County of Los Angeles
Sheriff's Department Headquarters
4700 Ramona Boulevard
Monterey Park, California 91754-2169

LEROY D. BACA, SHERIFF

February 7, 2012

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
Los Angeles, California 90012

Dear Supervisors:

REPORT BACK FROM THE SHERIFF AND THE DIRECTOR OF MENTAL HEALTH REGARDING THE RELEASE OF MENTALLY ILL FELONS IN CUSTODY INTO THE GENERAL POPULATION

On January 10, 2012, your Board requested that the Los Angeles County Sheriff's Department and the Department of Mental Health report back on the motion to provide a plan regarding the parameters for when mentally ill felons in custody are released into the general population, and how they are monitored and supervised. The attached document provides the requested information regarding the movement of mentally ill inmates and the Jail Mental Evaluation Team.

Should you have any questions or require additional information, please contact Assistant Sheriff Cecil W. Rhambo, Jr., at (323) 526-5065 or Doctor Roderick Shaner, at (213) 738-4603.

Sincerely,

LEROY D. BACA
SHERIFF

MARVIN J. SOUTHARD, DIRECTOR
DEPARTMENT OF MENTAL HEALTH

MOVEMENT OF MENTALLY ILL INMATES AND HOW THEY ARE MONITORED AND SUPERVISED

COUNTY OF LOS ANGELES - SHERIFF'S DEPARTMENT

The purpose of this document is to provide the Los Angeles County (County) Board of Supervisors with a summary of the role of the County Department of Mental Health (DMH) and the process of handling mentally ill inmates within the County Jail system.

OVERVIEW

The County DMH Jail Mental Health Services (JMHS) is responsible for the provision of care for men and women identified as having mental health needs while incarcerated in the Los Angeles County Jails. Specific inmate mental health needs are based upon clinical assessments, regardless of legal status or whether their destination is the community, transfer to a state hospital, or state prison. Throughout the nation, jail facilities have been increasingly relied upon as a treatment site for those with serious and persistent mental illness. Among those incarcerated, the mental illness and co-occurring substance abuse acuity level has increased significantly. In turn, the focus of JMHS has been to enhance services available to the most severely ill, including expanded group programming and injectable medication for inmates with difficulties adhering to the administration of regular oral medication. In the face of unrelenting rates of recidivism as high as 93 percent, emphasis has also been placed on referring inmates facing release, to community-based services to help ensure the continuity of care, promote a better quality of life, reduce psychiatric relapse and associated jail recidivism.

The Jail Mental Evaluation Team (JMET) addresses the needs of mentally ill inmates within the custody of the Department. The primary responsibility of the JMET is to identify mentally ill inmates who may be in need of assistance and to address their special needs. There are a total of eight sworn personnel, which includes one sergeant, and seven deputies. Each team consists of one deputy and one mental health clinician. Two north teams are assigned to, and are responsible for, every facility within Pitchess Detention Center. Five south teams are responsible for the Century Regional Detention Facility (CRDF), Twin Towers Custody Facility (TTCF), and Men's Central Jail (MCJ). The JMET's are available seven days a week, primarily between 0600-1600 hours.

JMET also conducts the following tasks:

- Respond directly to custody housing areas regarding requests by custodial staff.
- Respond to crisis situations and/or tactical situations.
- Act as consultants or be used to communicate with a mentally ill inmate in an effort to defuse a situation, as a result of the specialized training they receive.
- Conduct sweeps of general population housing areas to look for and evaluate inmates in need of mental health care.

- Conduct follow-up with an inmate within 72 hours of declassification from mental health housing area.
- Provide intervention services and transportation to clinics.
- Conduct discipline follow-up checks to ensure inmates are disciplined for rule violations, and not issues related to mental health.

In 2011, JMET contacted approximately 236,740 inmates (see JMET documentation Attachment I).

In 2002, the Department entered into a Memorandum of Agreement with the United States Department of Justice (DOJ), Civil Rights Division as a monitor. In their most recent report, September 20, 2010, the DOJ provided favorable comments with the level of effort devoted to the needs of inmates at MCJ with serious mental illness as well as the "admirable performance" of the JMET. They also recommended in their report the need for additional JMET staff to serve at MCJ.

MENTAL HEALTH HOUSING

The entry points to the Jail system are Reception Centers (RC) at the Inmate Reception Center (IRC) and CRDF. IRC is located in downtown Los Angeles and is the processing area for approximately 13,000 men per month. The RC for women located at CRDF in Lynwood, processes approximately 4,500 women per month. During a medical and mental health screening process conducted by Department personnel, over 3,000 men and 1,500 women per month are referred to the JMHS mental health units of the RC's that operate 24-hours/ 7days per week.

Approximately 2,800 individuals or 17 percent of the total inmate population receive mental health services on any given day (details outlined in Attachment II). The majority are housed in mental health areas for men at TTCF and for women at CRDF where treatment and services are provided by professionals who understand the ways in which mental illness impacts behavior. Symptoms of schizophrenia include an unusual manner of relating, avoidance of eye contact and being distracted while responding to voices internally. Inmates who are manic are often loud and agitated, talking and moving fast and erratically, believing they are stronger, smarter, faster and perhaps even invincible. The movement and response time of inmates with depression can be markedly slowed and they are often unable to attend to what is going on around them. Because of such behavioral issues, it is important that anyone responsible for the care of mental health inmates have the knowledge and skills to interact effectively and ensure a safe environment.

Services in mental health housing areas are organized into four primary categories based on the intensity of care necessary to facilitate recovery of each inmate (Attachment III).

