout the justice system. Those booked into the Main Jail currently are seen by Registered

Nurses (RNs) in an office without acoustic privacy from the booking area. The office has multiple intake stations, each immediately adjacent to one another, with no separation between stations to create acoustic privacy. It is also important to note that these spaces are not accessible to persons with mobility impairments. In short, there is no acoustic or visual privacy between intake stations, nor is there acoustic or visual privacy between the nursing intake office and the general booking area. The effect of these shortcomings on healthcare operations cannot be overstated; people entering jail have no reasonable expectation of privacy during a medical encounter occurring at one of the most stressful moments of their lives. Combined with the astronomical rates of chronic medical conditions, acute injury in the process of arrest and detention, and risk for suicide, overdose, and other adverse events, the expectation of confidentiality is not only a legal right but an absolute medical necessity. While this issue is one of the cornerstones of the *Mays* Consent Decree, it bears repeating in any report; until there is an ADA compliant confidential space for medical intake, the facility cannot adequately accommodate the healthcare needs of a single person entering the jail.

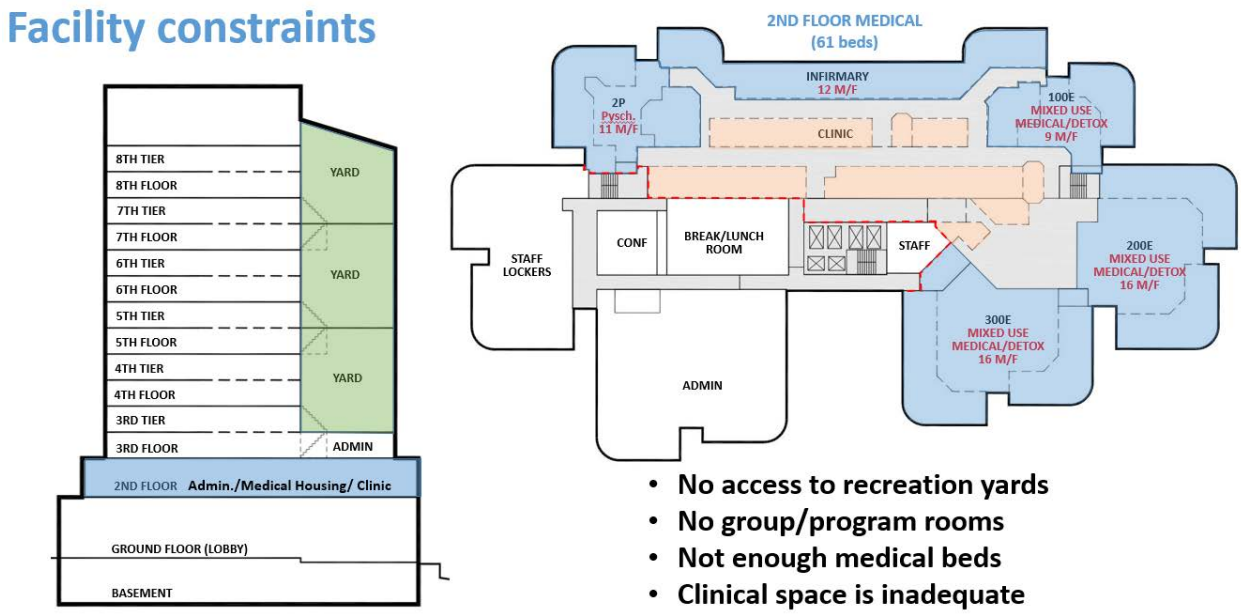
The intake area is located on the first floor of the existing jail. The following points enumerate the intake area's deficits *vis a vis* the consent decree:

- The receiving area (the portion of intake outside of the jail proper) only has a single, small noncompliant nurse triage area that cannot be expanded to meet ADA requirements.
- The area lacks multiple acoustically private stations, with one of those stations designed to meet ADA clearances.
- It does not have a secondary screening area needed to satisfy the consent decree. This area would need to include multiple acoustically primate stations, including at least one that is ADA compliant.
- There is not a proper, ADA-compliant exam room.
- It lacks observation cells, at least one of which would need to be ADA compliant.
- It does not have ADA-compliant sobering cells.
- It does not have ADA-compliant male and female holding cells (group and single cells).
- Transaction counters are not ADA compliant.
- Change-in spaces are not ADA compliant.

Existing Clinic/Infirmary and Long-Term Medical Housing

The existing medical and mental health service area is located on Level 2, shown in Figure 4.02, below.

