
October 7, 2026

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Re: DRC's Investigation and Findings, Butte County Jail and Behavioral Health Systems

Dear Sheriff Honea, Undersheriff Calkins, Mr. Hobson, and County Counsel:

Disability Rights California ("DRC") and its authorized agent, Aaron J. Fischer, have been investigating Butte County's jail and behavioral health systems pursuant to DRC's authority as California's protection and advocacy agency for people with disabilities. DRC initiated its investigation in August 2025. This letter summarizes our initial findings regarding Butte County Jail ("Jail").¹ Our investigation is ongoing.

We would like to thank leadership and staff from Butte County Sheriff's Office ("BCSO"), Butte County Behavioral Health ("BCBH"), and Wellpath (the contracted Jail health care provider) for their cooperation and professionalism during this process. We have been impressed by your willingness to share operational challenges, recognize areas

¹ DRC is also investigating Butte County's behavioral health system and intends to work with BCBH to address any deficiencies that we identify with respect to that system. As discussed below, there is significant overlap between the Jail and behavioral health systems. DRC has identified coordination challenges between BCSO and BCBH. *See* Section II.G.

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for growth, and consider strategies to resolve issues. We are confident that the County approaches these matters with a desire to meaningfully serve Butte County residents.

Despite leadership and staff's positive efforts and intentions, systemic deficiencies exist in Butte County that result in the denial of essential treatment, accommodations, and services for people with disabilities, both during incarceration and upon release.

DRC has identified policies, procedures, and practices that violate the Americans with Disabilities Act ("ADA"), Eighth and Fourteenth Amendments, and related law. DRC has further determined that there is probable cause to find that abuse and/or neglect of people with disabilities has or may have occurred, as those terms are defined in Disability Rights California's authorizing statutes and regulations.² These statutes and regulations authorize DRC to continue its investigation, including through accessing public and non-public documents and facility premises.³

This letter summarizes our initial findings regarding systemic deficiencies at the Jail regarding (1) the Jail's mental health care system, (2) the Jail's use of restrictive housing and solitary confinement, (3) the Jail's suicide prevention program, and (4) ADA compliance. We further provide findings on discrete aspects of the Jail's medical care system and environmental health and safety protocols. Finally, we provide findings regarding challenges, and recent improvement efforts, with respect to interagency coordination and critical information-sharing to serve people with disability and behavioral health needs.

We emphasize that Butte County possesses two significant advantages that will prove essential as necessary remedial measures are considered and implemented. First, the County benefits from notably strong, engaged leadership, both at the executive level and within its Corrections Division. Such leadership provides a genuine capacity for progress. Second, the new North Facility is well-designed and offers a meaningful opportunity to achieve the improvements that are required.

Given these strengths and the County's engagement with DRC to date, we are hopeful that we can work cooperatively with you to address the identified issues. We propose a meeting to discuss our findings and next steps.

² Cal. Welf. & Inst. Code ("WIC") §§ 4900(b), (g), (h); *id.* § 4902(a)(2); 42 U.S.C. §§ 10802(1), (5); 42 U.S.C. § 10805(a)(1)(A); 42 C.F.R. § 51.2.

³ WIC § 4902(b); 42 U.S.C. § 10805(a)(3); 42 C.F.R. § 51.42(b).

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I. BACKGROUND

A. DRC’s Investigation

DRC is the protection and advocacy system for the State of California. DRC is charged under state and federal law with investigating and protecting the rights of people with disabilities.⁴ For purposes of this investigation, DRC has designated the Law Office of Aaron J. Fischer as its authorized agent. DRC and Mr. Fischer have experience investigating and working with county agencies to address deficiencies in jail and behavioral health systems. In recent years, we have conducted investigations of county jail and/or behavioral health systems across the State, including in Alameda, Kern, Los Angeles, Napa, Orange, Sacramento, San Diego, San Joaquin, San Mateo, Santa Barbara, Sonoma, and Tulare counties. These investigations have led to important systemic improvements, which were realized through constructive engagement with the counties’ leadership and staff and, in some cases, through litigation. DRC’s public findings and reports can be found on DRC’s website.

⁴ DRC’s authority comes from WIC § 4900, *et seq.*; the Protection and Advocacy for Individuals with Mental Illness (“PAIMI”) Act, 42 U.S.C. § 10801, *et seq.*; 42 C.F.R. Part 51; Developmental Disabilities Assistance and Bill of Rights (“PADD”) Act, 42 U.S.C. § 15041, *et seq.*; 45 C.F.R. Part 1326; the Protection and Advocacy for Individual Rights (“PAIR”) Act, 29 U.S.C. § 794e; 34 C.F.R. Part 381.

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DRC opened its investigation into Butte County after receiving complaints that the County's Jail and behavioral health systems are failing to provide adequate behavioral health care as well as meaningful access to programs and services to people with disabilities, in violation of federal and state anti-discrimination laws, among other constitutional and legal requirements.

DRC and Mr. Fischer conducted site visits in Butte County in September 2025 and again in May 2026. We toured the Jail and county behavioral health facilities; interviewed incarcerated people with disabilities; and met with leadership and staff from BCSO, BCBH, the Psychiatric Health Facility ("PHF"), Wellpath, contract public defenders, and community advocates. We reviewed extensive records provided by the County. We reported and helped resolve several individuals' concerns related to their disability, medical, mental health, or other basic needs.

On July 27, 2026, we provided [initial findings and recommendations](#) regarding the County's Jail Medication Assisted Treatment (MAT) and Substance Use Disorder-related services. We sent a [follow-up letter](#) on September 14, 2026. We look forward to seeing meaningful progress on those topics in the near term.

The [Sheriff's Office](#) and [BCBH](#) have reviewed our findings and recommendations and each provided a written response, including on steps that the County is taking in light of issues we have identified as requiring remedial action.

B. Butte County Jail Population and System Overview

The current Butte County's Main Jail facility opened in 1964, with a second part added in the 1990s. A newly constructed North Facility, built adjacent to the Main Jail, will provide a new booking/intake unit as well as six (6) housing units. As of May 2026, the booking/intake unit and two (2) housing units had been activated and were in use.

Data collected by the Board of State and Community Corrections shows that Butte County Jail's average daily population was 524 as of December 2025. Since 2020, the average Jail population from month to month has ranged between approximately 450 and 565 incarcerated individuals. Historically, Butte County's Jail incarceration rate has been significantly higher than the statewide average. The County reports approximately 800 new jail bookings per month.

The County reported having 381 people on the mental health caseload in September 2025 and 365 people on the mental health caseload as of May 2026. This amounts to more than two-thirds of the overall jail population. Forty-six (46) people were identified as having a serious mental illness at the time of our September 2025 visit, though BCBH reports an estimated average of 60 incarcerated people having a serious mental illness at a given time.

Seventy-six (76) incarcerated people were identified as having "ADA/Special Needs" at the time of our September 2025 visit. As discussed below, processes for identification and tracking of people with disabilities require improvement.

II. INVESTIGATION FINDINGS

A. Mental Health Care System Deficiencies

1. *The Jail Lacks Structured Mental Health Care and Programming Necessary to Meet the Population's Treatment Needs.*

A remarkably large proportion of people incarcerated in the Butte County Jail have behavioral health needs, with scores of incarcerated people having a serious mental illness. Such data does not make Butte County an outlier in the state.⁵ However, Butte County Jail is behind other California counties in the provision of adequate mental health care services consistent with constitutional and legal requirements.

DRC observed many people with serious mental illness in states of decompensation and distress who did not have access to meaningful treatment. They were frequently placed in highly restrictive isolation settings that in fact contribute to the worsening of existing mental health conditions. *See* Section II.B, below.

We strongly urge the County to develop and implement designated, therapeutically driven mental health units to meet the treatment needs of the Jail population and applicable constitutional requirements.

In May 2026, we observed the designated Jail-Based Competency Treatment (JBCT) unit in the newly activated North Facility, which serves people deemed Incompetent to Stand Trial by a court. The unit's layout provides enormous opportunity, with space for dayroom, group programming, confidential clinical contacts, and adjacent access to outdoor recreation.

A second, similar North Facility unit was housing several men who had serious mental illness and/or cognitive disabilities. There was programming space in the unit but no structured therapeutic services. Individuals received less than one hour/day out of their cells, making the unit functionally one of solitary confinement.

The Main Jail facility's housing units lacked not only structured programming for the many men and women with mental health treatment needs but also adequate space to provide meaningful group and individual treatment activities.

Numerous people we interviewed expressed an interest and desire to participate in group treatment activities to help them improve their mental health and prepare for successful reentry into the community.

Moving forward, the provision of clinically necessary services—including structured individual and group treatment—to people with mental health disabilities in a therapeutic setting should be among the highest priorities for Jail and Wellpath leadership. The North Facility units provide a real opportunity to achieve this essential

⁵ Magnus Lofstrom & Brandon Martin, [*County Jails House Fewer Inmates, but Over Half Face Mental Health Issues*](#), Pub. Policy Inst. Of Cal. (Oct. 25, 2023).

