U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

September 5, 1997

Ms. Joanne Sturges
Los Angeles County Executive
500 W. Temple Street, Room 383
Los Angeles, CA 90012

Re: CRIPA Investigation of Mental Health Services in the Los Angeles County Jail

Dear Ms. Sturges:

On June 6, 1996, we notified you of our intent to investigate conditions in the Los Angeles County Jail system (Jail) to determine whether those conditions violate inmates' constitutional rights. The investigation was conducted pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. §§ 1997 et seq., and focused on allegations of inadequate mental health care, including but not limited to: inadequate facilities and staffing, improper use of physical restraints, inadequate suicide prevention, and the abuse of mentally ill inmates by sheriff's deputies working in the Jail. Having concluded our investigation, we are writing to advise you of our findings, supporting facts, and recommended remedial measures, as required by CRIPA.

The Los Angeles Sheriff's Department (LASD) operates eight primary detention facilities. At the time of our tour, the total inmate population was approximately 18,500 inmates. The average length of stay at the Jail is 36 days. For inmates held under California's three-strikes law, the average length of stay is 187 days for second-strike inmates and 127 days for third-strike inmates. At the time of our tour, the Jail system was nominally providing mental health services to approximately 1700 of these inmates. Our experts found the number of inmates in need of mental health care was significantly higher than 1700, and because the inmate population has risen significantly since the time of our tour, it is likely that the current number of inmates needing mental health services is also higher. Mentally ill inmates are housed primarily at Men's Central Jail (MCJ), the Sybil Brand Institute for Women (SBI), and North County Correctional Facility (NCCF).

We thank Frederick Bennett, Assistant County Counsel, Barry King, Chief of the Sheriff's Department's Custody Division, Areta Crowell, Director of the Los Angeles County Department of Mental Health (DMH), which provides mental health services to inmates in

the Jail, and the Sheriff's and Department of Mental Health's staff at the Jail for their cooperation and assistance during our investigation. We appreciate that this is an especially challenging time for the Jail, and that even under ideal conditions, operating a system such as the Los Angeles County Jail is difficult. The County has so far shown a professionalism and willingness to confront the serious problems at the Jail that make us optimistic that we will be able to resolve the issues raised in this letter in an amicable and efficient manner.

We would also like to thank the County for its March 15, 1997, response to our expert consultants' report. We found the County's response informative and constructive, and are encouraged that the County acknowledges many of the problems with the Jail's provision of mental health services and is already taking positive steps in response to several of the problems raised by our expert consultants. We have taken the County's response into consideration in completing our findings. When we do not agree with the County's assessment of what the conditions in the Jail are or should be, we have attempted to explain the reasoning behind our disagreement.

I. LEGAL FRAMEWORK

It is well settled that, with respect to inmates who have been convicted of criminal offenses, "the treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment." Helling v. McKinney, 509 U.S. 25, 31 (1993). Under the Due Process Clause of the Fourteenth Amendment, pretrial detainees "retain at least those constitutional rights . . . enjoyed by convicted prisoners." Bell v. Wolfish, 441 U.S. 520, 545 (1979). Further, with respect to pretrial detainees, the Fourteenth Amendment prohibits punishment of these persons and restrictive conditions or practices that are not reasonably related to the legitimate governmental objectives of safety, order and security. Id. at 535-37.

The Jail has a duty to ensure that inmates receive adequate medical care, including mental health care. See Farmer v. Brennan, 511 U.S. 825, 832 (1994). Deliberate indifference to inmates' serious medical needs violates the Eighth Amendment because it constitutes the unnecessary and wanton infliction of pain contrary to contemporary standards of decency. Helling v. McKinney, 509 U.S. 25, 32 (1993); Estelle v. Gamble, 429 U.S. 97, 104 (1976). It is firmly established in the Ninth Circuit that "medical needs" include mental health needs as well as physical health needs. See, e.g., Hoptowit v. Ray, 682 F.2d 1237, 1253 (9th Cir. 1982); Madrid v. Gomez, 889 F. Supp. 1146, 1255 (N.D. Cal. 1995); Balla v. Idaho State Board of Corrections, 595 F. Supp. 1558, 1576-77 (D. Idaho 1984).

The Eighth Amendment protects prisoners not only from present and continuing harm, but from future harm as well. Helling at 33. Thus, deliberate indifference to inmates' serious mental health needs violates the Constitution even if that indifference has not yet resulted in injury.

II. FINDINGS AND SUPPORTING FACTS REGARDING MENTAL HEALTH CARE

Based upon our investigation, we have concluded that unconstitutional conditions exist at the Los Angeles County Jail, including a deliberate indifference to inmates' serious mental health needs. This conclusion and our recommendations for remedial measures described in Section III, are based in significant part on the opinions of our four expert consultants whom we retained to advise us in this matter. We already have provided your counsel with the joint report of our consultants and you have had the opportunity to respond.

A. Summary

We believe that the Jail's provision of mental health care is constitutionally inadequate in numerous aspects. The Jail fails to identify adequately inmates with serious mental illnesses and does not adequately treat those inmates it has identified as mentally ill. Some inmates with mental illnesses enter the Jail without their illness being discovered; others report their mental illness, but are then "lost" in the Jail system, misclassified and placed in unsafe housing, or transferred repeatedly between facilities. For many mentally ill inmates who are properly identified, the treatment they receive is below constitutional minimum standards. They too often wait dangerously long periods before being evaluated or prescribed medication, have their illnesses misdiagnosed and their medications improperly administered. Mentally ill inmates are housed in conditions that often exacerbate their condition and they are not permitted to participate in the same programs as other inmates, even where their mental illness would allow such participation. They are the victims of predatory behavior at the hands of other inmates and have been abused by correctional staff. Clinical response to suicidal inmates is delayed, on occasion with tragic results, and suicidal inmates are placed in housing that permits them to act on their suicidal ideation.

The reasons for the poor state of mental health care in the Jail are manifold. The number of inmates in need of mental health care overwhelms available staff resources. The Jail's systems of medical record keeping and inmate tracking and classification are deficient to the point that custody and mental health staff cannot adequately access information necessary to provide appropriate care. The Jail does not adequately prevent abuse of mentally ill inmates and does not adequately investigate allegations of such abuse when it occurs. Many current custody

policies are obstacles to the provision of adequate mental health care. A lack of adequate training of custody staff in dealing with inmates with mental illnesses negatively impacts the provision of mental health care. The chronic overpopulation in the Jail results in insufficient housing and treatment space, further exacerbating the Jail's inadequate system of mental health care.