MOVEMENT OF MENTALLY ILL INMATES AND HOW THEY ARE MONITORED AND SUPERVISED

- A 46-bed mental health unit is licensed as part of the Correctional Treatment Center (CTC) to provide acute inpatient care as a Lanterman-Petris-Short (LPS) designated facility for individuals most in need due to their immediate danger to self or others and/or grave disability that severely interferes with their ability to function.

- Single and double cell High Observation Housing is assigned by Department personnel for those who do not need inpatient care to address the acuity of their illness, but require an intensive level of observation by custody to maintain their safety and security.

- Dormitory mental health housing is provided for inmates whose mental health needs can be cared for in a less intensive and more open setting than the high observation areas. Social workers, psychiatrists, psychologists, nurses, and group treatment providers including specialists in co-occurring mental health and substance abuse disorders, release planning and community-based resources use an interdisciplinary care coordination team approach to deliver care.

- General population housing, which includes housing areas in all seven custody facilities for those inmates that continue medication, but do not require the above treatments.

Individual and group interventions include assessment and treatment/release planning, medication management, stabilization of psychiatric symptoms, substance abuse, medication education, socialization skills and assistance with acquisition of skills that help people become successful in their communities and avoid recidivism.

TRAINING CURRICULUM

All deputies receive an eight hour course, taught by JMHS clinicians which focuses on recognizing symptoms of mental illness as well as effective approaches to interacting with inmates. In Jail Operations School, new recruits also receive a JMHS training module on mental illness for four hours. To continue and refresh their education, the Department regularly disseminates training bulletins, provides training classes and briefings (Attachment IV).

Over the past two years, a JMHS program manager has provided the training to more than a hundred sergeants and lieutenants in addition to Court Services staff. Training in triage assessment has been provided to custody assistants and nursing staff, and suicide prevention training is provided to the Department Medical Services Bureau on a monthly basis.

MOVEMENT OF MENTALLY ILL INMATES AND HOW THEY ARE MONITORED AND SUPERVISED

In addition to the standard training previously mentioned, JMET deputies undergo an extensive training program upon appointment to a JMET position. The following is a list of various training courses they attend:

- Introduction to Mental Illness (4 hours)
- Identification and types of mental illness and co-occurring disorders (2 hours)
- Crisis Intervention (8 hours)
- Suicide Prevention and Identification (4 hours)
- Pacific Clinic's conference on mental illness (8 hours)
- Mental Illness and Law Enforcement Systems conference (8 hours)
- Monitoring Mental Health in Jail Operations (4 hours)
- Sheriff's Academy – People with Disabilities POST class (12 hours)

MOVEMENT OF MENTALLY ILL INMATES

Generally, mentally ill inmates are either reclassified or declassified to a specific housing location. During the reclassification process when custodial staff encounters inmates whom they feel may need the attention of a mental health clinician, the appropriate JMET is notified to assess and reclassify if necessary. JMET interviews the inmate to assess their mental health needs. JMET may determine the inmate is not suitable to remain in a general population setting, in those cases, a Behavioral Observation and Mental Health Referral form is completed. Arrangements are made to transfer the inmate for a medical health clearance, then placement in intake mental health housing. If JMET determines an inmate needs further mental observation and/or housing, they may also handle the escort.

After hours, when JMET is not available, deputies regularly assigned to security functions have to transport the inmates to IRC for medical clearance, mental health assessment, and ultimately accompany them to a permanent housing location. In some cases this process takes several hours and removes security deputies from their primary assignment, which creates inadequate staffing levels for security and Title 15 purposes. Whereas, during dayshift hours, JMET is available to respond to requests, provide a mental health assessment, and provide transportation to a mental health housing location, if necessary. Although all deputies receive training on mentally ill symptoms, the JMET have enhanced training and experience. They also have a special interest in their assignment and their dedicated position allows them the opportunity to diffuse situations. Consequently, during evening hours, the custodial staff lacks the availability of JMET, which ultimately leads to an increased risk of force incidents.

All medical observation referrals must be medically cleared prior to transfer and are prioritized by Medical Services personnel. These inmates must be evaluated to determine if they are appropriate for transfer to mental health housing at TTCF. While JMET is on sight, they recommend the appropriate housing location at TTCF based on

their initial assessment of the inmate. The watch commander, in conjunction with Medical Services personnel, makes the final determination for immediate or routine transportation of the inmate.

During the declassification process, an inmate may be housed at a less-stringent mental health housing area or placed back into general population. When the inmate is placed in a less stringent mental health housing area, the custodial staff is aware of the inmate's mental health condition. However, when the inmate is placed back into general population, the custodial staff is often unaware of the inmate's mental health status. This is due to the large number of inmates moving through the jail system. In addition, custodial staff job assignments rotate, which also prevents them from becoming familiar with the inmates they supervise.

When an inmate is deemed to be fit to return to the general population, on occasion they become recalcitrant and refuse to cooperate with custodial personnel. In order to prevent these incidents from becoming instances where force may become necessary, the Department implemented policy to include language which states inmates will be returned to IRC and rehoused to a location other than that from which they originated. Attached are four flow charts that depict situations in which mental health inmates are moved on a daily basis (Attachments V through VIII):

- **Intake (Attachment V)** - Inmates that are initially booked into IRC and report mental health problems are placed in a High Observation Housing area and are reassessed by a mental health clinician. If it is determined that they do not have a mental illness (declassed), they are escorted to general population (approximately four inmates per day).

- **Reclassification (Attachment VI)** - Inmates housed in general or special population areas that have decompensated either because they have a mental illness that was not previously identified or are no longer stabilized are assessed by Mental Health and reclassified to a High Observation Housing for further assessment (approximately five inmates per day).