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remedy, but there will also need to be sufficient mental health staffing and operational resources.

There are several California county jail systems that provide useful models for such an effort. Foundational to such an effort will be the development of a levels-of-care system, with defined clinical criteria, structured programming, and individualized treatment planning.⁶ The Jail reports that Wellpath is “fully staffed” with three mental health clinicians (including one who serves in a Mental Health Coordinator role in addition to providing direct care). It is our strong impression that additional mental health staff will be needed to deliver all necessary services to the population.

As discussed in Section II.G, below, it is essential to pair this mental health treatment with effective diversion and reentry services that connect people to housing and community mental health services in order to reduce recidivism and future in-custody mental health care demands. DRC does not support efforts that would expand the Jail system’s overall bed capacity.

2. *The Jail Does Not Provide Required Confidentiality for Clinical Contacts.*

Confidentiality for individual clinical mental health encounters is the standard of care and is necessary to comply with constitutional requirements.⁷

Jail mental health staff expressed a commitment to providing confidential clinical contacts whenever possible. However, given current operational procedures and physical plant challenges, confidential care is not consistently provided.

People reported having cellside mental health contacts, with the conversation occurring through the closed cell door. They also described being seen by mental health staff in a holding cell or room with a deputy standing *in the room* able to hear the entire clinical exchange. Such contacts are *not* confidential and do not meet the standard of care or constitutional requirements. People are understandably reluctant to discuss with mental health staff sensitive topics such as mental health symptoms, medication side effects, suicidality, and trauma without appropriate privacy. In detention settings, confidential clinical contacts must be the default, with modifications or exceptions as appropriate to address any security concerns identified through individualized assessment.

We expect that the new North Facility’s full activation will facilitate opportunities to provide confidential clinical contacts as a matter of course. Policy and practice, for both custody and healthcare staff, should be updated and aligned. Attention must also be given to confidentiality requirements in the Main Jail facility, including through utilization of new treatment spaces.

⁶ See Cal. Code Regs. Tit. 15, § 1210 (requiring Individualized Treatment Plans).

⁷ See, e.g., *Gray v. Cnty. of Riverside*, No. EDCV 13-00444, 2014 WL 5304915, at *10 (C.D. Cal. Sept. 2, 2014); *Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1184, 1210-1212 (M.D. Ala. 2017).

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We note our considerable concern with the planned use of telephone-booth-sized wire mesh enclosures (commonly referred to as “cages”) to hold mental health patients during all clinical contacts, including in the newly activated North Facility units.⁸ Similar enclosures were criticized by the United States Supreme Court.⁹

Putting people into these small cage-like enclosures as a blanket rule does not comport with modern detention practices. We have observed that such a practice serves as a deterrent to attending appointments, further negatively impacting provision of treatment. We are in fact aware of California sheriffs who have rejected their use.

We urge the Jail to provide mental health treatment in the least restrictive setting appropriate, and to avoid such a counter-therapeutic restriction unless security issues based on individualized assessments require it. If individualized clinical or security factors are such that the provision of confidentiality cannot occur, it should be documented (with the specific reason noted) and reviewed by supervisory staff for quality assurance. Treatment, like other programs, services, and activities, must be provided in the most integrated setting appropriate to each individual with a disability.¹⁰

3. *The Jail Lacks a System to Ensure Adequate Psychiatric Services.*

DRC has found that the County fails to ensure timely and appropriate psychiatric medication and care at the Jail, due in large part to insufficient psychiatric provider availability. At the time of our September 2025 visit, there was only one psychiatric provider for the Jail, and that provider was working only one eight-hour telepsychiatry shift per week. This psychiatric provider coverage was plainly inadequate, and it contributed to people with disabilities not receiving timely and adequate psychiatric services.

When there is insufficient psychiatric provider availability to meet demand, it is common—but not acceptable—for other mental health staff to act as “gatekeepers” who limit access to services. At Butte County Jail, before an incarcerated person can see a psychiatrist, they generally must first see a mental health clinician, who determines whether a follow-up with a psychiatric provider is clinically indicated. Our investigation found that mental health clinician staff have been overly restrictive in connecting patients with a psychiatric provider.

DRC spoke to a number of incarcerated individuals during our September 2025 visit who reported that they had diagnosed mental health conditions, had requested psychiatric medication at the Jail, and had the Jail’s mental health clinician decline to

⁸ Perplexingly, people report being locked in these cage-like enclosures even during telepsychiatry appointments when they are *alone* in a locked room.

⁹ *Brown v. Plata*, 563 U.S. 493 (2011), Appendix C (embedding photo of such cages in support of finding of constitutional violations).

¹⁰ 28 C.F.R. § 35.130(d); 28 C.F.R. § 41.51(d).

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refer them to the psychiatric provider. In multiple cases, DRC inquired regarding such patients, which led to provision of clinically indicated psychiatric medications.

Inadequate psychiatric provider availability also contributes to disruptions in continuity of care. We spoke to multiple individuals who were taking psychiatric medication prior to arriving at the Jail but could not continue their medications in Jail because staff could not “verify” the prescriptions. As a result, these individuals, who often have lengthy psychiatric histories, decompensate during lengthy delays to see the psychiatric provider. One woman had been at the Jail for five days and was still waiting to have her psychiatric medications restarted. She reported difficulty sleeping, mood swings, increased anxiety and negative thoughts while she was without her medications. We identified other people who had gone even longer without necessary medications.

Issues with verification of prescriptions is a common challenge in Jail healthcare and one that must be addressed. The standard of care in jails is for individuals who report taking psychiatric medication prior to incarceration to be promptly assessed by a psychiatric provider if the prescription cannot be verified. This has not reliably occurred at Butte County Jail, a deficiency that likely cannot be remedied absent sufficient psychiatric provider staffing.

In addition, we are informed that psychiatry coverage is being provided entirely by telehealth. Appropriate psychiatry telehealth procedures may in most cases provide for clinically adequate care. However, jail/prison mental health experts advise that some amount of on-site coverage is important, including for psychiatric providers to observe the setting where their patients are detained and to address challenging patient cases.

DRC has additional concerns about access to psychiatric medication and care for people being released from the Jail. The default procedure is for Jail staff to call in prescriptions to an outside pharmacy for patients to pick up after they are released. A supply of medication is provided upon release, per policy, only “when appropriate” and for a limited category of individuals, such as people in the “Mental Health Special Needs” monitoring program.

Many people with mental health disabilities at the Jail are not enrolled in this program and do not receive their prescriptions upon release. Our investigation found, based on Jail census data for September 23, 2025, that there were only 61 individuals designated “Mental Health Special Needs,” yet nearly twice that number were prescribed at least one psychiatric medication. We spoke with staff, incarcerated individuals, and community service providers who reported that many people receiving psychiatric medication in the Jail experienced a significant break in access to medication following release. Such a system risks decompensation and re-incarceration that in many cases can be avoided with better release planning and medication continuity practices.

The California Department of Corrections and Rehabilitation (CDCR) provides individuals with a 60-day supply of psychiatric medication upon their release from state prison. Many county jails in California also provide a multi-week supply of medications upon release, with positive outcomes. The Justice-Involved (“JI”) Reentry Initiative, a

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new Medicaid Waiver that is part of the state's program to expand Medicaid, California Advancing and Innovating Medi-Cal ("CalAIM"), seeks to improve continuity of care. One of the program's mandates is for all counties to provide a supply of prescribed and over-the-counter medication upon release from jail. The Jail has indicated that its deadline to implement the JI Reentry Initiative is October 1, 2026, and so we expect that individuals released from Jail after that date will be provided with adequate supplies of medication. We look forward to monitoring the implementation of the JI Reentry Initiative.

The County and Wellpath have taken concrete steps to address psychiatric provider coverage since we raised it in 2025. When we returned for our May 2026 visit, Jail leadership shared that psychiatric provider coverage had recently been increased from eight (8) hours per week to twenty-four (24) hours per week. This is a positive and meaningful step. Ongoing assessment is needed to ensure that the current staffing model meets the needs of incarcerated people with mental health disabilities, including continuity of care at all stages of detention.¹¹

When a psychiatric medication cannot be verified upon booking, Jail staff should refer the person to a psychiatric provider for prompt evaluation. In addition, the County should audit the Jail's referrals (and non-referrals) to psychiatric providers to determine whether there are improper barriers to psychiatric care.

B. Overuse and Misuse of Isolation, Particularly for People with Mental Health and Intellectual Disabilities

Generally, when our offices evaluate a jail system's use of isolation or restrictive housing units (called "Administrative Separation" at Butte County Jail), we examine: (1) who goes into isolation; (2) how long they stay; (3) how they get out; (4) conditions in the isolation units; and (5) whether there are viable, appropriate alternatives, especially for people with mental health or intellectual disabilities. The features of the Jail's Administrative Separation housing system are consistent with established definitions of solitary confinement and raise very significant legal and constitutional concerns that require urgent action.