Figure 4.02 Facility Resources and Constraints (2nd Floor)



Infirmary and Clinic Area

The second-floor Medical Housing Unit (2M) is a 10-bed infirmary operating 24 hours per day, 365 days per year, housing patients whose medical needs cannot be adequately met on a housing unit. Many have acute illnesses or injuries requiring skilled care, including wound care, intravenous therapy, or frequent monitoring by licensed personnel. This unit is also used to stage patients in preparation for off-site specialty procedures like surgeries at local hospitals, and to receive and convalesce post-surgical patients upon return to the Main Jail. Other patients housed here often include individuals with signs of moderate to severe substance withdrawal, individuals experiencing acute exacerbation of chronic conditions, and others who require close medical monitoring. The unit is designed to house individuals for short periods of time, and the beds are not included in the rated capacity of the facility.

The rooms in the medical unit are not all compliant with the Americans with Disabilities Act (ADA), and the two rooms designated for negative airflow are not functional and built without necessary ante rooms. This is a critical flaw like the lack of confidentiality in the intake area; unless the negative pressure rooms are remedied, the jail is incapable of providing adequate medical care for any individual suspected of having a communicable disease such as Tuberculosis or COVID-19, and likewise incapable of providing adequate protection from the same to the rest of the population housed in the Main Jail.

The hallways of the Medical Housing Unit are used for storage, with floor-to-ceiling shelves and boxes of medical supplies stacked. This violates code restrictions on storage of materials in exit access routes as well as minimum clear corridor widths. The nursing station does not provide sightlines to most of the rooms, and some of the rooms at the end of the hallway have been allocated to the Acute inpatient psychiatric program. These issues have been clearly identified by the Monitors associated with the consent decree as critical elements to remedy.

The medical unit is "always" at capacity according to many staff, utilization information, and direct observations of the consultant team. As a result, patients who require an infirmary level of care are subsequently unable to access that level of care and support, inevitably leading to undertreatment of illness and injury.

The outpatient clinic is located in the same space as the infirmary (2M). It provides limited specialty care clinics, such as podiatry, optometry, OBGYN, dental, and other special medical services. Many of the basic nursing and physician functions occur in the single office/exam room on each housing floor (3-8), servicing all persons residing on those floors and utilizing a complex matrix of scheduling for various disciplines and services. Individuals requiring more intensive outpatient treatments or specialty clinics are brought to the clinic space on 2M.

Long-Term Medical Housing

Out of necessity, the facility has designated a secondary medical housing unit adjacent to the primary unit, with a stated mission of housing those patients whose conditions do not warrant admission to the Medical Housing Unit, but who are unable to be housed in a typical housing unit due to their medical needs. While this unit is often used as a temporary housing placement for those discharged from infirmary-level care, it is also used to house patients whose chronic medical conditions require more intensive monitoring than is available in a typical housing unit, such as those with brittle conditions, those needing frequent physical therapy, or patients requiring assistance with Activities of Daily Living (ADL). Patients who require Durable Medical Equipment (DME) such as oxygen tanks or Continuous Positive Airway Pressure (CPAP) are also housed here despite the ability to provide many of these treatments at a lower level of care due to a lack of electrical outlets to use this equipment in a typical housing unit.

Although this housing unit does have some spaces that are ADA-compliant, most are not, and there is no treatment space available that affords acoustic or visual privacy from other patients and staff.

The following points enumerate the clinic's and infirmary's deficits *vis a vis* the consent decree:

- It is small and only provides a fraction of the space necessary to provide the services now required in a modern facility.
- There is no space to expand it.
- The dental area is not ADA compliant.

- The medical exam space in not ADA compliant.
- There is no space for adequate staff offices.
- There is no space for radiology services.
- There is no secure holding area for inmate waiting.
- There is not adequate space for dialysis.
- There are no ADA compliant patient rooms, toilets, showers, or other facilities. A majority of patient rooms in the infirmary and long-term medical housing should be ADA compliant, for both males and females.
- There are no respiratory isolation rooms with proper ante rooms- and no way to modify the existing rooms to add them.
- There is no space for an open ward.
- There is no access to dayrooms, programs, or yards in this area.
- There are no ADA compliant behavioral health cells, toilets, showers, or other facilities. A percentage of each type of patient rooms in the psych and mental health housing should be ADA compliant, for both males and females.
- The infirmary, long-term medical, and behavioral health areas do not currently have enough capacity to serve the needs of the facility. This has likely resulted in recent deaths in the facility, and likely to result in future deaths.

