Senate Criminal Justice Committee

Interim Report to the 80th Legislature

December 2006

Senator John WHITMIRE, Chair

SENATE CRIMINAL JUSTICE COMMITTEE

January 1, 2007

The Honorable David Dewhurst
Lieutenant Governor of the State of Texas
Capitol Building, 2nd Floor

Dear Governor Dewhurst:

The Senate Committee on Criminal Justice submits its Interim Report in agreement with the Interim Charges that were issued this past year. The Criminal Justice Committee has held hearings over the last year to gather information on these charges. The hearings have been well attended and informative. In compliance with your request, a copy of this report will be circulated to all senators and other interested parties.

As you are aware, the charges that your issued to the Committee were very comprehensive and challenging. We have worked hard to respond to this challenge by developing broad recommendations that will benefit all Texans in the years to come. We anticipate that the Committee's recommendations will provide a guide for fiscal and operational improvement in the Texas Criminal Justice System. We thank you for your leadership and support.

Respectfully submitted,

Senator John Whitmire
Chairman

Senator Kel Seliger
Vice Chairman

Senator Rodney Ellis

Senator Juan 'Chuy' Hinojosa

Senator John Lindsay

Senator Steve Ogden

Senator John Carona

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Executive Summary

Interim Charge One Recommendations

Study the resources and facilities available to offenders with mental health needs in the Texas criminal justice system. Provide an inventory of resources and facilities. Develop recommendations to better allocate existing resources and efficiently address the needs of this population.

Offenders with mental illnesses present special challenges to the Criminal Justice system. With the implementation of the Mental Health/Criminal Justice initiative, the availability of targeted supervision and mental health treatment has significantly improved the state's response to these high risk offenders. **However, the major issue is to provide adequate funds to provide the appropriate level of service and treatment required at each element of the State's Continuum of Care (attached flow chart) for mentally ill offenders.** Based upon the testimony and reports provided by agency and interested parties, the following recommendations are offered by the committee:

1. The DSHS should collect monthly data on the length of time 46.B defendants are held in local jails waiting for state hospital commitment. In addition, DSHS should explore other options for competency restoration, particularly for misdemeanors, that can be implemented in the community by the local MHMRA's.
2. The process for cross-referencing the TDCJ offender database against the state mental health agency's client registry should be conducted on a more frequent basis. There appears to be no established time period to generate reports, therefore important information regarding an offender's prior or current mental health service history is not provided in a timely manner.
3. Continued efforts to improve the identification of mentally ill offenders at time of arrest and incarceration in local jails must be a priority. The earlier the identification is made, the earlier the courts can make more informed decisions on sentencing options and thus impose conditions reflecting the offender's need for specialized supervision and mental health treatment.
4. Current statutory requirements for DSHS and local MHMRA's to report prevalence rate information to TCOOMMI should be strengthened. Based on preliminary reports received by TCOOMMI on implementation activities, there is minimal compliance to the Rider's requirements for local MHMRA's to provide quarterly reports to TCOOMMI on cross-referencing activities with local jails.
5. An evaluation of the juvenile mental health program should be conducted to determine its impact on recidivism. This evaluation could be assigned to the Legislative Budget Board's (LBB) evaluation unit for a completion date by the 81st Legislative session.

Interim Charge Two Recommendations

Study the expenditure patterns and identify trends in the community supervision and corrections departments' use of state and local monies, known collectively as the Judicial Districts Trust Funds. Ascertain the percentages spent on direct supervision of probationers and identify notable policy decisions. Provide recommendations for improvements and methods of maximizing the use of these funds.

To ensure that state general revenues provided for adult probation services, are expended in compliance with legislative intent, it is recommended that the legislature:

1. Continue to utilize the Diversion Program Funds for additional increases, rather than the formula funding line items.
2. Continue to use appropriation riders to direct and provide controls of the expenditure of these funds.
3. Instruct TDCJ-CJAD to review its allowable expenditures with emphasis on improving the consistency of expenditures among the individual CSCDs.

Interim Charge Three Recommendations

Examine the allegations of abuse and neglect within the Texas Youth Commission (TYC) facilities and the appropriateness of TYC response. Include an analysis of factors that may be affecting the safety of inmates and staff and make recommendations for Legislative actions to improve the safety of inmates and staff at these facilities.