There are numerous cells and units at the Jail that operate as Administrative Separation housing, including the A unit, the F unit, a portion of the W unit, and several individual cells situated throughout the Main Jail facility. At least one of the recently activated North Facility units was also being operated as Administrative Separation when we toured it in May 2026.

¹¹ We are informed of the County and Wellpath's recent implementation of a psychiatry residency rotation. Such a program can bring resources and energy to the Jail's mental health system and may also serve as a useful staff recruitment tool. We support this program while cautioning that there must be adequate clinical supervision of residents.

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The County reported that, as of May 2026, there were 63 people in Administrative Separation, approximately 12% of the overall incarcerated population. Based on our observations, it was apparent that many people held in this extremely restrictive setting have mental health and/or intellectual disabilities. We reviewed housing rosters indicating that 93% of the Administrative Separation population was on the mental health caseload, and that 52% were identified as having a “serious mental illness” (meaning that this group is overrepresented in Administrative Separation by a factor of 6 as compared to the overall Jail population). Many people in Administrative Separation very clearly require a higher level of mental health care.

Living conditions in the Administrative Separation housing areas are extremely restrictive, isolating, and unsafe. For individuals in the A unit, F unit, and North Facility Administrative Separation units, individuals have extremely limited access to dayroom or “recreation” space. With the exception of the North Facility unit, there is essentially no access to natural light. When individuals are out of their cell, they are alone, without the opportunity for meaningful social interaction. Staff reported that they endeavor to provide 45 minutes/day of out-of-cell time in the dayroom, which is also the only opportunity to shower or use the phone. Our review of yard/dayroom logs over a recent one-month period confirms this to be the practice. It is extremely unusual for someone to be provided more than one hour of out-of-cell time on a given day. The log further indicates that people in Administrative Separation units A and F “refused” yard more than 90% of the time. In our experience, such a high “refusal” rate indicates deficiencies in the offering and provision of recreation yard.¹²

Conditions are even more restrictive in the individual Administrative Separation cells at the Main Jail facility. These cells have no access to a dayroom. The cells are exceedingly small, with nothing more than a bed frame, a small metal table, and a toilet with a sink mounted atop. There are just a few square feet of floor space for a person to stand. As discussed in Section II.C, these units have been hotspots for serious suicide attempts and a recent suicide death.

Many of the Administrative Separation housing areas lack direct supervision, meaning that staff cannot observe individuals to ensure safety (other than periodic walk-by checks, also discussed in Section II.C). Of additional concern, we observed that emergency call buttons in several Administrative Separation cells were not functioning, leaving people without an effective method to summon help in the event of an emergency.

¹² The system as it currently operates does not appear to comply with California State regulations on minimum out-of-cell time. *See* Cal. Code Regs. Tit. 15, § 1065 (mandating a “minimum of 10 hours of out of cell time distributed over a period of seven days to include (1) an opportunity for three hours of exercise, and (2) an opportunity for seven hours of recreation”).

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Photo: Administrative separation cell (Women's Unit, U2)



Photo: Administrative separation cell (Women's Unit, R2)

The acuity of mental illness in these units cannot be overstated. We observed one man in Administrative Separation to be unclean and unkempt. He told us, “I rub feces in my beard, put feces in mouth, and spit it.” Isolation without meaningful therapeutic activities worsens this man’s condition and increases the risk of harm to his health and well-being.

We spoke with women in Administrative Separation who could not coherently communicate and showed signs of decompensation, poor hygiene, and an inability to complete basic daily activities on their own. One woman with diagnosed serious mental illness reportedly had not been provided her psychiatric medication in several weeks. She was not doing well in Administrative Separation. She had recently completed a period on suicide watch, where staff had taken her clothes and provided her a safety smock. When we met with her, approximately five hours after she discharged from suicide watch, she was still in a safety smock. It was unclear why she remained in a safety smock, an item that is appropriate *only* in clinically indicated cases while a person is on suicide precautions.

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We met with one man who reported suicidality (specifically, a “plan to slice his throat, the sooner the better”) when he arrived at the Jail. He was placed on the Jail’s Suicide Prevention Protocol for 11 days, the entire period of which he was held in Administrative Separation without his personal property. He reported that he was not permitted to shower, a restriction that was causing him significant distress. A log indicated that he had not been allowed out of his cell for the 11-day period.



Photo: Administrative separation cell, man on suicide precautions on floor under a safety smock in foreground (Men’s A Unit)

We were informed that it is a relatively frequent practice for people requiring suicide precautions to be placed in Administrative Separation, often for multiple days at a time.

The extreme and disproportionately high representation of people with mental health or intellectual disabilities in Administrative Separation raises significant concerns under both disability antidiscrimination law and the Eighth and Fourteenth Amendments.¹³

Regular and adequate monitoring of people in isolation-type housing is also essential. The National Commission on Correctional Health Care (“NCCHC”) advises that such individuals receive *daily* monitoring contacts from a qualified health care professional (“QHCP”), and at least *weekly* contacts from a qualified mental health

¹³ See *Coleman v. Brown*, 28 F. Supp. 3d 1068, 1095, 1099 (E.D. Cal. 2014) (placement of people with serious mental illness “in the harsh, restrictive and non-therapeutic conditions of California’s administrative segregation units for non-disciplinary reasons for more than a minimal period . . . violates the Eighth Amendment”); *Hernandez v. County of Monterey*, 110 F. Supp. 3d 929, 946-48, 960 (N.D. Cal. 2015) (“While housed in segregation, the mentally ill are especially vulnerable, and their mental health symptoms—including depression, psychosis, and self-harm—are especially likely to grow more severe.”).

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professional (“QMHP”).¹⁴ But at Butte County Jail, records indicate that even individuals with diagnosed serious mental illness, including those identified as being at risk of suicide or experiencing active hallucinations, receive QHCP checks just once per week (rather than daily) and QMHP checks just monthly (rather than weekly). The lack of adequate monitoring frequency for people in these high-risk settings must be remedied.

We have further concern about the adequacy of these monitoring checks themselves. We reviewed a sample of ten Administrative Separation rounding records covering a recent period of approximately two months. We did not observe documentation of a single referral to a mental health clinician, even where notes indicated that a person was “unkempt,” “speaking to unseen others,” or unresponsive. One nurse appears to utilize a copy-and-paste note across multiple patients: “[patient] resting in bed, eyes closed, breathing rhythmic and unlabored, 0 objective [symptoms] cardiac or respiratory distress noted, appearance appropriate for ethnicity.”

We were encouraged that the Jail’s classification team understood that Administrative Separation can be risky and harmful, particularly for people with mental health disabilities. The Jail’s policy and reported practice is for classification staff to review people housed in Administrative Separation, including with a face-to-face (cell-front) interaction, every seven (7) days, with a goal of moving individuals into less restrictive settings at the earliest possible time. This is good practice, though we recommend that reviews be done in a private out-of-cell setting whenever possible.

Classification staff reported that there is no “formal involvement” with mental health staff when making Administrative Separation placement decisions. This is concerning. Correctional standards require jail systems to take proactive steps to avoid the placement of people in Administrative Separation-type units because of a mental health condition or intellectual disability *and* to identify and prevent such placements if they are clinically contraindicated.

Wellpath recently reported to us that they have begun conducting individual evaluations to address this deficit. Based on our review of a sample of those evaluations, significant work remains. In multiple cases, the documented *reason* for the Administrative Separation placement was “Mental Health Concerns.” In one case, healthcare staff documented that “based on assessment and/or medical record review, placement [in segregated housing] is contraindicated,” with notification of that finding sent to custody staff. Yet that individual remained in Administrative Separation.

Butte County must reform its practices and implement new protocols to ensure that: (1) members of vulnerable populations, including people with mental health and intellectual disabilities, are not placed in restrictive housing; (2) mental health staff conduct assessments prior to any person’s placement in restrictive housing, with

¹⁴ NCCHC Standards for Mental Health Services in Correctional Facilities, MH-G-02, Restrictive Housing (Essential); NCCHC Standards for Health Services in Jails, J-G-02, Restrictive Housing (Essential).

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appropriate action taken; and (3) people in restrictive housing have adequate access to mental health care and follow-up.

The Jail should set defined upper limits on the period of time a person can remain in Administrative Separation, develop criteria and strategies to minimize use of Administrative Separation, and ensure that people understand why they are placed in Administrative Separation and when and how they will be removed from it. These reforms should be reflected in written policies that clearly define the criteria for placement in and removal from restrictive housing, review requirements, step-down processes, and documentation practices. Placement decisions should be documented in a timely manner, including the basis for the decision, participants in the review process, and any information communicated to the incarcerated person regarding their status, expectations, and opportunities for return to a less restrictive setting.

