April 28, 2010

Testimony before the House Corrections Committee Hearing

Regarding Interim Charge #4 on Special Needs Offenders

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A. Introduction

Texas Department of Criminal Justice Offenders with Mental Health and Mental Retardation (MHMR) Matches

Division	Number of Offenders	Percent of Offenders
Prisons	42,556	27.25
Probation	55,276	12.84
Parole	21,345	27.09

** Represents all Clients served since 1985, including those whose diagnosis is no longer eligible for MHMR*

Texas Department of Criminal Justice Offenders Target Population

Division	Number of Offenders	Percent of Offenders
Prisons	11,388	7.29
Probation	18,845	4.37
Parole	5,497	6.97

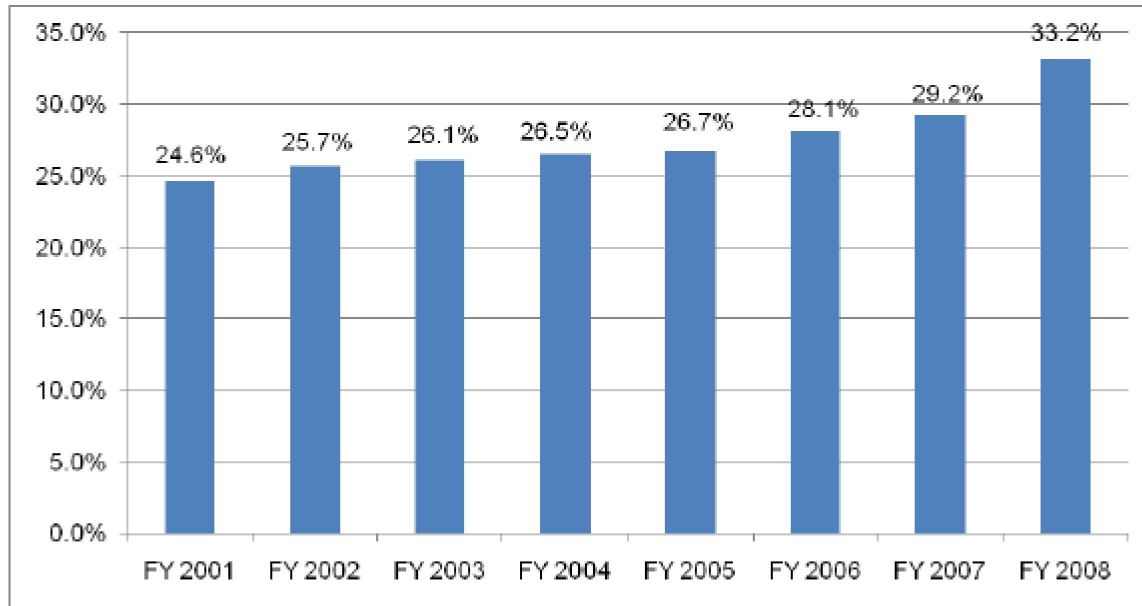
*** Schizophrenia, Bipolar, Major Depression (the three target groups for which there is funding)*

The number of offenders with special needs and the seriousness of the conditions that many of these offenders suffer from poses a major challenge to Texas' criminal justice system as it seeks to accomplish the goals of public safety, restoring victims, and reforming offenders. While the fact that an offender may have a mental illness or other special need does not in any way detract from the gravity of their offense or the harm that it may have caused, early identification of these offenders and effective treatment strategies can produce better outcomes for victims, taxpayers, and the offenders involved.

The figures on the left obtained from the Texas Department of Criminal Justice (TDCJ) indicate that more than 100,000 adult offenders in prison or under community supervision in Texas have at one time received services through a state or local mental authority for mental illness or mental retardation. These numbers do not include those adult offenders who received only privately provided services for such a condition.

Although mental illness and mental retardation are the most prevalent special needs, many other offenders have other conditions that fall within the special needs category such as development and physical disabilities. In the last few years, some veterans returning from Iraq and Afghanistan are entering the criminal justice system with conditions such as posttraumatic stress disorder (PTSD) and traumatic brain injury. Texas' juvenile justice and health agencies are working together to implement a new $2 million federal grant that will screen juveniles entering the justice system for brain injury if their initial screening indicates cognitive issues. This may reveal that some youths now being treated for another type of mental disorder actually have a brain injury, illustrating how a proper diagnosis is vital to efficiently utilizing limited treatment resources.
As indicated below, Texas Juvenile Probation Commission data show that a third of juveniles referred to probation or deferred adjudication have been identified as having a mental illness and that this number has been steadily increasing in recent years.