- **Declassification (Attachment VII)** - Mental health inmates in High Observation Housing areas that have been stabilized on psychotropic medication and no longer require that level of care are transferred (declassified) to general or special population areas (up to eight inmates per day).

- **After Hours (Attachment VIII)** - When JMET is not available, deputies regularly assigned to security functions have to transport the inmates to IRC for medical clearance and accompany them until permanent housing is identified in High Observation Housing (approximately five inmates per day).

MOVEMENT OF MENTALLY ILL INMATES AND HOW THEY ARE MONITORED AND SUPERVISED

FORCE ANALYSIS REGARDING MENTALLY ILL INMATES

The Department conducted a five-year analysis relating to force involving inmates with a history of mental illness. Throughout the five years, approximately 31 percent of the involved inmates had some history of mental illness; of those incidents, approximately 44 percent resulted in no injuries (Attachment IV). A further analysis of incidents in 2011, revealed a quarter of all incidents involving inmates with a history of mental illness were "rescue force," (where custodial staff responded to incidents in which force was necessary to prevent injuries to inmates involved in inmate assaults, or inmate attempts to harm themselves). The Department's analysis also revealed that force incidents primarily occurred during movement of inmates with mental illness. The analysis also notes that force was higher at TTCF and CRDF, due to these locations being primary housing of mentally ill inmates.

MENTAL HEALTH SERVICES

The Men's Jail Mental Health Services Program serves one of the largest populations of men suffering from mental illness and co-occurring substance abuse disorders in the country. The goal of the program is to provide correctional-environment based mental health services which instill hope and prepare inmates for a successful and sustainable reintegration into our communities. Inter-disciplinary care coordination teams utilize individual and group interventions for evaluation, treatment and release planning, medication services and crisis intervention. Teams include psychiatrists, psychologists, social workers, nurses, trainees, counselors and service coordinators who function as release specialists and facilitators of group activities, as well as staff from the Department's Department Medical Services Bureau and Custody Division.

The Women's Jail Mental Health Program provides services for women incarcerated at CRDF in Lynwood. In addition, cognitive behavioral interventions, motivational interviewing and small topic focused groups are among the many approaches utilized. Focus is on initiating a plan for sustainable integration into the community upon release from jail, including linkage with the nearby Women's Community Reintegration Services and Education Center, where comprehensive services address the mental health, substance abuse, health, housing, education, vocation and family support needs of women who have been or are at risk of incarceration. Many of these women struggle with histories of repeated arrests and incarcerations, persistent co-occurring mental health and substance disorders, domestic and community violence, unemployment, financial instability and children in out-of-home placement.

Inmates work with staff and peers to address crises, set goals, participate in individual and group treatment, and educational activities which focus on assisting inmates in acquiring skills which will be beneficial to their lives, one example is, "Moral Resonation Therapy," an evidence-based practice used successfully with prison populations to help those who are willing to stop the cycle of criminal related thinking and behaviors.

MOVEMENT OF MENTALLY ILL INMATES AND HOW THEY ARE MONITORED AND SUPERVISED

To aid mental health inmates in their transition from the correctional environment back into our communities, an emphasis is placed on best practices and cultural competency; as they relate to better preparing inmates for what is sometimes a difficult process.

RECOMMENDATIONS

The proposal for the expansion of JMET would fund six teams to work evening hours in order to enhance access to mental health clinicians and specially trained deputies, particularly focused on assisting custody staff when inmates need to be moved to or from mental health housing areas of the jail. Six additional deputies would add three additional teams without a social worker or six teams with social workers. The additional teams would provide overlap coverage during peak hours, from 1400 to 2400 hours. Due to the constant flow of inmates into and out of the men's facilities, housing assignments often change.

Based on the above, the Department is requesting $777,000 in annual funding for the 6 additional JMET deputies. The Department of Mental Health is requesting $547,299 annual funding be allocated to their budget to provide 6 additional Psychiatric Social Worker II items to assist the deputies in providing mental health services, which will directly impact the Department's mission to reduce violence in the jails.

In addition to augmenting JMET, the Department is working with Mental Health to expand our current training and provide specialized training to all custodial staff on an annual basis to include a review of general information on mental health related illnesses and techniques to assist in interacting with individuals suffering from co-occurring mental health and substance abuse disorders.

Attachment I

JAIL MENTAL EVAL TEAM STATATISTICS 2011

JMET SOUTH STATISTICS 2011	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Pro-Active Contacts													
High Observation Declass Follow-up Within 72 hours All I/M's from HOH that are de-classed to GP	140	120	118	105	110	107	105	120	116	121	129	132	1423
GP Sweeps twice a week	16300	15700	15300	15500	15700	15750	15820	15740	15726	15710	15790	15800	188836
Discipline Follow-up Seen by Custody Staff daily	200	180	190	110	190	135	159	172	167	152	148	154	1957
Re-Active Contacts													
All Mental Health Referrals	700	528	584	616	530	544	510	498	564	602	625	590	6891
Deputy Escorted Clinician Psychiatrist Interviews	655	595	694	550	628	615	585	668	624	621	566	540	7341
Direct Admit to Tower 1 (Mental Observation) JMET transfers directly to Tower 1	8	10	10	12	10	8	6	16	10	9	7	10	116
Direct Admit to Tower 1 (Suicide precaution) JMET transfers directly to Tower 1	25	27	18	20	15	18	20	18	20	15	12	17	225
TOTALS PER MONTH	18028	17160	16914	16913	17183	17177	17205	17232	17227	17230	17277	17243	206789

