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Sent via electronic mail

To
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Interim Charge #4 - Availability of Behavioral Health Services for individuals in county jails

Good morning Chair Stucky and committee members,

My name is Krish Gundu. I am one of the co-founders and executive director of Texas Jail Project (TJP). We are a small grassroots advocacy organization working on pretrial detention and county jail issues since 2006. Our focus populations have been some of our most vulnerable community members such as pregnant people, persons with mental illness and developmental disabilities and veterans. We help families and friends navigate the often complex and frustrating mental health and criminal punishment system as they advocate for their loved ones inside county jails. On average we receive between 15 to 25 phone calls, letters and emails per week specifically about these populations.

As you all know, we are beyond crisis levels with over 2,300[1] individuals currently waiting in 240 county jails for a state hospital bed - many of them for upto 2 years or more. Over 600 state hospital beds are offline due to a staff shortage of over 2,000 healthcare professionals. The population of individuals with behavioral health needs is rapidly growing within our county jails. For instance, over 40% of the population in Travis county jail is designated as PSY, needing psychiatric and/behavioral health care. That number is over 50% in Tarrant county and 80% in Harris county jail. Data is either not collated or easily available for a large majority of the smaller jails.

Over 80% of the calls, emails and letters we receive from jails and families are about persons with mental illness, developmental disabilities, traumatic brain injuries, neurocognitive disorders and behavioral health needs that are unmet in the community leading to criminalization of their behaviors which arise from their illnesses. Once in jail, the challenges they face are enormous from a lack of continuity of medications to neglect and excessive use of solitary and restraints.

In our experience, three areas can be categorized as gaps in access to care arising from:

- Lack of a standardized, clear protocol between Local Mental Health Authorities (LMHAs)/Local Behavioral Health Authorities (LBHAs)/Local Intellectual Development and Disability Authorities (LIDDAs) and county jails, along with poor oversight and accountability
- Lack of protocol for information sharing between jails and families/caregivers and providers

1. IMMEDIATELY AFTER BOOKING

From the moment a person is booked into a county jail, there is a crisis in the continuity of care, especially for individuals with serious mental illness, developmental disabilities and behavioral health needs. Mandated Continuity of Care (CCQ/16.22) checks to identify current clients in the state's mental health database are supposed to help fill the gaps in continuity of care but a range of issues from lack of contracts/MoUs between Local Mental Health Authorities and county jails, to lack of data, accountability and oversight of these systems are leading to poor outcomes for these vulnerable populations who are already at a disadvantage in the jail system.

Many of the complaints we receive at TJP are concerning individuals with serious mental health and behavioral needs who are not receiving adequate care or who are being confined in solitary or restrained physically for extended lengths of time despite the extreme harm known to be caused by these practices. This month alone we received 9 phone calls from desperate family members including the family of a combat veteran, whose loved ones are in suicide watch either due to a change in medication or complete lack of access to medications and services from an LMHA/LBHA. In the past

[1]https://www.kxan.com/investigations/horrifying-wait-times-for-state-hospital-beds-official-says/

week alone, we've filed 4 complaints with the Office of the Ombudsman at the Health and Human Services Commission and referred several more cases to be filed directly by either whistleblower jail staff or families.

The gaps are even more challenging for veterans with mental health needs. The CCQ checks in the jail do not identify them if they are receiving services from Veterans Affairs which is often the case. No statewide standardized policies or procedures exist for jail staff to facilitate coordination between the LMHAs/LBHAs and the VA. Jails that do not have an existing contract/MOU with their LMHA/LBHA for services inside the jail, can reach out to the LMHAs when an individual is in crisis, but if and when there is a response, the extent of service is crisis stabilization, often through telehealth. The delays and gaps grow wider for veterans.

As per the latest Technical Assistance Memo (TA) issued by the Texas Commission on Jail Standards (TCJS)[2] on SB 49 which deals with continuity of mental health medication, the language directing jails to require a qualified medical professional to review and provide prescriptions *"as soon as possible"* is vague and problematic especially for high risk and high need individuals.

To add to the vagueness, in the same TA, TCJS further states - *"The Commission understands that this does not mean that jails must provide any medication that the prisoner was prescribed before booking but only that the jail must provide the medical and mental health medications that are determined necessary by the jails medical or mental health provider."*

We believe instead of ensuring seamless care with a clearly mandated timeline, this langauge further entrenches the issue of break in continuity leading to preventable tragedies including suicides such as that of Jared Bell[3] who committed suicide on Feb, 9, 2022 within two days of being booked into Travis county jail; Cameron Pritchett[4] who committed suicide in Washington County jail within 3 days of booking; and Brenda Worl[5] in Callahan County within 2 days of booking. These are just three of the dozens of suicides reported annually in our county jails. We provided recommendations to prevent these types of tragedies in a 2016 report titled "Preventable Tragedies: How To Reduce Mental-Health Related Deaths in Jails" authored by the University of Texas Civil Rights Law Clinic.[6]