1. Funding issues at TYC have significantly hindered the agency's ability to operate safely and effectively. Facilities are understaffed, suffer from extremely high turnover rates, and staff are poorly prepared for the demanding nature of the job. An increased training period may decrease turnover and improve interaction with students.
2. The legislature must also improve the manner in which students are currently housed, some age requirement should be established and applied that regulates interaction between students with significant differences in age. This effort would be served by limiting the number of beds to a room.
3. Although abuse is reported to law enforcement, resources limit the ability of local and county police to pursue most incidents. The TYC inspector general should have the capacity to bring criminal assault charges so reports of abuse will no longer end with the termination or resignation of the employee, and staff will feel more protected from student aggression. When staff feel endangered, they are more likely to overreact to intense situations.

Interim Charge Four Recommendations

Monitor the implementation of legislation relating to reducing the production and abuse of methamphetamine, including the predicted impact of methamphetamine's increased availability on state resources and criminal justice populations, and make recommendations for additional programs for further reductions in abuse and production.

1. Due to media attention, the methamphetamine 'epidemic' has produced widespread beliefs that have little evidentiary support, or have been exaggerated in the hopes of deterrence. A particularly damaging claim is that methamphetamine addiction does not respond to treatment. Studies suggest that methamphetamine addiction responds as effectively to treatment as most addictive substances. Also, It should be noted that figures indicate that meth use among teenagers has decreased in recent years.
2. Although retailers have complied with log book laws, authorities do not monitor the books. A comprehensive, electronic system is necessary, as the current paper logs allow a user to visit multiple locations.

Interim Charge Five Recommendations

Study and make recommendations for methods to reduce kidnapping and violence along the Texas Border, focusing on reducing drug-related crime.

1. Future grants to border operations should be made through a fiscally accountable state agency. The method of distribution did not account for population size, department size, or crime rates. There was no measure for success or failure built into the program, and an alarming lack of stipulations on the use of the money.

Interim Charge Six Recommendations

Monitor the expenditure of funds for adult probation services dedicated to lowering revocations to state prisons and state jails. Examine the compliance with, and effectiveness of, the associated budget riders and make recommendations for future funding needs.

1. The additional resources to the community supervision segment of the criminal justice system have demonstrated a positive impact on the utilization of incarceration alternatives. Expanding this initiative to non-funded CSCDs may result in additional benefits in reducing revocation and lowering the recidivism rate for probationers.
2. It is recommended that community supervision funding be maintained and expanded. The best means of allocating this funding is through the diversion line item of the TDCJ-CJAD budget, along with the controlling appropriation riders.

Interim Charge Seven Recommendations

Study the feasibility of the State of Texas establishing or contracting with a private prison facility in the country of Mexico in order to house non-violent Mexican Nationals currently being housed in Texas prisons.

1. Inter-American Convention on Serving Criminal Sentences Abroad and the United States-Mexico Treaty on the Execution of Penal Sentences both state that once a prisoner is transferred to the receiving country, that country assumes all responsibilities for the care of the prisoner. So long as these treaties are in effect, the State is obligated to follow the terms and conditions of them. Without further changes to these federal treaties, the Committee cannot recommend the State of Texas establish or contract with a private prison facility in the country of Mexico in order to house non-violent Mexican Nationals currently being housed in Texas prisons.
2. The language in the Texas Constitution can be interpreted as prohibiting the State from transporting inmates out of Texas to any other country for a crime committed in Texas. Meanwhile, the United States Prisoner Transfer Treaties and Article 42.17, Texas Code of Criminal Procedure expressly allow the transfer of federal and state inmates of foreign nationality to their home countries. Therefore, the Committee recommends the amending of Section 20, Article I, Texas Constitution to reflect allowances made by the U.S. Prisoner Transfer Treaties and Article 42.17, Code of Criminal Procedure.

Interim Charge Eight Recommendations

Review other states' correctional health care systems and make necessary recommendations to improve the effectiveness and efficiency of Texas' system.

1. The appropriate level of health care provided to Texas inmates must be addressed. As major problems exist in the five general types of health care systems in other states, improving the current Texas Managed Health Care Committee services is recommended.
2. Improvements to the system should consider, the increasing prison population, the aging of the offender population and the increase in commutable diseases among the incoming offender population. Efforts to reduce the impact of these known contributors should be utilized to the maximum and funded accordingly.