Second Floor Behavioral Health Housing

The second floor is also where the Acute Unit is located (2P), housing individuals who have diagnosed psychiatric disorders and are either imminently dangerous to self or others, or who are gravely disabled by the condition. The Acute Unit is designated as a Langerman-Petris-Short (LPS) unit, and follows the legal requirements as outlined in Welfare and Institutions Code §5000 et. seq. But for their incarceration and justice-involvement, these patients would otherwise be admitted to a community-based LPS unit as the least restrictive means of safely providing for their safety and that of others.

This unit is a 17-bed psychiatric emergency room located inside a jail. It has a centralized nursing station with sightlines to cells with glazing on the top and bottoms of doors. There is a small common milieu area. Staff are dedicated to this unit and deputies are specially trained and self-selected to work here.

The following are major limitations to the existing space:

- 17 beds are very inadequate, often leaving an equal number identified as needing acute care in an LPS unit held in a temporary housing unit within an IOP unit on the third floor.
- There is no access to individual or group therapy space.

- There is no access to recreation space.

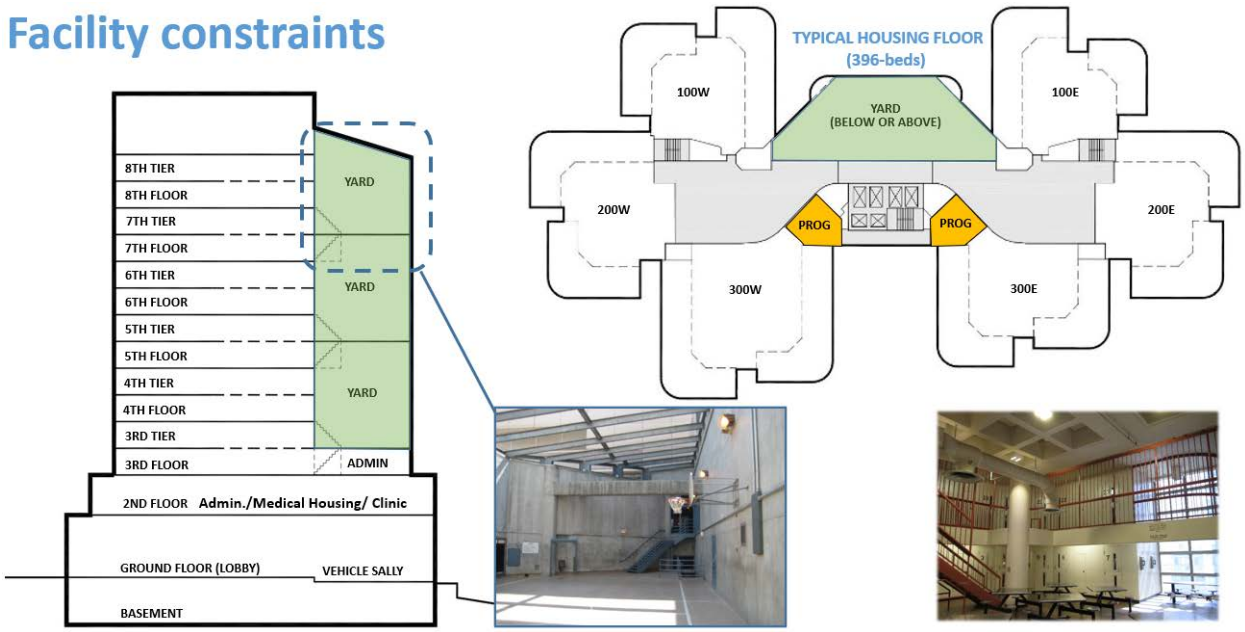
Standard Housing Floors – Candidates for Accommodating Behavioral Health Units

The majority of housing pods are located on floors 3 through 8, which include tier levels. This results in 12 levels of housing, half of which are not accessible by elevator. The following sections describe the physical layout of these areas and the principal constraints they present in terms of the needs of the behavioral health population: access to care, group/program room capacity, and access to outdoor recreation.

These floors have smaller footprints than floors 1 and 2 described above. Tiered housing pods typically consist of from 30 to 40 cells, many of which have a second (upper) bunk resulting in capacities ranging from 60 to 80 beds. The individual housing pods are defined by an articulated outline, with many exterior and interior corners providing opportunities for daylight to enter cells and dayrooms. Each of these housing floors contain six pods, organized into two pairs of three pods each on either side of an elevator core. There are also two-story outdoor exercise yards at on the north side of the core; they are located at the tier level of floors 3, 5 and 7 (meaning that housing floors require a stair to access to the yard levels).

