

Preventable Tragedies

How to Reduce Mental Health-Related
Deaths in Texas Jails



The University of Texas at Austin School of Law Civil Rights Clinic

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EXECUTIVE SUMMARY

The first section of this report tells the stories of ten tragic and preventable deaths in Texas jails. These ten people suffered from mental disorders and related health needs, and died unexpectedly in jail as a result of neglect or treatment failures.

Terry Borum was a 53-year-old grandfather who suffered from depression and alcoholism. He died from a head injury sustained during severe, untreated alcohol withdrawal in Swisher County Jail.

Gregory Cheek was a 29-year-old artist and surfer who had bipolar disorder and schizophrenia. He died from a bacterial infection in Nueces County Jail after the jail failed to transfer him to a state hospital or attend to his medical needs.

Amy Lynn Cowling was a 33-year-old mother of three who had bipolar disorder and was in treatment for opioid addiction. She died in Gregg County Jail after suffering severe withdrawal seizures resulting from abrupt withdrawal from prescribed medication.

Lacy Dawn Cuccaro was a 28-year-old mother of two who had bipolar disorder, depression, and anxiety. She committed suicide by hanging in Hansford County Jail after the jail failed to properly monitor her.

Eric Dykes was a 25-year-old man who had bipolar disorder. He committed suicide by hanging in Hays County Jail in a cell that was not suicide-resistant after jail staff ignored his statements that he felt suicidal.

Victoria Gray was an 18-year-old young woman who had bipolar disorder and schizophrenia. She committed suicide by hanging in Brazoria County Jail after jail staff failed to notify a magistrate about her.

Jesse C. Jacobs was a 32-year-old man who suffered from anxiety. He died in Galveston County Jail after several seizures caused by unsupported withdrawal from his prescription anti-anxiety medication, which the jail denied him.

Robert Montano was a 41-year-old father with a known history of psychiatric illness. He died in Orange County Jail after five days of isolation without any mental health assessment or treatment.

Robert Rowan was a 27-year-old man who died in an isolation cell in Smith County Jail from complications stemming from unsupported withdrawal from anti-anxiety medication after jail staff failed to properly monitor him.

Carl Chadwick Snell was a 39-year-old father who suffered from bipolar disorder. He committed suicide by hanging in Denton County Jail after the magistrate took no action following notification.

The second section of this report sets forth widely accepted policy recommendations based on national standards and best practices to improve diversion and treatment of persons with mental illness and related health needs who are incarcerated in Texas county jails.

RECOMMENDATION NO. 1: INCREASE JAIL DIVERSION FOR LOW-RISK PEOPLE WITH MENTAL HEALTH NEEDS.

As state and local stakeholders develop pretrial diversion programs, they should ensure that mental illness is factored in, and not as a barrier to pretrial release. In addition, the Legislature and counties should find new ways to reduce warrants and arrests for low-level misdemeanors, to prevent the use of jails for low-risk arrestees.

RECOMMENDATION NO. 2: IMPROVE SCREENING.

As counties implement the revised mental health screening instrument, they should train correctional officers to recognize signs of mental illness and suicide risk, and explore partnerships with their local mental health authority (LMHA) to have mental health professionals from the LMHA assist with intake screening.

RECOMMENDATION NO. 3: INCREASE COMPLIANCE WITH TEX. CODE CRIM. P. §§ 16.22 AND 17.032.

The legislature should clarify the law to increase compliance with the requirement that magistrates be notified of an arrestee's mental illness or suicide risk, so as to enable pretrial diversion into mental health treatment when appropriate. Counties should implement the law's requirements, using partnerships with LMHAs if needed.

RECOMMENDATION NO. 4: STRENGTHEN SUICIDE PREVENTION.

Counties should make their suicide prevention plans more effective by: (1) increasing training and promoting culture change; (2) providing for ongoing suicide risk assessment throughout an inmate's stay in the jail; (3) avoiding housing at-risk inmates alone; (4) designating suicide-resistant cells; and (5) having mental health professionals assist with the assessment of suicide risk.

RECOMMENDATION NO. 5: COLLABORATE WITH LOCAL MENTAL HEALTH AUTHORITIES.

County jails should form broad—and preferably formal—partnerships with their area LMHAs, and work to place LMHA staff in the jail full-time. The Legislature should fund LMHAs to add capacity to provide more services in jails.

RECOMMENDATION NO. 6: BOLSTER FORMULARIES.

County jails should promote continuity of mental health care by (1) including in their formulary the medications listed in the local mental health authority's formulary and (2) contracting with outside providers to quickly acquire any medication not kept in stock.

RECOMMENDATION NO. 7: PROMOTE MEDICATION CONTINUITY.

County jails should promote continuity of care by allowing inmates to continue taking prescribed medication that the inmate had been taking prior to booking, after taking certain precautions. Specifically, county jails should replace policies of denying access to prescribed medications with more flexible alternatives.

RECOMMENDATION NO. 8: DEVELOP AND UPDATE DETOX PROTOCOLS.

Each county jail's health service plan should include a detoxification protocol for supporting withdrawal from alcohol, opioids, benzodiazepines, and other commonly used substances, in conformance with current national standards.

RECOMMENDATION NO. 9: ADD FORENSIC PEER SUPPORT.

County jails should strengthen their mental health care services by implementing a forensic peer support program.

RECOMMENDATION NO. 10: IMPROVE MONITORING.

Counties should promote more effective monitoring of inmates by: (1) requiring jail staff to proactively engage inmates and take action during regular observation; (2) increasing the frequency of observation for at-risk inmates and setting irregular monitoring intervals; (3) ensuring adequate staffing; (4) using technology along with personal interaction to make observation more accountable; and (5) using technology to alert staff of inmate crises.

RECOMMENDATION NO. 11: REDUCE THE USE OF RESTRAINT AND SECLUSION.

County jails should (1) set an explicit goal to reduce the use of restraint and seclusion, with an eye toward eliminating them altogether; (2) abolish the most dangerous restraint and seclusion practices; and (3) train officers to reduce reliance on restraint and seclusion, and collect data to evaluate performance. The Texas Legislature should require stricter regulation of seclusion that mirrors its strict regulation of restraint.

RECOMMENDATION NO. 12: LIMIT THE USE OF FORCE.

County jails should strengthen their policies and training on use of force, explicitly address use of force against inmates with mental health needs, promote the goals of eliminating excessive use of force, and use force only as a last resort.

Authors

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Methodology

Section I of the report is based on one or more of the authors' interviews of family members of the individuals profiled here. Notes of interviews are on file with the Civil Rights Clinic of the University of Texas School of Law. For each story, the authors reviewed the Texas Rangers' Report of Investigation on the custodial death if one existed, as well as the Texas Commission on Jail Standards' file on the custodial death (which typically included a booking sheet, suicide screen, round sheet, autopsy report, and final report). The authors also reviewed select court filings in related wrongful death lawsuits, where available. Court filings referenced in the Endnotes are available through the Public Access to Court Electronic Records (PACER), an online electronic public access service (found at <https://www.pacer.gov>).

Section II of the report is based on based on one or more of the authors' research, with sources cited in the Endnotes. We consulted state jail regulations in the Texas Administrative Code whenever applicable, in addition to national standards and best practices. We also made Public Information Act requests to various counties. The Endnotes provide valuable research sources relating to jails and mental health.

For Section II, the authors also interviewed a number of subject matter experts who provided critical information and insights. These experts included: Michele Deitch, Senior Lecturer, LBJ School of Public Affairs and University of Texas School of Law; Matt Simpson, Senior Policy Strategist, ACLU of Texas; Douglas Smith, M.S.S.W., Policy Analyst, Texas Criminal Justice Coalition; Adan Munoz, Jr., former Executive Director of the Texas Commission on Jail Standards; Cate Graziani, Mental Health Campaigns Coordinator, Grassroots Leadership; Kathryn Lewis, Attorney, Disability Rights Texas; Tim Murray, Director Emeritus, Pretrial

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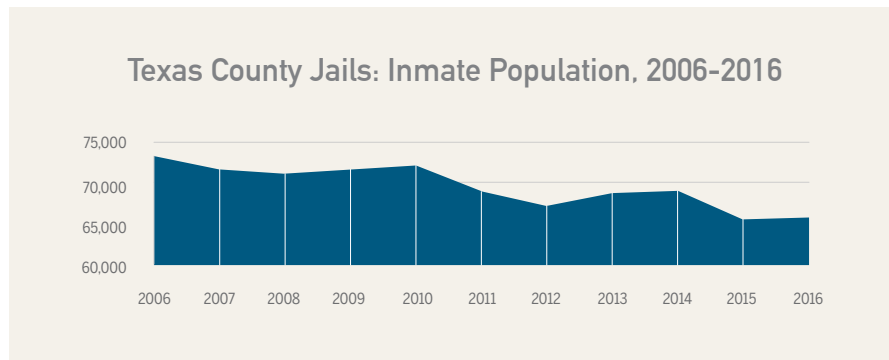
Photos on the front cover, page 32 and page 33 are courtesy of the Travis County Sheriff's Office. Unless otherwise noted, all photos in the family stories section were provided by the families.

INTRODUCTION

County jails around Texas, including the smallest rural jails, regularly house inmates with mental disorders and co-occurring substance use disorders.¹ These inmates have substantial needs for health care, and when those needs are unmet, the consequences can be fatal. This report tells the stories of ten Texas families whose loved ones passed away in county jails, in order to shed light on these preventable tragedies. The report also summarizes twelve key policy recommendations, which can be used by sheriffs, county officials, and state policymakers to reduce and help eliminate these jail deaths.

A significant percentage of county jail inmates have mental disorders. Some studies estimate that in the nation's jails, 14.5 percent of men and 31 percent of women suffer from serious mental illness.² Over 70 percent of people in jails who have serious mental illness also suffer from co-occurring substance use disorders.³ Despite this, studies show that between 83 and 89 percent of people in jails and prisons do not receive adequate care.⁴

People with mental disorders suffer in incarcerated settings. Jails are not designed or operated to provide a therapeutic setting; the lights, noise, rules, and real and perceived threats of violence are especially harmful to inmates with mental disorders.⁵ They are likely to stay for longer periods, have difficulty following facility guidelines, and spend more time in solitary confinement.⁶ Often, their mental health deteriorates, making them harder to manage for staff.⁷ When untreated, they are more likely to be the victims of violent behavior or to initiate violent acts.⁸



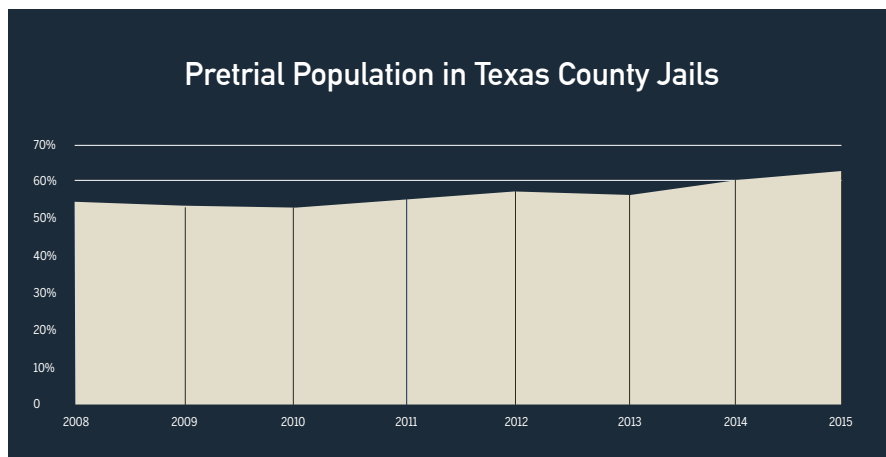
Source: Texas Commission on Jail Standards, Quarterly Inmate Population Reports, available at <http://www.tcjs.state.tx.us/index.php?linkID=326>

County jails, especially small ones or those in rural areas, often lack the financial or infrastructural resources to adequately address inmates' mental health needs.⁹ They may also lack adequate training and oversight, which are critical to detecting and attending to suicide risk and mental health crises. Further, some jails may lack a culture, instituted by jail leadership, that promotes the human dignity of all inmates, including those coping with mental illness and substance use disorders. As a result, inmates with mental health needs may go ignored and untreated, be subject to force, attempt to inflict self-harm, or even lose their lives.

This report documents the stories of ten Texas families who lost their loved ones to sudden and untimely deaths inside small and mid-size Texas county jails. Each story shows that when county jails lack the resources, training or will to provide adequate care, the consequences can be deadly. In July 2015, the untimely death of Sandra Bland in Waller County Jail sparked a discussion about the additional steps that could be taken to prevent jail deaths related to mental illness. The stories in this report shed further light on this important goal. This report also sets forth twelve widely accepted policy recommendations for steps that counties can take to reduce the risk of harm to inmates and staff, and to promote the dignity and recovery of inmates with mental health needs.

The Scope of Mental Health Needs in County Jails

County jails in Texas held approximately 65,000 inmates during each of the last few years.¹⁰ Currently, over 60% are being held pretrial, awaiting trial or convictions. Nationally, jail admissions have almost doubled in the last four decades, and the average length of stay has increased from 9 days to 23 days in the same time.¹¹ Although crime rates have dropped since 1991, jail use has grown, with small and mid-size counties experiencing the most growth.¹²



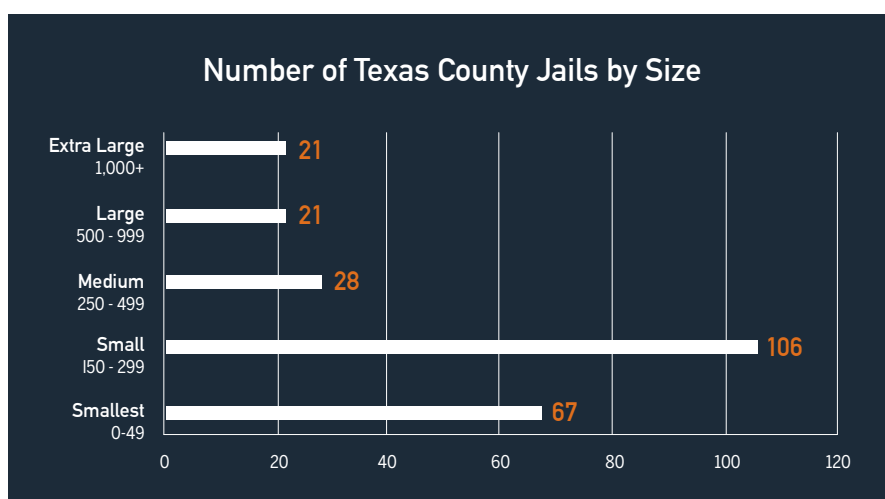
Source: Texas Commission on Jail Standards, 2013 and 2014 Annual Reports

The number of jail inmates with mental disorders has also grown, in part because of shortages of outpatient mental health services that followed a movement to deinstitutionalize long-term psychiatric treatment from state hospitals to community-based settings.¹³ Relatively few counties have developed diversion programs to avert arrests and move individuals with mental health needs out of jail and into community-based services that integrate mental health, substance use and homelessness services.¹⁴ As a result, local jails in Texas and around the country are tasked with providing mental health services for growing numbers of individuals.

According to the Bureau of Justice Statistics, 64 percent of the jail population in the U.S. has a mental illness.¹⁵ Jails across the nation serve an estimated two million people with serious mental illness each year.¹⁶ Three times as many people

with severe mental illness are in jails and prisons as are in hospitals.¹⁷ Based on numerous studies, it is estimated that 15 to 20 percent of jail inmates suffer from serious mental illness.¹⁸ Over 70 percent of inmates with serious mental illness also struggle with co-occurring substance use disorders.¹⁹

In Texas, state health officials estimate that 30 percent of jail inmates have one or more serious mental illnesses.²⁰ One survey found that one in five clients accessing state-funded mental health services reported prior criminal justice involvement.²¹ Those clients typically had a diagnosis of schizophrenia, bipolar disorder, or clinically severe major depression. Officials estimate that the cost of caring for those individuals in jail is approximately \$60 per day, while the cost of outpatient care through state-funded community mental health services is almost a fifth of that, or \$13.52 per day.²²



Based on data from Texas Commission on Jail Standards - Abbreviated Population Report for 6/1/2016 (2016), available at <http://www.tcjs.state.tx.us/docs/AbbreRptCurrent.pdf>

Evidence suggests that in Texas, low-risk arrestees with mental illness are overincarcerated—in jail when they should be receiving treatment instead.²³ A variety of factors contribute to this result, including state mental hospitals that are at full capacity, the lack of robust community behavioral health services across the state, and variances in pretrial diversion programs and usage between counties.²⁴

Nationally, small and mid-size county jails hold more than 75 percent of the jail population.²⁵ In Texas, small and mid-size county jails with a capacity under 250 account for over two-thirds of 243 county jails.

Counties face many challenges in meeting the needs of this population, including coordination of criminal justice and behavioral health systems, training staff on mental health, and operating with minimal resources.²⁶ Rural counties, such as the 172 in Texas, face additional hurdles such as having to share local mental health resources with nearby counties and lacking in-jail mental health staff.²⁷ Jails spend two to three times more on adults with mental illnesses that require intervention than on people who do not have these needs, without seeing improvements in

recovery or recidivism.²⁸ In Texas, for example, Harris County Jail is the largest mental health provider in the state.²⁹ Dealing with inmates suffering from mental illness also requires specialized training for staff.

Jails struggle to manage inmates with serious mental illnesses. They are more likely to stay longer, and if untreated to see their conditions worsen.³⁰ They are more likely to be subjected to physical attacks and victimization, and to solitary confinement.³¹ They are also more likely to attempt suicide.³²

The importance of meeting the medical needs of inmates with serious mental illness cannot be overstated. Access to appropriate medication can ameliorate psychotic symptoms and severe mood disturbances. When inmates do not have access to psychotropic medications in jail, their mental health can quickly and severely decline.³³

Promoting Recovery for Inmates with Mental Health Needs

For too long, the population of inmates with mental health needs has been treated as a criminal justice challenge, rather than as a part of a public health challenge. In recent years, more and more counties have realized not only that mental health and criminal justice are intertwined, but that effective treatment and recovery systems must be in place both in the community and inside jails.³⁴ Counties of varying size have undertaken efforts to develop jail diversion programs for people with mental health needs, using local resources to meet local needs.³⁵ For example, counties have hired a full-time licensed mental health therapist at the jail to make assessments and provide treatment at the jail; provided telepsychiatry services at the jail through partnership with local mental health agencies; developed jail-based crisis intervention training for jailers; and designed community reentry programs.³⁶

Jail diversion is a critical component of reform. Diversion, which refers to the processes of connecting people with mental illness to treatment outside of the incarceration system and thereby reducing the number of low-risk inmates with mental illness, is critical to promoting recovery and preventing recidivism.³⁷ Diversion requires collaboration by stakeholders including law enforcement, mental health and other diversionary courts, mental health professionals, and judges.³⁸ Counties both urban and rural are beginning to implement diversion strategies based on the recognition that unnecessary pretrial detention harms the individual, is costly without reaping public safety benefits, and can be counter-productive in terms of impacting future criminal behavior.³⁹

Equally important, counties must improve access to mental health care for jail inmates. This means more and better staff training on mental illness, more effective jail leadership and oversight, a jail culture promoting human dignity for all, and a commitment to providing access to treatment for every jail inmate with mental disorders. The levels of care provided should meet community standards.

From implementing best practices for suicide prevention, to ensuring that people retain access to their prescribed medications, to providing peer support to enable

inmates to cope with their incarceration without resorting to self-harm, practices to promote health and recovery will enable counties to reduce the risk of death and harm to inmates with mental health needs.

Here in Texas, the Texas Commission on Jail Standards is a critical resource to counties in improving jail mental health policies. The Commission develops and enforces compliance with state regulations, conducts annual and additional facility inspections, and provides technical assistance on critical jail issues, among other things.⁴⁰ Counties should take advantage of the Commission's resources as they design solutions to meet the needs of inmates with mental illness.

Finally, robust data collection and analysis will help county jails measure successes and remaining challenges. For example, national jail suicide experts recommend that counties should investigate and review each attempted jail suicide to determine what additional steps to take to prevent future suicides.⁴¹ In Waller County, following the death of Sandra Bland, county authorities commissioned an independent investigation that resulted in a number of recommendations, including periodic psychiatric evaluations for jail staff and the use of emergency medical technicians to aid in the early mental health screening and assessment of inmates.⁴² Self-study by county jails shows promise for preventing jail deaths relating to mental illness.

The Benefits of Improving Jail Mental Health Policies

Jail policies promoting mental health treatment and recovery have numerous benefits. First, such policies produce significant health and public safety benefits.⁴³ Tens of thousands of jail inmates return to the community after their jail stays each year. Lapses in mental health treatment undermine these individuals' path to recovery, and result in greater burdens on state and local mental health systems. In addition, disability-related behavior that may have led to a prior jail stay is less likely to recur after adequate and consistent treatment, thereby preventing re-arrest.

Second, jail policies promoting mental health treatment make good economic sense.⁴⁴ Rather than spending significant funds to jail low-risk arrestees with mental health needs, counties can refer them to less expensive and more effective outpatient treatment. Rather than paying for settlements and verdicts in wrongful death lawsuits to inmates' families, counties can invest in training and oversight procedures to reduce the risk of harm.

Finally, both state and federal law obligate county jails to identify the mental health needs of inmates and provide medication, treatment and other supports as needed.⁴⁵ Federal anti-discrimination laws prohibit county jails from denying essential benefits—such as safe housing and medical care—to inmates on the basis of their disability, including psychiatric disability.⁴⁶ The law also requires jails to make reasonable accommodations for inmates with psychiatric disabilities, rather than ignoring their unique needs.⁴⁷

PREVENTABLE TRAGEDIES: STORIES FROM FAMILIES

On July 13, 2015, the untimely death of Sandra Bland in Waller County Jail following a questionable traffic stop and arrest presented another preventable tragedy in the ongoing national conversation on race and law enforcement. Bland herself had been active in a growing grassroots political movement, and news of her suicide by hanging shocked her family, loved ones, and allies. The case prompted an investigation in Waller County, as well as efforts by Texas policymakers and jailers to examine more ways to prevent jail suicides. In the wake of her death, legislators convened hearings, the state jail oversight agency revamped the jail suicide screening tool and related training, and advocates proposed additional measures to prevent suicide and improve jail safety.

As Sandra Bland's mother herself reminded people, Bland was not the only person to die in a Texas jail. Many Texans with unmet mental health needs unexpectedly lost their lives while awaiting trial or serving time in county jails for petty crimes. For people with mental health needs and related medical needs, jails have sometimes proven deadly. Jails have failed to screen and safely house inmates with elevated suicide risk, restricted access to prescribed psychiatric medications, failed to connect inmates with urgently needed mental health diagnosis and treatment, subjected them to improper seclusion and poor observation, and more. As a result, people with mental health disorders have died unexpectedly or committed suicide in Texas county jails.

The stories of people with mental health needs who died in Texas county jails are rarely told, but each story provides important insight into jail safety reforms that can save lives. Below are the stories of ten such individuals who lost their lives too soon while in jail, and whose families hope that telling these stories will spur much-needed jail reforms.



Terry Borum was a 53-year-old grandfather who suffered from depression and alcoholism. He died from a head injury sustained during severe, untreated alcohol withdrawal in Swisher County Jail.

On January 28, 2013, Terry Borum was arrested on an outstanding warrant for an incident that had occurred months earlier. After pulling their truck out from a ditch on Terry's land, some men demanded Terry pay them for damage to the truck. Outnumbered, Terry got his .22 from his trailer and went to the men to get his money back. "He popped one off in the dirt and he asked for his money," his son Justin says.

The police were called, but they decided not to arrest him. Months later, a warrant was issued, and the police picked him up and booked him into jail. Three days after that, Terry Borum was dead, having hit his head in a fall while suffering from severe alcohol withdrawal.

Justin Borum remembers his father Terry as a loving yet tough man who upheld the traditional country values on the cotton farm where Justin was raised. "He was a strong guy," Justin says of his dad. "German, with the dark hair and bright blue eyes. He was a good-looking dude and a football player." To Justin, his father seemed larger than life—a cowboy with huge sandpaper hands and unruly bushy black eyebrows. "His wedding ring won't fit around even my thumb!" Justin exclaims.

Terry was a long-haul truck driver for more than twenty years. On his long rides around the country, he'd listen to all kinds of music. Justin recalls, "I was into long hair and rock bands, while he was into John Wayne and True Grit. But we did share a love for music."

Terry struggled with depression, and with alcohol dependence. "Dad drank his whole life, and that's just how he dealt with the depression," Justin laments. As a proud man rooted in traditional values, Terry didn't talk about his depression with his family, but Terry did seek out help for his mental health and alcohol dependency. "There were pamphlets and articles taped to the fridge," Justin says, "including AA materials and Bible verses—motivational things to stay strong."

Terry's struggle with depression had deepened in 2010 when he attempted suicide by gunshot. He survived, but lost most of his cheek and jaw, and had to have several reconstructive facial surgeries. "I was engaged and living in Lubbock when I heard Dad had shot himself. I went running." Having survived the suicide attempt, Terry was able to reconnect with his family. "I was there every day during his recovery," Justin recalls. "I remember the first time he opened his



eyes, his big baby blue eyes, I just thought: This is special, he made it through and now I get more time with him.”

Surviving the suicide attempt left Terry with serious medical issues, such as difficulty breathing from his destroyed nasal cavity, blindness in one eye, and a feeding tube sewn into his stomach. But these limitations didn’t keep him from living a full life with his children and grandchildren. Justin and his son would drive out to see Terry at his trailer, where he would teach the younger generations of his family how to cook.



But Terry was still alcohol-dependent when he was arrested in January 2013; once in jail, Terry went into alcohol withdrawal almost immediately.⁴⁸ The sheriff knew Terry, and he and his jail staff knew that Terry suffered from chronic alcoholism.⁴⁹ In the 12-cell jail, officers could see and hear Terry ranting, raving, and talking to an invisible friend as he hallucinated from the delirium tremens, a severe form of alcohol withdrawal.⁵⁰ “You could obviously tell he was a medical risk,” a jail officer later admitted in a deposition. “I mean, we couldn’t—we couldn’t take care of him.”⁵¹

Despite Terry’s withdrawal symptoms, the jail’s only treatment was to throw him in a so-called detox cell by himself and give him orange juice and honey instead of nutrition through his feeding tube.⁵² In a deposition, the sheriff admitted that he didn’t think the jail’s orange-juice-and-honey treatment was appropriate at the time, but that he intentionally chose not to call a doctor or take Terry to the hospital because of budgetary concerns; the jail’s annual medical care budget was just \$7,500.⁵³

On February 1, 2013, three days after being taken into custody, Terry fell in his cell and hit his head. The jail finally called 911, but with Terry’s medical condition, the lack of nutrition, and untreated alcohol withdrawal, he was already in a weakened state from which he would never recover. He died at the hospital from a subdural hematoma—a pooling of blood around the brain.⁵⁴

While Terry was on his way to the hospital, jail officials and the sheriff scrambled to release him from custody in order to avoid the medical costs. Before they even notified Terry’s family, they released him from custody by dropping all of the charges against him.

A jury later directed Swisher County to pay Terry’s family \$1 million for their loss.⁵⁵

Justin will never forget his father. “He was such a hoot to be around. He was a funny guy. I had some of the best times of my life with him. I sure do miss him. I miss him so badly. My sister and I loved him so much.”

Gregory Cheek was a 29-year-old artist and surfer who had bipolar disorder and schizophrenia. He died from a bacterial infection in Nueces County Jail after the jail failed to transfer him to a state hospital or attend to his medical needs.



On October 22, 2010, covered in blue paint, Gregory Cheek was arrested in someone else's backyard on charges of criminal trespass. Gregory had broken into the home and painted the walls blue and yellow.⁵⁶ Gregory had a long history of mental illness that included paranoid schizophrenia and bipolar disorder resulting in delusions and hallucinations.⁵⁷ Less than four months later, after being found incompetent to stand trial,⁵⁸ Gregory died at age 29 in Nueces County Jail on February 7, 2011.



Although Gregory's mental illness was serious, his family remembers him not for his illness but for the man he was: an artist, surfer, skater, and a beloved husband, father, and son. Known also as an artist named Sueños, Gregory Cheek is still remembered through events such as the Sueños Memorial Surf & Skate Jam in Corpus Christi, a tribute to his impact on the Gulf Coast art and sport culture.⁵⁹

But his illness was not always easy to manage. If he got off his medications, Gregory was unable to care for himself, and on several occasions he was involuntarily committed to inpatient mental health facilities.

At the time of his arrest in October 2010, Gregory weighed 175 pounds and was in good physical health.⁶⁰ His intake form indicated no medical problems or medication.⁶¹ His form also indicated no mental illness despite Gregory's delusional state at the time of his arrest.⁶²

Nonetheless, it became clear how ill Gregory was very quickly. Twice in November, the jail's psychiatrist urged the jail to transfer him to the state hospital, though neither request was granted.⁶³ On December 20th, a magistrate judge deemed Gregory incompetent to stand trial and ordered him transferred to a state hospital.⁶⁴ That order was not followed.⁶⁵

Gregory did not fare well in jail. In the Texas Rangers' postmortem investigative interviews, other inmates said Gregory "would tear up books and eat them"⁶⁶ and that he was "often naked and was usually close to the door and running in place."⁶⁷ Gregory often slept on a cold concrete floor without blankets because jail officials had removed his mattress and bedding when he tore it up; instead, he would sometimes sleep on Styrofoam food containers.⁶⁸

Even though his mother Katie Cheek called the jail repeatedly and told them of his condition, his medications, and gave contact information for his physicians, the jail provided her no information on his health. Moreover, the jail kept Katie

from seeing or speaking to him, despite her many calls. Gregory asked the jail to allow Katie to visit him, but they denied him because he couldn't remember her birth date.⁶⁹ "It was heartbreaking," says Katie, "not to be able to visit him."

The jail allowed Gregory to make collect calls to his family only once per month, and always in the middle of the night. Katie explains, "The first time, I woke up the next morning to a voicemail: 'You are receiving a collect call from:' and then I hear his voice saying, 'Greg Cheek.' The second time, I woke up the next morning to a voicemail, 'You are receiving a collect call from: Greg Powers'—Powers is my maiden name. The third time I woke up to a voicemail where all I could hear was unintelligible murmuring." By the time she heard that last recording, Katie knew from Greg's voice that he had deteriorated very badly and she began to fear for his life.

Despite Gregory's severe symptoms, the jail psychiatrist ignored requests from medical staff to check on Gregory and give him injectable medication.⁷⁰ She also did not refer Greg to emergency treatment at a nearby hospital. Katie laments that the doctor "knew everything about Greg's condition, yet she did nothing. It is truly scary to think of anyone being in that doctor's care."

By early February, Gregory's physical condition also had declined severely. On February 2, 2011, he was seen for severe swelling in his legs and calves.⁷¹ Jail nurses recorded his temperature as 95.6°F and cleaned his legs, which were "swollen and seeping."⁷² No physician was contacted to evaluate his hypothermia or his swollen legs.

In the very early morning on February 6th, jail staff found Gregory lying on the floor of the cell unresponsive and extremely hypothermic, with an extremely low body temperature. They finally took him to the hospital. Katie was not notified until almost twenty hours later, and she immediately drove from Houston to Corpus Christi. By the time she arrived at the hospital, Greg was on life support. He died later that day from Waterhouse-Friderichsen syndrome.⁷³ At the time of his death, Greg weighed only 146 pounds.⁷⁴

Katie knows her son Greg's untimely death was preventable. "Greg was issued a court order to be sent to a psychiatric hospital, and this would have allowed him to stabilize and reunite with his family. But this did not happen. Instead, Greg's mental condition continued to spiral downward, and his physical condition deteriorated along with it. The jail infirmary just failed over and over to treat him. Every step of the way, proper steps could have been taken, had the jail adhered to proper protocol. Instead, their gross negligence led to my son suffering horribly and dying too soon."

The Cheek family agreed to a confidential settlement with Nueces County over the loss of their son and father.



Amy Lynn Cowling was a 33-year-old mother of three who had bipolar disorder and was in treatment for opioid addiction. She died in Gregg County Jail after suffering severe withdrawal seizures resulting from abrupt withdrawal from prescribed medication.

On Christmas Eve 2010, Amy Lynn Cowling was driving to her East Texas methadone clinic when she was pulled over for speeding. When the officer saw two outstanding misdemeanor warrants, she was arrested and booked into jail. Five days later, Amy was found dead in a solitary confinement cell.

Amy's mother, Vicki Bankhead, describes her daughter as a sweet, kind woman who worked hard to care for her three children. Amy struggled with addiction and with her health, but she had been receiving methadone treatment since 2003 to recover from a prescription drug addiction. The treatment helped Amy stay clean and achieve a certain amount of stability. Amy also took medication to treat her bipolar disorder, heart problems, and her one remaining kidney.

At booking, Amy told jail officials that she had been receiving daily methadone treatment for years, and that cutting off her treatment abruptly would put her at risk of serious harm. She told them about her other health problems, and her purse contained her prescribed bottles of Seroquel, for her bipolar disorder, and Xanax, an anti-anxiety medication.⁷⁵

But because Gregg County Jail prohibited methadone, Xanax, and Seroquel,⁷⁶ Amy's medications sat in her purse for five days as her condition worsened. Vicki called the jail and pled with them to let Amy take her prescribed medications. "I kept telling them that if she didn't have the methadone, it would be bad," Vicki says. "I knew it would be bad. And they completely ignored me."

The Texas Commission on Jail Standards' regulations require that county jails dispense medication according to a health care plan, which each county must develop on its own.⁷⁷ Gregg County Jail, like many Texas jails, had decided it would only dispense medication prescribed by its own doctor. The jail would not give Amy the life-saving medications she had already been prescribed.

The jail's doctor says that Amy was given appropriate substitute medications.⁷⁸ But Amy never saw the jail's doctor. Amy was booked on a Friday, and the jail's doctor only visited the jail on Wednesdays.⁷⁹ Instead, she was seen that week by a nurse who took orders from the doctor by phone.⁸⁰

Meanwhile, the jail kept Amy's family from seeing or speaking with her. "I kept calling and calling," Vicki says. "When my husband and son went down there to see her, they said, 'You can't see her, she's acting up.'"



Amy's condition deteriorated quickly. In the Texas Rangers' postmortem investigative interviews, other inmates reported that within the first couple of days, Amy became unable to eat, "could barely walk," "used the restroom on herself," hallucinated, and had seizures.⁸¹

On the morning of December 28, Amy was brought to an isolation cell in a wheelchair.⁸² Inmates in nearby cells told the Rangers that Amy was "screaming" and "moaning" the entire day.⁸³ She was seen twice by medical staff; in the early evening, a nurse told the doctor that Amy was "hollering and uncooperative" over the phone, and the doctor ordered her to be given an antipsychotic and placed on suicide watch.⁸⁴

The initial autopsy concluded that Amy likely died from seizures brought on by withdrawals from her medication.⁸⁵ When emergency personnel arrived at the jail shortly after midnight on Wednesday, December 29, 2010, they found Amy alone on the floor of her isolation cell, already gone.

Because of Amy's medical condition, she was supposed to be observed every fifteen minutes on the night she died. Instead, the officer assigned to Amy's hall only checked on her four or five times after 7:30.⁸⁶ Shortly after Amy's death, two jail officers were arrested for falsifying the observation logs that night.⁸⁷

The county denied any wrongdoing, but ultimately settled a wrongful death lawsuit for \$1.9 million.⁸⁸



While Vicki was present at her daughter's funeral, Amy's son was with his girlfriend as she gave birth to Amy's only granddaughter, for whom Vicki now cares. They still live in East Texas.

"I had called the jail and called and called and called and said 'Please help my daughter, please!'" Vicki says. "And we didn't have the money to get her out. I mean: What do you do?"