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Interim Charge Number Eight

Review other states' correctional health care systems and make necessary recommendations to improve the effectiveness and efficiency of Texas' system.

Introduction

The policy decision to under take a large prison building program in early 1990, selecting mass incapacitation to deal with the crime rate, has resulted in a State prison capacity of over 154,702. On June 1, 2006, the Legislative Budget Board (LBB) released their projections for the future state prison population. The LBB estimates that by the time the legislature convenes in January, 2007, Texas will have a prison population of 153,101 inmates. State funds will be required to house, feed, and provide **constitutionally mandated health care** to the entire prison population. Texas currently spends over two billion dollars a year to maintain the state's prison, parole and probation systems.

Our state prison system has a permanent bed capacity of 154,702. According to LBB projections, when the 80th Legislature convenes in January '07, the prison system will be operating at 98.7% of that capacity. In addition the State will have temporary contracts for 3,000 beds to maintain our prisons at a 97.5 % operational level. The Texas Department of Criminal Justice (TDCJ) is required to maintain this level of operation for safety and classification purposes. **The increasing average inmate age and the increased presence of communicable diseases, along with longer sentences and time served all add to the need for increased funds required to maintain the current constitutional mandated level of services.**

The 80th Legislature will have to address and resolve, not only the immediate needs of the criminal justice system, but also the projected growth throughout the next biennium. The LBB projects that by August, 2009, the prison population will reach 158,162; a number that will totally overwhelm our total current prison capacity.

Consequently, while state Leadership has instructed most state agencies to plan for a budget decrease of 10% for FY 2008/2009, the Texas Department of Criminal Justice has been exempted from this requirement.

Background

The growing number of inmates under state supervision has lead to increased health care costs in accordance with court decisions that have effectively set state corrections policy and requires correction officials to provide adequate inmate health care.[42] In 1972 *Newman v. Alabama* established the precedent for future cases involving adequate inmate health care: a federal district court found that the entire state correctional system was in violation of both the Eighth and Fourteenth Amendments because inmates were not provided with adequate medical care.[43]

[42] Correction Health Care Cost, the Council of State Governments, Kinsella, Jan. 2004.
[43] Ibid, page 5.

This court order to remedy these health care deficiencies was soon followed in 1976 by the landmark Supreme Court case *Estelle v. Gamble*, which set forth the major guidelines for correctional health care systems.[44] *Estelle v. Gamble* established that prisoner have a constitutional right to health care service and provides:

- that "Deliberate Indifference" (Knowing and disregarding an excessive risk to health and safety) is the standard of measure
- the right to medical care access
- the right to professional medical judgment
- the right to receive the medical care called for by professional medical judgment[45]

Due to the aggressive prison building program of the early '90s, the state soon faced spiraling medical costs that were increasing at 6% a year and accounted for 10% to 14% of the prison system's total operating budget.[46] At that time TDCJ employed its own medical staff for primary care and contracted with local physicians and hospitals for specialized care. The legislature soon noted that this system lacked the incentive to contain cost.[47] Consequently in an effort to control these increasing costs and maintain a constitutional level of prisoner medical care, the 73rd Legislature (1993) established the correctional managed Health Care Committee (CMHCC). CMHCC was meant to design–in cooperation with the University of Texas Medical Branch (UTMB) and the Texas Tech University Health Science Center (TTUHSC)–a managed health program for the prison system.

The creation of the CMHCC allowed the state to coordinate the delivery of health care to prisons through two of the States medical schools. At the time, this was a major departure from the traditional approach to correctional medical services and remains relatively unique today. CMHCC contracts for services in designated areas with UTMB (which services approximately 80% of TDCJ prisons) and TTUHSC (which services approximately 20% of TDCJ prisons). CMHCC administers the contracts and establishes the specific capitation rate, while another element, the Health Services Division of TDCJ, monitors health care access.