The Jail should also implement a multidisciplinary review board that includes mental health staff to regularly review placements in and retention in Administrative Separation. The board should assess whether there are any contraindications to placement in Administrative Separation, whether the reasons for placement continue to exist, whether continued placement remains necessary, and whether less restrictive alternatives are available.

The Jail must make changes to improve the conditions and operations in all restrictive housing, including Administrative Separation, on issues like out-of-cell time, provision of structured activities and socialization, in-cell opportunities for sensory stimulation, mental health checks, custody checks, and cleanliness. As discussed in the next section, it is our very strong recommendation that the County deactivate and cease using certain individual Administrative Segregation isolation cells in the Main Jail facility that are simply too dangerous to remain in use.

Core to achieving these essential improvements is the development of a meaningful levels-of-care mental health system with sufficient capacity, programming, and staffing to treat and care for people with mental health needs in less restrictive settings than Administrative Separation. *See Section II.A.1, above.*

We emphasize that meaningful change in this area is possible, and it is happening across the state. We have worked with several county jails to greatly reduce and in some cases nearly eliminate the use of solitary confinement-type housing, including in the

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counties of Kern¹⁵, Orange¹⁶, San Mateo¹⁷, and Santa Barbara¹⁸. The Jail should adhere to core principles regarding the use of restrictive housing, which we and other organizations have worked to compile.¹⁹

C. Deficiencies in Suicide Prevention and Dangerous Physical Plant Features

It is well established that people in detention settings, particularly those with existing mental health disabilities, are at heightened risk of suicide and self-harm. It is thus essential that a jail system implement an effective suicide prevention program with adequate policies and procedures for screening, clinical assessment and intervention, supervision, interdisciplinary coordination, emergency response, and training. The system must have procedures to review critical incidents, identify areas for improvement, and take appropriate corrective action.

Our investigation has revealed that Butte County Jail currently lacks an effective suicide prevention program, which puts people in detention at serious and unacceptable risk of harm.

A critical deficiency requiring urgent action is the dangerous misuse and overuse of solitary confinement-type housing, especially for people with significant mental health needs or a known history of suicidality. These isolation units impede normal interpersonal interactions that are essential to psychological health, lack adequate supervision, and stymie the delivery of clinically necessary treatment—all increasing the risk of suicide and serious harm.

We are aware of an in-custody suicide at the Jail that occurred during the period of our investigation. In March 2026, a man died by hanging in a dangerous isolation cell at the Jail. At his initial mental health evaluation, mental health staff noted a history of suicidal ideation and that the man was “somewhat emotional.” The follow-up plan simply checked a box reading “MH will follow up within ____ days or before ____ (date),” with neither blank filled in. He was shortly thereafter placed in an Administrative Separation isolation cell for “being disrespectful/rude towards custody staff.” The location of the isolation cell was down a hallway, with no direct supervision by staff.

¹⁵ Veronica Morley, [*Reforms reduce use of solitary confinement at Kern County Lerdo Jail by more than 95%*](#), KERO Bakersfield (Jul. 10, 2026, 5:01 pm).

¹⁶ Disability Rights California, [*Comprehensive Settlement Reached in Orange County Jail Investigation*](#) (Apr. 2022).

¹⁷ San Mateo County Sheriff’s Office, [*San Mateo County Sheriff’s Office Improving Correctional Facilities Through Collaboration with State and Nonprofit Monitors*](#) (Jan. 21, 2025).

¹⁸ Delaney Smith, [*‘Extreme Isolation Cells’ Banned from Santa Barbara County Jail*](#), Santa Barbara Independent (Jul. 21, 2020).

¹⁹ [*Practices and Principles for Remedial Measures Regarding the Use of Segregation in County Jails*](#), Prison Law Office & Disability Rights California.

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Four days later, the man communicated to custody staff that he wanted to speak with mental health. A mental health staff member visited his cell, finding the cell “disheveled,” but the clinician did not meet with the man because he was reportedly in the yard area. Later that day, the man hanged himself using a sheet that was secured to the bars of the cell door. The tied-off sheet around the cell door’s bars hampered staff’s emergency response efforts, as they were initially unable to open the door.



Photo: Isolation cell, with little room to stand, and with bars that have been used by suicidal incarcerated people as tie-off points

These cells are dangerous for many reasons: the severe level of restriction and isolation, the lack of supervision, the many tie-off points that facilitate suicide attempts by hanging, and more.

This man was found during a “post check” conducted by custody staff walking through the Jail. Custody logs show that these checks in isolation cell areas were conducted every 40 to 50 minutes. The practice is inconsistent with the American Correctional Association’s guidance directing that “all restrictive housing inmates are personally observed by a correctional officer twice per hour, but no more than 40 minutes apart, on an irregular schedule.”²⁰

Several county jail systems have committed to conducting safety checks for all people in solitary confinement-type housing at least every 30 minutes, at staggered intervals, with timely documentation and regular auditing by supervisory staff for quality assurance purposes. Examples include Los Angeles

County, Sacramento County, Santa Barbara County, and Orange County, among others. (We are also aware that, in October 2025, the Board of State and Community Corrections (BSCC) found the Jail noncompliant with a state regulatory requirement that safety checks occur at varied intervals.)²¹

²⁰ Standard 5-ALDF-2F-08, American Correctional Association, *Performance-Based Standards for Adult Local Detention Facilities* 48 (5th ed. 2023).

²¹ [Letter from Board of State and Community Corrections to Sheriff Kory Honea, Butte County Sheriff’s Office](#), (Oct. 24, 2025) (finding a violation of Section 1027.5 of Title 15).

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One month after the March 2026 in-custody suicide, another man had a serious suicide attempt, also by hanging, in a similar Administrative Separation isolation cell. He required outside medical care but thankfully survived.

Other incidents involving a suicide attempt or serious self-harm illustrate the Jail's need to change its practices, including with respect to placing higher-risk individuals in isolation units.

In one incident, a man held in the A pod Administrative Separation isolation unit was found bleeding profusely after self-lacerating his right arm. He was in extreme distress, kicking his cell door repeatedly as "a lot of blood" collected on the cell floor. Custody and medical staff worked to address the bleeding, and he was taken by ambulance to the hospital. He was treated and returned to the jail, *where he was placed right back into the same isolation unit*, with no clothing and only a safety smock. Records do not evince the development of an appropriate treatment plan to address this man's serious mental health needs. Stunningly, custody staff instead issued the man a major rule violation for the "Flagrant failure to follow safety or sanitation regulations." This sort of punitive response to an act of self-harm, without due consideration of mental health treatment needs and appropriate housing needs, is inconsistent with modern correctional standards and constitutional requirements.

Another man had three incidents of serious self-harm with indications of suicidality over a 10-day period in 2025. The Jail's response raises additional concern regarding the system's management of people at risk of suicide. The man, with a well-known history of suicidality (including two earlier suicide attempts at the Jail), was found in his dorm with multiple self-inflicted lacerations on his wrist. After going to an outside medical facility for care, he was returned to the Jail and placed on the Suicide Prevention Protocol. He was then, however, placed in an Administrative Separation cell, where three days later he was found purposely cutting his arm, again requiring treatment at an outside medical facility. He received medical care, was returned to the Jail, and was placed back in Administrative Separation. Six days later, he was found bleeding from his lower neck area, having stabbed himself with a pencil. Emergency medical services were summoned to transport him to a hospital by ambulance.

We have additional serious concerns about the Jail's practice of stripping people at elevated risk of suicide of all clothes and underwear and giving them only a "safety smock," made from heavy tear-free material fastened with straps or Velcro. These individuals are commonly held in a "safety cell," which is a small, windowless room with rubberized walls, no furniture, and no bedding. They are left to sit or lie on the ground, using a grate on the floor as a toilet.

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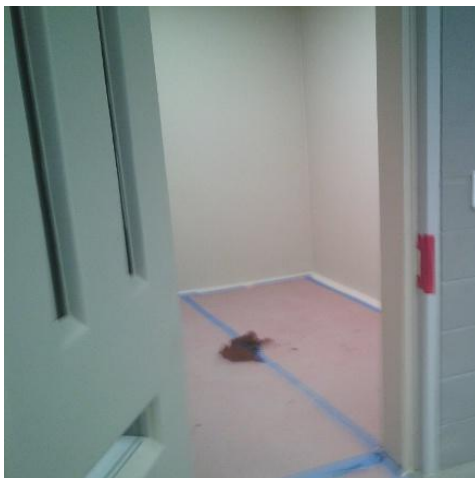


Photo: A “Safety Cell” that holds people at risk of suicide or self-harm, with a grate in the center of the floor to use as a toilet

Others on suicide precautions are commonly held in Administrative Separation, confined to their cells with nothing but a safety smock. These kinds of restrictions and conditions can be experienced as unduly punitive and can deter people with suicidal thoughts from seeking help. Such restrictions must be clinically (not custodially) driven and consistent with clear, carefully calibrated policy direction.