Lacy Dawn Cuccaro was a 28-year-old mother of two who had bipolar disorder, depression, and anxiety. She committed suicide by hanging in Hansford County Jail after the jail failed to properly monitor her.

On July 16, 2012, Lacy Dawn Cuccaro was arrested and booked into Hansford County Jail. Three days later, while she was on suicide watch in a jail big enough to house only nine people,⁸⁹ Lacy hung herself in her cell.

Jonathan Shepard had been with his wife Lacy for ten years when it happened. They had had their first son together in 2004, and their second in 2007. They were raising their boys in the small Panhandle town of Gruver, Texas (pop. 1,162).⁹⁰ Jonathan worked in construction, and Lacy stayed home with the kids. “She loved her boys,” Jonathan said. “She was a good mom. She loved playing with them, loved being with them.”

Lacy had her troubles. She had long suffered from mental health disorders, going back to her teenage years when she had attempted suicide at age fifteen. She had spent some time in a treatment facility in Dallas after the kids were born. Her diagnoses included bipolar disorder, depression, and anxiety serious enough that it kept her from working.



In 2012, she had been to the Texas Panhandle Centers, the local mental health center, for treatment. She had been taking medication, on and off.

Then she got arrested following a spat in the front yard with Jonathan’s brother. “They were yelling outside, things got heated, somebody called the cops,” is Jonathan’s abridged version. And when Lacy was booked into the tiny Hansford County Jail, Jonathan says there was no question that her mental health issues placed her at serious risk of harm: “They put her on suicide watch right away.”⁹¹

The first day after Lacy’s arrest, her sister Melissa visited to check on her medications.⁹² Melissa told the sheriff that Lacy’s mental health issues were serious, and that she belonged in a mental health facility, not in a jail.⁹³ The sheriff told Melissa that Lacy was being watched closely.⁹⁴ Melissa came again the next day to bring Lacy money to make phone calls, and reiterated to the jail staff that Lacy could become suicidal unexpectedly.⁹⁵ Again they reassured Melissa that Lacy was being watched carefully.⁹⁶

Hansford County Jail’s policy required that inmates on suicide watch be observed face-to-face every fifteen minutes⁹⁷—a policy stronger than the state minimum, which only requires observation every thirty minutes.⁹⁸ But on the morning of July 19, 2012, only one jailer was on duty—the deputy sheriff.⁹⁹ And after 8:30 a.m., the deputy sheriff became too busy with her other duties to continue checking on Lacy in person; the rest of the morning, she only checked on Lacy via the two video cameras that watched her cell.¹⁰⁰



The last observation the deputy sheriff made that morning was at 10:45 a.m.¹⁰¹ She didn't make the 11 a.m. observation because she was busy filling out arrest forms and answering the phone, or the following two observations because she was busy making the inmates' lunches.¹⁰²

Meanwhile, video footage between 10:30 and 11:00 showed Lacy crying in her cell, measuring a towel against the bars of the cell, tying the towel to the bars, and wrapping a towel around her neck.¹⁰³ There was nobody else at the jail to see this video footage, or to check on Lacy in person, while the deputy sheriff was busy. The deputy sheriff didn't see Lacy again until just after noon, when she brought around Lacy's lunch.¹⁰⁴

When the deputy sheriff found Lacy hanging in her cell, she didn't enter the cell to cut her down and try to resuscitate her.¹⁰⁵ She wasn't allowed to—jail policy prohibited staff from entering cells alone.¹⁰⁶ So she called the sheriff, who was eating lunch down the road.¹⁰⁷ When he arrived at the jail, he didn't cut her down, either.¹⁰⁸

"They left her hanging in that cell for four hours until the funeral home came to get her," Jonathan recalls. "They didn't try to cut her down, didn't try to help her. What would you do if you found someone like that?"

The jail also didn't call Jonathan right away. He learned about his wife's death when he showed up later that afternoon with his sons for visitation—the first chance they had to come see Lacy since she'd arrived at the jail. "It was devastating to the kids. They were eight and four. What do you say to your sons? They had just seen their mom a couple of days ago."

The county eventually settled the civil rights lawsuit against them for \$345,000.¹⁰⁹ Jonathan and his sons still live in Gruver.

"They knew," Jonathan says of Lacy's mental health problems. "If someone comes in on suicide watch, they shouldn't be in jail. Jail's the last place they should be."

Eric Dykes was a 25-year-old man who had bipolar disorder. He committed suicide by hanging in Hays County Jail in a cell that was not suicide-resistant after jail staff ignored his statements that he felt suicidal.



Eric Dykes had been in jail for fourteen months as a pretrial detainee when, on March 26, 2011, he was found hanging in his Hays County Jail isolation cell. He died two days later in the local hospital. Diagnosed with bipolar disorder, Eric had told jail staff only days earlier that he would kill himself if placed in isolation.

Eric's mother, Diana Riley, remembers her son as a personable young man. The middle child of three brothers, Eric was a well-liked athlete who loved being outdoors, playing soccer, listening to music, and drawing tattoos. At the time of his arrest, Eric lived in San Marcos with his girlfriend and her child, and he worked for a local warehouse. He had dreams of becoming a surgical assistant because he wanted to help people.

Eric had a history of troubles with the criminal justice system that his mother says was closely linked to his mental illness. For years, Eric bounced around in the juvenile justice system, but did not receive appropriate mental health treatment. At 21, Eric was diagnosed as bipolar, and his doctor prescribed antidepressants that Diana says Eric could not stop taking without adverse effects, and which required Eric had to have his blood tested every few months to monitor the medication's effects.¹¹⁰

Eric was the main provider for his girlfriend and her child. In December 2009, he found himself short on rent, and in a moment of lapsed judgment, Eric took a purse sitting on the trunk of a car in a mall parking lot while the owner was looking the other way. He did not use force or threaten force during the theft. A warrant was issued for his arrest on a robbery charge. Full of remorse, Eric turned himself in.

From January 2010 to March 2011, Eric sat in jail awaiting trial. During these fourteen months, he was primarily housed at Hays County Jail, but on occasions when that jail became overcrowded, county officials transported him to Guadalupe County Jail, where he did not receive his bipolar medication and was usually housed in isolation for his own protection. At least twice, Eric filed complaints with officials at Guadalupe County Jail because he was not receiving his medication.¹¹¹

According to Ms. Riley, the officers liked Eric. They referred to him as the "Ta-Da guy," because when they administered his medication he would shout out, "Ta-Da!" and open his mouth to show the officers he had actually taken the medication. The officers were aware of his mental illness, and when his anxiety was high the officers would grant him special privileges to "walk it off" alone in the yard.

Eric's mother visited him almost every week while he was in jail. She repeatedly requested that the jail's medical staff test his blood because she noticed marked changes in her son. Eric had become anxious and his appearance had become disheveled. He had always been proud of his appearance and clean-shaven, but in jail he began growing an unkempt beard. His mother saw that his mental health was deteriorating.

In the weeks leading up to Eric's death, Ms. Riley was not able to visit her son because she had foot surgery and was unable to make the drive. On March 22, 2011, Eric got in a fight and was placed in administrative segregation. As officers escorted him to his isolation cell, he yelled, "If you put me back in seg, I'll kill myself!" They did not believe him. Officers told Ms. Riley later that Eric was the last person they thought would try to kill himself.



Four days later, Eric used a mesh bag and towel to hang himself in his isolation cell. Officers found him unresponsive in his cell at about 4 p.m. They performed CPR before transporting him to Seton Medical Center Hays, where doctors pronounced him brain-dead and put him on life support. Around 6 p.m. that evening, officers from the Sheriff's office pulled up to Ms. Riley's home to notify her of her son's condition. She went straight to the hospital, where Eric was still in the emergency room.

On March 28, 2011, after fourteen months of incarceration while awaiting trial, Eric Dykes died of cardiac arrest at the age of 25. That same day, a county judge dismissed Eric's case.

In 2013, Ms. Riley filed a wrongful death suit against the Hays County Jail. The county settled for \$40,000 and agreed to improve its suicide prevention plans. The county agreed to reasonably address the existence of ligature points or other substantial safety issues in segregation cells and single inmate housing, such as the hole in the wall Eric used as a tie-off point. Additionally, the county agreed to institute policies that (1) require an inmate placed in segregation to be seen by a health care professional within two hours of the placement; (2) require inmates transferred to Hays County Jail to be assessed for mental health conditions by healthcare professionals within two days of transfer; and (3) ensure that all currently employed corrections officers have completed a suicide identification, prevention and treatment course.

Ms. Riley hopes that Hays County has followed through on its promises to train officers and improve its processes, "so that other parents won't have to go through the sadness and loss of a child."

Victoria Gray was an 18-year-old young woman who had bipolar disorder and schizophrenia. She committed suicide by hanging in Brazoria County Jail after jail staff failed to notify a magistrate about her.



Credit: ThinkProgress.org | John Gray

Over Labor Day weekend in 2014, Victoria Gray was arrested for violating her probation by running off and quitting her medications.¹¹² Eighteen-year-old Victoria, who was diagnosed as bipolar and schizophrenic, was found dead on her third day in Brazoria County Jail, hanging by her bedding in her cell.¹¹³

Victoria's father describes her as a loving individual who cared about everyone else above herself. Her passions were singing and writing. She was her own toughest critic. According to

her father, John Gray, there was no doubt that Victoria suffered from mental illness. At 13 years old, Victoria was diagnosed as schizophrenic and bipolar.¹¹⁴ From then, Victoria cycled in and out of juvenile detention centers, state hospitals, group homes, mental institutions, and eventually, jail.

A few months before her death, Victoria spent several months in a state hospital after being convicted of arson for setting her father's house on fire.¹¹⁵ "[She said] the walls told her to do it," John said. She had been transferred to the state hospital after attempting suicide in Brazoria County Jail. In August 2014, she was on probation, with conditions that included following a curfew and taking her medication.¹¹⁶

On August 29, Victoria was arrested because she stopped taking her antipsychotic medication.¹¹⁷ The jail screened her for mental health conditions, and because she gave them information indicating that she was suicidal,¹¹⁸ jail staff placed her in a single-person cell. Although state law requires jails to notify a magistrate judge within 72 hours of receiving an inmate believed to be mentally ill, nobody from Brazoria County Jail tried to notify the magistrate judge about Victoria until after she died.¹¹⁹

Further, Victoria should have been identified as a heightened suicide risk under Brazoria County's suicide prevention plan because she had indicated that she was suicidal—and because she had attempted suicide in the jail once already. Under the suicide prevention plan, jail staff would have checked on her at least every fifteen minutes.¹²⁰ Instead, she was classified as a low-risk inmate and ordered to be checked every thirty minutes. Even then, the guards failed to check on Victoria every thirty minutes, at times being as late as a full hour.¹²¹

Jail staff found Victoria hanging from her bedding tied to a small bookshelf in her cell.¹²² They had checked on her 25 minutes earlier—within the state’s minimum standards.¹²³

John Gray first learned that his daughter was in jail on September 3rd, when a constable arrived at John Gray’s home at 4 a.m. and told him that his daughter had died. John had been searching for his daughter, but the county had not attempted to contact him about her arrest.

John has since filed several open record reports for information pertaining to his daughter, most of which were denied—including the request for the names of the officers on duty at the time of Victoria’s death. John has been left to piece together the story of his daughter’s from information he gathered from other jail inmates who later reached out to him.

John has struggled to move on from his daughter’s untimely death. He questions how “putting suicidal inmates in a segregated cell makes any sense,” and echoes what many studies show: “Suicidal individuals need support.” John continues to search for answers about his daughter’s death, and to call attention to the inadequate mental health care available to jail inmates and to jails’ lack of compliance with state law and policies. John is determined that his daughter be heard: “I am her voice now,” he states.



Credit: Houston Chronicle, Mayra Beltran



Jesse C. Jacobs was a 32-year-old man who suffered from anxiety. He died in Galveston County Jail after several seizures caused by unsupported withdrawal from his prescription anti-anxiety medication, which the jail denied him.

Jesse Jacobs, Jr. entered Galveston County Jail on March 6, 2015, expecting to serve twelve to fifteen days on a DUI sentence.¹²⁴ Jesse, who had never served time in jail before, recognized he had made a mistake, and was ready to serve the sentence and put the charge behind him. Five days later, after the jail had failed to give him his prescribed anti-anxiety medication, he was found unresponsive on the floor of his isolation cell and transported to the hospital where, despite attempts to revive him, he died on March 14, 2015.¹²⁵

Jesse was the only child of Jesse Jacobs, Sr. and Diane Jacobs, with whom he was very close. After graduating early from high school, Jesse began college but ultimately quit to work in real estate and later for home health care companies. After a few years of working and living in the Houston area, Jesse went back to college at the University of Houston, while continuing to work full-time. He completed his bachelor's degree in 2012, making his parents very proud. "He was the light of our lives," says Diane.

He spent time with his parents at their Houston-area homes on weekends and holidays, and he was also close with a small group of loyal friends. Jesse was also a weather enthusiast who loved to watch the storms come in and analyze weather patterns.

In his late teens, Jesse began experiencing severe digestive pain and discomfort. After a battery of tests, a doctor diagnosed him with Crohn's disease, a chronic inflammation of the gastrointestinal tract. He responded well to medication, and the disease went into remission. Around the same time, Jesse was diagnosed with ADHD and later, with anxiety disorder and manic depression. After trying a few medications, his psychiatrist prescribed him Xanax, which helped Jesse effectively manage his illness for ten years.¹²⁶ According to his mother Diane, Jesse was very disciplined about taking all of his medications.

Before he entered jail in March 2015, Jesse called the jail to find out how to make sure they gave him his medications.¹²⁷ Jail personnel advised him to bring his prescriptions with him, along with a letter from his psychiatrist.¹²⁸ He complied, giving them copies of all his prescriptions for Crohn's disease, high blood pressure, and Xanax, along with his psychiatrist's letter, at intake.

Jesse's parents say that according to jail medical records, the jail never gave him his Xanax.¹²⁹ Although they gave him other medications for blood pressure and

Crohn's, they did not even have a mental health professional talk with Jesse.¹³⁰ Jesse's parents talked with Jesse on the first night of his incarceration. He said that he had not yet seen a physician or been given any of his medications. Three days later, Diane went to visit Jesse at the jail. During the video visitation, he told his mom that his heart was racing, he had not received his Xanax, and he was not feeling well. The next day, Diane talked to Jesse over the phone, and he repeated that he was not doing well.

Jesse's parents say that jail medical records show that Jesse suffered a seizure, which is a symptom of unsupported Xanax withdrawal, on the fourth day of his incarceration.¹³¹ According to his family and his doctor, it was the first seizure he had suffered in his life.

In response, the jail put him in an isolation cell. He suffered at least three more seizures in the next three days, but jail officials did not take him to a hospital or move him to a medical unit at the jail. After one seizure, they gave him only ammonia caps to inhale, Gatorade, and water.¹³²

On the eighth day of his sentence, Jesse's parents drove together to the jail early in the morning to visit him. When they got there, Diane received a phone call from jail officials on her cell, telling her that Jesse had been found unresponsive in his cell, and had been taken to the UTMB hospital in Galveston. His parents immediately drove to the hospital.

They found Jesse in the emergency room, hooked up to a ventilator. "I knew in the E.R. that he wasn't there anymore," says Diane. Despite the best efforts of hospital personnel, Jesse had suffered multiple organ failure, and he passed away the next afternoon.

During the ordeal at the hospital, Jesse's dad went to the jail to find out what had happened. He spoke to a jail official who said only that all medical care at the jail was handled by a third party medical provider. "To this day, nobody from the Sheriff's Department, from Galveston County, or from the third party provider

has ever contacted us to express any condolences, or any compassion," says Jesse Sr.

The loss has been excruciating for Jesse's parents. His parents express shock that the jail "cold turkeyed" Jesse from Xanax even though the dangers of doing so are well-known, and even though he gave thorough medical documentation to the jail. "He had so many aspirations. Now there's nothing," says Diane.



Credit: Houston Chronicle, Gary Coronado



Robert Montano was a 41-year-old father with a known history of psychiatric illness. He died in Orange County Jail after five days of isolation without any mental health assessment or treatment.

Robert Montano was taken to jail by police on October 7, 2011, after a neighbor called to say that he was on the street outside his home, acting erratically and yelling incoherently. Although Montano had a long history of psychiatric illness, police took him to jail instead of to a hospital. He was charged with “public intoxication” on suspicion of taking a street drug known as “bath salts,” even though he had not in fact taken any drugs.

At booking, jail staff were unable to complete their paperwork because Robert was paranoid, delusional, and incoherent; he could not answer their questions.¹³³ Jail staff knew that he had previously obtained mental health care through the county mental health system and had been on anti-psychotic medications. In addition, a magistrate judge who would see Robert the next day concluded that Robert was too incoherent to be arraigned. Despite all this, jail staff never contacted a mental health professional to evaluate Robert.

Instead, jail staff stripped him of his clothes and placed Robert in an isolation cell with two glass walls through which they observed him. He continued to be incoherent and paranoid. Over the next few days, they heard Robert yell and scream nonstop, say that someone was trying to kill him, and voice other delusions. They saw Robert throw away his water repeatedly because he believed it was poisoned, and crawl around on the floor.

Through all of this, jail staff did not contact the jail doctor, who only came to the jail once a week, or contact a county mental health professional, or even a family member. They incorrectly believed that he was detoxing from “bath salts” despite knowing of his psychiatric history. Even so, they did not respond to his consistently erratic and delusional behavior by seeking any medical attention.

On the fifth day, early in the morning, a jail nurse noticed that Robert was lying motionless on his mat. After checking, she discovered that he was not breathing. Although jail staff applied CPR, they could not resuscitate him. Robert was pronounced dead shortly thereafter, after being taken to the hospital by ambulance. He had died of renal failure as a result of not drinking enough water. When his body was found, his legs were purple as a result of the kidney failure—a symptom likely to have preceded death by several hours. Tests showed he had no illegal drugs in his body.

When Robert’s family received word of his death, they were shocked. His son Josh, who had just finished boot camp with the U.S. Marines, says, “I love my dad and I miss him. Nothing will ever compare to him.”

Robert is survived by four adult children, including Josh, who is 23. When his kids were growing up, Robert spent time with them by showing them how to fix things around the house and yard. Josh remembers that his dad was also his confidant and friend. "I could talk to him about anything. I miss being able to tell somebody anything that is on my mind. I miss him," says Josh.

Robert's family remembers him fondly as a person with a heart of gold who was devoted to his children, and who would help others at the drop of a hat. Robert grew up as one of eight siblings in Groves, Texas. After high school, he worked as a longshoreman, and he also did odd jobs. His older brother Tony recalls that Robert was a family man. "He loved his kids and he was a great dad. His kids came before anybody. He was always working in the yard and teaching his kids how to fix things."

According to Tony, Robert made it a priority to treat his schizophrenia with the right medication. "He was really normal when he had the right medications. When he had the wrong medication, he would say, 'I have to go back to the doctor and try something different.'" Tony remembers taking Robert to see his doctor a number of times. Tony says that Robert always took excellent care of his children, and he had no serious criminal history.

In 2013, Robert's estate and family filed a wrongful death suit against Orange County Jail and its employees, alleging that jail staff had been deliberately indifferent to his medical needs, and that the County's de facto policy of holding incoherent inmates without contacting a doctor was constitutionally deficient.

In 2015, after trial and a jury verdict, the judge ultimately entered a judgment of over \$1.5 million for Robert's family.

For Tony, his brother's death was entirely preventable. "Robert was ill and needed medical attention. He didn't get it, and it cost him his life, and it caused such sorrow and pain for our family. You would never want this to happen to anybody's family. People should have their medication. Everyone in jail is somebody's mom, or dad, or son or daughter."



Robert Rowan was a 27-year-old man who died in an isolation cell in Smith County Jail from complications stemming from unsupported withdrawal from anti-anxiety medication after jail staff failed to properly monitor him.



Robert Rowan was arrested on October 24, 2014 for failure to pay child support, and three days later he began his 180-day sentence at Smith County Jail. Although Robert entered jail as a healthy 27-year-old man, he died less than two weeks later in a solitary confinement cell of heart failure that his family believes was associated with untreated drug withdrawal and physical abuse he received in jail.

Robert's family describes him as an outgoing man who spent most of his free time outdoors, on a boat, riding four-wheelers, or hanging out with his friends. He took pride in his car, but he was most proud of his family. "He would always stand up for his family," says his mother Gloria Hudson. "Robert often would spin around the corner to check on me."

He had strong relationships with his extended family. Before his arrest, Robert worked with his uncle Bill and cousin William at a flooring and tile business. He was close with his stepfather Danny, who taught him how to work on cars. "Robert always had a grin on his face," William says. "You can see that grin on his daughter." Robert's daughter Brielle is nine years old. She smiles readily whenever someone mentions the similarity to her father.

At the time of his arrest, Robert was living with his father to help take care of his siblings after the recent death of his stepmother. Despite being a loving family member, Robert didn't always have the financial means to support his own two children. A judge ordered Robert to pay all of his income to child support, regardless of his other financial obligations. The burden weighed heavily on Robert. He relied on Xanax and Vicodin on a daily basis, though he did not have prescriptions for them.



As soon as she learned of Robert's arrest, Gloria called the jail repeatedly to make sure jail officials knew of his psychiatric and medical needs. Gloria spoke with a sergeant and urged him to put Robert on anything to help prevent the difficult and potentially dangerous detox. They reassured her that Robert would be taken care of, but Gloria was persistent, convinced they were not following through on their promises. Gloria went twice to the jail to see her son, but because Robert did not submit his visitation list on time, Gloria was not allowed to speak to him.

Robert's intake form indicates that he answered "No" to questions about current medications and concerns about withdrawal.¹³⁴ His uncle Bill is skeptical,

however: “It’s hard to believe Robert wouldn’t admit to his drug use. He’s been through a bad detox experience once, so he would know what it would mean to not tell the officers he was on those medications.”

One of Robert’s friends was able to pay him a visit. She reported to Gloria that Robert was not doing well. He was hallucinating, thinking that he was in a Walmart parking lot. By the second day in jail, Robert began screaming for his girlfriend and his son Jaden. That night, he began complaining of chest pains.

One of Robert’s cellmates told the family he saw Robert hallucinate, and had witnessed guards repeatedly pull him from his bunk and beat him. The cellmate also reported that guards did nothing for Robert as he experienced seizures, foamed at the mouth, and urinated on himself.

After Robert was beaten by other inmates, jail officials moved Robert to a single-person medical cell, where jail staff was required to perform visual checks every 30 minutes.¹³⁵

Robert was discovered unresponsive in his isolation cell at 5:30 p.m. on November 3rd. Jail staff reported that they had checked on him four times between 4:30 p.m. and 5:30.¹³⁶ However, according to the Texas Rangers report, video surveillance footage shows that the officers who signed the observation sheet during that interval did not actually observe Robert.¹³⁷ In addition, the man in the cell next to Robert’s said that he told jail staff that he heard Robert breathing erratically and asking for help that afternoon, but they ignored him.¹³⁸

The autopsy ruled Robert’s death a result of irregular heart complications—heart failure in an otherwise physically healthy 27-year-old man. “There is no way Robert died of natural causes,” says his uncle Bill. Robert had no history of heart complications. The autopsy also reports “no evidence of significant injuries” despite a photo showing bruising on Robert’s face and what looks like a missing piece of his ear.¹³⁹ Robert’s family is still struggling to obtain answers to the questions surrounding his death.





Carl Chadwick Snell was a 39-year-old father who suffered from bipolar disorder. He committed suicide by hanging in Denton County Jail after the magistrate took no action following notification.

Carl Chadwick Snell—he went by Chad—was arrested in Denton County on December 12, 2014. He sat in jail until he was indicted three months later on March 6, 2015. The next day, Chad was found dead in his cell, having hung himself with a piece of his mattress cover. In his cell were five handwritten suicide notes and his indictment, across which he had scrawled, “You win!”

Chad had a long history of mental health problems. He was diagnosed with bipolar disorder at age 20 while serving time in a Washington State prison. He also had a history of methamphetamine use, but had been sober for two years by late 2014. When he sought help from the Denton County Mental Health and Mental Retardation (MHMR) Center in August 2014, he was also diagnosed with major depression and post-traumatic stress disorder. He was living out of his car at the time.

By late 2014, Chad had been making progress. Despite the felony conviction on his record, he was working and had rented a small apartment. To comply with a Washington State court order requiring him to seek regular drug rehab and mental health counseling, he had been attending AA meetings, staying sober, and taking medication to treat his bipolar disorder. His son was eight years old.

Chad was arrested on a Friday following an altercation with his girlfriend. The following Tuesday, the arresting officer called his mother, Connie Griffin, to discuss Chad’s situation. Connie told the officer that Chad has “got to be seeing somebody, he’s got to, because his reality is not real.” Connie said that she had “a lengthy conversation” with the arresting officer about Chad’s mental health history and that the officer was aware of Chad’s mental health needs. Connie was even hopeful that while in custody, Chad might get the help that he needed.

The reality turned out to be quite different. While Chad was in jail, “he never saw anyone,” Connie says. Although Chad did see a doctor on three different occasions in the jail, he was treated only for an eye problem and a heart-attack scare. None of those visits addressed Chad’s mental health needs.

Of course, the jailors were aware that Chad had mental health needs. In addition to the conversation that Connie had with the arresting officer and the Washington State court order, the jail had run its routine Continuity of Care Query (CCQ) check when Chad was booked and saw that he had recently been receiving care from the Denton County MHMR.

When a CCQ check indicates that the inmate may have mental illness, the jail is required to notify a magistrate within 72 hours. The jail did so, in an email stating simply: “Inmate Snell, Carl W/M DOB: 6/28/75 has received prior MHMR services.”¹⁴⁰

When a magistrate learns about an inmate’s mental illness, she must collect and review a written assessment within a month.¹⁴¹ In Chad’s case, however, the magistrate took no action following the email from the jail. In an article in the Denton newspaper, the judge was quoted as saying that the “jail staff send him four or five mental health email alerts each day” and “it doesn’t mean that [the inmates] are suffering from mental illness now.”¹⁴²

In his three months in Denton County Jail, Chad never saw a mental health professional or received mental health treatment, despite having 74 pages of MHMR records indicating his treatment and medication needs.

Chad was found dead at 3:51 in the morning on March 7, 2015. Several hours earlier, at 11:30 on March 6, the jail’s report indicates that an officer had spoken to Chad about the indictment he had just received and noted that Chad had been “writing a lot of personal letters.” Those letters turned out to be suicide notes.

To Connie, her son Chad’s death resulted from indifference. “When somebody’s doing something out of the ordinary, [jail staff] have an obligation to go check it out,” Connie said. “They should act on it when something weird is happening—one letter would have showed him. They did not care. If he had a counselor he was seeing, after he got handed that indictment he would have said, ‘I want to talk to my psych.’ He would not have backed off if he had someone to talk to.” Connie still lives in Denton, where she is raising her grandson.



The Tip of the Iceberg

The tragic stories of the ten women and men featured in this report are calls to action which ought to inspire Texans to demand better from their jails on their own. But they, along with Sandra Bland, are just the tip of the iceberg. Over 100 women and men—daughters and sons, mothers and fathers—die every year in Texas jails.ⁱ Many of them, like the people in this report, suffer from mental illnesses that contributed to their deaths.

With more time and more space, this report could have told the stories of many more people with mental illness who died unnecessarily in Texas jails. For example, below are three tragic stories that cry out for justice and reform just as loudly as the stories featured in this report. There are, sadly, many more. Some make the news; most go untold, felt only by the family, friends, and loved ones that are left behind.

Michael Angelo Martinez hung himself in his cell in November 2015, three months after being arrested for unlawful gun and drug possession.ⁱⁱ Although Martinez was being housed in a cell that required him to be checked every 30 minutes, nobody actually checked on him for hours before he was found unresponsive in his cell.ⁱⁱⁱ Three officers were ultimately indicted for failing to do their required observations and then later falsifying the observation logs.^{iv} Martinez was 25.^v

Robert Rodriguez committed suicide in Bexar County Jail just days after being arrested on misdemeanor drug and trespass charges.^{vi} Rodriguez sought transfer to protective custody because he suffered from major anxiety disorder and was not receiving his prescribed doses of Xanax to treat his anxiety.^{vii} The day after his transfer was approved, Rodriguez cried on the way to his cell, saying, “I need help. The past is haunting me.”^{viii} Thirty minutes later, he stabbed a plastic spoon into his dialysis shunt and bled to death.^{ix} He was 29.^x

Wendell Carl Simmons died in the hospital from injuries sustained in Randall County Jail.^{xi} In June 2014, Simmons was arrested for lacking a driver’s license and insurance and failure to vaccinate and leash his pets.^{xii} Although Simmons suffered from seizures, he was never given medication to treat his seizures.^{xiii} Within a few days, Simmons was talking to imaginary people; not long afterward, he fell in his cell and hit his head.^{xiv}

Simmons was taken to the hospital, where he spent weeks being treated for a brain injury.^{xv} He died in April 2016 from the head injury without regaining his ability to walk or “participate in any meaningful activity.”^{xvi} A judge ordered him released from jail just as he was admitted to the hospital, letting Randall County off the hook for his medical bills.^{xvii}

Increasing Transparency After a Jail Death

If a person dies in custody in a Texas county jail, state law requires the sheriff to investigate the death and file a written report on the cause of death to the attorney general's office within thirty days.^{xviii} In addition, state regulations require county jails to notify the Texas Commission on Jail Standards of every death in custody within 24 hours, and to forward the report of investigation of the death by a law enforcement agency within ten days of completion.^{xix}

Most family members do not know that these reports, as well as the autopsy of the deceased family member, are available to them. Many families are unable to make written requests under the Public Information Act because they are grieving, and others who make such requests are deterred by the delays and costs involved. Yet families uniformly express a deep desire to know what happened to their loved one who died in custody.

To increase transparency after a jail death, counties should inform the families of loved ones in writing that they are entitled to these reports, and make them available to them without requiring a written request.

Ensuring Independent Investigations of Deaths in Custody

State law requires the operator of a county jail, typically the Sheriff, to investigate every death in custody and file a report with TCJS and with the state Attorney General.^{xx} Some Sheriffs use their own officers to conduct the investigation, while others request the Texas Rangers, a division of the Texas Department of Public Safety, to do so.

Death-in-custody investigations are more likely to suffer from bias – whether overt or sub-conscious – when the investigators know the jail staff involved or work for the jail operator. That bias can lead investigators to take short-cuts, neglect to gather relevant evidence, or fail to challenge factual assertions made by their colleagues.

To promote thorough and reliable investigations of deaths in custody, the state should ensure that investigations are done by a law enforcement agency and investigators who do not have connections to the jail or jail staff.

Advocating for Inmates Across Texas: The Texas Jail Project



Diana Claitor is the Executive Director of the Texas Jail Project (TJP). TJP helps families advocate for their loved ones in county jails across Texas, through communication with the Texas Commission on Jail Standards, sheriffs' offices, local mental health providers, civil rights attorneys, non-profit legal and mental health organizations, and the media. TJP also provides resources for families and inmate stories on its website.

In March 2016, TJP launched a website of first-person and family accounts and interviews of pretrial detainees in Texas county jails, called Jailhouse Stories—Voices of Pretrial Detention in Texas. Stories of Texans who languished or died in jail as a result of inadequate mental health care were featured.

An Interview with Diana Claitor

Q: What's a common complaint that you hear from families who have a loved one in jail, where that person has a mental illness?

DC: The most common complaint is that a loved one is not receiving psychiatric medications that were prescribed in the free world. Or the loved one is in a mental health crisis but has not been seen by a psychiatrist or any doctor since being booked, for weeks or months. Sometimes we hear these complaints together. Since most jails won't accept medicines from the free world, the person is untreated and goes into crisis. Often the jail doesn't have a psychiatrist available, treatment is delayed, and the person's condition worsens.

Q: What happens when people in jail don't get the mental health treatment they need?

DC: An untreated person with mental illness in a high stress and sometimes hostile environment like jail can deteriorate badly, especially if threatened with punishment. Officers with little training will try to enforce rules with threats or violence, and this can cause the inmate to act out or suffer injuries from other inmates or staff. Solitary confinement is used to punish inmates, and that can further damage mental health. When inmates are held in seclusion, they are not able to communicate with their families. Families become frantic to get the loved one out and into treatment, but they often cannot afford bail.

Q: Do jails have officers who will talk to the family members of inmates?

DC: Most don't, although it would be very helpful if they did. Families want to provide the jail with information on the person's medical and mental health history and prescriptions, and to make sure a doctor sees them. Families can ask to speak to the jail administrator, the commanding officer on duty, or the medical officers, but the requests are often ignored. Some jails have good information on their websites or phone lines, or a chaplain who will help, and others have nothing.

Q: What happens if the family can't communicate with their loved one?

DC: When people are held in seclusion – whether for punishment or their own protection – they are told they cannot call out or receive visitors. When that happens, the person may feel more isolated, and the chances of the person attempting suicide increase. It's very scary for families when they lose contact.

Q: What's the lesson you draw from these advocacy experiences?

DC: Jail is no place for a person with mental health needs. Despite this, county jails are being tasked with holding people with mental illness, without the training or resources to safely support them. However, the public and policy makers are paying more attention, and working on how to get more people with mental illness out of jail and into treatment. Meanwhile, county jails need to evolve their culture and training to understand and address mental illness more effectively, and prevent people from deteriorating or even dying.

Texas Sheriffs Support Mental Health Reforms



Sheriff Dennis Wilson

Photo credit: Sheriffs
Association of Texas

“As the Sheriffs’ Association of Texas... we want to make a difference in people’s lives. I’m gonna tell you, a person in a mental health crisis is just like you and I. He’s a human being created by God and he deserves every bit of care that we can give him, bar none. I don’t care what economical level he’s on. If he or she is in a mental health crisis, we should do everything that we can do to get them services. Beyond anything else that we do, that human being comes first.”

– **Limestone County Sheriff Dennis Wilson, testifying before the Texas Senate Criminal Justice Committee, March 30, 2016**

The Texas sheriffs who run our county jails are tasked with the challenge of caring for people with mental illness on a daily basis. They understand the challenges of responding people in crisis and treating people’s mental health symptoms in a correctional setting.

Many Texas county jails—especially small jails in rural counties—lack the resources to provide adequate mental health treatment. Accordingly, many Texas sheriffs have become vocal advocates for diverting people with mental illness out of jail and devoting more resources to improving jail mental health care and staff training.

For example, the Sheriffs’ Association of Texas stated in its 2015 legislative platform that: “Texas Sheriffs believe that the county jail is not the appropriate place to hold a patient in mental crisis.”^{xxi} For the 2017 legislative session, the Association supports increased state funding for local mental health authorities that provide community mental health services, as well as pre- and post-arrest diversion for people with mental illness.^{xxii}

Sheriffs in other counties also support moving more people with mental illness out of jail and into community-based treatment:

“There is a problem across this state where people in mental health crisis don’t have the alternatives they need for treatment in the communities and across the state.... These people in mental crisis, the last place they need to be is in a jail.”

– **Brazos County Sheriff Christopher Kirk**^{xxiii}

“It’s crucial to reduce the number of nonviolent defendants who are mentally ill and waiting in jails and prisons while their charges are pending.”

– **Bexar County Sheriff Susan Pamerlau**^{xxiv}

Advancing Wellness: Perspectives from Mental Health Advocates

Each year, mental illness plays an outsized role in deaths in Texas jails. Reducing the number of deaths in Texas jails will require input from and collaboration with the mental health community. Below, three mental health advocates share their thoughts for advancing wellness and recovery for Texans with mental illness.



Dr. Lynda Frost

Director of Planning and Programs, Hogg Foundation for Mental Health

For all the welcome talk of improving mental health screening in jails and diverting people with mental health conditions, it's worth remembering that for most people, it's a traumatic experience to be put in jail.

Jails are punitive settings and we can never know who will respond poorly to such a stressful experience, so it is crucial to be sure that anyone sent to jail needs to be there. Jail stays – especially in solitary confinement – can create or exacerbate psychological vulnerabilities in all of us.