There are two small program/classrooms next to the core. Each serves three pods. Many of these program rooms have been repurposed for other uses. A typical housing floor is shown in Figure 4.03 below.

Figure 4.03 Facility Resources and Constraints (Typical Housing Floors)



Access to Care

A key to an adequate healthcare delivery model is the ability for an individual to easily access healthcare services without encountering unnecessary barriers. A core component of access to care is the sick call process, whereby an individual in custody can document a request for healthcare services in a way that allows for the prompt and efficient triage of the request, dissemination to the appropriate clinical department or specialty, and planful response from healthcare staff in a timely manner. The provision of these outpatient sick-call services requires auditory and visual privacy, and these encounters should be provided in one office on each floor of the Main Jail. Most floors house 396 incarcerated persons, and with the one office also used for physician visits, specialty clinics, and many other clinical and correctional functions, a review of the utilization and schedule indicate no possible way that individuals can receive sick call visit with nurses in a timely manner. Across points in time, there were an average of 200 sick call requests in "backlog" status at the Main Jail.

Group Room Capacity

The consultant team conducted a study of the spaces needed to meet the group therapy requirements of the remedial plan and consent decree. Starting with the specific populations identified in the consent decree and counting those who had been clinically identified as needing the specific level of care represented in the remedial plan, the current population was adjusted

upward based on the assumption that the facility could be at capacity and must meet the consent decree at that level of population. Working with Adult Correctional Health, the contracted provider of mental health services, and the Sheriff's Office, the consultant team identified the number of hours available for group programming each week. Additionally, the court-appointed monitor for the mental health components of the remedial plan provided input into the maximum number of individuals that can be effectively treated in a therapeutic group. With all this information, the remedial plan requirements for IOP and OPP were reviewed, and the team found that the number of spaces required to be substantially compliant far exceeded the existing number of appropriate group spaces available in the Main Jail.

For the IOP population, the remedial plan requires each individual to be offered 10 hours of group programming per week.[1] With a maximum of eight individuals in a group and 17.5 hours of available time for group therapy per week, the IOP population would require at least eight group rooms to meet these requirements under those assumptions. The OPP population requires seven hours of group programming to be offered per week. With a maximum of eight individuals in a group and 17.5 hours of available time for group therapy per week, the OPP population would require at least 23 group rooms to meet these requirements under those assumptions. Lastly, while the Acute unit was not identified in the remedial plan as requiring a specific group size, the consultant team felt strongly that these individuals unequivocally require access to group therapy on a daily basis (five days per week) and assumed there should be no more than five participants in a group. With 17.5 hours available for group therapy each week, four group rooms would be required. In sum, operating under these assumptions and calculations, the estimated population of those requiring Acute, IOP, and OPP levels of care would necessitate 34 group spaces to comply with the remedial plan and be consistent with community standards of care if the jail were at its full rated capacity, compared to the 12 rooms that are potentially available in the Main Jail (assuming all of them were "recaptured" for program functions).

[1] In order to ensure the required hours are offered, generally the schedule will require an additional 20-50% to allow for exigent circumstances, so these estimates should be considered conservative.

Impacts of Group Room Capacity

Based on the priorities discussed in Chapter 03.00 Approach & Methodology, the group room needs of Acute Inpatient, IOP, and OPP women can be met during JPS' operating hours. That leaves 305 OPP men who cannot be provided their required group therapy for lack of adequately sized confidential space.

This would also leave limited program opportunities for inmates in general population and administrative segregation. There would remain 42 hours per week in the custody schedule to use the 12 rooms for up to 14 inmates at a time. The remaining inmates would have up to 4

hours per week in group programs, and somewhat less when programming administrative segregation in groups of 4.

Currently, some of the program rooms are being used for office space. Office functions would have to be accommodated elsewhere to meet the group therapy needs of inmates with SMIs, however leaving the rooms available for other programs outside of JPS hours.

An important consideration is the time (not to mention staff) needed to escort inmates from the housing areas to the program rooms, often on adjacent floors, requiring the use of elevators (stairwells are never used to move inmates between floors). The time needed to move inmates also reduces the room's use.

Recreation Yard Capacity and Access

The Main Jail has three recreation yards, each of which is two stories tall. Each has a capacity of 52 based on the requirements of CCR Title 15. The Sheriff's office calculates that the Main Jail's schedule leaves about 11 hours a day, 7 days a week available for inmate activities. On the basis of space and schedule alone, the existing recreation yards could provide the required three hours of recreation time per week for 4,004 inmates. Despite this apparent abundance, several factors further limit the recreation yards' ability to serve the entire population.

