

**THE  
BIENNIAL REPORT  
OF THE  
TEXAS CORRECTIONAL OFFICE ON OFFENDERS  
WITH MEDICAL AND MENTAL IMPAIRMENTS**

**SUBMITTED TO  
THE TEXAS BOARD OF CRIMINAL JUSTICE  
JANUARY 28, 2005**

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**SECTION I.**  
**ADVISORY COMMITTEE MEMBERSHIP**

**GUBERNATORIAL APPOINTEES**

Judy Briscoe, Chair *Term Expires 2/1/2006*

- |                       |                                |                       |                               |
|-----------------------|--------------------------------|-----------------------|-------------------------------|
| • Dr. Mike Arambula   | <i>Term Expires 7/20/2010</i>  | • Judge Jan Krocker   | <i>Term Expires 7/20/2008</i> |
| • John Martin Bradley | <i>Term Expires 10/21/2008</i> | • Dennis Myers, Ph.D. | <i>Term Expires 2/1/2005</i>  |
| • Ellen Cokinos       | <i>Term Expires 7/20/2008</i>  | • Ross Taylor, M.D.   | <i>Term Expires 0/21/2010</i> |
| • Joseph Gutheinz     | <i>Term Expires 7/20/2008</i>  | • Frank Webb          | <i>Term Expires 7/20/2006</i> |
| • Christopher C. Kirk | <i>Term Expires 0/21/2006</i>  |                       |                               |

**STATE AGENCIES/ORGANIZATIONS**

- |  |   |
|--|---|
| • Texas Department of Criminal Justice<br>- Institutional Division<br>- Parole Division<br>- Community Justice Assistance Division | • Commission on Jail Standards  |
| • Texas Juvenile Probation Commission  | • Texas Council for Developmental Disabilities  |
| • Texas Youth Commission   | • Health & Human Services Commission<br>- Department of Aging and Disability Services<br>- Department of Assistive and Rehabilitative Services<br>- Department of State Health Services |
| • Texas Education Agency   | • National Alliance for the Mentally Ill – Texas  |
| • Mental Health Association in Texas   | • ARC of Texas  |
| • Commission on Law Enforcement Officer Standards and Education  |   |
| • Texas Council of Community Mental Health and Mental Retardation Centers  |   |

**ADHOC MEMBERS**

- University of Texas Medical Branch at Galveston
- Texas Tech University Health Science Center
- Board of Pardons and Parole

## SECTION II. EXECUTIVE SUMMARY

Since the establishment of the Texas Council on Offenders with Mental Impairments (TCOMI) in 1987, the policy initiatives enacted by the Legislature have proven to have had a positive impact on the overall service delivery system for juvenile and adult offenders with special needs. In the last 17 years, Texas has, through legislative action, created a nationally recognized system that addresses all aspects of the criminal justice continuum. This has been accomplished through the adoption of statutory guidelines that have resulted in improved regulatory, procedural and programmatic practices in this state's response for this offender population.

Two years ago, the Legislature again demonstrated its commitment to this issue by reauthorizing a \$35 million funding package for the enhanced mental health/criminal justice initiative. This funding has resulted in a renewed effort to emphasize the front end of the juvenile justice and adult criminal justice systems. In addition, legislation impacting pre-trial stages of the criminal justice system was enacted. These policy initiatives, coupled with the mental health/criminal justice initiative, should further strengthen the state's efforts to enhance the front end of the system.

The legislature also enacted another key piece of legislation, SB 591. It revised the name to the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) and reorganized the functions of the Council to that of an advisory committee. In addition, new responsibilities were added to TCOOMMI's mandates to address those front end policy initiatives previously referenced.

During the past biennium, TCOOMMI initiated and/or completed the following activities relating to the new and existing legislative directives:

- **Cooperated with the Texas Commission on Jail Standards, to study the current mental health screening and treatment practices of local jails.** A more detailed overview of this study is found in Section V of this report;
- **Developed a process to review defendant competency evaluations conducted to ensure compliance with art. 46.B, Code of Criminal Procedure.** A summary of this activity is found in Section V of this report;
- **Implemented a process to reimburse local jails for new generation medications for art. 46.B defendants being returned to jail after a finding of competency.** A status report on this new initiative is found in Section V of this report;
- **Implemented new statutory provisions for the Medically Recommended Intensive Supervision (MRIS) program.** As a result of the statutory revisions, the

approval rate increased by 122%. A more detailed report of this program is found in Section IV of this report;

- **Cooperated with Harris County (MHMRA, jail, courts, etc.), in establishing a community-based competency restoration pilot.** A summary of this pilot program is provided in Section V of this report;
- **Established a statewide MHMR client/offender data cross-referencing process between TDCJ and the Department of State Health Services (DSHS).** This activity represents the first of its kind in the country toward identifying current or former MHMR clients who are involved in the adult criminal justice system.

While not an exhaustive list, the above projects do represent further evidence of the Legislature's commitment to issues impacting offenders with special needs. This biennium saw continued progress toward the establishment of a comprehensive continuity of care system that emphasizes its primary goals of public safety and treatment interventions. More importantly, the efforts of TCOOMMI toward accomplishing these critical goals have occurred through the elimination or reduction of duplication, improved coordination, collaboration and commitment to minimizing overall costs to local and state governments.

Although tremendous progress has been made; there is continued room for improvement and refinement. This report addresses areas of concern that require additional work to further the goals of the state in its response to offenders with special needs.

**SECTION III.  
OVERVIEW OF TCOOMMI and  
ADVISORY MEMBERSHIP  
FUNCTIONS**

TCOOMMI was created by the 70<sup>th</sup> Legislature to address the multi-faceted problems presented by juveniles and adults with mental illness, mental retardation and developmental disabilities. HB 93, 72<sup>nd</sup> Legislature, expanded TCOOMMI's role to include offenders with serious medical conditions, physical disabilities or who are elderly.

During the past biennium, the composition of the Advisory Committee was revised to reflect legislative or executive changes enacted by the 78<sup>th</sup> Legislature. Most notably, the number of members was reduced from 31 to 26. This change resulted from the consolidation of Health and Human Service Agencies and the elimination of the Criminal Justice Policy Council.

Despite these membership changes, the Advisory Committee continued its work on addressing the following legislative mandates:

1. *To determine the status of offenders with special needs in the state criminal justice system;*
2. *To identify needed services for offenders with special needs;*
3. *To develop a plan for meeting the treatment, rehabilitation and educational needs of offenders with special needs, including a case management system and the development of community-based alternatives to incarceration;*
4. *To cooperate in coordinating procedures of represented agencies for the smooth and orderly provision of services for offenders with special needs;*
5. *To evaluate various in-state and out-of-state programs for offenders with special needs and recommend to the directors of current state programs methods of improving those programs;*
6. *To collect and disseminate information about available programs to judicial officers, law enforcement officers, probation and parole officers, social service and treatment providers;*
7. *To distribute money appropriated by the Legislature to political subdivisions, private organizations or other persons to be used for the development, operation, or evaluation of programs for offenders with special needs;*
8. *To apply for and receive money made available by the federal or state government or by any other public or private source to be used by the council to perform its duties;*

9. *To develop and implement pilot projects to demonstrate a cooperative program that identifies, evaluates, and manages, outside of incarceration, offenders with special needs;*
10. *To develop and implement a medically recommended intensive supervision or early release program for inmates who are elderly, physically handicapped, terminally ill or mentally retarded as established in HB 93, 72<sup>nd</sup> Legislature;*
11. *To monitor and coordinate the establishment of a continuity of care system for offenders with special needs;*
12. *To develop a process for reviewing all competency evaluations to determine compliance with statutory guidelines; and*
13. *To develop and implement a continuity of care process for all 46.B defendants being returned to jail upon restoration of competency.*

To address these and the new statutory mandates, the advisory committee created an additional sub-committee to lead the review and response to those activities impacting the front end of the criminal justice system. The new sub-committee, Jail and Pre-trial Diversion, will operate in the same manner as the other standing groups (Program/Research, Planning/Legislative, and Juvenile Committee) by identifying and responding to barriers or gaps in the service delivery system that impact offenders with special needs.

The functions of the TCOOMMI committee may have changed to that of an advisory role, but the mission remains unchanged. Through the collaborative efforts of this diverse body of juvenile and adult criminal justice, health and human service and advocacy representatives, the focus continues toward creating a seamless system of care for juvenile and adult offenders with special needs.

The following sections of this report provide a detailed accounting of TCOOMMI's current and future activities toward fulfilling its responsibility to the legislature and the citizens of this state.

## **SECTION IV. TCOOMMI PROGRAMS**

Prior to the 78<sup>th</sup> Legislative Session, TCOOMMI operated three (3) major programs: (1) Community Based, which includes the jail diversion and mental health/criminal justice initiative, (2) Continuity of Care (COC) and (3) Medically Recommended Intensive Supervision (MRIS). HB 1 expanded TCOOMMI's programs to include pre-trial activities relating to defendants being returned to jail after a determination of competency. This particular initiative will be further discussed in Section V of this report. This section of the report will provide an overview of the TCOOMMI programs and an update on performance outcomes.

### **COMMUNITY-BASED PROGRAMS ADULT PROGRAMS**

The community-based services provided through TCOOMMI funding are a critical component to an offender's success on pre-trial, probation or parole. The most important factor is that the service is immediately accessible to the offender.

Prior to the mental health/criminal justice initiative in 2001, the majority of offenders served by TCOOMMI were parolees with mental impairments or other medical/psychological disabilities. Due to the pre-release planning of TCOOMMI's Continuity of Care Program, parolees were referred to services before release, thus avoiding or minimizing the need for a waiting list. Typically the offender would have been released to a community with specialized parole officers and TCOOMMI-funded services. Those community providers not funded by TCOOMMI, would usually receive a four to six month advance notice of the offender's pending release. This time period would allow the inmate to be placed on a waiting list for service while still in custody, thus avoiding a lengthy service delay upon release from prison or other correctional facility.

The Probation system on the other hand was plagued with problems in accessing mental health services. The probationer could not gain immediate access to the service due to waiting lists. In some circumstances it was months before an initial intake was conducted. For a probationer with serious mental illness, the lack of treatment contributes to the person's inability to comply with conditions of supervision, thus increasing the risk of recidivism and ultimately revocation.

The passage of the mental health/criminal justice initiative by the 77<sup>th</sup> Legislature provided the mechanism to address this service gap. The initiative allowed for the creation of 84 specialized probation caseloads and targeted mental health treatment funding in selected sites across the state. The intent of the initiative was to provide accessible supervision and mental health treatment in order for the courts to have a sentencing alternative to incarceration.



In addition, the initiative has resulted in a number of other accomplishments including:

1. **Improved coordination and collaboration between local probation and MHMR agencies.** Joint staffings, co-location of offices, joint field or home visits with probation and MHMR staff are but a few examples of the improved working relationship between the probation and mental health systems.
2. **Fewer revocations due to CSCDs and MHMRAs jointly working on supervision and treatment issues.** Prior to the initiative, issues of non-compliance were decided solely at the CSCD's discretion with the courts. Now it is a collaborative process to ensure that mental health issues are not contributing to non-compliance;
3. **Significantly reduced duplication of effort.** Historically, CSCDs have preferred to contract with private providers for psychological assessments or counseling, rather than access the public mental health system. As a result, if the offender required a service offered by the local MHMR, (such as case management or medication), another psychiatric assessment was required by the MHMR in order to determine eligibility. This duplication has been mostly eliminated due to the targeted funding from the initiative; and
4. **Public safety issues rather than availability or a client's right to choose determines the intensity of MHMR services.** TCOOMMI requires all MHMR contract agencies to provide intensive service coordination and monitoring of treatment compliance. Failure to comply with treatment requirements is reported immediately to criminal justice entities. As a result, illegal activities that may have occurred due to treatment non-compliance can be avoided or minimized.
5. **Established a sixty (60) bed residential program for probationers with mental illness who were at risk of incarceration.** This program, jointly funded by TDCJ-CJAD, TCOOMMI, Bexar County CSCD, and the local MHMR Center serves as an excellent resource for not only San Antonio, but other probation departments as well.
6. **Expanded the jail diversion program to Harris, Dallas and Travis Counties.** Each county was provided additional funding to create mental health liaisons assigned to criminal courts to assist in screening and developing conditions of release for defendants with mental illnesses.

In addition to these accomplishments there have also been areas identified that have not achieved the same level of success. Based upon routine audits conducted by TCOOMMI, a number of program issues have been identified that require further refinement and improvement. Those areas include:

1. **Increased attention to the identification and referral process is required due to new mental health service criteria.** With the passage of HB2292, the guidelines for MHMR service eligibility were more narrowly defined. Based upon TCOOMMI's review of the new criteria, approximately 15% of its current offender population will no longer be eligible for mental health services. The effect this change will have on TCOOMMI programs will need to be monitored over the next biennium to determine what, if any, impact this has on offender services and recidivism rates.