Eliminating confinement for minor offenses and using risk-based bail procedures rather than focusing on money bail can go far toward averting tragic outcomes in our jails.



Kathryn Lewis

Attorney, Disability Rights Texas

Jail detainees have a constitutional right to adequate medical and mental health care. When this right is not upheld, individuals and families suffer needlessly and counties face costly litigation. No one wins. Most Texas jails are ill-equipped to handle the complex needs of persons with disabilities.

Behavior related to an individual's mental illness is too often criminalized – not because these individuals pose a greater risk to society (research consistently refutes this) – but because the individual's behavior heightens their visibility and risk of interaction with law enforcement. Examining the biases and policies that lead to the criminalization of disability-related behavior is key to reducing the number of people with serious mental illness in Texas jails.

When diversion into treatment is not an option, jails must adopt proven strategies to reduce suicide. For example, every Texas jail should be required to have at least one suicide cell to house detainees at risk of self-harm. Straight forward and cost-effective strategies such as this will help save lives.



Greg Hansch

Public Policy Director, National Alliance on Mental Illness (NAMI) Texas

The Texas mental health system faces chronic underfunding, a severe workforce shortage, and a lack of coordinated, integrated care. It is for reasons like these that Texas ranks in the bottom 20% of the states for access to mental health treatment and has so many individuals with mental illness in the criminal justice system, in emergency rooms, and on the street.

For far too many people in our state, treatment is only accessed through the criminal justice system, which is far from being the setting that is most conducive to recovery and can easily be counterproductive and unsafe. The criminalization of mental illness is a serious issue in Texas that needs to be addressed.

PREVENTABLE TRAGEDIES – PATHWAYS TO REFORM

Investigations, lawsuits, and legislative hearings have each revealed that jails can do more to prevent the untimely deaths of inmates with mental health needs. Below, we outline some of these critical life-saving measures.

- 1 County law enforcement and courts should work together with local mental health providers to divert low-risk arrestees who need mental health treatment out of jail and into treatment.
- 2 County jails should implement measures to prevent suicide and self-harm, including stronger screening, safer housing, effective observation, and referral to treatment.
- 3 Jails and local mental health authorities should work together to ensure inmates' access to previously prescribed or needed medications, develop detox protocols, and implement peer support programs—these are essential components of effective behavioral health treatment.
- 4 Jails should work to prevent excessive uses of force, seclusion, and restraint against inmates with mental illness.

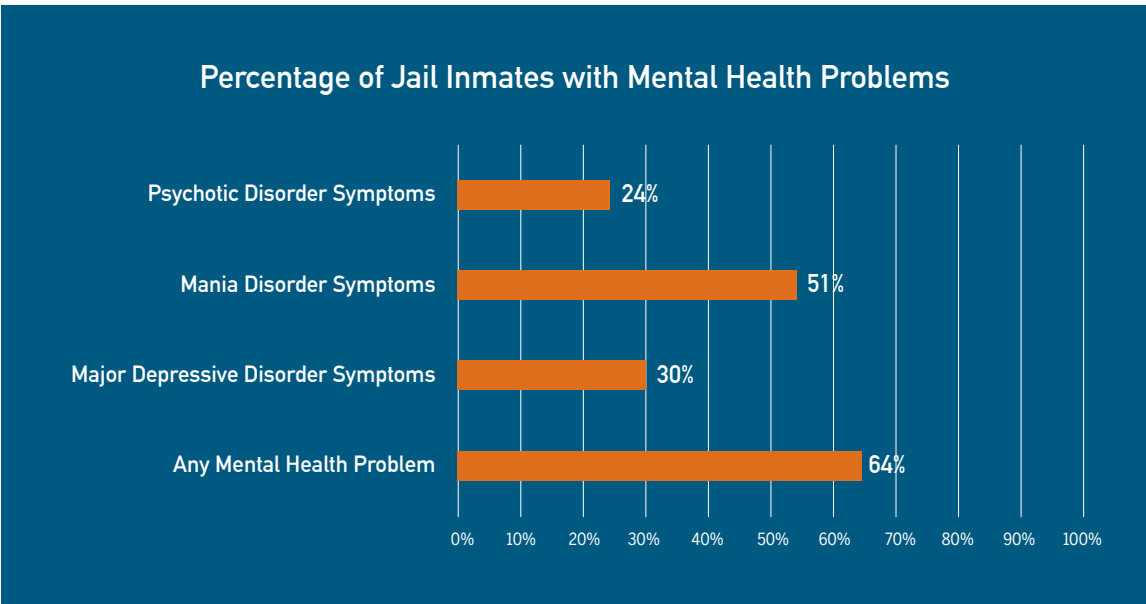
Much work remains to be done. When jails fail to assess, treat, support and properly observe persons with mental illness or disability, people can die. With a sustained commitment to improving jail conditions and access to treatment for inmates with mental health needs—through training, data collection, and oversight—jail and other local officials can prevent deaths and promote treatment.

INCREASE JAIL DIVERSION FOR LOW-RISK PEOPLE WITH MENTAL HEALTH NEEDS.

As state and local stakeholders develop pretrial diversion programs, they should ensure that mental illness is factored in, and not as a barrier to pretrial release. In addition, the Legislature and counties should find new ways to reduce warrants and arrests for low-level misdemeanors, to prevent the use of jails for low-risk arrestees.

Assessing the Problem

Thousands of low-risk defendants like Jesse Jacobs and Amy Lynn Cowling are booked into jails across Texas for minor or nonviolent offenses and kept locked up for weeks or months awaiting trial. People with serious mental illness typically do not find the treatment they need in jail. Adequate treatment, which may involve psychiatric medication and cognitive-behavioral or skill-building interventions, are expensive and require the involvement of qualified mental health professionals.¹⁴³ With almost three quarters of people with mental illness in jails also suffering from substance use disorders, mental health treatment must be integrated with substance use services in order to be more effective in paving the road to recovery.¹⁴⁴ Too often, county jails cannot afford to provide the best medication, much less integrated services, to inmates with serious mental illness. Even so, county jails spend significantly more on inmates with mental illness.



Source: Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates (2006).

People with serious mental illness can experience significant trauma in the jail setting because they have reduced privacy and are exposed to threats to personal safety and high-intensity interactions. They tend to stay longer in jail than other inmates and are less likely to be placed on parole or probation, even if they pose little risk when properly treated. When they are released, they experience greater challenges upon reentry to find adequate housing, employment, and treatment. Jailing inmates with mental illness, when they pose little flight risk or danger, results in greater costs for the county jail as well as reduced chances of recovery or successful reentry for the individual.

Keeping people with unmet mental health needs in jail undermines and delays their treatment and recovery, costs counties significantly more in medical bills and, in the most tragic cases, results in deaths and expensive jury verdicts and settlements. Diverting low-risk people with mental health needs from jail to community-based treatment is critical to avoiding these negative outcomes.

Standards and Best Practices

Pretrial jail diversion is a critical strategy to reduce the number of people with serious mental illness in jail and to refer them to community-based treatment. The most widely used model for designing systems of collaboration between mental health and criminal justice systems in order to facilitate jail diversion and promote treatment and recovery is the Sequential Intercept Model (SIM) developed by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation.¹⁴⁶

SIM enables local jurisdictions to coordinate their criminal justice, mental health, and substance use systems to develop integrated plans to reduce criminal justice involvement for persons with mental illness and co-occurring substance use disorders. The GAINS Center has identified five different moments, or "intercepts," where local actors can divert people with mental health needs into treatment and out of the criminal justice system, if appropriate. These include:

- a. Training law enforcement on mental health** to enable them to direct people with acute mental health crises into treatment rather than jail;
- b. Screening inmates for mental illness and substance use disorders** during their initial detention and using pretrial diversion processes at their first appearance in court to get people released to treatment when appropriate;
- c. Using specialized treatment courts to divert** and refer people to treatment, as well as jail-based interventions to link incarcerated people to mental health treatment services;
- d. Focusing on reentry** by assessing needs and making plans for inmates with mental illness to access treatment and supportive services when they are released and reenter the community; and
- e. Screening and crafting a supervision strategy for parole or probation** that enables access to treatment and ensures appropriate conditions while in the community.

The GAINS Center emphasizes that localities must map out these processes based on their local needs and resources, although GAINS provides training and technical assistance.¹⁴⁷

Despite having no state-based pretrial services agency and no mandated local pretrial services programs, some local jurisdictions in Texas have made important strides in pretrial diversion. San Antonio has implemented numerous pretrial diversion strategies, with components at every stage of the sequential intercept model, including mental health and substance use treatment services and supportive housing to address housing insecurity.¹⁴⁸ Houston has invested in Crisis Intervention Training for law enforcement officers, and indeed has trained officers across the state, with resulting reductions in the use of jail bookings for people with mental illness in acute crisis.¹⁴⁹ These and other strategies are promising, and warrant further study, replication, and state financial support.¹⁵⁰

In addition, Texas law requires the thirty-nine Local Mental Health Authorities (LMHAs) across the state to incorporate jail diversion strategies into their plans for managing adults with common mental illnesses such as schizophrenia and bipolar disorder, to reduce their involvement in the criminal justice system.¹⁵¹ LMHAs allocate, coordinate, and develop resources to provide mental health services in their local service areas. As part of their mission, LMHAs develop and submit these plans to the Department of State Health Services (DSHS), the state agency charged with oversight and provision of mental health and substance abuse services.

“The majority of law enforcement encounters with people with mental illnesses are individuals suspected of committing low-level, misdemeanor crimes or who are exhibiting nuisance behavior.”

– Council for State Governments
Law Enforcement Responses to
People with Mental Illness (2009)

LMHAs vary widely, however, in the resources they devote to jail diversion, perhaps due to resource constraints. State law does not require LMHAs to post personnel in jails for screening, assessment, or to coordinate treatment services. State law also does not require LMHAs to report on the number of people in the criminal justice system actually diverted through LMHA intervention. Likewise, DSHS does not track LMHA performance measures relating to people already in jail or facing charges.

Additional opportunities exist to increase and systematize pretrial diversion for all Texans, including those with mental health needs.

First, the Legislature should expand the list of misdemeanors for which law enforcement agencies may issue citations and summonses and release persons instead of booking them into jail. Currently, state law only allows citation and summons for seven such misdemeanors.¹⁵² In many counties, the process remains under-utilized. The Legislature should study how the process has worked in counties where it is used, and expand the list of misdemeanors as appropriate.¹⁵³

Second, the Legislature should limit the authority of law enforcement to make arrests for some or all Class C misdemeanors, the vast majority of which are traffic

offenses.¹⁵⁴ Arrest warrants across the state for these low-level misdemeanors easily surpass a million annually, dwarfing warrants for more serious misdemeanors.¹⁵⁵ Class C arrests result in the use of jail for offenses the Legislature has deemed punishable by fine only.

Although neither of these changes would aim squarely at people with mental illness, they would undoubtedly benefit that population because they are more likely to encounter police.¹⁵⁶

Third, the Legislature, counties, and other stakeholders can ensure that the current proposals to develop pretrial release systems incorporate methods for releasing people with mental health needs, and that mental illness does not serve as an impediment to pretrial release.¹⁵⁷ Stakeholders across the state are undertaking efforts to develop evidence-based risk assessment tools for magistrates to use, with the goals of sharply increasing the use of personal bond for low-risk and medium-risk people facing criminal charges.¹⁵⁸

Nationally, the use of an evidence-based risk assessment, combined with a policy favoring release of low-risk individuals, is an emerging best practice that is slowly replacing the old system of money bail, which leaves low-income people in jail not because of danger but because of a lack of money.¹⁵⁹ In Texas, local jurisdictions are also developing the infrastructure, often through their community supervision or probation departments, to coordinate the risk assessment process and assist magistrates to set appropriate conditions when necessary.¹⁶⁰

As state and local stakeholders develop these processes, it is imperative that they analyze mental health and include the perspectives of mental health advocates. A majority of people with mental illness can be released safely into the community without posing a danger to others. Mental illness is not a marker of greater or different danger.¹⁶¹ Rather, people with mental illness have a more urgent need for release and referral to community-based treatment.

Recommendations

Counties should:

Use Sequential Intercept Mapping to develop and implement jail diversion strategies to the fullest extent possible. Counties should nurture cross-collaboration between law enforcement, courts, and mental health providers to plan, develop and expand opportunities for jail diversion.

Replace arrests with citations and summonses for Class C misdemeanors. Use the citation and summons law wherever possible to replace warrant and arrest policies, including arrests aimed at the lowest-level (Class C) misdemeanors.

Use mental health professionals and advocates to plan pretrial diversion programs. Use mental health professionals' expertise to ensure that mental illness does not pose an obstacle to pretrial release.

Target LMHA jail diversion efforts on people already in jail or facing charges.

In addition to pre-booking diversion, counties should create and promote diversion strategies for low-risk individuals with behavioral health needs who have been charged or are in jail pretrial.

The Texas Legislature should:

Amend the Code of Criminal Procedure to permit law enforcement agencies to issue citations and summonses for more misdemeanors.

Amend the Code of Criminal Procedure to reduce the number of warrants and arrests for some or all Class C misdemeanor offenses, such as traffic violations.

Require DSHS to track and assess jail diversion programs used by LMHAs to focus on people who are in jail, have open warrants, and have a history or high risk of law enforcement involvement.

Increase funding for DSHS and LMHAs to target pre-arraignment jail diversion aimed at people already in the criminal justice system.

RECOMMENDATION NO. 2

IMPROVE SCREENING.

As counties implement the revised mental health screening instrument, they should train correctional officers to recognize signs of mental illness and suicide risk, and explore partnerships with their local mental health authority (LMHA) to have mental health professionals from the LMHA assist with intake screening.

Assessing the Problem

To improve the detection of mental illness and referral to magistrates under Texas Code of Criminal Procedure § 16.22, the Texas Commission on Jail Standards (TCJS) recently introduced a new screening tool that Texas county jails must use.¹⁶² County jails were required to begin using the new form on December 1, 2015.¹⁶³ The new form gives specific guidance about when jail staff must notify a magistrate, supervisor, and mental health professional.¹⁶⁴ The new form also asks about substance abuse, recognizing that substance use disorders often co-occur with mental illness.¹⁶⁵ TCJS has provided counties with instructions and training on the new form.¹⁶⁶

The new screening tool represents a substantial development for screening practices, and understanding current challenges to effective screening and referral will require a study of how well the new tool is working.

As for training on this issue, TCOLE (Texas Commission on Law Enforcement) provides an eight-hour training for jailers on suicide prevention and detection which is different from the required basic jailer training. This training is not required for

every jailer who books in inmates. A national suicide expert who reviewed Harris County Jail's suicide prevention practices recommended that the jail require this training for all new employees.¹⁶⁷ State regulations also do not require annual or frequent refresher training on suicide detection and prevention for jailers conducting bookings.

In addition, jails are not required to conduct any audit or internal review of their suicide screening process at booking. The same national suicide expert's report on Harris County Jail recommended a "quality assurance audit" of the intake screening process to ensure that all questions required by the state screening instrument are in fact asked, with appropriate follow-up.¹⁶⁸

Finally, effective screening must be followed by assessment and treatment planning, if applicable.¹⁶⁹ Currently, no data is being collected or analyzed to determine whether and how jails take these additional critical steps.



Standards and Best Practices

Studies show that within justice settings, suicide attempts are five times more likely among people who have mental disorders.¹⁷⁰ The Substance Abuse and Mental Health Services Administration (SAMHSA) has noted that in light of the high prevalence of mental disorders with co-occurring substance use disorders, inmates should be screened for both during intake.¹⁷¹ Integrated screening—for mental and substance use disorders—is associated with more favorable outcomes and will better locate appropriate treatment resources. Screening should also include questions relating to trauma and post-traumatic stress disorder (PTSD) because of the high prevalence of these conditions in inmates with mental disorders.¹⁷² Inadequate staff training on the goals and methods of screening can lead to the under-identification of co-occurring mental or substance use disorders, and of suicide risk.¹⁷³

For inmates identified as having some suicide risk, timely assessment by mental health professionals is critical.¹⁷⁴ Assessment will connect the inmate to counseling, medication or other treatment as necessary, and will result in stabilization and reduction of the suicide risk.

Recommendations

Counties should:

Ensure that all correctional staff who are booking inmates have been trained in suicide detection and prevention. As the NIC guidelines recommend, jailers should have initial training and annual refresher training in mental illness and suicide detection and prevention to ensure the effectiveness of screening.

Collaborate with their area LMHA to have a licensed mental health professional conduct intake screening. Like Lubbock County, counties should explore partnerships with their area LMHA to have trained mental health professionals assist with screenings, either in person or through telepsychiatry if appropriate.

The Texas Commission for Jail Standards should:

Publish a study of the new screening tool. TCJS should collect data on implementation and outcomes under the new screening tool, including mental health assessment and treatment and magistrate referrals under § 16.22, and publish a study with recommendations based on review of the data.

The Texas Legislature should:

Provide funding to LMHAs for placing staff in county jails to assist with intake screenings. LMHAs are resource-strapped, but the state can promote better screening by funding LMHAs to add capacity for staff that will be placed in county jails in the LMHA's service area. Additional staff can assist with intake screening, perform post-screening assessments, coordinate care for inmates who were receiving LMHA services prior to booking, and provide other supportive services. LMHAs can also collect data and report on outcomes.

RECOMMENDATION NO. 3

INCREASE COMPLIANCE WITH TEX. CODE CRIM. P. §§ 16.22 AND 17.032.

The legislature should clarify the law to increase compliance with the requirement that magistrates be notified of an arrestee's mental illness or suicide risk, so as to enable pretrial diversion into mental health treatment when appropriate. Counties should implement the law's requirements, using partnerships with LMHAs if needed.

Assessing the Problem

Texas law requires jails to identify mental illness or suicide risk and notify magistrates of that information, so that magistrates may order the person's pretrial release into treatment when appropriate.¹⁷⁵ This law ensures that courts can promptly and appropriately divert low-risk arrestees from jail into treatment and promote recovery.¹⁷⁶ Due to lack of training and oversight, compliance with the law is lacking across the state. As a result, low-risk persons who should be in treatment remain in jail inappropriately.

1. How the Process Should Work

Section 16.22 of the Code of Criminal Procedure requires jail officials to notify a magistrate within 72 hours of receiving information to support a reasonable belief

that an inmate has a mental illness.¹⁷⁷ Jail officials can obtain this information through observation of an inmate, or by running the required Continuity of Care Query (CCQ) database check during intake, which reveals whether the inmate has received state mental health services.¹⁷⁸

If the magistrate determines there is reasonable cause to believe that the inmate has a mental illness, the magistrate must order the local mental health authority (LMHA) or other qualified expert to collect information regarding whether the inmate has a mental illness and to provide the magistrate a written assessment.¹⁷⁹ The assessment must include findings pertaining to whether the inmate has a mental illness, evidence of incompetence to stand trial, and recommended treatment.¹⁸⁰ The assessment must be provided within 10 to 30 days, after which time the trial court may initial competency proceedings if needed.¹⁸¹

Additionally, Section 17.032 states that a magistrate judge *must* release a defendant on personal bond—unless good cause shows otherwise—if the defendant (1) has not been previously convicted of a violent offense; (2) has been examined by an LMHA or another mental health expert under § 16.22; (3) the written assessment under §16.22 concludes that the defendant has a mental illness and recommends treatment; and (4) the magistrate determines with the LMHA that mental health services would be available to the defendant.¹⁸²

2. How the Process Routinely Breaks Down

The § 16.22 process should be common practice in every jail. More than 40 percent of all bookings into Texas jails are for defendants with an “exact” or “probable” CCQ match, which should result in notification to a magistrate.¹⁸³ National Bureau of Justice Statistics data on jail populations show that 64 percent of jail inmates have a mental health issue.¹⁸⁴ Fifteen to 20 percent of jail inmates have a mental health problem characterized as “serious.”¹⁸⁵ Texas incarcerates people with serious mental illness at higher rates than most other states, with 7.8 people suffering from serious mental illness incarcerated for every one person suffering from serious mental illness in a hospital.¹⁸⁶

Despite jails’ extensive experience with inmates with mental illness, there are still routine failures all along the process: (1) Jails fail to notify magistrates of inmates suffering from mental illness; (2) magistrates fail to respond to jails or order mental health assessments; and (3) magistrates fail to release qualifying defendants for lack of treatment options within the community.

First, even when an individual with a mental illness is properly identified, jail staff often fail to notify magistrates. TCJS recently testified that jail staff frequently reported in custodial death investigations that they had not notified magistrates of inmates who had indicated a mental illness on the screening form.¹⁸⁷ Prior to recent training efforts,¹⁸⁸ just 34 percent of counties responding to a 2015 Texas Public Policy Foundation survey indicated that they notify magistrates of an inmate’s mental health problems.¹⁸⁹

**Only 34%
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health problem**

Failure to notify magistrates under § 16.22 is a common reason that jails are found noncompliant by TCJS.¹⁹⁰ One survey of 244 Texas judges found that most did not find out about the defendant's mental health status until arraignment or during trial, a delay that leads to inmates being held for longer periods of time than necessary.¹⁹¹

Second, delays sometimes occur because magistrates are not aware of their responsibilities under § 16.22 and § 17.032. In 2015, TCJS testified that “[c]ounty jails often receive resistance from magistrates regarding [16.22] referrals because magistrates are unsure of their role and responsibilities.”¹⁹²

Third, magistrates fail to release defendants with mental release pretrial, even when they qualify for referral to treatment, for at least two reasons. First, magistrates conduct bail hearings within 48 hours of arrest, pursuant to state law.¹⁹³ Magistrates often do not receive notification from jails of signs of mental illness or suicide risk within that time. Moreover, they almost never receive any assessment by an LMHA or mental health professional regarding eligibility for release and treatment within that time. As a result, magistrates lack the necessary information to grant pretrial release.

For example, over a recent twelve-month period, Bexar County booked 7,216 people with mental illnesses who were eligible for release under § 17.032, yet only 2,170 received mental health assessments, and only 125 were released to treatment.¹⁹⁴ The Council of State Governments expects that referrals to the LMHA would increase to 2,164 using new, faster assessment processes.¹⁹⁵

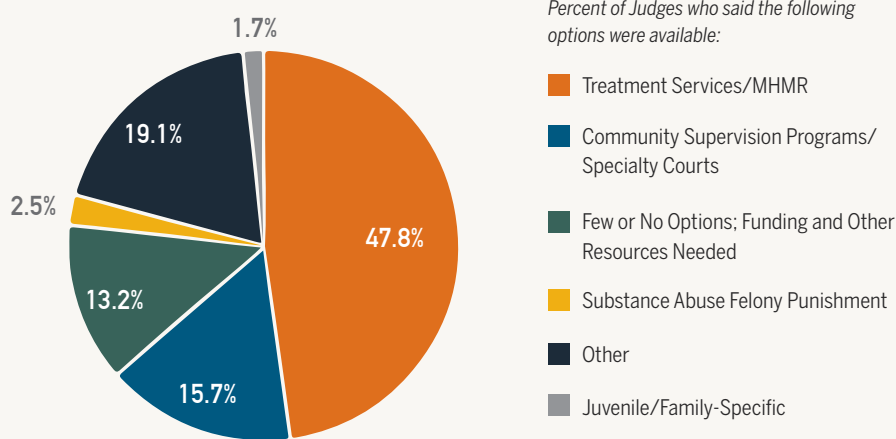
Second, magistrate judges sometimes fail to release defendants to treatment because of a real or perceived lack of local treatment options. In a 2008 survey, 1 out of 7 judges surveyed responded that they had “Few or No Options; Funding and Other Resources Needed” when asked what options they had to address the mental health needs of defendants who come before them.¹⁹⁶ Almost every judge was aware of § 17.032 (83 percent), but one-third of respondents said that “Treatment Service Availability Poses Problems.”¹⁹⁷

3. The Consequences of Failure

When Carl Chadwick Snell—Chad—was booked into Denton County Jail in December 2014, the jail ran a CCQ check and saw that he had recently been receiving care from the Denton County LMHA.¹⁹⁸ The jail notified the magistrate with an email stating simply: “Inmate Snell, Carl W/M DOB: 6/28/75 has received prior MHMR services.”¹⁹⁹

The magistrate took no action following the jail's email. In an article in the Denton newspaper, the judge was quoted as saying that the “jail staff send him four or five mental health email alerts each day” and “it doesn't mean that [the inmates] are suffering from mental illness now.”²⁰⁰

Survey: Many Texas Judges Have No Treatment Options to Address Mental Illness



Source: Judicial Perspectives On Substance Abuse & Mental Health Diversionary Programs and Treatment, Preliminary Judicial Survey Findings Presented To The Judiciary Advisory Council (2008).

In his three months in the Denton County Jail, Chad Snell never saw a mental health professional or received mental health treatment, despite having 74 pages of MHMR records indicating his treatment and medication needs. In March 2015, he hanged himself in his cell.

Recommendations

Counties should:

Ensure that jail staff timely notify magistrates of every inmate with a possible mental illness or suicide risk. Sheriffs should monitor their jail staff's compliance with the deadlines in § 16.22 to ensure timely notification to magistrates.

The Texas Commission for Jail Standards should:

Develop specific standards to help counties comply with § 16.22. TCJS, which is required by statute to monitor compliance with § 16.22, should provide technical assistance and best practices information to counties, and collect and review data to monitor compliance with § 16.22 notification requirements.²⁰¹

The Texas Legislature should:

Amend the law to require assessments by mental health professionals to be provided to magistrates prior to § 15.17 bail hearings. Magistrates need mental health assessment and treatment plan information at the Texas Code Crim. P. § 15.17 bail hearing in order to order pretrial release and referral to treatment.

Require training for jail staff and magistrates on §§ 16.22 and 17.032. TCJS recently recommended that jail staff and magistrates receive mandatory mental health training with an emphasis on § 16.22 and 17.032.²⁰² In 2015, the legislature

required the Texas Department of State Health Services (DSHS) to develop training for judges on competency restoration;²⁰³ DSHS should be required to expand that training to include § 16.22 and 17.032.

Fund additional community-based treatment options for low-risk arrestees.

A recent survey of judges indicated overwhelmingly that LMHAs were the primary resource for providing mental illness treatment, that limited treatment options were the biggest barrier to releasing defendants pretrial, and that expanding treatment services would greatly enable judges to release individuals and refer them to mental health treatment.²⁰⁴

Require mental health professionals to assess inmates within eight hours of intake and provide information to magistrates.

Currently, inmates with mental illness who do not appear to be in crisis at booking may wait days to be assessed by a qualified mental health professional.²⁰⁵ TCJS recently recommended that jails be required to have a mental health professional assess any inmate suspected of having a mental illness within eight hours of intake.²⁰⁶ The legislature should require a mental health professional to provide this early assessment to a magistrate.

Provide funding for magistrate-ordered assessments under § 16.22.

TCJS recently recommended that the state contribute to the cost of the LMHA assessments ordered by magistrates, which are currently borne by counties and LMHAs.²⁰⁷ Funding the assessments will increase capacity and reduce delays.

RECOMMENDATION NO. 4

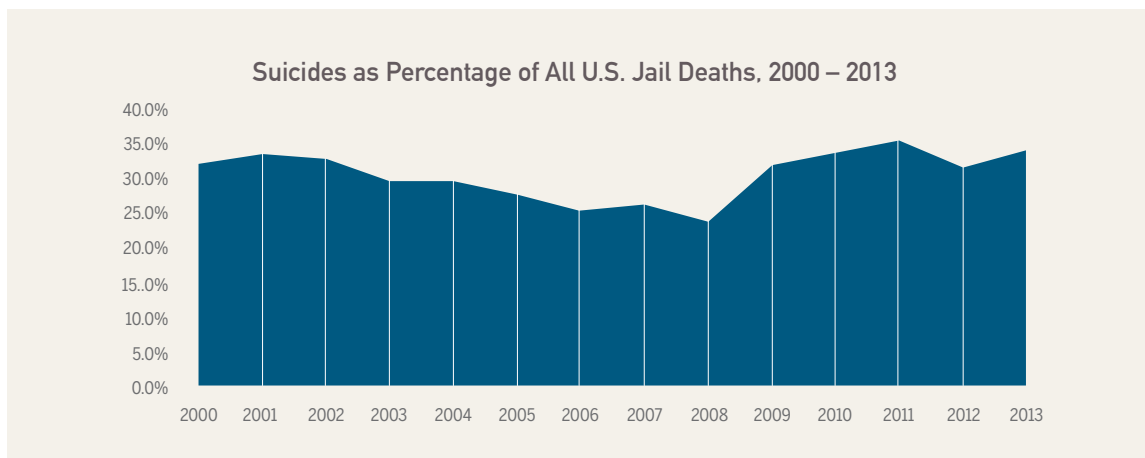
STRENGTHEN SUICIDE PREVENTION.

Counties should make their suicide prevention plans more effective by: (1) increasing training and promoting culture change; (2) providing for ongoing suicide risk assessment throughout an inmate's stay in the jail; (3) avoiding housing at-risk inmates alone; (4) designating suicide-resistant cells; and (5) having mental health professionals assist with the assessment of suicide risk.

Assessing the Problem

Suicide is the second leading cause of death in Texas jails,²⁰⁸ which have seen over 140 suicides since 2009.²⁰⁹ Forty-two percent of suicides occur within a week of confinement; eighteen percent occur within a day.²¹⁰ Inmate suicides are significantly more likely to happen in single cells,²¹¹ and by hanging.²¹²

Although Texas law requires sheriffs to develop and implement a mental disabilities/suicide prevention plan that is shared with the Texas Commission on Jail Standards (TCJS),²¹³ suicides often follow jails' failures to comply with their own plans. Victoria Gray's story is one such example. Admitted to Brazoria County Jail just before Labor Day in 2014, Victoria indicated at intake that she was suicidal, and



Source: Bureau of Justice Statistics, *Mortality in Local Jails and State Prisons, 2000–2013* (2015).

had previously attempted suicide in the jail.²¹⁴ Jail staff nevertheless placed her in a cell by herself and classified her as a low suicide risk.²¹⁵ Brazoria County’s suicide prevention plan required staff to perform visual observations every 30 minutes²¹⁶—had she been classified as a higher risk, the plan would have required staff to observe her every 15 minutes, and to temporarily replace her clothing and bedding with a suicide blanket until she could be stabilized.²¹⁷ On Victoria’s third day in jail, Victoria used her bedding to commit suicide.²¹⁸

Texas regulations require jails to develop suicide prevention plans that address training, identification, communication, housing, supervision, intervention and emergency treatment, reporting, and follow-up review.²¹⁹ State regulations also require jails to screen newly admitted inmates through a Department of State Health Services database,²²⁰ and to notify a magistrate of newly admitted inmates with mental illness.²²¹ In 1991, TCJS published a Guide for Development of Suicide Prevention Plans to help counties develop a successful plan.²²²

Despite these regulations, the number of suicides in Texas jails is not much different today than it was in the late 1980s and early 1990s, before the current regulations were in place.²²³ Two problems contribute to the lack of improvement: (1) many counties’ suicide prevention plans are minimal—an expert described Waller County’s plan as “bare-bones” after Sandra Bland’s death²²⁴—and (2) county jails sometimes fail to comply even with their minimal plans.²²⁵ Lacy Cuccaro is just one tragic example of the consequences of failing to comply with the 30-minute observation requirement.²²⁶

People in jail face an increased risk of suicide. National data show that the rate of suicide in jails is roughly three times higher than among the general public.²²⁷

Moreover, a disproportionate number of suicide attempts in jails involve inmates with mental illness.²²⁸ A 2002 study in Washington State found that 77 percent of people who attempted suicide in jail were mentally ill,²²⁹ and experts have estimated that, nationally, more than half the jail inmates who commit suicide suffer from mental illness.²³⁰

Suicide has been the leading cause of death in U.S. jails every year since 2000.

– Bureau of Justice Statistics

This risk is even more troubling given that over 60 percent of people held Texas county jails are pretrial detainees who have not been convicted of a crime.²³¹ Male pretrial detainees attempt suicide at a rate 7.5 times higher than males in the general population.²³²

Standards and Best Practices

Experts and national standards point to several things that Texas jails can do to improve compliance with their suicide prevention plans, and to improve the plans themselves: (1) increase training and change staff culture; (2) provide for ongoing suicide risk assessment throughout an inmate's stay in the jail; (3) avoid housing at-risk inmates alone; (4) modify watch cells to be more more suicide-resistant; and (5) have mental health professionals, not jail staff, assess suicide risk.

1. Increase Training and Change Staff Culture

The National Commission on Correctional Health Care's (NCCHC) Standards for Health Services in Jail state that correctional officers should receive health-related training every two years that includes training on "procedures for suicide prevention."²³³

Because correctional officers are often the first to discover a suicide attempt, experts recommend that training for all staff should include "mock drills" to ensure an effective emergency response to suicide attempts.²³⁴ The Federal Bureau of Prisons (BOP) recommends suicide emergency drills to help "identif[y] and correc[t] systemic flaws in [the existing] suicide prevention plan."²³⁵

The BOP also recommends that correctional facilities "create a culture of suicide prevention."²³⁶ Because correctional officers are often the only staff available 24 hours a day, they form the first line of defense in preventing suicides. The BOP recommends that sheriffs model interest in the topic of suicide prevention, make it a common practice to discuss suicide prevention with mid-level supervisors, and encourage staff to know the inmates and make referrals of inmates at risk of suicide.²³⁷ Effective suicide prevention requires jail staff to create supportive relationships with inmates and increase trust between inmates and staff.²³⁸ Jail leadership is critical to enacting culture change.

Texas lawmakers acknowledge the importance of culture change. In a 2015 hearing, Texas Senator John Whitmire observed, with regard to suicide prevention, that "[w]e can change all the forms we want, and we can pass all the new laws we want, but if we don't change the attitude and culture of the jail system, then we will still have the same problem."²³⁹

2. Provide Ongoing Suicide Risk Assessment

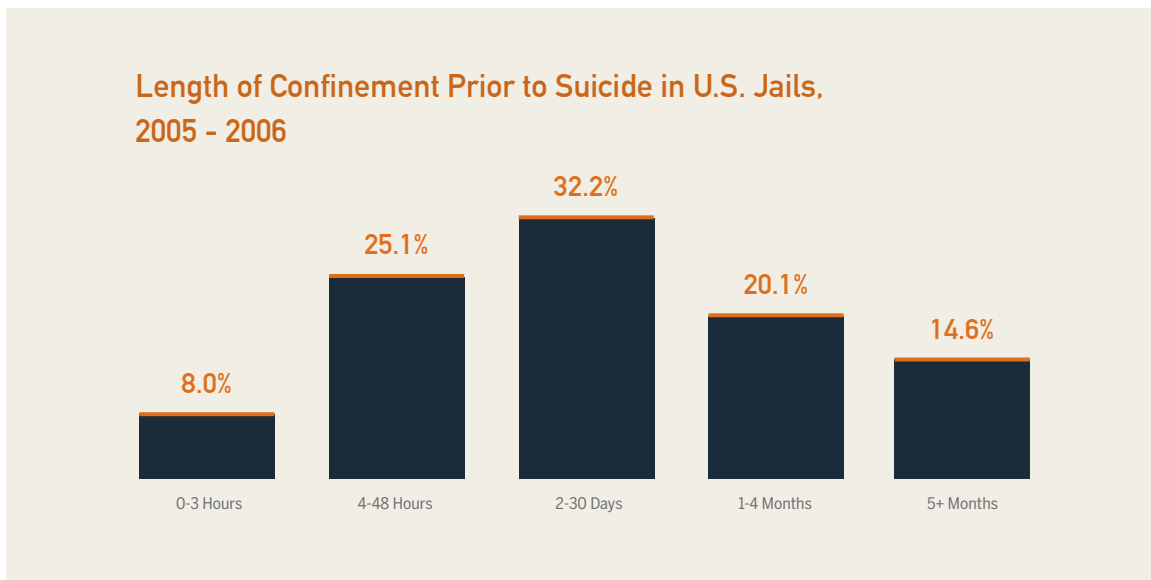
A recent national study of jail suicides by the National Institute of Corrections found that suicides did not all occur in the first few days of confinement, but rather were fairly evenly distributed across the term of confinement; over 40 percent

occurred more than two weeks after booking.²⁴⁰ The same study found that 80 percent of suicides occurred within two days of a court hearing²⁴¹—as in the case of Eric Dykes.²⁴²

Accordingly, experts recommend that screening for suicide risk “should not be a single event” at intake, “but a continuing process because inmates can become suicidal at any point.”²⁴³ Experts recommend key points for assessment, such as after returning from court, after receiving bad news, during solitary confinement, or after a prolonged period in jail.²⁴⁴ Our review of a number of county jail suicide prevention plans revealed that counties typically make no provision for formal assessment at any point after initial screening.²⁴⁵

3. Avoid Housing At-Risk Inmates Alone

A recent national study of jail suicides found that 38 percent of inmates who commit suicide do so in an isolation cell.²⁴⁶ The BOP notes that “single-cell status is one of the strongest correlates with suicide.”²⁴⁷ Accordingly, the BOP recommends that jails “should double cell all inmates in locked cells [as] a general practice, except when there is a compelling reason not to do so.”²⁴⁸ The American Public Health Association states that “[i]solation may increase the chance that a prisoner will commit suicide and must not be used as a substitute for continuity of contact with staff and appropriate supervision.”²⁴⁹



Source: Hayes, National Study of Jail Suicides: 20 Years Later (2010).