The first factor is the path-of-travel between housing units and the recreation yards. The three are shared among the six housing floors. Because the yards are located at tier levels between floors, inmates either need to take a stair up from the lower floor or down from the upper floor to access the yard level. A single elevator has access to the yard levels but moving inmates by elevator to get to a recreation yard presents operational, staffing and security challenges. Although a path of travel is available, the inmate toilet on that level requires renovation to meet the accessibility requirements California Building Code Chapter 11B.

Second, special management yards are needed for some of the individuals in the behavioral health units and all those in Administrative Segregation, because by classification they must spend their out-of-cell time individually or in small groups for their own safety and/or the safety of others. While the existing large group recreation yards can be used to meet the required recreation time for these individuals and small groups, doing so uses the yards to the extent that the overall capacity of the jail is reduced.

A third factor is the time (not to mention staff) required to escort inmates from housing areas to the recreation yards.

Impacts of Recreation Yard Capacity

The recreation yard demand was calculated for the housing assignments using the assumptions described in Chapter 3.00. The three recreation yards provide 231 hours, with a total demand of 238 hours for all classifications that can be housed consistent with the assumptions. As a result, 121 inmates in general population would not be able to receive the required three hours of recreation time per week.

Miscellaneous Impacts

Other limitations of the Main Jail resulted in the facility's capacity being rated below demand for certain groups, either directly or as a secondary consequence.

Infirmary, Long-Term Medical, and Detox predominantly need housing without tiers and often without upper bunks. The only single-level housing in the Main Jail is the existing medical and mental health area and 100E through 300E on the 2nd Floor. These groups also require access to medical resources and accessible outdoor activity areas next to, or at least convenient to their housing. The 2nd Floor has 61 beds, and the estimated demand is 68 beds, not significantly greater. In this case, the issue is not the number of beds, but the lack of design features needed to support inmates with medical needs. While not all these amenities are required by Title 15, they are required by the consent decree.

In addition, though we have assigned mental health units to the available tiered housing pods, these inmate patients cannot use the upper tier levels due to ADA limitations as well as best practices. Thus, the ability to house inmates in the general population is further reduced.

Allocation of Main Jail Housing

To determine the capacity of the Main Jail under the consent decree, the consultant team allocated existing housing based on access to program rooms and recreation yards, as explained in the Assumptions section of Chapter 3.0 and in the sections above. The process went through a number of iterations, with the final one consisting of the following steps, in order of priority:

- The smaller units 300W and 400W on the 7th and 8th Floors were utilized for small, high acuity populations. Acute men and women were assigned to 300W, Ad Seg men to 400W on the 8th Floor, IOP women were added to 300W, and higher security women to 400W on the 7th Floor.
- All other women were assigned to the 7th Floor, beginning with IOP women in 400W. 100E was assigned to OPP women based on efficient unit capacity for the population and use of the east side program room.

- General population women were assigned to three other 7th Floor units, leaving one available for general population males.
- IOP males were assigned to 300W, 100E, and 200 E on the 3rd through 6th Floors. This fully utilized the program rooms for group therapy during JPS hours, so no OPP males could be accommodated.
- The remaining units on the 3rd through 6th Floors were assigned to long-term medical and general population males. Long-term medical males would be best assigned to the 3rd Floor for the best existing accessible path-of-travel afforded to a recreation yard.
- The infirmary would expand to 100 through 300E on the 2nd Floor.
- Recreation yard time was allocated to mental health and administrative segregation inmates first, with the remaining usable time allocated to general population. The number of general population males that could be accommodated was set based on remaining recreation yard resources rather than remaining bed availability.

The results of these allocations are described in the section below.

Population Reduction Results

Recognizing that the number of inmates that can be housed in the Main Jail under the consent decree is a function of the compromises that would need to be made, the analysis provides an order-of-magnitude view of the substandard level of performance that could be accomplished.