Our findings are based upon several sources, including: (a) the February 10, 1997, Report by Department of Justice Expert Consultants Mr. Ray Coleman, Dr. Joel Dvoskin, Dr. Dennis Koson, and Dr. Jeffrey Metzner, (Expert Report) previously provided to your counsel; (b) interviews with Sheriff's Department and Department of Mental Health staff; (c) interviews with inmates conducted by personnel from the Department of Justice and their consultants; (d) documents provided by the Jail; (e) written communications sent directly to us by inmates, former inmates, families of former inmates, and advocates; and, (f) the County's March 15, 1997, response (Response) to our expert consultants' report.

B. Inadequate Screening/Intake And Evaluation

Whether at the Inmate Reception Center (IRC) at MCJ or Twin Towers, inmates entering the Jail system are not adequately screened for mental illness. Based on interviews with staff, information provided by the Jail, and our observations during our tour of MCJ's IRC and SBI's intake area, we believe that the Jail fails to question each inmate privately and individually regarding the inmate's medical or mental health, but instead relies on a group videotape orientation that instructs each incoming inmate to inform medical personnel if he or she has medical or mental health problems.1/ Only if an inmate tells medical personnel during intake that he or she has medical or mental health problems will medical services ask an individual inmate appropriate screening questions about his or her medical and mental health, recording this information on the Jail's

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1/ The County states in its March 15 response that the Jail's "screening methodology meets the California legal requirements as set forth in Title 15." Response at 33. However, whether the Jail's policies are deemed to comport with California law is not dispositive of whether the actual conditions at the Jail comply with minimum standards required by the Constitution. Moreover, the Jail's stated and observed practice of completing a medical screening form only for inmates who self-identify as having medical or mental problems does not appear to comply with Title 15's requirement that the Jail's health authority maintain "individual, complete, and dated health records which shall include . . . receiving screening form/history." Cal. Code Regs. Tit. 15, § 1205 (1996).

"medical services data base form."2/ When this form is created by nursing staff for patients who self-identify as mentally ill at intake, there is no medical examination. The database is thus not an adequate medical screening instrument because it is not completed for every inmate, and it is not an adequate medical assessment because it does not include a medical examination.

The system relies on inmates self-reporting mental health problems, a method which is likely to result in a significant number of inmates entering the Jail with undetected mental illnesses. Many mentally ill inmates will fail to self-report their illness to the Jail unless they are independently and privately questioned by trained personnel. Our consultants found that there are strong disincentives for mentally ill inmates to self-report. Those who have been in the system before will have learned that identifying oneself as mentally ill may lead to being put in lock-down housing, and an increased likelihood of abuse. In addition, according to the September 1996 report of Merrick Bobb, the Special Counsel retained by the County to advise the Board of Supervisors regarding progress by the LASD, deputies report that because inmates in holding cells are sometimes not fed, "savvy" inmates will wait to report medical problems until they are in permanent housing. Los Angeles Sheriff's Department 6th Semiannual Report by Special Counsel Merrick J. Bobb & Staff at 12 (September 1996).

As discussed below, the Sheriff's deputies' lack of training in identification of mentally ill inmates, and the Jail Mental Health Services policy of targeting only "high impact" seriously mentally ill inmates, also results in an under-identification of inmates who may be just as mentally ill as the "high impact" inmates, only more quiet. The Jail also appears to fail to make use of "special handling" cards. We were told by an IRC Lieutenant that special handling cards are the method by which IRC staff are informed that an incoming inmate has been previously identified as having a mental health problem. However, it appears that these cards are not consistently filled out or passed on. We understand that the Jail is now reviewing the special handling card procedures in its custody facilities. Response at 12.

Intake mental health referrals are assigned to a clinician, who evaluates the inmate "as soon as possible." Response at 11. Due to delays in this process, many inmates who are screened positive for mental illness do not receive an evaluation for days. This delay is unacceptable and dangerous. In one case

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2/ We found that the question on the Spanish-language version of the medical announcement regarding suicide was not as comprehensive as the question on the English-language version. We are told this problem has been corrected. Response at 12-13.

noted by our consultants, an inmate was screened positive for mental illness and a mental health assessment was ordered at that time. By the time a mental health worker was able to get to that inmate's evaluation two days later, it was too late—the inmate had killed himself earlier that day. Further, it appears that the mental health worker was not even aware that the inmate killed himself, as the notation in the inmate's chart states "discharged." We agree with the County that it would be appropriate to have mental health staff immediately evaluate inmates who are identified as requiring mental health services, Response at 28; however, as the County acknowledges, unless an inmate is having a mental health crisis, an inmate is not immediately evaluated. Response at 11.

The intake mental health evaluation is inadequately documented. The documentation consists only of a check on the inmate's screening form with no mention of diagnosis or level of impairment. Another troublesome aspect of intake is that when inmates enter the Jail with properly prescribed psychotropic medications, these medications are taken from them upon arrival. They receive no mediation until assessed. Such inmates are thus placed in danger of decompensating to crisis level immediately upon entering the Jail system. We are encouraged by the County's statement that physicians at the Jail can prescribe certain psychotropic medications to such inmates for a limited period of time, Response at 28, and encourage the County to ensure that this practice is implemented to avoid unnecessary and dangerous decompensation. The Jail has had similar problems with inmates returning to the Jail from outside facilities, such as Patton or Metropolitan State Hospitals. These inmates are sometimes placed in general population where they may wait weeks to see a psychiatrist or receive the medications they were previously prescribed, needlessly and dangerously decompensating as they wait to be reevaluated.

An additional deficiency in the Jail's screening process is its policy of "screening" male inmates (i.e. asking inmates to self-report) upon intake into the IRC and re-"screening" them each time they are transferred to or from any of the Jail's facilities. While this practice may have the effect of serving as a "back-up system to the initial screening at IRC," Response at 29, this practice increases the inefficiency and inconsistency of the screening process and would not be necessary if the Jail's initial screening process and referral system were adequate. Many inmates are transferred numerous times during their incarceration. By not adequately screening each inmate at the IRC and then providing this information with the inmate upon transfer, the Jail causes unnecessary duplication of work, delay in providing mental health services, and an increased likelihood that an inmate will be inconsistently classified. Although the development of the County's Jail Hospital Information System is still in its nascent stages, Response at 3, such a system has the

potential to solve the Jail's problems with maintaining consistent, accessible medical records for every inmate. However, the Jail is unable to provide even a "ballpark" estimate for when this system might be implemented, and there are indications that it may take years. Thus, we encourage the County to take interim steps to improve medical records and screening, as it stated in its response it is currently considering. Response at 29.