JAIL MENTAL EVAL TEAM STATATISTICS 2011

JMET NORTH STATISTICS 2011	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Pro-Active Contacts													
High Observation Declass Follow-up Within 72 hours All I/M's from HOH that are de-classed to GP	18	7	17	16	9	9	16	19	11	25	18	34	199
GP Sweeps twice a week	1501	1281	1589	1314	1357	971	713	605	446	396	411	961	11545
Discipline Follow-up Seen by Custody Staff daily	1101	941	1084	992	906	873	803	743	346	328	318	571	9006
Re-Active Contacts													
All Mental Health Referrals	451	443	572	447	459	568	520	621	566	563	612	741	6563
Deputy Escorted Clinician Psychiatrist Interviews	156	138	162	139	152	190	203	229	194	213	212	242	2230
Direct Admit to Tower 1 (Mental Observation) JMET transfers directly to Tower 1	16	16	29	14	23	25	21	26	19	32	19	27	267
Direct Admit to Tower 1 (Suicide precaution) JMET transfers directly to Tower 1	5	5	11	5	4	9	13	10	11	14	19	27	133
TOTALS PER MONTH	3248	2831	3464	2927	2910	2645	2289	2253	1593	1571	1609	2603	29943

Attachment II

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
ADULT JUSTICE, HOUSING, EMPLOYMENT AND EDUCATION SERVICES

MENTAL HEALTH CLIENT CENSUS
As of January 17, 2012

MEN'S JAIL MENTAL HEALTH SERVICES

	DORMITORY MENTAL HEALTH HOUSING	HIGH OBSERVATION SINGLE MAN	HIGH OBSERVATION DOUBLE MAN	MENTAL HEALTH UNIT OF THE CORRECTIONAL TREATMENT CENTER	TOTAL CLIENTS IN MENTAL HEALTH HOUSING	GENERAL POPULATION CLIENTS ON PSYCHOTROPIC MEDICATION	TOTAL CLIENTS RECEIVING MENTAL HEALTH SERVICES
SA 1 & 2	238	45	13	5	301		
SA 3 & 7	259	27	18	5	309		
SA 4	220	37	17	3	277		
SA 5 & 8	295	52	23	5	375		
SA 6	256	28	26	4	314		
TOTAL MEN	1,268	189	97	22	1,576	780	2,356

WOMEN'S JAIL MENTAL HEALTH SERVICES

TOTAL WOMEN	125	84		10	219	234	453

TOTAL JMHS CLIENTS	1,393	273	97	32	1,795	1,014	2,809

Note: The inmate population count for males is 14,224. 2,356 males receive mental health services and represent 16.5% of the male inmate population.
The inmate population count for females is 1,880. 453 females receive mental health services and represent 24.1% of the female inmate population.
The inmate count is 16,104. 2,809 clients receive mental health services and represent 17.4% of the total inmate population.

Attachment III

Mental Health Housing			
Step Down Chart			
CTC	Correctional Treatment Center	Hospital	46 Beds
172 ABC	INTAKE- 15 min checks	Single Man Cells	48 Beds
172 DEF	High Observation Housing - 15 min checks	Single / Two Man Cells	48 to 96 Beds
171	High Observation Housing - 15 min checks	Single Man Cells	96 Beds
162 ABC	High Observation Housing - 15 min checks	Single / Two Man Cells	48 to 96 Beds
162 DEF	Service Area - 60 Minchecks	Multi Man Cells	104 Beds
161	Service Area - 60 Minchecks	Multi Man Cells	272 Beds
152	Service Area - 60 Minchecks	Multi Man Cells	268 Beds
151	Service Area - 60 Minchecks	Multi Man Cells	256 Beds
142	Service Area - 60 Minchecks	Multi Man Cells	272 Beds
GP	General Population	Dorm / Cells	------

Attachment IV

MENTAL HEALTH TRAINING

MANDATED TRAINING

In the academy, Deputies receive 8 hours of classroom instruction, and an additional 8 hours of practical application relating to mental health training. We are still awaiting verification that Custody Assistants receive the same academy training.

An additional 4 hours of mental health training is received during the Jail Operations Class for both deputies and custody assistants prior to their jail assignment.

CUSTODY DIRECTIVE 10-001

Custody Directive 10-001 was issued June 2010 mandating recurring training for Custody and Correctional Division personnel.

The directive requires :

- 4 hours of training within the first 6 months of returning to Custody for all personnel (including supervisors and any professional staff who interact with inmates);
- Newly assigned deputies and custody assistants receive the 4 hour class in Jail Operations;
- 2 hour refresher course shall be completed each year;
- Briefings will be held quarterly.

INTENSIFIED FORMATTED TRAINING (IFT)

There are 2 IFT's currently available (each is a 2 hour block):

- Suicide Prevention
- Effective Interaction with the Mentally Ill

CUSTODY DIVISION FORCE TRAINING UNIT –RECURRING BRIEFING

Responding to Assaultive/High Risk Situations #October 2011 10/20/2011

CUSTODY OPERATIONS DIVISION-CORRECTIONAL SERVICES DIVISION

INFORMATIONAL BULLETIN
REBRIEFINGS

Bulletin	Date Sent
Recognizing the Early Warning Signs of Suicide #2007-02	07/14/2010
Mental Observation Inmates vs. Discipline Inmates #2007-03	09/16/2010
Inmate Suicide Prevention High Level Security Checks #2009-06	10/18/2010
Early Warning Signs of Inmates Nearing Suicide # 2009-05	11/22/2010
Recognizing the Early Warning Signs of Suicide #2007-02	12/21/2010
Initiation of a Behavioral Observation and Mental Health Referral Form # 2010	01/11/2011
Mental Observation Inmates vs. Discipline Inmates #2007-03	03/14/2011
Inmate Suicide Prevention High Level Security Checks #2009-06	04/11/2011
Recognizing the Early Warning Signs of Suicide #2007-02	05/11/2011
Initiation of a Behavioral Observation and Mental Health Referral Form #2011/01	06/14/2011
Early Warning Signs of Inmates Nearing Suicide # 2009-05	11/21/2011
Mental Observation Inmates vs. Discipline Inmates #2007-03	12/02/2011