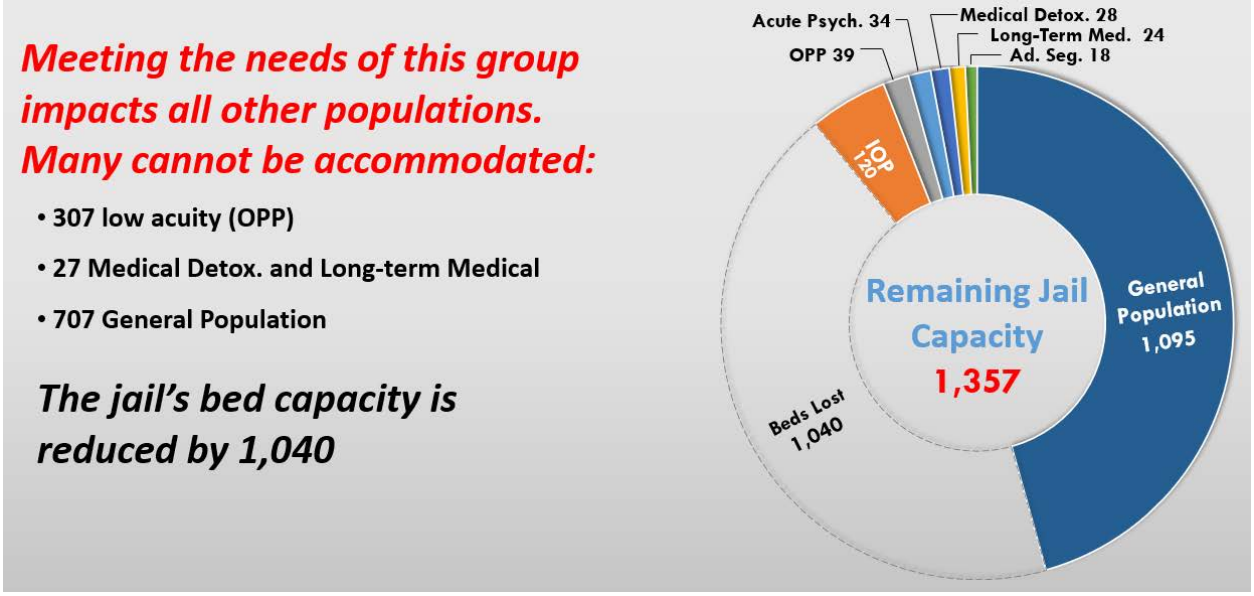
Table 4.05 shows a breakdown of the 1,357 inmates the Main Jail can house while generally complying with the consent decree, including the deficits for those populations that cannot be fully accommodated.

Table 4.05: Bed Needs Compared with Capacity

	Bed Need		Existing Adequate Capacity		Difference	
Housing Type	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
SMI Populations						
Acute Inpatient	27	4	27	4	0	0
Acute Inpatient/ADS1	3	0*	3	0*	0	0
IOP	103	13	102	13	(1)	0
IOP/ADS1	4	0*	4	0*	0	0
OPP	295	37	0	37	(295)	0
OPP/ADS1	10	2	0	2	(10)	0
Rated Medical Beds						
Long-Term Medical	32	4	21	3	(11)	(1)
Medical Detox	38	5	25	3	(13)	(2)
Administrative Segregation						
ADS1	6	1	6	1	0	0
ADS2	10	1	10	1	0	0
General Population	1,601	201	903	192	(698)	(9)
Subtotal Rated Capacity	2,129	268	1,101	256	(1,028)	(12)
Total Rated Capacity	2,397		1,357		(1,040)	
Infirmary†	20	10	9	3	(11)	(7)

* Small number in classification accommodated with compatible inmates.
† Infirmary is scoped for the study but is not counted in the rated capacity.

Figure 4.06 Impact on Other Populations



Attempting to meet the consent decree in the Main Jail without making changes to the facility reduces the jail's capacity by 1,040 inmates and, even then, it fails in meeting consent decree requirements. Even at the reduced capacity, the jail fails to accommodate the following groups which would have to be housed elsewhere:

- 307 low-acuity OPP patients.
- 27 medical detox and long-term medical patients.

In addition, 707 beds are rendered unavailable even for the general population inmates.

Table 4.06 below shows the degree to which the principal facility-related requirements of the consent decree would be met (green), partially met (yellow), or not met at all (red).