4. Modify Watch Cells to Be More Suicide-Resistant

Studies find that up to 93 percent of jail suicides are committed by hanging.²⁵⁰ Of the 102 suicides that occurred in Texas jails between 2005 and 2009, over 87 percent were committed by hanging or strangulation.²⁵¹ A national study found that over 80 percent of inmates used their bedding or clothing,²⁵² and over 70 percent tied the strangulation device to their bunk, cell bars, or ventilation grate.²⁵³

38%
of people who
commit suicide
in jail are alone
in their cell

According to the BOP, “research has demonstrated... [that] removing the chosen method or the most obvious methods of death can delay suicide until the crisis passes.”²⁵⁴ Accordingly, the BOP recommends that in areas where high-risk offenders are housed, jails should make every effort to make cells more suicide-resistant, such as covering vents and modifying sprinkler heads so that they cannot be used as tie-off points.²⁵⁵ Cameras should be able to view the entire cell and display a feed adequate for staff to observe self-harm behaviors.²⁵⁶ Our review of county jails’ suicide prevention plans indicates that many require the removal of bedding and clothing from cells housing high-risk inmates, but do not require the additional steps recommended by the BOP.²⁵⁷

5. Have Mental Health Professionals Help Assess Suicide Risk

A recent national study found that the majority of people who committed suicide in jail were not seen by a qualified mental health professional prior to their death.²⁵⁸

The NCCHC’s Standards for Health Services in Jail state that screening should be done by “qualified health care professionals or health-trained personnel,”²⁵⁹ and that inmates with positive screens be given a mental health evaluation by “qualified mental health professionals or mental health staff.”²⁶⁰ Additionally, the BOP states that inmates “should be reassessed by a mental health clinician every time they present with risk for suicide.”²⁶¹ In other words, anything beyond simply screening for suicide risk should be done not by ordinary staff, but by mental health professionals.

Experts acknowledge that “[v]ery few suicides are actually prevented by mental health [staff]” because suicides often happen at times when only correctional staff are on duty.²⁶² The reality is that mental health professionals will not be on hand to assess every suicide risk, and that properly training correctional staff to assess risk is essential.²⁶³

Nonetheless, correctional staff should treat suicide threats seriously—especially from inmates with mental health illness—until a mental health professional can review the staff’s assessment. Eric Dykes’ story illustrates the problem. Eric, diagnosed as bipolar, told Hays County Jail officers that he would kill himself if placed in isolation.²⁶⁴ Nevertheless, jail staff placed Eric in an isolation cell, where he hanged himself. The officer who had checked on Eric the hour before he died reported that Eric “seemed fine.”²⁶⁵

93%
of jail suicides
are committed
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Recommendations

Counties should:

Train correctional staff on suicide prevention. Training should be mandatory and should recur annually. Training should be live and interactive, rather than simply reviewing written procedures or watching a video.

Update their suicide prevention plans to provide for ongoing assessment.

The plan should specifically provide for suicide-risk assessment by mental health professionals at certain discrete points after intake, such as several days before and after a court hearing or at regular intervals during solitary confinement.

Avoid housing at-risk inmates alone and use suicide-resistant cells for high-risk inmates. County jails' suicide prevention plans should state that (1) whenever possible, inmates at risk for suicide should be housed with other inmates; and (2) that designated cells for high-risk inmates should use adequate video surveillance and have modified physical features to prevent hanging.

Require mental health professionals to evaluate at-risk inmates. Jail suicide prevention plans should require prompt evaluation by a mental health professional of any inmate who presents even a low suicide risk, and correctional staff should be trained to liberally refer inmates to qualified professionals for evaluation.

The Texas Commission for Jail Standards should:

Publish an updated guide and provide technical assistance to counties on suicide prevention. TCJS published a useful guide in 1991 to advise counties on developing a suicide prevention plan.²⁶⁶ TCJS should publish a new guide that accounts for more current standards and practices, and draws on lessons from successful Texas counties. TCJS should also collect and review data to periodically provide technical assistance and best practices information on suicide prevention.

Require jails to send people at high risk of suicide to a mental health facility for emergency treatment and stabilization. TCJS should require jails to take immediate steps to treat and stabilize those who are at high risk of suicide by transporting them to mental health facilities if needed.

The Texas Legislature should:

Require mandatory suicide prevention training for jail staff. In 2015, the Texas Legislature required that public school teachers receive suicide prevention training.²⁶⁷ The Legislature should pass the same requirement for jail staff, both when they are hired and on an annual basis thereafter, and provide TCJS with the financial resources to provide that training on an annual basis.

Require each county jail to have at least one suicide-resistant cell. Hanging is the most common form of suicide in county jails. The Legislature should require each jail to have at least one available cell at all times that meets national standards for suicide resistance.

Require LMHAs to provide resources for suicide prevention to county jails. LMHAs have suicide prevention expertise that can help county jails evaluate and improve their suicide prevention protocols on an annual basis.

Provide additional resources to TCJS to enable the agency provide technical assistance on suicide prevention. TCJS is already required to approve county

jails' suicide prevention plans;²⁶⁸ an additional staff member with mental health expertise would allow TCJS to provide jails with technical assistance for improving suicide prevention measures. Recent TCJS appropriations requests suggest that hiring a program specialist to provide technical assistance would cost about \$50,000 to \$60,000 per year.²⁶⁹ This specialist could also provide technical assistance for the other mental-health-related programs recommended elsewhere in this report.

RECOMMENDATION NO. 5

COLLABORATE WITH LOCAL MENTAL HEALTH AUTHORITIES.

County jails should form broad—and preferably formal—partnerships with their area LMHAs, and work to place LMHA staff in the jail full-time. The Legislature should fund LMHAs to add capacity to provide more services in jails.

Assessing the Problem

In Texas, there are 39 publicly funded community health care centers, called Local Mental Health Authorities (LMHAs), that contract with the Texas Department of State Health Services (DSHS) to provide mental health care to all of Texas.²⁷⁰ Each LMHA serves a county or set of counties.²⁷¹ Each LMHA's services vary, but they typically include crisis services, veterans' services, housing programs, substance abuse programs, peer support, and more.²⁷²

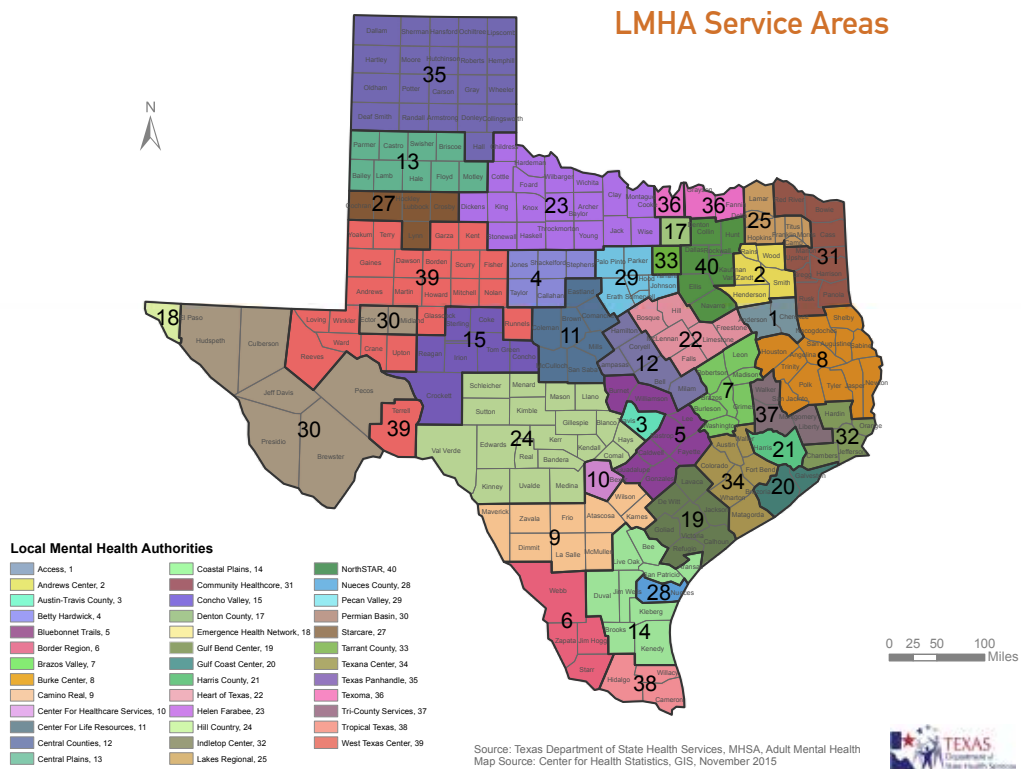
LMHAs and jails treat many of the same people. A national study found that 64 percent of people in local jails reported a mental health issue.²⁷³ Many people suffering from serious mental illness can become stuck in “a chronic cycle” between jail and the community.²⁷⁴ At least 40 percent of people booked into Texas jails have received mental health services through the state.²⁷⁵

Texas law already requires some interaction between jails and LMHAs. DSHS requires LMHAs to input patient information into a statewide database, which jails then query in order to help identify inmates with mental illness at booking.²⁷⁶ Judges can order LMHAs to provide assessments of inmates identified as mentally ill.²⁷⁷ LMHAs are required to assess inmates experiencing a crisis within one hour.²⁷⁸ LMHAs must incorporate jail diversion strategies into their disease management practices.²⁷⁹ In addition, LMHAs may make recommendations relating to “the most appropriate and available treatment alternatives” for individuals who are in local jails and in need of mental health services.²⁸⁰

Nevertheless, the level of collaboration between jails and LMHAs can vary widely. Some LMHAs provide very little or no mental health services to individuals in jails.²⁸¹ This lack of collaboration may result from a lack of resources or capacity, as compared to the community need; differences between county jail leadership

and LMHAs over how best to achieve public safety and mental health recovery objectives; or lack of perceived criminal justice expertise by LMHA personnel. Some LMHAs and county jails may simply have failed to consider the full extent of their possible collaboration.

There is an opportunity for LMHAs to help jails treat inmates with mental illness. A 2004 study found that only eleven percent of jails had a mental health professional on staff.²⁸² According to LBJ School of Public Affairs Professor Michele Deitch, “there is a real need for jails to have clearly written arrangements with local mental health facilities to provide emergency mental health care as well as routine treatment services.”²⁸³



Standards and Best Practices

A number of LMHAs have established close relationships with the local jails in their service area—for example, by providing services in the jails²⁸⁴ or maintaining a continuous presence in the jails.²⁸⁵ For example, MHMR Tarrant County has an office at the jail and is present there 24 hours a day, seven days a week.²⁸⁶

Bluebonnet Trails Community Services (BTCS) serves eight central Texas counties surrounding Austin and is able to place a full-time representative in each of its county jails.²⁸⁷ According to BTCS staff, full-time staff are in each jail daily, providing formal training to correctional officers and offering real-time informal advice on how to handle inmates’ mental health needs.²⁸⁸ This continuous presence allows correctional officers to build trusting relationships with the BTCS staff, thereby

improving treatment.²⁸⁹ For example, the BTCS staff that work in jails report that they advise magistrates on diverting people with mental illness into treatment, tell the jail what medication new inmates were receiving in the community, and provide feedback on the jail's suicide prevention protocols.²⁹⁰

Another example of an LMHA that maintains a continuous presence in its area jails is Border Region Behavioral Health Center (BRBHC), which serves four south Texas counties.²⁹¹ BRBHC has a jail diversion plan that includes in-jail services in which inmates with mental health needs are assigned a qualified mental health professional charged with trying to reduce or drop the charges against the defendant.²⁹² The BRBHC staff member makes arrangements with the court, district attorney, public defender's office, and sheriff's department to gain the defendant's release to the community or to a state hospital for treatment.²⁹³

LMHAs that are unable to physically place staff in a jail can use telemedicine as an alternative to provide mental health services to inmates. For example, Texas Panhandle Centers serves 21 rural Texas counties and uses telemedicine to provide mental health services to inmates across its expansive service area.²⁹⁴

Collaboration can be formalized by a contract or memorandum of understanding (MOU), or it can be informal. Our small survey of several LMHAs found that most had some form of contract or MOU with area jails.²⁹⁵ Staff from the MHMR Authority of Brazos Valley (MABV) report that MABV has strong informal relationships with some of its seven east Texas county jails, but does not have formal contracts or MOUs with them for services.²⁹⁶

MOUs can take various forms. For example, in its MOU with Bastrop County Jail, Bluebonnet Trails Community Services agrees to provide psychiatric services at the jail by a licensed psychiatrist, including psychiatric evaluation, pharmacological reviews, and malpractice insurance.²⁹⁷ The MOU also provides for crisis and emergency screening services to inmates in psychiatric emergencies in need of immediate evaluation.²⁹⁸

Gulf Coast Centers (GCC) has an MOU with the Galveston County Jail—and a contract with the jail's private health services contractor—to provide psychiatric care by a medical doctor, nurse practitioner, or physician assistant responsible for screening, assessment, crisis intervention, patient education, and psychiatric consultation of those individuals in the jail.²⁹⁹

Texas Panhandle Centers (TPC) entered into MOUs with the many rural counties it serves for the provision of telemedicine video equipment.³⁰⁰ TPC provides and installs the video equipment, outlines procedures for use, and trains staff on using the equipment.³⁰¹

Recommendations

Counties should:

Forge a broad—and preferably formal—partnership with their area LMHA.

Every county jail should forge a partnership with its area LMHA to allow the LMHA to help fill mental health service needs at the jail. The partnership can include: assessment (at intake and ongoing) for treatment diversion, crisis response, mental health care policy review, or psychiatric services by LMHA staff in the jail. Preferably, the partnership should be formalized by an MOU or contract.

Work with their area LMHA to have LMHA staff visit or work in the jail regularly.

County sheriffs should ask the LMHA to have LMHA staff work in the jail every week, as Bluebonnet Trails Community Centers does for the central Texas county jails it serves. On-site LMHA staff can provide real-time advice about inmates' mental health needs, help review mental health and suicide prevention protocols, and train staff in skills to help manage inmates with mental illness.

Work with their area LMHA to explore alternative funding sources. Asking LMHAs to provide additional services may require additional resources that the LMHA does not have. Local funds account for only thirteen percent of LMHA funding;³⁰² much of the rest comes from the state, which has a limited budget for mental health care.³⁰³ Nevertheless, there are numerous other potential sources for funding.³⁰⁴ Counties should work with their LMHA to apply for additional funding to increase capacity for jail mental health services.

The Texas Commission on Jail Standards should:

Promote partnerships between county jails and LMHAs through technical assistance. TCJS should assist counties with forming deepened partnerships with LMHAs, and publicize the existing LMHA-jail programs and services that promote mental health recovery and treatment, so that they can be replicated as appropriate.

The Texas Legislature should:

Allocate funding to LMHAs for placing full-time staff in jails. In the 2012-13 session, the legislature made a number of new investments into community mental health through budget riders for a jail-diversion pilot program in Harris County, to reduce waitlists at LMHAs, and more.³⁰⁵ The legislature should build on that commitment by providing funding to LMHAs to place full-time staff in jails to provide training, technical assistance, and treatment services.

BOLSTER FORMULARIES.

County jails should promote continuity of mental health care by (1) including in their formulary the medications listed in the local mental health authority's formulary and (2) contracting with outside providers to quickly acquire any medication not kept in stock.

Assessing the Problem

Abruptly taking an inmate off of her mental health medications can be fatal. In some cases, inmates are denied access to prescribed medications because the jail does not include that medication in its formulary, which is a list of pre-approved

In a small sample of records requests to 15 counties, two county jails responded that they did not have a formulary.

drugs that the jail keeps in stock in its pharmacy. When an inmate needs a drug that is not on the jail's formulary, she can face long delays or an outright denial of life-saving medicine. County jails' formularies should include the mental health medications listed in the standard state formulary that local mental health authorities (LMHAs) use, and counties should contract with outside providers to quickly acquire non-formulary medication.

In our research, we requested the formularies from fifteen Texas jails of varied sizes. We also requested from a number of LMHAs any contracts, MOUs, or policies for the provision of services to county jails. The formularies, contracts, and policies we received reveal several things.

First, county jails' formularies vary widely from one another. Some jails—particularly those whose medical care was provided by a local public hospital—have detailed formularies as long as 72 pages.³⁰⁶ Other jails have simple formularies running only six pages that list only a handful of mental health medications.³⁰⁷ And still other jails—not necessarily the smallest jails—have no formulary at all.³⁰⁸ Although many Texas counties rely on private contractors to provide health care services, our research indicated that private providers did not use more robust formularies, and in some cases did not even use formularies.³⁰⁹

Second, almost every county jail's formulary was missing many of the mental health drugs listed in the standard Department of State Health Services (DSHS) formulary that every LHMA uses.³¹⁰ For example, the DSHS formulary's list of psychotropic medications—medicine that affects the mind, emotions, and behavior—is eleven pages long on its own, and indicates not just preferred drugs, but also recommends dosages and intervals for administration.³¹¹ The DSHS formulary also provides a procedure by which a clinician may prescribe *non*-formulary drugs if needed.³¹²

Third, counties and LMHAs do not consistently have arrangements—contractual, policy-based, or even informal—for the coordinated provision of mental health services or medication in county jails.³¹³ County jails are not required to coordinate

care with their area LMHA. Nor are they required to enter into a contract or MOU with the LMHA to ensure that inmates receive necessary mental health medication that the jail may be unable to provide. Accordingly, counties and LMHAs often fail to develop relationships to coordinate care for inmates who may frequently cycle from community care to the jail and back.

When the county jail's mental health formulary differs from the LMHA's formulary, a person might be receiving a medication in the community that the jail doesn't have, which means the person's treatment may be abruptly disrupted when he arrives at the jail. The seriousness of such a disruption will vary according to each patient, but generally can lead to negative health outcomes as well as jail management problems. According to one study, changing a person's medication when he enters a secure facility "contribute[s] to poor relationships with prison health staff, disrupts established self-medication practices, discourages patients from taking greater responsibility for their own conditions, and detrimentally affects the mental health of many prisoners at a time when they are most vulnerable."³¹⁴

Standards and Best Practices

According to the National Commission on Correctional Health Care's standards, a jail should maintain a formulary for clinicians and a procedure for timely acquisition of pharmaceuticals.³¹⁹ The formulary should be developed by the mental health authority and one of the jail's clinicians, with the assistance of a consulting pharmacy.³²⁰ The jail should also have a procedure for the use of non-formulary medications, and should allow non-formulary medication prescribed by outside providers if approved by a jail physician.³²¹ Small facilities should use the current American Society of Health-System Pharmacists drug formulary for reference.³²² Even small and medium-sized counties can and should maintain a formulary with an appropriate set of mental health medications. For example, the Brazoria county jail lists many of the drugs that appear in the DSHS formulary.³²³

To the extent that a jail is unable to stock a full range of standard mental health medications, it should partner with its local LMHA to promptly acquire such medication on an as-needed basis. For example, Lubbock County has contracted with the Lubbock Regional MHMR Center to provide services to inmates with serious mental illness.³²⁴ Among other things, the contract provided for provision of psychotropic medications not listed on the jail's formulary.³²⁵ As another example, the Brazoria County Jail currently has a policy for acquiring and maintaining medications supplied by its LMHA, the Gulf Coast Centers.³²⁶

At the very least, jails and LMHAs should be aware of one another's formularies so that they can better stabilize treatment as people transition from the community to jail and back. The Texas Commission on Jail Standards has recommended that the state compile and publish the mental health formulary of every criminal justice and mental health entity to promote continuity of care.³²⁷

The Commission also has advised jails to take advantage of the state's 46B program, administered through TCOOMMI. This program provides for 76 days of

state reimbursement for medication provided to an inmate who is returning to the jail from a state hospital after a forensic or 46B commitment.³²⁸

Recommendations

Counties should:

Develop procedures related to the jail's formulary. In accordance with national standards, county jails should develop, update, and strengthen their formularies to address mental health needs, and should develop procedures for prescribing and quickly acquiring non-formulary medication.

Review their jail formularies with their area LMHAs to ensure that jail formularies include necessary mental health medications. At the very least, jails and LMHAs should be aware of each other's formularies to better stabilize medication as inmates transition between the community and jail.³²⁹ Even better, jails should include as many core mental health medications as the area LMHA recommends.

Contract with the nearby LMHA to provide non-formulary medications. Like Lubbock and Brazoria Counties, counties should work with their nearby LMHA to update and strengthen their formularies and to promptly acquire any medications not on the jail's formulary.

The Texas Commission on Jail Standards should:

Provide technical assistance to county jails regarding best practices on mental health medications. TCJS should, in coordination with DSHS and LMHAs, assist counties to ensure that county jails stock the most commonly prescribed mental health medications, including medications most commonly prescribed by LMHAs, for purposes of adequacy and continuity of care.

Require counties to report to TCJS on medication gaps. TCJS should be aware of all medications, including non-formulary medications, that inmates need but county jails are not able to obtain. TCJS should collect and review this data and, in coordination with DSHS and LMHAs, develop strategies for filling these medication gaps.

The Texas Legislature should:

Require every county jail to create a formulary and related procedures. At a minimum, every county jail should have a written formulary. In accordance with national standards, county jails should also have procedures for updating their formulary and for prescribing and acquiring non-formulary medication. The Legislature should require county jails to adopt the mental health portion of the DSHS formulary.

Provide additional resources to TCJS so that it can review jails' formularies and provide technical assistance. The legislature should require TCJS to audit every Texas jail's formulary and to publish a best-practices resource that identifies essential mental health medications. To allow ongoing oversight and technical

assistance on mental health care protocols, TCJS should receive funding to hire an inspector with mental health care experience. Recent TCJS appropriations requests suggest that hiring an inspector or a program specialist to provide technical assistance would cost about \$50,000 to \$60,000 per year.³³⁰

Provide additional resources to LMHAs. To take a more active role in filling service gaps in county jails, LMHAs will need additional funding from the state. The state should provide funds to LMHAs that provide medication and other services to jail inmates.

Expand the existing TCOOMMI 46B program on reimbursement of medications. The state should expand the 46B program to cover all mental health medications that an inmate was prescribed by an LHMA, in addition to medications prescribed by state hospitals following commitments.

Require county jails to adopt the mental health portion of the DSHS formulary. The best way to ensure that people who cycle between the community and jail have continuity of care is to require county jails to provide all of the same mental health medications that an LMHA provides.

RECOMMENDATION NO. 7

PROMOTE MEDICATION CONTINUITY.

County jails should promote continuity of care by allowing inmates to continue taking prescribed medication that the inmate had been taking prior to booking, after taking certain precautions. Specifically, county jails should replace policies of denying access to prescribed medications with more flexible alternatives.

Assessing the Problem

Withdrawal from prescribed medications—including psychotropic and narcotic medications—can be fatal. In some cases, withdrawal occurs when a patient is booked into a jail that will not allow the inmate to continue taking currently prescribed medications or of refusing access to certain psychotropic or narcotic medications. County jails need to have policies and procedures for verifying inmates' prescriptions at intake and ensuring that the inmate continues take her prescribed medications without delay or disruption.

In December 2010, 33-year-old Amy Lynn Cowling died in Gregg County Jail from seizures caused by prescription drug withdrawal because jail officials refused to give her the medicine that sat in her purse in the jail's storage room for five days.³³¹ Cowling had been receiving methadone treatment for a decade, and was taking Xanax and Seroquel to treat her bipolar disorder and anxiety. She told jail officials about her prescriptions and her poor health when they booked her

for outstanding misdemeanor warrants.³³² Nonetheless, the jail's officials refused to let her continue taking her medication because her medications were banned as a policy of the doctor contracted by the county.³³³

In March 2015, 32-year-old Jesse Jacobs died in Galveston County Jail from seizures caused by prescription drug withdrawal because jail officials refused to allow him to take his medications.³³⁴ Jacobs' psychiatrist of over a decade had long been prescribing Xanax to help him cope with his mental health disorders, and the doctor had written a letter to the jail about Jacobs' medical needs before Jacobs was booked into jail to serve a two-week sentence for DWI.³³⁵ Nonetheless, the jail's officials refused to let Jacobs take his medication because Xanax is a narcotic, and Jacobs died six days later from a seizure—the first of his life—that his doctor believes was caused by acute drug withdrawal.³³⁶

Although opiate withdrawal is not typically fatal, the stress of acute drug withdrawal may also increase suicide risk for jail inmates,³³⁷ for whom such risk is already three times higher than it is generally in the U.S.³³⁸ Additionally, severe withdrawal can increase the mortality risk from co-occurring conditions,³³⁹ as was the case for Amy Lynn Cowling.

Likewise, abrupt discontinuation of psychotropic medication can have serious, and sometimes fatal, consequences. Discontinuing antidepressants increases suicide risk.³⁴⁰ Abruptly discontinuing benzodiazepines (a class of psychiatric medications that includes Xanax) can cause seizures that in serious cases can be fatal, as it was for Jesse Jacobs.³⁴¹ Discontinuing antipsychotic medication can provoke dangerous psychotic episodes.³⁴²

The Galveston and Gregg County policies that led to the deaths of Amy Lynn Cowling and Jesse Jacobs are not unusual. In our research, we found that jails' policies typically either (1) state that only medications prescribed by the jail's doctor are allowed,³⁴³ or (2) go further to specify certain drugs or classes of drugs that will never be allowed.³⁴⁴ These inflexible policies do not make any exception for current, verifiable prescriptions made by doctors outside the jail.

These policies have dire consequences. Although there are no data tallying the number of withdrawal-related deaths in U.S. jails, news reports demonstrate that Amy Lynn Cowling and Jesse Jacobs are only two of many who die in jail each year following abrupt discontinuation of prescribed medication.³⁴⁵



Gregg County's medication policy in 2010, when Amy Lynn Cowling died.
Source: Gregg County Jail's Drug Policy Explained, KYTX-Longview (Jun. 8, 2011).

No state regulation guides jails' policies for prescription medications.³⁴⁶ Accordingly, each jail may draw up its own policy, and many have no formal written policy at all.³⁴⁷

Standards and Best Practices

Sheriffs should do everything they can to avoid the serious—and at times, fatal—consequences of abruptly taking inmates off of their prescribed medication. Sheriffs may be concerned either that (1) certain drugs must be restricted because their potential for abuse makes jail management more difficult, or (2) that medications brought to the jail cannot be distributed because the jail would expose itself to legal liability by allowing an inmate to take a medication that the jail did not itself prescribe and procure.

However, national standards and best practices suggest that flexible policies can account for both concerns. Policies promoting continuity of care are consistent with a growing body of evidence showing that taking inmates off of their prescribed medication does not improve jail management or reduce legal liability.

The American Bar Association's Standards on Treatment of Prisoners state that "prisoners who are determined to be lawfully taking prescription drugs... when they enter a correctional facility... should be maintained on that course of medication."³⁴⁸

The National Commission on Correctional Health Care (NCCHC) recommends that jails adopt one of several policy options for previously prescribed medications: (1) contact the on-call physician for a verbal order after health staff have verified the prescription with the pharmacy or prescribing physician; (2) authorize nurses to dispense the medication based on the community clinician's verified order until the jail's physician can see the inmate; or (3) allow use for any verified medication that is properly packaged and labeled.³⁴⁹

The NCCHC's recommended policies are more flexible than the standard policy of many Texas counties, which simply provides that inmates can take only those medications prescribed by the jail's doctor.³⁵⁰

Several Texas counties already take the NCCHC's flexible approach. For example, see McLennan County's policy in the spotlight box below.³⁵¹

Spotlight: McLennan County's Medication Continuity Policy

McLennan County allows inmates to bring medication into the jail "for reference purposes only unless otherwise ordered by a physician." The jail holds the medication as the inmate's property, and a nurse verifies the prescription and orders the medication through the jail pharmacy. If needed, the jail can dispense the held medication until the pharmacy's order arrives.

Ector County takes a similar approach. Its Health Services Plan provides that an inmate's family may bring prescription medications to the jail, and that the jail will dispense those medications if in the original container, with an intact label showing a current prescription date.³⁵²

As for commonly banned medications such as methadone, national standards do not recommend the blanket prohibition of particular medications. For example, the NCCHC's Standards recommend that a jail allow inmates taking "methadone or similar substances" to "have their therapy continued."³⁵³ Federal regulations require that any provider who dispenses narcotic drugs to patients for maintenance or detox be registered, and a jail's doctor(s) should do so.³⁵⁴ If registration is not possible, jails should consider releasing people receiving narcotic treatment pretrial, or adopting a policy similar to Dallas County's, which takes advantage of an exception in federal law that allows for short-term distribution.³⁵⁵

Some counties have already demonstrated that it is unnecessary to create a health risk by denying access to prescribed narcotic medication. McLennan County does not prohibit narcotic medication, but simply uses extra protocols to safeguard against abuse.³⁵⁶ Harris County Jail provides methadone treatment to pregnant women to prevent miscarriages.³⁵⁷ The Metropolitan Detention Center in Albuquerque has distributed methadone to opioid addicts for almost a decade; not only has the program reduced recidivism,³⁵⁸ but it also "helped create a more stable inmate population," according to the former vice president of the NCCHC.³⁵⁹ These examples demonstrate that prescribed narcotics can be consistent with jail safety.

Sheriffs' concerns about legal liability arising from allowing inmates to continue taking prescribed medication brought with them to jail must also account for the liability arising from death or injury resulting from denying access to such medication. That liability can be very high; Amy Cowling's family settled with Gregg County for \$1.9 million in the lawsuit following her death.³⁶⁰ A county would best limit its liability by adopting a flexible policy that allows for verification and control by the jail—avoiding the twin pitfalls of either allowing unverified medications into the jail on the one hand, or of dangerously discontinuing inmates' prescribed medications as a matter of practice on the other.

Recommendations

Counties should:

Amend inflexible policies that ban certain prescribed medications under any circumstances. Instead of outright bans on certain medications, counties should promote continuity of care. One method is to allow inmates to bring in previously prescribed medications, have a nurse promptly verify the prescription and order the necessary dosage through the jail's pharmacy, and dispense the inmate's personal medication as needed until the pharmacy order arrives. Determinations about the clinical appropriateness of the prescribed medication should be made promptly

by a clinician with mental health treatment qualifications—*not* by custodial or administrative staff. Jails should order the prescribed medication themselves, and use medication brought to jail by the inmate or inmate's family only as a stopgap until the jail's order arrives.

Take necessary steps to provide continuity of prescribed medications for inmates. Counties should use the TCOOMMI 46B program, or other avenues through their LMHAs, to ensure that every inmate has access to his or her prescribed mental health medications without harmful delays.

The Texas Commission for Jail Standards should:

Advise counties to develop a policy for handling outside medications. TCJS should advise counties to add a policy to their health services plan that provides procedures for verifying and providing sealed, prescribed medications that inmates or families bring to the jail. TCJS should share with counties the national standards and the best local practices of other Texas counties.

Require jails to write and publicize their medication policies. TCJS should require county jails to include their policies on outside medications in their health services plans. In addition, TCJS should require jails to publicize those policies through their website, inmate handbook, and correctional staff who receive phone calls from inmates' family members.

Require any jail in which an inmate dies following the denial of prescribed medication to provide a written, specific, and individualized justification for the denial. County jails must notify TCJS of every death in custody within 24 hours, and must forward the report of investigation of the death by a law enforcement agency within 10 days of completion.³⁶¹ For each death where denial or discontinuation of previously prescribed medication was involved, TCJS should require counties to explain their reasons for the denial in writing, within 10 days.

The Texas Legislature should:

Provide additional resources to TCJS to help the agency provide technical assistance on mental health care and substance dependence. Because jails are required to care for so many people suffering from mental illness and substance dependence, TCJS should be given sufficient funding to provide jails with technical assistance for providing adequate mental health care in jails. Recent TCJS appropriations requests suggest that hiring a program specialist to provide technical assistance would cost about \$50,000 to \$60,000 per year.³⁶²

DEVELOP AND UPDATE DETOX PROTOCOLS.

Each county jail's health service plan should include a detoxification protocol for supporting withdrawal from alcohol, opioids, benzodiazepines, and other commonly used substances, in conformance with current national standards.

Assessing the Problem

Terry Borum was an alcoholic, and the jail staff in Swisher County knew it even before they booked him.³⁶³ During his three days in the jail, Terry began hallucinating and suffering from delirium tremens, a severe form of alcohol withdrawal.³⁶⁴ The jail's only attempt to treat Mr. Borum's severe withdrawal was to give him orange juice and honey, which jail staff later admitted was inappropriate,³⁶⁵ but which was nevertheless the jail's standard method of treating alcohol withdrawal.³⁶⁶ Eventually, jail officials put Terry in a detox cell, where he spent the night screaming, talking to invisible friends, and trying to pull an imaginary person out of the toilet.³⁶⁷ At 8 a.m. on February 1, 2013, Terry collapsed, struck his head, and fell unconscious.³⁶⁸ He died later that day from internal bleeding around his brain.³⁶⁹

Sheriffs know that they will have to frequently deal with drug and alcohol withdrawal. By any measure, drug or alcohol use is implicated in a high percentage of crimes,³⁷⁰ and studies tend to find that the majority of jail inmates regularly used or abused drugs or alcohol before imprisonment.³⁷¹

In addition to being common, withdrawal from alcohol and drugs is a serious medical issue. "Although some people experience relatively mild withdrawal symptoms," wrote a group of doctors in one peer-reviewed article, "AW [alcohol withdrawal] can cause significant illness and death."³⁷² Acute alcohol withdrawal can result in severe seizures and delirium tremens (DTs),³⁷³ as it did for Terry Borum. The mortality rate among patients experiencing DTs is 5 to 25 percent.³⁷⁴

The symptoms and risks of drug withdrawal vary, but the withdrawal symptoms for common drugs can, in serious cases, be fatal. For example, the Federal Bureau of Prisons' (BOP) treatment guidelines state that untreated withdrawal from benzodiazepines (a class of drugs that includes Xanax) can result in hallucinations, seizures, and death.³⁷⁵ The BOP guidelines note a similar mortality risk level for barbiturate withdrawal,³⁷⁶ and that opiate withdrawal can be dangerous for "medically debilitated" and pregnant inmates.³⁷⁷ Although there are no data tallying the number of withdrawal-related deaths in U.S. jails, news reports demonstrate that inmates regularly die during alcohol or drug withdrawal.³⁷⁸

Although alcohol and drug withdrawal is a serious medical issue, state laws and county jail policies do not treat it that way. State regulations require every jail

Questions remain after Bexar County Jail detox death.

