HOUSE COMMITTEE ON CORRECTIONS
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2006

A REPORT TO THE
HOUSE OF REPRESENTATIVES
80TH TEXAS LEGISLATURE

JERRY MADDEN
CHAIRMAN

COMMITTEE CLERK
RAENETTA NANCE

House Committee On Corrections

November 22, 2006

Jerry Madden
Chairman

P.O. Box 2910
Austin, Texas 78768-2910

The Honorable Tom Craddick
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on Corrections of the Seventy-Ninth Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighteenth Legislature.

Respectfully submitted,

Jerry Madden

Delwin Jones, Vice Chairman

Patrick "Pat" Haggerty

Scott Hochberg

Jim McReynolds

Rick Noriega

Kirk England

Jerry Madden
Chairman

Delwin Jones
Vice-Chairman

Members: Patrick "Pat" Haggerty, Scott Hochberg, Jim McReynolds, Rick Noriega, Kirk England

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INTRODUCTION

At the beginning of the 79th Legislature, the Honorable Tom Craddick, Speaker of the Texas House of Representatives, appointed seven members to the House Committee on Corrections. The Committee membership included the following: Jerry Madden, Chair; Delwin Jones, Vice-Chair; Pat Haggerty; Ray Allen; Scott Hochberg; Jim McReynolds; Rick Noriega.

Representative Melissa Noriega was sworn in to replace her husband as Acting Representative on January 11, 2005 while Representative Rick Noriega served in Afghanistan. She served on the Corrections Committee until Representative Rick Noriega returned to his home and resumed responsibilities as the elected representative on August 26, 2005. Representative Melissa Noriega contributed greatly to the work of this committee in the regular session and her service was greatly appreciated by all of the committee members.

On January 18, 2006 Representative Ray Allen resigned from the legislature. Representative Ray Allen did a great service to this committee and the criminal justice community in the past as Chairman of the Corrections Committee and as a serving member. In a special election, Kirk England was elected to represent the Texas House of Representatives District 106 and was later appointed by the Speaker of the House to serve on the House Committee on Corrections as well as the House Committee on County Affairs.

During the interim, the Corrections Committee was assigned eight charges by the speaker:

1. Study the organizational structure of the department to determine if the current system is effectively and efficiently addressing the needs of all components of the criminal justice system in conjunction with the Sunset review of the Texas Department of Criminal Justice (TDCJ) in 2007.

2. Examine the probation system and reforms debated during the 79th Legislature, including using strategies such as graduated sanctions and specialized courts for reducing revocations and recidivism. Study the organization and cost of our probation system and make recommendations about how to prioritize and strengthen general supervision.

3. Evaluate the correctional health care systems in other states as they compare to the Texas health care system, with a focus on greater accountability and competition among providers.

4. Assess the programming needs for special populations in the Texas Department of Criminal Justice (TDCJ).

5. Review the operation and organization of the Windham School District.

6. Study the adequacy of the state accountability system in measuring the effectiveness of Disciplinary Alternative Education Programs (DAEPs) based on academic performance, behavior modification and percentage of students referred to the juvenile justice system. (Joint Interim Charge with the House Committee on Public Education)

7. Study the effectiveness of prevention programs, such as after school programs, in reducing the actual indices of crime and the rate of young offenders entering the criminal justice system. (Joint Interim Charge with the House Committee on Juvenile Justice and Family Issues)

8. Monitor the agencies and programs under the Committee's oversight and monitor the Governor's Criminal Justice Advisory Council.

Charges 1, 2, 7 and 8 were studied by the full Corrections Committee. In order to undertake all of the charges efficiently and effectively Chairman Madden also appointed two subcommittees: the Subcommittee on Education and the Subcommittee on Healthcare and Special Populations.

The full committee and the subcommittees have completed their hearings and investigations and have issued their respective reports. The Corrections Committee has approved all reports, which are incorporated as the following final report for the entire committee. The members approved all sections of the report with the exception of Representative Rick Noriega. Representative Noriega was on active duty with the National Guard during the interim hearings and drafting of the report recommendations. Representative Noriega felt it was inappropriate to sign something that he was not directly involved with.

Finally, the Committee wishes to express appreciation to the Committee Clerk, Raenetta Nance, for her work in preparing the reports and to Representative Madden's staff, Marsha McLane, Taryn Dusek, and Mark Hey for their contributions in research, writing, and editing. The Committee also wishes to express gratitude to the agencies that assisted the Committee and supplied valuable information for the preparation of the report, in particular the Texas Department of Criminal Justice, TDCJ executive staff, the TDCJ-Criminal Justice Assistance Division, Texas Board of Pardons and Paroles, State Auditor's Office, Texas Correctional Office on Offenders with Medical and Mental Impairments, Texas Juvenile Probation Commission, Texas Youth Commission, Council on Sex Offender Treatment, and the citizens who testified at the hearings for their time and efforts on behalf of the Committee.

HOUSE COMMITTEE ON CORRECTIONS

INTERIM STUDY CHARGES, HEARINGS, AND SUBCOMMITTEE ASSIGNMENTS

CHARGE NO. 1- Study the organizational structure of the department to determine if the current system is effectively and efficiently addressing the needs of all components of the criminal justice system in conjunction with the Sunset review of the Texas Department of Criminal Justice (TDCJ) in 2007.

This charge was not delegated to a subcommittee, the full committee responded to charge 1.

In response to its charge, the Committee on Corrections held a public hearing dedicated to this charge on March 22, 2006. The Committee heard both invited and public testimony during the course of this hearing.

CHARGE NO. 2- Examine the probation system and reforms debated during the 79th Legislature, including using strategies such as graduated sanctions and specialized courts for reducing revocations and recidivism. Study the organization and cost of our probation system and make recommendations about how to prioritize and strengthen general supervision.

This charge was not delegated to a subcommittee, the full committee responded to charge 2.

The Committee on Corrections held a public hearing dedicated to this charge on March 22, 2006. The Committee heard both invited and public testimony during the course of this hearing. Much of the public testimony highlighted how the probation system contributes to prison overcrowding.

CHARGE NO. 3- Evaluate the correctional health care systems in other states as they compare to the Texas health care system, with a focus on greater accountability and competition among providers.

This charge was assigned to the Subcommittee on Healthcare and Special Populations. Members included Representative Pat Haggerty (Chair), Representative Jim McReynolds, and Representative Rick Noriega.

In response to its charge, the Subcommittee held a public hearing on April 26, 2006. The sub committee heard both invited and public testimony during the course of this hearing.

CHARGE NO. 4- Assess the programming needs for special populations in the Texas Department of Criminal Justice (TDCJ).

This charge was assigned to the Subcommittee on Healthcare and Special Populations. Members included Representative Pat Haggerty (Chair), Representative Jim McReynolds, and Representative Rick Noriega.

