U.S. Department of Justice
National Institute of Corrections

Critical Incident Response Team
SITE VISIT REPORT

TARRANT COUNTY SHERIFF'S OFFICE

Fort Worth, Texas
May 13-15, 2024

NIC
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Disclaimer

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Dr. Steven J Helfand, PsyD, CCHP and Raymond Herr, MD, NIC/Falcon Technical Assistance Providers

Introduction and Background

This report contains the observations, conclusions, and recommendations of technical assistance (TA) providers Dr. Steven Helfand and Dr. Raymond Herr of Falcon, Inc. following the review of documentation and a site visit to the Tarrant County Sheriff's Office (TCSO) and facilities of the Tarrant County Detention Bureau in Fort Worth, Texas, on May 13-15, 2024.

These observations, conclusions, and recommendations are based on the technical assistance providers' understanding of:

(1) The concerns of Sheriff Bill Waybourn; Executive Chief Deputy Charles Eckert; and other leadership staff of the Tarrant County Detention Bureau, especially those that relate to the care and custody of persons who appear to be at risk for health crises, suicide, or self-injury and/or have a mental illness at the time of their arrest and during their incarceration.
(2) Applicable standards of practice set forth by recognized professional organizations involved with the health/mental health care of incarcerated individuals.
(3) The relevant evidence-supported and best practice information available in the current literature.
(4) More than 50 combined years of experience and clinical knowledge acquired in assessing, developing, and managing the many components of jail health operations as they exist throughout the United States.

Sheriff Waybourn, Executive Chief Deputy Eckert, and their entire administrative staff are committed to operating the detention system in accordance with constitutional mandates and correctional and ethical standards. The Texas Commission on Jail Standards (TCJS) sets rules and procedures and establishes minimum standards for the construction, maintenance, and operation of county jails. The Tarrant County Detention Bureau has passed this certification every year since 1995. Consistent with Sheriff Waybourn's voiced commitment to secure an objective and transparent process review of the medical and mental health operations in the detention facilities, he worked with Chief Stephen Amos and National Programs Advisor Michael Jackson of the National Institute of Corrections (NIC) Jails Division to request this technical assistance. This assistance, made possible through the sole financial support of NIC and completed by Falcon, Inc, was defined as including:

1. A review of materials relevant to an assessment of the Tarrant County Detention Bureau's medical and mental health care programs, including intake screening documents, statistical data, procedures for incarcerated individuals to access a range of health, crisis, and ongoing

mental health services, relevant policies and procedures, staff credentials, and more listed within this report.
2. A review of relevant policies, procedures, and practices concerning the medical and mental health services provided in the Tarrant County detention facilities.
3. An assessment of the operations of the mental health provider, My Health My Resources (MHMR) of Tarrant County, as they relate to the care and custody of persons who have acute and chronic health and mental health challenges and/or who are at risk for suicide.
4. Interviews of key staff and stakeholders, including administrators, program staff, medical and mental health staff, and other contributing members of the organization and the community providers who are responsible for or otherwise invested in the administration and success of various components of the medical and mental health programs.
5. An assessment of the physical environment of the TCSO Detention Bureau, also referred to as the Tarrant County Jail (TCJ), especially as it relates to the care and treatment of persons with medical/mental health challenges.
6. Preparation and provision of an exit presentation with key officials, including Sheriff Waybourn, Executive Chief Deputy Eckert, and NIC Chief Amos, to discuss preliminary findings and recommendations.

Circumstances That Led to a Request for Technical Assistance

TCJ experienced 59 in-custody deaths, including expected and unexpected events over the past 7 years (54 of which died in hospitals). For 2023, it was reported to the TA review team that there were 9 in-custody deaths, including 1 suicide. At the time of the visit, there were 5 in-custody deaths between January 1 and May 12. As would be expected, deaths in custody often cause significant concern inside correctional facilities that experiences them, affecting most other incarcerated people and staff. It is also the TA review team's understanding that Sheriff Waybourn invited the U.S. Department of Justice in February 2024 to inspect the facility. The sheriff and his staff should be assured that this review and its recommendations will support their efforts to manage the risks of and mitigate the opportunities for death and significant injury for the individuals incarcerated in Tarrant County Jail.

TCSO Site Information

This report focuses on the TCJ. It has a capacity of approximately 5,000 incarcerated individuals and processes approximately 50,000 admissions and discharges per year. The average length of stay was reported as 144 days.

TCJ is composed of four unique facilities: Green Bay Jail, Lon Evans Corrections Center, Tarrant County Corrections (Detention) Center (TCC /Lamar), and the Belknap Facility. All of these

except the Green Bay Jail share a common campus in downtown Fort Worth. The Green Bay Jail is in north Fort Worth. Tarrant County's Mental Health Diversion Center was toured during the visit and is operated by MHMR with two TCSO deputy posts provided. At the time of the visit on May 15, 2024, there were a total of 4,034 incarcerated individuals with 3,581 in the primary facilities and an additional 453 housed temporarily at the Dalby Correctional Center in Garza County due to HVAC improvements at the TCC/Lamar. The Garza facility was not toured during the visit. The current TCSO budget for the Detention Bureau is $113 million inclusive of approximately $8 million for behavioral health care and not including the provision of medical health care services.

There are 48 male infirmary beds and 48 female infirmary beds for subacute and long-term care in the Detention Bureau plus an additional 26 COVID/DETOX/infirmary beds in the 55CD Lamar unit.

With regard to acute inpatient care, John Peter Smith (JPS) Hospital provides eight inpatient acute care beds on a locked unit.

Tablets are provided to staff for recording intake data, and tablets are available for use by incarcerated individuals for ordering commissary and requesting sick call appointments. Telehealth video visits are used for some specialty visits.

II. MEDICAL, MENTAL HEALTH, AND RELATED SERVICES

Medical care at the TCJ is provided by the local county hospital, John Peter Smith Hospital (JPS Health Network), and mental health services are provided by the local mental health authority, My Health My Resources (MHMR) of Tarrant County. The medical services provided by JPS include primary care services, nonacute infirmary-level care, detox care, dental services, dialysis, radiology, and weekly onsite specialty care, including obstetrics, orthopedics, and infectious disease. The county employs a registered nurse (RN) as a clinical liaison to the executive chief deputy at TCJ and for the judicial system.

III. SCOPE OF WORK / OVERVIEW OF TECHNICAL ASSISTANCE ACTIVITIES

Preparation and Onsite Activities

The TA review team held a virtual meeting with Sheriff Waybourn, Niki Hehn, and Glen Richardson from TCSO and Michael Jackson from NIC on April 17, 2024. This meeting focused on the recent deaths and the sheriff's interest in having an outside expert review of the medical and mental health care currently provided by JPS and MHMR for the individuals incarcerated in the jails. The meeting included document requests and discussions about the site visit agenda.

Document Review

At the time of the visit, the TA review team was provided with the requested documents. The team was able to review many of the documents with the JPS and MHMR staff, who provided additional information and answered the team's questions. The TA review team is incredibly grateful to Executive Chief Eckert and the JPS and MHMR teams for their cooperation in responding to the many document requests and for being so generous with their time during the visit.

The list of documents requested and reviewed before, during, and after the site visit to Tarrant County can be found in appendix A of this report. A summary of overall strengths and validations can be found in appendix B.

Onsite Visit

The TA review team completed three days of onsite tours and interviews on May 13-15. The first day on site began with a meeting with Executive Chief Eckert and TCSO Medical Liaison (RN) Amber Wilhite, who serves as the county's medical liaison to JPS. This meeting provided a thorough introduction to the jail, including the facilities and housing units, an overview of the incarcerated population, and an understanding of an incarcerated individual's experience in the jail from intake to discharge. On the first day, the team toured the main housing units of downtown facilities (TCC/Lamar facility, Lon Evans facility, Belknap facility) and then visited the Green Bay Jail. During the three-day visit, the team toured all jail units and met with JPS and MHMR leadership, which included Zelia Baugh, Clarence Cryer, Brytni Elliott, Dr. Aaron Shaw, and Michael Gardner in addition to the primary tour guide, Executive Chief Eckert. On the last day of the site visits, the team visited the Tarrant County Diversion Center and met with its director.