Source: Greg Harman, San Antonio Current, Jan. 25, 2010.

Nueces County Jail inmate dies from heroin withdrawals.

Source: Justin Fira, KZTV10-Corpus Christi, June 21, 2016.

to draw up a health services plan,³⁷⁹ and they identify particular categories for which particular procedures are required—such as dental services, medication distribution, or pregnant inmates.³⁸⁰

However, there is *no* requirement that county jails have any protocol in place for detoxification. In the absence of any regulation, county jails often fail to develop any detox procedure for treating inmates experiencing withdrawal.³⁸¹ With no procedures in place, jails end up simply throwing very sick people in detox cells with no treatment, and sometimes with deadly consequences.

Standards and Best Practices

National standards recommend that jails develop detox protocols. The National Commission on Correctional Health Care's (NCCHC) Standards for Health Services in Jails lays out a straightforward detox procedure, which includes assessment, monitoring by health care professionals, and the transfer of severe cases to a licensed acute care facility.³⁸² The NCCHC standards require that the detox protocols are approved by a physician, and are consistent with current nationally accepted treatment guidelines.³⁸³

The BOP recently published a set of guidelines for detoxifying chemically dependent inmates.³⁸⁴ The BOP guidelines can be used by any county jail; they lay out the common symptoms of alcohol and drug withdrawal and describe recommended treatment that is not only consistent with the national standard of care but appropriate within the correctional setting.

Adequate detox protocols do not need to be expensive. For example, the core components of the BOP's recommended alcohol treatment plan, thiamine (B1 vitamin) and lorazepam,³⁸⁵ are widely available and inexpensive. And whatever the costs of a detox program, they must be measured against the million-dollar lawsuits that a jail is exposed to when a person dies because of inadequate treatment.³⁸⁶

Dallas County, for example, has established a specific "Intoxication and Withdrawal" protocol based in part on the NCCHC standards.³⁸⁷ The protocol doesn't spell out specific courses of treatment, but does provide general guidelines about assessment, housing, and monitoring, and requires that detox is done under the supervision of a physician.³⁸⁸

Another way to avoid the difficulties and costs of treating alcohol- and drug-dependent inmates is to divert them away from jail, either before or after booking. Since the late 2000s, San Antonio has been diverting arrested people with mental illness and/or substance abuse issues to a treatment center that provides psychiatric services, detox, and more.³⁸⁹ City officials say that the diversion program has saved San Antonio over \$10 million per year.³⁹⁰

Recommendations

Counties should:

Develop protocols for alcohol and drug detox. For counties whose health services plans don't even mention detox, simply creating detox protocols is an important first step.

Conform detox protocols to the NCCHC or BOP standards. Counties should treat alcohol or drug detox like any other medical issue and conform their treatment to the national standard of care in correctional settings.

Improve efforts to divert, or release pretrial, people with serious substance abuse problems. Counties should avoid the liability and difficulty of managing people with substance abuse problems by expanding efforts to either refer them to a treatment facility or release them pretrial.

The Texas Commission on Jail Standards should:

Train county officials on best-practice detox protocols. TCJS should train leadership at county jails on the best current models for providing detox treatment in jail. Training should include recognizing that withdrawal is a serious medical issue and that substance use disorder often co-occurs with mental illness.

The Texas Legislature should:

Require the Texas Commission on Jail Standards to establish minimum standards for county jails' detox protocols. As it did for pregnant inmates, the legislature should amend Tex. Gov. Code § 511.009(a) to require the TCJS to establish minimum standards for detox protocols and procedures. Then, as it did for pregnant inmates, TCJS could require by regulation that counties establish a detox procedure while allowing each county to determine its own procedures.

ADD FORENSIC PEER SUPPORT.

County jails should strengthen their mental health care services by implementing a forensic peer support program.

Assessing the Problem

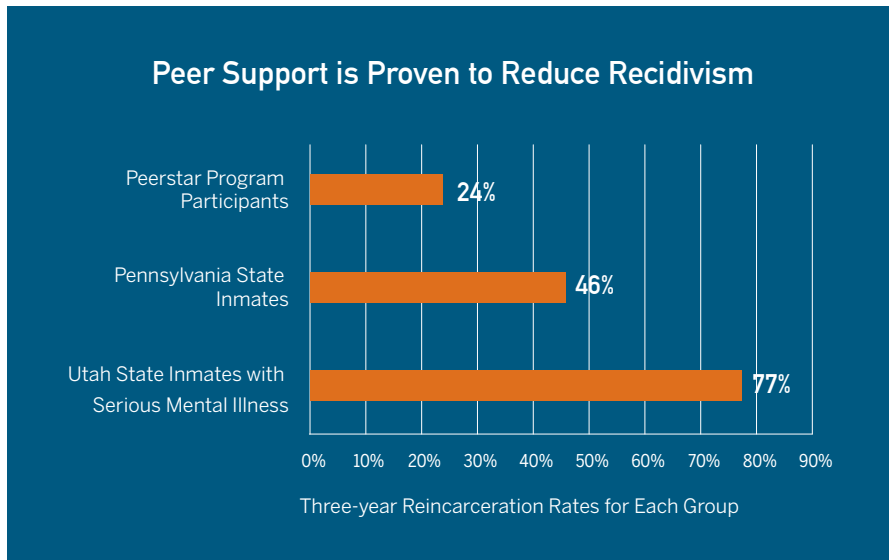
Mental health needs often remain unmet in Texas jails. Suicide accounts for one-third of the roughly 100 deaths in Texas jails each year,³⁹¹ due in part to the high rate of mental illness among jail inmates. A federal survey found that 64 percent of people in local jails reported a mental health issue.³⁹² Mental health treatment is essential to reducing deaths in Texas jails.

Peer support is a mental health treatment program with demonstrated success;³⁹³ in the criminal justice context, the program is called *forensic* peer support (FPS).³⁹⁴ FPS specialists are people who have experienced mental illness, substance use and/or criminal justice involvement, and who have obtained special training to treat others with similar backgrounds.

In Texas, there is an official certification process for mental health peer providers that includes required training and testing to become a Certified Peer Specialist.³⁹⁵ FPS specialists assist people with similar histories in various ways, such as instilling hope; serving as a model of recovery; helping clients engage with treatment and support services; guiding clients through the psychological, social, and financial challenges of re-entry; and assisting with adherence to conditions of supervision.³⁹⁶

In a typical FPS program, a team of trained peer support specialists is employed by the local mental health authority (LMHA) and works in partnership with the local jail. The team spends time regularly in the secure facility, intermingling with the inmates in a mixture of unstructured interaction and structured programs such as meditation or counseling. Through their interaction with inmates, FPS specialists are able to build the relationships and trust that are necessary to serve as role models, counsel inmates about transitioning back to the community, and offer support and advice for coping with daily life in custody.

FPS specialists, unlike most staff in Texas jails, often have experience coping with mental illness and have faced the challenges of returning to community life after contact with the criminal justice system. They have a unique ability to: (1) relate positively to inmates who share their life experience; (2) offer personal encouragement and model appropriate behaviors; (3) serve as practical guides in managing recovery; and (4) offer the day-to-day supports that people with mental illnesses need to live successfully, either in the community or in confinement.³⁹⁷



Source: Center for Public Policy Priorities, From Recidivism to Recovery: The Case for Peer Support in Texas Correctional Facilities (2014).

Standards and Best Practices

Outside of the correctional context, peer support has a history of demonstrated success. At least 38 states have established programs to train and certify mental health peer specialists, and eight more are in the process of developing or implementing a program.³⁹⁸ A ten-year study on peer support by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) found demonstrable increases in well-being and personal empowerment alongside improvements in clinical symptoms and reduced hospitalizations.³⁹⁹

Peer support in the correctional context is new, but results are promising. Pennsylvania implemented a low-cost FPS program in 2010 called Peerstar that dramatically reduced recidivism for high-risk inmates.⁴⁰⁰ Specifically, a preliminary evaluation of Pennsylvania’s program suggested that recidivism rates for participating individuals were *half* that of Pennsylvania’s general incarcerated population and *one-third* that of a similar high-risk population of individuals with severe mental illness.⁴⁰¹ FPS programs are currently operating in secure facilities in at least five states.⁴⁰²

Texas recently joined the handful of states at the head of the FPS curve. In 2015, the legislature approved a pilot program to implement FPS programs in Harris, Tarrant, Cameron, Willacy, and Hidalgo Counties.⁴⁰³ The pilot program is expected to serve over 750 people at a cost of only \$1 million to the state and at no cost to the counties.⁴⁰⁴ The programs are joint efforts of the Department of State Health Services, which pays for the program; the LMHAs, who train and supervise the peer specialists; and the county jails, whose staffs work collaboratively with the peer specialists as they do with other health services providers.

The infrastructure already exists in Texas to expand the pilot program statewide. Texas has a Certified Peer Specialist training program offered by Via Hope, which

has trained peers who are now working in every LMHA in the state.⁴⁰⁵ As of 2014, there were over 500 certified mental health peer specialists operating across the state, in all of Texas' 39 LMHAs.⁴⁰⁶

Recommendations

Counties should:

Reduce employment bars affecting justice-involved peers. A study found that county policies barring people with criminal histories from working in jails was the most common problem for implementing a FPS program.⁴⁰⁷ There is no state law barring individuals with criminal justice history from working in county jails, and sheriffs should adopt flexible policies to allow certified peers with criminal justice life experience to provide services in jails. For example, Cameron County made an exception to allow peer specialists with a history of criminal justice involvement to work in its jail, without any negative jail safety consequences.⁴⁰⁸

The Texas Commission on Jail Standards should:

Advise county jails on implementing forensic peer support programs. As it has done with suicide screening and the 46B program, TCJS should provide technical assistance to promote peer support and guide jails in developing effective peer support programs.

The Texas Legislature should:

Expand the forensic peer support pilot program. The program launched in 2015 in five counties only cost \$1 million.⁴⁰⁹ In the upcoming session, Texas should allocate a similar fund to expand the program to serve more counties and significantly more inmates.

RECOMMENDATION NO. 10

IMPROVE MONITORING.

Counties should promote more effective monitoring of inmates by:

- (1) requiring jail staff to proactively engage inmates and take action during regular observation;*
- (2) increasing the frequency of observation for at-risk inmates and setting irregular monitoring intervals;*
- (3) ensuring adequate staffing;*
- (4) using technology along with personal interaction to make observation more accountable; and*
- (5) using technology to alert staff of inmate crises.*

Assessing the Problem

For inmates who are suicidal, mentally ill, or sick, monitoring can mean the difference between life and death. Because 24-year-old Jasen Mosley indicated he “had thought about killing himself today” at intake, state law required Smith County

Jail officers to observe him every 30 minutes.⁴¹⁰ That did not happen; immediately following his arrest and booking, Jasen was placed in a holding cell alone.⁴¹¹ He was found hanging in his cell 34 minutes later.⁴¹² Sandra Bland went visually unobserved for 110 minutes until she was discovered asphyxiated by a noose made from a plastic bag.⁴¹³ Alex Guzman went a full 80 minutes before jailers performed cell checks to find him hanging by a noose made of bedding.⁴¹⁴

National standards state that inmates who are suicidal must be observed every 15 minutes

These deaths reveal the importance of complying with state regulations. However, national standards suggest that Texas county jails should be doing even more than simply complying with current state regulations. Monitoring and observation should lead to action beyond mere documentation when jail staff detect unusual conditions.

Currently, only inmates on suicide watch are constantly supervised.⁴¹⁵ Due to errors in the screening process, many inmates who should be monitored continuously or more frequently fall through the cracks. Between 2009 and 2015, screening and observation failures played a role in about a third of all jail suicides that occurred in the Houston metro area.⁴¹⁶ Jail staff must be trained to recognize and intervene in instances of emerging mental health issues either missed in (or concealed by an inmate during) the initial screening, or that develop after screening as a result of incarceration.⁴¹⁷

State regulations require jailers to observe all inmates face-to-face once an hour.⁴¹⁸ For inmates who are known to be assaultive, suicidal, have mental health needs, or have demonstrated “bizarre behavior,” jailers must conduct face-to-face observation at least every 30 minutes.⁴¹⁹

State regulations also require jailers to document supervision at least once every 60 minutes.⁴²⁰ Jails are required to establish procedures to document these observations.⁴²¹ In some egregious cases where an inmate suffers serious harm or death, noncompliant jail staff have forged observational logs to conceal their noncompliance.⁴²²

The Texas Administrative Code requires little by way of observation. Visual observation and documentation of the fact of observation are required, but engagement with inmates is not. Neither is any assessment of the inmate’s condition. Jailers also are not required to determine whether an inmate should be observed more regularly than in 30-minute or 60-minute intervals.

Additionally, state regulations require jails to have an appropriate number of jailers at the facility 24 hours each day to ensure regular observation of inmates by correctional officers,⁴²³ and that staffing plans be approved by TCJS.⁴²⁴ Staffing in excess of minimum requirements may be required by TCJS “when deemed necessary to provide a safe, suitable, and sanitary facility.”⁴²⁵

Finally, jails are required to have “a two-way voice communication capability between inmates and jailers, licensed peace officers, bailiffs, and designated staff at all times. Closed circuit television may be used, but not in lieu of the required

personal observation.”⁴²⁶ State regulations, however, do not require regular maintenance or testing of any device used to facilitate the two-way communication. Additionally, practical realities may prevent jailers from complying “at all times”—if jailers present at the facility are away from a stationary two-way communication device (to assist a delivering correctional officer, making required face-to-face observation at another housing facility, or tending to personal needs), an emergency may not be timely addressed.

Standards and Best Practices

National best practices point to several opportunities for Texas jails to better monitor inmates with mental illness: (1) proactive observation; (2) more frequent and irregular observation; (3) more staff; (4) using technology to make observation more efficient and accountable; and (5) using technology to alert staff of inmate crises.

1. Proactive Observation

a. Observation Should Include Health Screening and Appropriate Action

Observation of inmates should include regular health screening by a trained correctional officer. Experts writing for the National Institute of Corrections (NIC) recommend that jailers be trained to identify an inmate’s changing mental health needs, and determine appropriate action to meet the inmate’s needs.⁴²⁷

An actively suicidal inmate requires constant observation, according to suicide experts.

The NIC guide emphasizes that during every observation, jailers should determine whether each inmate needs interventional action or more frequent monitoring to mitigate any mental health issue that may arise, or is arising.⁴²⁸ Jailers should be required to learn through effective training to recognize signs of serious mental disorders, monitor inmates for signs of emerging problems, and distinguish acute and serious conditions from less serious ones.⁴²⁹

Additionally, the American Correctional Association’s (ACA) Core Jail Standards require that health screens be regularly conducted during observational periods for any inmate with a health flag.⁴³⁰ Accordingly, jailers responsible for monitoring inmates with health flags should be trained in observation of “behavior, including state of consciousness, mental status, appearance, conduct, tremor, or sweating; and symptoms of psychosis, depression, anxiety and/or aggression.”⁴³¹

b. Notify Mental Health Personnel

The ACA’s Core Jail Standards recommend that jailers refer any person who has been observed to be deteriorating in mental health or who demonstrates unusual or bizarre behavior to medical personnel, who can determine the level of supervision needed and assess mental health needs.⁴³² Even if an individual has never had mental health needs or exhibited concerning behavior before, he or she is not immune to mental deterioration during incarceration. Thus, the ACA recommends that any changes in the behavior or mental health of an inmates that indicates elevated risk should automatically trigger action.⁴³³

2. More Frequent and Irregular Observation

a. Increase Observation for High-Risk Individuals

Monitoring rounds for individuals deemed at risk of suicide should be increased to every 15 minutes to align with the standard used for patients in inpatient psychiatric facilities who are on suicide watch.⁴³⁴ In the American Bar Association's Criminal Justice Standards on the Treatment of Prisoners, the ABA also recommends checking on potentially suicidal inmates every 15 minutes.⁴³⁵ The ACA jail standards require that medical personnel be able to set the level of observation needed—which may require much more frequent observation than the minimum standards require.⁴³⁶

The Texas Commission on Jail Standards (TCJS) has recommended to jails that they observe at-risk inmates more often than the minimum 30-minute interval. In a 2014 email to the Brazoria County Jail following an inmate suicide, TCJS recommended that the jail require 20–25 minute checks for inmates who are “assaultive, potentially suicidal, mentally ill, or who have demonstrated bizarre behavior.”⁴³⁷ According to TCJS, “[m]ore and more jails have gone to this way of operating and it appears to be working as [at] jails that have implemented this policy, fewer custodial deaths have been registered because more frequent checks are being conducted.”⁴³⁸

b. Schedule Irregular Monitoring Rounds

The ACA jail standards recommend that monitoring intervals be irregular⁴³⁹—that is, if the minimum requirement is to check every 30 minutes, jailers should check after 23 minutes, then 28, then 20, and so forth.⁴⁴⁰ Irregular intervals not only reduce time between observational rounds, but also prevent an inmate from knowing when he or she would next be observed, which may reduce the chance of a planned suicide attempt.⁴⁴¹

3. Adequate Staffing

The ACA jail standards dictate that sufficient staff, including a designated supervisor, should be provided at all times “to perform functions relating to the security, custody, and supervision of inmates and as needed to operate the facility in conformance with the standards.”⁴⁴²

4. Use Technology to Make Staff Observation More Efficient and Accountable

A number of jails around the county have begun using radio-frequency identification (RFID) technology to monitor the location of inmates and staff.⁴⁴³ By outfitting inmates and staff with RFID devices, jails can track in real-time where everyone in the jail is, enabling it to better investigate incidents and send out alerts when staff are in need of assistance.⁴⁴⁴

RFID can make monitoring more efficient and accountable. The jail in Chattanooga, Tennessee recently installed RFID readers that allow officers to log each observation using a handheld device to scan a chip mounted near the door of the cell.⁴⁴⁵ The scan automatically records the time, date and location of the check, and then the officer can tap through a short series of options to

describe the inmates' behavior instead of writing by hand.⁴⁴⁶ The jail's sheriff says, "It validates our checks[.] We are striving for accreditation that [is] standard-based, and this helps capture the data that shows we are meeting those standards."⁴⁴⁷

Additionally, the Harris County Jail recently debuted an electronic monitoring system for its jail staff, which records when jailers check on inmates.⁴⁴⁸

5. Use Technology to Alert Staff of Inmate Crises in Real Time

The National Institute for Justice (NIJ) supports the use of new technology that can measure an inmate's heart rate, breathing rate and body motions from a wall-mounted range controlled radar (RCR) system that measures subtle motions on the body's surface caused by heart and lung activity.⁴⁴⁹ The system activates an alarm when it detects suspicious changes in heart rate, breathing rate or body motion.⁴⁵⁰ The ACA jail standards emphasize, however, that technological advancement should not replace personal contact between staff and inmates.⁴⁵¹

Recommendations

Counties should:

Amend monitoring policies to require proactive observation. Jails should amend observation policies to require regular health screens by correctional staff that trigger notifications to mental health personnel whenever inmates' behavior raises a health flag. Correctional staff should be trained to recognize warning signs of mental health disorders.

Increase the frequency of observation for high-risk individuals. Counties should observe suicidal inmates at least every 15 minutes or more if required by medical standards, rather than every 30 minutes.

Schedule irregular observation rounds. As the ACA recommends, jail staff should schedule irregular observation rounds to prevent inmates from planning their behavior around predictable schedules.

Use technology to increase the efficiency and accountability of staff observations. County jails should explore RFID and electronic monitoring for staff and inmates, giving particular attention to using those technologies to make observation more efficient and reliable, while maintaining personal communication and engagement with inmates.

Use technology to alert staff of inmate crises. County jails should explore outfitting cells with radar technology that alerts staff of suspicious changes in inmates' heart rate, breathing, or body motion.

The Texas Commission on Jail Standards should:

Amend the inmate supervision regulations to require more frequent observation. Currently, Tex. Admin. Code §275.1 sets minimum intervals at which inmates must be observed. TCJS should amend the regulation to require 15-minute monitoring for suicidal inmates or more, as required by medical personnel.

REDUCE THE USE OF RESTRAINT AND SECLUSION.

County jails should (1) set an explicit goal to reduce the use of restraint and seclusion, with an eye toward eliminating them altogether; (2) abolish the most dangerous restraint and seclusion practices; and (3) train officers to reduce reliance on restraint and seclusion, and collect data to evaluate performance. The Texas Legislature should require stricter regulation of seclusion that mirrors its strict regulation of restraint.

Assessing the Problem

Restraint and seclusion are often used to control or punish inmates with mental illness. These tactics are dangerous, however, and in serious cases can cause death. National standards and best practices recommend that jails reduce or eliminate the use of restraint and seclusion. Additionally, Texas should regulate seclusion more strictly than it currently does.

1. Restraint

Texas regulations define “restraint” as “[t]he use of any personal restraint or mechanical restraint that immobilizes or reduces the ability of the individual to move his or her arms, legs, body, or head freely.”⁴⁵² A common restraint device in jails is the restraint chair: Designed for violent inmates who pose an immediate threat to themselves or others, a restraint chair usually is equipped with belts and cuffs that prevent an individual’s legs, arms, and torso from moving.⁴⁵³



The Devil’s Chair: Sgt. James Brown, who suffered from PTSD, died in a restraint chair while surrounded by jail officers.

Source: Erika Castillo, KFOX Exclusive: Video Obtained of Ft. Bliss Soldier Shows Moments Before His Death While in Custody, KFOX14, May 13, 2015.

Use of restraints on inmates—especially inmates with mental illness—is dangerous, and can be lethal. Although there are no national data tallying the number of deaths caused by restraints each year, some experts estimate that it is as high as 150.⁴⁵⁴

For example, in 1999, Tarrant County Jail inmate James Arthur Livingston was pepper-sprayed and placed in a restraint chair, which prevented him from cleaning the spray from his mouth, nose, and eyes.⁴⁵⁵ Twenty minutes later, he was dead.⁴⁵⁶ An officer who entered Livingston's cell to try to revive him had to leave the room to vomit because of the pepper spray.⁴⁵⁷

Restraint chairs are not the only potentially lethal form of restraint. In November 2015, a man suffering from mental illness in Tarrant County Jail named Jonathan Ryan Paul died from respiratory failure while being restrained.⁴⁵⁸ During an acute psychotic episode in which Paul flooded his cell with toilet water, repeatedly undressed, and shouted “I am the Lion King!”, officers pepper-sprayed Paul, handcuffed him, and took him to the ground.⁴⁵⁹ When his handcuffs were removed a few minutes later, Paul lay motionless; he died in the hospital soon after.⁴⁶⁰ Paul's autopsy stated that “his apparent psychosis would most likely have been treatable with a medical evaluation and hospital treatment. This apparent psychosis left Mr. Paul vulnerable to sudden death during restraint.”⁴⁶¹

Because restraints can be so dangerous, Texas law strictly regulates the use of restraints in jails.⁴⁶² Jail staff may only use restraints on inmates who pose a danger to themselves or others, and not as a punitive measure.⁴⁶³ Only supervisory or medical personnel may make the decision to apply the restraints, jail staff must observe the inmate every 15 minutes, and the inmate should receive medical care at least every two hours.⁴⁶⁴ Restraints should restrict the inmate's movement to the minimal degree necessary, padded restraints should be used, and restraints must be removed at the earliest possible time—and in no case more than 24 hours later.⁴⁶⁵ These regulations generally track the National Commission on Correctional Health Care's Standards for Health Services in Jails standards for restraints.⁴⁶⁶

Despite these regulations, incidents like Jonathon Ryan Paul's death suggest that compliance is uneven across Texas counties. In February 2016, for example, Ector County Jail was found noncompliant after restraining an inmate for 25 hours, failing to observe him every 15 minutes, and failing to provide medical care every two hours.⁴⁶⁷ A 2011 report found that Texas jails continued to place pregnant inmates in restraints during labor even after the practice was banned in 2009.⁴⁶⁸

2. Seclusion

Texas regulations define “seclusion” as “[t]he involuntary separation of an individual from other individuals for any period of time and or the placement of the individual alone in an area from which the individual is prevented from leaving.”⁴⁶⁹

Clinical experts recognize that seclusion is “not [a] benign intervention, [and that] [s]ignificant morbidity and mortality have been associated with [its] use”

because “the isolation and lack of sensory stimulation that characterize 23 hours a day of seclusion can lead to clinical deterioration, worsening of symptoms, and further behavioral outbursts.”⁴⁷⁰ Seclusion increases the risk of suicide.⁴⁷¹

Robert Montano’s story illustrates the dangers of secluding the mentally ill. In 2011, Montano died after five days in a medical seclusion cell.⁴⁷² Montano, who suffered from schizophrenia, was placed in the seclusion cell because he was behaving erratically.⁴⁷³ Although staff and nurses could observe him through glass windows, no one entered his cell for five days.⁴⁷⁴ Montano ultimately died from kidney failure after not eating or drinking for several days.⁴⁷⁵

Because seclusion is dangerous, Texas law places some limitations on its use. Jails must periodically reassess secluded inmates.⁴⁷⁶ Secluded inmates must retain access to services and activities unless doing so would adversely affect jail safety.⁴⁷⁷ Secluded inmates must have access to a day room for at least one hour each day.⁴⁷⁸ Jail staff must monitor inmates in suicide cells at least every 15 minutes.⁴⁷⁹

Nonetheless, jails are largely left to develop their own policies on the use of seclusion. Jails’ failures to develop adequate seclusion policies or to comply with state regulations can lead to tragedies like the deaths of Robert Montano; Lacy Cuccaro, who committed suicide alone in her cell after not being observed for an hour;⁴⁸⁰ Robert Rowan, who died of seizures alone in a cell after not being observed for an hour;⁴⁸¹ and many others. Although there are no national data tallying the number of seclusion-related jail deaths each year, news reports demonstrate that it is not uncommon.⁴⁸²

Standards and Best Practices

National standards and best practices suggest several ways Texas counties can better comply with state and federal⁴⁸³ regulations of restraint and seclusion: (1) set explicit goals to drastically reduce, or to eliminate, the use of restraint and seclusion; (2) abolish the most dangerous practices; and (3) train staff to reduce reliance on restraint and seclusion and collect data to evaluate performance. Finally, national standards suggest the need for stricter regulation of seclusion.

1. Set Explicit Goals to Reduce or Eliminate Restraint and Seclusion of the Mentally Ill

A number of organizations support the total elimination of restraint and seclusion for people with mental illness: the Substance Abuse and Mental Health Services Administration (SAMHSA),⁴⁸⁴ American Psychiatric Nurses Association,⁴⁸⁵ Mental Health America,⁴⁸⁶ and the National Association of State Mental Health Program Directors (NASMHPD).⁴⁸⁷

Professional organizations that do not support eliminating seclusion and restraint nonetheless recommend using them only in extreme circumstances. The American Psychiatric Association supports using seclusion and restraint only as “an

emergency measure” to prevent imminent harm to the patient or other persons.⁴⁸⁸ The National Commission on Correctional Health Care (NCCHC) Standards for Health Care in Jails state that seclusion and restraint are appropriate only for “patients exhibiting behavior dangerous to self or others.”⁴⁸⁹

Thus, national standards recommend near- or complete elimination. Deliberate efforts by secure facilities to eliminate restraint and seclusion have been promising. In 1997, Pennsylvania’s state mental hospitals set out to eliminate restraint and seclusion; by 2000, time spent by patients in restraint or seclusion was down 96 percent.⁴⁹⁰ There was no increase in injuries to staff, and changes were implemented with no additional funding.⁴⁹¹

Four of Texas’ psychiatric hospitals received a federal grant from SAMHSA in 2007 to implement a program—the STARS project—to reduce the use of restraint and seclusion.⁴⁹² The hospitals reported successful reductions in the number of incidents of restraint or seclusion, and in the length of time that individuals spent in restraint or seclusion.⁴⁹³

NASMHPD has identified specific strategies to reduce the use of restraint and seclusion that Texas county jails can use.⁴⁹⁴ A 2010 SAMHSA evaluation of 43 facilities that implemented the NASMHPD strategies found significant reductions in the use of seclusion and restraint; for example, facilities reduced restraint use by an average of 55 percent.⁴⁹⁵

A report by the Government Accountability Office found that reducing reliance on restraint and seclusion “save[s] money in the long run by creating a safer treatment and work environment.”⁴⁹⁶ SAMHSA’s evaluation found that state hospitals that reduce the use of restraint and seclusion saved millions of dollars, increased staff satisfaction, and decreased turnover.⁴⁹⁷

Moreover, deaths caused by restraint or seclusion are costly. A jury returned a verdict of \$2.4 million for Robert Montano’s family.⁴⁹⁸

2. Abolish the Most Dangerous Practices

In the absence of totally eliminating seclusion and restraint, counties can limit their liability and protect inmates by abolishing the most dangerous restraint and seclusion practices. For example, the American Psychiatric Association singles out restraint chairs as particularly problematic in a correctional setting.⁴⁹⁹

Some counties have formally abolished practices like the restraint chair. After restraint chairs caused three deaths in ten years, the Maricopa County Jail in

Organizations supporting banning the use of restraint and seclusion for inmates with mental illness:

- Substance Abuse and Mental Health Services Administration
- American Psychiatric Nurses Association
- Mental Health America
- National Association of State Mental Health Program Directors

Arizona replaced them with “safe beds.”⁵⁰⁰ After several multi-million-dollar verdicts against the county, the county hired a consultant, who stated: “The best recommendation I can professionally make in respect to the restraint chair is to remove it from any use.”⁵⁰¹ Sheriff Joe Arpaio agreed, stating that it was “time to move in the direction of what many hospitals and psychiatric wards do to restrain combative people.”⁵⁰²

Utah has banned the restraint chair entirely, as has Florida’s adult and juvenile corrections departments.⁵⁰³

In the absence of abolishing certain dangerous restraints, counties should ensure compliance with Texas’ strict regulation of restraint use, which limits the time a person can be placed under restraint, requires medical personnel to be involved in their application, and requires frequent checks on a person’s vital signs and range of motion.

3. Training and Data Collection

The APA emphasizes the need for “training and re-training” of health care and correctional staff on the procedures for restraint and seclusion.⁵⁰⁴ Training is one of NASMHPD’s core strategies for reducing reliance on restraint and seclusion—in particular, training staff to create an “environment that is less likely to be coercive or trigger conflicts.”⁵⁰⁵ SAMHSA has created a training manual, available for free online, that jails can consult.⁵⁰⁶

Data collection is another one of the NASMHPD’s core strategies for reducing reliance on restraint and seclusion.⁵⁰⁷ The NASMHPD recommends that jails record data on usage by unit, shift, and day; the staff members involved; characteristics of the inmates restrained or secluded; concurrent use of medications; and related injuries to staff or inmate.⁵⁰⁸ Jails should set improvement goals based on the data collected and monitor changes over time.⁵⁰⁹

The APA agrees, recommending that jails keep a detailed “logbook” for the use of restraint and seclusion to “facilitate quality improvement reviews.”⁵¹⁰

4. Stricter Regulation of Seclusion

First, national standards recommend parallel regulation of restraint and seclusion. For example, the NCCHC Standards for Health Care in Jails recommend regulating restraint and seclusion in the same way, requiring for example that orders for either restraint or seclusion are not to exceed 12 hours.⁵¹¹ Texas, however, regulates the use of restraint without parallel regulation of seclusion.⁵¹²

Second, national standards recommend stricter regulation of seclusion than what Texas currently requires. NCCHC standards recommend that health-trained personnel check on any inmate in seclusion every 15 minutes.⁵¹³ The APA recommends that a physician should assess secluded inmates in person at least

Unlike national standards, Texas regulations place **no limit** on the frequency, duration, or monitoring of inmates in seclusion.

every 24 hours, that the order to use seclusion should come from qualified health personnel, and that inmates with mental illness should not be secluded in disciplinary housing units where they are “locked down” for 23 hours per day.⁵¹⁴

Recommendations

Counties should:

Set an explicit goal to reduce the use of restraint and seclusion, with an eye toward eliminating them altogether. Counties should set up explicit targets for reducing the use of restraint and seclusion that work toward full elimination. Counties should look to the NASMHPD and SAMHSA guides for strategies to reach those targets.

Abolish the most dangerous restraint and seclusion practices. Devices such as the restraint chair—often called “the Devil’s chair”⁵¹⁵—are clinically inappropriate and expose counties to legal liability. Counties should abolish the restraint chair and similarly dangerous methods of restraint and seclusion.

Train staff to reduce reliance on restraint and seclusion, and collect data to evaluate performance. Counties should consult SAMHSA’s guide for training staff to reduce reliance on restraint and seclusion. Counties can also consult the Texas psychiatric hospitals involved with the STARS project to learn what practices were successful, and then train staff on those practices. Counties should collect detailed data on every incident of restraint or seclusion and use that data to track usage and give feedback to staff.

The Texas Commission on Jail Standards should:

Train county officials to reduce reliance on restraint and seclusion. TCJS should publish guidance for and train leadership at county jails on (a) the best practices for drastically reducing reliance on restraint and seclusion for the mentally ill, and (b) methods of data collection and review to help reach the stated goals.

Collect data on the use of restraint and seclusion. TCJS should collect data on the use of restraint and seclusion both to identify counties that overuse restraint and seclusion and to identify models that effectively minimize the use of restraint and seclusion.

The Texas Legislature should:

Require the Texas Commission on Jail Standards to regulate seclusion in the same detailed manner that it regulates restraint. The Texas Administrative Code contains a detailed regulation on the use of restraint that is consistent with national standards,⁵¹⁶ but no corresponding regulation on the use of seclusion.⁵¹⁷ The legislature should direct TCJS to regulate seclusion in a similar fashion under Title 37, Chapter 273 of the Administrative Code.

Provide additional resources to TCJS so that it can review jails’ restraint and seclusion practices and provide technical assistance. The legislature

should provide TCJS with funding to publish a best-practices resource on the use of restraint and seclusion. To allow ongoing oversight and technical assistance on restraint and seclusion protocols, TCJS should receive funding to hire an inspector with mental health care experience. Recent TCJS appropriations requests suggest that hiring an inspector or a program specialist to provide technical assistance would cost about \$50,000 to \$60,000 per year.⁵¹⁸

RECOMMENDATION NO. 12

LIMIT THE USE OF FORCE.

County jails should strengthen their policies and training on use of force, explicitly address use of force against inmates with mental health needs, and promote the goals of eliminating excessive use of force and using force only as a last resort.

Assessing the Problem

Inmates suffering from mental illness are more likely if untreated to break rules in jail,⁵¹⁹ and are more likely to be subject to the use of force.⁵²⁰ For people with mental illness, the use of force can pose special dangers. Texas county jails' use-of-force (UOF) policies should require officers to use only the minimal force necessary, as well as require more careful treatment for people with mental illness. Officers should be trained to handle mental health issues, and mental health professionals should be involved in planned decisions to use force. Jails should document every use of force and sanction officers who use excessive force.

Although there no national or statewide data on deaths resulting from the use of force against inmates with mental illness,⁵²¹ news reports suggest that it is not uncommon. In June 2008, for example, Corey Bailey was pepper sprayed by Dallas County Jail officers when he became "confrontational" due to his paranoid delusions; he suffocated to death after jailers left him shackled hand and foot with a mask over his face.⁵²²

Tony Chance Ross was a mentally ill man who died after Hopkins County Jail officers stunned him with a Taser for over 30 seconds.⁵²³ Ross, who had suffered from delusions for fourteen years, was arrested by Sulphur Springs police during an episode.⁵²⁴ When Ross—who was handcuffed in a padded cell⁵²⁵—resisted the removal of his pants, officers Tasered him repeatedly, leaving 14 burns on his chest, neck, and back.⁵²⁶ His death was ultimately ruled a homicide.⁵²⁷

Thirty four-year-old Kenneth Christopher Lucas died in the Harris County Jail during a cell extraction in 2014.⁵²⁸ Five officers in riot gear rushed into Lucas' cell to subdue him when he refused to hand a sharpened piece of plastic through his cell door.⁵²⁹ Officers removed him from his cell and hogtied him; then a guard sat on his back for 20 minutes despite Lucas' repeated pleas that he could not breathe and was going to pass out.⁵³⁰ He died of heart failure.⁵³¹

Excessive use of force occurs because of a combination of inadequate policies, training, and supervision.⁵³² However, experts also note that unnecessary use of force against inmates with mental illness is more likely in jails that are that are overcrowded, understaffed, or lacking programming.⁵³³

“Texas’ minimum jail standards are silent on the issues of staff use of force.”