In response to its charge, the Subcommittee held a public hearing on April 26, 2006. The Subcommittee heard both invited and public testimony during the course of this hearing.

CHARGE NO. 5- Review the operation and organization of the Windham School District.

This charge was assigned to the Subcommittee on Education. Members included Representative Jerry Madden (Chair), Representative Delwin Jones, and Representative Scott Hochberg.

In response to its charge, the Subcommittee held a public hearing on April 18, 2006. The Subcommittee heard both invited and public testimony during this hearing.

CHARGE NO. 6- Study the adequacy of the state accountability system in measuring the effectiveness of Disciplinary Alternative Education Programs (DAEPs) based on academic performance, behavior modification and percentage of students referred to the juvenile justice system. (Joint Interim Charge with the House Committee on Public Education)

This charge was assigned to the Subcommittee on Education. Members included Representative Jerry Madden (Chair), Representative Delwin Jones, and Representative Scott Hochberg.

In response to its charge, the Subcommittee held a public hearing on April 18, 2006. The Committee heard both invited and public testimony during this hearing.

CHARGE NO. 7- Study the effectiveness of prevention programs, such as after school programs, in reducing the actual indices of crime and the rate of young offenders entering the criminal justice system. (Joint Interim Charge with the House Committee on Juvenile Justice and Family Issues)

This charge was not delegated to a subcommittee, the full committee responded to charge 7.

In response to its charge, the Committee on Corrections held a public hearing in conjunction with the House Committee on Juvenile Justice and Family Issues on April 18, 2006. The Committee heard both invited and public testimony during the course of this hearing.

CHARGE NO. 8- Monitor the agencies and programs under the Committee's oversight and monitor the Governor's Criminal Justice Advisory Council.

This charge was not delegated to a subcommittee, the full committee responded to charge 8.

In response to its charge, the Committee on Corrections held a public hearing on March 22, 2006. The Committee heard both invited and public testimony during the course of this hearing.

CHARGE 3: EVALUATE THE CORRECTIONAL HEALTHCARE SYSTEMS IN OTHER STATES AS THEY COMPARE TO THE TEXAS HEALTHCARE SYSTEM, WITH A FOCUS ON GREATER ACCOUNTABILITY AND COMPETITION AMONG PROVIDERS.

SUBCOMMITTEE ON HEALTHCARE AND SPECIAL POPULATIONS

BACKGROUND

Correctional Managed Healthcare

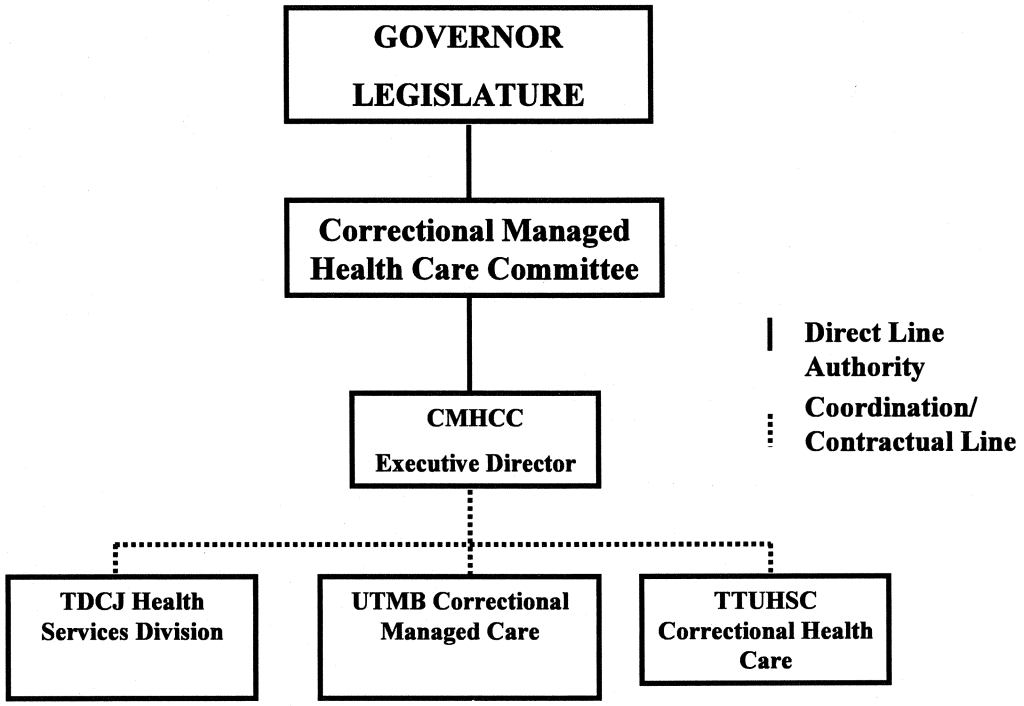
The only people guaranteed healthcare by law are prisoners. People currently in prison do not receive Medicaid or Medicare, so the state pays for all of their healthcare expenses and this is very expensive. It is important that the state looks at how other states finance prisoner healthcare so that we can provide this care at the most reasonable cost possible.

There are several models that other state correctional systems use to deliver healthcare services:

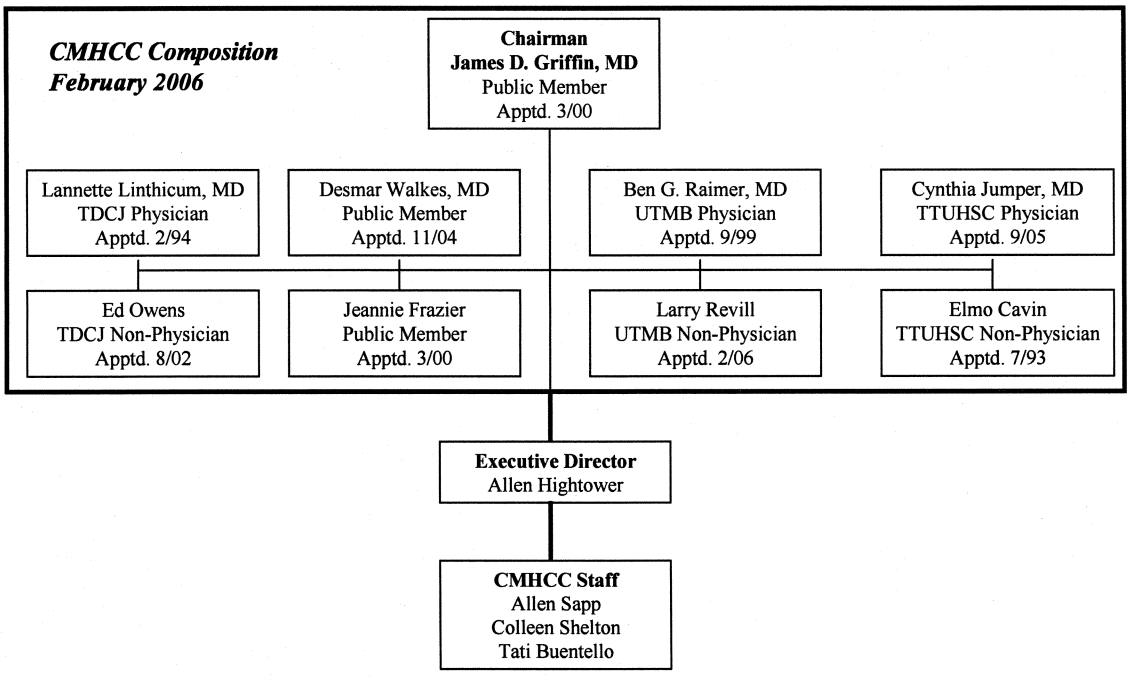
- delivering healthcare services with staff employed by the department of corrections;
- contracting with a private vendor or vendors for correctional healthcare services;
- contracting with state, local or university-based healthcare programs for services; or
- combination of some or all of the above.