Assessment Methodology

This technical assistance was requested by Sheriff Waybourn for the purpose of securing "an objective review and assessment of Tarrant County Jail medical and mental health policies, procedures, and practices." The National Institute of Corrections agreed to fund the work of two appropriately credentialed and experienced technical resource providers to satisfy the director's

request. Dr. Steven Helfand served as the lead technical resource provider for the review of mental health and related practices in the Tarrant County Jail, and Dr. Raymond Herr was the technical resource provider for the review of medical and related practices in the Tarrant County Jail. Understanding the critical importance of collaboration in correctional health care, the TA work conducted on site and in the development of this report underscores the collaborative approach to providing this technical assistance.

The goal as technical resource providers was to gain a firm understanding of the current operations of the detention facilities; to situate its operations within a broader correctional and public health framework; to consider the fit between current operational procedures, accreditation, and contemporary standards of best practices; and to end this consultation with a report and recommendations that would further the sheriff's goal of providing safe, comprehensive, and responsive total health care to those incarcerated in the Tarrant County Jail.

Exit Interview

Prior to concluding this site visit, the team met with Sheriff Waybourn, Executive Chief Eckert, JPS and MHMR leadership, and NIC Chief Amos to provide a summary of the TA review team's initial impressions and recommendations and to provide an opportunity for all parties to ask and respond to questions related to the visit. The exit interview was also attended by several county staff, including County Administrator Chandler Merritt and County Judge Tim O'Hare.

Drafting of the Report

While there is often overlap between medical and mental health services, this report divides those services so that findings and recommendations are most clear to the parties that will be addressing them.

IV. MEDICAL AND RELATED SERVICES FINDINGS AND RECOMMENDATIONS

The findings in this section are focused on key areas that affect the delivery of medical health care within a correctional setting, including staffing, physical areas where care is delivered, and key processes that are critical to the effective provision of acute and chronic care to incarcerated populations. As noted above, the provision of health care services at Tarrant County is conducted by JPS, the local county hospital. The jail and the hospital share the same EMR system and share the same provider group. This model of using the local county hospital has numerous benefits for the incarcerated individuals and for the county. The most notable is related to improved continuity of care that this model provides as many of the incarcerated individuals receive healthcare through the county hospital system when they are in the community.

Staffing

The staffing model for the Tarrant County Detention Bureau as provided by JPS demonstrates adequate staffing levels for a facility with a population of 4,500 incarcerated individuals. Key areas of the jail such as intake, the resource clinic, and infirmaries have 24/7 RN staffing. TCJ has 24/7 provider coverage on site. As is common in all health care settings, nurse and provider vacancies exist and are more significant for security staff, which are down 196 positions out of 701. It was shared by JPS staff that the security staffing shortages have led to a limit of daily medical transports for routine off site specialty visits. At the time of the visit, the medical and mental health staff were not significantly affected by vacancies within their respective departments. There was a current vacancy for an assistant medical director, a position that includes both clinical and administrative duties.

JPS has a robust employee recruitment and retention program with numerous strategies that could be a model for other agencies. Per JPS, there are no significant delays in obtaining security clearances for individuals being offered employment.

Recommendations:

The issue of adequate staffing is complex and is one of the most challenging issues facing correctional agencies.[1] Tarrant County Detention Bureau custody officer vacancies are being addressed through hiring and retention measures, and there is currently a mandatory 52 hour/week requirement for custody officers. Due to its effect on access to care (delays in transports, specifically) for incarcerated individuals, it is critical to increase efforts to hire and retain custody staff. Improved staffing will help with staff morale and can change an all-too-common culture of simply housing incarcerated individuals, moving instead toward the goal of rehabilitating individuals who will once again rejoin their communities.

It is recommended that TCJ work with JPS on strategies to improve retention. JPS has already put in place many ideas to improve staff morale (e.g., leadership rounding and presence in the jail; an employee of the month program; a quarterly celebration and recognition events; a continuous employee feedback forum; an employee newsletter that includes work anniversaries and birthdays; and an event planning group to organize picnics and other social activities) and thus improve retention.

It is also recommended that TCJ explore ways to improve the interior spaces to reflect a more welcoming and healing environment by adding murals, art, and colors to otherwise plain wall surfaces. Furnishings in common spaces is another opportunity to improve the physical environment for all.

Intake and Initial Health Assessment

Intake is the most critical process for an incarcerated individual as it will influence the health and wellbeing of the individual during their incarceration. The TCJ has 123 bookings per day or

[1] https://nij.ojp.gov/topics/articles/workforce-issues-corrections

approximately 880 per week and 44,772 per year. During the intake process, the following occurs:

- initial health assessment
- initial risk assessment for health conditions, suicidality, and security risk
- assignment of housing according to an individual's risk
- orientation to the facilities
- sharing of information on how to access care
- initial processing for discharge and reentry into the community

At TCJ, the intake staff includes RNs and mental health staff from MHMR. Any arriving individual with emergent needs is not accepted for booking and is transported by the arresting agency to JPS hospital for evaluation and medical clearance. For individuals with chronic care needs, a referral is placed for them to be evaluated and assessed in the resource clinic by an RN and, if needed, to be seen by a provider (APP). This referral is known as the HPAS (high-priority assessment) and takes place within the first 48 hours of incarceration. Individuals without any acute medical issues and without identified chronic care needs are then classified for the appropriate housing unit and are not scheduled for any further medical assessments. Individuals who are identified as being at risk for withdrawal from "street" drugs are referred to the HPAS evaluation in the resource center.

Recommendations:

Consider adding a 10- to 14-day health assessment for all individuals incarcerated at TCJ that would address the current gap in care for those individuals who are not on medications at the time of booking and thus are not assessed by the medical staff after intake. The 10- to 14-day health assessment being done in in jails accredited by the National Commission on Correctional Health Care (NCCHC) benefits both the incarcerated individuals and the correctional facility.[2] The benefit of this assessment is a more detailed evaluation of newly incarcerated individuals that provides more subjective and objective health information beyond what is gathered by the initial health screening at intake. There is the opportunity to further educate individuals about accessing care and services within the jail, and the contact can be used to continue discharge planning for when individuals are released back to the community.

It could be argued that the HPAS resource clinic assessment would suffice for the 10- to 14-day health assessment, especially as these individuals will get regularly scheduled followup chronic care visits.

Acute Care/Sick Call

Requests for acute care are made via the sick call or kite request system at TCJ, which includes requesting care via a tablet or on a paper "kite." These requests are triaged daily by a nurse. For conditions that are not covered by the nursing care guidelines, which JPS also refers to as

[2] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, J-E-04, 2018.

standing delegation orders (SDO), a referral is placed for an individual to be seen in the resource clinic. At TCJ, the resource clinic serves the patient population as an "urgent care" clinic, which is important due to the large population at TCJ. The clinic has 24/7 RN staffing in the clinic with an APP, who is also available 24/7 in the jail. The Green Bay Jail has a similar sick call process with nurses using the SDOs for care and then sending the referrals to a provider who is on site daily.

The resource clinic at TCJ serves the population in two key ways: (1) conducting initial assessment for all patients on chronic care medications within the first 48 hours and (2) providing acute care for conditions requiring provider-level evaluations. This clinic is commendable as a best practice model for the timely care of the TCJ patient population, reducing the likelihood of delayed medication continuation for newly incarcerated individuals while also functioning as an urgent care clinic.

At the time of the visit, the TA review team was not made aware of any delays in care access for acute/sick call requests.

Recommendations:

The current set of SDOs are well written with appropriate guidance for the nursing staff; however, it is recommended that JPS leadership consider adding more guidelines/SDOs for several high-risk conditions and then providing training on the use of any new guidelines. Below are suggested new guidelines:

Chronic Care

The TCJ policy for addressing chronic care conditions begins with identification of individuals with chronic care needs at intake. These individuals are referred to the resource clinic for evaluation and orders from a provider. Per discussions with JPS leadership, the followup visits are typically scheduled after 6 months.