C. **Inadequate Referral System**

Because the Jail's screening and evaluation process misses many mentally ill inmates at intake, it is especially important that the Jail maintain an effective system for referring general population inmates who may be mentally ill to a mental health professional. The Jail's referral process fails to adequately identify and obtain services for mentally ill inmates. The referral system is deficient in several respects. The primary problem with the referral process is that the Jail has set too high a threshold for what is referable. Jail Mental Health Services has an explicit, written policy of limiting mental health services to "high impact" seriously mentally ill inmates. An inmate must be actively and observably suicidal or psychotic, or in the words of one deputy "bouncing off the walls," before he or she has a chance of being referred to mental health for treatment. This policy not only excludes the entire subset of seriously mentally ill inmates whose mental illness may not manifest itself through outward aggression or bizarre behavior, but increases the likelihood that no inmate's mental illness will be treated until the inmate decompensates to an acute crisis. Treating inmates' serious mental illness only when they reach crisis level is not only inadequate from a mental health care perspective, but also wastes the Jail's scarce mental health resources, as providing crisis care requires far greater resources per inmate than providing non-crisis mental health care.

Another deficiency in the Jail's referral process is that the mental health staff tours the Jail's housing units too infrequently. When they do tour they do not ask the deputies on duty if there is anyone in need of mental health services, but rather rely on deputies to refer such cases to mental health staff unprompted. Finally, the Jail's use of different colored jumpsuits for mentally ill inmates decreases the efficacy of the referral system because it indicates to deputies that all mentally ill inmates already have been identified, encouraging them to attribute aberrant behavior of general population inmates (i.e., those not in special clothing) to other causes (e.g., manipulation or defiance) rather than possible mental illness.

D. Inadequate Treatment

1. Summary

Treatment available to mentally ill inmates is inadequate at all of the Jail's facilities. Other than psychotropic medications, treatment of the Jail's mentally ill inmates consists of: a day treatment program at MCJ for approximately fifty inmates; inpatient mental health care at MCJ's Forensic Inpatient Unit (FIP) for thirty-five male and female inmates; and an attempt at therapy for some of the women with mental illnesses at SBI. The rest of the approximately 1700 identified mentally ill inmates in the Jail receive no mental health treatment other than perhaps psychotropic medications.3/ We commend the County for its establishment of the day treatment program at MCJ; however, the program is far too small to treat the number of people who are in serious need of non-psychotropic treatment. In addition, FIP is inadequate as a forensic inpatient unit. It lacks an adequate number of rooms, clinical staff, auxiliary services such as occupational therapy and education, and sufficient aides to observe ambulatory patients, which increases reliance on physical restraints.

As LASD and DMH staff (including management) have explicitly stated, the Jail currently lacks the staffing resources necessary to provide adequate treatment for inmates with serious mental illness. For example, there are only eight nurses providing mental health nursing care to over 800 mentally ill inmates at MCJ, and there is a severe shortage of psychiatrists. Our expert consultants found that the majority of problems in the Jail's provision of mental health care are the direct and predictable result of inadequate staffing. The Jail's staffing shortage is due not only to an inadequate number of budgeted positions; the Jail also has problems filling positions already budgeted. In all types of mental health staffing (e.g., psychiatrists, psychologists, therapists, nurses, psychiatric technicians, and administrative staff) there were many more positions budgeted than filled at the time of our tour. In addition, supervisory staff at MCJ stated that many current staff members are not working to their full potential. Others are being asked to perform tasks, such as mental health evaluations or crisis

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3/ The County has informed us that since our site visit in August 1996, Jail Mental Health Services has begun daily visits to the acute units at MCJ. Response at 4. These visits appear to be in the nature of monitoring inmates' mental health condition. While such visits are important, they do not constitute treatment unless they involve actual treatment, such as counseling.

intervention, for which they are not properly trained and educated. There is also a shortage of Spanish-speaking mental health staff.4/

2. Sybil Brand Institute

At Sybil Brand, the mental health staff appeared strongly committed to providing mental health care other than psychotropic medications to the Jail's female mentally ill inmates. But their attempts at programming and therapy were overwhelmed by a lack of office and treatment space and inadequate staffing. The County reports that since June 21, 1997, Sybil Brand has been closed and all female inmates have been moved to Twin Towers. At the time of our tour, the Jail did not plan to move SBI's female inmates to Twin Towers, so we could not assess whether Twin Towers provided adequate office and treatment space for female inmates with mental illness. At Sybil Brand, treatment and office space was clearly inadequate. SBI's psychiatrist did not have adequate space to see inmates housed in the Correctional Treatment Center (CTC) or brought into the clinic area for examination. Nor was there adequate private or quiet space to conduct individual or group therapy. Individual counseling of mentally ill inmates at Sybil Brand was generally done cellside, between either one or two sets of bars. At the time of our SBI visit, no group therapy was being conducted because of the lack of space. Recreational therapy was also compromised by the lack of treatment space. Although the lack of treatment space was exacerbated by the use of the only dayroom in mental health housing as an 18-bed suicide observation dorm, a dorm-setting should be maintained in housing for suicidal inmates, as the benefits of a dorm setting for such inmates outweigh the loss in treatment space. Nevertheless, a Jail's mental health program should not be forced to choose between providing two services as important as treatment and appropriate housing for suicidal inmates because of a lack of space.

SBI's medical area, including its CTC, was also inadequate for mental health treatment. The Director of LASD's Medical

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4/ The County has recently informed us that approximately seventeen new mental health staff members have been hired since June 30, 1996. It is unclear how many of these seventeen staff members were hired since our tour, nor have we been informed what positions these staff members have filled. Given the severity of mental health staffing shortages at the time of our tour, the retirement of MCJ's chief psychiatrist, and the County's recent statement that it is currently reviewing staffing strategies to implement a plan to provide "appropriate staffing levels for service delivery at the Twin Towers Correctional Facility and elsewhere in the system," Response at 7, it appears that mental health staffing continues to be inadequate.

Services agreed with us that CTC rooms were generally unsafe for mental health purposes. Only one CTC room had a bed affixed to the ground. There were hazards such as horizontal bars on the windows, peeling drywall, and protruding boxes. Still, this was where all actively suicidal (those who have recently attempted suicide) or psychotic inmates were housed, unless the Jail was able to place them in Metropolitan State Hospital, Patton, or MCJ's FIP. There are usually more inmates who need beds at one of these facilities outside the Jail than there are beds available.

If more treatment and office space becomes available at Twin Towers, the housing of female inmates at Twin Towers is almost certain to result in improved mental health care for the Jail's female inmates. However, this potential for improvement in mental health care can only be realized if the additional treatment space is combined with procedures and staffing adequate to provide minimally acceptable care.

3. Pitchess Detention Center

The Pitchess Detention Center (PDC), which includes the East, North, South, and North County Correctional Facilities, houses the majority of the Jail's inmates. However, there is no mental health treatment available at any of these four facilities other than the administration of psychotropic medications and crisis intervention. Inmates with serious mental illnesses at any of the PDC facilities other than NCCF have an especially difficult time accessing the treatment that is available at PDC.