In Texas, correctional managed healthcare is a strategic partnership between the Texas Department of Criminal Justice (TDCJ), The University of Texas Medical Branch at Galveston (UTMB), and Texas Tech University Health Sciences Center. This partnership is managed by a statutorily established body, the Correctional Managed Health Care Committee. The shared mission of the partnership is to develop a statewide healthcare network that provides TDCJ offenders with timely access to a constitutional level of healthcare while also controlling costs.

CMHCC Organizational Relationships



CMHCC Organizational Detail



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The Texas model of coordinating services between the state's correctional system and two of the state's medical schools through an entity like the CMHCC is relatively unique. A number of other states including Ohio, Connecticut, Mississippi and California have examined the Texas model to determine the extent to which it could be employed within their programs.[28] Most recently, a special independent review of the California Department of Corrections commissioned by Governor Arnold Schwarzenegger has recommended that California move to a university-based healthcare delivery system like the Texas model[29] Within the last year, the federal court has placed the California correctional healthcare program in receivership, effectively taking control of the delivery system from the state as costs for the program are continuing to escalate. These are conditions similar to what Texas experienced in the late 1980's and early 1990's that led to the development of the CMHCC and the current program structure.[30]

State Survey on Prison Population Healthcare

In December of 2005, the Corrections Committee requested a state survey on prison population healthcare from the Texas Legislative Council. In response to the request for information on the correctional healthcare systems in other states and any available evaluations of such system, the Texas Legislative Council submitted the following information:

Summary of Other States

- Thirteen states provide correctional healthcare through comprehensive contracts with private vendors:

Alabama, Delaware, Idaho, Illinois, Indiana, Maine, Maryland, Mississippi, Missouri, New Jersey, Pennsylvania, West Virginia, and Wyoming

- Four states (including Texas) provide correctional healthcare by means of a contract or agreement with a state university or college:
  Connecticut, Georgia, and Massachusetts
- Eleven states provide correctional healthcare through a blend of departmental personnel and contract services:
  Arkansas, Florida, Michigan, Minnesota, New York, North Carolina, North Dakota, Ohio, Oregon, Tennessee, and Virginia
- Four states provide correctional healthcare primarily through departmental personnel, and contract services only when departmental personnel are unavailable:
  Alaska, California, Colorado, and Washington
- Three states provide correctional healthcare exclusively through departmental personnel:
  Hawaii, Nevada, New Hampshire

States With Contracts or Agreements With State Universities or Colleges[31]

Connecticut

- The University of Connecticut Health Center assumed all healthcare (medical, mental health, pharmacy, and dental) service provisions from the Department of Corrections in November 1997.
- A managed care and quality improvement initiative has established a formal utilization review that provides a standard physician review process, including an appeals process, for physician requests for specialty services.

Georgia

- The Office of Health Services in the Georgia Department of Corrections provides on-site healthcare services to inmates primarily through a contract with the Medical College of Georgia.
- The Office of Health Services monitors the contract.

Massachusetts

- The Health Services Division of the Massachusetts Department of Corrections is responsible for the delivery of healthcare.
- Since 1992, the University of Massachusetts Medical School has provided comprehensive health and mental health services to inmates in the custody of the DOC, including management of Bridgewater State Hospital.
- Commonwealth Medicine is a part of the University of Massachusetts Medical School that provides specialized expertise to the public sector healthcare initiatives. Health and Criminal Justice Programs, a division of the Commonwealth Medicine, serves as a technical, research, and consultive resource for criminal justice agencies in the planning and delivery of healthcare, mental health, and substance abuse services to their populations.
- These programs combine service delivery with broader efforts to promote best practices through academic initiatives and fostering linkages between criminal justice agencies and

the Commonwealth's healthcare, mental health, and public health systems.

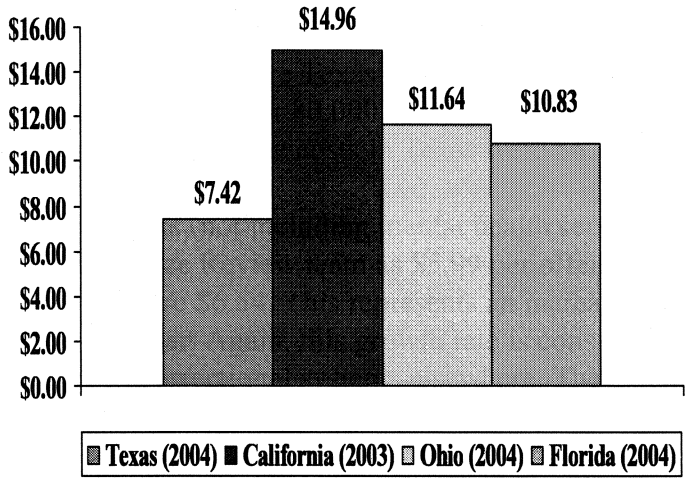
Correctional Managed Healthcare Costs of Care

The Texas correctional healthcare program has consistently provided healthcare services at a per capita rate much lower than experienced in many other large correctional jurisdictions. The Corrections Yearbook, 2002, published by the Criminal Justice Institute reports that the national average medical costs in 2002 (the latest year for which they have data published) was $8.03. The costs for Texas was $6.65 or about 20% below the national average.[32]

A study conducted last year by a special commission in California reported that their correctional healthcare costs are approximately $1 billion per year for a population of offenders just slightly larger than in Texas, where Texas costs are about $375 million per year. In Florida, a state with a prison population of about 80,000 offenders, the medical cost per inmate per day in FY 2003 was $10.13. The same year, the costs in Texas were $6.78.[33]

Medical care costs (not including mental health services) were documented by the Comptroller's Texas Performance Review team as $5.99 per offender per day in FY 1993. In FY 2004, total medical costs were $6.54. This represents an increase of only $0.55 over an 11 year period, or about $.05 per year. Again, this growth rate is considerably lower than the growth rate experienced in correctional systems elsewhere. The Council of State Governments issued a Trends Alert on Corrections Health Care Costs in January 2004 that found correctional healthcare costs nationally were growing at a rate of ten percent per year.