2. **Efforts to maximize third party payments, such as Medicaid, will continue to be a top priority.** The differences in Medicaid billing reported by local MHMRAs suggest some centers do a much better job of accessing Medicaid. Since the population served is virtually the same across the state, the discrepancies in Medicaid revenue are in all likelihood an agency-specific issue. Efforts to improve Medicaid reimbursement, such as training and technical assistance on completing related disability applications, will be emphasized.
3. **Expanded residential options are needed as alternatives to incarceration.** Currently the majority of court residential programs are geared toward offenders who have no mental health or other special needs. As a result, the placement options available to the courts or parole are limited. Without structured residential alternatives, revocations to jail or prison, the most costly response for both local and state governments, may be the only viable option for decision makers.
4. **Increased access to substance abuse treatment for offenders with special needs is critical to a successful completion of probation or parole.** The availability of substance abuse treatment programs has proven to be an important factor in reducing recidivism. For the offender population with mental impairments, access to such treatment programs is in short supply.

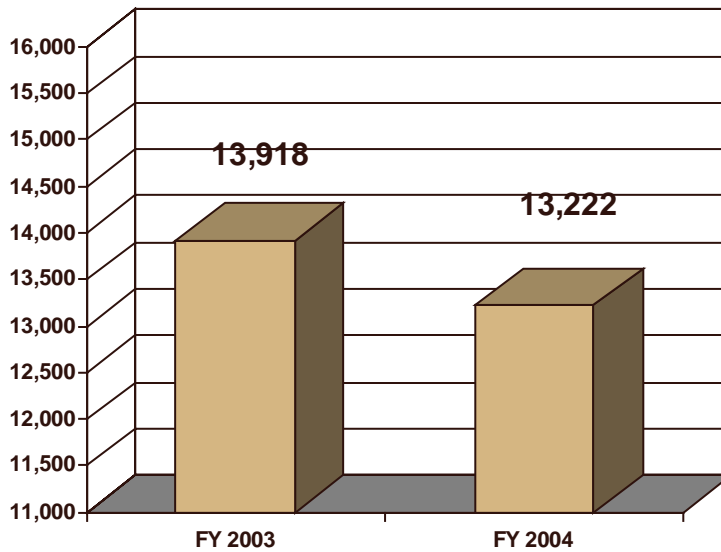
## **OTHER COMMUNITY-BASED PROGRAMS**

### **CONTINUITY OF CARE**

TCOOMMI funds a continuity of care program designed to provide a responsive system for local referrals from jails, family and other sources. Components of this program include but are not limited to:

- Screening and Linkage to Appropriate Services
- Federal Entitlement Application Processing
- Jail Screening
- Court Intervention

The following chart depicts the number of offenders served through the Continuity of Care Program in FY 03 and 04.

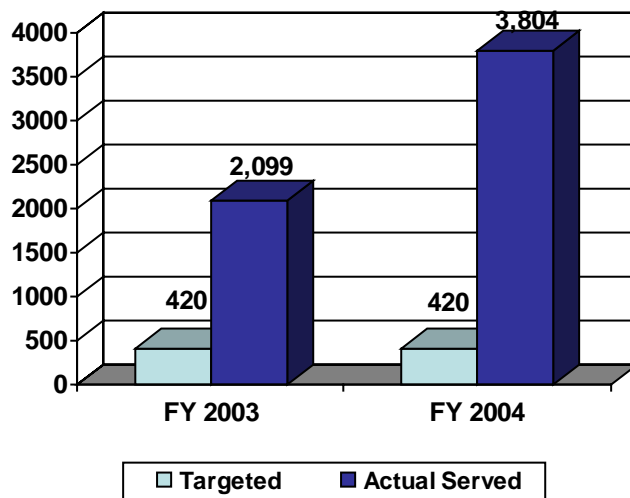


The primary purpose of the community-based COC program is identification and referral. There is no outcome data currently collected on the service group. However, if adequate resources were available, TCOOMMI could conduct an evaluation of recidivism rates of the offenders served through case management compared to COC. Policy-makers need to know the impact that targeted treatment and supervision has on offenders with mental impairments and other special needs.

### JAIL DIVERSION

During the past biennium, TCOOMMI contracted with five (5) sites for targeted jail diversion services. These services included: specialized mental health deputies; designated mental health staff assigned to district courts; and screening for mental health issues.

The following chart reflects the number of offenders served through the Jail Diversion program for FY 03 and 04:



The higher than anticipated targets can be attributed to several factors:

1. **As a new initiative, there was no previous reference data to use as a starting point on projected numbers.** As a result, the targeted numbers were developed on the conservative side.
2. **The Harris County mental health court liaison program was expanded from four (4) to all 22 district courts.** This in turn accounted for 83% of the overall numbers; which was higher than originally estimated for the initial four courts.

Overall, the jail diversion component of TCOOMMI's community-based program has far exceeded initial expectations. During the next biennium, an evaluation of these programs will be conducted to examine not only recidivism rates, but also cost benefit to local and state government.

## **JUVENILE JUSTICE PROGRAMS**

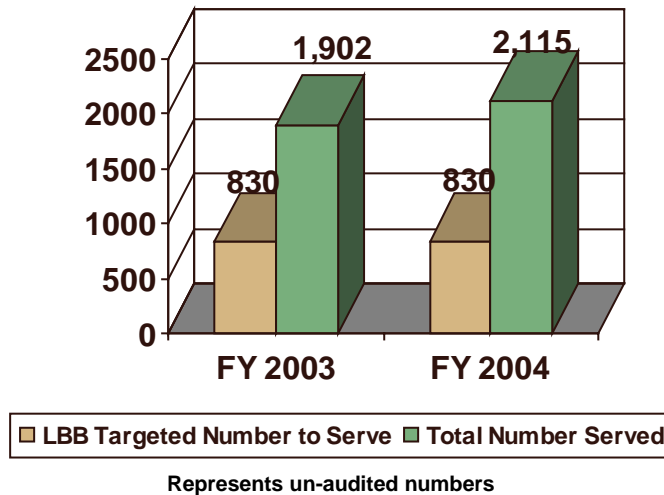
### **JUVENILE PROBATION**

In order to provide a more responsive front-end service delivery system, the Legislature appropriated \$9.5 million to provide supervision and treatment services to youth on local probation and on parole from the Texas Youth Commission (TYC). Juvenile service programs are designed as a family-based, multi-service approach to meet the mental health needs of youth in the Texas juvenile justice system, ages 10-18, who have been assessed with severe emotional disturbances.

Twenty-two (22) statewide service programs provide a wrap-around, case management philosophy and managed care practices, with a strong emphasis on flexible programming. TCOOMMI contracts with local MHMRs for the following services that support this treatment model:

- Assessments for service referral;
- Service coordination and planning;
- Medication and monitoring;
- Individual and/or group therapy and skills training;
- In-home services such as Multi-Systemic Therapy or Functional Family Therapy;
- Family focused support services;
- Benefit eligibility services; and
- Transitional services.

During the past biennium, juvenile offender programs jointly operated and funded by TCOOMMI and TJPC exceeded expectations in the overall number of juveniles served. As depicted on the following chart, LBB Performance targets were exceeded by 152%.



Several contributing factors have been identified as impacting these performance outcomes. TCOOMMI's juvenile programs have achieved the following accomplishments during this report period:

1. **Medicaid revenue generated by the juvenile program sites has increased by 155% since the inception of the initiative.** During FY 2004 \$1,015,000 in Medicaid revenue was collected compared to \$397,000 in FY2002. By increasing the federal revenue, the programs were able to serve more clients without additional state dollars.
2. **Increased contract monitoring has yielded faster problem identification and remedy.** Program reviews (audits) and hands-on technical assistance have provided opportunities for improved efficiency and effectiveness in serving children and their families.
3. **For the most part, many of the problems that were associated with the initial program implementation, such as communication and coordination, have been eliminated or minimized.** Many of the programs have co-located supervision and treatment staff to enhance coordination between the two systems. In addition, program sites are contractually required to provide joint treatment and supervision plans, fostering improved communication between the juvenile justice and mental health agencies.

In addition to these accomplishments, the following areas require continued monitoring during the next biennium:

- **The state mental health agencies' newly developed Resiliency Disease Management (RDM) service model will require monitoring to ensure the needs of juvenile offenders are met.** RDM standards may conflict with TCOOMMI and Special Needs Diversionary Program requirements. Once program sites have more experience with the new RDM service packages, conflicts and inconsistencies will be monitored and corrected as needed.

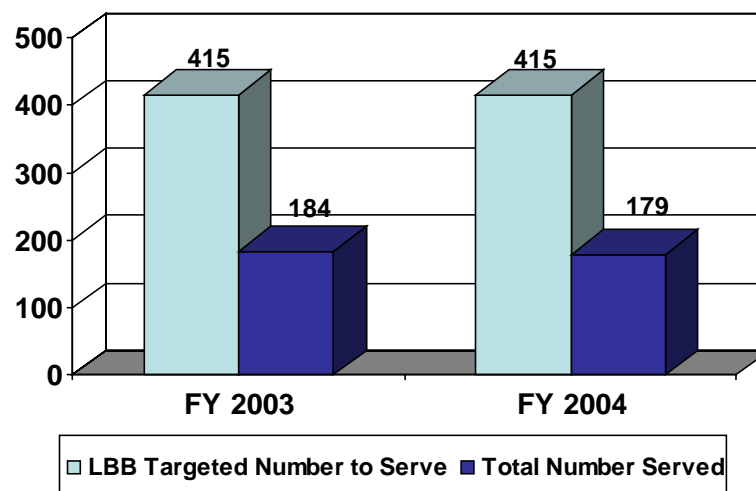
- **Increased access to substance abuse treatment is essential for the juveniles' successful completion of probation.** Reports from the program sites indicate that substance abuse services, especially in-patient, are difficult to access for indigent juveniles and their families.
- **Medicaid revenue shortfalls resulting from the newly implemented RDM service package may decrease program capacity.** During the first quarter of FY 2005, Medicaid revenue decreased by 22%, as compared to the first quarter of FY 2004. If this trend continues, a corresponding decrease in service rates is anticipated.

## TEXAS YOUTH COMMISSION

According to a study conducted by the Criminal Justice Policy Council, it has been suggested that approximately 49% of TYC youth have a diagnosed mental health problem. In order to provide an appropriate aftercare treatment plan for those juveniles being released on parole, TCOOMMI contracts with local MHMR centers for an array of post-release services. Those services, which are provided primarily through a fee-for-service contractual arrangement, include:

- Individualized assessments;
- Service coordination;
- Medication monitoring;
- Advocacy services;
- Transitional services to other treatment programs for youth being discharged from parole; and
- Benefit eligibility services.

As noted in the following chart, the targeted numbers for TYC youth served through TCOOMMI programs were considerably lower than the LBB targets for FY 03 and FY04.



The following factors contributed to these performance targets, including:

1. The primary diagnosis of the youth may not have been appropriate for MHMR service guidelines. In these cases, referrals were initiated to other treatment providers with more flexible eligibility criteria.
2. A number of youth, due to the severity of their mental illness, were placed in residential treatment programs immediately upon release. As a result, the youth were not referred to TCOOMMI for aftercare treatment.
3. Due to the intensity and efficacy of treatment services provided to TYC youth, the juveniles' mental health status was stable upon release; therefore follow up treatment was not required.

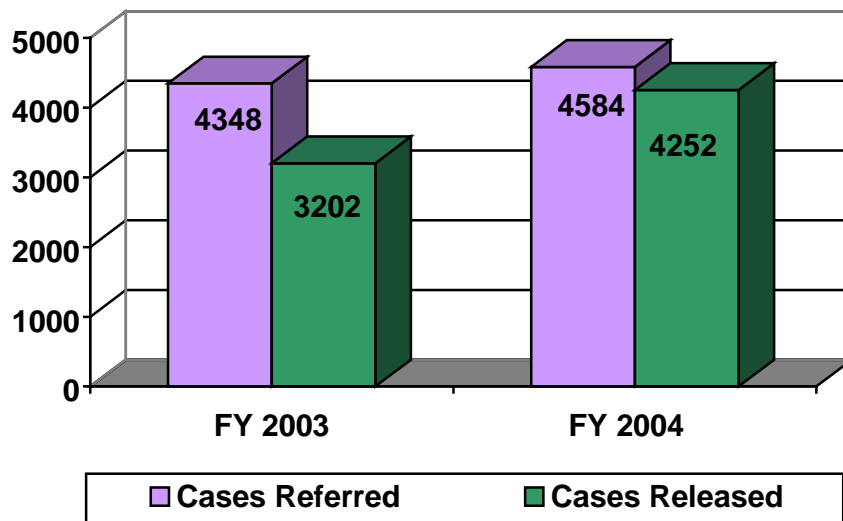
### **TCOOMMI INSTITUTIONAL SERVICES:**

#### **CONTINUITY OF CARE**

The Institutional Continuity of Care (COC) program provides a formal pre and post release aftercare system for all offenders with special needs released from TDCJ facilities (state jails, Substance Abuse Felony Punishment Facilities {SAFPFs}, prisons). By identifying offenders who are in need of aftercare treatment prior to their release, the offenders' chances for a more successful re-entry into the community are improved.