4. Administration Of Medication And Diagnosis

Our expert consultants found that, throughout the Jail, medications were improperly prescribed, their effects improperly monitored, and documentation of their use and effect incomplete, inaccurate, and often illegible. Mental health staff also appear to be misdiagnosing some inmates. For example, at NCCF, all of the inmates our expert consultants interviewed had been diagnosed by Jail psychiatrists as having a bipolar disorder. Our expert consultants talked with a number of inmates who, despite having been diagnosed as having a bipolar disorder, appeared to our experts not to have this disorder. They found that based on the sample of inmates they interviewed, "it is likely that the bipolar disorder diagnosis is being overused." Expert Report at 45.

The poor treatment received by one seriously mentally ill inmate illustrates the deficiencies in the administration of medications and diagnosis, as well as other deficiencies in the Jail's mental health services system. Records indicate that the inmate, a woman with a history of serious mental health problems, was doing well when transferred from Patton State Hospital to SBI

in June 1996, pending release from the Jail system. However, after only three days this inmate decompensated while at SBI and had to be transferred to FIP. Two days later after the transfer she was observed having a seizure, and a few days later the inmate died.

From our expert consultants' review of available medical records, there appear to have been numerous serious problems with the mental health care this inmate received. It appears that the inmate did not receive the proper dosage of prescribed medications. An improper medication may have resulted in the inmate's dangerous decompensation and the use of restraints. According to the coroner's report, the inmate appears to have died of a pulmonary embolism. It also appears that the inmate may have had a medical illness, in addition to her mental health problems, that was not treated. In addition, it appears that a diagnosis of neuroleptic malignant syndrome was considered and testing was ordered to determine the proper diagnosis, but the testing does not appear to have been carried out. It is unclear whether this was due to a lack of adequate staffing, poor communication, and/or some other problem. The inmate's mental health records from Patton appear to have not arrived at the Jail until four days after her admission. Charting also was haphazard. For example, the inmate's medical chart indicates that the inmate was pronounced dead at 2035 hours, but also indicates that CPR was begun and doctors called to her cell at 2100 hours.

The deficiencies in the administration of medications and diagnosis of mental illnesses appears directly linked to the Jail's severe shortage of psychiatrists. Based on their collective experience, our expert consultants believe that the maximum caseload for a typical Jail psychiatrist should be approximately 75-100 inmates. Due to the high volume of inmates coming through the County's jail system, they believe that Los Angeles County Jail psychiatrists should have a caseload at the lowest end of that range. This ratio would allow a psychiatrist to prescribe medication, adequately monitor and document its administration, and evaluate inmates to determine whether they need medication or other mental health services. These functions currently are not adequately performed by the psychiatrists in the Jail because of their overwhelming caseloads. By the Jail's own estimate, there are approximately 1200 male inmates receiving psychiatric services, but only seven full-time-equivalent (FTE) psychiatrists, one of whom is also in an administrative role -- a ratio of one psychiatrist for every 171 identified mentally ill male inmates. At SBI, there is, at most, one FTE psychiatrist available, with an average caseload of 415 women, including more than 300 inmates on psychotropic medications, and many more who, in the view of our expert consultants, "desperately need to be seen and likely medicated." Expert Report at 40.

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inmates in mental health housing. It also appears that an inmate in mental health housing cannot be classified pro se, and that without this classification the inmate does not have access to the Jail's law library. The County, itself, has acknowledged that staffing levels and physical plant factors, "do in fact, challenge the provision of the minimal [California Code of Regulations] Title 15 requirements for the inmates," and that audits of recreation, out-of-cell time and Title 15 compliance at all Jail facilities have been completed. We are encouraged by the County's statement that "[c]orrective action is being taken to ensure that compliance is achieved and that neither staffing nor so-called 'deputy attitude' preclude mandatory compliance and service provision to inmates." Response at 5-6.

The County agrees that "the high volume of inmate movement and jail crowding exacerbates conditions in the jails designed for housing less inmates," Response at 29-30, and responds to our expert consultants' assessment of current treatment inadequacies largely by noting anticipated staffing increases and the anticipated full opening of Twin Towers. The County states that Twin Towers "should help improve conditions by providing treatment and office space and improved housing conditions," Response at 30, and explains that the Twin Towers design is more conducive to management of special housing inmates, that the inmates will be more likely to get exercise, recreation, and showers because these areas are adjacent to or easily accessible from inmate housing areas, and that no inmates will supervise other inmates. Response at 14.

Although we agree that the opening of Twin Towers could have a beneficial impact on treatment for the Jail's seriously mentally ill, it is uncertain whether this potential will be realized. First, it is our understanding that there is no set date for opening the medical tower at Twin Towers. Thus, although some areas of Twin Towers are open, the Twin Towers Correctional Treatment Center, including the much-needed increase in number of inpatient beds for mentally ill inmates, is reportedly currently unavailable. Second, many of the potential treatment benefits in opening Twin Towers' medical areas (increased treatment space, inpatient beds, etc.) can only be realized if combined with staffing adequate to provide minimally acceptable treatment. While touring NCCF we observed that its large, relatively new infirmary was empty except for one inmate. This is an unfortunate waste of needed health care beds that may be repeated at Twin Towers without adequate staffing. Finally, the County's intention "to move the most severely impaired mentally ill inmates to the Twin Towers in the next few months," Response at 14, does not address the needs of those inmates whose needs are only slightly less acute.

The County's plans regarding who will be housed at Twin Towers remain fluid. For example, although we were told

throughout our tour that no female inmates would be housed at Twin Towers (with the exception of female inpatients of the facility's CTC), as of June 21, 1997, all female inmates were moved to Twin Towers. We understand and appreciate that there are numerous factors to consider when deciding who to house at Twin Towers, e.g., the security benefits of housing inmates currently housed in dorms at East in smaller cell settings. However, regardless of whether and under what conditions Twin Towers is fully occupied, the County must provide adequate treatment to inmates with serious mental illness. Moreover, many of the treatment inadequacies can be remedied without waiting for mentally ill inmates to be housed at Twin Towers.

7. Non-release Of Inmates With Mental Illnesses

Despite the Jail's lack of adequate resources for mentally ill inmates, the Jail currently holds persons it believes to be mentally ill in custody for violations that would normally warrant release pending trial, on bond or on their own recognizance, if not for the fact that they are mentally ill. The County states that this is because California law permits the Sheriff's Department to hold a mentally disordered individual for 72-hour treatment and evaluation. Response at 9, 34. However, the statutes cited do not appear to mandate that the County hold or charge an individual, nor do they indicate that when an individual is held, he or she should or must be held in a correctional setting. Cal. Welf. & Inst. Code § 5150 (West 1996); Cal. Penal Code § 4011.6 (West 1996). In fact, California law mandates that a law enforcement officer transporting a mentally disordered person to a facility for evaluation cannot be instructed to keep or transport the individual to a jail solely because there is no acute bed available in a mental health facility. Cal. Welf. & Inst. Code § 5150.1 (West 1996). The County has provided no rationale for its policy of holding individuals with illnesses it cannot adequately treat, in a facility which is already overwhelmed, for allegedly committing misdemeanors that normally permit immediate pretrial release.