One of CMHCC's major functions is to prevent two occurrences, both of which can result in negative litigation–first, it helps prevent correctional administrators from making medical decisions and, conversely, it prevents medical professionals from making security decisions.[48]

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[44] Ibid, page 5.
[45] *An overview of Correctional Managed Health Care*, Correctional Managed Health Care Committee, March 1, 2006.
[46] *Correctional Health Care in the Texas Department of Criminal* Justice, Raimer, Patterson, Govwest.com.
[47] Ibid, page 1.
[48] *Self Evaluation Report*, CMHCC, August 19, 2005

In compliance with the court mandates of correctional care the CMHCC has established the following definitions for the provision of their services:

- *Health Care* - Health related action taken, both preventive and medically necessary, to provide for the physical and mental well being of the offender populations.
- *Medically Necessary* - Services, equipment or supplies furnished by a health care provider which are determined to be:

    1. *Appropriate and necessary* for the symptoms, diagnosis or treatment of the medical condition; and
    2. Provided for the *diagnosis or direct care and treatment* of the medical condition; and
    3. within *standards of good medical practice* within the organized medical community; and
    4. *Not primarily for the convenience* of the TDCJ offender Patient, the physician or another provider, or the TDCJ Offender Patient's legal counsel; and
    5. The *most appropriate* provision or level of service which can safely be provided.[49]

At this committee's June 21, 2006, hearing, public testimony from family members of current inmates highlighted the inadequate access to medical care and showed that older, less effective pharmaceuticals were being used in an effort to cut costs. How the managed health care system implements the above definitions in practice, determines if the State is providing the mandated constitutional health care to its prisoners.

A Review of Other States Correctional Health Services

Few other States's adult correctional system provides an apple to apple comparison with the Texas Department of Criminal Justice (TDCJ) due to its size (bed capacity and over 100 facilities) and the geographic distribution. Print and internet research provides some general information on the approach utilized by thirty-five other states, including five inmate health care design types.

With thirteen states utilizing this design, the most common approach is to use a **comprehensive contract with a private vendor** for prison health services. Alabama, Delaware, Idaho, Illinois, Indiana, Maine, Maryland, Mississippi, Missouri, New Jersey, Pennsylvania, West Virginia and Wyoming all operate their prison health system as such. In all the above, a division of the state's department of correction is tasked with monitoring the contracts and assuring the delivery of services through a private prison health provider, such as Correctional Medical Services (CMS) or Prison Health Service, Inc (PHS).

[49] *CMHCC Overview*, CMHCC, March 1, 2006, page 7

In 2004, Alabama–with a prison population of 27,000 plus–cancelled its prison health care contract with NaphCare Inc. At the time of cancellation, the contract was worth $30 million a year, and provided for both general medical care and mental health care[50]. In lieu of this, Alabama executed a $143 million, three year contract with PHS, Inc. for general medical care and a $29.2 million, three year contract with MHM Correctional Services Inc. for mental health care[51]. The Alabama Department of Corrections has been under United States District Court oversight pursuant to a 2002 federal lawsuit concerning medical care. The state settled in 2004.[52]

During May, 2006, the Delaware General Assembly failed to pass a prison health care wholesale improvement bill, due to the cost associated with the proposed reforms. The bill would have added $30 million to the existing $28.8 million private health care contract the State has with CMS.[53] Delaware prison medical care is currently the subject of an investigation by the Civil Rights Division of the U.S. Department of Justice.[54]

The second most common approach noted, with eleven states utilizing this design, is to use a **blend of state corrections department personnel and contracted service** through one of the national private prison health services, or local community health providers. Arkansas, Florida, Michigan, Minnesota, New York, North Carolina, North Dakota, Ohio, Oregon, Tennessee, and Virginia operate their prison health system using this design. Department personnel often maintain medical records and operate infirmaries at individual units with higher levels of medical care contracted out.

On August 22, 2006, a Detroit Free Press editorial called Michigan's prison health care system dangerously dysfunctional and sometimes even deadly. This has prompted Michigan Governor Granholm to order an independent review of the Department of Corrections entire prison health care system.[55] The allegations are that the state has neither met its constitutional duty to provide adequate medical care to its 50,000 plus prisoners nor its obligation to taxpayers, who spend $190 million a year on an unaccountable system operated by CMS.[56]

Texas is among four states that have developed **a managed prison health care design where the state contracts for medical services with a state university system.** Connecticut, Georgia, and Massachusetts are the other three states using this design–the major difference being that in other states, their department of correction (DOC) oversees the contracted services.