Recommendations:

The policy of having an individual with chronic care needs receive an additional assessment in the resource center within the first 48 hours after booking is a good and important practice. Due to the importance of starting medications without significant delays, auditing and monitoring compliance with this activity is recommended. Mitigating delays in care and continuing most chronic care medications can reduce unnecessary send outs, improve the care of this large subset

of individuals in the jail with chronic care needs, and meet the legal and ethical obligations of TCJ.

It is recommended that the time interval for provider followup of a patient with any chronic condition be 90 days or less depending on whether changes have been made to the treatment of the specific condition. Often, more frequent visits are needed for newly incarcerated individuals due to their lack of receipt of regular care in the community prior to arrest.

Infirmary Care

TCJ has two infirmaries, which have 24/7 nursing and provider staffing. There is a 24-bed male infirmary and a 24-bed female infirmary. Nursing and provider rounds are completed daily in these units. The level of care is consistent with a skilled nursing facility. Per JPS staff, typical reasons for housing in the infirmary include advanced wound care, intravenous therapy, and late-term pregnancy.

Bed availability in the two infirmaries is a frequent challenge. Administrative and clinical rounds are done daily with the site medical director to determine the ongoing need for this level of care.

Recommendations:

To address the issue of bed availability in the infirmaries, JPS and TCJ should consider creating a lower level of care unit where some of the chronic and non-acute care patients could be housed when 24/7 nursing is not needed.

Substance Use Disorder and Addiction Care

The proper care of individuals in a jail setting who have a substance use disorder is critically important. It can reduce the risk of bad outcomes; it can reduce recidivism[3] for psychiatric patients; it can reduce overall healthcare costs in the jail and in the community at large; and it is simply the standard of care for a jail.

TCJ has been providing detox care and medications for opioid use disorder for several years. The detox protocol used in TCJ by JPS staff is based on NCCHC standards.[4] The policy indicates that any individual that an RN has identified to be at risk for withdrawal is to be referred to the resource/team nurse for assessment and initiation of the appropriate withdrawal scoring protocol (the Clinical Institute Withdrawal Assessment for Alcohol [CIWA], the Clinical Opiate Withdrawal Scale [COWS], or both). The typical housing for *stable* patients being monitored for withdrawal is general population and those with more severe withdrawal symptoms as noted by either the CIWA or COWS scores (8 and above) are housed in gender-appropriate detox housing. The individuals in this housing unit are confined to their cells for 23 hours daily. It is the TA review team's opinion that this level of confinement for any individual is detrimental to their mental and physical health.

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[3] https://digitalcommons.law.scu.edu/cgi/viewcontent.cgi?article=2843&context=lawreview
[4] SDO 6006 TCJ Detox Protocol, 5/9/2024.

Individuals arriving in the jail who are currently receiving treatment in the community with buprenorphine for opioid use disorder (OUD) are eligible to continue buprenorphine while at TCJ. Pregnant incarcerated individuals with OUD are either continued on methadone if they are already receiving this in the community or induced on methadone by the local opioid treatment program clinic. Pregnant patients on methadone are housed in the infirmary.

At the time of the visit, individuals with OUD and not already receiving buprenorphine from a community MAT program were medically detoxed and monitored as noted above. The TA review team was made aware of a new TCJ vendor for MAT services, Texas Treatment Group, which will begin offering MAT, including initiation therapy, in the coming months.

Recommendations:

The TA review team encourages the use of urine drug screens at intake for all arriving individuals to better identify those at risk of withdrawal and to better select individuals for MAT care.

Given that the mental and physical stress of alcohol and illicit drug withdrawal is overwhelming even when medications are used to reduce symptoms, the physical environment in which one withdrawals, including the amount of time one spends in seclusion, can aggravate symptoms and increase suicidality.[5] The TA review team recommends that TCJ use a different housing option with more out-of-cell time and potentially family visitation to improve the stress of withdrawal for those currently being placed.

Medication Services

As noted above, pharmacy services at TCJ use automation for medication preparation/ packaging for dispensing to patients, which reduces medication errors and delays. Medication passes are offered up to four times daily; however, the majority of the medications are offered at the two main medication passes, which are at 3am and 3pm.

Data from the past 12 months was reviewed, and it was found that there is an average of 71% of the TCJ population on medications and an average of 33% of TCJ patients on 5 or more medications.

A 14-day supply of non-controlled medications is available for newly released individuals to pick up at the JPS pharmacy.

Recommendations:

Polypharmacy is a significant problem that should be addressed when present.[6] Polypharmacy often negatively affects the patient, but in a correctional setting there are added concerns related to the labor and costs associated with overprescribing. In corrections, there is also the unique

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[5] Nurse J, Woodcock P, Ormsby J. Influence of environmental factors on mental health within prisons: focus group study. BMJ. 2003 Aug 30;327(7413):480

[6] *Am Fam Physician.* 2019;100(1):32-38

issue of prescribing certain medications that can be misused as contraband.[7] Polypharmacy will likely become more problematic in corrections as correctional populations age. It is recommended that JPS providers review their prescribing practices and that clinical leadership provide additional training and oversight for the prescribers at TCJ.

Dental Services

TCJ has one full-time dentist and two hygienists. The dentist provides care at the TCC/Lamar facility three days a week and is at the Green Bay Jail two days a week. Individuals with dental needs are scheduled according to level of urgency. Patients with emergent issues are seen at the next available appointment. Patients with urgent issues are seen within two weeks and patients with non-urgent conditions are scheduled to be seen within 1-2 months.[8]

Recommendations:

None.

Mortality Review Process

The current process for review of an in-custody death includes separate reviews by the IRC (incident review committee), which is composed of JPS correctional clinical leadership and MHMR correctional leadership, and a review by custody as dictated by the Texas Commission on Jail Standards. The JPS/MHMR or IRC review of a death is completed during the IRC's weekly meeting. Custody staff do not attend these meetings.

The TA review team was able to read the minutes of the most recent IRC meeting at the time of the visit. There were no recommendations or corrective actions related to a recent death noted within this document.

Recommendations:

It is recommended that custody and IRC members meet collectively to review all in-custody deaths after each group has completed their own review. The benefit is to ensure transparency and share insights from each group to improve care and improve practices that affect both clinical and security staff.

Physical Environment

The TCJ housing units are dated and lack natural light in most areas. A former warehouse building, the Green Bay Jail had been converted to a correctional setting using large barred dormitory housing units. Unfortunately, this environment does not reinforce a culture of

[7] PLoS One. 2022 Nov 3;17(11).
[8] Data provided by Eboni Williams, RDA.

rehabilitation and humane treatment. This environment is unlikely to foster a feeling of humanity and rehabilitation.[9]

Recommendations:

It is recommended that current TCJ facilities and housing units are remodeled or replaced. Less costly improvements to the existing facilities may also be explored and completed. Where possible, it is suggested that color, murals, and art be added to the walls, especially in common areas. Consider better furnishings, art, etc. in staff areas, including workout areas for staff. Consider adding greenery/plants to staff areas. If possible, add or create outdoor areas for staff to eat and relax.

V. BEHAVIORAL HEALTH SERVICES FINDING AND RECOMMENDATIONS

Overview of Leadership and Structure

Jail-based behavioral health services are provided by MHMR staff under a contract between Tarrant County and MHMR of Tarrant County (FY 2024 Contract Between Tarrant County and MHMR of Tarrant County for Behavioral Health / Intellectual Disability Services for Inmates at the Tarrant County Jail). Contract terms are for one-year periods. The contract details the duties of both the TCSO and MHMR, including treatment space, housing units, staffing, intake screening, etc. The contract as written is comprehensive in its outline of duties and resulting policy.