Table 4.06 Remaining Compliance Shortfalls

	Compliance Level
II. Americans with Disabilities Act (ADA) Compliance	
D. Screening for Disability and Disability-Related Needs	
F. Health Care Appliances, Assistive Devices, Durable Medical Equipment	
H. Access to Programs, Services and Activities	
Q. Accessibility Remedial Plan to Address Physical Plant Deficiencies	
V. Mental Health Care	
F. Placement, Conditions, Privileges, and Programming	
1. Placement	
2. Programming and Privileges	
3. Conditions	
4. Bed Planning	
5. General Exclusion of Prisoners with Serious Mental Illness from	
6. Access to Care	
G. Medico-Legal Practices	
H. Clinical Restraints and Seclusion	
I. Training	
VI. Medical Care	
A. Staffing	
B. Intake	
C. Access to Care	
D. Chronic Care	
E. Specialty care	
F. Medication administration and monitoring	
G. Clinical space and medical placements	
H. Patient privacy	
I. Health Records	
L. Reproductive and Pregnancy-Related Care	
M. Transgender and gender nonconforming health care	
N. Detoxification protocols	

	Compliance Level
VII. Suicide Prevention	
A. Substantive Provisions	
B. Training	
C. Nursing Intake Screening	
D. Post-Intake Mental Health Assessment Procedures	
E. Response to Identification of Suicide Risk or Need for Higher Level of Care	
F. Housing of Inmates on Suicide Precautions	
G. Inpatient Placements	
H. Temporary Suicide Precautions	
I. Suicide Hazards in High-Risk Housing Locations	
J. Supervision / Monitoring of Suicidal Inmates	
K. Treatment of Inmates Identified as at Risk of Suicide	
L. Conditions for Individual Inmates on Suicide Precautions	
O. Beds and Bedding	
VIII. Segregation / Restrictive Housing	
A. General Principles	
B. Conditions of Confinement	
C. Mental Health Functions in Segregation Units	
D. Placement of of Prisoners with Serious Mental Illness in Segregation	
E. Administrative Segregation	
b) **Administrative Segregation Phase 1:**	
c) **Administrative Segregation Phase 2:**	
F. Protective Custody	
G. Disciplinary Segregation	
Quality Assurance Systems for Health Care Treatment	
Generally	
Quality Assurance, Mental Health Care	
Quality Assurance, Medical Health Care	

Summary of Conclusions

Even with the bed reductions stated above, the Main Jail as-is cannot achieve substantial compliance with the consent decree. Acute Inpatient and IOP inmates can be housed in circumstances that allow them to receive their required group therapy and recreation time, but the plan still leaves 307 OPP males and 27 Medical Detox and/or Long-term Medical inmates unserved. Achieving this partial level of compliance is at the expense of losing 1,040 beds, reducing the maximum capacity of the Main Jail to 1,357 inmates.

In summary, the Main Jail is also unable to meet the following requirements of the consent decree:

- Minimum group therapy time requirements cannot be met for all mental health patients.
- Existing housing is inadequate to safely serve the mental health populations. There is a limited number of single-level housing units and excessive movement is required to access recreation and confidential rooms for group therapy.
- The clinic and intake areas are not ADA or HIPAA compliant. The lack of accessible, confidential interview space is a major impediment to screening and properly identifying and serving the medical, detox, and mental health needs of arrestees for the proper provision of in-custody services.
- The Clinic cannot provide all the required services. Insufficient spaces exist to provide simultaneous or timely specialty care clinics, nor is there even minimally adequate storage (such that boxes and supplies are stacked throughout).

- The Infirmary and Long-Term Medical housing do not provide direct access to outdoor recreation from the 2nd Floor; rather access requires escort via Elevator #4. There will usually be a few Infirmary patients able to engage in some level of activity if given their weekly recreation time, and inmates in Long-Term Medical will typically be able to engage in normal or adaptive activities.
- Medical beds do not fit in any of the 2nd Floor's patient rooms, including those in the Infirmary.
- The Main Jail already lacks the support space needed for current treatment staff, much less the additional staffing planned to meet the consent decree. Use of the existing program rooms for group therapy will further reduce the amount of staff space available. This will impact jail program staff as well as medical and mental health clinical staff.

Additionally, the entire jail population would experience reductions in several services because of serving the planned of mental health patients and administrative segregation inmates:

- Prioritizing the scheduling of program rooms for group therapy of high acuity mental health patients reduces access for other types of inmates to programs and opportunities for out-of-cell time.
- With only large-capacity recreation yards and no smaller special management yards for special populations, the inability to meet Title 15 requirements for outdoor recreation would result in a loss of 121 general population beds.

Finally, there remain deficiencies that impact the entire jail population:

- Without the ability to expand and remodel the clinic, medical services will remain noncompliant and substandard.
- Accessibility of many jail services to inmates with disabilities will remain noncompliant, including intake, the clinic, inmate housing, visiting, and recreation.

As a final note, though not a focus of the current study or this report, it is important to recognize that there are many factors related the Main Jail's design and construction that, while they might allow remediation to meet a few of the consent decree's requirements, they make such interventions impractical and/or prohibitively expensive. These include structural limitations and the security and operational impacts that result from construction within a jail, especially one that must remain operational 24/7.