The competency-based training points, referenced in the ACLU lawsuit (pg. 12), are included throughout the Custody and Correctional Informational Bulletins.

a. Interpreting or responding to bizarre or aberrant behaviors, (#2007-03)
b. Recognizing and responding to indications of suicidal thoughts, (#2007-02)
c. Proper suicide observation, (#2009-06)
d. Recognizing common side effects of psychotropic medications, (new bulletin in process)
e. Professional and humane treatment of mentally ill inmates, (#2007-04)
f. Response to mental health crises including suicide intervention and cell extractions. (#2009-05, CDM 5-05/080.00)

FUTURE TRAINING

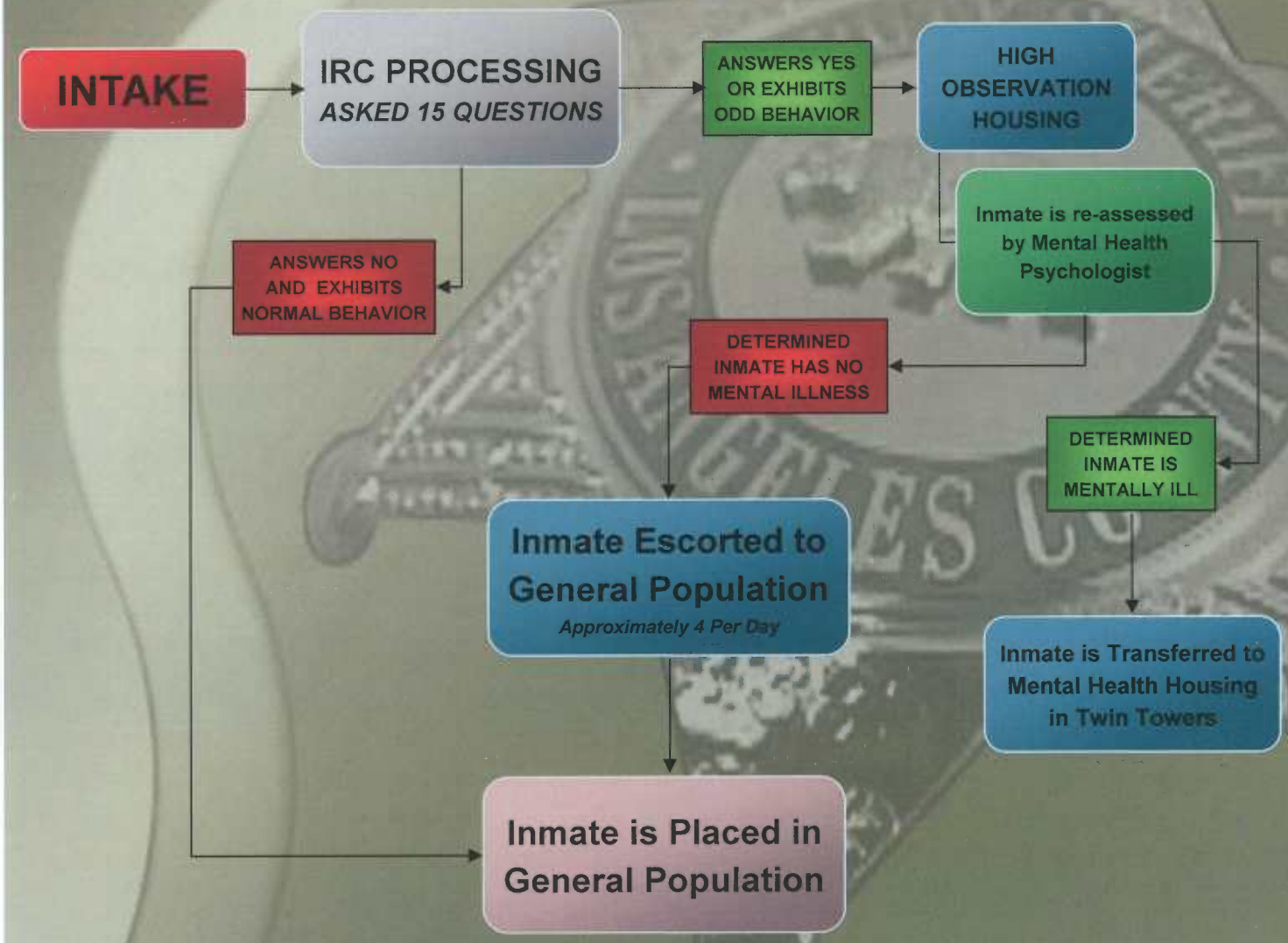
VIDEOS—Commander's Management Task Force (CMTF) has identified several videos currently being used in formal mental health training classes. These 15 minute videos will be made available to all personnel by uploading them to the Department's "LASD Training On-Line" web site and can be used in shift briefings.

NEW UNIT ORDERS—Facilities with DMH housing (TTCF/CRDF) will be required to write new unit orders mandating additional training for those personnel who work full time within DMH housing areas.