It is our very strong recommendation that the County deactivate and cease using the Administrative Separation isolation cells at the Main Jail facility (including Cells T1, T2, U1, U2, U3). **These cells are simply too dangerous to remain in use.** These cells constitute a hyper-isolation setting, are filled with dangerous attachment points, have no designated space for regular out-of-cell dayroom time, and do not allow for adequate supervision. Serious critical incidents occur in these cells with alarming frequency, including the March 2026 suicide. We urge the County to deactivate these dangerous isolation cells as it continues to activate the North Facility, which provides safer housing options and opportunities to shift the paradigm from isolation to treatment.²²

Physical plant deficiencies that raise the risk of suicide and self-harm must be eliminated wherever possible, most urgently in restrictive housing settings and in units housing people with mental health disabilities.²³

²² The County’s letter, dated September 24, 2026, responding to our findings states that the Sheriff’s Office has now discontinued use of the T and U section single cells.

²³ Suicide prevention expert Lindsay Hayes provides an essential resource on this topic. Lindsay M. Hayes, National Center on Institutions and Alternatives, [Checklist for the “Suicide-Resistant” Design of Correctional Facilities](#) (2016); see also NCCHC, [Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections](#) (2019).

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The Jail (and Wellpath) must reevaluate current suicide prevention protocols and make appropriate reforms that ensure safety and prevent the punitive and/or counter-therapeutic use of things like “safety smocks” and “safety cells.” Property, clothing, suicide-resistant furnishings and bedding, including an appropriate mattress, and privileges (e.g., social visits, out-of-cell time, showers) should be provided, consistent with individualized clinical assessments of each person’s current condition and needs.

D. Disability Antidiscrimination Law Compliance Issues

Under the Americans with Disabilities Act (“ADA”) and related federal and state law, the County is required to provide incarcerated people with disabilities equal access to the Jail’s services, programs, and activities.²⁴ To ensure equal and meaningful access, the County must make reasonable accommodations when necessary to avoid discrimination, unless such accommodation would fundamentally alter the nature of the relevant service, program, or activity.²⁵

The County must have effective systems in place to identify people with disabilities, track and provide disability accommodations, and ensure incarcerated people have an effective means of requesting accommodations and grieving disability-related concerns.

The current ADA/disability compliance system requires a near-complete reset, with affirmative efforts and outreach to individuals with disabilities. Below are areas of focus that are necessary for the Jail’s ADA/disability compliance work ahead.

1. The Jail Lacks Adequate Disability Identification and Tracking Systems.

To comply with the ADA, the Jail must develop a centralized tracking system that is available to and reliably used by custody, programs, and healthcare staff. We observed a lack of effective procedures to identify people with disabilities and their accommodation needs, and to track those needs to ensure they are addressed.

Disability identification and tracking at the Jail currently rely largely on informal communications. The lack of a centralized system means that individuals must repeatedly describe their disability and request accommodations from different staff members, resulting in gaps in the provision of necessary accommodations.

Identification must begin at intake with adequate screening. The Jail attaches an “ADA/Special Needs” flag to an incarcerated person’s electronic file, but the flag does not suffice to ensure compliance and accountability. The system must be upgraded to include identification, requests, individualized assessments, confirmed accommodation needs, and reasoning for the approval or denial of requested accommodations.

²⁴ 42 U.S.C. § 12132; 29 U.S.C. § 794; 28 C.F.R. § 35.130; Cal. Gov’t Code § 11135(b).

²⁵ 28 C.F.R. § 35.130(b)(7)(i).

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2. ***The Jail Fails to Provide Sufficient ADA-Related Notice and Information to the Jail Population.***

The Jail system must inform people with disabilities of their right to equal access and reasonable accommodations, including the accommodation request process and disability-related grievance procedures.

Although the Jail’s Custody Manual requires “notice to incarcerated persons regarding the rights and protections afforded by the ADA (e.g., posters, published notices, handbooks, and orientation . . . materials),” this policy has not been implemented. We observed no publicly available notice regarding the ADA that complies with federal disability law.²⁶

BCSO’s Jail Inmate Handbook itself is problematic with respect to disability accommodation information. The “ADA section” of the handbook lacks adequate guidance to individuals with disabilities beyond that they may “submit a Sick Slip to be seen by a medical provider to have their ADA needs assessed.” This does not constitute sufficient guidance. Multiple incarcerated people reported that they have submitted such requests via “sick slips” but never received a response.

The Jail Inmate Handbook’s non-discrimination statement is further concerning. It reads (emphases added):

Title II of the Americans with Disabilities Act of 1990

The Butte County Sheriff’s Office does not discriminate on the basis of disability in providing access to its facilities, programs, services, and activities. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990. If you have questions, complaints or request for additional information regarding the ADA, forward your inquiry to the **designated ADA Division Representative** by completing the **ADA Request for Accommodation Form**.

Notably, there is *no* notice as to who the “designated ADA Division Representative” is, and the Jail system does *not* currently have an “ADA Request for Accommodation” form.

One man in fact recently submitted a written “Inmate Request form” (a copy of which he shared with us) asking for the “ADA Request for Accommodation” form referenced in the handbook. Six weeks later, he still had received no response.

We observed signage in the Jail (specifically, in the medical services area) that *affirmatively deters* individuals from making reasonable accommodation requests, including for a lower bunk placement, housing without stairs, an extra mattress (to

²⁶ 28 C.F.R §35.106; *see also* 28 C.F.R. § 35.107(b) (requirement to “adopt and publish grievance procedures providing for prompt and equitable resolution of complaints”).

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accommodate physical disability/pain issues), and dietary accommodations. This signage is illustrative of the Jail's inadequate ADA policies and practices.

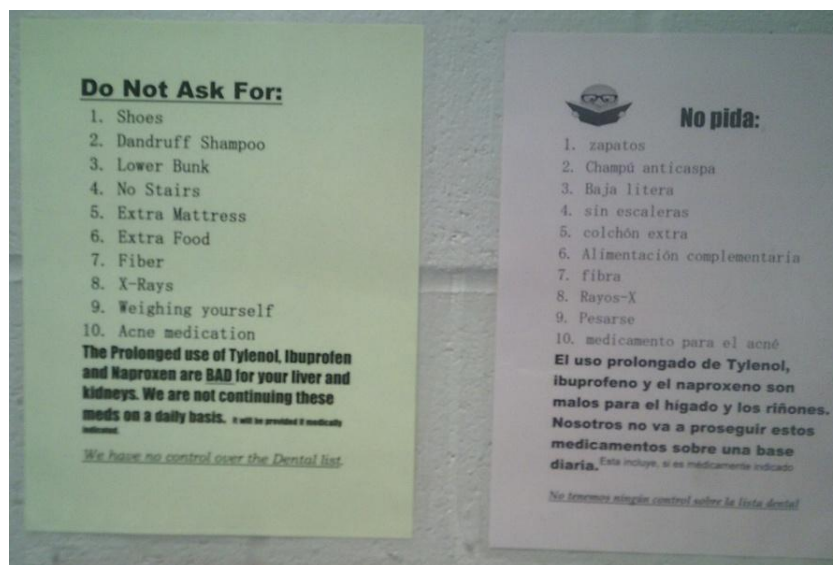


Photo: Signage discouraging certain reasonable accommodation requests²⁷

Nearly all incarcerated people with whom we communicated did not understand their rights under the ADA or the procedures for requesting accommodations at the Jail.

To be sure, we were impressed by the staff members who respond to concerns from people with disabilities, including the lieutenant who handles many ADA-related issues. However, there is not sufficient staffing allocation to allow for essential ADA Coordinator duties, including regular check-ins and follow-up to ensure that people with disabilities have the accommodations they need throughout their incarceration. Without designated ADA staff conducting regular documented contacts, an effective ADA accommodations system is unlikely to be achieved.

The County needs to update and improve its dissemination of disability rights-related information and documentation. DRC recommends designation of an ADA Coordinator who is dedicated to ADA/disability accommodation matters, with support from other custody and healthcare staff as warranted. The Jail should provide contact information for the ADA Coordinator on orientation materials, signage, and online for detainees' family members and loved ones to use.

3. *The Jail Fails to Ensure Provision of Assistive Devices as Reasonable Accommodations.*

We observed frequent failures to provide appropriate assistive devices and related assistance to people with disabilities at the Jail.

²⁷ The County's letter, dated September 24, 2026, responding to our findings states that this signage has now been removed and that staff have been trained regarding restrictions on access to care and accommodations.

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First, people have a range of disability needs that require individualized assessment and accommodation. There should be no one-size-fits-all restrictions when it comes to assistive devices, whether they be wheelchairs, walkers, knee braces, or anything else. It is essential that people have the appropriate assistive device to meet their individual needs (with clear procedures to address specific security issues).