Healthcare Cost/Day Comparisons to Other Large Jurisdictions



Council of Governments Trends Alert (Jan 2004) found ***national average increase in costs for correctional health care was 10% per year.*** Costs are driven by chronic & communicable diseases; aging prisoner populations; mental health costs; and costs of Rx drugs.

Ongoing cost containment initiatives in Texas that work to keep the healthcare costs of prisoners down includes the following:

- Use of Disease Management Guidelines
- Strict Formulary Controls
- Access to 340B (PHS) pricing for drugs
- Utilization Management program
- Active participation in MRIS referral process
- Use of telemedicine/EMR technologies
- Cluster management team approach

Healthcare Beyond the Basic Constitutionally Guaranteed Standard

The Committee is interested in further exploring two issues that relate to the constitutionally mandated level of care for prisoners. The first issue has to do with healthcare that is above and beyond the basic constitutionally guaranteed level of healthcare for inmates with additional funds. For example, if an offender wishes to have chiropractic care, but is refused this service, should the offender be able to use his or her own money to pay for the cost of this care, including bringing a chiropractor in to the unit and paying for an extra correctional officer to oversee the process?

The second issue relates to transplants and donor lists. If a transplant is determined to be medically necessary for the survival of an inmate, should the inmate be placed on the donor list and should the state be required to pay the cost of the transplant? The Committee recommends that the legislature take a directive on these two particular issues

Prisoners have a constitutional right to healthcare services. The US Supreme Court Case, *Estelle v. Gamble* (1976), was a Texas case that went to the U.S. Supreme Court and set national standards for correctional healthcare. This particular case set the term "*Deliberate Indifference*" as a standard of measure defined as knowing and disregarding an excessive risk to health and safety. The federal courts also defined three rights for prisoners, the right to access medical care, the right to professional medical judgment, and the right to receive the medical care called for by professional medical judgment.

The key components of the healthcare delivery system in Texas prisons include initial health assessments, transfer screenings, periodic physical exams, dental clinics, chronic care clinics, telemedicine/EMR, mental health programs (including inpatient and outpatient specialty care), physically handicapped offender programs, and in-prison hospice programs.

The term "medically necessary", as defined by the CMHCC, is services, equipment or supplies furnished by a healthcare provider which are determined to be:

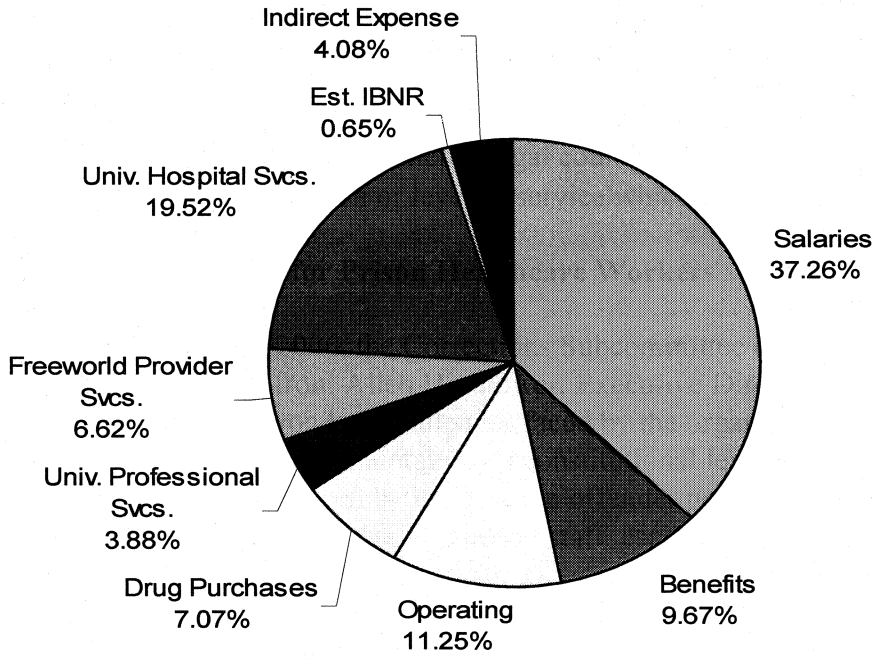
- *Appropriate and necessary* for the symptoms, diagnosis or treatment of the medical condition; and
- Provided for the *diagnosis or direct care and treatment* of the medical condition; and
- Within *standards of good medical practice* within the organized medical community; and

- *Not primarily for the convenience* of the TDCJ Offender Patient, the physician or another provider, or the TDCJ Offender Patient's legal counsel; and
- The *most appropriate* provision or level of service which can *safely* be provided.

Incentives and Hiring Bonuses for Prison Healthcare Workers

In a public hearing on April 26, 2006, the Corrections Subcommittee on Healthcare and Special Populations received testimony from Allen Hightower, Executive Director for the Correctional Managed Healthcare Committee on key challenges faced by the organization. One of the primary concerns for the CMHCC is maintaining a constitutional level of care while facing significant resource needs being driven by increases in offender populations, rapid growth in the aging offender population, and a shortage of medical staff, especially nursing staff.

Below is a breakdown of total healthcare costs by Category for FY 2005:



Mr. Hightower explained that the medical staff costs are increasing, driven by market demand for professionals, especially for mid-levels (PA, NP) and RN's. Vacancy rates in early 2004 reached critical levels and the only way to stem loss of professionals was to make market adjustments in salaries and shift differential pay. Future salary increases for prison healthcare workers should be a priority in the upcoming session because the correctional healthcare system must be able to offer a constitutionally guaranteed right to healthcare for prisoners.

RECOMMENDATIONS

Legislative Directive for Healthcare Beyond the Basic Constitutionally Guaranteed Standard

- The Committee recommends that the legislature take a directive on whether or not a prisoner should be allowed access to healthcare beyond the basic constitutionally guaranteed standard if the prisoner has funds to pay for it.
- The Committee recommends that the legislature take a directive on whether or not a prisoner should have access to transplants if the transplant is medically necessary.
- The issue of access to healthcare not traditionally provided by the correctional managed healthcare system should be heard in public testimony before language is drafted.