MHMR is responsible for employing a director of forensic services who serves as the Responsible Mental Health Authority. Additional employees include 2 full-time employee (FTE) forensic program managers, 14.5 FTE psychiatrists and/or advance practice registered nurses/physician assistants, 2 FTE registered nurses, 1 FTE licensed forensic team leader, 24 FTE forensic case managers, 1 FTE forensic continuity of care liaison, 4 FTE forensic team leaders, 5 FTE clinical therapists, 7 FTE forensic support specialists, .10 FTE senior director, and 1 FTE forensic data management specialist. Mental health staff provide 24-hour coverage seven days per week. The use of the MHMR staff will be detailed within the staffing section of this report. The MHMR team also assists in diversion processes, often attending court proceedings and working with the district attorney's office. MHMR staff are also involved with the Mental Health (Competency) Docket and attend court for those proceedings to facilitate community-based competency restoration opportunities. It is noted that the TA review team had the opportunity to attend and observe the Mental Health (Competency) Docket proceedings. MHMR also provides the staffing and services for discharge/reentry and diversion-related services.

[9] https://cdn.penalreform.org/wp-content/uploads/2017/06/Prisons-and-the-mentally-ill-%E2%80%93-why-design-matters.pdf

Scope of Review

This review addresses the most salient mental health processes and key areas of focus that cut across several jail standards for mental health care including the NCCHC Standards for Health Services in Jails, 2018 and the NCCHC Standards for Mental Health Services in Correctional Facilities, 2015. This report section is intended to augment the concurrent reviews of the medical services.

Key Areas of Focus

Responsible Mental Health Authority

MHMR leadership (director of forensic services) reported that they have autonomy in decision making related to assessment and treatment. They reported that they often consult with JPS staff at the TCJ related to individuals with comorbid medical and behavioral health issues.

Although this two-provider dynamic (MHMR and JPS) is not completely uncommon in a system where the local mental health authority or other behavioral health community provider group provides some services to the jail, it does require establishment and maintenance of a coordinated communication strategy. The contract between TCSO and MHMR notes that MHMR functions in the capacity of an independent contractor and details a myriad of duties for MHMR that establishes it as the Responsible Mental Health Authority with autonomy in behavioral health clinical decision making.

Recommendations:

It is recommended that standing meetings at all levels between MHMR and JPS be strengthened or established and adhered to as a means of addressing individual cases of concern and coordinating approaches to processes such as suicide watch and reduced food intake.

The TA review team also recommends a brief (e.g., 10-minute) multidisciplinary huddle each day before a whiteboard or equivalent review tool in a private location. Attendees should include the medical director, mental health leadership, and others on duty to address current patients of concern and other practice issues.

Policy and Procedure

The MHMR policy and procedure manual, which was reviewed. The 18 policies it contains are adequately developed and appear to address each applicable standard issued by the TCJS. The policies are relatively site specific. All policies reviewed are clear, concise, thorough, and thoughtful to address each matter. There is also a gap between policy language, such as "direct care triage" and "suicide watch," with actual practice not using the same nomenclature. It is not clear from the document how often they are reviewed. Although the TCSO has not pursued NCCHC accreditation, the policies reviewed include elements of NCCHC standards. The industry generally accepts NCCHC standards as the prevailing framework for correctional health and mental health care.

Recommendations:

As the reviewed policies incorporate only some aspects of NCCHC standards, it is recommended that the next revision begin to formally incorporate more specific NCCHC compliance indicators into existing policy and that other policies are added to the procedure manual to address essential aspects of correctional mental health care. It is also recommended that the MHMR Manual includes evidence of annual review and revisions within the document. It is further recommended that MHMR align the language of the policies with the language used by staff through trainings across mental health, medical, and TCSO staff.

Patient Privacy

MHMR forensic case managers, therapists, and psychiatric providers deliver the majority of their one-to-one services at an incarcerated individual's cell side as opposed to in a private setting outside of the cell. While there is not an MHMR policy that addresses procedures for ensuring the privacy of services whenever safe and possible, the Contract Between Tarrant County and MHMR of Tarrant County for Behavioral Health / Intellectual Disability Services for Inmates at the Tarrant County Jail details duties of the sheriff to provide:

- Four provider interview rooms for the My Health My Resources of Tarrant County (MHMRTC) providers in the medical unit and one provider interview room at the Green Bay Jail.
- Eight interview rooms for the use of MHMRTC personnel; four interview rooms in Tarrant County Corrections Center one interview room in the Belknap facility; two interview rooms in the Green Bay Jail and one room in the Cold Springs facility, if necessary.
    - Detention officer for supervision during psychiatric and nursing interviews.

These requirements contemplate that mental health services provide privacy of care and out-of-cell treatments. The contract also requires MHMR to provide in-person visits from a qualified mental health professional (QMHP) to each single-cell incarcerated individual housed in "MHMR Observation Housing." It is the TA review team's opinion that in-person visits by QMHPs require a level of privacy that is ideally provided by seeing an individual outside of their cell or open housing pod (e.g., Green Bay Jail). There is an operating procedure that does not regularly use the above areas of other private spaces. Unfortunately, this default approach does not allow for full adherence to standards (NCCHC J-A-07)[10] and does not reflect use of spaces required by the contract.

Recommendations:

It is recommended that MHMR establish a policy on privacy of care requiring that "clinical encounters shall occur in private, without being observed or overheard." It is further recommended that this issue is addressed by an ongoing multidisciplinary leadership committee, that training is provided to MHMR and TCSO officer staff, and that this is monitored and

[10] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018

addressed through the continuous quality improvement (CQI) process so that all efforts are made to adhere to the policy safely.

Health Records

Given that behavioral health services are provided by MHMR and medical services are provided by JPS, it is challenging for all medical and mental health staff to have adequate access to each other's electronic health records system, including two-way access with the general health record. MHMR psychiatric staff use while all other MHMR staff use MHMR leadership reported that they have access to however, a full review of a mental health record currently requires separately reviewing each system. This made the TA review team's reviews difficult to conduct, making it hard to obtain a full picture of mental health care.

Recommendations:

It is recommended that a policy be developed to specifically address this requirement to ensure adherence to NCCHC J-A-08[11] and NCCHC MH-H-02[12] so that pertinent information is readily accessible and retrievable by both medical and mental health (JPS and MHMR) personnel to facilitate continuity of care. It is optimally recommended that MHMR jail-based staff use directly or that an interface is built between and to ensure access to an automatic and real time integrated record.

Intake Process and Receiving Screening

The TA review team observed entry into detention at TCCC in the booking area through the TCSO processing areas, medical and mental health areas, and housing. It is noted here that admitted individuals are not dropped off directly by the police departments. Rather, the TCSO staff picks up individuals from the 54 police municipalities across the county. During the TCSO booking process, a TCSO officer conducts a Texas Continuity of Care Query and notes whether the individual has a history of receiving mental health services from state-funded mental health and intellectual disability programs.

After being booked into the facility, the admitted individual is screened (which includes pregnancy testing for females and TB testing for all individuals) by JPS staff (RN) and, if referred by detention and/or JPS staff, also screened by MHMR staff (forensic case manager). The mental health screening includes the Columbia-Suicide Severity Rating Scale (C-SSRS) as well as a query of the and Client Assignment Registration System databases to obtain history of mental health diagnosis, hospitalizations, or medications. The individual then goes for fingerprinting and photographs and finally classification, which considers the medical and mental health issues that were identified. If indicated, individuals may then be placed in withdrawal observation cells. Individuals remain at TCCC (initial jail) for eight to ten days to address possible withdrawal concerns and then may be transferred to facilities such as the Green

[11] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018
[12] The National Commission on Correctional Health Care (NCCHC) Standards for Mental Health Services in Correctional Facilities, 2015

Bay Jail. Based on these practices, there is evidence that the receiving section screenings are conducted in a timely and adequate manner and that referrals are promptly communicated to mental health staff in accordance with NCCHC standard of care J-E-02[13].

Recommendations:

None.