One man reported that he has a neuromuscular condition which requires a mobility device. He arrived at the Jail with an electric wheelchair, which was taken at intake. The Jail provided him with a standard-size manual wheelchair in its place. However, for someone with a neuromuscular condition, the physical exertion required to operate a manual chair can lead to rapid fatigue, muscle degradation, or secondary injuries. A wheelchair can be highly specialized for an individual's support needs, mobility, measurements, dimensions, and accessibility features, and the failure to provide an individually suitable chair likely violates the ADA.²⁸

Jail staff later abruptly removed this man's manual wheelchair, based on a report that the man had been ambulating in his housing unit and a physician assistant's decision to "transition [him] from a wheelchair to a walker to encourage conditioning of his lower extremities." While a treatment plan that includes a goal of "conditioning" may be useful, we are concerned about the decision to remove the wheelchair. In this case, the man reported significant pain in his legs and that he "did not feel like his legs were getting any stronger." Three weeks after the wheelchair was taken, and after inquiry from our office, a physical therapy referral was made.

Second, the Jail must ensure reliable tracking of the appropriate assistive device needs for each person, rather than relying on accommodations being provided in an *ad hoc* manner. We interviewed a woman with a mobility disability who used a cane in her housing unit but requires a wheelchair to navigate long distances. The Jail did not consistently provide her a wheelchair when she left her housing area, causing her significant hardship and putting her at risk of a fall.

Third, assistive devices must be maintained in good working order. In September 2025, we observed a man with a prosthetic limb that was in disrepair and requiring maintenance. The man reported that he had requested assistance approximately six weeks earlier and was still awaiting resolution. When we returned to the Jail in May 2026, the man's prosthetic-related concerns still had not been addressed.

²⁸ See *Wright v. New York State Dep't of Corr.*, 831 F.3d 64, 77 (2d Cir. 2016) (finding that the failure to conduct an individualized assessment for a prisoner requesting use of a motorized wheelchair may violate the ADA); *Wright v. New York State Dep't of Corr.*, 242 F. Supp. 3d 126 (N.D.N.Y. 2017) (on remand, entering judgment for the plaintiff and finding that the prison denying electric wheelchair, as applied to plaintiff, denied meaningful access to activities and services).

4. *The Jail Lacks Effective Screening and Adaptive Support Protocols for People with Intellectual and/or Developmental Disabilities.*

The County does not have an adequate process for screening incarcerated people with intellectual and/or developmental disabilities (“IDD”). The results are concerning, with individuals with IDD sometimes even wrongly identified as under the influence of narcotics or other substances when they arrive.

The County also lacks a system to develop and implement an individualized adaptive support plan that ensures that each person with IDD receives appropriate resources, medical care, and accommodations. These failures leave people with IDD at risk of harm.

We met with one man who had a traumatic brain injury and showed clear indication of needing individualized supports. He had been placed in an isolation cell when he arrived at the Jail, where he engaged in self-harm, leading to placement in a safety cell. On another occasion, he was observed banging his head against the wall in his cell. This man had a reported history of participating in BCBH-affiliated group treatment activities in the community. He shared with us that he would like to join group activities if they were offered at the Jail, stating, “I participate.” When we met with him, he remained in an Administrative Separation unit, confined to his cell approximately 23 hours per day.

People with IDD are frequently bypassed for program opportunities. This problem was manifest in the unequal allocation of electronic tablets that are distributed in the housing units. People with cognitive disabilities frequently miss out on tablet use, as their peers exercise control over the limited supply of tablets. (Such a problem can be addressed by providing 1:1 distribution of electronic tablets. At the time of our September 2025 site visit, there was generally one tablet provided for every four individuals in a housing unit.)

Wellpath is already working to improve IDD screening and adaptive support protocols in other jail systems. They must work with BCSO to do so here as well.

5. *The Jail Fails to Ensure Effective Communication.*

Butte County Jail must “take appropriate steps to ensure that communications with [people] with disabilities are as effective as communications with others,” including through “appropriate auxiliary aids and services” and other accommodations as needed. Importantly, the ADA requires that the Jail give *primary* consideration to a person’s request as to the method of communication.²⁹

We identified examples where a communication-related accommodation was indicated but not provided. The lack of protocols to ensure effective communication for people with hearing disabilities, as well as people with IDD or other disabilities

²⁹ 28 C.F.R. § 35.160.

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requiring communication-related accommodations, is concerning. In the jail setting, without effective communication assistance, people may be disciplined unjustly because they do not hear directives, miss important announcements (e.g., pill call, meals, medical appointments, emergencies), and may be unable to communicate during healthcare appointments and important exchanges with due process implications (e.g., disciplinary hearings, classification interviews).

We met with one woman with a hearing disability who clearly indicated to us that her preferred method of communication is sign language. Our brief interaction was limited but informative. When we inquired with BCSO and Wellpath about this woman's effective communication needs, we were informed that she has "reported [to Jail staff] that she was able to communicate effectively thru loud speech and reading lips." At the same time, BCSO acknowledged that the local court's minute orders for this woman's case documented that "ASL [American Sign Language] interpreter needed."

The Jail informed us that this woman with a hearing disability had "upon request . . . been provided with access to a TTY phone" kept at the Jail. However, TTY phones are antiquated and rarely used in the community.

Encouragingly, we were recently informed that the County is working to implement services to accommodate people with hearing disabilities. We strongly urge the County to implement in-person or Video Remote Interpreting (VRI) services to provide sign language interpretation for communications at the Jail, and Video Relay Services (VRS) to ensure that people with hearing disabilities have an opportunity to communicate with people outside the Jail commensurate to others' access to phones. Procedures should be implemented to address the range of effective communication needs among the Jail population, as has been achieved in other county jail systems.

6. *The Jail's Physical Plant Deficiencies Harm People with Disabilities.*

The physical plant of the decades-old Jail facilities creates several very significant challenges to providing necessary programs, services, and activities consistent with today's legal requirements and standards for jail operations. Among the areas of serious deficiency is the lack of necessary accessibility for people with disabilities.

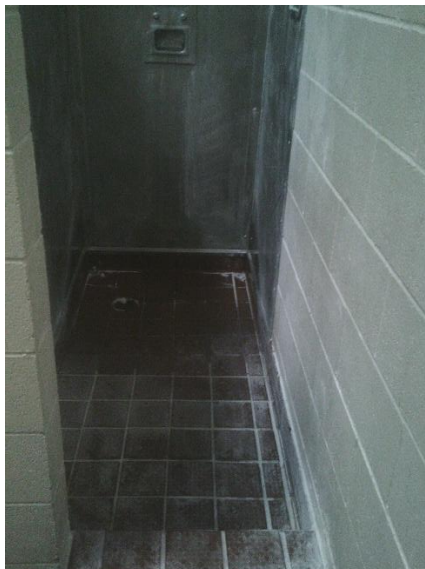
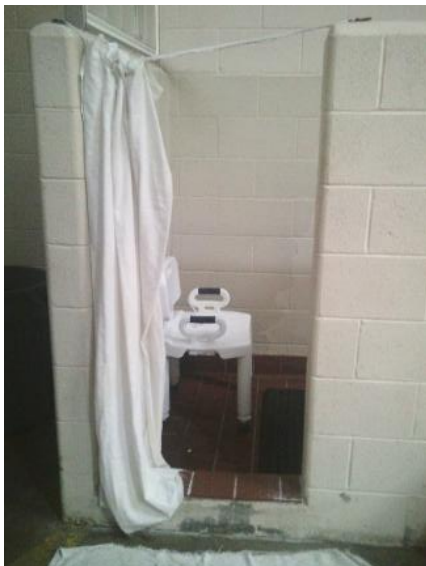
The Jail facilities, including living areas, hallways, yards, sleeping quarters, and restrooms, must be accessible to people with disabilities. Based on our interviews and observations, physical accessibility at the Jail is inadequate in ways that have practical, tangible, and negative impacts on people with disabilities.

Several people with mobility disabilities reported serious accessibility concerns. For example, people reported losing their balance or falling in inaccessible shower areas. With respect to showers, both federal law and California building regulations require accessibility such as (1) transfer-type showers or roll-in showers, (2) accessible clearances and thresholds, (3) appropriate placement of grab bars, (4) accessible controls,

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and (5) handheld showerheads.³⁰ The Jail facilities do not meet these requirements. Individuals with mobility disabilities report great difficulty getting up and down steps to reach shower areas. Adding to the problem, we heard from individuals that moveable shower chairs are not consistently available to them when they shower.



Photos: Inaccessible shower areas

Similarly, the Jail housing units' toilet stalls and dayroom seating areas had insufficient clearance space to accommodate people with mobility disabilities. We observed people with wheelchairs, walkers, and other mobility access needs in housing units that lacked accessibility, creating serious barriers and safety risks.