Attachment V

LASD MENTALLY ILL INMATES

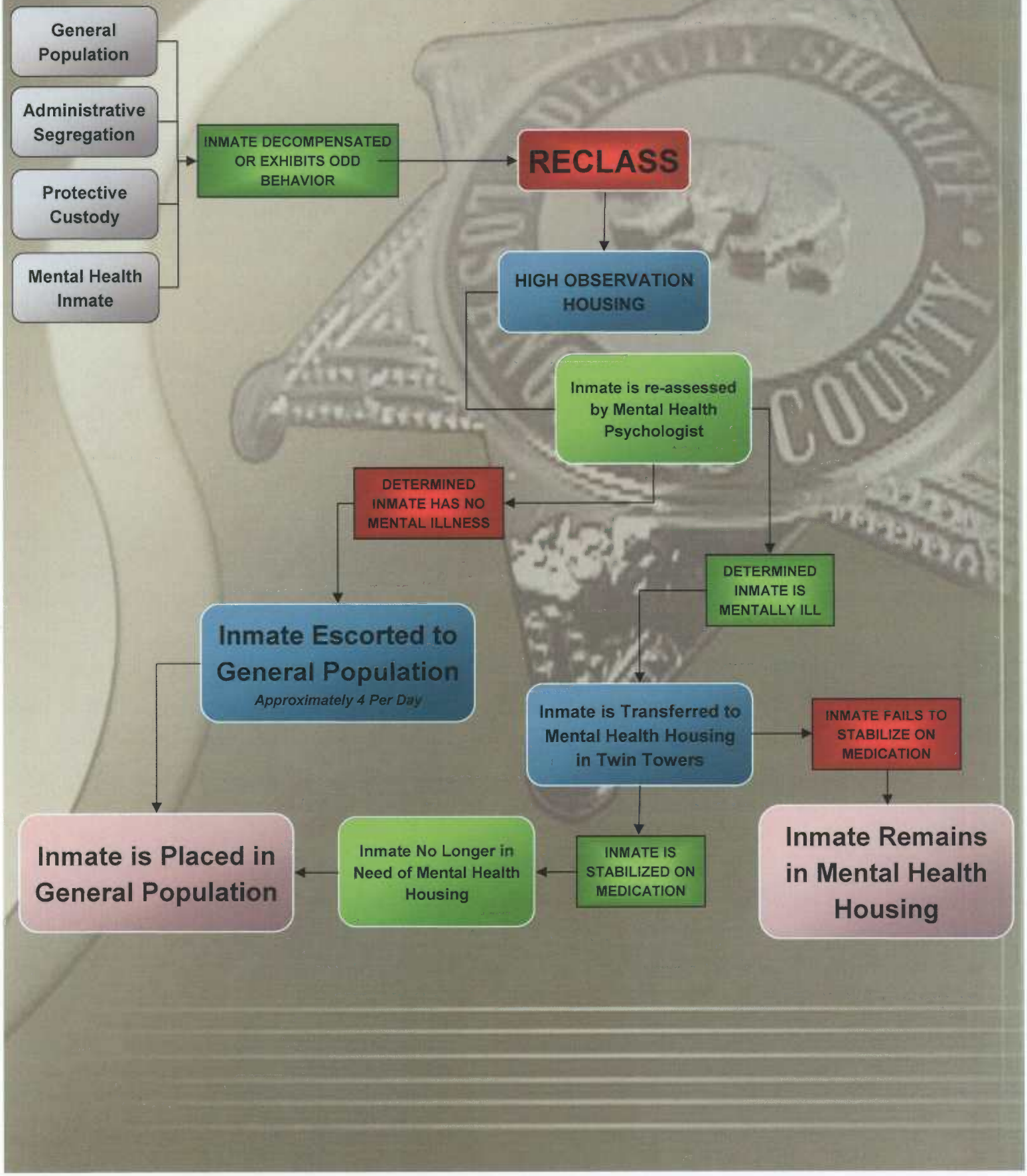
Movement and Monitoring in Custody—Intake



Attachment VI

LASD MENTALLY ILL INMATES

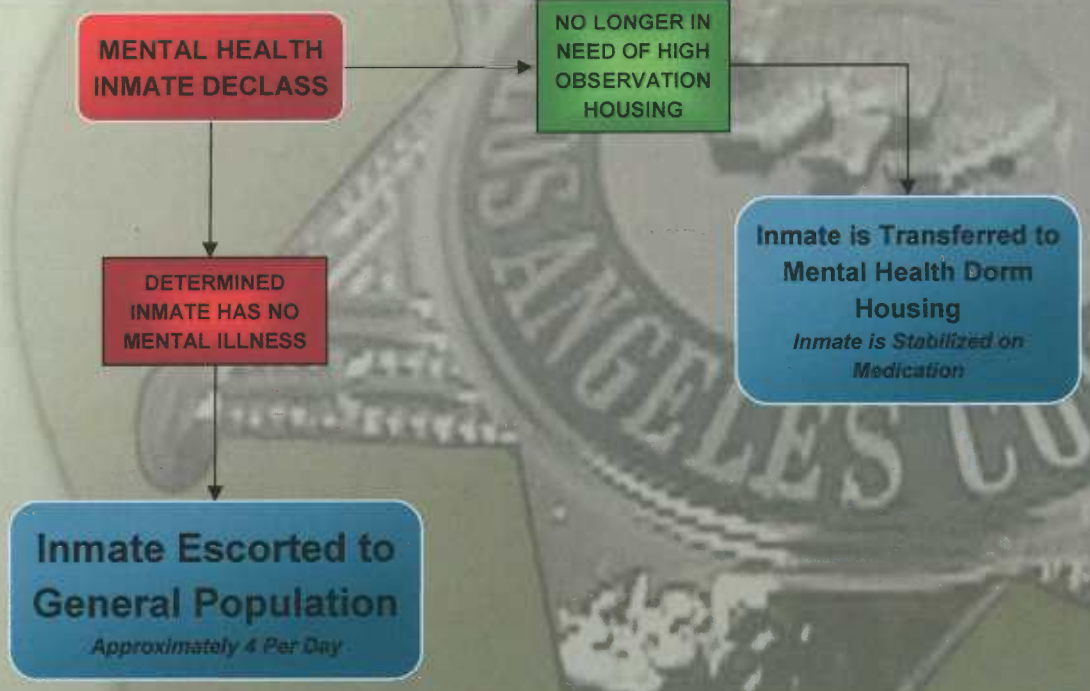
Movement and Monitoring in Custody—Reclass