CMHCC staff reported that in recent months, a number of other states including Ohio, Connecticut, Mississippi, and California have examined the Texas model to determine if,

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[50] *Prison Medical Contracts Blocked*, Mobile Register, Barrow, January 9, 2004
[51] Ibid, page 2
[52] *Alabama Department of Corrections Ask Federal Judge to Dismiss Contempt Motion Filed by HIV-Positive Inmates,* Medical News Today, May 2005.
[53] *No Money to Improve Del. Prison health Care*, delawareonline.com, Jackson and Parra, May 19, 2006.
[54] Ibid.
[55] *Begin Cure of Prison Health Care*, Detroit Free Press, August 22, 2006.
[56] Ibid.

and to what extent, it could be employed within their programs. A special independent review of the California Department of Correction, commissioned by Governor Arnold Schwarzenegger, has recommended that California move to a university based health care delivery system similar to that of the Texas managed health care model.[57]

Primary care in four states is **provided by departmental personnel in which contracts for services are only used when department personnel are unavailable**. Alaska, California, Colorado and Washington are found among this category. Again, when contracted services are utilized, they are contracted through and overseen by the state DOC. The contracts usually are for very specific services or locations where department services are not offered.

On July 1, 2005, U. S. District Judge Thelton Henderson ordered that a receiver take control of California's prison health care system, which he described as operating under deplorable conditions. The court required urgent action to stop the needless deaths of inmates due to malfeasance.[58] Although the state spends in excess of $1.1 billion per year on inmate medical services, substandard care has contributed to the death of 64 inmates each year. The receiver reports to the Judge, not Schwarzenegger's administration and will have the power to order improvements regardless of how much it costs the taxpayers.[59]

Only three states were noted for providing health care services at their state prisons **exclusively through departmental personnel**. Hawaii, Nevada and New Hampshire use this design. It is notable that Nevada is one of the few states which have no correctional vendors operating in the state. The two experiments with contracted private facilities and with private medical providers were both cancelled. The state then assumed operations with DOC staff because it was determined that the state could operate at a cost level under those sought by the private correctional provider.

Developing Issues with Texas Prison Health Care

Testimony before this committee and other related legislative committees sounded an early warning that additional resources will be required to maintain the state's constitutional medical care status. Dr. Ben Raimer, Vice President for Correction Health Care for the University of Texas Medical Branch at Galveston provided:

- Medical care under their system was approaching the line where the continuing degradation of the care delivered would be considered unconstitutional.
- Many of their prison clinics now operate with a skeleton staff, some are closed most of the time (UTMB operate medical services at approximately 80% of TDCJ units). In other clinics, as many as 17% of the authorized Doctor and or nurse positions are unfilled. Increased salaries are needed to recruit these professionals.

[57] cpr.ca.gov/report/indrpt/corr/index.htm.
[58] *U. S. seizes state prison health care Judge cites preventable deaths of inmates, depravity of system*, San Francisco Chronicle, Sterngold, July 1, 2005
[59] Ibid.

- Substandard and outdated dental and dialysis equipment, left over from when TDCJ operated its medical department, is currently being used on inmates; equipment a private doctor would refuse to use. Less than 50% of the old X-ray machines are working. These machines are so outdated that inoperative machines must be scavenged for parts to keep others operating.
- The contract rate no longer pays for prison health care services. UTMB projects that it will spend $24 million more than it receives in FY 2007, and TTUHSC will spend $7.8 million more than it receives, requiring a supplemental appropriation to be considered.
- That in FY 2006 UTMB spent $9.5 million more than it was paid to perform services.
- UTMB hospital in Galveston is in serious need of external repair. Bricks are falling off of the exterior of the building, constituting a severe safety hazard.[60]

Dr. Raimer summed up his information stating that without an infusion of funding, it will be difficult for the University of Texas' president and regents to continue to participate in the managed health care contract. He also asserts that under these conditions doctors cannot be expected to provide first-rate care. This sentiment was also supported by representatives from the TTUHSC.