The COC program operates on a regionalized system of care that utilizes local Mental Health Mental Retardation Authorities (MHMRA) or Division of Aging and Disabled Services (DADS) staff to perform their respective job functions. Through contracts between TCOOMMI and these agencies, twenty-seven (27) COC workers and seven (7) Eligibility Benefits Specialists are assigned to cover each TDCJ operated facility within the state. COC workers develop pre-release plans in conjunction with the primary service provider in the community to which the inmate is scheduled to be released. In addition, 90 days prior to release, the Benefit Eligibility Specialist initiates all relevant applications for federal entitlements for which the inmate may be eligible (i.e., Social Security Insurance, Social Security, Social Security Disability Insurance, Veterans Benefits, Food Stamps, AIDS medications, etc.).

The following chart depicts an overview of COC referrals and releases during the current and previous fiscal years:



As a result of TDCJ's effort to continually improve offender re-entry programs, TCOOMMI conducted a number of studies relating to the continuity of care program. The first involved a study of the identification process for inmates confined within the TDCJ facilities. The second involved a review of parolees who had been sent to an Intermediate Sanction Facility (ISF) in lieu of revocation to Correctional Institutions Division (CID).

In September 2004, the entire census of TDCJ-CID inmates was provided to the state's mental health agency for cross-referencing purposes. Based upon the results of that data run, over 33,000 (22%) of the CID's inmate population were identified as former MHMR clients. In essence, one out of five inmates had a prior service history with the public mental health system. Using that number as a reference point, it is reasonable to assume that one out of every five (5) releasees (parole, mandatory supervision, flat discharge) could potentially have a mental health diagnosis and consequently a need for post-release treatment. If this statistic were applied to the total number of releases for FY 2004, **then potentially 13,000 of the 60,000 persons released from incarceration had a mental impairment.**

As the preceding chart depicts, only 4,252 offenders were involved in the COC program. This number included all special needs inmates (elderly, terminally ill, physically handicapped, mentally ill, and mentally retarded) who were identified by medical staff as needing post-release treatment. The disparity between the potential number (13,000) compared to the actual number of inmates processed (4,252) by the COC program would suggest significant work is needed in the identification process.

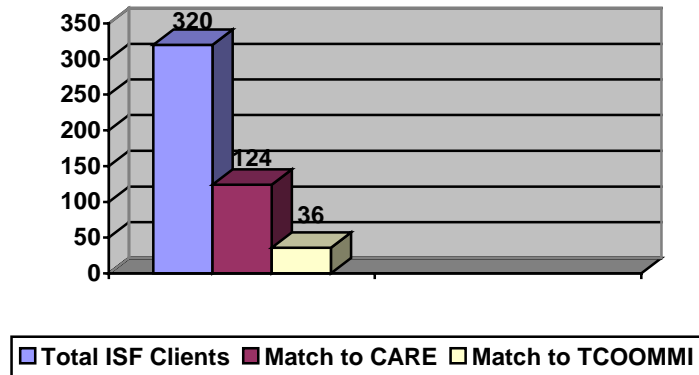
In addition, the appropriate identification of inmates also has implications for post-release outcomes. An example of this involves a recent review of parolees confined in an Intermediate Sanction Facility (ISF). The ISF placement is initiated when a parolee has demonstrated some form of non-compliance to conditions of release, and in lieu of revocation, is sent to the ISF for a set period of time.

TCOOMMI initiated its review as a result of an increased number of parolees exhibiting serious mental health problems during their placement. As part of the review, a cross-reference of the ISF residents against the statewide MHMR client database was conducted.



In addition, the same listing was cross-referenced against the TCOOMMI database to determine if the parolee had been part of the pre and post release COC process while incarcerated in TDCJ. The results of the review are as follows:

### DATA OUTCOMES FOR ISF RESIDENTS



Based upon these findings, it would appear that inmates with prior mental health service history are not being identified as such while in TDCJ's custody. As a result, **71%** of the ISF offenders who were prior MHMR clients were released from TDCJ without any pre or post release treatment requirements.

A number of factors could contribute to the findings presented in these two data matches. Those would include the following:

1. The inmate, while incarcerated, may have not shown any mental health symptoms during the identification process.
2. The original MHMR service was related to one acute episode that was situational; consequently no further psychiatric treatment was required.
3. The offender may have refused treatment while in TDCJ, which would have resulted in no identification on the medical reports TCOMMI utilizes for initiating pre- and post-release care.

One factor that may impact the appropriate identification of inmates confined in TDCJ involves the mental health screening process at local jails. As part of TCOOMMI's work with the Texas Commission on Jail Standards, a review of medical records submitted by local jails to TDCJ was conducted on 100 new inmate admissions. This review, which occurred at three (3) different transfer facilities- Byrd, Hutchins and Holiday units, focused on the information included on the Uniform Health Status Update form that jails are required to submit on all inmates admitted to TDCJ. Based on TCOOMMI's review, the following findings were made:

- Of the **100** inmate records reviewed, **15** or **15%** had a mental health diagnosis noted (**10** had the same diagnosis as that noted on the Client Assessment Registry, or CARE, system);
- Of the remaining **85**, **29** or **34%** were found on the CARE system as current or former clients of MHMR, but no mental health notation was indicated by the jail;
- **44%** of the **100** were former or current clients of MHMR.

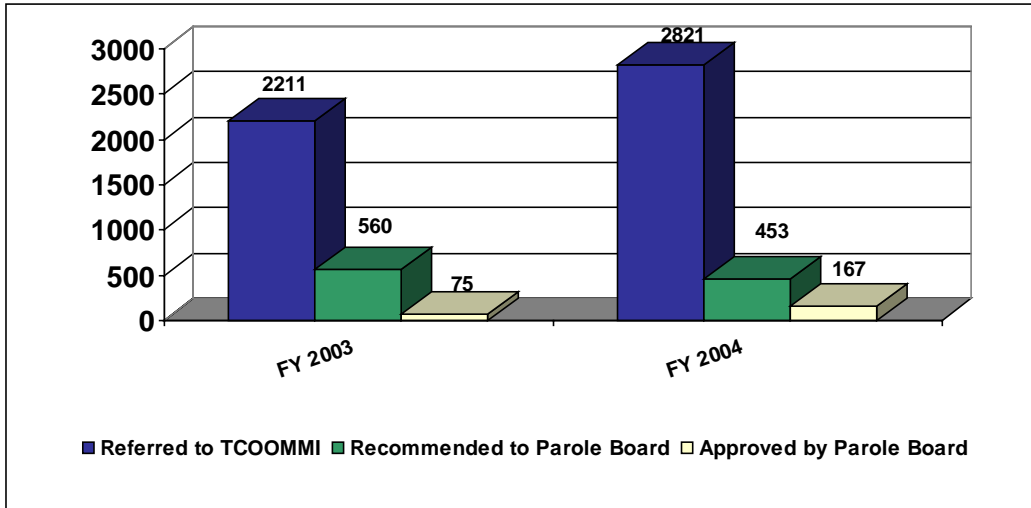
Instead these results indicate a compelling argument for improving mental health screening conducted by local jails. Fortunately, the Texas Commission on Jail Standards (TCJS) in cooperation with TCOOMMI, has just completed a legislatively mandated study on the mental health screening and treatment practices in county jails. The results of that study should contribute to an improved process of identification of inmates with mental illness incarcerated in jails.

### **MEDICALLY RECOMMENDED INTENSIVE SUPERVISION (MRIS)**

The passage of HB 1670 during the 78<sup>th</sup> Legislative Session has resulted in a number of substantive changes to the statutory provisions pertaining to the Medically Recommended Intensive Supervision (MRIS) program. Those changes included:

- Repealing the requirement that parolees requiring long term care be released to the designated skilled nursing facility in Kenedy;
- Excluding inmates with a sex offense from MRIS consideration;
- Allowing 3g offenders to be considered for MRIS if the medical conditions were either terminal or required long term care.

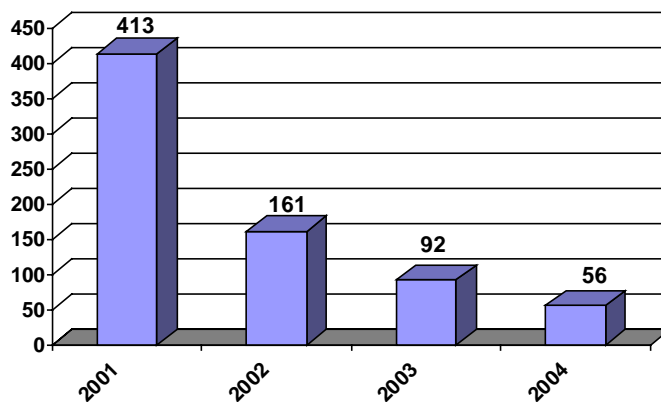
Since the enactment of the legislation on September 1, 2003, a number of positive outcomes have occurred. As noted in the following chart, the referral, submission and approval rates have shown a steady increase during the past fiscal year:



As noted on the chart, the approval rate improved by 122% compared to FY 03. In part, this can be attributed to the expanded pool of inmates who were previously excluded. Since September 1, 2004, **3,118** 3g offenders, who previously were ineligible under the old law, were now eligible for MRIS consideration.

In addition, the legislation's repeal of the designated nursing home also appears to have impacted the overall number of inmates to be considered. As noted in previous reports to the Legislature, inmates have refused MRIS consideration due to the location of the skilled nursing facility in Kenedy, Texas. The following chart reflects a comparison of inmate refusals during the past four (4) years:

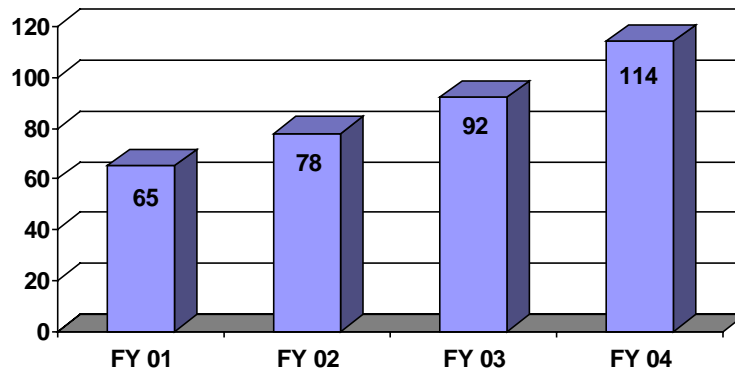
MRIS – INMATE REFUSALS



The decline in inmate refusals for MRIS consideration represents a 86% decrease from 2001 to 2004. There are, however, continued problems with placement options that, in some respects, negate the positive intention of the legislation. The following chart depicts the number of days inmates remained in TDCJ after MRIS approval.

One area of continued concern is the number of inmates who die shortly after referral or during the MRIS process. As the following chart reflects, there has been a steady increase in the number of deaths over the past four years:

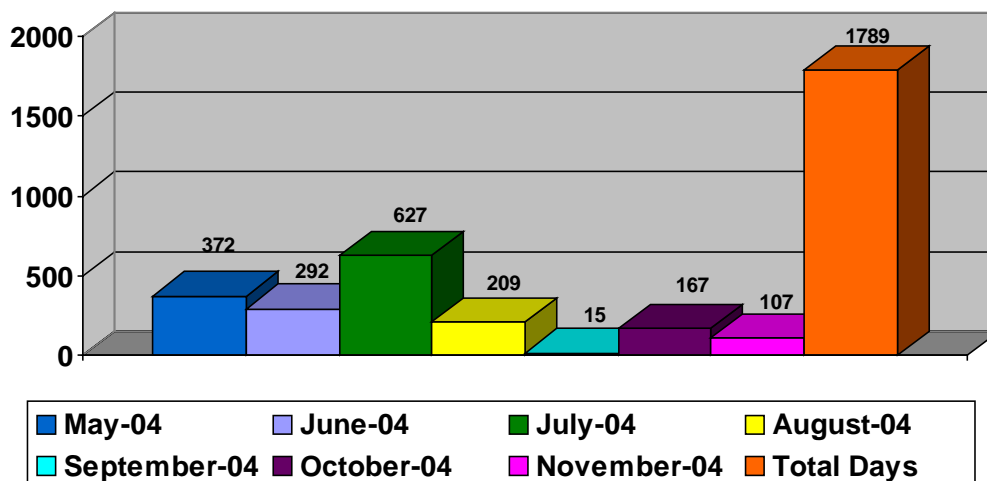
### MRIS – INMATE DEATHS



In order to ensure a timely referral and processing of these cases, the TCOOMMI has implemented a review procedure for all deaths that occur for inmates who were eligible for MRIS consideration. This review, which is being conducted in conjunction with the Correctional Managed Care Advisory Committee, will potentially identify problems that can be corrected to expedite the identification and referral process.