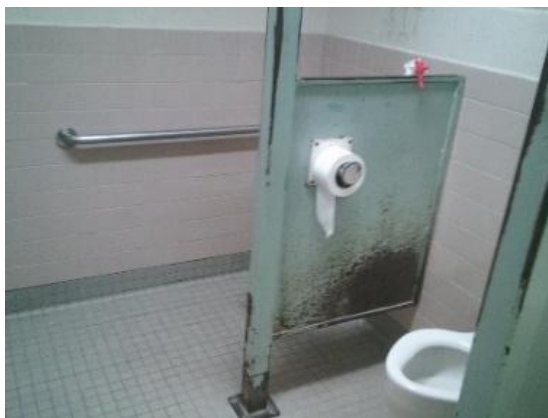


Photo: Bathroom stalls that are inaccessible due to inadequate space for wheelchair

³⁰ *Armstrong v. Schwarzenegger*, 622 F.3d 1058, 1068 (9th Cir. 2010) (“use of toileting and bathing facilities” is a “benefit” under ADA); 24 Cal. Building Code Chapter 11B §§ 604-610.

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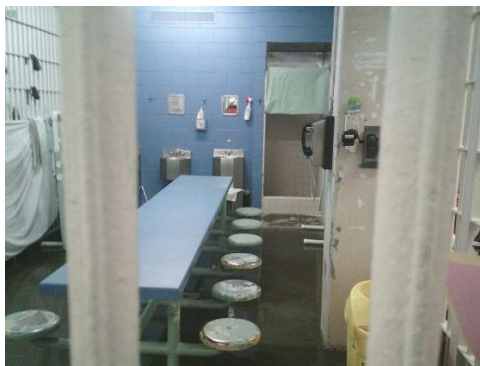


Photo: Inaccessible common area in housing unit



Photo: Person with walker in cell with no accessibility features

These accessibility deficiencies violate well-established technical standards, preclude the provision of program access as legally required, impose unacceptable safety risks to individuals, and create substantial liability exposure to the County.

The North Jail will offer much improved accessibility features. For example, the new building is already utilized for the intake and initial booking process, offering an important solution to the long-used and clearly inaccessible spaces in the Main Jail's intake area.

However, given that multiple existing inaccessible housing units will remain occupied in the old Jail facility, the County must take steps to ensure appropriate accessibility with respect to the physical plant and in the provision of housing accommodations. All people with disabilities must have safe, meaningful access to all programs, services, and activities.

We urge the County to conduct a systemwide ADA/Disability accessibility assessment of all areas of the facility, using an appropriately qualified expert, and to complete remediation as warranted to ensure accessibility.

Through an effective disability tracking system, as discussed above, the Jail must identify specific housing- and accessibility-related needs and ensure that people with disabilities are safely and appropriately housed and provided equal access to programs, services, and activities.

E. Jail Medical Service System Issues

Based on DRC's partial review of the Jail's medical service system, we have identified the following discrete issues that require attention and corrective action.

1. *The Jail's Chronic Care System, Including for Diabetes, Requires Improvement.*

The Butte County Jail's chronic medical care system raised concerns, and we urge the County and Wellpath to ensure that its chronic care policies and procedures reflect applicable standards of care, including based on the recently updated NCCHC standards governing health care in jails.³¹

One specific and important category of chronic care that warrants mention is diabetes care. The American Diabetes Association has issued well-defined standards for the treatment of people with diabetes in detention settings.³² We confirmed that the Jail's current practices are inconsistent with several core components of that guidance.

First, the Jail has a blanket rule prohibiting the use of continuous glucose monitors and insulin pumps, both of which are treatment modalities that should be available to people with diabetes consistent with individual clinical need. We encountered one incarcerated individual who had been using a continuous glucose monitor to manage his diabetes prior to detention but was prohibited from using it in the Jail. He reported a recent history of severe hypoglycemia that led to an injurious fall. According to the American Diabetes Association, a continuous glucose monitor "can be an important tool to monitor glucose levels and to proactively prevent severe hypoglycemia episodes." Several other people with insulin-dependent diabetes expressed interest in being evaluated for a continuous glucose monitor. A continuous glucose monitor should be seriously considered and provided when clinically indicated.

With respect to insulin pumps (a small wearable device that delivers insulin through a thin tube or patch under the skin), the Jail should update its protocols to, at minimum, allow for individuals coming into the facility to continue use of an insulin pump they were using before incarceration, to support continuity and adequacy of care. Consistent with American Diabetes Association guidance, the Jail should use an individualized case-by-case assessment of security and other considerations in determining whether a person with diabetes has access to these important devices.

Second, the Jail does not utilize appropriately individualized treatment plans for diabetes management, instead utilizing a one-size-fits-all approach to blood sugar management. For example, all incarcerated people dependent on insulin injections are offered blood glucose checks three times per day, and individuals with diabetes who do not use insulin are offered checks once per day. We further received reports that people

³¹ NCCHC, *Standards for Health Services in Jails* (2026).

³² Daniel L. Lorber, et al., [*Diabetes Management in Detention Facilities: A Statement of the American Diabetes Association*](#), 47(4) *Diabetes Care* 544-555 (Mar. 25, 2024).

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with diabetes did not receive individually tailored insulin doses based on both meal content (using an individualized insulin-to-carbohydrate ratio) and current blood glucose levels (i.e., a “correction factor”). Diabetes management plans should be individualized to meet the specific needs of each person.

We urge the County and Wellpath to review and update their chronic care protocols, including for diabetes, to ensure alignment with the standard of care.

2. *The Jail’s Lack of a Keep-on-Person (KOP) Program Creates a Risk of Dangerous Denials of Timely Access to Essential Medications.*

We learned that the Jail does not currently have a Keep-on-Person (“KOP”) medication program that allows incarcerated persons to carry and administer their own routine medications, consistent with individual security and clinical factors. Such KOP medication programs are customary in well-functioning county jail systems and serve both to reduce the burden on nursing staff and to ensure that patients have timely access to essential medications.

Take, for example, asthma rescue inhalers. In Butte County Jail, we were informed that patients who are prescribed inhalers get access to them twice per day (during scheduled medication distribution times).³³ Incarcerated people described to us situations during which their asthma symptoms went untreated for extended periods of time. They were unable to get the attention of staff and secure access to their prescribed rescue inhaler to treat their respiratory distress. We are informed that, in such situations, the County relies on individuals utilizing the emergency buttons (many of which are not functioning) to summon medical staff to receive a rescue inhaler. Such a practice brings significant, avoidable risk to patients.

We urge the County to implement, with well-defined policies and procedures, a KOP medication program, which the NCCHC and other authorities have identified as providing important benefits to patient care.

F. Concerns about Environmental Health and Safety Conditions

Every jail system must ensure an acceptable level of cleanliness, maintenance, and safety throughout its facilities. It must sustain basic environmental health and safety protocols that ensure sufficient cleanliness and sanitation standards. A failure to meet minimum standards may result in exposure of the incarcerated population (and staff) to a risk of serious harm to individual health and safety, including MRSA and other bacterial infections, lice, scabies, skin infections, and respiratory illness.

Maintaining minimally adequate environmental health and safety standards is challenged in a dilapidated facility like the Main Jail, which has operated 24/7 for more

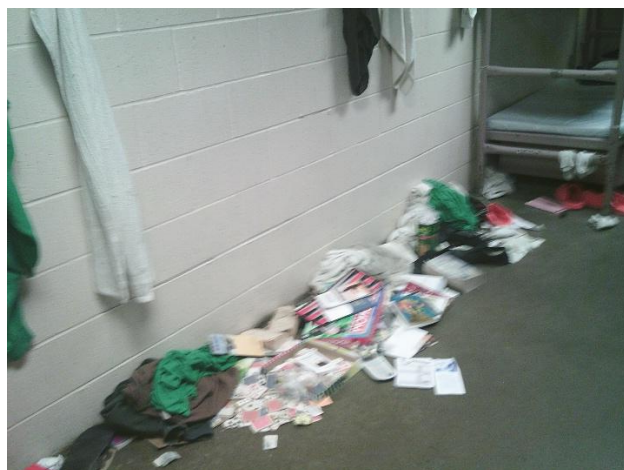
³³ The County’s letter, dated September 24, 2026, responding to our findings states that it has updated its KOP policy and now allows rescue inhalers to be kept on person if needed.

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than six decades. In our experience, it is people with serious health conditions and disabilities who are at the greatest risk when environmental health and safety requirements are not met.

We found evidence of deficits in cleanliness and sanitation, specifically in isolation units and crowded Jail units, where food and other detritus were allowed to accumulate, and in shower/bathroom areas where grime buildup was visible.