Incentives and Hiring Bonuses for Prison Healthcare Workers

- The Committee recommends funding incentives and hiring bonuses for prison healthcare workers.

CHARGE 4: ASSESS THE PROGRAMMING NEEDS FOR SPECIAL POPULATIONS IN THE TEXAS DEPARTMENT OF CRIMINAL JUSTICE (TDCJ).

BACKGROUND

Healthcare Expenses of Elderly Inmates

American Correctional Association's publication of best practices indicated that "geriatric care and programming are definite necessities for the immediate future".[34] Trends indicate that the elderly inmate population is on the rise; however, policymakers and prison administrators are not provided with standard directives on what types of special programming are useful and needed. This is a problem because while the elderly inmate population continues to grow, programs designed for elderly prisoners have not.

The older offender requires an environment that is more slowly paced as well as specialized programming and medical services. Not surprisingly, per capita costs of incarcerating elderly inmates have soared. According to the National Institute of Corrections (NIC) overall spending on healthcare increased nationally by 27% from 1997 to 2001.[35]

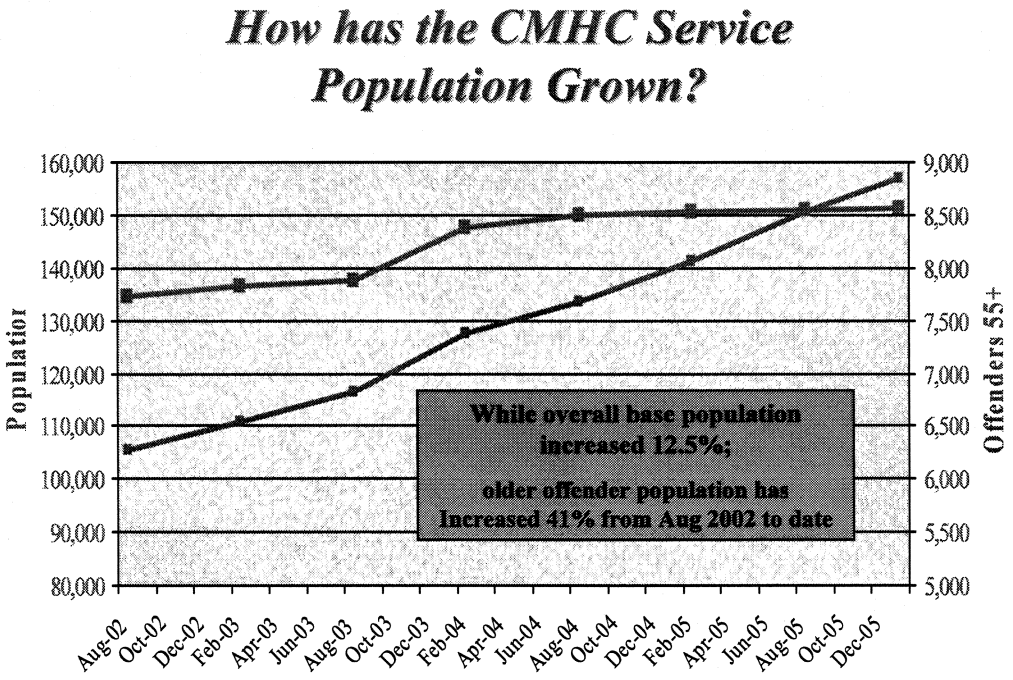
ACA Best Practices states that "Given the poor physical and mental health of the inmates entering the correctional setting, the provision of adequate health and mental health care necessarily must become a higher priority in the years ahead".[36] This is particularly important concerning the healthcare needs of elderly inmates. Due to the effects of aging, the older offender places far different demands on the system than does the younger inmate and this is especially true of healthcare needs.

It is important to note that elderly inmates are functionally older than their chronological age. Although there is no definitive, nationwide standard for what constitutes an "elderly inmate," most researchers identify 50 as the threshold age. A report conducted by the Florida DOC in 1999 noted that inmates are typically functionally older than their chronological age due to their lifestyle, lack of medical care, and environmental factors.[37] Whatever the definition, it is clear that the transformation to "elderly" is accelerated among prison inmates compared to the general population. According to the NIC, this faster physiological aging adds 11.5 years, on average, to inmates' chronological ages after age 50.[38]

Additionally, more people will be dying in prison, not only due to longer sentences but also because of diseases such as AIDS, hepatitis C, and drug-resistant tuberculosis. These diseases are often accompanied by mental despair and depression. Compounding this problem is fear of dying in prison, lack of family and support group, and even fear of being released from prison. Programmatically, this can lead to serious problems because most prison programs are designed to help younger offenders reenter society and assume productive roles once released.[39] However, these elderly offenders require specialized medical care as well as special housing and programming.

- The average cost per day is $40.06 per TDCJ offender, which comes to $14,622 per year.
- The cost of housing an elderly inmate is approximately three times the cost of housing a younger one.[40]
- Inmates over the age of 55 suffer, on average, three chronic health problems, such as hypertension, diabetes, alcoholism and emphysema.[41]

- In most prisons, counseling focuses on rehabilitating younger inmates, rather than coping with issues that are more germane to the elderly prisoner, such as chronic illness or death.[42]



What are Other States Doing?

Few states have fully implemented plans that address the needs of elderly offenders. Those states that have separate facilities for elderly prisoners typically combine the elderly population with the younger disabled population. Some states do not construct separate facilities for, or designate particular facilities as "elderly offender" institutions, but choose instead to segregate the older inmate population in separate halls or dormitories.[43]

- Federal Bureau of Prisons- Heart Healthy Eating Program
  - The primary goals of the Heart Healthy Program is to address inmate health and contain medical costs.

- Maryland- Transfer to Nursing Homes
  - Maryland law has special provisions for transferring elderly inmates to nursing homes or state hospitals, and also allows for medical parole that is used as a means of removing elderly inmates from correctional institutions.[44]

- Alabama- Hamilton Correctional Facility for the Aged and Infirm
  - The Alabama Department of Corrections refitted an old mental hospital as Hamilton Correctional Facility for the Aged and Infirm. The facility houses quadra and paraplegics, heart and lung patients, and prisoners suffering from

diabetes and cancer. It has around-the-clock nursing staff and a doctor who visits two or three times a week.