For the most part, the primary reason for release delay was the lack of an immediate placement option. Another area of concern involves the availability of placement options once an inmate is approved for MRIS. If the inmate's condition requires certain medical treatments, and the nursing facility, community of release or family is unable to provide such care, the release is frequently delayed. In some cases, families agreed to accept the offender in their home but reversed their decision when confronted with the extensive care giving that would be required. The following chart provides an overview of the cumulative number of days releases were delayed primarily as a result of placement issues:

### Days to Release After Approval



One strategy on which TDCJ/TCOOMMI is working involves a pilot release program with University of Texas Medical Branch (UTMB). The pilot program would transfer MRIS approved inmates from Hospital Galveston to the free-world John Sealy Hospital within 24 hours of parole approval. TDCJ has established internal deadlines for which its affected divisions must adhere in these specific MRIS cases. In addition, UTMB is working with the John Sealy Hospital staff to implement similar procedures to ensure a timely transfer of care to the regular hospital setting. For those inmates who qualify for federal entitlements, TCOOMMI staff will give the highest priority to completing the necessary applications for SSI and Medicaid. If this new initiative proves to be effective in reducing the length of time an inmate remains in custody after MRIS approval, TDCJ and UTMB will begin discussions on expanding these activities to other specialty units and regional medical facilities.

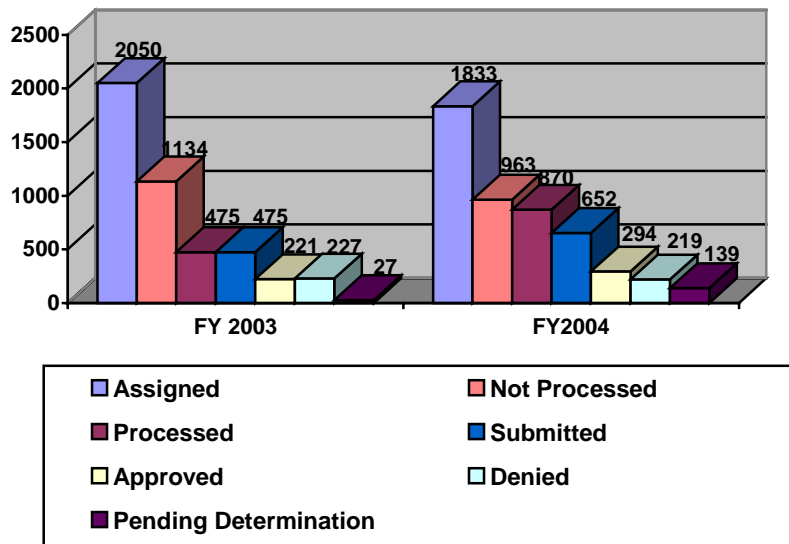
## **SOCIAL SECURITY PILOT PROJECT**

Fiscal Year 2004 marked the fifth year of operation for the Social Security Pilot Project between the Social Security Administration and TDCJ/TCOOMMI. It also represents another “first of its kind” in the country that Texas has initiated on behalf of offenders with special needs.

As noted in previous reports to the Legislature, the project is designed to initiate the social security application process for any potentially eligible offender who is within 90 days of release from custody. The social security application process includes the following activities:

- TCOOMMI staff identifies inmates confined in the TDCJ facilities (state jails, SAFPFs and prison) that have a medical and/or psychiatric alert code as reported on the system-wide offender data base.
- Benefit Eligibility Workers interview the inmate while still in custody to obtain their permission to initiate the Social Security/Social Security Insurance (SS/SSI) application; gather all relevant medical/psychiatric information from health care providers, including free world records; conduct a review of financial status; complete and submit all entitlement applications to the Social Security Administration office.
- Benefit Eligibility Specialists report all activities to TCOOMMI staff; who in turn compile routine status reports that are distributed to all local MHMRs, regional TDHS staff who will ultimately be responsible for providing services to offenders upon their release from incarceration.

During the first five (5) years of the SS Pilot Project operation, considerable progress has been made in improving an offender’s post-release access to financial and health care coverage through Medicaid. The chart below shows total number of SSI cases processed, approved and denied for the past two years.



One particularly noteworthy number reflected on the preceding chart is the number of cases not processed. As noted, over 50%, or 963 applications were not processed in FY 2004. The primary reason was the inmate’s refusal to have an application submitted on his/her behalf.

Based upon federal guidelines, a person cannot be coerced into applying for benefits, nor are they required to explain their decision not to participate. As a result, TCOOMMI has no choice but to comply with the inmate’s request.

Despite this issue, the social security program continues to provide a valuable contribution to local and state government. By obtaining social security eligibility for offenders prior to release Medicaid is initiated immediately upon release. This allows medical providers (public and private hospitals, etc.) to bill Medicaid for the majority of health care costs that previously would have been solely the responsibility of the county or state.

## **SECTION V. NEW INITIATIVES**

During the past biennium, significant progress was made toward creating a more comprehensive continuity of care system. For the most part, the progress was made as a result of the new legislative mandates that focused TCOOMMI's efforts on the front end of the criminal justice system. Those mandates included the following:

1. Reviewing all competency evaluations conducted on defendants and assessing the report's compliance to statutory guidelines set forth in SB 1057.
2. Developing a continuity of care system for all defendants committed to a state facility for a determination of competency. A component of this charge included the mandate for TCOOMMI to assume fiscal responsibility for a 90-day supply of new generation medication for the defendant after their return to jail.
3. Participating in a joint study with the Texas Commission on Jail Standards (TCJS) on the current process for screening, tracking and coordinating mental health related activities of inmates with mental illnesses incarcerated in local jails.

Due to the relatively short time period since these laws went into effect, it is premature to assess the impact that has resulted from these new policy initiatives. There is, however, preliminary information that would suggest the state is moving in the right policy direction. A more detailed overview of each legislative initiative is provided in this section of the report.

### **COMPETENCY EVALUATION REVIEW**

Prior to January 1, 2004, there existed no statutory requirements for reviewing competency evaluations. As a result, there was no mechanism in place to ensure that: competency evaluations were conducted in accordance to state law; the persons performing the evaluations possessed the necessary credentials to do so; or the courts were receiving evaluations that were adequate in scope to address the fundamental elements needed to make a determination of competency.

Due to these and other factors, the Legislature enacted SB 1057 which resulted in sweeping changes in the competency evaluation process. One key outcome of this legislation involved creating a formal mechanism for TCOOMMI to examine the evaluations submitted by the courts. With the passage of SB 591, this mandate was incorporated into TCOOMMI's statutory activities. In addition, forensic psychiatrists and psychologists were added to the TCOOMMI Advisory Committee membership to provide the necessary expertise to conduct a professional review of the evaluations.

From January 1, 2004 (the effective date of SB 1057) to August 31, 2004, 754 competency evaluations have been submitted from the courts to TCOOMMI. Of that number, a random

sample was conducted on 110 competency evaluations to determine compliance to statutory provisions set forth in 46.B, Code of Criminal Procedure. Based upon this review, the following observations are offered:

1. The majority of competency evaluations reviewed complied with the statutory provisions established by SB 1057;
2. The most frequent deviations from the statutory guidelines involved informing the defendant of the purpose of the report and to what entities it would be shared; and
3. The quality and the comprehensiveness reflected wide variations; In some cases the report was two pages compared to others that exceeded 20 pages.

These preliminary observations are good indications that the professionals engaged in competency determinations are adhering to the criteria set forth in SB 1057. In addition, the review also highlighted a few areas that may require further legislative attention. These include:

1. **Evaluators should provide documentation of their qualifications with each evaluation submitted to the court and, subsequently, to TCOOMMI.** There is currently no legal requirement for the courts to require documentation of the evaluator's professional expertise, training or academic qualification. Consequently, there is no way for TCOOMMI to determine if the evaluators actually meet the requirements set forth in the statutory provisions;
2. **Statutory guidelines should be developed for the courts to follow in submitting evaluations to TCOOMMI.** Based upon feedback from court personnel, a number of jurisdictions did not submit all the evaluations due to misunderstanding the requirements. As a result, TCOOMMI is unable to accurately report on the number of evaluations actually conducted in the state during this reporting period; and
3. **Based upon the wide variations in content and format of the reports, it would be beneficial to develop a template for competency evaluations.** By requiring a standardized reporting format, there will be more uniformity and consistency between the jurisdictions. In addition, it would make the information easier to review by both the courts and TCOOMMI.

### **RIDER 68 – CONTINUITY OF CARE ART 46.B DEFENDANTS**

A related issue to the competency determination process involves the restoration and maintenance of competency for those defendants released from a state mental hospital to the jail. According to the SB 553 task force report, a significant number of defendants refused medication after their return to jail and, subsequently, would decompensate to an incompetent state. In an attempt to avoid or minimize this situation, the Legislature included an appropriation on TDCJ's funding that required the following:



*“...Continuity of Care. Out of the funds appropriated above in Strategy B.1.1., Special Needs Projects, the Texas Council on Offenders with Mental Impairments shall coordinate with the Texas Department of Mental Health and Mental Retardation, county and municipal jails, and community mental health and mental retardation centers on establishing methods for the continuity of care for pre- and post-release activities of defendants who are returned to the county of conviction after the defendant’s competency has been restored. The Council shall coordinate in the same manner it performs continuity of care activities for offenders with special needs.*

*As part of the Continuity of Care Plan and out of funds appropriated above in Strategy B.1.1., Special Needs Projects, the Texas Council on Offenders with Mental Impairments shall provide a 90-day post-release supply of medication for a defendant who, after having been committed to a state mental health and mental retardation facility for restoration of competency under Chapter 46, Code of Criminal Procedure, is being returned to the committing court for trial. The 90-day supply of medication shall be the same as prescribed in the Continuity of Care Plan prepared by the state mental health and mental retardation facility.”*

An important component of the Rider involved establishing a new system to reimburse county jails for up to a 90-day supply of new generation medications. This activity was deemed critical to the defendants’ compliance to medication, thus maintenance of competency. In order to expedite the reimbursement process, TCOOMMI opted to contract with the local MHMR centers to serve as the coordinating entity for the provision of all new generation medications to jails. This choice was made for several reasons.

First, local MHMRs are, by law and agency rules, the entity responsible for insuring a continuity of care system for all persons being released from state hospitals to the community. Second, as the state public mental health provider, MHMRs are the logical choice to provide pre- and post-release care for defendants who may be sentenced to some type of community supervision and are in need of mental health treatment. Also, with the majority of defendants being indigent, private insurance coverage is likely not available, therefore publicly funded mental health is the only viable option for post-release treatment services. Finally, since TCOOMMI had pre-existing contracts with the majority of local MHMRs for offender related services, amending the current contractual requirements to include this function seemed to be the least complicated choice.

Based upon numbers provided by the state Mental Health Agency, an estimated 500 to 600 46.B defendants were anticipated to meet the criteria for post-release continuity of care. Using these numbers, TCOOMMI estimated that the funding required would be approximately \$500,000. The following chart provides a status on the art. 46.B medication program based on the art. 46.B medication program’s first eight (8) months of actual expenditures since the law went into effect on January 1, 2004.

**Summary of 46.B Defendants Referred from  
State Hospitals and Invoiced for Medication  
January, 2004 - August, 2004**

	<b>46.B Defendants</b>
Number Referred	1069
Number Invoiced	461
• Invoiced from Harris County	438 (95%)
• Invoiced from all other Counties	23 (5%)
Number/Percentage Not Invoiced	608 (57%)

As a new initiative, it was anticipated that there would be implementation delays and those were factored into the funding projections. There were however unanticipated factors that impacted the outcomes. Those included:

1. Two of the largest county jails, Dallas and Tarrant, had existing contracts for medical services that precluded them from accessing the 46.B medication funds. Due to these contractual issues, 189 defendants who were eligible for TCOOMMI medication funding were excluded.
2. A large number of defendants, once returned to the county of conviction, were either released on bond or charges were dismissed. This in turn resulted in no or fewer expenditures for new generation medications being requested by the jail.

In addition to the fiscal issues, a number of operational factors were identified that prevented a more qualitative analysis of the initiative:

1. **The ultimate disposition of the defendants' cases, once criminal proceedings were re-instated, was not reported.** Currently there exists no mechanism to require the local MHMRAs or the courts to report on the outcome of the defendants' criminal status once returned to jail.
2. **The defendants' maintenance of competency via compliance to medication is unknown.** SB1057 allowed for the involuntary medication of 46.B defendants if medication was necessary to maintain competency. Since no reporting mechanism is in place to capture this information, the status of the defendants' competency could not be determined.
3. **A reduction in re-commitments to state facilities was anticipated due to the provision of new medications for 46.B defendants;** however, there is no information to suggest this goal was accomplished. Again, without a formal process to collect this information from the local MHMRAs, jails, or the courts, it is not possible to assess whether this objective was met.

As previously noted, new program are expected to encounter implementation problems. Despite the shortcomings noted above, the potential benefit of the program can be realized through the establishment of a formal reporting mechanism. The current statutory provisions could be amended to require routine reports from the appropriate entities in order to collect the necessary outcome data for an evaluation study.