8. Special Clothing

The practice of clothing inmates identified as mentally ill in special jumpsuits adversely affects the inmates' treatment. Our experts had not seen this practice in any other system in the nation and found that it results in stigmatization and creates barriers to treatment (e.g., many inmates will not seek treatment due to the associated stigmatization). In addition, special clothing makes inmates in jumpsuits easy targets of predatory inmates. Although we agree with the County that special clothing may assist correctional officers in "exercising proper judgment," Response at 31, towards differently clothed inmates when they exhibit improper or bizarre behaviors, there are other, less therapeutically damaging ways to elicit appropriate custodial

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case the inmate, who was awaiting court-ordered placement in a County operated mental health facility, was discharged from FIP without the medication which had stabilized his severe depression and suicidal ideation. Despite repeated requests over a period of six days, the inmate never received the needed medications. At intake, the inmate admitted to a history of suicide attempts and mental illness, and had been housed in FIP under suicide watch for an extensive period. When discharged from FIP, the inmate was placed in normal mental health housing, rather than in a suicide observation cell. According to progress notes and other jail documentation, a jail social worker first saw the inmate four days after he had been discharged from FIP. The social worker reported that the inmate stated that he had been in FIP for six weeks where he had been stabilized by medication. The social worker noted that the inmate was anxious because he had not received his medications since he had been discharged from FIP. The social worker placed the inmate's name on the "psychline" list to be seen by the next day to enable the inmate to receive his medications. When the social worker returned two days later to see the inmate, he still had not received his medications. The inmate was agitated and asked the social worker if he could see the bugs crawling over the inmate's body. The social worker went to the clinic and informed the nurse for that area that the inmate had not received his medications for "4-5 days" and needed his medications immediately. The inmate hanged himself that evening, apparently without ever receiving the needed medication. Shortly before the inmate killed himself, he began shouting, loud enough to awake the inmates in the adjacent cell, that he had bugs on his body. If a deputy had responded he likely would have seen that the inmate was in need of immediate mental health crisis intervention. There is no explanation in the deputy's report, and there appears to have been no follow-up investigation of why no officer responded to the inmate's shouts or referred him to Jail Mental Health Services. According to the Jail's documentation, the last row safety check was 21 minutes before the inmate was discovered dead and "cold to the touch." The deputy that found the inmate hanging had trusties cut the inmate down and then waited for a second deputy to arrive to take the inmate's vital signs.

In the other case, an inmate who had previously attempted to kill himself succeeded in doing so soon after being removed from suicide observation for reasons the Jail cannot explain. Despite repeated statements to staff and inmates that he would kill himself, the inmate was removed from FIP and placed alone in a single cell in mental health housing. This inmate did not receive his prescribed medication for the two days prior to his suicide. According to jail documentation, the nurse did not give the inmate his medications on one occasion because another mentally ill inmate was throwing feces, and on the next occasion because the module was under lock-down. These are not acceptable reasons for not providing needed medication. Such occurrences

are not uncommon in the Jail and mental health staff must be provided with adequate custody assistance and supervisory encouragement to enable them to provide necessary medical care under these difficult conditions. According to Jail documentation, the last safety check was almost forty minutes before the inmate was discovered dead.

The Jail also fails to respond adequately to suicide gestures and other inmate disturbances. In one instance, in which three inmates slit their wrists and several others tore clothing and flooded toilets, the Watch Commander responded by ordering all the inmates to remove their clothing until the row was mopped and cleaned. This appears to have lasted for at least several hours and perhaps more than a day. The County has offered no penological rationale for this response. In this same incident, the Jail characterized the three inmates slitting their wrists as "an attempt to disrupt operations." Response at 35. The Jail is currently investigating an allegation that a deputy challenged inmates to commit suicide. This challenge reportedly occurred after several inmates in the housing area had made suicide gestures. The Jail must recognize that suicide gestures are potentially life threatening and that correctional staff may incorrectly assess an inmate's motive for suicidal gestures. Custody staff should not be required to discern genuine from disingenuous suicide attempts. The Jail should treat all attempts as serious incidents, requiring at least a mental health consultation.

F. Physical Abuse And Mistreatment Of Mentally Ill Inmates

Inmates who are mentally ill or housed in mental health housing are subject to an unacceptably high risk of physical abuse and other mistreatment at the hands of other inmates and custody staff. Moreover, the Jail does not adequately investigate allegations of abuse against its inmates.

We have received numerous reports from inmates and advocates regarding serious physical abuse of inmates in mental health housing by other inmates and by Sheriff's deputies, including kicks, punches, beatings, and sexual assaults. Although the Jail claims that it has discounted some of these claims, as discussed later, the investigation of these claims was inadequate and serious questions remain regarding the extent of physical abuse of mentally ill inmates. We agree with Special Counsel Merrick Bobb's finding that in the Jail "there is callous treatment [of inmates] at times, a problem that LASD management knows about but has not acted sufficiently aggressively to

resolve." Los Angeles Sheriff's Department 6th Semiannual Report by Special Counsel Merrick J. Bobb & Staff at 11-13 (September 1996).5/

The treatment received by one inmate indicates that excessive use of force and physical mistreatment of inmates with mental illnesses may be in part the result of inadequate training. Although we have not been able to review the entire record regarding this inmate, according to documents provided by the Jail, in early April 1997, Jail Mental Health Services requested that an inmate housed in mental health housing be sent to FIP for treatment as he had decompensated to the point where he refused to shower or go to court, was sleeping on the floor in trash and water, and was smearing feces on himself and his cell. The inmate had been refusing to take his medications for several days. A deputy told the inmate to stand up to be handcuffed and escorted to FIP, but the inmate refused. After various custody officials failed to convince the inmate to allow himself to be escorted to FIP, custody called for the extraction team, a team trained to remove non-compliant inmates from their cells. Custody also called the mental health unit to inform them that an extraction was about to be performed and ask that a mental health staff person observe the extraction. Less than ten minutes after the mental health observer arrived at the inmate's cell, the extraction team arrived. It is unclear whether deputies were already in the cell trying to remove the inmate when mental health staff arrived at the cell. According to the mental health observer, the inmate was shot twice in the legs with rubber bullets and dragged from his cell once he was subdued. According to FIP records, the inmate, who weighed approximately 375 pounds, was then hand-cuffed with his hands behind his back, placed on his stomach and brought up to FIP on a stretcher. There are some reports that he was hog-tied. He died later that night. The Jail did not provide the coroner's report; therefore, it is not possible for us to state at this point how the inmate died. However, according to our expert consultant, due to the risk of positional asphyxia in such a large person, it is not a proper tactic to place an obese person on his stomach with hands tied behind his back. It is also unlikely that firing a direct hit with rubber bullets was appropriate in this situation. Further, it appears that the Jail did not attempt to involuntarily administer medication to the inmate in the cell, which is acceptable in psychiatric emergencies and which could have eliminated the need for most of the force used. According to our expert consultant, the Jail also should have allowed trained mental health officials adequate opportunity to persuade the