- California- Elm Hall
  - The California Institution for Men (CIM) houses older offenders in its Elm Hall. Elm Hall was designated as an older offender housing unit, but, over time, has evolved into a housing unit for both older offenders, and offenders with non-acute care medical needs.
  - CIM has an arrangement with California Polytechnic Institute to act as a training ground for social work and geriatric social work students, helping to augment the Correctional Counselors whose caseload has not been adjusted to reflect the increased amount of time necessary to deal with older offenders.
  - Individual institutions in California which have significant numbers of older offenders have developed policies such as nutritional consultations, assignment to lower bunks and tiers as medically indicated, support groups, such as the "over 50" group, and clustered housing.[45]

- Florida- Established Geriatric Inmate Facilities and Special Training for COs
  - In May, 2000, the Florida Legislature passed Senate Bill 2390 (Chapter 2000-214, Laws of Florida), "An Act Relating to Elderly Offenders".
  - The Act directed the Department of Corrections to "establish and operate a geriatric facility or an institution specifically for generally healthy elderly offenders who can perform general work appropriate for their physical and mental condition."
  - The Department of Corrections was also directed to develop statewide programming specific to the needs of elderly offenders.
  - The legislation required the department to develop and implement a preventive fitness/wellness program, specifically designed to maintain the mental and physical health of elderly offenders.
  - The Florida DOC has obtained approval from the Criminal Justice Standards and Training Commission, housed within the Florida Department of Law Enforcement, for the course, *Elder Abuse: Neglect and Exploitation*, as part of the certified training that all correctional officers must undergo.[46]

The Florida Department of Corrections- Office of Program Services evaluated existing programs to determine which are best suited for the elderly inmate. The recommendations of this report highlight that programs for the elderly should include (but should not be limited to):

- all existing academic and special education programs that are currently being offered for the general population;
- vocational programs such as cabinet making, environmental services, and horticulture;
- wellness education that provides information pertinent to elders' specific health needs;
- wellness facilities that fit their particular fitness capabilities;
- substance abuse programming specific to elders' needs; and

- betterment programs that are age-specific.[47]

In-prison Geriatric Communities
As of November 30, 2004, there were approximately 3,533 TDCJ offenders over age 60. TDCJ currently has a 60 bed geriatric facility located within the Estelle Unit in Huntsville, Texas for very old inmates who usually require excessive medical care. There are other units around the state that have wings dedicated primarily to older inmates who are still functional, but Estelle is the only unit with a geriatric facility.

To address many of the concerns regarding the elderly inmate population, Representative Harold Dutton filed a bill on in-prison geriatric communities during both the 78th and 79th Legislative Sessions. This bill was left pending in committee both sessions, but in light of the alarming statistics regarding elderly inmates, the Corrections Committee believes that the legislature should take another look at Representative Dutton's proposal.

- Establish a program to confine and treat inmates who are 60 years of age or older in in-prison geriatric communities.
- The institutional division of TDCJ and the Texas Department of Aging and Disability Services should jointly develop methods of screening and assessing inmates to determine their needs as geriatric inmates.
- The institutional division should be required to separate inmates participating in the program from the general population of the division and house the inmates in discrete units or areas within units, except for medical and security purposes.

According to the fiscal note for HB 448, 79th Legislative Session, it is assumed that the screening and assessment activities performed by TDCJ would provide a constant population of 800 inmates who are 60 years of age or older who would receive treatment that addresses the special problems of geriatric inmates. Costs for enhanced treatment programming required by the bill are assumed to be an additional $3.93 per offender per day. Assuming a daily cost of $3.93 per day for 800 inmates receiving treatment, the yearly cost of implementing the provisions of the bill would be $1,147,560.

There are many benefits to developing In-Prison Geriatric Units:
- TDCJ could provide special training for Correctional Officers in how to handle elderly prisoners, but would not have to train all staff- only those working in the geriatric units.
- Elderly inmates would be less vulnerable and have a lesser risk of being abused by other inmates.
- Elderly inmates would be less vulnerable to contagion (less exposure to germs and disease of regular (large) population), and may get sick less therefore easing the burden on CMHC.
- Segregation provides a concentration of specialized staff and resources for the elderly, thereby reducing costs.
- The older offender requires an environment that is more slowly paced than the general population (these units would be quieter at night and quieter in general).

MRIS, Special Needs Parole, and Diversion Programs for the Elderly

Federal funding for eligible special needs offenders can be used to offset program costs and state costs in general. Since the state cannot receive federal funds for TDCJ inmates, moving the responsibility for the offenders to other state agencies could generate federal monies. Medicaid and Medicare are available for those offenders released to community care. Financial eligibility for community care or institutional services is administered under Title XIX and Title XX of the Social Security Act of 1990. Title III of the Older Americans Act is designed to assist older persons who remain independent in the home environment.[48]

During the 79th Legislative Session, the House Committee on Corrections unanimously passed HB 1383 by Representative Jesse Jones. This bill would have required the Texas Department of Criminal Justice (TDCJ) and the Correctional Managed Health Care Committee (CMHC) to conduct a study of inmates at least 60 years of age receiving health care services from TDCJ who may be released on parole with a reasonable belief that they will not engage in further criminal activity. The bill would have required the study to calculate the savings from releasing such inmates and report the findings to the Legislature.

The Committee recommends requiring TDCJ and CMHC to conduct the study outlined in Representative Jones' bill with minor changes discussed in the recommendations portion of this report.

Releasing elderly inmates to community care through Medically Recommended Intensive Supervision (MRIS), special needs parole, or diversion programs for elderly inmates would relieve the financial burden on the state because these offenders would be eligible for Medicaid and Medicare benefits. Possible alternatives that the legislature should consider are geriatric halfway houses and nursing home care. Consideration of inmates for special needs transfer or diversion should be limited to those whose release would not jeopardize the public safety and whose offense of record was not a violent crime such as murder, sexual assault, kidnapping or aggravated robbery. Also, special needs offenders should have, prior to release, an approved treatment plan that insures appropriate supervision, service provision, and placement.

Any of these programs (MRIS, special needs parole, or diversion programs for the elderly) would also open up new beds. A transfer program (whether to a half-way house or nursing home) would help alleviate current overcrowding pressures in the short term by removing from the prisons those inmates who meet specific criteria of special needs. Even though parole of such inmates will not completely solve the prison space problems, it will open up needed prison beds and help relieve the prisoner backlog held in many county jails.

Furthermore, many studies have shown that elderly inmates have the lowest recidivism rates, with the progressively lower rates reaching 7.4 percent of released inmates 65 and older.[49] This has led some researchers to conclude that there is a net savings in releasing elderly prisoners, although such releases may aggravate other problems, since many elderly inmates have alienated friends and families, and may be too sick to re-enter the workplace.

Medically Recommended Intensive Supervision- State Jail Offenders
Statutory provisions for Medically Recommended Intensive Supervision (MRIS) currently apply to those offenders who are incarcerated in the Texas Department of Criminal Justice (TDCJ) prison. For those offenders who are in state jail, and whose medical condition is terminal or requires long term care, there is no legal recourse for discharging them from custody.