Attachment VII

LASD MENTALLY ILL INMATES

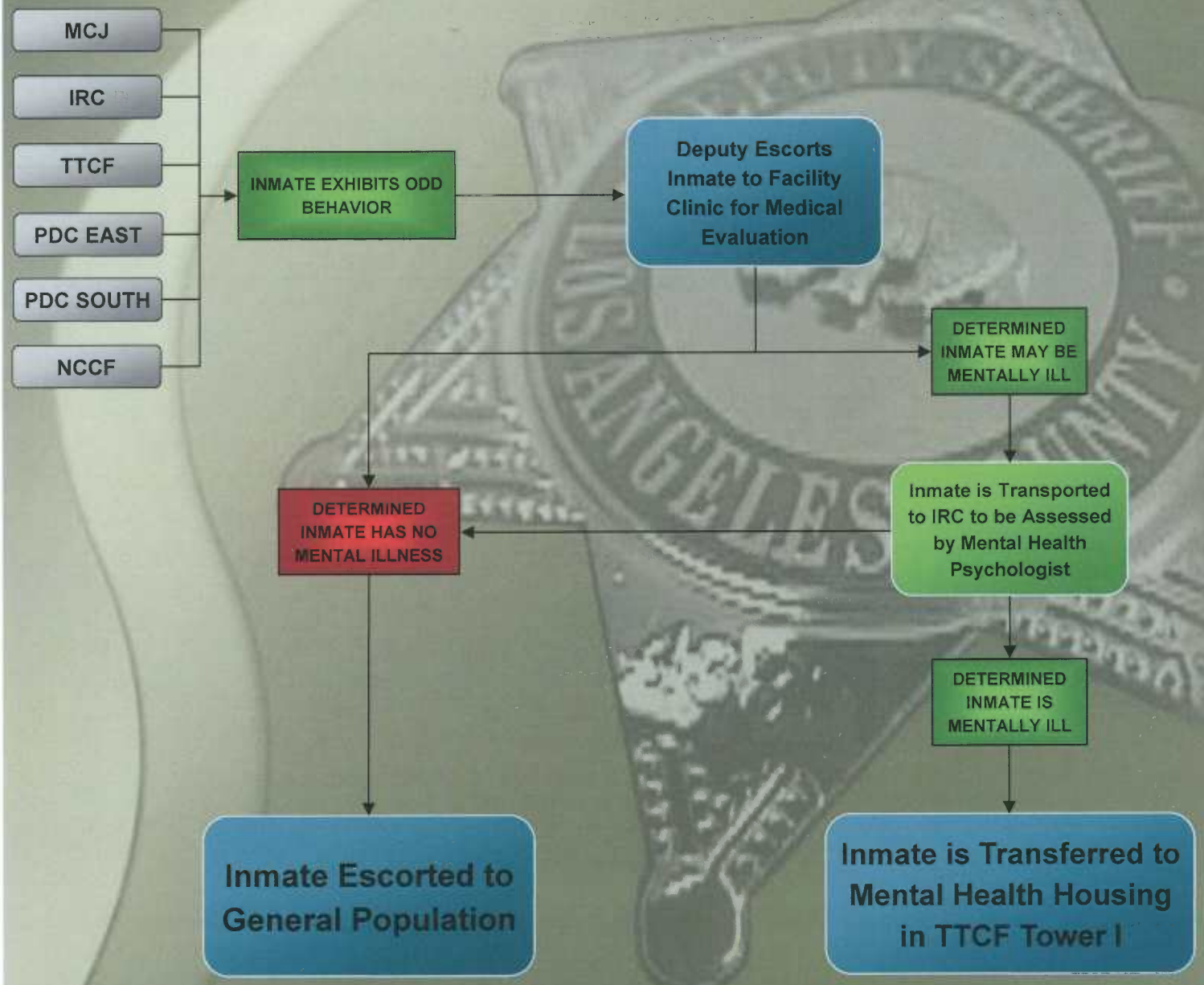
Movement and Monitoring in Custody—Declass



Attachment VIII

LASD MENTALLY ILL INMATES

Movement and Monitoring in Custody—After Hours



PLEASE NOTE: *INMATES HOUSED AT CRDF THAT EXHIBIT SIGNS OF MENTAL ILLNESS AFTER HOURS ARE EVALUATED AND HOUSED WITHIN CRDF*

Attachment IX

LOS ANGELES COUNTY SHERIFF'S DEPARTMENT

Use-of-Force Incidents involving
Inmates with/without Mental History
2007-2011*
FAST Data

USE-OF-FORCE INCIDENTS						
Facility	2007	2008	2009	2010	2011*	Total
CRDF	80	70	65	83	93	391
EAST	27	17	41	19	23	127
IRC	268	244	214	142	107	975
MCJ	367	273	330	168	172	1,310
MLF	11	8	5	5	3	32
NCCF	83	73	71	102	77	406
NORTH	40	33	8	0	0	81
SOUTH	5	17	26	19	13	80
TST	8	2	0	0	0	10
TTCF	225	243	296	201	94	1,059
Total	1,114	980	1,056	739	582	4,471