## HARRIS COUNTY - RUSK DIVERSION PROJECT

Historically, the courts have committed incompetent defendants to state hospitals for a restoration of competency. This commitment, which varied in duration as well as facility placement, was unquestionably a costly option for state and local government. With few exceptions, the entire cost of a state hospital is subsidized by general revenue. County government assumed fiscal responsibility for the transportation to and from the facility, primarily associated with personnel and travel expenditures.

In November of 2003, Harris County MHMRA, in conjunction with TCOOMMI, the Harris County Sheriff and Courts, initiated a community based competency restoration project, the Rusk Diversion Program. The primary goal of the program was to identify certain defendants in the county jail who could potentially be restored to competency while at the jail, thus avoiding a lengthy and costly commitment to a state facility. A more detailed overview of the project is included in Appendix I. To accomplish this goal, the following objectives were identified as targets:

- Reduce the number of state hospital bed days utilized by Harris County;
- Provide a community-based pilot that was shorter in duration than a typical state hospital commitment;
- Reduce the overall transportation costs associated with transporting inmates to and from the state hospital; and
- Provide information to the courts about the psychiatric conditions of inmates to assist with release and detention decisions.

Although a cost benefit analysis is not yet completed, several preliminary observations can be made:

1. **The number of defendants diverted from state hospital commitments was 419. Of the total number of 567 referrals, 419 (74%) were served by the competency restoration project.**
2. **Due to a shorter length of time defendants spent in the Rusk Diversion Project compared to a state hospital commitment, an estimated 21 days to 100 days, a speedier disposition of cases occurred.**
3. **The transportation costs were significantly reduced for the Harris County Sheriff's Department due to fewer state hospital admissions.**

In addition to these preliminary findings, other issues were raised that warrant further examination. Those issues include:

1. **A more detailed review is needed to determine why certain defendants were sent to the state facility rather than to the jail-based pilot project.** This review

should examine a profile of the defendant including past and present criminal and psychiatric history, treatment compliance and other related factors.

2. **A review should also be initiated to determine the disparity between the number of defendants sentenced to probation compared to TDCJ-CID admissions (9 probation to 105 TDCJ admissions).** Although TDCJ per day costs are considerably lower than those of the state hospital, probation costs are by far the least expensive. Also, TCOOMMI, in cooperation with CJAD, operates a community based supervision and treatment program for probationers with mental illnesses in Harris County that could have provided an alternative to incarceration. Again, without additional information regarding the defendants' history, reliable cost or outcome evaluation cannot be provided.

The preliminary outcomes of the Rusk Diversion program suggest that potential cost savings could be achieved by the state. Furthermore, implementing similar programs in other urban areas may result in decreased utilization of state hospitals and reduced county expenses associated with transportation by the sheriff's departments. In order to accurately assess the project's benefit, a comprehensive and independent cost benefit analysis and evaluation of outcomes is needed. TCOOMMI will work with Harris County officials on pursuing this activity during the next biennium.

### **TEXAS COMMISSION ON JAIL STANDARDS STUDY - MENTAL HEALTH**

An additional issue raised in the previously cited SB 553 Task Force Report, involved the mental health screening and identification process at the local jails. Based upon the findings of the task force, it was recommended that a comprehensive study be conducted on the current screening process and that the study include strategies for improving the identification of inmates with mental illness incarcerated in county jails. Toward this objective, the Legislature directed the TCJS to conduct the following:

***“...Mental Health Screening.***

- a. *The Commission on Jail Standards shall use funds appropriated above to conduct an analysis of the process for determining the mental health status of inmates in county jails in coordination with the Texas Council on Offenders with Mental Impairments.*
- b. *This analysis shall include reviews of screening methods for determining mental health status, referral procedures for diagnostics and treatment, and level of coordination with the public mental health system on identification and treatment activities...”*

As a co-collaborator of the study, TCOOMMI worked with the TCJS to address the specific issues set forth in the rider. As a result of this collaborative endeavor, a final report has been published and is available on the TCJS web site for review. A summary of the report's findings and recommendations has been highlighted below:

- 1. The current intake process for mental health screening is unreliable.** This was best demonstrated by a random sample of recently admitted inmates to TDCJ from county jails. Per statutory requirements, local jails and TDCJ have utilized a common medical report referred to as the Uniform Health Status Report Form. This reporting mechanism was designed to provide a uniform method for jails and TDCJ to document medical conditions of inmates being admitted and/or released to each entity's custody.

Based upon a random sample of 100 of the reports submitted by local jails to TDCJ, the following observations were made:

- Of the **100** inmate records reviewed, **15** or **15%** had a mental health diagnosis noted (**10** had the same diagnosis as what was found on the CARE system);
  - Of the remaining **85**, **29** or **34%** were found on the CARE system as current or former clients of MHMR, but no mental health notation was indicated by the jail;
  - **44%** of the **100** were former or current clients of MHMR.
- 2. There appears to be an inconsistent interaction between local jails and the public mental health system.** In a survey conducted with local jails, the respondents noted that MHMR was the primary contact for conducting assessments on inmates, but few jails reported having a formal relationship with the MHMR centers (i.e. contacts or written agreements).

Also, the survey responses reported that the jail's primary problems with MHMR were:

- A. Lack of responsiveness to referrals;
  - B. Refusal to provide services due to limited responsibility for jail inmates; and
  - C. Inmates not meeting priority population diagnosis. The surveys also suggested that the primary medical provider, including mental health, was with a private contract provider (i.e. local physician, hospital district, etc.).
- 3. There appears to be no linkage between the jail and community for pre-release planning and post-release treatment for offenders with mental illnesses.** Since the vast majority of experts cite aftercare treatment as a key to reduced recidivism for such offenders, a system of transition between jail and the community is needed. This is particularly needed in light of the reported frequency of persons with mental illnesses cycling in and out of county jails.
  - 4. In the absence of treatment alternatives, there are few opportunities to divert offenders with mental illnesses from incarceration under the appropriate circumstances.**

In response to these and other issues, the TCJS's final report identified several recommendations toward addressing these concerns:

1. **Require local jails to submit inmate's names to the local MHMR center for cross-referencing against the local and statewide client database.** As noted previously, the study conducted on TDCJ inmates noted a significant number of former MHMR clients that had not been identified by the jail as having a mental illness. By mandating a cross-referencing requirement, inmates with a prior or current MHMR history will be identified in a more timely fashion, and if appropriate could be diverted to treatment alternatives within the community.
2. **Develop a 24-hour hotline that local law enforcement or jail staff could contact to ascertain MHMR status at time of initial contact.** In addition, jail staff requested access to the statewide MHMR database.
3. **Monitor the local MHMRs' interactions with jails to ensure compliance with current statutory compliance relating to continuity of care.** Chapter 614, Health and Safety Code, requires TCOOMMI to monitor the development of a continuity of care system for all offenders with special needs. A part of this provision requires the MHMR centers to have written agreements with local criminal justice entities. Currently, there are no enforcement capabilities to hold MOU entities responsible for carrying out the mandate. Consequently, TCOOMMI can only encourage local jails and MHMRs to comply with the statutory mandates.
4. **Encourage local county governments to contract directly with the local MHMR for psychiatric services within the jail.** In the TCJS review of best practices, the counties that had contracts or written agreements with the public mental health system appeared to have the most consistent and clearly defined relationships, including pre- and post- release planning services.

## **TDCJ – TCOOMMI CONTINUITY OF CARE ACTIVITIES**

### **DATA SHARING**

Currently, Texas is the only state in the country with a legislatively mandated Continuity of Care System that covers the entire criminal justice continuum. As noted in Section IV of this report, the Continuity of Care Program operated by TCOOMMI is recognized as one of the most comprehensive in the nation.

The need for a statewide criminal justice continuum of care cannot be overstated. Aside from the anticipated benefits for offenders with special needs, the estimated prevalence rates suggest the need is significant.

As part of TCOOMMI's on-going continuity of care activities, TDCJ data is routinely shared with the state Mental Health agency to cross-reference for matches. The following chart shows the results of one such data comparison conducted in August of 2004:

**CROSS-REFERENCE OVERVIEW**  
**OF CLIENT ASSESSMENT REGISTRY (CARE) MATCHES**

(Total Offender Population: 628,343)

PROBATION:	<b>59,612 (15%)</b>
CID:	<b>33,008 (22%)</b>
<u>PAROLE:</u>	<b>12,332 (16%)</b>
<b>TOTAL:</b>	<b>104,952 (17%)</b>

Based upon the data produced by this single cross-referencing activity, approximately **17%** of the adult offenders under TDCJ's supervision were current or former clients of the public mental health system. This percentage is certainly in line with other prevalence studies that have reported an estimated **16%** of the adult offender population had a serious mental illness. While this number is a good starting point, it can certainly by no means be considered the actual prevalence rate.

According to the state mental health agency, current resource availability allows for the treatment of approximately one third of the potentially eligible clients. With this service information, the 17% can only be viewed as a conservative baseline of prevalence rate. Understanding this limitation, TDCJ has actively worked toward identifying, at a minimum, those offenders who were former or are current clients of MHMR. Strategies toward improving the timely identification of these offenders within TDCJ include the following:

- 1. TDCJ-CJAD provides a monthly data report to the local CSCDs on those offenders who were reported on the Client Assessment Registry (CARE) System as current or former clients of MHMR.** This allows for a timely notification process for probation departments on those probationers who may have a mental illness, but had not been identified previously. This in turn allows for a modification of probation conditions, to include specialized supervision or mental health treatment, when warranted.
- 2. TDCJ, through its information technology division, has established a weekly process to cross-reference all new admissions against the state MHMR data base.** This will allow former MHMR clients to be flagged with a potential need for mental health treatment. Also, this process will enable TCOOMMI to initiate requests for obtaining supporting medical and/or psychiatric records during the offender's initial intake period into TDCJ. Again, the records can assist the institutional medical staff to better assess the inmate's psychiatric condition based on prior treatment history.
- 3. Finally, TCOOMMI is utilizing the data to improve on the pre and post release treatment activities for offenders being released from incarceration.** This should greatly enhance the offender's re-entry to the community by setting up the necessary treatment services prior to his/her release.

As noted, TDCJ's current cross-referencing activities have focused on one segment of the special need offender population, those with mental health issues. During the next biennium, this activity will be expanded to include other offender populations who are current or former clients of other health and human service agencies. Ultimately, the data sharing among the criminal justice and health and human service agencies should enhance the identification process, thereby strengthening the continuum of care of offenders with special needs.

## **CONTINUITY OF CARE – MEMORANDA OF UNDERSTANDING**

During the past decade, the Legislature has enacted a number of legislative measures to strengthen the continuity of care process for offenders with special needs. One component of the continuity of care legislation involves the development and implementation of memoranda of understanding (MOUs) between local and state criminal justice and health and human service agencies. The MOUs are to address the following statutory requirements:

*“(a) the Texas Department of Criminal Justice, the Texas Department of Mental Health and Mental Retardation, representatives of local mental health or mental retardation authorities appointed by the Commissioner of the Texas Department of Mental Health and Mental Retardation, and the Directors of Community Supervision and Corrections Departments shall adopt a Memorandum of Understanding that establishes their respective responsibilities to institute a continuity of care and service program for offenders with mental impairments in the criminal justice system. The office shall coordinate and monitor the development and implementation of the Memorandum of Understanding.*

*(b) the Memorandum of Understanding must establish methods for: (1) identifying offenders with mental impairments in the criminal justice system and collecting and reporting prevalence rate data to the office; (2) developing interagency rules, policies, procedures, and standards for the coordination of care of and the exchange of information on offenders with mental impairments by local and state criminal justice agencies, the Texas Department of Mental Health and Mental Retardation, local mental health or mental retardation authorities, the Commission on Jail Standards, and local jails; (3) identifying the services needed by offenders with mental impairments to reenter the community successfully; and (4) establishing a process to report implementation activities to the office.*

*(c) the Texas Department of Criminal Justice, the Texas Department of Mental Health and Mental Retardation, local mental health or mental retardation authorities, and Community Supervision and Corrections Departments shall: (1) operate the continuity of care and service program for offenders with mental impairments in the criminal justice system with funds appropriated for that purpose; and (2) actively seek federal grants or funds to operate and expand the program. (d) local and state criminal justice agencies shall, whenever possible, contract with local mental health or mental retardation authorities to maximize Medicaid funding and improve on the continuity of care and service program for offenders with mental impairments in the criminal justice system. (e) the office, in coordination with each state agency identified in subsection (b)(2), shall develop a standardized process for collecting and reporting the Memorandum of Understanding implementation outcomes by local and state criminal justice agencies and local and state mental health or mental retardation authorities. The findings of these reports shall be*



*submitted to the office by September 1 of each even-numbered year and shall be included in recommendations to the board in the office's Biennial Report under section 614.009..."*

Due to the number of new legislative initiatives impacting TDCJ/TCOOMMI , the written agreements or MOUs between TDCJ and the affected entities were revised to incorporate the changes made in the 78<sup>th</sup> Legislative Session. The revised MOU that was adopted by the Texas Board of Criminal Justice in December, 2004, is found in Appendix II.

The MOUs are intended to define each entity's individual as well as collective role and responsibility in the Continuity of Care process. In essence, it provides a blueprint for the various local and state criminal justice and health and human agencies to follow in respect to the agencies' role on behalf of the offender.