Residential Infant Care Program for Mothers in TDCJ
During fiscal year 2004, the Texas Department of Criminal Justice (TDCJ) admitted over two hundred pregnant inmates with a three year or less sentence. Once the babies are born, they are taken from their mother and not reunited until the mother is released from prison. As a result, the baby and the mother cannot bond. The mother is returned to her prison unit without a program to develop the hands-on parenting skills and bonding needed to give the inmate mother and infant the best chance at a productive life.

Considering a residential infant care program for mothers in TDCJ, an idea that Representative Ray Allen has been pushing for years, may have a serious impact on closing the revolving door of recidivism and could potentially help hundreds of small children avoid following in their parent's footsteps. The Committee may want to work with the Texas Youth Commission to learn more about what works best in TYC's mother/baby program and apply lessons learned to any future legislation.

TCOOMMI Programs for Offenders With Special Needs
Texas is the only state in the country with statutory provisions for continuity of care of offenders with special needs. The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) is legislatively mandated to coordinate the continuity of care activities of local and state criminal justice, health and human service and regulatory agencies through Memoranda of Understandings (MOUs) between the various entities. Currently, the MOUs are in the process of being revised to reflect current statutory provisions.

Continuity of Care for Offenders with Special Needs (COC)[50]
Special needs groups include those with mental illness, mental retardation, terminal or serious medical condition, physical disabilities, and the elderly. COC provides pre-release screening and referral to aftercare treatment services for special needs offenders referred from the TDCJ Correctional Institutions Division, state jails, SAFPF's, local jails, or other referral sources.

Continuity of Care activities include:

- Identifying offenders with special needs who require aftercare treatment services.
- Participating in joint treatment planning with Institutional Units, State Jails, SAFPF's, local jails, or other facilities in order to provide a positive transition from incarceration to the community.
- Securing resources in the community for all offenders referred with special needs.

- Working towards improved systems of coordination and communication among local and/or state criminal justice, social service, and other appropriate disciplines to ensure responsiveness to the needs of offenders with special needs.
- Post release follow-up through 90 day reports.

The Institutional COC program provides a formal pre and post release aftercare system for all offenders with special needs released from TDCJ facilities (state jails, SAFPFs, and 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 COC workers and seven 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.).

COC referrals and releases during the current and previous fiscal years:

FY 2003:	FY 2004:
Cases Referred- 4,348	Cases Referred- 4,584
Cases Released- 3,203	Cases Released- 4,252

During the regular session of the 79th Legislature, a number of reports were provided to the members on problems associated with accurate identification of offenders with mental illnesses. As a result, a number of legislative initiatives were enacted designed to improve the screening and identification process throughout the criminal justice continuum. The status of those activities are provided in the following section.

TDCJ/TCOOMMI Identification Activities

During FY 2006, TCOOMMI in cooperation with TDCJ Health Services, and UTMB established a process for Continuity of Care (COC) workers to access critical medical or psychiatric information via the Electronic Medical Record (EMR) system. In doing so, the COC workers are able to conduct the majority of the pre and post release activities from their office rather than traveling to the units. This initiative, another first of its kind in the country, results in cost savings due to significant reductions in travel expenses, yet maintains the integrity of the COC

program.

In addition, TCOOMMI recently initiated a more accurate process for identifying former or current clients of the MH/MR system. The need for an improved identification process is best demonstrated by the cross-referencing results noted in the following chart.

Texas Department of Criminal Justice CARE Match Rates
Feburary 2006

	Total	CARE Matches
Probationers	430,312	57,719 or (13%)
Parolees	77,167	21,097 or (27%)
CID	151,528	45,628 or (30%)
TOTAL	659,007	124,444 or (19%)

* CARE: Client Assignment and Registration System
* Data includes all persons served by MHMR and is not limited to current target populations of Schizophrenia, Bipolar or Major Depression

Based on the February cross-referencing data match, approximately 19% of the total TDCJ offender population were former or are current clients of the state or local MH/MR service system. The data, however, is misleading due to the presence of client data that includes populations who no longer qualify for MH/MR services. This could include clients who may have received a one time only service of crisis intervention or individuals committed to state mental hospitals for alcohol treatment during the period MH/MR was authorized to provide such services. Currently, the target populations served by MH/MR includes individuals with a diagnosis of Schizophrenia, Bipolar or Major Depression. This new cross-referencing process, as shown in the following chart, will allow TDCJ/TCOOMMI to target limited psychiatric or supervision services to those offenders most in need of treatment. In addition, more reliable data on prevalence rates of mental illnesses in the criminal justice system will now be available for the Legislature.

TDCJ System Wide Data Match With CARE
June 2006

Summary Information

	Number	Percent of Total	Percent of all Active Clients*
Matched Clients Meeting Criteria	**50,174**	**100.00%**	**7.66%**
			Percent of all Incarcerted Clients**
Incarcerated Clients Age 22 and Over	**14,698**	**29.29%**	**9.87%**
With Major Depresion	4,540	9.05%	3.05%
With Bipoloar Disorder	2,871	5.72%	1.93%
With Schizophrenia	2,814	5.61%	1.89%
With a Non-TPDx or Crisis	4,473	8.91%	3.00%
Incarcerated Clients Under Age 22	**1,780**	**3.55%**	**1.20%**
With Major Depresion	261	0.52%	0.18%
With Bipoloar Disorder	169	0.34%	0.11%
With Schizophrenia	53	0.11%	0.04%
With a Non-TPDx or Crisis	1,297	2.59%	0.87%
			Percent of all Parole Clients†
Parole Clients Age 22 and Over	**7,192**	**14.33%**	**9.35%**
With Major Depresion	2,515	5.01%	3.27%
With Bipoloar Disorder	1,603	3.19%	2.08%
With Schizophrenia	1,665	3.32%	2.16%
With a Non-TPDx or Crisis	1,409	2.81%	1.83%
Parole Clients Under Age 22	**297**	**0.59%**	**0.39%**
With Major Depresion	39	0.08%	0.05%
With Bipoloar Disorder	24	0.05%	0.03%
With Schizophrenia	9	0.02%	0.01%
With a Non-TPDx or Crisis	225	0.45%	0.29%
			Percent of all Probation Clients‡
Probation Clients Age 22 and Over	**24,468**	**48.77%**	**5.70%**
With Major Depresion	9,524	18.98%	2.22%
With Bipoloar Disorder	6,633	13.22%	1.55%
With Schizophrenia	2,627	5.24%	0.61%
With a Non-TPDx or Crisis	5,684	11.33%	1.32%
Probation Clients Under Age 22	**4,174**	**8.32%**	**0.97%**
With Major Depresion	849	1.69%	0.20%
With Bipoloar Disorder	687	1.37%	0.16%
With Schizophrenia	151	0.30%	0.04%
With a Non-TPDx or Crisis	2,487	4.96%	0.58%

*Includes prison/state jail, active parolees, & on probation as of May 31, 2006: 655,043
**Includes prison and state jail as of May 31, 2006: 148,914
†Includes active parolees as of May 31, 2006: 76,925
‡Includes clients on probation as of May31, 2006: 429,204

Jail Screening

In an attempt to improve the identification process at the local jails, the 79th Legislature attached two (2) separate riders to the Department of State Health Services (DSHS) and the Texas Commission on Jail Standards (TCJS) appropriations which required the establishment of a cross-referencing process between local MH/MRA's and jails.