– Lyndon B. Johnson
School of Public Affairs
Professor Michele Deitch

State regulations set no minimum standards for county jails’ UOF policies,⁵³⁴ so each jail draws up its own policy with little guidance or limitation.

The Texas Commission on Law Enforcement (TCOLE) training for officers on the use of force in jails makes little mention of mental health or mental illness, except to state that “[t]reatment of violent individuals who are diagnosed as mentally/emotionally disturbed has limited effect on their violent behavior,” and “[m]ental health professionals don’t like treating criminals.”⁵³⁵

Standards and Best Practices

National standards and best practices suggest five things that Texas county jails can do to reduce the excessive use of force against inmates with mental illness: (1) state in jail policies that force is to be used only as a last resort, and that staff should consult a mental health professional before using planned force against a person with mental illness; (2) train correctional staff to recognize mental illness and respond appropriately; (3) limit cell extractions to emergencies, and require medical or mental health staff to be present whenever possible; (4) require supervisory authorization before chemical agents can be used outside of emergencies, and provide for immediate medical attention; and (5) require supervisory authorization before electronic control weapons can be used outside of emergencies and use them as a last resort.

1. Use Force as a Last Resort and Consult a Mental Health Professional Before Planned Use

The American Correctional Association’s Core Jail Standards state that the use of force must be “restricted to instances of justifiable self-defense, protection of others, protection of property, and prevention of escapes, and then only as a last resort.”⁵³⁶ The American Bar Association’s (ABA) Standards for Treatment of Prisoners state that officers should use force only “to protect and ensure the safety of staff, prisoners, and others; to prevent serious property damage; or to prevent escape” and “as a last alternative after other reasonable efforts to resolve the situation have failed.”⁵³⁷

Additionally, the ABA’s standards state that “staff should seek intervention and advice from a qualified mental health professional prior to a planned or predictable use of force against a prisoner who has a history of mental illness or who is exhibiting behaviors commonly associated with mental illness.”⁵³⁸

The Pennsylvania prison system recently revised its UOF policy to state that “[i]f an inmate with [mental illness] presents a non-emergency security threat, a [mental health professional], a person who is appropriately trained in Crisis Intervention, or a member of the Hostage Negotiation Team will be notified and that person will attempt to de-escalate the situation so that use of force is not necessary and/or to reduce the level of force required.”⁵³⁹

2. Train Correctional Staff to Recognize Mental Illness and Respond Appropriately

The current state-provided training on use of force in a jail setting does not expressly address mental illness.⁵⁴⁰ Guidelines published by the National Institute for Corrections (NIC) emphasize the importance of training correctional officers to work with the mentally ill.⁵⁴¹ According to the NIC, correctional officers need training similar to that given to workers in state psychiatric hospitals in order to successfully manage inmates with mental illness.⁵⁴²

A consensus guide published by the Council of State Governments on handling the mentally ill in criminal justice settings recommends at least two hours of mental health training for law enforcement personnel so that officers will know how “to stabilize and de-escalate” situations.⁵⁴³ A law enforcement officer is quoted in the Houston Police Department’s guide for responding to the mentally ill as saying, “I have had crisis intervention training and whole heartedly endorse it. It has helped me verbally de-escalate the vast majority of situations I have encountered involving individuals in serious mental health crisis, rather than having to use force.”⁵⁴⁴

Jail officials should have at least two hours of mental health training each year.

A number of jails around the country have responded to litigation by agreeing to train correctional officers to identify signs of mental illness, respond effectively to inmates with mental illness, and make referrals to mental health staff.⁵⁴⁵ For example, the Los Angeles County Jail agreed to provide “‘custody-specific, scenario-based, skill development training’ for staff to enable them to identify and work with inmates who have a mental illness as well as such training in crisis intervention and conflict resolution.”⁵⁴⁶

3. Allow Cell Extractions Only in Emergency Situations, and Require Medical or Mental Health Staff to be Present Whenever Possible

Correctional officers may sometimes be required to use force to remove inmates from their cells. Forced extractions are often done by tactical teams using SWAT gear such as helmets, shields, batons, pepper spray, and electronic control weapons.⁵⁴⁷ The team rushes into the cell, subdues the inmate, and places him in restraints or handcuffs.⁵⁴⁸

In addition to causing physical harm—in some cases, serious or lethal physical harm⁵⁴⁹—cell extractions can exacerbate the symptoms of a person suffering from mental illness. According to a psychiatric expert who spoke to Human Rights Watch, trauma from one use of force can aggravate pre-existing conditions, trigger a psychotic episode, or deepen depression or mania.⁵⁵⁰

Because forced extractions are dangerous, officers should avoid them unless there is an emergency, and be trained instead to summon mental health staff, talk further with the inmate, and give him time to cool down.⁵⁵¹

Medical or mental health staff should be present during every planned cell extraction.

Medical or mental health staff should be present at every planned cell extraction, according to experts.⁵⁵² The Los Angeles County Jail recently revised its cell-extraction policy to require a mental health professional to be present to try to resolve the situation before any cell extraction.⁵⁵³ Following the death of Kenneth Lucas, the Harris County Jail added a medical staffer to the jail's cell-extraction team.⁵⁵⁴

4. Require Supervisory Authorization Before Chemical Agents Can Be Used Outside of Emergencies, and Provide for Immediate Medical Attention

Chemical agents such as pepper spray inflict severe pain without employing direct physical force.⁵⁵⁵ Although pepper spray is typically listed on the higher end of the use-of-force continuum,⁵⁵⁶ corrections experts note that pepper spray's ease of use can lead officers to turn to it routinely.⁵⁵⁷ “[Pepper spray] brings with it great danger because it's so easy,” says one former department of corrections director.⁵⁵⁸ A number of stories like Corey Bailey's reveal how dangerous pepper spray can be when combined with restraints.⁵⁵⁹

The ACA's jail standards state that chemical agents may be used only with the authorization of a jail administrator.⁵⁶⁰ The ABA's Standards for the Treatment of Prisoners state that whenever an inmate is subjected to chemical agents, he should receive an immediate health care examination and appropriate treatment, including decontamination.⁵⁶¹

Arizona and California recently revised their use-of-force policies to prohibit the use of chemical agents against inmates who have difficulty understanding orders absent an emergency or high-level authorization.⁵⁶²

5. Require Supervisory Authorization Before Electronic Control Weapons Can Be Used Outside of Emergencies and Use Them as a Last Resort

There are significant risks associated with Electronic Control Weapons (“ECWs”), such as cardiac capture, where the current sends the detainee's heart rhythm into overdrive.⁵⁶³ Further, repeated application of ECWs can result in cardiac arrest.⁵⁶⁴

For example, Chad Ross (discussed above) died in Hopkins County Jail as a result of excessive tasing.⁵⁶⁵ Ross had suffered from delusions for fourteen years, and his illness was known to police officers.⁵⁶⁶ Officers nevertheless shocked him for a total of 53 seconds over less than 27 minutes, mostly because, while handcuffed in a padded cell, he resisted removal of his pants.⁵⁶⁷ An excessive force expert has questioned why officers needed to shock Ross when he was secured in a padded cell and posing no danger.⁵⁶⁸ Highlighting the need for better supervision, Police Chief James Sanders defended his officers' actions by claiming it was better than “hitting him with the old-fashioned” baton.⁵⁶⁹

The ACA's jail standards state that ECWs may be used only with the authorization of a jail administrator.⁵⁷⁰ A recent guidance manual produced by the Department of Justice's Community Oriented Policing Services stated that ECW policies should recognize ECWs as weapons with "the potential to result in a fatal outcome even when used in accordance with policy and training," and therefore should be a last-resort option.⁵⁷¹ The manual also emphasized that jailers should employ non-force options such as communication and de-escalation practices before even considering ECWs as an option.⁵⁷² Even then, officers must consider whether the detainee poses such a threat to safety that use of potentially lethal force is appropriate.⁵⁷³

Recommendations

Counties should:

Have specific use of force policies that explicitly promote the goals of eliminating excessive use of force, and using force only as a last resort.

Counties should adopt and update their use of force policies to ensure that officers are aware of the use of force continuum, are equipped with techniques of de-escalation and effective communication, and are committed to using force as a last resort to promote inmate and officer safety.

Train correctional officers on the intersections of mental health and use of force, and collect data to track incidents. Counties should train jail staff on ways to communicate with inmates suffering from mental illness to de-escalate and minimize the use of force. Counties should collect detailed data on every incident of use of force and use that data to track usage and give feedback to staff.

The Texas Commission on Jail Standards should:

Develop minimum standards for the use force—both generally and against the mentally ill. TCJS should publish and distribute information on standards and best practices on use of force to counties, including use of force and de-escalation techniques relating to inmates with mental illness.

The Texas Legislature should:

Require mental health training for correctional officers. The Legislature should promote inmate and officer safety by requiring mental health and crisis intervention training for all correctional officers. Because officers are likely to encounter difficult situations requiring determinations of when to use force, often involving inmates with mental illness, such training is critical to ensuring that officers respond effectively.

CONCLUSION

Every family member interviewed for this report echoed a single refrain—they hoped that county jails would learn from the deaths of their loved ones and take life-saving measures to improve jail safety.

Families and sheriffs both recognize that jails can be traumatic and dangerous places for persons with serious mental illness. Diverting people with mental health needs to treatment settings when it can be safely done is a critical step to preventing jails from becoming de facto mental health facilities. This requires planning and ongoing collaboration between local criminal justice and behavioral health entities.

Equally important is the implementation of policies and practices to strengthen jail mental health screening, assessment, and treatment, including continuity of care. From suicide prevention to mental health medications, Texas jails should strive to meet national standards and best practices. Jail leadership should model a commitment to treating mental illness rather than ignoring it. Through improved training and oversight, jails should protect inmates from preventable harm and link them to necessary treatment.

Jails in Texas may not become therapeutic environments, but so long as they house inmates with mental and behavioral health needs, jails must attend to those inmates' needs and prevent foreseeable harms.

ENDNOTES

¹ At the federal level, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines “mental disorders” as “changes in thinking, mood, and/or behavior” that “can affect how we relate to others and make choices.” SAMHSA defines a subset of mental disorders known as “serious mental illness” among people ages 18 and older as “having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment.” See *Mental and Substance Use Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, <http://www.samhsa.gov/disorders> (last visited October 26, 2016) (citing SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, ESTIMATION METHODOLOGY FOR ADULTS WITH SERIOUS MENTAL ILLNESS, F.R. Doc. 99-15377 (1999), available at <https://www.gpo.gov/fdsys/pkg/FR-1999-06-24/html/99-15377.htm>). Jails are county-level facilities housing inmates who are pretrial detainees (awaiting trial and in some cases sentencing), and those serving relatively brief sentences (typically less than a year).

² Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVICES 761, 764 (2009).

³ *NRRC Facts & Trends*, Council for State Governments, https://csgjusticecenter.org/nrrc/facts-and-trends/#foot_11, (last visited October 26, 2016). SAMHSA defines “substance use disorders” as occurring “when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.” *Mental and Substance Use Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, <http://www.samhsa.gov/disorders> (last visited October 26, 2016).

⁴ Gregory Acquaviva, *Mental Health Courts: No Longer Experimental*, 36 SETON HALL L. REV. 971, 979 (2006).

⁵ VERA INSTITUTE FOR JUSTICE, *INCARCERATION’S FRONT DOOR: THE MISUSE OF JAILS IN AMERICA* 12 (2015), available at <http://www.safetyandjusticechallenge.org/wp-content/uploads/2015/01/incarcerations-front-door-report.pdf>.

⁶ TREATMENT ACTION CENTER, *THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY*, APRIL 2014 7, 14-17 (2014).

⁷ *Id.*

⁸ *Id.*

⁹ STEPHANIE J. VETTER AND JOHN CLARK, *THE DELIVERY OF PRETRIAL JUSTICE IN RURAL AREAS: A GUIDE FOR RURAL COUNTY OFFICIALS* 3 (2015). Out of 254 counties in Texas, 172 are considered rural. See *Definitions of County Designations*, DEP’T OF STATE HEALTH SERVICES, <http://www.dshs.texas.gov/chs/hprc/counties.shtm> (last visited October 26, 2016). Out of 253 county jails in Texas, 173 jails have a capacity of 249

or fewer inmates. See TEXAS COMMISSION ON JAIL STANDARDS, *ABBREVIATED POPULATION REPORT FOR 6/1/2016* (2016), available at <http://www.tcjs.state.tx.us/docs/AbbreRptCurrent.pdf>.

¹⁰ For trends in Texas’ jails’ populations, see the Texas Commission on Jail Standards’ Population historical population reports, available at <http://www.tcjs.state.tx.us/index.php?linkID=326>.

¹¹ VERA INSTITUTE FOR JUSTICE, *IN OUR OWN BACKYARD: CONFRONTING GROWTH AND DISPARITIES IN AMERICAN JAILS* 11 (2015).

¹² *Id.* at 8, 14; see also VERA INSTITUTE FOR JUSTICE, *INCARCERATION’S FRONT DOOR: THE MISUSE OF JAILS IN AMERICA* at 7 (reporting that the number of jail admissions almost doubled between 1983 and 2013, and incarceration rates also grew until 2007).

¹³ VERA INSTITUTE OF JUSTICE, *FIRST DO NO HARM: ADVANCING PUBLIC HEALTH IN POLICING PRACTICES* 5 (2015); RACHEL GANDY AND ERIN SMITH, *POLICY BRIEF: PRIORITIZING TREATMENT OVER PUNISHMENT: AN OVERVIEW OF MENTAL HEALTH DIVERSION FROM JAIL IN TEXAS* (2016); NATIONAL ALLIANCE ON MENTAL ILLNESS, *GRADING THE STATES 2009: A REPORT ON AMERICA’S HEALTH CARE SYSTEM FOR ADULTS WITH SERIOUS MENTAL ILLNESS* (2009) (noting urgent need in Texas for equitable funding for community based mental health services and for improvements in access to service across the state, among other things).

¹⁴ See VERA INSTITUTE OF JUSTICE, *FIRST DO NO HARM: ADVANCING PUBLIC HEALTH IN POLICING PRACTICES* 16–18 (2015) (noting Bexar County diversion programs); see also TEXAS HEALTH AND HUMAN SERVICES COMMISSION, *TEXAS STATEWIDE BEHAVIORAL HEALTH STRATEGIC PLAN FISCAL YEARS 2017–2021* 12 (2016) (reporting that among Texans potentially eligible for substance use disorder services, only six percent of adults currently access services through state programs).

¹⁵ BUREAU OF JUSTICE STATISTICS, *MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES* 1 (2006), available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

¹⁶ Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVICES 761, 765 (2009).

¹⁷ TREATMENT ADVOCACY CENTER, *MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES* 1 (2010), available at http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

¹⁸ *Id.* at 4; see also *id.* at 7 (“In 2008, 17.3 percent of Harris County Jail inmates were taking psychotropic medications”).

¹⁹ BUREAU OF JUSTICE STATISTICS, *MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES* 1 (2006), available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

²⁰ LAUREN L. LEWIS, *PRESENTATION TO THE SENATE CRIMINAL JUSTICE COMMITTEE* (2015), available at <http://www.dshs.texas.gov/legislative/default.shtm>.

²¹ TEXAS DEPARTMENT OF STATE HEALTH SERVICES, *ANOTHER LOOK AT MENTAL ILLNESS AND CRIMINAL JUSTICE INVOLVEMENT IN TEXAS: CORRELATES AND COSTS* 4 (2010).

- ²² LAUREN L. LEWIS, PRESENTATION TO THE SENATE CRIMINAL JUSTICE COMMITTEE 5 (2015), available at <http://www.dshs.texas.gov/legislative/default.shtm>.
- ²³ RACHEL GANDY AND ERIN SMITH, POLICY BRIEF: PRIORITIZING TREATMENT OVER PUNISHMENT: AN OVERVIEW OF MENTAL HEALTH DIVERSION FROM JAIL IN TEXAS (June 2016).
- ²⁴ See generally TEXAS PUBLIC POLICY FOUNDATION, OVERINCARCERATION OF PEOPLE WITH MENTAL ILLNESS (2015).
- ²⁵ NATIONAL ASSOCIATION OF COUNTIES, THE STEPPING UP INITIATIVE: REDUCING MENTAL ILLNESS IN RURAL JAILS 5 (2016), available at http://www.naco.org/sites/default/files/documents/Reducing%20Mental%20Illness%20in%20Rural%20Jails_FINAL.pdf.
- ²⁶ *Id.*
- ²⁷ *Id.*
- ²⁸ *Id.*
- ²⁹ Emily Deprang, *Barred Care*, TEX. OBSERVER (Jan. 13, 2014), <https://www.texasobserver.org/want-treatment-mental-illness-go-to-jail/>; see also Gail Delaughter, *Recent Case Calls Attention to Mental Illness in Harris County Jail*, HOUSTON PUBLIC MEDIA (Jul. 29, 2016), <https://www.houstonpublicmedia.org/articles/news/2016/07/29/162224/recent-case-calls-attention-to-mental-illness-in-harris-county-jail/>.
- ³⁰ TREATMENT ACTION CENTER, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY, APRIL 2014 7, 14-17 (2014); see also VERA INSTITUTE OF JUSTICE, TREATMENT ALTERNATIVES TO INCARCERATION FOR PEOPLE WITH MENTAL HEALTH NEEDS IN THE CRIMINAL JUSTICE SYSTEM: THE COST SAVINGS IMPLICATIONS 1 (2013).
- ³¹ TREATMENT ACTION CENTER, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY, APRIL 2014 7, 14-17 (2014).
- ³² *Id.*
- ³³ *Id.* at 26.
- ³⁴ See generally NATIONAL ASSOCIATION OF COUNTIES, THE STEPPING UP INITIATIVE: REDUCING MENTAL ILLNESS IN RURAL JAILS.
- ³⁵ TEXAS PUBLIC POLICY FOUNDATION, OVERINCARCERATION OF PEOPLE WITH MENTAL ILLNESS 7-10 (2015) (providing examples of diversion programs in Harris Co., Bexar Co., Williamson Co., Palo Pinto Co., and others); NATIONAL ASSOCIATION OF COUNTIES, THE STEPPING UP INITIATIVE: REDUCING MENTAL ILLNESS IN RURAL JAILS, at 5.
- ³⁶ NATIONAL ASSOCIATION OF COUNTIES, THE STEPPING UP INITIATIVE: REDUCING MENTAL ILLNESS IN RURAL JAILS, at 8-9.
- ³⁷ TREATMENT ACTION CENTER, MENTAL HEALTH DIVERSION PRACTICES: SURVEY OF THE STATES 4 (2013).
- ³⁸ VERA INSTITUTE OF JUSTICE, INCARCERATION'S FRONT DOOR: THE MISUSE OF JAILS IN AMERICA 19 (2015).
- ³⁹ *Id.* at 5; see also COUNCIL OF STATE GOVERNMENTS, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESSES AT THE PRETRIAL STAGE (2015).
- ⁴⁰ TEXAS CRIMINAL JUSTICE COALITION, THE TEXAS COMMISSION ON JAIL STANDARDS: THE STATE'S SOLUTION FOR IMPLEMENTING A STRONG COUNTY JAIL SYSTEM, WHILE PROTECTING COUNTIES FROM LIABILITY 2-3 (2012).
- ⁴¹ See, e.g., LINDSAY M. HAYES, NATIONAL STUDY OF JAIL SUICIDE: 20 YEARS LATER 39 (2010), available at <http://static.nicic.gov/Library/024308.pdf> (stating that "every completed suicide, as well as attempts that require hospitalization, should be examined through a morbidity-mortality review process").
- ⁴² See generally WALLER COUNTY SHERIFF'S OFFICE, COMMITTEE RECOMMENDED POLICE AND JAIL PRACTICES (2016), available at <http://www.looneyconrad.com/upload/pdf/RecommendationsFINAL3.pdf>.
- ⁴³ See, e.g., TEXAS DEP'T OF STATE HEALTH SERVICES, ANOTHER LOOK AT MENTAL ILLNESS AND CRIMINAL JUSTICE INVOLVEMENT IN TEXAS: CORRELATES AND COSTS 11 (2010) (noting health benefits of diversionary mental health services).
- ⁴⁴ VERA INSTITUTE OF JUSTICE, TREATMENT ALTERNATIVES TO INCARCERATION FOR PEOPLE WITH MENTAL HEALTH NEEDS IN THE CRIMINAL JUSTICE SYSTEM: THE COST SAVINGS IMPLICATIONS 1 (2013) (noting that community based treatment services in Texas cost an average of \$12 per day for adults, as opposed to a jail bed that costs \$137 or an emergency room visit that costs \$986).
- ⁴⁵ See *Estelle v. Gamble*, 429 U.S. 97, 104-105 (1976) (deliberate indifference to inmates' serious medical needs violates the Eighth Amendment); *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 822 (E.D. Cal. 2009) (holding that minimum requirements for mental health services in correctional settings must include proper screening, timely access to appropriate care, proper administration of psychotropic medication, a basic suicide prevention program, competent staff in sufficient numbers, and an adequate medical record system).
- ⁴⁶ 42 U.S.C. § 12132 (Title II of the Americans with Disabilities Act, prohibiting discrimination by state and local government agencies against a qualified person with a disability); 42 U.S.C. § 12102 (defining disability); see also 29 U.S.C. § 794 (Section 504 of the Rehabilitation Act, prohibiting discrimination against a qualifying individual with a disability by entities receiving federal financial assistance); 28 C.F.R. § 35.152 (prohibiting disability discrimination by jails and detention facilities).
- ⁴⁷ 28 C.F.R. § 35.130(b)(7)(i) (reasonable accommodations under the ADA); 28 C.F.R. § 42.511 (reasonable accommodations under Rehabilitation Act).
- ⁴⁸ Memorandum Opinion and Order at 2-3, *Borum v. Swisher County*, No. 2:14-CV-127-J (N.D. Tex. Jan. 26, 2015).
- ⁴⁹ *Id.* at 2.
- ⁵⁰ Plaintiffs' Amended Complaint at 3-4, *Borum v. Swisher County*, 2015 WL 8664023 (N.D. Tex. 2015) (No. 2:14-CV-127-J).
- ⁵¹ Memorandum Opinion and Order at 2-3, *Borum v. Swisher County*.
- ⁵² *Id.* at 9.
- ⁵³ *Id.* at 4, 11.
- ⁵⁴ *Id.* at 4-5.
- ⁵⁵ Jury Verdict at 4-6, *Borum v. Swisher County*, 2015 WL 8547665 (N.D. Tex. 2015) (No. 2:14-CV-127-J).
- ⁵⁶ RANGER ROBERTO D. GARZA, JR., REPORT OF INVESTIGATION: GREGORY LYNN CHEEK 2-3 (2011), on file with The University of Texas School of Law Civil Rights Clinic.
- ⁵⁷ Plaintiffs' First Amended Original Complaint at 4, *Cheek v. Nueces*

County (S.D. Tex. Feb. 4, 2013) (No. 2:13-CV-26).

⁵⁸ RANGER ROBERTO D. GARZA, JR., REPORT OF INVESTIGATION: GREGORY LYNN CHEEK at 3.

⁵⁹ See, e.g., PORT ARANSAS SOUTH JETTY, http://www.portasouthjetty.com/news/2014-09-11/Island_Life/Skate_contest.html (the memorial skate festival) (last visited June 18, 2016); TEX. GULF SURFING ASS'N, <http://www.surftgsa.org/oldsite/Archives/Archives> (a memorial paddle-out event by the Texas Gulf Surfing Association after his death) (last visited June 18, 2016).

⁶⁰ Plaintiffs' First Amended Original Complaint at 4, Cheek v. Nueces County.

⁶¹ Nueces County Jail Screening Form for Gregory Cheek dated Oct. 22, 2010, provided by the Texas Commission on Jail Standards (TCJS) and on file with The University of Texas School of Law Civil Rights Clinic.

⁶² *Id.*

⁶³ Plaintiffs' First Amended Original Complaint at 6, Cheek v. Nueces County.

⁶⁴ Plaintiffs' First Amended Original Complaint at 8, Cheek v. Nueces County.

⁶⁵ RANGER ROBERTO D. GARZA, JR., REPORT OF INVESTIGATION: GREGORY LYNN CHEEK at 3; Plaintiffs' First Amended Original Complaint at 8, Cheek v. Nueces County.

⁶⁶ RANGER ROBERTO D. GARZA, JR., REPORT OF INVESTIGATION: GREGORY LYNN CHEEK at 4.

⁶⁷ *Id.* at 17.

⁶⁸ E.g., RANGER ROBERTO D. GARZA, JR., REPORT OF INVESTIGATION: GREGORY LYNN CHEEK at 31 (inmate's statement that Cheek would sleep on Styrofoam containers); *id.* at 32 (inmate's statement that Cheek had not had a mattress or blanket for two weeks leading up to February 5, 2011).

⁶⁹ *Id.* at 7.

⁷⁰ Plaintiffs' First Amended Original Complaint at 9–10, Cheek v. Nueces County.

⁷¹ NUECES COUNTY SHERIFF'S OFFICE, INCIDENT REPORT: DEATH OF GREGORY LYNN CHEEK 1 (June 20, 2013), provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic.

⁷² Plaintiffs' First Amended Original Complaint at 11, Cheek v. Nueces County (Cheek's internal temperature); REPORT OF INVESTIGATION: GREGORY LYNN CHEEK at 20 (Cheek's swollen legs).

⁷³ Plaintiffs' First Amended Original Complaint at 12, Cheek v. Nueces County (cause of death); REPORT OF INVESTIGATION: GREGORY LYNN CHEEK at 21 (hypothermia).

⁷⁴ Plaintiffs' First Amended Original Complaint at 12, Cheek v. Nueces County.

⁷⁵ Gregg County Jail Booking Report for Amy Lynn Cowling dated Dec. 24, 2010, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic.

⁷⁶ *Gregg County Jail's Drug Policy Explained*, KYTX-LONGVIEW (Jun. 8, 2011), <http://www.cbs19.tv/story/14870547/gregg-county-drug-policy>.

⁷⁷ TEX. ADMIN. CODE tit. 37, § 273.2 (2015).

⁷⁸ Brandi Grissom, *Inmate's Death Exposes Health Care Problems in Local*

Jails, N.Y. TIMES (Feb. 12, 2011), http://www.nytimes.com/2011/02/13/us/13ttjail.html?_r=0.

⁷⁹ Glenn Evans, *Gregg County Death Lawsuit Settled*, LONGVIEW NEWS-HERALD (Jan. 16, 2013), <http://www.news-journal.com/news/2013/jan/16/gregg-county-jail-death-lawsuit-settled/>.

⁸⁰ Brandi Grissom, *Woman's Death One of Many in Troubled Texas Jail*, TEXAS TRIBUNE (Feb. 12, 2011), <http://www.texastribune.org/2011/02/12/womans-death-one-of-many-in-troubled-texas-jail/>.

⁸¹ RANGER BRENT DAVIS, REPORT OF INVESTIGATION: AMY LYNN COWLING 13–15 (2011), on file with The University of Texas School of Law Civil Rights Clinic; see also Plaintiffs' Amended Complaint at 6, Bankhead v. Gregg County, 2:11-cv-00279-JRG (E.D. Tex. Aug. 13, 2012).

⁸² RANGER BRENT DAVIS, REPORT OF INVESTIGATION: AMY LYNN COWLING at 5.

⁸³ *Id.* at 5–8.

⁸⁴ Brandi Grissom, *Woman's Death One of Many in Troubled Texas Jail*, TEXAS TRIBUNE.

⁸⁵ Glenn Evans, *Gregg County Death Lawsuit Settled*, LONGVIEW NEWS-HERALD.

⁸⁶ RANGER BRENT DAVIS, REPORT OF INVESTIGATION: AMY LYNN COWLING at 9.

⁸⁷ *Update: Second Gregg County Jailer Arrested*, KYTX-LONGVIEW (Jan. 3, 2011), <http://www.cbs19.tv/story/13777391/gregg-county-jailer-arrested-4-resign?clienttype=printable>.

⁸⁸ Glenn Evans, *Judge Approves \$1.9M Settlement in Gregg County Jail Inmate Death*, LONGVIEW NEWS-HERALD (Feb. 11, 2013), <http://www.news-journal.com/news/2013/feb/11/judge-approves-19m-settlement-in-gregg-county-jail/>.

⁸⁹ TCJS, ABBREVIATED POPULATION REPORT FOR 3/1/2016 4 (last accessed Apr. 14, 2016), available at <http://www.tcjs.state.tx.us/docs/AbbreRptCurrent.pdf>.

⁹⁰ CITY OF GRUVER, GRUVER DEMOGRAPHICS, <http://www.gruvertexas.com/demos.html> (last accessed Apr. 14, 2016).

⁹¹ The federal court record corroborates Jonathan's account. See *Shepard v. Hansford Cty.*, 110 F. Supp. 3d 696, 703 (N.D. Tex. 2015) ("jail administrator Debbie Hornsby placed Lacy on suicide watch at 4:00 PM on July 16, 2012").

⁹² See *Shepard v. Hansford Cty.*, No. 2:14-CV-147-J, 2014 WL 6662082, at *1 (N.D. Tex. Nov. 24, 2014).

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Shepard*, 110 F. Supp. 3d at 703.

⁹⁸ TEX. ADMIN. CODE tit. 37, § 275.1 (2015).

⁹⁹ *Shepard*, 110 F. Supp. 3d at 704.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.* at 705; *Shepard*, 2014 WL 6662082, at *1.

¹⁰⁴ *Shepard*, 110 F. Supp. 3d at 704.

- ¹⁰⁵ *Id.* at 705.
- ¹⁰⁶ *Id.*
- ¹⁰⁷ *Id.*
- ¹⁰⁸ *Id.*
- ¹⁰⁹ See Aaron Davis, *\$345K Settlement Reached in Hansford County Jail Suicide*, AMARILLO GLOBE-NEWS (Dec. 14, 2015), <http://amarillo.com/news/latest-news/2015-12-14/345k-settlement-reached-hansford-county-jail-suicide>.
- ¹¹⁰ Plaintiffs' Second Amended Complaint at 6, *Riley v. Hays County*, No. 1:13-CV-00153-JRN (W.D. Tex. Feb. 6, 2014) (noting that Eric was prescribed Klonopin (clonazepam) and Ambien in July 2010).
- ¹¹¹ *Id.*
- ¹¹² St. John BARNED-SMITH, *Teen Girl's Suicide Exposes Challenges Jailers Face with Mentally Ill Inmates*, HOUSTON CHRON. (Apr. 11, 2015), <http://www.houstonchronicle.com/news/houston-texas/houston/article/Teen-girl-s-suicide-exposes-challenges-jailers-6194112.php>
- ¹¹³ *Id.*
- ¹¹⁴ *Id.*
- ¹¹⁵ *Id.*
- ¹¹⁶ *Id.*
- ¹¹⁷ *Id.*
- ¹¹⁸ Email from Shannon Herklotz, Asst. Dir., TCJS, to Charles Wagner, Sheriff, Brazoria Cty. Jail (Oct. 14, 2014), provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic.
- ¹¹⁹ *Id.*
- ¹²⁰ Brazoria County Jail Mental Disabilities/Suicide Prevention Plan, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic.
- ¹²¹ Email, Shannon Herklotz to Charles Wagner, dated Oct. 14, 2014.
- ¹²² St. John BARNED-SMITH, *Teen Girl's Suicide Exposes Challenges Jailers Face with Mentally Ill Inmates*, HOUS. CHRON.
- ¹²³ Email, Shannon Herklotz to Charles Wagner, dated Oct. 14, 2014.
- ¹²⁴ Meagan Flynn, *Jesse Jacobs Died in Lockup Six Days After Galveston County Jailers Cut Off His Meds*, HOUSTON PRESS (Aug. 6, 2015), <http://www.houstonpress.com/news/jesse-jacobs-died-in-lockup-six-days-after-galveston-county-jailers-cut-off-his-meds-7646761>.
- ¹²⁵ *Id.*
- ¹²⁶ *Id.*
- ¹²⁷ St. John BARNED-SMITH, *Family Files \$25 Million Lawsuit In Son's Galveston Jail Death*, HOUSTON CHRON. (Mar. 15, 2016), <http://www.houstonchronicle.com/news/houston-texas/houston/article/Family-files-25-million-lawsuit-in-son-s-6889879.php>.
- ¹²⁸ Meagan Flynn, *Jesse Jacobs Died in Lockup Six Days After Galveston County Jailers Cut Off His Meds*, HOUSTON PRESS, Aug. 6, 2015, <http://www.houstonpress.com/news/jesse-jacobs-died-in-lockup-six-days-after-galveston-county-jailers-cut-off-his-meds-7646761>.
- ¹²⁹ St. John BARNED-SMITH, *Family Files \$25 Million Lawsuit In Son's Galveston Jail Death*, HOUS. CHRON.
- ¹³⁰ Meagan Flynn, *Jesse Jacobs Died in Lockup Six Days After Galveston County Jailers Cut Off His Meds*, HOUS. PRESS.
- ¹³¹ *Id.*
- ¹³² *Id.*
- ¹³³ Dan Wallace, *U.S. Judge Upholds Verdict in Orange County Jail Death Case*, BEAUMONT ENTERPRISE (Apr. 13, 2015), <http://www.beaumontenterprise.com/news/article/U-S-judge-upholds-verdict-in-Orange-County-jail-6197048.php>; Manuella Libardi, *Trial Begins in Orange County Jail Death*, BEAUMONT ENTERPRISE (Feb. 3, 2015), <http://www.beaumontenterprise.com/news/article/Trial-begins-in-Orange-County-Jail-death-6059131.php>.
- ¹³⁴ Smith County Screening Form for Robert Rowan dated Oct. 24, 2014, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic.
- ¹³⁵ See RANGER BRENT DAVIS, REPORT OF INVESTIGATION: ROBERT ROWAN 2–3 (2014), on file with The University of Texas School of Law Civil Rights Clinic.
- ¹³⁶ Email from Deal Folmar, Smith Cty. Jail, to Anthony Mikesch, TCJS (Nov. 5, 2014), on file with The University of Texas School of Law Civil Rights Clinic.
- ¹³⁷ RANGER BRENT DAVIS, REPORT OF INVESTIGATION: ROBERT ROWAN at 5.
- ¹³⁸ *Id.*
- ¹³⁹ Medical Examiner's Report of Robert Rowan, dated Dec. 17, 2014, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic.
- ¹⁴⁰ Email from Ashley Owens to Robin Ramsey dated Dec. 12, 2014, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic.
- ¹⁴¹ TEX. CODE. CRIM. P. tit. 1, § 16.22 (2016).
- ¹⁴² Christian McPhate, *Cry for Help*, DENTON CTY. RECORD-CHRONICLE (Aug. 25, 2015), <http://www.dentonrc.com/local-news/local-news-headlines/20150825-cry-for-help.ece>.
- ⁱ On average, 101 people died in Texas jails each year from 2005 to 2015. The two highest annual totals came in 2006 (126 people) and 2015 (112 people). See *Jail Custody*, TEXAS JUSTICE INITIATIVE, <http://texasjusticeinitiative.org/jail-custody/> (last visited August 23, 2016).
- ⁱⁱ Olivia Messer, *Jailed Waco Man Found Dead Of Apparent Suicide*, WACO TRIBUNE (Nov. 3, 2015), http://www.wacotrib.com/news/police/jailed-waco-man-found-dead-of-apparent-suicide/article_74b15e1e-9738-53fa-9a71-d2130bb76727.html.
- ⁱⁱⁱ Olivia Messer, *3 Officers Arrested In Wake Of Jail Death For Allegedly Tampering With Documents*, WACO TRIBUNE (Nov. 13, 2015), http://www.wacotrib.com/news/mclennan_county/officers-arrested-in-wake-of-jail-death-for-allegedly-tampering/article_97112e2a-4a8c-5615-8af2-647a3a4ced27.html.
- ^{iv} *Id.*
- ^v *Id.*
- ^{vi} Michael Barajas, *Why Have Jail Suicides Soared Under Sheriff Ortiz's Watch?*, S.A. CURRENT (Oct. 16, 2012), <http://www.sacurrent.com/sanantonio/why-have-jail-suicides-soared-under-sheriff-ortizs-watch/Content?oid=2243446>.
- ^{vii} *Id.*
- ^{viii} *Id.*
- ^{ix} *Id.*

^x *Id.*

^{xi} Aaron Davis, *Randall County Faces Lawsuit Over Former Inmate's Death*, AMARILLO GLOBE-NEWS (May 21, 2016), <http://amarillo.com/news/latest-news/2016-05-21/randall-faces-lawsuit-over-inmates-jail-death#>.