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5/ The incidents of abuse and mistreatment by trusties and deputies of inmates in mental health housing discussed in Special Counsel Merrick Bobb's Semiannual Reports will not be reiterated here.

inmate to leave his cell voluntarily. Because custody officers called the extraction team before calling down mental health staff to "observe" the extraction, and because the extraction was begun only fifteen minutes after the team's arrival, it appears that the Jail did not allow mental health staff adequate opportunity to persuade the inmate to leave his cell. According to our experts, there were several alternatives to the amount and type of force used to remove this inmate from his cell. It appears that the Jail failed to employ any of these tactics.

At the time of our tour the Jail was attempting to compensate for inadequate staffing (both custodial and mental health) by using inmate trusties as assistants in mental health housing. The practice of using inmate trusties in place of custodial or mental health staff is unacceptably dangerous. The potential for physical abuse and mistreatment is too high, and we, as well as the Jail, received allegations before our tour in August that this practice had resulted in incidents of serious abuse and injury at the Jail. In addition to physical abuse, there are reports that trusties deny food to some mentally ill inmates, steal their property, or steal money from them by using their vending machine cards for their own use. We have been told that as of August 21, 1996, the Jail no longer uses trusties to escort mentally ill inmates or in any way supervise their activities, although they are still used for food distribution and cell cleaning. Response at 8.

The Jail does not adequately investigate allegations of abuse towards mentally ill inmates. For example, in April 1996, the Jail was informed by the Department of Mental Health of numerous allegations of serious abuse of mentally ill inmates by deputies and trusty inmates. In August 1996, we were told that the investigation into allegations of abuse had still not been completed, and that we would be provided with the Jail's findings upon completion of the investigation. After repeated requests for the County's response to these allegations, the County finally provided a partial response in the form of a summary of its investigation in June 1997. The Sheriff's Department Internal Affairs Bureau investigators did not interview the alleged victims of the abuse, or the Patients' Rights Advocate who had presented the information to the Jail, until October 1996. The investigation was completed in May 1997, over one year after the custody division had received the allegations of abuse. It is clear even from the incomplete information provided that the Jail's response to these allegations was inadequate. The memorandum requesting inactivation of the investigation states that there was "insufficient information to substantiate any charges or to name any individual as a subject of the investigation." A review of the investigation summary however, indicates that there was adequate information to act upon. For example, numerous inmates in mental health housing alleged that they had bleach thrown on them by trusties, or had

seen this happen to other inmates. The Supervising Line Deputy on the mental health housing module reportedly told the investigators that he "was aware of several bleach throwing incidents involving inmates and occasionally the suspect was a trusty." The Line Deputy reported that when the "incident involved a trusty, the trusty would be removed from inmate worker status" and a report would be written. It thus appears that the Jail's own supervisors acknowledged that such incidents had occurred, yet the investigators found these allegations unsubstantiated. It appears that investigators did not even review the Supervising Line Deputy's reports regarding these incidents.

Another inmate alleged in an affidavit that he was beaten in his cell by trusties and deputies. During an interview by Sheriff's investigators, the inmate recanted his allegations that deputies beat him, but repeated that he was beaten by trusties who escorted him to the showers. The Department of Mental Health had earlier provided photographs to investigators of the inmate's injuries, which had been taken at Metropolitan State Hospital upon his admission there from the Jail. Despite the inmate's statement, the supporting evidence, and the lack of any contradictory evidence, the Jail found that the charge that trusties had beat the inmate could not be substantiated.

Another inmate told investigators that he was beaten on the head by two female deputies who escorted him to his cell on his first day. Investigators do not appear to have attempted to identify the deputies through normal investigatory techniques, such as checking who was on duty in that area on that day, or showing the victim pictures of female deputies in the jail to see whether he could identify the individuals he alleged beat him. In another incident, an inmate named one deputy that had allegedly allowed a trusty to beat an inmate in mental health housing and named another who had allegedly allowed a trusty to throw water on inmates during the evenings. Although it appears that the investigators interviewed the two named deputies, there is no indication that they interviewed other deputies who were on duty with these deputies and may have been witnesses, or checked into the background of the deputies to see whether there were other reports of similar allegations.

It also appears that more information would have been available to Internal Affairs if it had not delayed its investigation for months and if investigators had not failed to interview available witnesses. For example, although the Jail received these allegations in April of 1996, it appears that Internal Affairs did not begin its investigation until October of 1996. By this time, fourteen of the twenty-one mental health inmates involved in the allegations could not be located. It is likely that if the investigation had begun earlier, more of these individuals could have been located.

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Semiannual Report by Special Counsel Merrick J. Bobb & Staff at 23 (April 1997). We agree with the County's Special Counsel that "[t]here is too great a risk of erroneous releases, over-detentions, misclassifications, and grim failures to provide medical and mental health care. We cannot stress enough to the Board of Supervisors and the LASD how critically deficient is the current [jail information] system for medical and mental health care." Id. at 24.

The County's current practice of maintaining a separate medical record at each facility for the same inmate has a serious negative impact on mental health care. Maintaining several medical/mental health records for each inmate exacerbates communication problems, creates unnecessary duplication of work, and increases the likelihood that important medical information will be missed. Each time an inmate is transferred to a new facility, a new medical chart is created. Our expert consultants found that it was often necessary to look in several records in order to find the answer to questions as basic as why an individual was restrained. Multiple records create delays of days or even weeks before information from an inmate's medical record at one facility can be transferred to medical staff at another. In some instances, medical information is not transferred at all.

During our tour, we observed problems with the mental health staff's ability to access an inmate's medical records. For example, at SBI the psychiatrist sometimes did not have access to an inmate's mental health chart when he reviewed a patient's medication, and mental health workers did not always know what medication an inmate was taking. We are told that the Jail is now maintaining integrated inpatient (for CTC/FIP patients) and outpatient records at the men's facilities and has integrated mental health and medical charts at SBI. Response at 32. This should resolve some of the problems we observed regarding insufficient access to medical records.