USE-OF-FORCE INCIDENTS INVOLVING AT LEAST ONE INMATE WITH A MENTAL HISTORY						
Facility	2007	2008	2009	2010	2011*	Total
CRDF	18	35	28	41	47	169
EAST	0	1	1	2	0	4
IRC	84	64	67	56	47	318
MCJ	2	39	43	24	25	133
MLF	0	0	1	0	1	2
NCCF	1	1	2	6	0	10
NORTH	0	3	0	0	0	3
SOUTH	0	2	1	1	1	5
TST	2	0	0	0	0	2
TTCF	120	144	211	164	79	718
Total	227	289	354	294	200	1,364

USE-OF-FORCE INCIDENTS INVOLVING INMATES WITH MENTAL HISTORY As Percentage of All Incidents						
Facility	2007	2008	2009	2010	2011*	Total
CRDF	23%	50%	43%	49%	51%	43%
EAST	0%	6%	2%	11%	0%	3%
IRC	31%	26%	31%	39%	44%	33%
MCJ	1%	14%	13%	14%	15%	10%
MLF	0%	0%	20%	0%	33%	6%
NCCF	1%	1%	3%	6%	0%	2%
NORTH	0%	9%	0%	N/C	N/C	4%
SOUTH	0%	12%	4%	5%	8%	6%
TST	25%	0%	N/C	N/C	N/C	20%
TTCF	53%	59%	71%	82%	84%	68%
Total	20%	29%	34%	40%	34%	31%

*2011 data is preliminary.
N/C: Not calculable.

Source: FAST as of 01/04/12.

LOS ANGELES COUNTY SHERIFF'S DEPARTMENT

Inmate Mental History Status and Use-of-Force*

FAST Data

2007 - 2011**

				Inmate Injuries				Staff Injuries			
				No Injuries		Some Injury or Complaint of Pain		No Injuries		Some Injury or Complaint of Pain	
Incidents	Inmates	Staff		# Inmates	%	# Inmates	%	# Staff	%	# Staff	%
1,365	1,451	3,796	Use-of-Force Incidents involving at least one **Inmate with Mental History**	632	44%	819	56%	3,416	90%	380	10%
3,112	4,158	7,984	Use-of-Force Incidents involving only **Inmates without Mental History**	2,207	53%	1,951	47%	7,285	91%	699	9%
4,477	**5,609**	**11,780**	**Total**	**2,839**	**51%**	**2,770**	**49%**	**10,701**	**91%**	**1,079**	**9%**

There were 4,477 use-of-force incidents during the time frame. Within these incidents, 5,609 inmates and 11,780 staff members were involved.

There were 1,365 incidents involving at least one inmate with a mental history. Within these incidents, 1,407 of the inmates had a mental history and 44 inmates had no mental history (but were involved in an incident with an inmate who did). 3,796 staff members were involved in these incidents.

The remaining 3,112 use-of-force incidents did not involve any inmates marked as having a mental history. There were 4,158 inmates and 7,984 staff members involved in these use-of-force incidents.

Source: FAST as of 1/26/12.

* Accuracy of the chart depends on data entry and proper weapon/inmate/staff member association and classification.

** 2011 data is preliminary.

LOS ANGELES COUNTY SHERIFF'S DEPARTMENT

Inmate Mental History Status and Use-of-Force
FAST Data
2007 - 2011 YTD*

Percentage of Force Response to Inmates with a Mental History by Force Type**	
Use of Force Weapon/Action Type	**Percentage of Total Force Used**
Contol (Control Techniques)	33.3%
Restraint Device: Handcuffs	7.9%
Baton (Control)	0.0%
Contol Hold (Takedown)	9.6%
Control Hold (Team Takedown)	8.4%
Chemical Agents (OC Spray)	9.0%
Chemical Agents (Tear Gas)	0.1%
Chemical	0.0%
Taser	3.3%
Personal Weapon: Feet/Leg-Kick	1.3%
Personal Weapon: Feet/Leg-Sweep	0.4%
Personal Weapon: Hand/Arm	15.1%
Personal Weapon: Other	2.0%
Personal Weapon: Push	3.1%
Choke Hold	0.1%
Carotid Restraint	0.2%
Restraint Device: Hobble - Legs Only	3.9%
Restraint Device: Hobble (TARP)	0.4%
Baton (Impact)	0.1%
Flashlight	1.2%
Other Weapon: Blunt Object	0.1%
Other Weapon: Other	0.0%
SAP	0.0%
Shield	0.3%
Flashbang	0.0%
Firearm (Other)	0.0%
Arwen	0.1%
Sting Ball	0.0%
37MM Stinger	0.0%
Grand Total	100.0%

The primary force used on inmates with a mental history from 2007-2011 was the use of control techniques (33.3% of the force used). The next most common force response was the use of hands and arms as a personal weapon at 15.1%. Individual takedowns and team takedowns together made up 18% of staff force response. The use of restraint devices was next most common, with 7.9% handcuff use and 3.9% leg hobble use. OC spray was 9% of force used during these incidents. Use of personal weapons other than hands and arms together made up almost 7% of the force used. Taser use made up only 3.3% of the total force.

Use of all other types of force made up less than 3% of the force response. Flashlight use was 1.2% of all force response, and other impact weapons (batons, SAP, blunt objects) were less than half of a percent of the total force used.

*2011 data is preliminary.

**Only incidents involving only one inmate, where inmate action and staff force response could be determined, and where inmate mental history was determined were included in the analysis. Errors in data entry or classification may skew results. A total of 1,296 incidents were used in this analysis. This chart counts individual uses of force: force types were counted each time an individual staff member used force, but only one type of force per staff member was recorded.

Source: FAST system as of 01/26/12.