Mental Health Screening and Assessment

Mental health assessments are conducted upon referral from the TCSO staff or nurse at intake. In these instances, mental health assessments appear to be completed in a timely manner (a maximum of four hours within booking and a maximum of eight hours for those already housed) by MHMR. The query of the and databases supports robust continuity of care practices as does MHMR's use of two registered nurses to verify active medications reported or otherwise identified during the intake assessment. When the assessment is completed within booking, the assessment culminates in a disposition that includes the following options: No intervention currently needed, Routine, Urgent, and Emergency. The assessment also results in housing recommendations as follows:

- Special Precaution Cell Status
- Single Cell Status
- House Per Jail Standards
- Male Mental Health Housing

While the mental health assessment completed by MHMR staff for individuals who are referred is comprehensive, it does not seem to be the case that an adequate mental health assessment is conducted for all admitted individuals within 14 days. The current query and referral practices result in approximately 80% of all individuals being referred.

Recommendations:

It is recommended that the director of forensic mental health review the 14-day screening and evaluation requirements to ensure that all elements of the NCCHC standard for mental health screening and evaluation (J-E-05)[14] are incorporated into the receiving section's screening, 14-day history, and physical examination or other mental health assessment. It is also recommended that MHMR expand its disposition options. Disposition option examples might include "General population with no treatment indicated at this time," "General population with referral to therapy and/or psychiatric services," "Mental Health Housing," "Non-acute suicide watch," and "Constant observation suicide watch." Staff training on this matter is strongly recommended as well.

[13] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018
[14] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018

Suicide Prevention and Intervention

This section details a broad range of suicide prevention issues that may cut across other domains. A suicide prevention program is a key NCCHC standard (J-B-05)[15] and required area of focus for a jail given that rates of suicide in jails are approximately three times that of the community. While there are policies and practices in place at the jail across mental health, medical, and custody, there are several notable shortcomings marked by inadequate observation levels and the conditions of reassessment. The TCSO leadership staff informed the TA review team that there have been four suicide deaths within the past three years. The most recent suicide occurred when an individual housed in a two-person cell attempted suicide after the cellmate walked out of the cell. TCSO has data that reflects that they have intervened to prevent suicides or serious self-injury in 279 instances in 2023.

Identification

The process for placing an incarcerated individual/patient on a status to prevent suicide is adequate with all levels of staff able to do so. The notification of the MHMR mental health staff and the multiple pathways for doing so is also adequate. However, a status called suicide watch does not exist; rather, individuals are placed on a special precaution status. has three levels of observation, including 1:1 observation, 10-minute observation, and 30-minute (standard) observation. TCJ policy states that 1:1 observation and 10-minute observation be used with individuals on While the MHMR policy for Special Management Area Criteria uses the term "suicide watch," neither the TCSO staff nor the MHMR staff whom the TA review team spoke with used that term at all. MHMR categorizes patients into the categories of "emergency," "urgent," or "routine." While these categorizations drive the staff type and timeliness of followup, they do not denote the minimum level of observation or the need for an individualized level of observation for each category.

Monitoring

The prevailing best practice and standards, including NCCHC J-B-05,[16] require procedures for monitoring an incarcerated individual identified as potentially suicidal. Acutely suicidal individuals are to be placed on constant observation, which involves continuous monitoring by staff. Non-acutely suicidal individuals are to be monitored on an unpredictable (staggered) schedule with no more than 15 minutes between checks. The three levels of observation noted in the section titled Identification do not appear in MHMR policies, including the policies for Special Management Area Criteria and Special Precautions Cell Tracker. Staff also did not seem to be aware of the three levels of potential observation. In practice, acutely suicidal patients/incarcerated individuals are not typically observed under constant observation; rather, they are observed every 15 minutes. For those assessed as non-acute, the observation frequency is either 10 or 30 minutes. TCJ uses an electronic system (to record the 1:1

[15] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018
[16] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018

monitoring. observation logs were not made available to the TA team for review. While some individuals had logs taped to their cell doors, this reflects a monitoring practice for when individuals are off the unit. The TA review team was informed that such sheets are used for convenience when an individual leaves the unit. Based on discussions with TCSO and MHMR staff, the TA review team infers that the use of 1:1 or constant observation is rare. These practices do not meet the NCCHC standards with regard to monitoring. Finally, it was observed by the TA review team that individuals on status are all placed in suicide prevention gowns with suicide prevention blankets and do not have personal clothing. Such individuals are also restricted to their cells for 23 of 24 hours a day. While this practice may ultimately keep individuals from death by suicide, they are overly restrictive in the name of safety for patients that policy describes as "presenting with mental health symptoms or behaviors that are not suitable for general population."

Evaluation and Followup

While the initial evaluation process appears adequate, the timelines for evaluation and followup assessments for continued suicide risk is lacking and can be enhanced. The MHMR policy for direct care triage notes that patients who score a 6 or higher on the C-SSRS will be scheduled to be seen by a mental health provider within three to four days. The TA review team notes that a score of 6 to 10 is considered moderate risk and that this timeframe does not adequately respond to the risk. While the same policy notes that patients who receive a score of 10 or higher on the C-SSRS should be housed on suicide special precautions regardless of denial of suicide ideation, the TA review team notes that a score of 10 to 15 is considered moderate/severe risk and the policy should include an immediate and expanded assessment in addition to the housing placement.

The followup practices for those on related to suicide concerns has solid practices amidst some shortcomings. A positive practice is that patients on must be seen based on their assessed level of "emergency," "urgent," or "routine." Patients maintained on urgent or emergency suicide status are seen daily by assigned staff. However, all patients on suicidal status are seen at least weekly per policy by the assigned prescriber (psychiatrist or APRN/PA) and it is only the prescriber who can remove a patient from status. In practice, the prescriber tends to see the patient every three days in line with a departmental goal that exceeds the policy. This practice may not allow for the most timely stepdown from the aforementioned restrictive housing conditions of

With regard to privacy of care, while reassessment is completed daily by a qualified mental health professional, the TA review team's observations and interviews noted that MHMR staff do not typically reassess incarcerated individuals outside of their cells. This does not lend itself to an open and full opportunity to spend optimal time understanding risk and protective factors. Once status is discontinued, there is a process for scheduling a two-day followup visit for the patient with MHMR staff. Per policy, the two-day followup focuses on the patient's ability to transition from suicide precautions to a new housing unit safely and successfully. Followup is a feature of best practices and standards, though this single followup may be expanded on.

Recommendations:

- The TA review team recommends a formal suicide watch status within the existing statuses.
- Provide readily available access and constant observation (otherwise referred to as one-on-one) for those deemed to be acutely suicidal.
- To meet standards (NCCHC standard J-B-05), ensure that the practices for "Suicide Observation" include staggered observation for those deemed as non-acutely suicidal.
- Those on a watch should be treated and reevaluated by mental health staff in a private setting for an amount of time commensurate with a full reassessment for suicide risk.
- Add frequency of observation (e.g., constant, staggered 15 minutes) to the categories of "emergency," "urgent," or "routine."
- With 14.5 FTE of psychiatric staff, it is recommended that psychiatric staff see each patient on suicide watch daily rather than every three to seven days to facilitate clinical assessment and timely step down as indicated. Alternatively, MHMR can reconsider having the clinical therapists be able to discontinue suicide watch (which is in line with MHMR's past practices.
- Expand suicide watch discontinuation followup protocol to include additional followups in addition to the existing two-day follow-up. This might include a protocol cover the first day, second day, fifth day, and tenth day to be enhanced as clinically necessary.
- Ensure that individuals with C-SSRS scores of 6 to 10 are further evaluated the same day. Revise policies to include all of the above.

Access to Care

The review team was not made aware of any significant backlogs for individuals seeking mental health services, although this area should be continually monitored through the continuous quality improvement program.

MHMR uses a live time referral tracking system. This empowers officers to make referrals and is continually updated to note the time elapsed between each referral. The tracking system notes the referring party, the assigned housing unit, and a description of the concerns. A review of the logs reveals a wide range of referral concerns that goes well beyond disruptive behavior. Examples include referrals based on a positive continuity of care query, wanting to speak with mental health staff, feelings of anxiety, observation of odd behavior (e.g., talking to oneself), cellmate concerns about unkemptness, crying (without suicidal ideation), panic attack, hearing voices, and depression. The TA review team commends this live time system and the culture that is responsive to a range of internalizing and externalizing symptoms. There is also a self-referral system called Telmates that is an application available on the tablets that patients use to request MHMR services without officer intervention. Telmates requests are reviewed daily during all MHMR shifts. Individuals housed at Lon Evans who do not have access to tablets are able to request a paper "kite" that correctional staff then provide to MHMR staff.