A critical component of the MOU is the sharing of information between the affected agencies. Texas, unlike other states, has permissive legislation allowing for the release of confidential information without consent if the information is for the purpose of continuity of care. Without the MOU or continuity of care provisions, the efforts that have been initiated to better identify offenders with special needs could not have occurred. This aspect of the MOU has proven to be the most beneficial in this state's efforts toward a comprehensive continuity of care system. There are, however, other MOU-related activities that have not yielded the same level of success.

The most notable limitation is the lack of consistent oversight by TCOOMMI on the implementation activities. A number of factors contribute to this problem, but the number of agencies involved in the MOU process is perhaps the biggest impediment. For example, the MOU for offenders with mental impairments requires TDCJ to obtain signed agreements with 41 local MRMR centers, 121 CSCDs and 238 jails. This number becomes higher when factoring in the MOUs required for the other TCOOMMI offenders such as elderly, terminally ill, physically handicapped, etc.

TCOOMMI monitoring and implementation activities are further hampered by the lack of enforcement authority. If a jail or local MHMR does not implement the MOU, there are no consequences available.

With the current resource limitations confronting local and state governments, it would be fiscally unwise to abandon the MOU activity. A more logical response would be to strengthen reporting and enforcement requirements associated with the MOUs. This could be achieved by amending current statutory, regulatory, procedural or programmatic practices that impact the implementation activities. In addition, routine status reports to the appropriate legislative oversight committees or governing boards could prove to be a worthwhile incentive for affected agencies.

Whatever action is ultimately taken, the goal of creating a comprehensive continuity of care system should be given the highest level of priority. Without such a system, the state can anticipate increased fragmentation and duplication of effort. More importantly, resulting cracks in the service delivery system could contribute to decreased treatment coordination, and increased recidivism.

## SECTION VI. FUTURE ISSUES

Based upon the accomplishments noted in this report, continued progress has been made toward establishing a more comprehensive continuity of care system for offenders with special needs. Despite the progress, several areas will require additional work and refinement during the next biennium. Those areas and possible recommendations toward addressing them have been outlined throughout this report.

In addition, there are several issues that have been identified by the TCOOMMI office and advisory committee that warrant further review during the next biennium. Those issues include:

1. **Offenders with special needs, such as the elderly or those with significant medical problems will continue to present significant fiscal and operational challenges to the criminal justice system.** Local jails and state correctional facilities have legal obligations to provide adequate medical care, and these costs are anticipated to increase dramatically the next decade. Efforts to provide community based sentencing alternatives or pre-trial release options to medically challenged offenders should be explored to minimize the treatment costs for local and state governments
2. **Efforts should be initiated to establish a service history cross-referencing special needs offenders, similar to the activity currently in place for offenders with mental illnesses.** As demonstrated by the cross-referencing of TDCJ and MHMR data, a significant number of offenders with prior MHMR history were under-identified by local jails and subsequently by TDCJ. The same situation could apply to offenders with medical or physical impairments. By obtaining prior service history from local and state health and human service agencies, better identification and more timely treatment interventions can be initiated on behalf of these offenders.
3. **Increased attention should be made on improved identification and service delivery needs of juvenile and adult offenders with mental retardation.** As noted in this report, enhanced identification activities have been made for those offenders with a mental illness. In addition, treatment services have been targeted for these offenders to ensure immediate treatment access. The same level of effort for offenders with mental retardation has not been made, thus no reliable prevalence data on recidivism studies can be provided.
4. **Communication between local and state criminal justice and health and human service agencies must be enhanced.** The TCOOMMI advisory committee members are charged with sharing information to and from their respective agencies and/or associations on issues related to offenders with special needs. Based upon numerous experiences during the biennium, it has become clear that TCOOMMI members are not disseminating information to their respective agencies. As a result,

tremendous energy is expended working on issues that have previously been addressed by TCOOMMI. In an environment of limited and scarce resources, this duplication should be avoided at all costs.

Formulating responses to these and other issues identified in this report will be the focus of TCOOMMI's efforts during the next biennium. As in years past, the ultimate goal of our work will be towards enhancing safety by promoting effective regulatory, statutory, procedural and programmatic practices impacting offenders with special needs.

**SECTION VII.  
APPENDICES**

APPENDIX I

Rusk Diversion Project Overview

APPENDIX II

Memorandum of Understanding

# State Hospital (Rusk) Diversion Project

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Location: Harris County Sheriff Department,  
Houston, Texas 77002

Steven B. Schnee, PhD., Executive Director  
Mental Health & Mental Retardation Authority of Harris County

co-sponsor

**TEXAS CORRECTIONAL OFFICE on OFFENDERS WITH  
MEDICAL or MENTAL IMPAIRMENTS PILOT  
(TCOOMMI)**

# Newest Component to Harris Co. Diversion Programs

- Addresses the need to reduce lengthy and repeated hospitalizations
- **State Hospital (Rusk) Diversion Project**
  - ◆ resulted from a task force consisting of County Leaders from all major areas, Administrative Judges, attorneys, Court Managers, Executive Directors of MHMRA, MHA, Community Supervision & Parole, and Harris County Sheriff's Department top administrators.
  - ◆ TCOOMMI agreed to sponsor the cost of New Generation Medications associated with this project under the same guidelines as those consumers returning from a State Hospital with Competency restored.

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## Introduction

- ◆ This program began November 17, 2003 as a new component of the Screening/Outpatient Mental Health Jail Services.
- ◆ Offenders who indicate mental health problems during their first court appearance are referred to this unit for psychiatric stabilization versus automatic requests for a competency evaluation.
- ◆ This program was designed to reduce the number of Mentally Ill Offenders (MIOs) referred to the state hospital for competency restoration through the Harris County Criminal Justice System.

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## Introduction Cont'd.

- ◆ Studies indicated that a majority of MIOs transferred to the State Hospital (Rusk) for restoration arrived at the hospital and were in no need of restoration due to the fact that medications had been initiated by the MHMRA Jail Unit while awaiting their transfer to the state hospital.
- ◆ Further studies indicated that court officers were automatically requesting mental health competency evaluations on all consumers reporting or exhibiting any indication of mental illness at the first court appearance.
- ◆ Requesting a screening and/or rapid stabilization by medications might have eliminated the recommendation for a formal competency evaluation.

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## Objectives

- Reduce the number of bed days being utilized by Harris County at the State Hospital
- Provide a local treatment site and enable family visitation (Rusk State Hospital is more than a 2 hours drive).
- Educate officers of the courts in identifying and managing behaviors of mentally ill impaired offenders
- Provide information to the courts about the psychiatric conditions of inmates to assist with release and detention decisions
- Reduce the amount of money spent by Harris County on transportation to the State Hospital.

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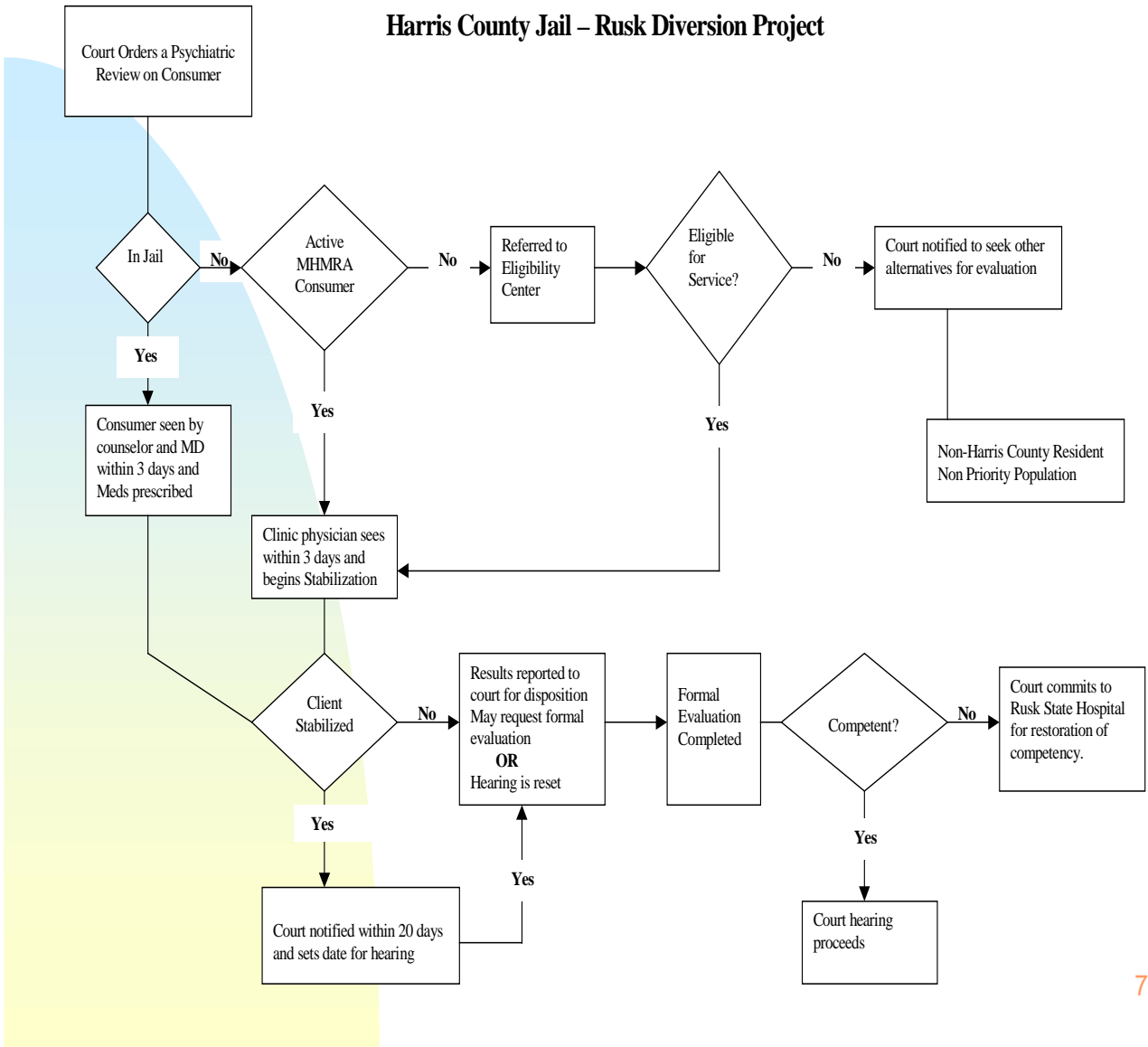


## Attachments

- Flow Chart of Project
- Sample of Court Order for Psychiatric Review
- Sample of Psychiatric Status Report
- Chart of Statistical Data from November 17, 2003 - August 31, 2004



## Harris County Jail – Rusk Diversion Project



CAUSE NO. \_\_\_\_\_

THE STATE OF TEXAS § IN THE \_\_\_\_\_ DISTRICT COURT /  
§ COUNTY COURT AT LAW NO. \_\_\_\_  
§  
VS. §  
§  
§ OF HARRIS COUNTY, TEXAS  
DEFENDANT §  
SPN \_\_\_\_\_ CELL \_\_\_\_\_

ORDER FOR PSYCHIATRIC OR MEDICAL REVIEW

Today, the Court was presented with evidence indicating that the defendant may be in need of psychiatric and / or medical examination.

THIS EVIDENCE INCLUDES THE FOLLOWING:  
\_\_\_\_\_  
\_\_\_\_\_

The Court **ORDERS** the Sheriff of Harris County to take necessary steps to ensure that qualified personnel perform a psychiatric or medical exam to determine if the defendant needs psychiatric and/or medical care and/ or medication.

- The inmate is currently incarcerated in the Harris County Jail.
- The inmate will be arriving in Harris County Jail on \_\_\_\_\_ (date).

The Court **ORDERS** the Clerk of the Court to fax a copy of this Order to the doctor indicated below and to place the fax confirmation receipt in the Court's file.

- (Psychiatric exam)  (Medical exam)
- Medical Director Medical Director
- MHMRA Forensic Unit Harris County Jail Medical Unit
- Voice (713) 755-7241 Voice (713) 755-6541
- FAX (713) 755-8821 FAX (713) 755-6011

The Court **ORDERS** the doctor who conducts the evaluation to file his findings no later than the twenty-first (21<sup>st</sup>) day after the issuance of this Order.