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[2]https://www.tcjs.state.tx.us/wp-content/uploads/2022/06/TA_Memo-Continuity_of_MH_Meds.pdf
[3]https://www.austinchronicle.com/news/2022-04-01/austin-mans-suicide-in-jail-after-seeking-medical-care-raises-question-why-was-he-there/#:~:text=An%20hour%20later%2C%20the%20corrections,hours%20after%20entering%20the%20jail.
[4]https://www.kagstv.com/article/news/inmate-dies-in-washington-county-jail-texas-rangers-investigating/499-dc877858-d5ac-44cd-a254-73c7de191cd6
[5]https://www.facebook.com/dean.malone.law.firm/posts/a-woman-commits-suicide-in-callahan-county-jail-federal-lawsuit-filedfor-immedia/10159106214159921/
[6] Preventable Tragedies: How To Reduce Mental-Health Related Deaths in Jails
https://law.utexas.edu/wp-content/uploads/sites/11/2016/11/2016-11-CVRC-Preventable-Tragedies.pdf

2. WHILE AWAITING COMPETENCY EVALUATION

A majority of the jails do not have any protocol on receiving and sharing information with family members or loved ones in the case of medical emergencies or crises. As a result, while individuals are waiting to be evaluated they begin to decompensate. That decompensation is especially hazardous in cases like that of Chastity Congious[7], a young Black woman with a history of intellectual and developmental disability (IDD) who was incarcerated for over 5 months during her first pregnancy in Tarrant county jail. Despite being an LBHA/LIDDA client in the free world, she did not receive any medication in jail which led to her decompensation to the point of becoming non-verbal. Multiple attempts by her guardian and family to contact jail staff were unsuccessful. Unable to recognize signs of labor, she gave birth alone in a single cell. Her baby was discovered hours later in her pants and subsequently died after 10 days in the hospital. After all the harm was done, the DA decided to drop the original charges against her which were a result of her IDD behaviors.

One reform that could mitigate gaps in medical care due to jail staffs' lack of medical information about the individuals in custody can be corrected by TCJS if it were to use its rule making authority in directing jails to develop new protocols and management actions which would allow families to provide information about medical and psychiatric histories of their incarcerated loved one to the jail.

In particular, TCJS can mandate that jails make medical authorization forms available to both the incarcerated individual and their family, to facilitate the exchange of information in a timely manner. Currently many jails refuse to accept information from families and deny families answers to questions, all under the widespread belief that HIPPA rules prevent authorizations and access. This is a common occurrence even when family members have medical power of attorney and signed medical releases. To alleviate the situation, each jail should appoint a staff member as designated family liaison for communication around medical issues and medical releases. Harris County jail's model of an online form[8] to facilitate communication between families and their facility could be easily replicated across the state.

Kelly Masten's[9] terrible injuries in the Tarrant County Jail this past April provide a shocking example of what happens when jails have no process or staff to accept information from family members who have a thorough, detailed knowledge of the medical history of a person with a serious disability. Kelly Masten is a 38 year old woman with a rare form of epilepsy and developmental disability who is

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[7] https://prismreports.org/2022/02/16/newborn-died-texas-prison-advocates-due-to-more-than-neglect/
[8] https://harriscountyso.org/JailInfo/inmateinfoinmateQOL
[9] https://www.star-telegram.com/news/local/fort-worth/article260776142.html

currently at JPS Hospital in Fort Worth after spending 10 days confined in Tarrant county jail where she was neglected and injured despite her serious disability.[10]

Kelly's booking and incarceration is questionable, but once in jail, it was obvious that she was a person with severe disabilities and medical conditions. Her sisters, grandmother and parents have cared for her with great devotion her whole life, and they attempted–repeatedly and desperately–to convey Kelly's medical needs to the sheriff, medical staff and officers. None of the jail staff listened or took appropriate action. When they were finally able to bond her out, Kelly was rushed from the jail straight to the ICU at JPS where she was in a medically-induced coma for 6 weeks; the amount of long-term damage to her brain is unknown, and her recovery is challenging and deeply problematic.

3. POST COMPETENCY RESTORATION

The final gap in continuity of care for the forensic population that is returned to county jails from state hospitals occurs after competency restoration. Due to backlogs in the court system, these individuals often run out of their state prescribed medications which are limited to 76 days. Jails are often reluctant to continue the medication prescribed by the psychiatrists at the state hospital, where the formulary differs from the formulary at the jails and the medications cost more. A reimbursement program exists under the Forensic Office of Health and Human Services Commission, but it is largely unused by jails due to the process being cumbersome and the failure of the program to address essential lab work and blood draws. As a result, the individual will often deteriorate due to the lack of appropriate medication and becomes incompetent to stand trial again, thus creating a revolving door for this vulnerable population at considerable human and fiscal cost. Lack of/access to any meaningful data from TCJS or the LMHAs on the scale of this issue prevents us from understanding the depth of this problem. TCJS has the authority to address this issue but it's unclear at this time what steps the agency is taking to protect these most vulnerable populations within our jails and compel the jails to work with the LMHAs/LBHAs to receive the reimbursement available.

Thank you for your consideration of these critical gaps and your efforts to address them.

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[10] https://www.star-telegram.com/news/local/fort-worth/article261167007.html