Left Photo: Detritus accumulation on housing unit floor



Right Photo: Shower with buildup of grime on retractable shower seat and elsewhere

We encourage Jail leadership and staff to redouble efforts to ensure appropriate cleanliness and sanitation throughout the Jail's housing, healthcare, and programming areas. Incarcerated people with behavioral health or other disabilities will in some cases require regular assistance to maintain proper cleanliness and sanitation in their living spaces. Such support should be guided by individualized treatment plans and interdisciplinary coordination among staff.

An expert assessment by an Environmental Health Specialist or Sanitarian can help to identify problem areas and effective strategies to address them. Some jail systems, including the Santa Barbara County Jail, have effectively utilized non-sworn staff to serve as Environment of Care Monitors who lead efforts to ensure appropriate sanitation and maintenance systems.

G. Interagency Coordination Among BCSO, Wellpath, and BCBH

In 2025, we identified several care coordination problems arising from a lack of effective cross-agency cooperation and information-sharing. This lack of coordination creates gaps in services and negatively impacts outcomes for justice-involved people with disabilities. However, we were impressed that County staff and leadership consistently recognized the importance of effective coordination. BCSO and Wellpath leadership have

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recently reported significant improvements in this area, particularly with BCBH. We look forward to further discussions regarding the issues identified below and how to build on the progress that has been made.

1. *Coordination between BCSO and BCBH Relating to Records and Behavioral Healthcare Requires Improvement.*

DRC's initial interviews with staff indicated that a lack of clear, effective processes to facilitate timely information-sharing between BCSO and BCBH, inhibiting timely provision of services to individuals. For example, at the time of our 2025 visit, Wellpath and BCBH did not have a coordinated system for accessing patient records, necessitating an onerous cross-agency request process to obtain records on an individual basis. One staff member reported that "the two systems don't understand each other." A false perception among some staff regarding HIPAA limitations may have contributed to the problem.³⁴ The BCBH records system itself is challenged, with a hybrid paper-electronic records system that can complicate efforts and impose burdens on staff.

We were further informed that, while the County's Department of Public Health has been charged with overseeing the Wellpath contract for jail health care, BCBH leadership's involvement in such oversight has been extremely limited.

In Fall 2025, we shared our considerable concern about how information-sharing barriers were causing delays in medication continuity and frustration for staff across these agencies. During our May 2026 visit, BCSO and Wellpath reported that coordination has improved significantly in recent months. This was welcome news. We encourage continued focus on improving information-sharing between BCSO, Wellpath, and BCBH to ensure timely access to healthcare, behavioral health, and disability-related accommodations. As part of these discussions, the County should consider allowing Wellpath to opt into the Health Information Exchange that BCBH uses, to facilitate timely information-sharing and coordination.

2. *Coordination between BCSO and BCBH for Reentry Services Requires Improvement.*

There must be robust coordination by BCSO, Wellpath, and BCBH to ensure that justice-involved people with mental health disabilities are enrolled in Medi-Cal and connected to County behavioral health services upon release, as indicated. This year's rollout of CalAIM and its JI Reentry Initiative provide an important opportunity for improvement in this area, with an eye toward meeting constitutional requirements regarding reentry services.³⁵

³⁴ See 42 C.F.R. § 164.512(k)(5) (providing exceptions to HIPAA restrictions for patients in detention settings, including to support care coordination).

³⁵ *Wakefield v. Thompson*, 177 F.3d 1160 (9th Cir. 1999); *Charles v. Orange County*, 925 F.3d 73 (2d Cir. 2019).

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We identified gaps in reentry services, particularly for incarcerated people with mental health disabilities and/or a substance use disorder. DRC spoke to several individuals who reported that they have been released during recent Jail detentions without provision of psychiatric medication or connection to services in the community. One woman with mental health needs reported that she has been cycling in and out of the Jail since she was a minor and had never been connected to community behavioral health services. On one occasion, she was released from the Jail in the middle of the night with no bus pass or service linkage.

We heard from people in need of BCBH services, community members, and Jail staff who were frustrated with the BCBH service system and confused about how to access services. Multiple people identified challenges in scheduling and accessing outpatient clinical care and complained that the BCBH-identified “24/7 Access Line” for behavioral health services closes at 5:00 pm.³⁶ During our visit in September 2025, Jail staff identified deficiencies in the behavioral health referral process, including a lack of cross-agency communication between the Jail and BCBH’s clinical hubs. Jail staff reported confusion about whom to contact to arrange appointments at BCBH clinics and identified long delays and unavailability of appointments. Jail staff expressed a desire for clear communication with BCBH outpatient centers (in Chico, Gridley, Oroville, and Paradise) to strengthen linkages for individuals preparing for reentry.

BCSO and Wellpath have more recently reported important work-in-progress efforts toward enhanced discharge planning, including to increase healthcare-side discharge planner staffing resources, enhance communication with BCBH leadership, and maintain biweekly meetings to discuss upcoming releases. Of additional note, BCBH staff have recently begun to come to the Jail to meet in-person with individuals with approaching release dates. The Jail reported 42 referrals to BCBH in the first approximately five months of 2026.

The Jail’s implementation of the JI Reentry Initiative presents an opportunity to continue this progress. The County should ensure that Jail and BCBH staff coordinate effectively so that people with serious mental illness are enrolled in Medi-Cal, receive appropriate medication supply upon release, and are connected to timely clinical appointments in the community. Transportation assistance for people being released should also remain an area of focus.

3. Coordination and Support for Diversion and Alternatives to Incarceration Requires Improvement.

Butte County detains significant numbers of people with disabilities and histories of cycling through the Jail, hospitals, and homelessness. Many can be better served through programs that connect people with appropriate and evidence-based housing and support services. Investing in these services can help prevent future incarceration and

³⁶ BCBH’s letter, dated August 28, 2026, responding to our findings stated that the Access Line is staffed 24/7.

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hospitalization, ensuring that BCSO's resources are being used efficiently and effectively to protect public safety.

We urge Butte County to take concerted action to reduce its Jail population and, in particular, the number of people with serious mental illness in custody.

The County's current Mental Health Diversion Program is a step in the right direction but appears to have insufficient capacity and services to meet the need. DRC's review indicates that the County lacks an effective system for assessing and enrolling eligible individuals into the Diversion Program. Jail staff identified backlogs in diversion assessments, and County data shows low rates of acceptance into and graduation from the Diversion Program. Recent legislative efforts to restrict eligibility and expand court discretion could worsen these trends. Critically, our investigation also indicates that participants may not receive the services they need to be successful. We were informed that program participants may be released with nothing more than instructions to meet with their clinician and with no housing support services.

The County appears to be underutilizing the Sobering Center as an alternative to Jail. This County resource should be utilized whenever appropriate so that people arrested for low-level infractions while intoxicated can receive services in a safe and therapeutic setting that avoids incarceration. It is well-established that the risks of negative health outcomes, including preventable death, are greatly elevated for people in detox who end up detained in a jail setting. Expanded use of the Sobering Center and similar resources can improve outcomes for individuals while decreasing the burden on the Jail and court systems.

We encourage the County to explore innovative and evidence-based strategies to strengthen diversion efforts and prevent unnecessary incarceration. One example may be an Early Representation program³⁷ that allows assigned criminal defense counsel to meet with newly arrested individuals early in the process. This can facilitate timely identification of diversion eligibility, effective preparation for bail hearings, early defense investigation, and more. Such a program is most effective when led by an established public defender office, which Butte County currently does not have (instead utilizing privately-contracted attorneys).

DRC recommends that staff expand resources to strengthen the Mental Health Diversion Program, with a goal of increasing program participation and graduation rates.

³⁷ Other counties' Early Representation programs have shown promising results. See Michael Wilson, MW Consulting, [Santa Barbara County Jail Population Overview and Projections](#), Appx. A (Mar. 14, 2025) (analyzing outcomes of READY Program for early representation, including reductions in lengths of detention and overall jail population); County of Santa Clara, Public Defender's Office, [Pre-Arrest Representation and Review \(PARR\)](#), (last visited Jul. 31, 2026); Alena Yarmosky, [The Impact of Early Representation: An Analysis of the San Francisco Public Defender's Pre-Trial Release Unit](#) (May 2018).

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To be successful, the Diversion Program must ensure that participants have access to meaningful housing and support services. The County should ensure that its sobering center(s) have capacity and resources to serve people detained by BCSO or other law enforcement agencies, and that those agencies utilize sobering center(s) whenever appropriate. DRC also recommends investment in other interventions, including crisis intervention, community navigation, and peer-led programs designed to connect people with community services that can prevent incarceration and increase public safety.

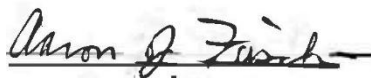
III. CONCLUSION

We greatly appreciate the County's professionalism during our investigation to date. We look forward to productive discussions regarding DRC's findings and recommendations, and next steps toward improving the County's Jail and behavioral health systems. Thank you for your ongoing cooperation and courtesy.

Sincerely,



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