The MHMR service also has an organized a grievance response process. Within 24 hours, individuals receive responses to their concerns robust and a detailed proposal is created to

communicate a plan and followup with the individual. This approach reflects a compassionate and patient-centered approach to addressing mental health concerns about processes or delays in care or competency-related actions. The multiple and timely pathways for access to care well exceed national standards such as NCCHC J-A-01[17] and comparable detention systems.

Recommendations:

While the TA review team was not made aware of any backlogs for individuals seeking mental health services, this area should be continually monitored through the continuous quality improvement program.

Jail-Based Mental Health Services

There is evidence that many mental health service types are available in accordance with prevailing standards (NCCHC J-F-03)[18] and (NCCHC MH-G-02)[19] for mental health services. The MHMR staff provide comprehensive hours across all days of the week and have processes for identification and referral of those with mental health needs, crisis intervention services, psychiatric/medication services, and residential unit-based service.

There are no true caseloads in place for individual services that are driven by individual patient needs. Rather, clinical therapists are assigned to places of "high intensity," which includes 2 FTEs for each of housing units, 2 FTEs for Lon Evans, and 1 FTE for the infirmary at Lon Evans. With the exception of and related mental health housing units, the facilities are devoid of mental health programs such as group interventions other than for substance use. In contrast to individuals on single-cell or status, individuals in the mental health housing units are out of cell approximately every other hour for much of the waking day.

The provision of adequate mental health services goes beyond specialized units and includes the provision of an outpatient level of care as clinically indicated to those within the general population. This would include planned followup for therapy (counseling) in addition to or as an alternative to psychiatric services. With over 1,540 patients receiving psychotropic medication, that group and others could benefit from ongoing therapy services. While MHMR is heavily staffed, the five therapist positions could be expanded through the conversion of some forensic case manager positions to meet those needs. It is also noted that the psychiatric component is strong with 14.5 FTEs, rapid access to psychiatric evaluations and followup, access to a full and relatively unrestricted range of psychotropic medications, and a judicial process available to consider compelled medication for those who meet the criteria.

Recommendations:

It is recommended that patients with outpatient needs in the general population are identified and placed on an outpatient or special needs caseload to receive therapy services beyond case

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[17] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018
[18] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018
[19] The National Commission on Correctional Health Care (NCCHC) Standards for Mental Health Services in Correctional Facilities, 2015

management in addition to or in lieu of psychiatric services. It is recommended that this is based on individual needs rather than just the location a patient is housed on. To accomplish this, it is recommended that additional therapists are added and forensic case managers commensurately decreased to achieve the best balance for providing therapy services. It is also recommended that group therapy services are added on the mental health housing units and added as a service for those within the general population.

Segregated Individuals

MHMR does not have a policy related to individuals within a segregated setting. For those on this status, primarily at the Lon Evans Correctional Center, it appears that MHMR practice is partially in line with NCCHC standards (J-G-02) for segregated individuals[20] regarding the need for mental health rounds to occur at least once per week. There was also no evidence that mental health services participates in the disciplinary process to identify those with contraindications to such placement. It is important to ensure that mental health staff are involved with documentation both in basic rounds and the disciplinary process to satisfy prevailing standards such as NCCHC J-G-02. In addition to segregation housing for disciplinary or classification reasons, MHMR must also be mindful of others within restrictive housing environments regardless of what those settings are referred to. Earlier in this report it was noted that those on for suicide concerns or other mental health reasons appear to experience extreme periods of lockdown and have limited access to personal items. Similarly, MHMR designates many patients as single cell based on their low functioning due to a mental health or intellectual/developmental issue. The MHMR leadership informed the TA review team that 45% to 55% of all single cell housing is driven by MHMR clinical decision making, while the remainder is due to security concerns (e.g., administrative segregation). In practice, all individuals in single-cell placements are confined to the cell for 23 of 24 hours. While these practices may be well intended to provide safety, the single cell experience is restrictive although it meets criteria for a segregated setting. MHMR leadership noted that many single cell patients do not want to leave the unit or status. The TA review team discussed the need to make decisions that are most clinically appropriate and include a consideration of the effect of such a restrictive setting.

Recommendations:

It is recommended that mental health staff conduct rounds once per week for all segregated individuals, including those who are separated from others and not out of cell for greater than one hour per day. This would include those placed on a single cell status who are within the cell for more than 22 hours per day as well as those on a detoxification protocol until such time that those conditions of confinement practices are changed. It is also strongly recommended that the culture of recommending single cell status is revisited such that the number of those placed in single cells is reduced and/or the conditions of confinement, including increased out-of-cell time, meaningful programming and treatment, and access to personal items is improved. It is also

[20] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018

recommended that tablets are used for those in single cell status to provide in-cell, evidence-based programming.

Reentry / Competency Restoration

The reentry process is well developed given MHMR's community experience and reach throughout the county, resulting in the potential for optimizing continuity of care both upon entry to the jail and upon discharge. There are several MHMR staff members allocated to reentry who assist with housing placement. A 30-day supply of psychotropic medication is provided upon release from custody within 24 hours through a local pharmacy of the patient's choosing. These practices meet and likely exceed most national standards such as NCCHC J-E-10[21].

While not reentry, there are also are progressive practices in place at TCSO, including the county mental health (competency) docket that helps facilitate transfer of individuals to the state hospital for restoration to competency. There is also an active and well-coordinated jail-based competency program in place with approximately 32 patients receiving services at the time of the site visit. A review of data reflects that for the period of September 2023 through February 2024, 123 patients entered the program with 37 being restored to competency and others having their case dismissed or a reduction of their time spent in a single cell or in detention.

Most often related to competency restoration, there is a petition process for civil court forced medications. At the time of the TA review team's site visit, there were approximately 26 individuals with orders for forced medications with approximately 3 petitions filed per week.

Of note is that at the time of the site visit there were 37 individuals identified with intellectual or developmental disorders. While there are processes for coordinated release and arrangements for housing, those dispositions are difficult to achieve. The MHMR policy for Monitoring Individuals with Cognitive Need is strong on verification of status, monitoring, and facilitation of competency evaluations; however, the timeliness of placements to either the state hospital, state-supported living center, or disability services in the community is poor.

At the time of the site visit, there were approximately 125 individuals awaiting transfer to the state hospital. This reflects that close to 3% of all incarcerated individuals within the TCSO jails are incompetent to stand trial. Despite the well-functioning competency docket and jail-based restoration program, this volume of individuals can take a toll on the system and draw resources away from others who could benefit from treatment and increased out-of-cell time. Most of those waiting wait for close to a year, with those in maximum-security housing waiting an average of over 15 months.

The jail-based competency program is well monitored through a comprehensive quality improvement process that includes a detailed clinical record review to evaluate the application of eligibility criteria, adherence to timeframes (e.g., intake completed within 72 hours of the court

[21] The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, 2018

order, treatment plan development within 5 days of program admission), and documentation requirements.

MHMR is proactive with addressing the waiting list for state hospital transfers and was proactively involved in the establishment of the Mental Health Docket Established with the Magistrate Judge and the District Attorney. MHMR has also established a competency-focused treatment team led by an MHMR psychiatrist, who participates in and drives a weekly compelled medication hearing with the probate court and works with the district attorney's office to recommend and develop alternative dispositions, such as outpatient competency restoration and the dropping of charges with discharge.