^{xii} *Id.*

^{xiii} *Id.*

^{xiv} *Id.*

^{xv} *Id.*

^{xvi} *Id.*

^{xvii} *Id.*

^{xviii} Texas Code of Criminal Procedure 49.18(b).

^{xix} Tex. Adm. Code 269.1(5).

^{xx} Texas Code of Criminal Procedure 49.18 (b).

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^{xxii} TEXAS SHERIFFS ASSOCIATION, LEGISLATIVE AGENDA – 85TH LEGISLATIVE SESSION (2016), available at http://www.sheriffstx.org/plugins/show_image.php?id=346.

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¹⁴³ *Breaking the Cycle: Mental Health and the Criminal Justice System: Hearing Before the S. Jud. Comm.*, 114th Cong., 2nd Sess. 7 (Feb. 10, 2016) (statement of Fred M. Osher, M.D.).

¹⁴⁴ BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006) (finding that 76% of local jail inmates who had a mental health problem met criteria for substance dependence or abuse).

¹⁴⁵ *Breaking the Cycle: Mental Health and the Criminal Justice System: Hearing Before the S. Jud. Comm.*, 114th Cong., 2nd Sess. 6 (Feb. 10, 2016) (statement of Fred M. Osher, M.D.).

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HOW TO SET UP A JAIL DIVERSION PROGRAM IN YOUR COMMUNITY (2007), available at <http://www.fairfaxcounty.gov/policecommission/subcommittees/materials/jail-diversion-toolkit.pdf>.

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¹⁵⁵ See, e.g., TEXAS OFFICE OF JUDICIAL ADMINISTRATION, MUNICIPAL COURTS SUMMARY OF ADDITIONAL ACTIVITY BY CITY, SEPTEMBER 1, 2014 TO AUGUST 31, 2015 27 (2016), available at <http://www.txcourts.gov/media/1295581/6-Municipal-Additional-Activity-by-City-2015.pdf> (counting all Class C misdemeanor arrest warrants in Texas in FY15 as 1,738,385; and all Class A or B misdemeanors as 44,195).

¹⁵⁶ See *U.S. Mentally Ill 16 Times More Likely To Be Killed By Police: Study*, REUTERS (Dec. 10, 2015), <http://www.reuters.com/article/us-usa-police-mentallyill-idUSKBNOTT2Y420151210> (citing a Treatment Advocacy Center report which “estimated that just under 4 percent of American adults were severely mentally ill but generated 10 percent of calls for police service”); see also *Jailing People With Mental Illness*, NAT'L ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness> (last visited Sep. 20, 2016) (“In a mental health crisis, people are more likely to encounter police than get medical help.”).

¹⁵⁷ TEXAS PUBLIC POLICY FOUNDATION, OVERINCARCERATION OF PEOPLE WITH MENTAL ILLNESS.

¹⁵⁸ See Texas Criminal Justice Coalition, A SURVEY OF PRETRIAL SERVICE PROVIDERS IN TEXAS: PRELIMINARY REPORT FINDINGS (March 2012), available at <http://www.texascjc.org/sites/default/files/publications/A%20Survey%20of%20Pretrial%20Service%20Providers%20in%20TX%20%28Mar%202012%29.pdf>; Nathan Fennell and Meredith Prescott, RISK NOT RESOURCES: IMPROVING THE PRETRIAL RELEASE PROCESS IN TEXAS (June 2016), available at <https://ljb.utexas.edu/sites/default/files/file/Risk,%20Not%20Resources-%20Improving%20the%20Pretrial%20Release%20Process%20in%20Texas--FINAL.pdf> (noting the adoption of pretrial risk assessments in 46 Texas counties and the reasons for replacing resource-based pretrial release with risk-based pretrial release).

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¹⁶⁰ See generally NATHAN FENNEL AND MERIDITH PRESCOTT, RISK, NOT RESOURCES: IMPROVING THE PRETRIAL RELEASE PROCESS IN TEXAS (2016), available at <https://ljb.utexas.edu/sites/default/files/file/Risk,%20Not%20Resources-%20Improving%20the%20Pretrial%20Release%20Process%20in%20Texas--FINAL.pdf>.

¹⁶¹ See COUNCIL FOR STATE GOVERNMENTS, LAW ENFORCEMENT RESPONSES TO PEOPLE WITH MENTAL ILLNESSES:

A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE 6 (2009), available at <https://csgjusticecenter.org/wp-content/uploads/2012/12/le-research.pdf> (observing that “[t]he stereotype that people with mental illnesses are more likely than the general population to be violent is not fully supported by the evidence.”).

¹⁶² TCJS, MEMORANDUM: REVISED INTAKE SCREENING FORM (Oct. 22, 2015), available at <http://www.tcjs.state.tx.us/docs/TAMemo-Revised-IntakeScreeningForm.pdf>.

¹⁶³ *Id.*

¹⁶⁴ See TCJS, SCREENING FORM FOR SUICIDE AND MEDICAL/MENTAL/DEVELOPMENTAL IMPAIRMENTS (2015), available at http://www.tcjs.state.tx.us/docs/ScreeningForm-SMMDI_Oct2015.pdf.

¹⁶⁵ TCJS, SCREENING FORM FOR SUICIDE AND MEDICAL/MENTAL/DEVELOPMENTAL IMPAIRMENTS (2015).

¹⁶⁶ See Jonathon Silver, *New Statewide Jail Form Aimed at Suicide Risks*, TEX. TRIBUNE (Nov. 13, 2015), <https://www.texastribune.org/2015/11/13/county-jails-adopt-revised-intake-form-next-month/>.

¹⁶⁷ Hayes, Lindsay M., *Report on Suicide Prevention Practices within the Harris County Jail System* (June 8, 2014) at 40.

¹⁶⁸ *Id.*

¹⁶⁹ See SAMHSA, SCREENING, ASSESSMENT, AND TREATMENT PLANNING FOR PERSONS WITH CO-OCCURRING DISORDERS (2006), available at <https://store.samhsa.gov/shin/content/PHD1131/PHD1131.pdf> (discussing the importance of integrating screening with assessment and treatment, and laying out best-practice procedures for integration).

¹⁷⁰ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *Screening and Assessment of Co-Occurring Disorders in the Justice System* (2015) at 45.

¹⁷¹ *Id.* at 11.

¹⁷² *Id.* at 25, 115.

¹⁷³ *Id.* at 11, 25.

¹⁷⁴ Anasseril E. Daniel, MD., *Preventing Suicide in Prison: A Collaborative Responsibility of Administrative, Custodial, and Clinical Staff*, J. Am. Acad. Psychiatry Law 34:165–75 (2006).

¹⁷⁵ TEX. CODE CRIM. P. tit. 1, § 16.22 (2015); *id.* at § 17.032.

¹⁷⁶ TEXAS HOUSE RESEARCH ORGANIZATION, BILL ANALYSIS: S.B. 1557 3 (2009), available at <http://www.hro.house.state.tx.us/pdf/ba81r/sb1557.pdf#navpanes=0>.

¹⁷⁷ TEX. CODE CRIM. P. § 16.22 (a)(1).

¹⁷⁸ See TCJS, MEMORANDUM: CCQ TO REPLACE CARE CHECK SYSTEM

(Sep. 21, 2010), available at <http://www.tcjs.state.tx.us/docs/TA%20Memo%20Care-CCQ.pdf> (describing the CCQ system); TEX. ADMIN. CODE § 273.5 (requiring sheriffs to run CCQ checks at intake, and develop procedures for complying with § 16.22).

¹⁷⁹ TEX. CODE CRIM. P. § 16.22 (a)(1)(A).

¹⁸⁰ *Id.* at § 16.22(b).

¹⁸¹ *Id.* (10 days for misdemeanors, and 30 days for felonies). After receiving the assessment, the trial court may resume criminal proceedings, resume or initiate competency proceedings, or consider the inmate’s mental health during the punishment phase of conviction. *Id.* § 16.22 (c)(1)–(3).

¹⁸² *Id.* at § 17.032 (b)(1)–(4).

¹⁸³ CENTER FOR PUBLIC POLICY PRIORITIES (CPPP), MENTAL HEALTH SCREENING AND INTAKE IN COUNTY JAILS: HOW WE IDENTIFY INDIVIDUALS WITH MENTAL HEALTH NEEDS AT THE POINT OF BOOKING 1 (2014) (citing 2013 data from TCJS). Note here the distinction between “bookings” and detainees; one detainee may be booked multiple times in one year. Each booking would nevertheless require a §16.22 notification.

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¹⁸⁷ TCJS, COUNTY AFFAIRS PRESENTATION ON MENTAL HEALTH 4 (July 30, 2015), available at <http://www.legis.state.tx.us/tlodocs/84R/handouts/C2102015073014001/8872dffe-8772-4f3b-aa1f-2d0a59a65ac0.PDF>.

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¹⁸⁹ TEXAS PUBLIC POLICY FOUNDATION (TPPF), OVERINCARCERATION OF PEOPLE WITH MENTAL ILLNESS: PRETRIAL DIVERSION ACROSS THE COUNTRY AND THE NEXT STEPS FOR TEXAS TO IMPROVE ITS EFFORTS AND INCREASE UTILIZATION 12 (June 2015).

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- ¹⁹² TEXAS ASS'N OF COUNTIES, JAIL SAFETY RECOMMENDATIONS PROVIDED TO COUNTY AFFAIRS COMMITTEE 1 (Aug. 7, 2015) (summarizing testimony by Texas Commission on Jail Standards).
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- ¹⁹⁴ MEADOWS MENTAL HEALTH POLICY INSTITUTE & COUNCIL OF STATE GOVERNMENTS JUSTICE CENTER, BEXAR COUNTY SMART JUSTICE, at 2.
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- ²⁴⁴ *Id.*
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- ²⁴⁷ FEDERAL BUREAU OF PRISONS, SUICIDE PREVENTION IN A CORRECTIONAL SETTING—LESSONS LEARNED at 1.
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- ²⁶⁹ TCJS, LEGISLATIVE APPROPRIATIONS REQUEST FOR FISCAL YEARS 2010–2011, Section 2.E. (2009).
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- ²⁷³ BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.
- ²⁷⁴ See Brandi Grissom, *Mental Health Cuts Would Strain Local Texas Jails*, TEX. TRIBUNE (Feb. 25, 2011), <https://www.texastribune.org/2011/02/25/mental-health-cuts-would-strain-local-texas-jails/> (quoting the Harris County MHMR’s medical director).
- ²⁷⁵ See Terri Langford and Cathaleen Qiao Chen, *Lawmakers to Ex-*

amine Rehab of Mentally Ill, Addicted Inmates, TEX. TRIBUNE (Apr. 22, 2014), <https://www.texastribune.org/2014/04/22/mentally-ill-substance-abusing-inmates-toughest-re/> (“Forty percent of people booked into Texas county jails have already touched the public mental health system,” said Lynda Frost, the director of the Hogg Foundation for Mental Health.”).

²⁷⁶ S.B. 839, 2007 Leg., 80th Sess. (Tex. 2007) (enacted).

²⁷⁷ TEX. CODE CRIM. P. § 16.22.

²⁷⁸ TEX. ADMIN. CODE tit. 25, § 412.321 (2016). See also TCJS, COUNTY AFFAIRS PRESENTATION ON MENTAL HEALTH 10 (July 30, 2015), available at <http://www.legis.state.tx.us/tlodocs/84R/handouts/C2102015073014001/8872dffe-8772-4f3b-aa1f-2d0a59a65ac0.PDF>.

²⁷⁹ TEX. HEALTH AND SAFETY CODE tit. 7, §§ 533.0354, 533.108 (2015).

²⁸⁰ TEX. HEALTH AND SAFETY CODE § 533.104.

²⁸¹ Compare SPINDLETOP CENTER, FORM O CONSOLIDATED LOCAL SERVICE PLAN 26 (2015), available at <http://stmhmr.org/DSHS/2016CLSP.pdf> (indicating no services in jail), with ATCIC, FORM O CONSOLIDATED LOCAL SERVICE PLAN 30 (2015), available at http://www.integralcare.org/sites/default/files/final_formo_1_15_2016.pdf (indicating services in jail) and CENTER FOR HEALTH CARE SERVICES, FORM Y CONSOLIDATED LOCAL SERVICE PLAN 26 (2015), available at <http://chcsbc.org/wp-content/uploads/2016/03/CHCS-CLSP-03.01.2016.pdf> (indicating services in jail).

²⁸² TCJS, HOUSE BILL 1660 REPORT TO THE TEXAS LEGISLATURE 36 (2004), available at <http://www.tcjs.state.tx.us/docs/hb%201660%20report.pdf>.

²⁸³ WRITTEN TESTIMONY OF MICHELE DEITCH, HOUSE COUNTY AFFAIRS COMMITTEE 3 (July 30, 2015), available at <http://www.legis.state.tx.us/tlodocs/84R/handouts/C2102015073014001/c5243bd3-f55a-48a6-8169-8e7898452b93.PDF>.

²⁸⁴ See ATCIC, FORM O CONSOLIDATED LOCAL SERVICE PLAN at 30.

²⁸⁵ MHMR TARRANT COUNTY, CONSOLIDATED LOCAL SERVICE PLAN 16 (2016), available at <http://www.mhmrtc.org/Portals/0/PDF/ConsolidatedLocalServicePlan2016.pdf?ver=2016-03-02-112734-223> (stating that MHMR Tarrant County currently has “have a contract to provide all mental health services in the Tarrant County Jail [and] staff are available 24 hours a day 7 days a week”).

²⁸⁶ *Id.*

²⁸⁷ Interview by Mandy Nguyen with Jenny Berkholt, Leo de la Garza, and Jonathan Lemuel, Bluebonnet Trails Community Services (Apr. 6, 2016).

²⁸⁸ *Id.*

²⁸⁹ *Id.*

²⁹⁰ *Id.*

²⁹¹ BORDER REGION BEHAVIORAL HEALTH CENTERS, <http://www.borderregion.org/> (last accessed May 24, 2016).

²⁹² BORDER REGION BEHAVIORAL HEALTH CENTERS, ADULT JAIL DIVERSION ACTION PLAN FY2012 5 (2012), available at http://www.borderregion.org/images/local_planning/Adults%20Jail%20Diversion%20Plan%20FY10-3-1-10.pdf.

²⁹³ *Id.*

²⁹⁴ *E.g.*, Texas Panhandle Centers, Memorandum of Understanding with the Gray County Jail (Oct. 12, 2011), on file with The University of Texas School of Law Civil Rights Clinic.

²⁹⁵ *E.g.*, Gulf Coast Centers, Contract with CareHere, LLC dated Sep. 30, 2013, on file with The University of Texas School of Law Civil Rights Clinic (agreeing that GCC will provide the Galveston County Jail with in-jail psychiatric services); see also TPPF, OVERINCARCERATION OF PEOPLE WITH MENTAL ILLNESS at 12 (reporting that “almost all of the counties that responded [to a 98-county survey] reported that they contract with the [LMHA] to assess and provide treatment recommendations for people with mental illness who are booked into the jail”).

²⁹⁶ Interview by Alex Stamm with Karlee Anderson, MHMR Authority of Brazos Valley (Mar. 3, 2016).

²⁹⁷ Bluebonnet Trails Community Services, Memorandum of Understanding with the Bastrop County Jail dated Sep. 22, 2008, on file with The University of Texas School of Law Civil Rights Clinic.

²⁹⁸ *Id.*

²⁹⁹ Gulf Coast Centers, Memorandum of Understanding with the Galveston County Jail dated Sep. 1, 2012, on file with The University of Texas School of Law Civil Rights Clinic; Gulf Coast Centers, Contract with CareHere, LLC dated Sep. 30, 2013, on file with The University of Texas School of Law Civil Rights Clinic.

³⁰⁰ Texas Panhandle Centers, Memorandum of Understanding with the Gray County Jail dated Oct. 12, 2011, on file with The University of Texas School of Law Civil Rights Clinic.

³⁰¹ *Id.*

³⁰² Tim Brown, *County Jails Are Not Mental Hospitals!*, TEX. ASS’N OF COUNTIES (May 7, 2015), <https://www.county.org/Legislative/news/Pages/County%20Issues%2005-08-15/County-Jails-Are-Not-Mental-Hospitals.aspx>.

³⁰³ See TEX. MED. ASS’N, MENTAL HEALTH FUNDING, <https://www.texmed.org/template.aspx?id=6491> (last accessed May 24, 2016) (“Texas ranks 49th in the nation for the amount it spends per person for mental health care.”).

³⁰⁴ A non-exhaustive list of potential funding sources includes: 1115 Healthcare Transformation Waiver; Donations; Grants from Local Foundations; Local Match Funds from Cities, Counties, Hospitals; Contracts with Managed Care Organizations; Medicaid and Medicaid Administrative Claiming; Medicare; Self-pay; Texas Commission on Offenders with Medical and Mental Impairments (TCOOMMI); Texas Department of Aging and Disability Services; Preadmission Screening and Resident Review; Texas Department of Assistive and Rehabilitative Services; Texas Department of State Health Services including Mental Health General Revenue and Specialty Services Contracts and Substance Use Contracts; Mental Health Block Grant Funds; and Texas Department of Transportation.

³⁰⁵ CPPP, SIZING UP THE 2014–15 TEXAS BUDGET: MENTAL HEALTH 3 (2013), available at http://forabettertexas.org/images/2013_10_PP_Budget_MentalHealth.pdf.

³⁰⁶ *E.g.*, LUBBOCK COUNTY JAIL, FORMULARY, on file with The University of Texas School of Law Civil Rights Clinic (produced, maintained and used

by the UMC Health System).

³⁰⁷ E.g., DENTON COUNTY JAIL, FORMULARY, on file with The University of Texas School of Law Civil Rights Clinic.

³⁰⁸ For example, Comal County contracts with a private health service provider, and indicated that the county's provider did not have a formulary in its response to a Public Information Act request.

³⁰⁹ *Id.*

³¹⁰ See TEXAS DEPARTMENT OF STATE HEALTH SERVICES AND DEPARTMENT OF AGING AND DISABILITY SERVICES, DRUG FORMULARY 2016 ii (Oct. 2015), available at <http://www.dshs.state.tx.us/mhprograms/Formulary.shtm> (stating that the formulary "is the publication that outlines the medications that have been approved for use in Community Mental Health Centers, Mental Health State Hospitals and the State Supported Living Centers.").

³¹¹ *Id.* at 11–21.

³¹² *Id.* at 127.

³¹³ See *supra* RECOMMENDATION 4: LMHA COLLABORATION and accompanying notes.

³¹⁴ Robert A. Bowen et al., *Medication Management and Practices in Prison For People with Mental Health Problems: A Qualitative Study*, 3 INT. J. MENTAL HEALTH SYS. 24 (2009), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2770990/>.

³¹⁹ NCCHC, STANDARDS FOR MENTAL HEALTH SERVICES IN CORRECTIONAL FACILITIES 59 (2015).

³²⁰ *Id.* at 60.

³²¹ *Id.*

³²² *Id.*

³²³ BRAZORIA COUNTY JAIL, FORMULARY, on file with The University of Texas School of Law Civil Rights Clinic.

³²⁴ TCJS, MENTAL HEALTH STUDY 7 (2005), available at <http://www.tcjs.state.tx.us/docs/MH%20Study.pdf>.

³²⁵ *Id.* at 8.

³²⁶ BRAZORIA COUNTY JAIL, POLICY: MEDICATIONS SUPPLIED BY THE MHMR, on file with The University of Texas School of Law Civil Rights Clinic.

³²⁷ TEXAS ASSOCIATION OF COUNTIES, JAIL SAFETY RECOMMENDATIONS PROVIDED TO THE COUNTY AFFAIRS COMMITTEE 2 (2015), available at http://www.county.org/Legislative/news/Documents/Recommendations_CountyAffairs.pdf

³²⁸ Texas Commission on Jail Standards Memorandum, *Mental Health Updates*, dated July 15, 2014, available at <http://www.tcjs.state.tx.us/docs/Technical%20Assistance%20memo-Mental%20Health%20Updates.pdf>.

³²⁹ See *id.*

³³⁰ TCJS, LEGISLATIVE APPROPRIATIONS REQUEST FOR FISCAL YEARS 2010–2011, Section 2.E. (2009).

³³¹ See *supra* STORIES FROM FAMILIES: AMY LYNN COWLING and accompanying notes. The autopsy for Ms. Cowling reported that her probable cause of death was "seizure due to methadone and prescription drug withdrawals." Robyn Claridy, *Amy Cowling's Autopsy Indicates Seizures From Withdrawal*, LONGVIEW NEWS-JOURNAL (April 18, 2011) <http://www>.

[news-journal.com/news/2011/apr/18/amy-cowlings-autopsy-indicates-seizures-from-withd/](http://www.news-journal.com/news/2011/apr/18/amy-cowlings-autopsy-indicates-seizures-from-withd/).

³³² See *supra* STORIES FROM FAMILIES: AMY LYNN COWLING and accompanying notes.

³³³ *Id.*

³³⁴ Meagan Flynn, *Jesse Jacobs Died in Lockup Six Days After Galveston County Jailers Cut Off His Meds*, HOUSTON PRESS (Aug. 6, 2015), <http://www.houstonpress.com/news/jesse-jacobs-died-in-lockup-six-days-after-galveston-county-jailers-cut-off-his-meds-7646761>.

³³⁵ *Id.*

³³⁶ *Id.*

³³⁷ Kevin Fiscella et al., *Benign Neglect or Neglected Abuse: Drug and Alcohol Withdrawal in U.S. Jails*, 32 J. OF L., MED. & ETHICS 129, 130 (2004).

³³⁸ Compare BUREAU OF JUSTICE STATISTICS, MORTALITY IN LOCAL JAILS AND STATE PRISONS, 2000-2013 1 (Aug. 2013), <https://assets.documentcloud.org/documents/2191181/mortality-in-local-jails-and-state-prisons.pdf> (documenting the 2013 jail suicide rate as 46 per 100,000 jail inmates) with *Suicide Statistics*, AM. FOUND. FOR SUICIDE PREVENTION, <http://afsp.org/about-suicide/suicide-statistics/> (last accessed on Feb. 7, 2016) (listing the suicide rate in the U.S. generally as 13 per 100,000 people).

³³⁹ See NAT'L COMMISSION ON CORRECTIONAL HEALTH CARE (NCCHC), STANDARDS FOR HEALTH SERVICES IN JAILS 125 (2014) (Standard J-D-02) ("withdrawal from opiates and depressant drugs . . . may be, on occasion, life-threatening"); Fiscella, *Benign Neglect or Neglected Abuse: Drug and Alcohol Withdrawal in U.S. Jails* at 129–30.

³⁴⁰ See SUICIDE PREVENTION RES. CTR., CONTINUITY OF CARE FOR SUICIDE PREVENTION AND RESEARCH 47 (2011), available at <http://www.sprc.org/sites/sprc.org/files/library/continuityofcare.pdf> ("For adults, there is strong evidence that stopping antidepressants increases suicide risk."); FEDERAL BUREAU OF PRISONS, CLINICAL PRACTICE GUIDE 20 (2014), available at <https://www.bop.gov/resources/pdfs/depression.pdf> (noting that abruptly discontinuing certain SSRIs, a class of antidepressants, can cause anxiety, panic attacks, and depression, among other side effects.)

³⁴¹ See Zioahong Hu, *Benzodiazepine Withdrawal Seizures and Management*, 104 J. OKLA. STATE MED. ASSOC. 62 (2011); Laurie Meyers, *Empty Bottles: Easing Clients off Meds*, 38 MONITOR ON PSYCHOL. 20 (2007), available at <http://www.apa.org/monitor/mar07/emptypill.aspx> ("Short-acting benzodiazepines like Xanax can cause seizures, coma and even death if the patient does not come off them slowly enough").

³⁴² See, e.g., Joanna Moncrief, *Does Antipsychotic Withdrawal Provoke Psychosis? Review of the Literature on Rapid Onset Psychosis (Super-sensitivity Psychosis) and Withdrawal-Related Relapse*, 114 ACTA PSYCHIATRICA SCANDINAVICA, 3, 9–12 (2006) (reviewing numerous studies on withdrawal following antipsychotic medication discontinuation and finding, among other things, that withdrawal can "increase the risk of relapse" of the disorder).

³⁴³ E.g., VICTORIA COUNTY JAIL, HEALTH SERVICES PLAN, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic (stating that "[d]rugs prescribed by non-authorized physicians will not

be allowed without express approval of the Medical Unit.”).

³⁴⁴ E.g., *Gregg County Jail's Drug Policy Explained*, KYTX-LONGVIEW (Jun. 8, 2011), <http://www.cbs19.tv/story/14870547/gregg-county-drug-policy> (reporting on Gregg County Jail doctor Lewis Browne's blanket policy prohibiting a number of common medications).

³⁴⁵ See, e.g., Rich Lord, *County Jail Death Rate is Among Highest*, PITTSBURGH POST-GAZETTE (May 8, 2011), <http://www.post-gazette.com/local/city/2011/05/08/County-jail-death-rate-is-among-highest/stories/201105080282> (“John Simeone III, then 36, was a narcotics addict who went into withdrawal in jail and hung himself in late 2007. . . . Committing suicide in 2008 [was] Jason Kindler, 28, who was deprived of psychiatric medicines and hung himself”); Gus Burns, *Inmate Dies “Excruciating” Death from Drug Withdrawal in Macomb County Jail*, MICHIGAN LIVE (Sep. 24, 2015), http://www.mlive.com/news/detroit/index.ssf/2015/09/inmate_dies_excruciating_death.html (“[David Stojcevski's] cause of death was determined to be acute withdrawal from chronic benzodiazepine, methadone and opiate medications.”); Donna Miller, *Sean Levert, Denied Medication, Hallucinated for Hours Before He Died in Jail*, CLEVELAND PLAIN DEALER (July 2, 2013), http://blog.cleveland.com/metro/2008/11/post_15.html (describing how a man died during acute withdrawal following denial of access to his prescribed medication, Xanax).

³⁴⁶ See TEX. ADMIN. CODE 273.2 (setting forth requirements for county jails' health service plans, which merely require counties to “provide procedures” for distributing prescribed medications); see also Brandi Grissom, *Woman's Death One of Many in Troubled Texas Jail*, TEXAS TRIBUNE (Feb. 12, 2011) (“State standards do not require that jails provide inmates with the same prescription drugs they took in the outside world, only that they provide treatment according to the facility's health care plan.”).

³⁴⁷ E.g., Letter from Terry Bouchard, Ochiltree County Sheriff, to Ranjana Natarajan, Director, The University of Texas School of Law Civil Rights Clinic (Feb. 8, 2016) (responding to the clinic's open record request by stating that “[w]e do not have any policies on restricted or prohibited medication.”).

³⁴⁸ AM. BAR ASS'N, STANDARDS ON TREATMENT OF PRISONERS, STANDARD 23-6.5, CONTINUITY OF CARE (2011), http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-6.5.

³⁴⁹ NCCHC, STANDARDS FOR HEALTH SERVICES IN JAILS at 61.

³⁵⁰ E.g., VICTORIA COUNTY JAIL, HEALTH SERVICES PLAN, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic; HIDALGO COUNTY JAIL, HEALTH SERVICES PLAN, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic (providing that medications brought to jail by an inmate will be confiscated, verified, and inventoried only if “deemed necessary by a physician”).

³⁵¹ MCLENNAN COUNTY SHERIFF'S OFFICE HEALTH SERVICES DIVISION, POLICIES AND PROCEDURES, CHAPTER 26: MEDICATION BROUGHT INTO JAIL, on file with The University of Texas School of Law Civil Rights Clinic. 352 ECTOR COUNTY JAIL, HEALTH SERVICES PLAN, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic.

³⁵³ NCCHC, STANDARDS FOR HEALTH SERVICES IN JAILS at 124.

³⁵⁴ 21 U.S.C. § 823(g)(1) (2008).

³⁵⁵ 21 C.F.R. § 1306.07(b); PARKLAND HEALTH & HOSPITAL SYSTEM, PHARMACY SERVICES MANUAL, POLICY PHR-D-022, PATIENT'S OWN MEDICATIONS (revised Nov. 7, 2013), on file with The University of Texas School of Law Civil Rights Clinic.

³⁵⁶ MCLENNAN COUNTY SHERIFF'S OFFICE HEALTH SERVICES DIVISION, POLICIES AND PROCEDURES, CHAPTER 24: NARCOTIC MEDICATION, on file with The University of Texas School of Law Civil Rights Clinic.

³⁵⁷ AMERICAN CIVIL LIBERTIES UNION, IMPLEMENTATION OF LAWS REGARDING TREATMENT OF PREGNANT WOMEN IN TEXAS COUNTY JAILS: A REVIEW OF THE SHACKLING BAN AND PREGNANT INMATE CARE STANDARDS 11 (2011).

³⁵⁸ Press Release, University of New Mexico, UNM Study Shows Promising Results of MDC's Methadone Treatment Program (Feb. 4, 2014), available at <http://news.unm.edu/news/unm-study-shows-promising-results-of-mdcs-methadone-treatment-program>.

³⁵⁹ Dan Frosch, *Plan to End Methadone Use at Albuquerque Jail Prompts Alarm*, N.Y. TIMES (Jan. 6, 2013), <http://www.nytimes.com/2013/01/07/us/alarm-in-albuquerque-over-plan-to-end-methadone-for-inmates.html>.

³⁶⁰ Staff Reports, *Gregg County Faces Lawsuit Over Man's 2011 Death in Jail*, LONGVIEW NEWS-JOURNAL (June 27, 2013), <http://www.news-journal.com/news/2013/jun/27/gregg-county-faces-lawsuit-over-mans-2011-death-in/>.

³⁶¹ Tex. Adm. Code 269.1(5).

³⁶² TCJS, LEGISLATIVE APPROPRIATIONS REQUEST FOR FISCAL YEARS 2010–2011, Section 2.E. (2009).

³⁶³ Memorandum Opinion and Order at 2, *Borum v. Swisher County*, No. 2:14-CV-127-J (N.D. Tex. 2015).

³⁶⁴ *Id.* at 3, 10.

³⁶⁵ See *id.* at 11 (citing a deposition in which a jail official responded “No” to the question: “You didn't think that [giving Terry orange juice and honey] was an appropriate medical treatment?”).

³⁶⁶ *Id.* at 3.

³⁶⁷ *Id.* at 4

³⁶⁸ *Id.*

³⁶⁹ *Id.* at 4–5.

³⁷⁰ E.g., Christopher Wren, *Drugs or Alcohol Linked to 80% of Inmates*, N.Y. TIMES (Jan. 9, 1998), <http://www.nytimes.com/1998/01/09/us/drugs-or-alcohol-linked-to-80-of-inmates.html> (reporting on a study which found that 4 out of 5 prisoners had either violated a drug or alcohol law, had been high when they committed their crimes, had stolen to support their addiction, or had a history of drug or alcohol abuse).

³⁷¹ E.g., BUREAU OF JUSTICE STATISTICS, PROFILE OF JAIL INMATES, 2002 1 (2004), <http://www.bjs.gov/content/pub/pdf/pji02.pdf> (finding that “77% of convicted jail inmates were alcohol or drug-involved at the time of their current offense”); FEDERAL BUREAU OF PRISONS, DETOXIFICATION OF CHEMICALLY DEPENDENT INMATES: FEDERAL BUREAU OF PRISONS CLINICAL PRACTICE GUIDELINES 1 (2014), available at <https://www.bop.gov/resources/pdfs/detoxification.pdf> (stating that “[s]ubstance use disor-

ders are highly prevalent among inmate populations, affecting an estimated 30–60% of inmates”).

³⁷² Dr. Louis Trevisan et al., *Complications of Alcohol Withdrawal: Psychopathological Insights*, 22 ALCOHOL HEALTH AND RESEARCH WORLD 61, 61 (1998), available at <http://pubs.niaaa.nih.gov/publications/arh22-1/61-66.pdf>.

³⁷³ *Id.* at 62–63.

³⁷⁴ *Id.*

³⁷⁵ FEDERAL BUREAU OF PRISONS, DETOXIFICATION OF CHEMICALLY DEPENDENT INMATES at 12.

³⁷⁶ *Id.* at 14.

³⁷⁷ *Id.* at 16.

³⁷⁸ See, e.g., Tim Hrenchir, *Autopsy: Shawnee County Jail Inmate’s Likely Cause of Death Was Alcohol Withdrawal*, TOPEKA CAPITAL-JOURNAL (Oct. 2, 2015), <http://cjonline.com/news/2015-10-02/autopsy-shawnee-county-jail-inmates-likely-cause-death-was-alcohol-withdrawal>; Kirk Mitchell, *Lawsuit Filed Against Jeffco Over Woman’s Withdrawal Death in Jail*, DENVER POST (Dec. 16, 2015), http://www.denverpost.com/news/ci_29264254/lawsuit-filed-against-jeffco-over-womans-overdose-death (describing 38-year-old Jennifer Lobato’s death following opiate withdrawal in Colorado jail); J.P. Lawrence, *Court Documents Describe Jailed Woman’s Painful Death Through Opiate Withdrawal*, ALBANY TIMES-UNION (Dec. 17, 2015) <http://www.timesunion.com/local/article/Court-documents-describe-jailed-woman-s-painful-6722889.php> (noting that death following untreated opiate withdrawal in upstate New York jail led to \$425,000 settlement).

³⁷⁹ TEX. ADMIN. CODE § 273.2.

³⁸⁰ *Id.* at 273.2(2), (5), and (6).

³⁸¹ See, e.g., DENTON COUNTY JAIL, HEALTH SERVICES PLAN, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic (making no mention at all of detox or managing withdrawal).

³⁸² NCCHC, STANDARDS FOR HEALTH SERVICES IN JAILS at 124–25 (“As a precaution, severe withdrawal syndromes must never be managed outside of a hospital.”).

³⁸³ *Id.* at 124.

³⁸⁴ See generally FEDERAL BUREAU OF PRISONS, DETOXIFICATION OF CHEMICALLY DEPENDENT INMATES.

³⁸⁵ *Id.* at 9.

³⁸⁶ E.g., Miriam Rozen, *\$1M Judgment in Prisoner’s Wrongful Death Case*, TEXAS LAWYER (Oct. 28, 2015), <http://www.texaslawyer.com/id=1202740961166/1M-Judgment-in-Prisoners-Wrongful-Death-Case?slreturn=20160302143348> (reporting on the \$1 million judgment against Swisher County, Texas, for its neglect of Terry Borum).

³⁸⁷ Parkland Health & Hospital System and Dallas County Jail Procedure G–06 (Aug. 2013), on file with The University of Texas School of Law Civil Rights Clinic.