Signed \_\_\_\_\_  
Judge Presiding

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CAUSE NO. \_\_\_\_\_

THE STATE OF TEXAS § IN THE \_\_\_\_\_ DISTRICT COURT /  
§ COUNTY CRIMINAL COURT AT LAW  
§ NO. \_\_\_\_\_  
VS. §  
§ OF HARRIS COUNTY, TEXAS  
DEFENDANT §  
SPN \_\_\_\_\_ CELL \_\_\_\_\_

PSYCHIATRIC OR MEDICAL STATUS REPORT

This Report is made not later than twenty-one (21) days of the issuance of the Court's Order in the above case. Pursuant to the Court's Order, I have conducted the following examination on the defendant: (check all that apply)

- Psychiatric examination
- Medical examination
- The defendant is no longer in custody and I did not conduct an examination
- The defendant is in custody, but I did not conduct an examination
- Other \_\_\_\_\_

(Check all that apply)

<input type="checkbox"/> PSYCHIATRIC STATUS	<input type="checkbox"/> MEDICAL STATUS
After examining the defendant, I have determined that, as of today, the defendant: <input type="checkbox"/> appears to be demonstrating aggressive and unpredictable behavior. <input type="checkbox"/> is receiving medication. <input type="checkbox"/> needs additional time, ____ (days), for stabilization. <input type="checkbox"/> does not need medications. <input type="checkbox"/> has refused to be placed on medication. <input type="checkbox"/> needs a formal mental health evaluation.	After examining the defendant, I have determined that, as of today, the defendant appears to be <input type="checkbox"/> physically <b>unable</b> to attend court. <input type="checkbox"/> physically <b>able</b> to attend court.

Other \_\_\_\_\_

Signed on the day \_\_\_\_\_ of \_\_\_\_\_ 20\_\_.

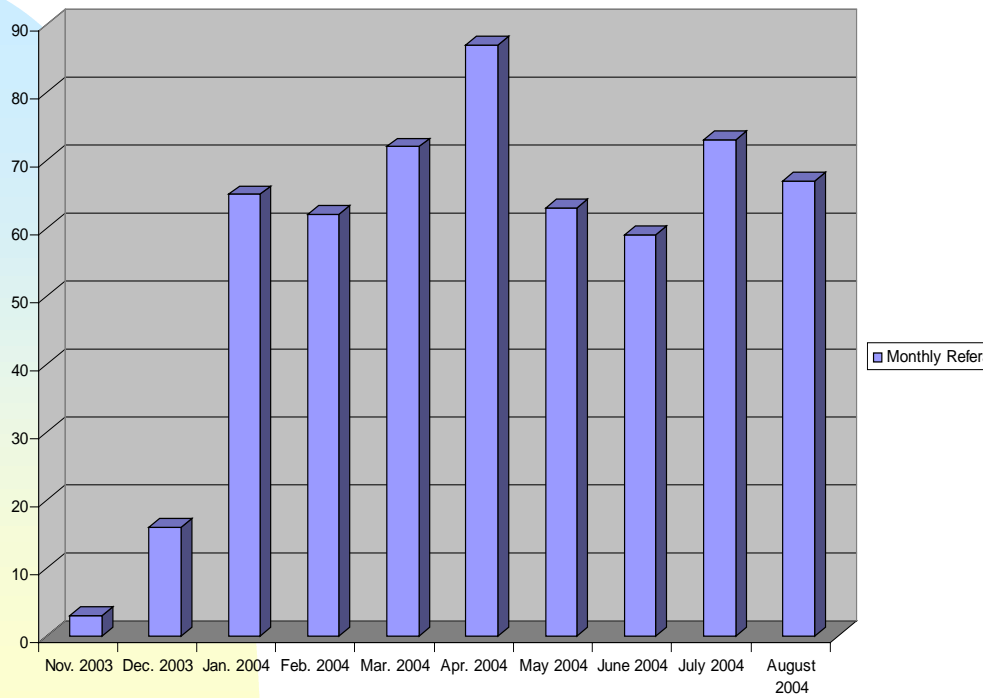
\_\_\_\_\_  
Attending Physician (Please Print) Attending Physician (Signature)

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Month	# of Referrals Served	Previous History with MHMRA CARE	Active with MHMRA at Referral *	Targeted Priority Pop. Diagnosis	Court		Probation	Parole	Diverted from State Hospital	State Hospital Transfers		Date of Transfer RUSK	Date of Transfer VERNON	Cases Pending
					Misd.	Felony				Rusk	Other			
Nov. 2003	3	3	2	3	3	0			2	1	0	02/05/04		0
Dec. 2003	16	15	11	11	16	0	1	1	13	1	2	02/18/04	03/16/04; 3/30/04	0
Jan. 2004	65	44	18	34	30	35	5	4	60	4	0	03/04/04; 03/22/04 & 4/01/04; 5/31/04		1
Feb. 2004	62	57	28	38	21	40	8	1	51	3	4	4/1/04; 4/22/04 & 5/20/04	4/27/04; 6/8/04; 6/22/04; 7/26/04	4
Mar. 2004	72	51	22	52	17	55	7	7	58	5	6	5/13/04; 5/20/04; & 6/1/04 (2); 6/17/04	5/18/04; 5/31/04; 6/8/04; 6/22/04; 7/15/04; 8/3/04	3
Apr. 2004	87	59	23	57	36	51	6	3	77	5	2	6/17/04 (2); 7/1/04; 8/5/04; 9/2/04	6/15/04; 8/10/04	3
May 2004	63	39	17	49	28	35	8	3	50	4	3	7/15/04; 7/26/04 (2); 8/19/04	8/31/04; 9/7/04; 9/8	6
June 2004	59	43	19	50	31	28	10		47	2	3	8/19/2004; 9/15	8/03/04; 8/10/04; 8/31	7
July 2004	73	36	14	52	22	51	8	10	40	3	1	8/30/2004; 9/15; 9/23	9/7	29
August 2004	67	34	18	44	29	40	8	1	21	0	0	-	-	46
<b>Total</b>	<b>567</b>	<b>381</b>	<b>172</b>	<b>390</b>	<b>233</b>	<b>335</b>	<b>61</b>	<b>30</b>	<b>419</b>	<b>28</b>	<b>21</b>			<b>99</b>
<b>Percentages</b>		<b>67%</b>	<b>30%</b>	<b>69%</b>	<b>41%</b>	<b>59%</b>	<b>11%</b>	<b>0%</b>	<b>68%</b>					

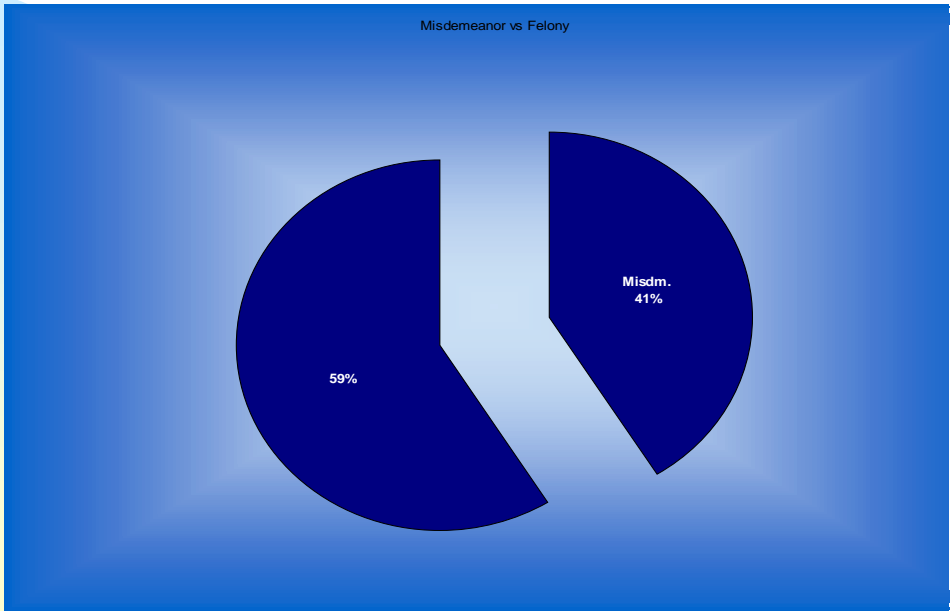
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Monthly Referrals



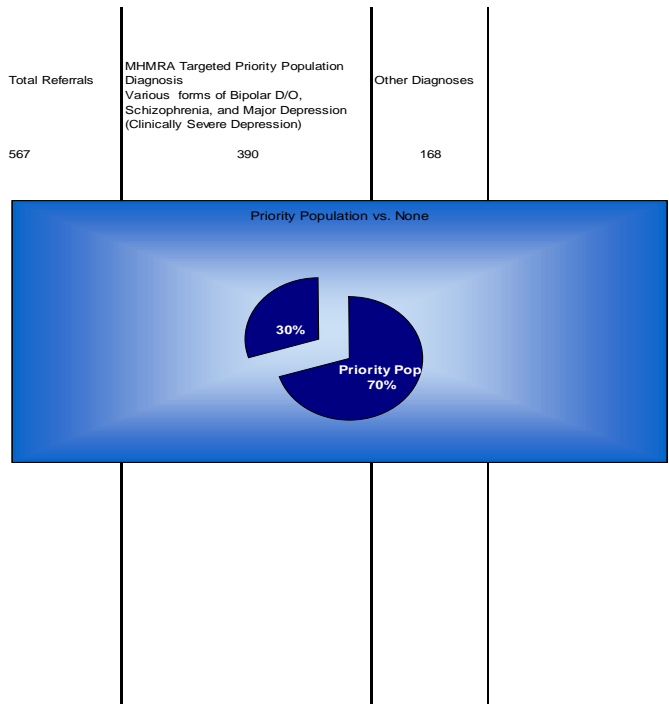
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Adult Forensic Unit  
 Rusk State Hospital Diversion Program  
 November 17, 2003 - August 21, 2004



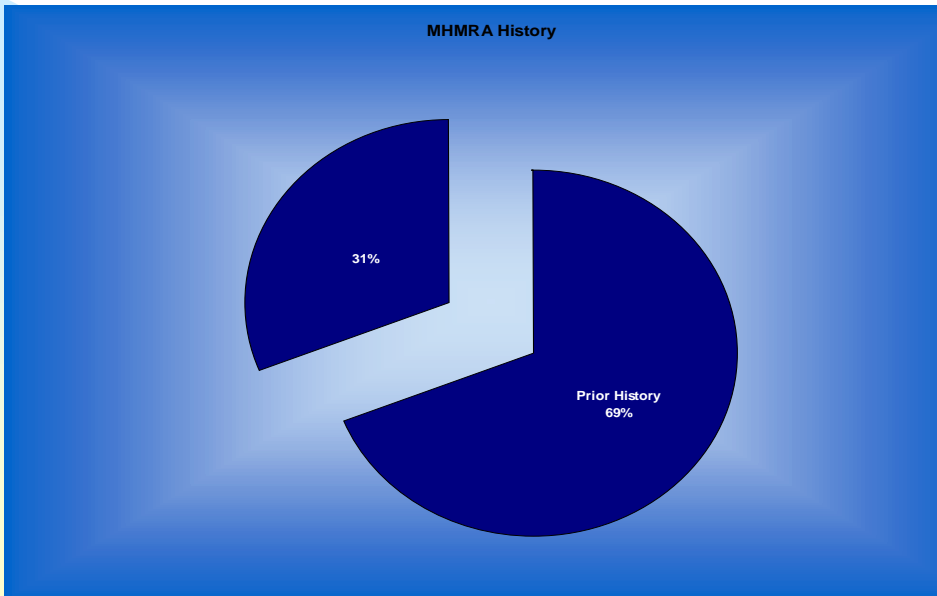
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Adult Forensic Unit  
 Rusk State Hospital Diversion Program  
 November 17, 2003 - August 21, 2004



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Adult Forensic Unit  
 Rusk State Hospital Diversion Program  
 November 17, 2003 - August 21, 2004



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Adult Forensic Unit  
 Rusk State Hospital Diversion Program  
 November 17, 2003 - August 21, 2004

The HCSO transported prisoners to Rusk State Hospital 40 times in 2003. The total cost per trip was approximately \$833.58. That includes salary, overtime costs, vehicle cost (fuel, service and depreciation), meals, etc. At \$833.58 a trip, the total cost of the 40 trips was approximately \$33,343.20.