Since its inception, the jail-based competency solutions have resulted in 901 individuals either receiving a dismissal or experiencing fewer days of waiting to begin their court proceedings. The jail-based restoration has saved a measurable number of days in custody or within a hospital, with jail-based competency taking an average of 48 days versus over a year within the state hospital. These initiatives year over year have reduced the state hospital waitlist from 193 (April 27, 2023) to 101 (May 2, 2024). MHMR's analysis of the outcome and trends is detailed and well presented to demonstrate the success of this innovation and collaboration with stakeholders.

Recommendations:

TCSO should continue to expand jail-based competency restoration services to reduce the number of those awaiting transfer to the state hospital. The restoration data is compelling and should be used to expand the program and have additional judicial resources allocated. It is also recommended that TCSO and MHMR work with local and state stakeholders, including Texas Health and Human Services and TCJS to increase the capacity for alternative housing for those with intellectual and developmental disabilities. While providing a 30-day prescription is proactive, it is recommended that a dispensing solution with childproof packaging from the jail is implemented so that discharged individuals without means to travel to a pharmacy can continue their medications in a timely manner.

Diversion

MHMR has initiated several grant-funded programs, including a navigator program that uses diversion navigators. The purpose of the diversion program is to identify those individuals who could benefit from treatment and wrap-around service in the community in lieu of staying in jail. In fiscal year 2024, MHMR identified 1,443 potential people to be served by facilitating entry into several community diversion programs, including the Jail Diversion Center in the Fairmount neighborhood, Enhanced Mental Health Services, Forensic Assertive Community Treatment, and other court-based programs.

MHMR has also initiated and operated an Enhanced Mental Health Services Docket program that works to find alternatives to detention for those with mental illness or co-occurring psychiatric and substance use disorder, a history of 2-4 arrests, and a current misdemeanor charge.

Grant funding is also used for the Jail-Based Competency Restoration program described within this report. All grants are through the Texas Department of Health and Human Services Mental Health Grants for Justice-Involved Individuals.

The Mental Health Diversion Center was toured, although it was not a focus of the current evaluation. It is included in this report, however, as it reflects progressive and coordinated practices across multiple stakeholders. The Diversion Center serves primarily as a post-arrest diversion opportunity with a dismissal of charges for persons meeting all of the following criteria:

- Adults (18 and older)
- Brought in by law enforcement
- Believed to have a mental health issue
- Medically stable
- Non-violent misdemeanor

The services provided at the Diversion Center include:

- Assistance with primary resources (food stamps, Medicaid, medications, identification, birth certificate, post office box, etc.)
- Transfer to crisis respite programs
- Drug treatment transfer
- Transitional housing
- Group homes

From January 21, 2024, to the time of the site visit, approximately 278 individuals have been admitted. The Diversion Center also functions as a deflection center with well under 50% of those admitted coming directly from a police department before ever entering the jail. There are educational efforts underway by the director of the Diversion Center with the 54 county municipalities and their police departments to increase direct admissions. Barriers remain that many jurisdictions have a long drive across the county, and some are concerned about the risk of bad outcomes secondary to not arresting individuals for non-violent misdemeanors, such as trespassing or loitering.

Recommendations:

It is recommend that the Diversion Center continues efforts to increase direct deflection services through meetings and workshops with the police departments and stakeholders from the municipalities that do not currently use the Diversion Center.

Staffing

Current mental health staffing levels allow for a variety of mental health services to be conducted that meet the needs of incarcerated individuals/patients, although the following should be noted:

- Staffing is provided through both the jail contract between TCSO and MHMR as well as what is referred to as forensic jail grant-funded MHMR personnel.

- The jail-based staffing through the contract between TCSO and MHMR includes:
    - 1.0 FTE Director of Forensic Services
    - 2.0 FTE Forensic Program Managers
    - 14.5 FTE Psychiatrists and/or APRN/PA
    - 2.0 FTE Registered Nurses
    - 1.0 FTE Forensic Team Leader
    - 24.0 FTE Forensic Case Managers
    - 1.0 FTE Continuity of Care Liaison
    - 4.0 FTE Forensic Team Leaders
    - 5.0 FTE Clinical Therapists
    - 7.0 FTE Forensic Support Specialists
    - .10 FTE Senior Director
    - 1.0 FTE Forensic Data Management Specialist

The jail-based staffing through the contract between TCSO and MHMR reflects overall high staffing levels as compared to other jails. For instance, the 14.5 psychiatry staff results in provider-to-patient ratios that are much lower than the community and correctional settings, which allow for more frequent contacts. The scope of positions reflects an emphasis on jail-based assessment, intervention, and treatment services as well as an emphasis on continuity of care when entering the detention bureau and reentry services for those preparing to return to the community. It is the TA review team's assessment that these staffing levels allow for the identification and treatment of those within the jail settings, although the staffing would benefit from a rebalancing to ensure therapy services for more individuals.

- The forensic jail grant-funded staffing includes:
    - 1.0 FTE Jail-Based Competency Restoration Team Leader
    - 6.0 FTE Competency Case Managers
    - 1.0 FTE Clinical Therapists
    - 1.0 FTE Psychiatrists
    - 1.0 FTE Jail Diversion Team Leader
    - 4.0 FTE Diversion Navigators
    - 1.0 FTE Clinical Therapist

The forensic jail grant-funded staffing reflects a commitment to pursuing best practices related to competency and diversion by applying for and staffing the programs. It is the TA review team's assessment that the implementation of these programs through diverse staffing is resoundingly effective at reducing or preventing time spent in the Tarrant County jails while facilitating treatment and community supports. There is also the pending addition of 1.5 FTE clinical therapists secondary to a recent grant award for justice-involved individuals.

Recommendations:

It is recommended that the 5.0 FTE clinical therapists are increased to be able to provide therapy services to identified mental health patients based on an individualized treatment plan. This may be accomplished in a cost-neutral manner by reducing the number of forensic case managers.

Staffing levels and the balance of staffing types should be continually reassessed after establishing and increasing the overall clinical therapist caseload to include general population individuals with clinical needs.

INTERVIEWS (Mental Health)

The TA review team interviewed the MHMR leadership (director of forensic services) and spoke with several staff members during facility tours. While MHMR staff are clearly dedicated and passionate about the services they provide, there are opportunities for improvements in the scope and scale of activities provided. For instance, group counseling should be introduced beyond substance use populations for both those in mental health housing and within the general population. As noted earlier in the report and discussed with staff is that there seems to be an understanding that individual therapy can be expanded. Similarly, a true schedule of programming on the mental health and related units would be beneficial. The other area for improvement based on the interviews is that MHMR staff seem to operate within the perceived limits of custody operations. One interviewee stated that the lack of privacy and seeing patients through the cell door doesn't seem like an issue because "we have to balance safety."

Recommendations:

It is recommended that MHMR develop or resume more of an advocacy role for promoting policies and providing trainings that prioritize a range of clinical interventions (e.g., out-of-cell sessions) that are driven by ideal clinical practices and standards and conducted in a safe manner in coordination with TCSO. The TA review team is hopeful that this report can serve as a springboard to renew those efforts.

CHART REVIEWS

Five health records were reviewed, including those on watch, those recently on watch for suicide, those housed on the mental health unit, and those in the general population. The chart reviews were primarily through with some additional information gathered on the same patients through which made the reviews less than straightforward. Those findings have been incorporated into this report.

VI. ADDITIONAL STRENGTHS AND VALIDATIONS (BEHAVIORAL HEALTH)

The TA review team isolated the following validations:

- Pretrial staff are successful in their recommendations to courts to facilitate diversion and to assist with maintaining employment and housing.
- There is a strong emphasis on diversion and reentry.
- There is an electronic referral system and a timeliness of response.
  There is use of the infirmary and Belknap facility for resulting in less restrictive conditions of confinement.