In addition, both state agencies were to report their implementation efforts and findings to TCOOMMI on a quarterly basis. Since September 1, 2006, TCJS has consistently provided

quarterly reports to TCOOMMI on implementation activities. This monitoring has been accomplished through the routine jail inspections that are conducted on an annual basis. Jail Inspectors not only verify that the process is in place, but also identify problems or obstacles the jails have encountered in implementing the cross-referencing activity. The report, which is found in Appendix A, has identified a number of barriers that warrant highlighting. Those include:

1) The response from MH/MRA's on the CARE matches oftentimes come after the defendant has been released, therefore no continuity of care is available.
2) Once identified, the lack of resources prevents any pre-trial or jail diversion opportunities.
3) Process for submitting and receiving information is inconsistent, and time consuming.

Unfortunately, the implementation status for local MH/MRA's is not known. Although the assumption can be made that local MH/MRA's are coordinating with the local jails based upon the reports generated by the Jail Commission, the majority of local MH/MRA's have not submitted required information to TCOOMMI. As a result, critical information on prevalence rate is unavailable to provide to the Committee at this time. TCOOMMI has been directed to aggressively work with DSHS to facilitate the submission of this legislatively required information prior to the 80th Legislative Session.

Not Guilty by Reason of Insanity (NGRI) Aftercare Treatment

Senate Bill 837 by Wentworth, passed during the 79th Legislative Session, revised the statutory provisions for the insanity defense. This bill did not change the substantive law in Texas, which still requires a defendant to prove that as a result of a severe mental disease or defect he/she did not know that the conduct was wrong. The significant change in the bill relates to release of a defendant found NGRI to court-ordered outpatient or community-based treatment and supervision after inpatient commitment to Vernon State Hospital. As a result of this legislation, the Trial Court must receive and approve an individualized treatment plan, must find that the services are available, and may mandate participation in treatment and order supervision by TCOOMMI.

The bill allows for the courts to order a defendant found NGRI to a TCOOMMI treatment program and a local Community Supervision and Corrections Department (CSCD) for supervision. However, the legislation did not include a provision for directing the state hospitals to notify TCOOMMI of NGRI discharges and the person's return to the community.

Additionaly, TCOOMMI faces a problem regarding NGRI cases that are releases directly from the jail rather than a state mental health facility. Since the individual is not technically an "offender" there are questions as to how TCOOMMI can become involved. These and any other concerns resulting from SB 837 should be solved through legislative directives and clarification of legislative intent.

RECOMMENDATIONS

Healthcare Expenses of Elderly Inmates

- The Committee recommends that a workgroup be formed during the 80th Legislative Session to examine the impact of the rising population of geriatric inmates within TDCJ and possible solutions to rising costs and programmatic needs. Given Representative Harold Dutton's experience in this area, it is recommended that the group work with Representative Dutton and his staff as well as the Correctional Managed Healthcare Committee and TDCJ to form an acceptable piece of legislation that will address the Committee's concerns regarding geriatric inmates.

MRIS, Special Needs Parole, and Diversion Programs for the Elderly

- The Committee recommends that the Texas Department of Criminal Justice (TDCJ) and the Correctional Managed Health Care Committee (CMHC) conduct a study of inmates at least 60 years of age receiving a substantial amount of healthcare services from TDCJ whose offense of record was not a violent crime such as murder, sexual assault, kidnapping or aggravated robbery. The study should calculate the savings from releasing such inmates and report the findings to the Committee.
- The Committee recommends altering statutory provisions for Medically Recommended Intensive Supervision (MRIS) to apply to offenders who are in state jail so long as their medical condition is terminal or requires long term care and there is no legal recourse for discharging them from custody.

Residential Infant Care Program for Mothers

- The Committee recommends that the legislature consider a residential infant care program for mothers in TDCJ that is reflective of the legislation previously filed by Representative Ray Allen. The Committee may want to work with the Texas Youth Commission to learn more about what works best in TYC's mother/baby program and apply lessons learned to any future legislation.

Continuity of Care for Offenders With Special Needs

- TCOOMMI should provide routine reports to the Committee on the status of any legislative directive which requires periodic reporting from other entities. This will allow the Committee to monitor progress on a more formal basis, and take corrective action if needed in a more timely fashion.
- As a result of the recent legislative initiative directing DSHS and TCJS to establish a cross-referencing of local jails' inmates with the MHMR database, TCOOMMI has outlined three areas of concern that require further research or debate by the Legislature. The Committee should work with TCOOMMI during the 80th Legislative Session to draft possible legislation and hold public hearings on the following three issues and any other recommendations that TCOOMMI and the Texas Commission on Jail Standards see fit:

    1). The data generated from legislative cross-referencing study will in all likelihood show a pattern of multiple arrests and incarcerations for some individuals. It is anticipated that these individuals will have a history of non-

compliance to mental health treatment. If voluntary compliance to mental health treatment has proven to be unsuccessful, should involuntary treatment be pursued in order to minimize criminal justice involvement? A review of the current process for civil outpatient commitments may be necessary to adequately address this problem.

2). Once a jail inmate has been identified as a current or former client of MHMR, how is the information forwarded to others in the criminal justice system, defense attorney, judge, prosecutor or CSCD? If part of the reason for improved identification is to allow the "courts" to be aware of a defendant's mental illness on a pre-trial or sentencing basis, a system of notification between the jail and other relevant criminal justice entities is warranted.

3) If the jail inmate is a current or former MHMR client, what if any role should the local MHMR agency play in relation to the inmates treatment coordination with the courts and pre and post release planning activities? In communities where TCOOMMI funds offender programs this presents no or little problems, however, in areas with no TCOOMMI funding, this will be problematic.

Not Guilty by Reason of Insanity (NGRI) Aftercare Treatment

- The Committee recommends requiring state hospitals to notify TCOOMMI of NGRI discharges and the person's return to the community.
- The Committee should work with Senator Wentworth to clarify how TCOOMMI is to become involved with NGRI cases that are released directly from the jail rather than a state mental health facility. These and any other concerns resulting from SB 837 should be solved through legislative directives and clarification of legislative intent.