Medical charting is deficient. Our expert consultants reported that they found inadequately documented mental health charts at every facility. The charts contained little or no basic information concerning assessments, treatment planning, or laboratory assessments of medication use. Our expert consultants found that it was sometimes impossible to tell from charts whether an individual had been properly medicated. They attributed the lack of documentation regarding treatment planning to the lack of treatment services, other than psychotropic medication use, generally available to inmates. The County states that the Jail's Medical Services Quality Assurance Program audits "medical related entries" in inmates' medical/mental health records for legibility and relevance. Response at 7. Our expert consultants' review of medical and mental health records indicates that these audits thus far have been unsuccessful at

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deficiencies have a severe negative impact on mental health services, including discontinuity of health service, poor coordination of effort, waste, and on occasion, danger to inmates.

Understaffing directly contributes to communication failures. Due to staffing shortages, clinicians often must choose between communicating and documenting important information, or providing mental health care. Some communication problems result from the LASD's inadequate record keeping system. The Director of DMH stated that it is often difficult to find a specific mentally ill person in the Jail, even if you know the person is somewhere in the system. Inmates are transferred frequently and the Jail's record keeping system is not adequate to keep up with these transfers. This results not only in "losing" mentally ill inmates, but also in inappropriate or unnecessary transfers. We were told of numerous incidents of inmates being sent from NCCF to MCJ for mental health care only to be sent back as soon as they had completed the long bus ride.

Communication between facilities is similarly inadequate. When an inmate who has already been identified as needing medical or mental health care is transferred to another facility, medical/mental health services at the new facility is not made aware that the inmate is on his way or has arrived. Instead, medical/mental health services at the new facility must hope that the inmate again self-identifies during intake and then contact the sending facility to inquire about the medical history or medication orders for that inmate. Thus, even if an inmate does self-identify again at the new facility, he is placed on the next available physician or psychiatric line to await re-evaluation, rather than receiving uninterrupted treatment. An inmate who does not self-identify will likely not receive medication or treatment at the new facility even if he was receiving medication and treatment while at another Jail facility. This results in inconsistent treatment and premature cessation of treatment, which can be dangerous. We found numerous instances in which an inmate was classified as mentally ill at the sending facility and sent to the receiving facility for treatment, only to be classified as not mentally ill and immediately returned to the sending facility.

The Jail does not have a settled mental health caseload roster or list. Despite the fact that the County had ample advance notice of our visit, it took several days after our arrival for the Jail to create and provide us with a list of the approximate number of inmates currently housed in mental health housing or receiving psychotropic medications. The Jail does create a daily census of the FIP and day treatment programs. We are told the Jail has begun creating a census of MCJ's Forensic Outpatient program. However, without a census of all inmates at every facility who are receiving mental health services, it is

difficult for the Jail to keep track of mentally ill inmates or ascertain the amount of resources required to treat them.

The LASD and DMH have serious communication problems that significantly hamper the provision of mental health care in the Jail. There is currently no clear understanding of each department's responsibilities, nor does there appear to be a mutually acceptable process for decision making and conflict resolution. In addition, DMH supervisors do not communicate DMH objectives adequately to DMH jail staff, which diminishes DMH's ability to provide adequate mental health care in the Jail.

J. Inadequate Mental Health Quality Assurance

The lack of any quality assurance program for mental health services in the Jail prevents the Jail from making itself aware of problem events and issues, understanding their causes, and developing mechanisms to avoid preventable injury and death. Although the County states that the Jail's Chief Physician "prepares documentation for his [mortality] findings," and that an overview of deaths is completed annually, Response at 33, this written material is not an adequate mortality review. We were told by the Jail's Chief Physician during our tour that written mortality reviews are never completed. Moreover, as the County appears to concede, Response at 9, the mental health documentation necessary to support a quality assurance system does not even exist in at least one facility, SBI.

K. Diversion Programs

The Los Angeles County diversion programs, Systemwide Mental Assessment Response Team (SMART) and Mental Evaluation Team (MET), and the County court/alternative sentencing programs, are effective in diverting mentally ill offenders from the Jail system, decreasing strain on the Jail, and connecting individuals with mental illness to the mental health services in the community. In addition, these programs can provide valuable training to deputies about mentally ill inmates, as exhibited by the Jail's new program of having deputies "ride-along" with MET.

From our review of documents provided by the Jail and from conversations with officers on MET and SMART, it appears that many law enforcement officers may not be aware of MET and SMART. Education for officers regarding how to utilize these programs would increase the programs' value. The Jail's new ride-along policy for deputies working with mentally ill inmates will likely assist in educating officers about how to use the diversion programs.

III. RECOMMENDED REMEDIAL MEASURES

1. Each inmate entering the Jail should be individually and privately asked questions appropriate to determine whether the inmate has or had a mental illness, has attempted suicide, or has suicidal propensities. This screening should be completed by an appropriately trained individual and should be documented on the medical services data base form, or comparable medical screening device, for every incoming inmate. The Jail's screening process should not rely on an inmate self-reporting his or her mental illness in a group setting.

2. An adequate and timely mental health evaluation, including a medical evaluation, should be completed and properly documented by a qualified and appropriately trained professional for each inmate screened positive for possible mental illness. Incoming inmates in need of crisis mental health care should receive it immediately upon intake. A reasonably quiet and private area should be available for the mental health evaluation at intake.

3. The Jail should ensure continuity of treatment to individuals identified as mentally ill prior to entering the Jail. Inmates identified as mentally ill at holding facilities or elsewhere, or already receiving psychotropic medications, should have this treatment continued uninterrupted upon entering the Jail.

4. Mental health staff should make rounds in non-mental health housing modules in all facilities on a regular basis to identify inmates who may have been missed during screening or have decompensated while in jail. Mental health rounds should include pre-classification housing, administrative segregation, and other special housing areas, as well as general population housing. The Jail should facilitate and encourage communication between deputies and mental health staff in order to ensure that inmates in need of mental health services are referred to Mental Health. This referral system should allow and encourage referral of all inmates with apparent mental illness to receive mental health services, regardless of whether the inmate's mental illness is disruptive to the Jail (e.g., severely depressed or withdrawn inmates). The Jail should institute a confidential self-referral system by which inmates can request mental health care without revealing their request to correctional officers.

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12. The County should ensure a sanitary and humane environment for all mentally ill inmates and all inmates housed in mental health housing. This includes, but is not limited to, seclusion and isolation units and cells, which may house inmates with mental illness.

13. The County should ensure that all inmates with mental illness or housed in mental health housing receive adequate recreation, exercise, access to courts, and shower time. Inmates with mental illness or housed in mental health housing should not be denied access to recreation, exercise, showers, privileges, services, programs, education, or work, based solely on their status as mentally ill or on their placement in mental health housing. The determination that an inmate with mental illness poses a clinical risk of dangerousness to self or others that precludes the provision of any right, service or program normally afforded to a general population inmate, should be made by a qualified professional on an individual basis and should be recorded in the inmate's file.