In addition, the team found the following strengths:

- Mental Health Staffing Levels
- Joint Meetings / Care Coordination between MHMR, JPS, and Detention Staff
- Diversion Center
- Competency Restoration docket
- Compelled medication docket
  Efforts / Innovation, patience with and support to the population with intellectual and developmental disabilities

VII. CONCLUSIONS AND NEXT STEPS

The TCSO-affiliated JPS and MHMR staff are progressive and serious about improving their services and embracing best practices to meet and exceed prevailing standards of care. As noted throughout the report, several practices meet and may even exceed national standards of care. The facilities were all quite clean as compared to the vast experience of the TA review team in assessing jail settings. Requesting and expediting this review so shortly after three deaths in custody and facilitating the access, openness, and candor that was exhibited during this process reflects leadership within TCSO and a system that seeks to treat incarcerated individuals as well as possible. On the medical side, high and diverse staffing levels allow for timely assessment and chronic care management supplemented with progressive onsite practices that include dialysis, radiology, and weekly specialty care, including obstetrics, orthopedics, and infectious disease. The biggest challenge will be to continue to maintain full staffing with individuals who are cleared to work within the detention bureau and can execute on the mission to provide compassionate care to the populations at TCSO. The tools are in place with solid partners of JPS, Maxor, and an excellent EMR system. The TA review team encourages JPS to review and update the SDOs and the mortality review process. JPS is also encouraged to ensure that all new arrivals get a full health assessment by day 14 of their stay at the jail.

On the mental health side, there has been tangible progress over the past two years to reduce the state hospital transfer list through innovative and coordinated competency restoration programs, the establishment of teams, and the pursuit and attainment of grants to assist with competency and diversion. Generally, the custody, medical, and mental health teams do a solid job of meeting the needs of incarcerated individuals within a high-volume setting. A key set of best practices relates to continuity of care practices upon admission and release. Notwithstanding those practices, there are some deficiencies and areas for improvement that have been identified to improve the delivery of medical, dental, and mental health care; the incarcerated individuals and staff experiences; and resulting outcomes. While staffing levels are generally adequate, there are opportunities to improve interdepartmental (e.g., medical, nursing, mental health) communications and to enhance and expand some services to achieve efficiencies. This will involve continued training and open communication to achieve buy in and to facilitate optimal performance and accountability.

Also on the mental health side, there are opportunities to add privacy as a tool and to make it in line with standards to more adequately assess and treat at-risk populations. There are also opportunities to enhance treatment modalities by expanding individual therapy services to meet the needs of the approximately 1,500 identified patients and to introduce group therapies for those identified with mental health needs in single cell, and general population settings. It is also recommended that in-cell evidence-based programming be provided through tablets.

The greatest concern and area for improvement is related to the restrictive conditions of confinement for those identified as having significant assessment and treatment needs, such as those at risk for suicide, those detoxing, and those on a mental health recommended single-cell status. They experience confinement for 23 of 24 hours per day and may have further restrictions to accessing some personal items. Appropriate changes would involve formalizing levels of suicide watch (constant observation and staggered observation) that do not simply restrict an individual to a cell and limit items that would provide opportunities to improve one's mental health, reduce distress, and allow interactions with others, including more private reassessment and treatment settings. Reduction in the single-cell status and culture would allow for more opportunities for normalization and treatment.

Suicide watch should not simply be a place with cell-side contacts by staff, but rather it should be an environment where there is timely treatment and daily reassessment of the status. Improvements with this population would include the provision of more meaningful interactions for patients in assessment, individual counseling, group counseling, and suicide watch observation practices.

In conclusion, one area worth noting is that while clearly interested in providing care to their patients, the medical and mental health staff appear to be accepting of traditional correctional practices and barriers to ideal care environments, resulting in limitations to access. They may accept those barriers as they may not feel able to continually advocate for accommodations to meet policy and/or standards. The TA review team's overarching recommendation is to connect the TCSO and medical/mental health cultures to empower clinical staff and to achieve synergy for optimal patient care.

The TA review team thanks TCSO and NIC for the opportunity to conduct this review, and it remains available for further discussion. While this technical assistance was partially a response by TCSO to recent deaths, it allowed for a comprehensive evaluation of many aspects of care. This report will be presented to TCSO leadership in conjunction with NIC leadership to review and clarify details and to address any potential next steps.

APPENDIX A: DOCUMENTS AND DATA REVIEWED

The TA review team reviewed the following documents and data during the site visit:

- Organizational Chart of JPS
- JPS Staffing Plan
- JPS Recruitment and Retention Strategies
- JPS data on substance use disorder in TCJ
- JPS Emergency Department transport data from TCJ
- JPS Pharmacy Utilization Reports
- JPS Vendor MOUs
- JPS Medical Intake form
- List of in custody deaths in TCJ for 2023 and 2024
- JPS Nursing Standing Delegation Orders
- Anaphylactic Shock
- Blood Pressure Monitoring
- Chest Pain, Constipation
- Detox Protocol
- Diabetes (Hypoglycemia, Hyperglycemia)
- Head and Body Lice, Heartburn/Dyspepsia
- Minor Trauma and Minor Pain
- Pregnant Patients
- Seizures
- Urinary Tract Infection
- Wound Treatment
- Mild Allergic Reaction
- Tuberculosis Screening
- Narcan Use, Patients Age 65+
- Urine Drug Screen for Patients on Buprenorphine
- High Calorie Diet
- JPS Clinical Policies:
- Blood Alcohol Drug or Toxicology Testing Requested by Law Enforcement
- Dr. Heart Response Team policy (highest level of medical response for clinical emergencies)
- Emergency Transfers to JPS Hospital
- Healthcare Philosophy
- Refusal Policies for medical treatment, diets, and medications
- Reporting Abnormal Results to Released Individuals
- Requests of Healthcare
- Referral for Medical, Dental, and MHMR Services
- Medical Intake Screening and Intake Medication
- Medical Housing Procedure

- Dental Triage Policy
- MHMR Weekly Reports (March/April/May 2024)
- Jail Based Competency Reports (JBCR) (2003-2024)
- Referral Tracking Reports (2024)
- Grievance Response Worksheet (April/May 2024)
- Telmates Sick Call Example
- Jail Based Competency Restoration Reports (2023-2024)
- Tarrant County Jail Mental Health Screening Form
- Columbia-Suicide Severity Rating Scale
- FY 2024 Contract Between Tarrant County and MHMR of Tarrant County for Behavioral Health / Intellectual Disability Services for Inmates at the Tarrant County Jail
- Forensic Jail Contract MHMRTC (My Health My Resources of Tarrant County) Personnel
- Forensic Jail Grant Funded MHMRTC Personnel
- Prescriber and Direct Care Staffing Plan
- MHMR Tarrant Forensic Unit Desktop Procedure Manual

a. Alcohol/Benzodiazepine Withdrawal Protocol
b. Assessment and Housing Recommendations
c. Booking Medication Tracker
d. Case Management Continuity of Patient Care
e. Court Ordered Medications
f. Direct Care Triage
g. Diversion Navigators
h. Emergency Medications
i. Jail Based Competency Restoration
j. Monitoring Individuals with Cognitive Need
k. Opiate Withdrawal Protocol
l. Referrals
m. Release from Custody Medication
n. Scheduling for a Provider Visit
o. Special Management Areas
p. Special Precautions Cell Tracker (
q. State Hospital Returnees and Continuity of Care
r. Verification of Medication

APPENDIX B: OVERALL STRENGTHS AND VALIDATIONS

The following lists the TA review team's overall assessment of strengths and weaknesses found during the site visit:

- The agency has an engaged and thoughtful jail administration and clinical staff leadership.
- The Tarrant County Sheriff's Office (TCSO) partners with the county hospital.
- The TCSO partners with My Health My Resources (MHMR).
- Tarrant County employs a full-time registered nurse as the clinical liaison in the jail.
- The agency uses the electronic medical record (EMR) for medical staff.
- They agency uses the resource clinic model of care.
- There is a plan to eliminate physical/standard mail for incarcerated individuals and move toward digital mail.
- State of the art medication services are provided.
- Cleanliness and odor mitigation are present in the various facilities.
- Parking and meals for staff are available.
- There is art in the Veterans Unit at Green Bay Jail.
- Medical staff access Computers on Wheels (COWS) and Internet for point-of-service, real time documentation.
- Solid retention and recruitment efforts for MHMR and John Peter Smith (JPS) include parking and food for staff.

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