[i] Murphy Conservatorships are court-ordered appointments of guardians for those unable to handle basic needs for themselves, and who are incompetent to stand trial, have outstanding felony charges causing great physical injury or death, are gravely disabled with a psychiatric disorder, and who pose a threat to self and /or others.

5.0 APENDICES

Firm Bios

nacht&lewis

FIRM BIO

Established in 1922, Nacht & Lewis has provided professional planning and architectural design services to California clients for 97 years as a California Corporation.

Throughout the years, we have built an outstanding reputation for designing innovative solutions with integrity and dedication. Our portfolio includes a number of award-winning projects for Federal, State, County and local government agencies. We are led by four managing principals where each principal oversees a different market sector, allowing for a focused and dedicated leader for each unique client type.

History of Detention and Corrections Work

Nacht & Lewis has over 50 years of justice experience and 38 years designing correctional environments such as new county jails, juvenile halls and California State Prison medical and mental health facilities. Our history in correctional design began in 1980 with Sacramento County, designing various new facilities and renovations at the County's Rio Cosumnes Correctional Facility. These experiences ultimately led to Nacht & Lewis' selection for the design of the downtown Sacramento Main Jail in partnership with HOK. Since that time, Nacht & Lewis has provided architectural design and planning services for jail projects in numerous California counties. These projects range in scale and complexity from large new jail facilities to facility renovations. Our work spans the state of California and into Nevada; our list of jail clients includes Amador, Butte, Colusa, El Dorado, Lake, Marin, Merced, Mendocino, Mono, Napa, Placer, Riverside, Sacramento and Siskiyou Counties.

Jay Farbstein & Associates

FIRM BIO

Jay Farbstein & Associates, Inc. is a leading practitioner of adult and juvenile correctional facility planning.

- We offer a comprehensive range of **corrections planning and related services** that include:
  - needs assessments to define system operations and long term needs
  - facility programs, including operational and architectural programs
  - site selection and master planning

- design consulting to ensure that program requirements are satisfied
- training and organization of training programs
- facility users manuals
- design evaluation studies
- expert witness in conditions of confinement cases.

- We have planned correctional facilities of a **wide range of sizes and types**, from small jails and juvenile detention facilities to large, maximum security prison complexes. These include, among others:

  - local, state and federal jurisdictions
  - large and small jails
  - medium & maximum security prison complexes — up to 3,000 beds
  - additions to existing facilities
  - facilities for juveniles, women, work release, and special populations such as mentally disturbed and drug and alcohol abusers.

- We have planned many **dozens of projects**, for many thousands of beds, valued at billions of dollars.

- We are at the **forefront of corrections planning methods**, many of which we developed for the National Institute of Corrections, National Institute of Justice, and California Board of Corrections. We have published numerous articles and books, such as our *Correctional Facility Planning and Design,* published by Van Nostrand Reinhold.

- Our methods entail a high degree of **client and user contact**. This involvement ensures a facility responsive to the needs of owners and staff.

- We are familiar with correctional **programs** as well as the activities and needs of all the various actors, including staff, community agencies, and inmates. We have planned areas for intake and release, living, dining, food preparation, education, recreation, crafts, shops, industries, counseling, visiting, administration, and courts.

- We are familiar with the range of **operating philosophies** which managers hold for correctional facilities — including special expertise in direct supervision — and are prepared to assist managers in developing facilities which are well matched to their intended operations.

- We are familiar with security and safety requirements for detention facilities.

- Our correctional facilities have been widely recognized. We have received awards from the American Institute of Architects, the American Correctional Association and Progressive Architecture magazine for the design, planning, and research of correctional facilities.

FALCON™
Reimagining Correctional Behavioral Health

FIRM BIO

Falcon, Inc. is a nationwide consulting and management firm that brings together the most distinguished and credentialed leaders in Correctional Mental Health. With dozens of specialized correctional mental health experts and hundreds of years of collective experience, Falcon Inc. exists to ensure jail and prison programs are successful and effectively address the unique challenges of the mental health population.

Falcon Inc. experts work in partnership with government and community leaders to advance mental health programs in jails and prisons, focusing on specific challenges and partnering with decision makers willing to seek change. Whether it's establishing sustainable care, jail planning, expansions, increasing inmate and staff safety, reducing liability, refining systems or reintegration strategies, Falcon, Inc. designs and implements custom programs to meet the industry's most complex mental health needs.