At appearances before this and related legislative committees Allen Hightower, Executive Director of the State's Managed Correctional Health Care Committee provided rationalization and causes for the observed increases in prison health care:

- Prisoners older than 55 tend to have more chronic illnesses, making it more expensive to provide appropriate medical care. The number of inmates that are 55 or older in TDCJ prisons has grown from approximately 5500 in FY 2000 (growing at 10% per year) to almost 9000 in FY 2006.
- 5.4% (age 55 plus) of inmates accounts for 25% of the total hospitalization expenditures each year.
- Additional dental care expenses due to the impact of "meth mouth". An increase in popularity for methamphetamine could result in an increase of offenders sentenced to the TDCJ system who have abused this substance.
- Pharmacy costs are estimated to increase by 4% next year, along with newer and more expensive drugs for treatment of Hepatitis C and HIV patients.
- 28% of prisoners committed to TDCJ test positive for Hepatitis C, an estimated total of 20,000 inmates will require treatment for this disease, at a cost that can reach $10,000 dollars per inmate. Currently an average of 400 inmates per year undergoes treatment. Next year the managed health care system plans to increase treatment to 800 inmates per year.[61]

[60] CMHCC Testimony to the House Appropriation Sub Committee on Criminal Justice, June 28, 2006.
[61] Ibid.

To resolve the degrading movement toward an unconstitutional prison health care system, CMHCC has proposed within their FY 2008 - 2009 Legislative Appropriation Request increases of:

- Daily operations funds - $47 million
- Retention of health care staff - $21.8 million
- Hospital / specialty care cost - $23.7 million
- Pharmacy costs - $7.1 million
- Critical equipment replacement - $6.3 million
- Supplies and services - $5.8 million
- Galveston hospital repairs - $10.4 million
- **Total new funds $122.1 million**[62]

Adding these requested new monies to the current level of financial appropriations would increase the cost of prison health care in Texas to just below $400 million per year.

Mortality in Texas Prisons

CMHCC utilizes several sub committees to review and report back to their policy making board members. One is known as the Joint Morbidity / Mortality Review Committee which is comprised of 6 to 8 clinical representatives appointed by the medical directors for TDCJ, UTMB and TTUHSC. They are tasked with reviewing the health record and circumstances of every death that occurs within the system.[63] The purpose of the committee review is to determine whether there are policy issues or care issues related to the death that need to be further evaluated and referred for a formal peer review. Although a referral for a formal peer review does not indicate that substandard care was provided, it is a request for a complete review of the case for quality assurance purposes. A formal peer review could also be made in order to consider policy issues that may improve the delivery of health care at Texas prisons.[64]

Allen Sapp, of CMHCC provided summary data from June 2005 to May 2006. The committee reviewed 369 deaths within the Texas prison system and made referrals for peer review evaluations as follows:

- Physician Peer Review - 10
- Nursing Peer Review - 12
- Physician and Nursing Peer Review - 2
- Physician and Mental Health Peer Review - 2
- Mental Health Peer Review - 3
- Utilization Review - 1

[62] Ibid.
[63] Morbidity/Mortality review sub committee, email Allen Sapp, Sept. 15, 2006
[64] Ibid.

Peer reviews were ordered in 8.1% of the deaths within Texas prisons, over a twelve month time frame. However, the proceedings and findings are protected from disclosure under the provisions of the Health and Safety Code, Chapter 161.032 and 161.033 relating to medical review committees.[65] Any improvements or corrective actions that resulted from these formal peer reviews are unknown.

A review of the TDCJ Mortality Reports from March 2006 through August 2006 provides some insight into the deaths of inmates observed within the Texas prison system. During this time frame, 215 inmates died, an average of 35.8 inmate deaths per month. Of these deaths, 45 where identified as sex offenders. The Medically Recommended Intensive Supervision Program (MRIS) allows the Board of Pardons and Parole to consider the supervised release of certain offenders with medical or mental health conditions under the provisions of the MRIS law; sex offenders are not eligible for consideration. It was noted on the above reports that many of the noted sex offenders where included in the 118 inmates who were referred for MRIS consideration prior to their deaths.

Recommendations

The appropriate level of health care provided to Texas inmates must be addressed. As major problems exist in the five general types of health care systems in other states, improving the current Texas Managed Health Care Committee services is recommended.

Improvements to the system should consider, the increasing prison population, the aging of the offender population and the increase in commutable diseases among the incoming offender population. Efforts to reduce the impact of these known contributors should be utilized to the maximum and funded accordingly.

[65] Ibid.