14. Inmates with mental illness should not be dressed in special clothing identifying them as mentally ill.

15. Inmate trusties should never be placed in a supervisory position or used as escorts for mentally ill inmates or inmates in mental health housing. Inmate trusties should be carefully selected and screened before being assigned trusty positions. Where trusties are allowed to work in mental health housing, they should be closely monitored.

16. Staff should not be permitted to use derogatory language towards mentally ill inmates. Allegations of derogatory language towards mentally ill inmates should be promptly and thoroughly investigated. Staff using derogatory language or otherwise taunting or abusing mentally ill inmates should be promptly and appropriately disciplined.

17. Staff should not be permitted to physically or mentally abuse inmates with mental illness. Allegations of abuse of mentally ill inmates or inmates in mental health housing should be promptly and thoroughly investigated and staff members found to have abused inmates should be promptly and appropriately disciplined.

18. The Jail should create and/or fill staffing positions to provide the following care:

a. Adequate psychiatric care, including: evaluating inmates for mental health services needs; admission into inpatient facilities; and prescribing, monitoring and documenting medication administration. All facilities should have a psychiatrist available, at least by telephone, twenty-four hours per day to evaluate and prescribe psychotropic medications in emergency situations. Psychiatric evaluation of inmates in the Jail requesting mental health care should be completed on a timely basis.

b. Adequate twenty-four hour medical and mental health screening of all incoming inmates at all intake/reception areas.

c. Adequate evaluation on a timely basis of inmates who screen positive for possible mental illness, at all intake/reception areas.

d. Adequate twenty-four hour crisis intervention, including transfer to special medical housing units, administration of psychotropic medications, provision of therapy treatment, and special observation, at all facilities.

e. Adequate correctional assistance to mentally ill inmates to ensure that they receive adequate exercise/recreation and hygienic care; that trusties are never used to escort or supervise mentally ill inmates; and that adequate suicide/mental health observation is maintained on a twenty-four hour basis.

f. Adequate mental health treatment to all mentally ill inmates, including therapy, preparation of individual treatment programs, discharge/transfer planning, and administration of medications, seven days per week at all facilities.

g. Adequate twenty-four hour care in all inpatient units, including, but not limited to, suicide observation and appropriate monitoring and documentation of physical restraints, and exercise at least every two hours for inmates in restraints.

h. Adequate clerical, supervisory and administrative assistance to support mental health services and assist in ensuring adequate documentation, supervision, coordination and communication of mental health services at all Jail facilities.

All staff should be properly trained and qualified for every function/duty they are expected to perform. Staffing should include sufficient numbers of bilingual clinicians trained to provide mental health care, including evaluations and therapy, to all inmates who do not speak sufficient English.

19. The County should implement mandatory pre- and continuing in-service training for correctional staff in the identification and custodial care of mentally ill inmates, including, but not necessarily limited to: interpreting and responding to aberrant or bizarre behaviors, recognizing and responding to indications of suicidal thoughts, proper suicide observation, recognizing common side-effects of psychotropic medications, professional and humane treatment of mentally ill inmates, and response to mental health crises, including suicide intervention and cell extractions. Officers assigned to mental health modules should receive more advanced training than those assigned to non-mental health housing.

20. The County should create and implement a management information system that allows prompt, up-to-date, and complete access to every inmate's medical/mental health record at all facilities, twenty-four hours per day. There should be a single, integrated medical/mental health record for each inmate rather than a separate record at each facility.

21. Documentation in inmates' medical/mental health records should provide complete, accurate, and legible information regarding an inmate's mental health, including but not limited to: assessments, treatment planning, administration and effect of medications, requests for and results of laboratory tests, and inmate progress or decompensation.

22. The Jail's inmate tracking system should permit mental health and correctional staff to locate promptly specific mentally ill inmates. The tracking system should also permit mental health or correctional services to ascertain quickly and accurately the total number of inmates receiving mental health care, including psychotropic medications, or housed in mental health housing.

23. Communication between the Jail's facilities should allow for consistent classification and treatment of inmates with mental illness. Sending facilities should notify receiving facilities when they are sending an inmate with mental illness. The Jail should develop a

system to classify inmates consistently between facilities in order to minimize transfers due to disagreement between facilities regarding proper classification.

24. Suicide observation cells and dormitories should be maintained in a manner that is safe and will not exacerbate a suicidal inmates' mental condition. Inmates under suicide observation should be housed within sight and sound contact of staff.

25. Suicide watch procedures should be modified to provide for five minute and one-on-one suicide watch as well as fifteen minute suicide watch. Observation should be documented.

26. The County should ensure that an inmate observed to be potentially suicidal receives immediate crisis intervention, including placement in a safe setting, and is evaluated in a timely manner by a qualified mental health professional to determine whether and what level of suicide observation is required. An inmate under suicide observation should be evaluated by a qualified mental health professional prior to being removed from mental health observation.

27. Suicide intervention procedures should permit correctional staff to administer appropriate first-aid measures immediately. All correctional officers should be trained in first aid and cardiac pulmonary resuscitation, cutdown techniques and emergency notification procedures in the event of hanging. Officers should be permitted to enter cells singly under some circumstances and should have cut down tools available.

28. The Jail should implement and document a continuous quality improvement program for mental health services in the Jail. This program should monitor the quality of mental health care, through, for example, clinical review of mental health records and peer review. The program should specify the procedures for medical and administrative review in the event of suicides, suicide attempts, mutilations, and other critical incidents. Chart reviews, mortality reviews, deliberations, and subsequent actions taken, should be thoroughly and accurately documented. The continuous quality improvement program should ultimately improve all aspects of mental health care in the Jail.

29. The County should continue its diversion and court alternative sentencing programs, and if possible expand

these programs, to reduce the number of mentally ill individuals unnecessarily detained in the Jail. County law enforcement officers should be educated regarding the availability of these programs and encouraged to use MET and SMART.

IV. RESOLUTION OF ISSUES

Pursuant to the Civil Rights of Institutionalized Persons Act, the Attorney General may initiate a lawsuit to correct deficiencies at an institution forty-nine days after appropriate officials are notified of them. 42 U.S.C. § 1997b(a)(1). We will, however, seek to resolve the issues raised above in the same cooperative spirit that has characterized the investigation to date. We look forward to your response to these findings and recommendations and to detailed discussions leading to a final resolution of these issues.

Sincerely,

Isabelle Katz Pinzler
Acting Assistant Attorney General
Civil Rights Division

cc: Sheriff Sherman Block
Los Angeles Sheriff's Department

Ms. Areta Crowell
Director
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