Facility	Avg. Cost/day	# of inmates touched by Jail Diversion	Avg. # of days	Total Cost/Day
State Hospital	\$270.38	49	137	\$1,815,060.94
State Jail*	\$38.57	52	90	\$180,507.60
TDCJ**	\$105.00	53	unknown	
Harris Co. Jail	\$50.60	225	90	\$1,024,650.00

\*The Criminal Justice Policy Council Report in 2002  
 \*\*TCOJ's 2001 Biennial Report

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**RSH Utilization Statistics for HC Jail Forensic  
Competency Restoration Cases (2/1/04 through 8/31/04)**

Category	Quantity	Fee	Total Cost
GR Admissions	33	425.00	\$14,025.00
GR Acute Bed Days	1956	300.00	\$586,800.00
GR Sub-Acute Bed Days	6072	260.00	\$1,578,720.00

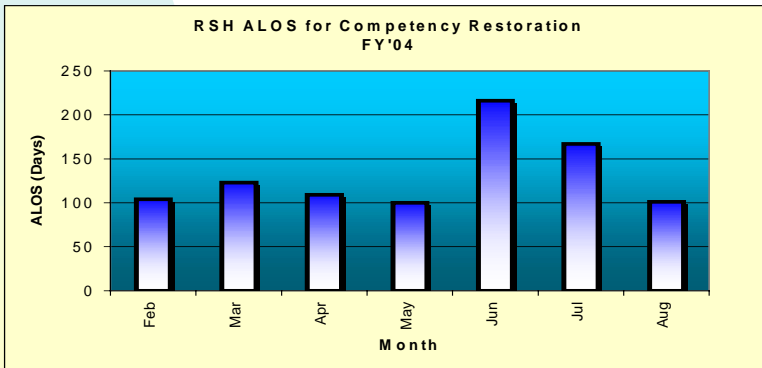
*\*Note: statistics do not include competency restoration cases transferred to RSH from VSH, Juvenile Forensic cases, or NGRI Forensic cases.*

<b>Total Cost</b>	<b>\$2,179,545.00</b>
<b>Total Bed Days</b>	<b>8061</b>

<b>Average Cost Per Member Per Day</b>	<b>\$270.38</b>
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<b>Average Length of Stay (bed days)</b>	<b>137.02</b>
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<b>Average Cost per Member per Total Stay</b>	<b>\$37,036.50</b>
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**Diversion Type**

Month	Referrals	Sentence Served @ Harris County Jail	Deferred Adjudication	Transfer to State Hospital	Cases Dismissed	Acquitted	Probation	Justice /State Jail (* see profile)	Cases Pending
Nov. 2003	3	2	0	1	0	0	0	0	0
Dec. 2003	16	9	0	3	4	0	0	0	0
Jan. 2004	65	34	5	4	6	1	1	13	1
Feb. 2004	62	21	3	8	7	2	2	15	4
Mar. 2004	72	24	4	11	7	0	1	22	3
Apr. 2004	87	41	4	7	9	1	1	21	3
May 2004	63	26	1	7	7	0	2	14	6
June 2004	59	24	6	4	7	0	1	10	7
July 2004	73	28	4	4	1	0	1	6	29
August 2004	67	16	0	0	1	0	0	4	46
<b>Total</b>	<b>567</b>	<b>225</b>	<b>27</b>	<b>49</b>	<b>49</b>	<b>4</b>	<b>9</b>	<b>105</b>	<b>99</b>

\* See No. of Cases Pending

Profile of those sentenced to Texas Department of Corrections		
	TDC	STATE Jail
Sentence	53	52
0-2 yrs	21	
3-6yrs	14	
7-10yrs	8	
11-20yrs	8	
Over 20 years	2	
Diagnosis		
Targeted priority population	38	36
Substance/Alcohol and other related	8	5
Other	7	11
New Generation Medication	29	30

*All inmates sentenced to both TDC and the STATE Jail were sent there following a felony offense*

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## Access to Services

- A Court Order for Psychiatric Review is generated at the first appearance of the consumer in court by the attorney if there is a question of mental instability.
- Every consumer referred is evaluated by a skilled screener and forwarded to a psychiatrist within 3 business days of receipt of the Court Order.
- The psychiatrist will re-evaluate the consumer 14 days after the initiation of treatment (medications, observation, etc..)

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## Access to Services Cont'd.

- A Psychiatric Status Report is forwarded back to the Court within 21 days of the initial court order recommending the following:
  - ◆ the consumer is referred for a formal mental health evaluation ( competency), or
  - ◆ additional time is requested for further stabilization, or
  - ◆ the consumer is stabilized on medications and the court process may continue, or
  - ◆ the consumers does not need medications.

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## Success Based On

- Continuous integration of all systems (criminal justice, social, behavioral) to find appropriate interventions to break the cycle
- It is critical to share information and any other resources to effectively break the cycle no matter which port of entrance the mentally ill comes through

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## Obstacles

- Initial Obstacles included:
  - ◆ courts refusal to utilize program (monitors set up by court managers offices help to reduce lack of usage)
  - ◆ courts orders used inappropriately -not used to help distinguish need for competency evaluation

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## Obstacles continued

- How to handle inmates who have bonded out of jail, but initiated into this process who
  - ◆ are not targeted population
  - ◆ have private insurance, private doctor and not part of MHMRA system

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## Obstacles continued

- Lack of additional staff (doctors and initial screeners) to meet the demands of the program (i.e. 2 -face to face contacts with MD's within less than 30 days).
- ability to provide aftercare services limited by
  - ◆ the number of who are non-targeted population
  - ◆ only 5 available slots for new incoming clients to MHMRA system for all inmates being released from the jail
  - ◆ no available medications upon release from system

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**TCOOMMI BIENNIAL REPORT  
APPENDIX II**

**MEMORANDUM OF UNDERSTANDING**

Between the

Texas Department of Criminal Justice

the

Health and Human Services Commission –Department of State Health

Services

Community Mental Health and Mental Retardation Centers

And

Community Supervision and Corrections Departments

For the purpose of establishing a continuity of care system for offenders with mental illness or mental retardation (mental impairments); the Texas Department of Criminal Justice (TDCJ); the Health and Human Services Commission (HHSC) – Department of State Health Services (DSHS); community Mental Health and Mental Retardation centers as the designated Mental Health/Mental Retardation (MHMR) authorities in Texas; and local Community Supervision and Corrections Departments (CSCDs), (The Entities) agree to the following:

1. AUTHORITY AND PURPOSE:

Texas Health & Safety Code, Section 614.013 authorizes TDCJ, HHSC-DSHS, local MHMR authorities, and CSCDs to establish a Memorandum of Understanding (MOU) that identifies methods for:

- identifying offenders with mental impairments in the criminal justice system and collecting and reporting prevalence rate data to the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI);
- developing interagency rules, policies, procedures, and standards for the coordination of care of and the exchange of information on offenders with mental impairments by local and state criminal justice agencies, the Health and Human Services Commission – Department of State Health Services, local mental health or mental retardation authorities, the Commission on Jail Standards, and local jails;
- identifying the services needed by offenders with mental impairments to reenter the community successfully; and
- establishing a process to report implementation activities to TCOOMMI.

2. ALL ENTITIES AGREE TO:

- a) Follow the statutory provisions in Chapter 614 of the Health and Safety Code relating to the exchange of information (including electronic) about offenders with mental impairments or mental retardation for the purpose of providing or coordinating services among the Entities; and when appropriate include such requirements in any relevant rules, policies or contract/grants.
- b) Develop rules, policies, procedures, regulations or standards that describe the agency's role and responsibility in the continuity of care process for persons with mental impairments and/or mental retardation.
- c) Develop procedures that provide for the preparation and sharing of assessments or diagnostics prior to the imposition of community supervision, incarceration, or parole, and the transfer of such diagnostics between local and state entities described in this agreement.
- d) Participate in cross training or educational events targeted for improving each agency's knowledge and understanding of the criminal justice and HHSC-DSHS systems' roles and responsibilities.
- e) Inform each other of any proposed policy, procedure, standard or rule changes which could affect the continuity of care system with each agency afforded thirty (30) days after receipt of proposed change(s) to respond to the recommendations prior to the adoption.

- f) Provide written status reports to TCOOMMI on the implementation of initiatives outlined in this MOU on a routine basis, but not less than once a year.
- g) Actively seek federal funds to operate or expand the service capability to include local and state criminal justice entities contracting with the public mental health system for the purpose of maximizing Medicaid and other entitlements.

3. TDCJ THROUGH ITS DIVISIONS SHALL:

- a) Cross reference offender database to the CARE system and make information available to the CSCDs on a monthly basis.
- b) Develop standards for specialized mental health caseloads and provide training/technical assistance to specialized officers on a routine basis.
- c) Establish a process for cross-referencing data on CID inmates with the HHSC-DSHS CARE system on a weekly basis. This process will include an internal mechanism for distributing the information to the appropriate division(s), contract entities or other providers as deemed necessary and allowed by law.
- d) Develop a process to ensure that any psychiatric, diagnostic or treatment information pertaining to offenders will be provided to relevant local and state criminal justice, mental health or other contract providers prior to release from custody.
- e) Ensure that offenders being released from institutional facilities have access to a ten-day supply of medications upon their release.

- f) Establish an internal procedure in cooperation with TCOOMMI to review Motion to Revoke cases (blue warrants) involving any parolee with a mental impairment. This review will address interventions that have been made or should be made prior to final revocation action.
- g) Report implementation activities to TCOOMMI on a quarterly basis.

4. HHSC-DSHS SHALL:

- a) Develop, in cooperation with TCOOMMI, continuity of care rules specific to juveniles or adults with mental impairments and/or mental retardation who are involved in the criminal justice system.
- b) Notify in accordance to Commissioners Rules, the local mental health authority and TCOOMMI, of a 46.B defendant's release from a state facility to the committing jurisdiction after restoration of competency has been determined.
- c) Include in the performance contract requirements for local MHMR centers to adhere to and implement the activities outlined in the MOU, including statutory provisions specific to sharing of information, and cross-referencing data with local and state correctional, juvenile justice and criminal justice entities.
- d) Respond to TDCJ's weekly data requests to cross-reference offender data to the CARE system and provide match information within 7 days.
- e) Provide quarterly reports to TCOOMMI on the status of MOU implementation activities.

5. COMMUNITY SUPERVISION AND CORRECTIONS DEPARTMENTS ARE RESPONSIBLE FOR THE FOLLOWING ACTIVITIES:

- a) Submit to the local MHMR Authorities a list of offenders who are being supervised (i.e., pre-trial, if applicable; deferred adjudication or placed on community supervision) by the department on a schedule mutually agreed upon by the department and the local MHMR authority. The initial list submitted should include all offenders on some form of supervision in order to establish a baseline. All lists thereafter will consist of new and/or deleted cases during the period being reported.
- b) Facilitate the coordination of supervision with local MHMR authorities or other treatment providers. This will include:
  - joint staffings of mutual offender/clients to review compliance to treatment and supervision;
  - input on modifications of conditions;
  - coordination with treatment providers on imposing new conditions, sanctions or motion to revoke/adjudicate in order to explore all possible alternatives to incarceration; and
  - coordination on the development of a joint supervision and treatment plan if governing standards for the respective participants can be adhered to in the proposed plan.
- c) Provide technical assistance and training to local MHMR staff on criminal justice issues specific to community supervision.

- d) Participate in quarterly meetings with the MHMR Executive Director(s) and/or his/her designee to review the implementation of MOU activities and to document status.
- e) Contract with the local MHMR authorities for mental health/mental retardation assessments or other treatment services in order to minimize duplication of effort and maximize Medicaid or other federal benefits.

6. THE LOCAL MHMR AUTHORITY WILL PERFORM THE FOLLOWING ACTIVITIES:

- a) Provide to the CSCD the name of the designated staff member who serves as the contact for all criminal justice referrals and other related issues (i.e., obtaining client information, records or assessments).
- b) Facilitate the coordination of supervision with the CSCD personnel that will include:
  - joint staffings of mutual offender/clients to review compliance to treatment and supervision;
  - input on modifications of conditions;
  - coordination with CSCD personnel on imposing new conditions, sanctions and/or motion to revoke/adjudicate in order to explore all possible alternatives to incarceration; and
  - coordination on the development of a joint supervision and treatment plan if governing standards for the respective participants can be adhered to in the proposed plan.
- c) Establish a process for cross-referencing probation and/or local inmate jail lists with the HHSC-DSHS CARE system. Progress toward or



obstacles to complying with this MOU activity will be reported to TCOOMMI with an explanation of obstacles and recommendations for correction. If a process cannot be established electronically, an alternative should be developed that will establish a referral and reporting system between the center and local CSCDs and jails in their catchment area.

- d) Coordinate with the jail on those persons incarcerated who have been returned to the local jail under a Section 46.B, Code of Criminal Procedure commitment, in accordance with TCOOMMI contract requirements with the local MHMR authority.
- e) Designate a continuity of care contact person for all 46.B commitments to serve as the primary liaison between local MHMR authorities, jails and TCOOMMI.
- f) Participate in quarterly meetings with the CSCD Director or his/her designee to review the implementation of MOU activities and to document status.
- g) Offer or provide technical assistance and training to the CSCD and other criminal justice entities (pre-trial, jail, courts) on mental health and related issues.
- h) Provide written quarterly reports to TCOOMMI and the HHSC-DSHS governing body on the implementation and status of MOU activities as outlined in this section. These reports will satisfy reporting requirements in Section 2 of this MOU.

7. REVIEW AND MONITORING:

- a) This MOU shall be adopted by the Health and Human services Commission – Department of State Health Services, the Texas Department of Criminal Justice, the boards of trustees of community MHMR centers and local CSCDs. Subsequent to adoption, all parties must provide status reports to TCOOMMI. Amendments to this MOU may be made at any time by mutual agreement of the parties.
- b) TCOOMMI will serve as the dispute resolution mechanism for conflicts concerning this MOU at both the local and statewide level.
- c) TCOOMMI, in coordination with each state agency identified, shall develop a standardized process for collecting and reporting the MOU implementation outcomes by local and state criminal justice agencies and local and state mental health or mental retardation authorities. The findings of these reports shall be submitted to TCOOMMI by September 1 of each even-numbered year and shall be included in recommendations to the legislature in TCOOMMI's biennium report.