³⁸⁸ *Id.*

³⁸⁹ See Whet Moser, *San Antonio Reduced Its Jail Population by Treating the Mentally Ill*, CHICAGO MAGAZINE (Aug. 20, 2014), <http://www.chicagomag.com/city-life/August-2014/San-Antonio-Reduced-Its-Jail-Population-By-Treating-the-Mentally-Ill/>

(describing some of the facility’s programs: “a very short term ‘sobering unit,’ in which treatment lasts four to six hours; a three-to-five-day detox, a 16-week intensive outpatient service; methadone treatment; methadone and outpatient treatment specifically for pregnant women; a community court; housing for the homeless; and more.”).

³⁹⁰ Jenny Gold, *Mental Health Cops Help Reweave Social Safety Net in San Antonio*, KAISER HEALTH NEWS (Aug. 19, 2014), available at <http://www.npr.org/sections/health-shots/2014/08/19/338895262/mental-health-cops-help-reweave-social-safety-net-in-san-antonio>.

³⁹¹ DILLON, A PORTRAIT OF SUICIDES IN TEXAS JAILS at 1–3 (2013).

³⁹² BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>; see also TPPF, OVERINCARCERATION OF PEOPLE WITH MENTAL ILLNESS at 4.

³⁹³ See, e.g., *Peer Support and Social Inclusion*, SAMHSA, <http://www.samhsa.gov/recovery/peer-support-social-inclusion> (last accessed June 19, 2016) (“Research has shown that peer support facilitates recovery and reduces health care costs.”); Matthew Chinman et al., *Peer Support Services for Individuals With Serious Mental Illnesses: Assessing the Evidence*, 65 PSYCHIATRIC SERVS. 429 (2014) (reviewing literature and finding that peer support services “demonstrated promising outcomes”).

³⁹⁴ CPPP, FROM RECIDIVISM TO RECOVERY: THE CASE FOR PEER SUPPORT IN TEXAS CORRECTIONAL FACILITIES 9 (2014).

³⁹⁵ TEXAS DEPARTMENT OF STATE HEALTH SERVICES, 2015 MENTAL HEALTH PEER SUPPORT RE-ENTRY PILOT 2 (2015).

³⁹⁶ *Id.* at 3–4.

³⁹⁷ RICHARD BARON, FORENSIC PEER SPECIALISTS: AN EMERGING WORKFORCE 2 (2011).

³⁹⁸ LAURA KAUFMAN ET AL., PEER SPECIALIST TRAINING AND CERTIFICATION PROGRAMS: A NATIONAL OVERVIEW 1 (2014), <http://sites.utexas.edu/mental-health-institute/files/2014/07/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview-2014-Update.pdf>.

³⁹⁹ CPPP, FROM RECIDIVISM TO RECOVERY at 2.

⁴⁰⁰ *Id.* at 10–13.

⁴⁰¹ *Id.* at 13.

⁴⁰² *Id.* at 27–29.

⁴⁰³ CPPP, *Innovative Mental Health Peer Support Program Comes to Texas Jails*, (Feb. 10, 2016), <http://bettertexasblog.org/2016/02/innovative-mental-health-peer-support-program-comes-to-texas-jails/>

⁴⁰⁴ TEXAS DEPARTMENT OF STATE HEALTH SERVICES, 2015 MENTAL HEALTH PEER SUPPORT RE-ENTRY PILOT at 1, 3.

⁴⁰⁵ CPPP, FROM RECIDIVISM TO RECOVERY at 19.

⁴⁰⁶ HOGG FOUNDATION FOR MENTAL HEALTH, A GUIDE TO UNDERSTANDING MENTAL HEALTH SYSTEMS AND SERVICES IN TEXAS, 2ND EDITION 51 (2014).

⁴⁰⁷ CPPP, FROM RECIDIVISM TO RECOVERY at 22.

⁴⁰⁸ Interview by Alex Stamm with Romy Zarate, Tropical Texas Behavioral Health (Apr. 14, 2016).

⁴⁰⁹ TEXAS DEPARTMENT OF STATE HEALTH SERVICES, 2015 MENTAL HEALTH

PEER SUPPORT RE-ENTRY PILOT at 1.

⁴¹⁰ RANGER BRENT DAVIS, REPORT OF INVESTIGATION: JASEN MOSLEY 9 (2015), on file with The University of Texas School of Law Civil Rights Clinic; TEX. ADMIN. CODE § 275.1.

⁴¹¹ RANGER BRENT DAVIS, REPORT OF INVESTIGATION: JASEN MOSLEY at 9.

⁴¹² *Id.*; see also Kenneth Dean, *Video Released Shows That Jasen Mosley Suffered From Depression*, TYLER MORNING TELEGRAPH (Sep. 23, 2015), <http://www.tylerpaper.com/TP-News+Local/224478/video-released-shows-that-jasen-mosley-suffered-from-depression>.

⁴¹³ Meghan Keneally, *Sandra Bland: How Her Body Was Discovered*, ABC NEWS (Jul. 21, 2015), <http://abcnews.go.com/US/sandra-blands-body-discovered-cell/story?id=32590986>.

⁴¹⁴ See St. John Barned-Smith, *Calls For Training, Better Cell Checks Follow Harris County Jail Suicides*, HOUS. CHRON. (Nov. 30, 2015), <http://www.houstonchronicle.com/news/houston-texas/houston/article/Calls-for-training-better-cell-checks-follow-6666190.php>.

⁴¹⁵ See, e.g., MCLENNAN COUNTY JAIL, MENTAL DISABILITIES/SUICIDE PREVENTION PLAN 2, provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic (requiring visual checks every five minutes for high-suicide-risk inmates).

⁴¹⁶ See Barned-Smith, *Calls For Training, Better Cell Checks Follow Harris County Jail Suicides*, HOUS. CHRON.

⁴¹⁷ Overcrowding, the lack of privacy, temperature and noise levels, victimization, and other environmental conditions, including incarceration itself can exacerbate a current mental health condition, contribute to increased present suicidal tendencies, or elicit mental health reactions from inmates without a previous diagnosis. See HOLLY HILLS ET AL., EFFECTIVE PRISON MENTAL HEALTH SERVICES: GUIDELINES TO EXPAND AND IMPROVE TREATMENT 6 (2004), available at <https://s3.amazonaws.com/static.nicic.gov/Library/018604.pdf>.

⁴¹⁸ TEX. ADMIN. CODE § 275.1.

⁴¹⁹ *Id.*

⁴²⁰ *Id.*

⁴²¹ *Id.*

⁴²² See, e.g., *2nd Jailer Arrested After Death Of Gregg Co. Inmate*, KLTUV7 (Jan. 5, 2011), <http://www.kltv.com/story/13780727/2nd-jailor-arrested-in-death-of-gregg-co-inmate>.

⁴²³ TEX. ADMIN. CODE §275.1.

⁴²⁴ The sufficiency standards require one jail staff member on each floor of a facility where ten or more inmates are housed, with no less than one jail staff member for every 48 inmates. TEX. ADMIN. CODE §275.4.

⁴²⁵ *Id.*

⁴²⁶ *Id.* at §275.1.

⁴²⁷ HILLS, EFFECTIVE PRISON MENTAL HEALTH SERVICES at 6. A jailer may choose to engage the inmate in trained de-escalation techniques, initiate emergency procedures, recommend the inmate be placed on suicide watch or increased observation, notify a superior, contact a mental health professional, etc. The point is to encourage *proactive* monitoring with training in order to decrease the likelihood of further deterioration in mental health.

⁴²⁸ *Id.*

⁴²⁹ *Id.*

⁴³⁰ AM. CORRECTIONAL ASS'N, CORE JAIL STANDARDS, 1-CORE-4C-09 (Ref. 4-ALDF-4C-22, 4C-29), available at <http://correction.org/wp-content/uploads/2014/09/Core-Jail-Standards-as-printed-June-2010.pdf>.

⁴³¹ *Id.*

⁴³² *Id.* at 1-CORE-2A-24 (Ref. 4-ALDF-2A-52); 1-CORE-4C-12, (Ref. 4-ALDF-4C-27, 4C-28), available at <http://correction.org/wp-content/uploads/2014/09/Core-Jail-Standards-as-printed-June-2010.pdf>.

⁴³³ See *id.* (requiring that inmates who demonstrate unusual or bizarre behavior be assessed by medical personnel).

⁴³⁴ See Jon E. Grant, *Failing the 15-Minute Suicide Watch: Guidelines to Monitor Inpatients*, 6 CURRENT PSYCHIATRY 6 (2007), <http://www.currentpsychiatry.com/articles/malpractice-rx/article/failing-the-15-minute-suicide-watch-guidelines-to-monitor-inpatients/fd39a8da-44342594aa91146d7447c616.html> (recommending 15-minute visual observation should be required to protect patients from self-harm; showing that 15-minute checks are even insufficient because approximately one-third of 1,500 inpatient suicides in the United States still occur with the 15-minute observational rounds).

⁴³⁵ AM. BAR ASS'N, ABA CRIMINAL JUSTICE STANDARDS ON THE TREATMENT OF PRISONERS, STANDARD 23–1.2 TREATMENT OF PRISONERS (2011), available at http://www.americanbar.org/content/dam/aba/publishing/criminal_justice_section_newsletter/treatment_of_prisoners_commentary_website.authcheckdam.pdf.

⁴³⁶ AM. CORRECTIONAL ASS'N, CORE JAIL STANDARDS, 1-CORE-2A-24 (Ref. 4-ALDF-2A-52).

⁴³⁷ Email from Shannon Herklotz, Asst. Dir., TCJS, to Charles Wagner, Sheriff, Brazoria Cty. Jail (Oct. 14, 2014), provided by TCJS and on file with The University of Texas School of Law Civil Rights Clinic.

⁴³⁸ *Id.*

⁴³⁹ AM. CORRECTIONAL ASS'N, CORE JAIL STANDARDS, 1-CORE-2A-24 (Ref. 4-ALDF-2A-52).

⁴⁴⁰ See *Suicide Prevention*, NCCHC, <http://www.ncchc.org/suicide-prevention> (last accessed May 25, 2016) (clarifying that for suicidal inmates, “inmates should be observed at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes)”).

⁴⁴¹ See *id.* (recommending staggered intervals to prevent suicide).

⁴⁴² *Id.*

⁴⁴³ See, e.g., LAURA J. HICKMAN ET AL., TRACKING INMATES AND LOCATING STAFF WITH ACTIVE RADIO-FREQUENCY IDENTIFICATION (RFID): EARLY LESSONS LEARNED IN ONE U.S. CORRECTIONAL FACILITY 9 (2010), available at <https://www.ncjrs.gov/pdffiles1/nij/grants/230781.pdf> (listing facilities).

⁴⁴⁴ *Id.* at 6.

⁴⁴⁵ See Shelly Bradbury, *Tracking Inmates: Jail Deploys Digital System to Monitor Prisoners*, TIMES FREE PRESS (Aug. 26, 2015), <http://www.timesfreepress.com/news/local/story/2015/aug/26/jail-deploys-digital-tracking-system-today/321698/>.

⁴⁴⁶ *Id.*

⁴⁴⁷ *Id.*

⁴⁴⁸ Barned-Smith, *Calls For Training, Better Cell Checks Follow Harris*

County Jail Suicides, HOUS. CHRON.

⁴⁴⁹ *Suicide Watch Technologies Could Improve Monitoring, Reduce Staff Time*, NAT'L INSTITUTE FOR JUSTICE, <http://www.nij.gov/topics/corrections/institutional/monitoring-inmates/pages/suicide-watch.aspx> (last accessed May 25, 2016).

⁴⁵⁰ *Id.*

⁴⁵¹ See AM. CORRECTIONAL ASS'N, CORE JAIL STANDARDS, 1-CORE-2A-03 (Ref. 4-ALDF-2A-05, 2A-06) (requiring personal contact and interaction). In particular, Sandra Bland was able to use the intercom system to get instructions to make a phone call 50 minutes after a visual check. Jail staff may have considered this interaction sufficient observation because she was not visually checked for another 60 minutes, at which time she had already committed suicide.

⁴⁵² TEX. ADMIN. CODE tit. 25, § 415.253(27) (defining "restraint" in the context of state hospitals and psychiatric centers).

⁴⁵³ Anne-Marie Cusac, *The Devil's Chair*, *The Progressive* (Apr. 1, 2000), http://www.progressive.org/mag_cusacchair.

⁴⁵⁴ See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES ET AL., SUMMARY REPORT: A NATIONAL CALL TO ACTION: ELIMINATING THE USE OF SECLUSION AND RESTRAINT 9 (2003), available at <http://www.restraint-freeworld.org/documents/Summary%20Report.pdf>. An abundance of news stories report deaths caused at least in part by restraint chairs each year. See, e.g., Radley Balko, *Stories from "The Devil's Chair"*, WASH. POST (Feb. 10, 2014), <https://www.washingtonpost.com/news/opinions/wp/2014/02/10/the-devils-chair/>.

⁴⁵⁵ Cusac, *The Devil's Chair*, *THE PROGRESSIVE*.

⁴⁵⁶ *Id.*

⁴⁵⁷ ANNE-MARIE CUSAC, CRUEL AND UNUSUAL: THE CULTURE OF PUNISHMENT IN AMERICA 234 (2009).

⁴⁵⁸ Claire Clardona, *Two Arlington Detention Officers Indicted In Death Of Man In Custody, Family Seeks Murder Charges Against Them*, *THE DALLAS MORNING NEWS* (Nov. 23, 2015), <http://crimeblog.dallasnews.com/2015/11/officer-indicted-in-case-of-man-who-died-in-arlington-jail-custody.html/>.

⁴⁵⁹ *Id.*

⁴⁶⁰ *Id.*

⁴⁶¹ *Id.*

⁴⁶² TEX. ADMIN. CODE §273.6.

⁴⁶³ *Id.*

⁴⁶⁴ *Id.* (stating also that medical care must be conducted by a certified medical professional and include changing position, exercising extremities, offering nourishment and liquids, offering toilet facilities, checking for medication needs, and taking vital signs.).

⁴⁶⁵ *Id.*

⁴⁶⁶ See NCHC, STANDARDS FOR HEALTH SERVICES IN JAILS at 145–46.

⁴⁶⁷ TCJS, SPECIAL JAIL INSPECTION REPORT: ECTOR COUNTY JAIL (Feb 16, 2016), available at http://www.tcjs.state.tx.us/docs/Ector_Special_NC_2-16-2016.pdf; see also Chelsea Trahan, *Ector County Jail in Non-Compliance*, NEWSWEST9 (Mar. 7, 2016), <http://www.newswest9.com/story/31409239/ector-county-jail-in-non-compliance>.

⁴⁶⁸ AMERICAN CIVIL LIBERTIES UNION, IMPLEMENTATION OF LAWS REGARD-

ING TREATMENT OF PREGNANT WOMEN IN TEXAS COUNTY JAILS: A REVIEW OF THE SHACKLING BAN AND PREGNANT INMATE CARE STANDARDS 2–5 (2011), available at https://www.aclutx.org/sites/default/files/field_documents/2011Shacklinglawimplementation.pdf.

⁴⁶⁹ TEX. ADMIN. CODE § 415.253(28) (defining "seclusion" in the context of state hospitals and psychiatric centers).

⁴⁷⁰ Michael K. Champion, M.D., *Commentary: Seclusion and Restraint in Corrections—A Time for Change*, 35 J. AM. ACAD. PSYCHIATRY L. 426 (2007), available at <http://www.jaapl.org/content/35/4/426.full>.

⁴⁷¹ FEDERAL BUREAU OF PRISONS, SUICIDE PREVENTION IN A CORRECTIONAL SETTING—LESSONS LEARNED 2 (2011), available at http://www.usmarshals.gov/prisoner/sp_lessons.pdf.

⁴⁷² Manuella Libardi, *Trial Begins in Orange County Jail Death*, BEAUMONT ENTERPRISE (Feb. 3, 2015), <http://www.beaumontenterprise.com/news/article/Trial-begins-in-Orange-County-Jail-death-6059131.php>.

⁴⁷³ See Sheriff's Report and Inmate Death Reporting Form dated Oct. 12, 2011, Robert Montano, Orange County Jail, from the Texas Commission on Jail Standards, on file with The University of Texas School of Law Civil Rights Clinic;

⁴⁷⁴ Libardi, *Trial Begins in Orange County Jail Death*, BEAUMONT ENTERPRISE.

⁴⁷⁵ Manuella Libardi, *Family Sues to Shut Down Texas County Jail*, BEAUMONT ENTERPRISE (Jul. 7, 2014), <http://www.correctionsone.com/corrections/articles/7382181-Family-sues-to-shut-down-Texas-county-jail/>.

⁴⁷⁶ TEX. ADMIN. CODE § 271.1(9), (10), (11).

⁴⁷⁷ *Id.* at § 271.1(11).

⁴⁷⁸ *Id.* at § 271.1(12).

⁴⁷⁹ *Id.* at § 273.5.

⁴⁸⁰ See *supra* STORIES FROM FAMILIES: LACY DAWN CUCCARO and accompanying notes.

⁴⁸¹ See *supra* STORIES FROM FAMILIES: ROBERT ROWAN and accompanying notes.

⁴⁸² E.g., Dylan Baddour, *Federal Suit Contends Violations In Cameron Jail Death*, HOUS. CHRON. (Sep. 17, 2015), <http://www.houstonchronicle.com/news/houston-texas/houston/article/Federal-suit-contends-violations-in-Cameron-jail-6512507.php> (describing a Texas man who "spent his last evening making gurgling noises on the floor of his [seclusion] cell"); Joey Garrison, *Death Of Inmate Placed In 'Spit Hood' To Cost Metro \$150K*, THE TENNESSEAN (Oct. 1, 2015), <http://www.tennessean.com/story/news/2015/10/01/death-inmate-3-hours-after-arrest-cost-metro-150k/73140798/> (describing how an inmate died after three hours in a seclusion cell wearing a "spit hood"; when the hood was removed, "vomit spilled out").

⁴⁸³ 42 C.F.R. § 482.13(f)(1) (1999).

⁴⁸⁴ *Alternatives to Seclusion and Restraint*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ASS'N (SAMHSA), <http://www.samhsa.gov/trauma-violence/seclusion> (last accessed May 19, 2016) ("SAMHSA is committed to reducing and ultimately eliminating the use of seclusion and restraint practices in organizations and systems serving people with mental and/or substance use disorders . . . [including] jails and

criminal justice settings.”).

⁴⁸⁵ APNA Position Statement on the Use of Seclusion and Restraint, AM. PSYCHIATRIC NURSES ASS’N, <http://www.apna.org/i4a/pages/index.cfm?pageid=3728#PositionStatement> (last accessed May 19, 2016) (“APNA supports a sustained commitment to the reduction and ultimate elimination of seclusion and restraint”).

⁴⁸⁶ Position Statement 24: Seclusion and Restraints, MENTAL HEALTH AM., <http://www.mentalhealthamerica.net/positions/seclusion-restraints> (last accessed May 19, 2016) (“Mental Health America (MHA) urges abolition of the use of seclusion and restraints”).

⁴⁸⁷ NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRECTORS, POSITION STATEMENT ON SECLUSION AND RESTRAINT (2007), available at http://www.nasmhpd.org/sites/default/files/S%26R%20position%20statement.Forensic%20Div.%20prop.%20approved%20by%20NASMHPD.07.07.final_.pdf (“It is NASMHPD’s goal to prevent, reduce, and ultimately eliminate the use of seclusion and restraint”).

⁴⁸⁸ AM. PSYCHIATRIC ASS’N, THE USE OF RESTRAINT AND SECLUSION IN CORRECTIONAL MENTAL HEALTH CARE RESOURCE DOCUMENT 1 (2006), available at https://www.google.com/l?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiAytrygvHMAh-VM4YMKHVPBCh8QFggcMAA&url=https%3A%2F%2Fwww.psychiatry.org%2Ffile%2520Library%2Fpsychiatrists%2FDirectories%2FLibrary-and-Archive%2Fresource_documents%2Frd2006_Seclusion.pdf&usq=AFQjCNFgcUYWgLP5DPiDJMdmCwg-N-niqA&bv=bv.122676328.d.amc.

⁴⁸⁹ NCCHC, STANDARDS FOR HEALTH SERVICES IN JAILS at 145.

⁴⁹⁰ PENN. DEP’T OF PUB. WELFARE, OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, PENNSYLVANIA SECLUSION AND RESTRAINTS REDUCTION INITIATIVE 1 (2000), available at http://www.power2u.org/downloads/Pennsylvania_S%26R_Initiative.pdf.

⁴⁹¹ *Id.*

⁴⁹² HOGG FOUNDATION FOR MENTAL HEALTH, A GUIDE TO UNDERSTANDING MENTAL HEALTH SYSTEMS AND SERVICES IN TEXAS, 2ND ED. 277 (2014).

⁴⁹³ *Id.*

⁴⁹⁴ NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRECTORS, SIX CORE STRATEGIES FOR REDUCING SECLUSION AND RESTRAINT USE (2006), available at <http://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf>.

⁴⁹⁵ SAMHSA, PROMOTING ALTERNATIVES TO THE USE OF SECLUSION AND RESTRAINT ISSUE BRIEF #2: MAJOR FINDINGS FROM SAMHSA’S ALTERNATIVES TO RESTRAINT AND SECLUSION STATE INCENTIVE GRANTS (SIG) PROGRAM 3 (2010), available at http://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-2.pdf (measuring the restraint reduction by hours of restraint used).

⁴⁹⁶ GOV’T ACCOUNTABILITY OFFICE, IMPROPER RESTRAINT OR SECLUSION USE PLACES PEOPLE AT RISK 21 (1999), available at <http://www.gao.gov/archive/1999/he99176.pdf>.

⁴⁹⁷ SAMHSA, PROMOTING ALTERNATIVES TO THE USE OF SECLUSION AND RESTRAINT ISSUE BRIEF #4: MAKING THE BUSINESS CASE 5 (2010), available at http://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-4.pdf.

⁴⁹⁸ Federal Jury Decides Orange County Should Pay \$2,421,650 to Family of Man Who Died While in Custody, 12NEWSNOW (Feb. 11, 2015), <http://www.12newsnow.com/story/28085682/federal-jury-decides-orange-county-should-pay-2617000-to-family-of-man-who-died-while-in-custody>.

⁴⁹⁹ See AM. PSYCHIATRIC ASS’N, THE USE OF RESTRAINT AND SECLUSION IN CORRECTIONAL MENTAL HEALTH CARE at 2.

⁵⁰⁰ WILLIAM P. ANGRICK II, INVESTIGATION OF RESTRAINT DEVICE USE IN IOWA’S COUNTY JAILS 21 (2008), available at <https://www.legis.iowa.gov/docs/publications/CI/9966.pdf>.

⁵⁰¹ *Id.*

⁵⁰² *Id.*

⁵⁰³ Balko, *Stories from “The Devil’s Chair”*, WASH. POST.

⁵⁰⁴ AM. PSYCHIATRIC ASS’N, THE USE OF RESTRAINT AND SECLUSION IN CORRECTIONAL MENTAL HEALTH CARE at 3.

⁵⁰⁵ NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRECTORS, SIX CORE STRATEGIES at 2.

⁵⁰⁶ SAMHSA, ROADMAP TO SECLUSION AND RESTRAINT FREE MENTAL HEALTH SERVICES (2006), available at <http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055>.

⁵⁰⁷ NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRECTORS, SIX CORE STRATEGIES at 1–2.

⁵⁰⁸ *Id.*

⁵⁰⁹ *Id.*

⁵¹⁰ AM. PSYCHIATRIC ASS’N, THE USE OF RESTRAINT AND SECLUSION IN CORRECTIONAL MENTAL HEALTH CARE at 3.

⁵¹¹ NCCHC, STANDARDS FOR HEALTH SERVICES IN JAILS at 146.

⁵¹² Compare 37 Tex. Admin. Code §273.6 (restraint) with 37 Tex. Admin. Code § 271.1(9), (10), (11) (separation).

⁵¹³ NCCHC, STANDARDS FOR HEALTH SERVICES IN JAILS at 145.

⁵¹⁴ AM. PSYCHIATRIC ASS’N, THE USE OF RESTRAINT AND SECLUSION IN CORRECTIONAL MENTAL HEALTH CARE at 1–2.

⁵¹⁵ See Balko, *Stories from “The Devil’s Chair”*, WASH. POST.

⁵¹⁶ See TEX. ADMIN. CODE §273.6.

⁵¹⁷ See TEX. ADMIN. CODE § 273 (describing the health-services regulations, and not regulating seclusion); *id.* at § 271.1(9), (10), (11) (providing limited regulation of disciplinary segregation, but no detailed regulation of clinically secluding the mentally ill).

⁵¹⁸ TCJS, LEGISLATIVE APPROPRIATIONS REQUEST FOR FISCAL YEARS 2010–2011, Section 2.E. (2009).

⁵¹⁹ HUMAN RIGHTS WATCH, CALLOUS AND CRUEL: USE OF FORCE AGAINST INMATES WITH MENTAL DISABILITIES IN US JAILS AND PRISONS 29 (2015), available at https://www.hrw.org/sites/default/files/reports/usprisoner0515_ForUpload.pdf (citing a nationwide BJS study which found that “58 percent of those who had a mental health problem had been charged with rule violations, compared to 43 percent of those without such problems”).

⁵²⁰ See, e.g., Jack Leonard and Robert Faturechi, *L.A. County Jailers More Likely To Use Force On Mentally Ill Inmates*, L.A. TIMES (Jan. 11, 2012), <http://articles.latimes.com/2012/jan/11/local/la-me-sheriff>

jails-20120111 (reporting that “[m]entally ill inmates make up about 15% of the Los Angeles County jail population but are involved in about a third of use-of-force incidents by deputies”).

⁵²¹ See HUMAN RIGHTS WATCH, CALLOUS AND CRUEL 44–45.

⁵²² Kevin Krause, *Families Seek Answers In Deaths Of Inmates Subdued At Dallas County Jails*, THE DALLAS MORNING NEWS (July 18, 2014), <http://www.dallasnews.com/news/community-news/dallas/headlines/20100318-families-seek-answers-in-deaths-of-inmates-subdued-at-dallas-county-jails.ece>.

⁵²³ Cheryl W. Thompson and Mark Berman, *Improper Techniques, Increased Risks*, WASH. POST (Nov. 26, 2015), <http://www.washingtonpost.com/sf/investigative/2015/11/26/improper-techniques-increased-risks/>.

⁵²⁴ *Id.*

⁵²⁵ *Id.*

⁵²⁶ Julia Janae, *Sulphur Springs Inmate Death Ruled A Homicide*, KLTUV7 (Aug. 17, 2015), <http://www.kltv.com/story/28997374/sulphur-springs-inmate-death-ruled-a-homicide>.

⁵²⁷ *Id.*

⁵²⁸ Ted Oberg and Trent Seiberg, *Lawsuit Filed In Harris County Jail ‘I Cannot Breathe’ Death*, ABC13 (Jul. 28, 2015), <http://abc13.com/news/lawsuit-filed-in-2014-harris-county-jail-death/888766/> (citing text and video).

⁵²⁹ *Id.*

⁵³⁰ *Id.*

⁵³¹ Madlin Mekelburg, *Wrongful Death Suit Filed In Harris County Jail Death*, HOUS. CHRON. (Jul. 28, 2015), <http://www.houstonchronicle.com/news/houston-texas/houston/article/Wrongful-death-suit-filed-in-Harris-County-jail-6411227.php>.

⁵³² *Id.* at 46 (quoting Ron Freeman, Major at the Ada County Jail in Idaho: “We teach inmate behavioral management instead of physical containment. We set expectations, use incentives and disincentives and hold inmates accountable to get the behavior we want. Force begets force. Officers are safer here if there is less force; the facility is calmer and less tense.”); see also Jeffrey A. Schwartz, *Use of Force in Correctional Facilities*, NAT’L COUNCIL ON CRIME & DELINQUENCY BLOG (Nov. 13, 2012), available at <http://www.nccdglobal.org/blog/use-of-force-in-correctional-facilities> (describing how excessive use of force indicates a lack of professionalism among jail staff).

⁵³³ See HUMAN RIGHTS WATCH, CALLOUS AND CRUEL 5, 46 & n. 136 (quoting Bernard Warner, Secretary of the Washington Department of Corrections: “If you have a well-run prison with good programming and mental health treatment, there will be less use of force.”).

⁵³⁴ See TEX. ADMIN. CODE tit. 37 (making no mention of use of force); see also Michele Deitch, *It’s Time to Bring Texas Jails Out of the Shadows*, UTNEWS (Aug. 6, 2015), <http://news.utexas.edu/2015/08/06/it-s-time-to-bring-texas-jails-out-of-the-shadows> (noting that “Texas’ minimum jail standards are silent on the issues of staff use of force”).

⁵³⁵ TEX. COMM’N ON LAW ENFORCEMENT, USE OF FORCE IN A JAIL SETTING: COURSE NUMBER 3504 40–41 (2010), available at <http://www.aele.org/law/2008JBOCT/texas3504.pdf>.

⁵³⁶ AM. CORR. ASS’N, CORE JAIL STANDARDS: 1-CORE-2B-01 (2010), available at <http://correction.org/wp-content/uploads/2014/09/Core-Jail-Standards-as-printed-June-2010.pdf>.

⁵³⁷ AM. BAR ASS’N, ABA STANDARDS OF CRIMINAL JUSTICE (3RD ED.): TREATMENT OF PRISONERS (2011), available at http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-5.6 (Standard 23-5.6(b)).

⁵³⁸ *Id.* (Standard 23-5.6(g)).

⁵³⁹ See HUMAN RIGHTS WATCH, CALLOUS AND CRUEL 49.

⁵⁴⁰ TEX. COMM’N ON LAW ENFORCEMENT, USE OF FORCE IN A JAIL SETTING (TRAINING MATERIALS), COURSE NO. 3504, available at <http://www.aele.org/law/2008JBOCT/texas3504.pdf>.

⁵⁴¹ HILLS, EFFECTIVE PRISON MENTAL HEALTH SERVICES at 33.

⁵⁴² *Id.*

⁵⁴³ COUNCIL OF STATE GOVERNMENTS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 214 (2002), available at <https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf>.

⁵⁴⁴ HOUSTON POLICE DEP’T, RESPONDING TO THE MENTALLY ILL: A GUIDE FOR TEXAS PEACE OFFICERS 23 (2015), available at <http://www.houstoncit.org/wp-content/uploads/2016/02/LE-Guide-QA-Oct-2015.pdf>.

⁵⁴⁵ See HUMAN RIGHTS WATCH, CALLOUS AND CRUEL 54–55.

⁵⁴⁶ *Id.* at 54 n. 161.

⁵⁴⁷ *Id.* at 58.

⁵⁴⁸ *Id.* See also Oberg and Seiberg, *Lawsuit Filed In Harris County Jail ‘I Cannot Breathe’ Death*, ABC13 (video of guards entering Kenneth Lucas’ cell, subduing him, and removing him).

⁵⁴⁹ See HUMAN RIGHTS WATCH, CALLOUS AND CRUEL 59–61 (reciting the facts of Gregory Kitchens’ death).

⁵⁵⁰ *Id.* at 62–63.

⁵⁵¹ *Id.* at 58.

⁵⁵² Andrew Cohen, *Handling, Not Manhandling the Mentally Ill*, THE MARSHALL PROJECT (Dec. 17, 2014), <https://www.themarshallproject.org/2014/12/17/handling-not-manhandling-the-mentally-ill#.7w7VtTMN>. Dr. Raymond Patterson, a psychiatrist with experience as a court monitor for prison and jail settlements, says that having mental health professional at cell extractions “should be standard in every system.”

⁵⁵³ See *id.* (excerpting language from the L.A. County settlement).

⁵⁵⁴ See Oberg and Seiberg, *Lawsuit Filed In Harris County Jail ‘I Cannot Breathe’ Death*, ABC13.

⁵⁵⁵ See HUMAN RIGHTS WATCH, CALLOUS AND CRUEL 65 (citing expert testimony that “pepper spray inflames mucous membranes”, “burns the eyes, throat and skin”, “makes breathing difficult”, and occasionally causes headaches and convulsive coughing).

⁵⁵⁶ See, e.g., *The Use of Force Continuum*, NAT’L INST. OF JUSTICE, <http://www.nij.gov/topics/law-enforcement/officer-safety/use-of-force/pages/continuum.aspx> (last accessed May 27, 2016); see also TEX. COMM’N ON LAW ENFORCEMENT, USE OF FORCE IN A JAIL SETTING: COURSE NUMBER 3504 8 (2010), available at <http://www.aele.org/law/2008JBOCT/texas3504.pdf>.

⁵⁵⁷ See HUMAN RIGHTS WATCH, CALLOUS AND CRUEL 66 (noting that “ab-

sent clear policies and diligent supervision, chemical sprays against those inmates can become the routine first response to perceived problems”).

⁵⁵⁸ Alysia Santo, *Adding Pepper Spray to the Prison Arsenal*, THE MARSHALL PROJECT (May 12, 2015), <https://www.themarshallproject.org/2015/05/12/adding-pepper-spray-to-the-prison-arsenal#.jLp4o-jC2r> (quoting Eldon Vail, former director of the Washington Department of Corrections).

⁵⁵⁹ See, e.g., See CUSAC, CRUEL AND UNUSUAL at 234 (telling the story of James Livingston, who died after being pepper sprayed while in a restraint chair).

⁵⁶⁰ AM. CORR. ASS’N, CORE JAIL STANDARDS: 1-CORE-2B-04 (2010), available at <http://correction.org/wp-content/uploads/2014/09/Core-Jail-Standards-as-printed-June-2010.pdf>.

⁵⁶¹ AM. BAR ASS’N, ABA STANDARDS OF CRIMINAL JUSTICE (3RD ED.): TREATMENT OF PRISONERS (2011), available at http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-5.6 (Standard 23-5.6(h)).

⁵⁶² See HUMAN RIGHTS WATCH, CALLOUS AND CRUEL 69.

⁵⁶³ See Jennifer Edwards Baker and Janice Morse, *American Heart Association: Tasers Can Cause Death*, USA TODAY (May 2, 2012), <http://usatoday30.usatoday.com/news/nation/story/2012-05-02/taser-study-deaths/54688110/1> (“Dr. Douglas Zipes, of Indiana University’s Krannert Institute of Cardiology, found that a shock from the Taser ‘can cause cardiac electric capture and provoke cardiac arrest’ as a result of an abnormally rapid heart rate and uncontrolled, fluttering contractions.”).

⁵⁶⁴ See Douglas Zipes, *TASER Electronic Control Weapons Can Cause Cardiac Arrest in Humans*, 129 CIRCULATION 101 (2014).

⁵⁶⁵ Cheryl W. Thompson and Mark Berman, *Improper Techniques, Increased Risks*, WASH. POST (Nov. 26, 2015), <http://www.washingtonpost.com/sf/investigative/2015/11/26/improper-techniques-increased-risks/>.

⁵⁶⁶ *Id.*

⁵⁶⁷ *Id.*

⁵⁶⁸ *Id.*

⁵⁶⁹ *Id.*

⁵⁷⁰ AM. CORR. ASS’N, CORE JAIL STANDARDS: 1-CORE-2B-04 (2010), available at <http://correction.org/wp-content/uploads/2014/09/Core-Jail-Standards-as-printed-June-2010.pdf>.

⁵⁷¹ U.S. DEP’T OF JUSTICE OFFICE OF COMMUNITY ORIENTED POLICING SERVICES AND THE POLICE EXECUTIVE RESEARCH FORUM, 2011 ELECTRONIC CONTROL WEAPON GUIDELINES 12 (2011), http://www.berkeleyside.com/wp-content/uploads/2014/04/www.policeforum.org_assets_docs_Free_Online_Documents_Use_of_Force_electronic-control-weapon-guidelines-2011.pdf.

⁵⁷² *Id.* at 3.

⁵⁷³ *Id.* at 20.

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