Youth on Deferred or Probation Supervision with Identified Mental Illness, FY 2001 – FY 2008



Finally, 37 percent of juveniles committed to the Texas Youth Commission in 2009 had a serious mental health problem and more than 300 had an IQ of 79 or less, some of whom may meet the definition of being mentally retarded.[1]

B. Recommendation #1: Increase utilization of front-end diversionary approaches such as mental health courts, crisis stabilization centers, and specialized probation caseloads and individualized case management in lieu of more costly incarceration for appropriate offenders

Mental health courts

Several counties in Texas, including Bexar, El Paso, Tarrant, and Dallas, have established mental health courts, which are designed to divert nonviolent mentally ill offenders from jail and prison. There are more than 150 mental health courts in operation throughout the United States. The evidence indicates that these courts reduce recidivism and total costs to taxpayers, as they divert appropriate offenders who would otherwise be committed to prison and, over the long-term, keep a greater share of them from returning to the criminal justice system.

Although no two mental health courts function exactly alike, all have 10 essential elements: planning and administration, target population, timely identification and linkage to services, terms of participation, informed choice, treatment support and services, confidentiality, court team, monitoring adherence to court requirements including taking medication as a condition of probation, and sustainability.[2]

- Planning and administration refers to the fact that a mental health court is multidisciplinary and thus must be both planned and administered from "the intersection of the criminal justice, mental health, substance abuse, and other social service systems."[3]

- All mental health courts have a target population that the court will service.[4]
- Timely identification and linkage to services means that "participants are identified, referred, and accepted into mental health courts, and then linked to community-based service providers as quickly as possible."[5]
- Each mental health court must provide the terms of participation to those it treats, and these terms of participation must be catered to each individual and his or her specific treatment plan.[6]
- Mental health courts must be an informed choice, which means the participants "must fully understand the program requirements before agreeing to participate in the court."[7]
- Mental health courts provide treatment support and services, connecting participants to comprehensive and individualized treatment supports and services in the community, including medications and case management.[8]
- Mental health courts employ multi-disciplinary court teams that are dedicated to helping "mental health court participants achieve treatment and criminal justice goals by regularly reviewing and revising the court process."[9]
- Mental health courts monitor "participants' adherence to court conditions, offer individualized graduated incentives and sanctions, and modify the treatment as necessary to promote public safety and participants' recovery."[10]

According to one of the most systematic and well-constructed research designs of mental health courts, in the long run the "drop in jail costs more than offset the treatment costs, suggesting that the mental health court program may help decrease total taxpayer costs over time."[11] A RAND Institute study found that "the leveling off of mental health treatment costs and the dramatic drop in jail costs yielded a large cost savings at the end of [its] period of observation."[12]

The RAND study is not alone in advancing this analysis. Julie Clements, a Pretrial Services Officer with the Washoe County Mental Health Court in Reno, Nevada, reported that the 2007 class of 106 graduates went from 5,011 jail days one year prior to mental health court to 230 jail days one year after, a 95 percent reduction.[13] Strikingly, the cost to the system was reduced from $566,243 one year prior to mental health court to $25,290 one year after.[14]

An evaluation of the Santa Barbara County Mental Health Court found that the participants in the metal health court averaged fewer "jail days after treatment than they had before, with a greater reduction in jail days for participants in the [mental health court] than for those in the [traditional judicial system.]"[15] *The American Journal of Psychiatry* found that "participation in the mental health court was associated with longer time without any new criminal charges or new charges for violent crimes."[16] It also reported that "successful completion of the mental health court program was associated with maintenance of reductions in recidivism and violence after graduates were no longer under supervision of the mental health court."[17]

There is also a record of success for mental health courts in Texas. The Tarrant County Mental Health Court focuses on jail detainees who have been screened for mental illness. Case management and clinical services are provided to participants who then report to the court each month to update the judge on their progress. Adults who complete the treatment protocol and do not re-offend have their cases dismissed. The Tarrant County Mental Health Court has achieved a 90 percent success rate, as measured by offenders diverted from jail or prison who do not re-offend.[18]

For these reasons, mental health courts are enjoying newfound status and popularity. Harris County's criminal district judges recently voted "to designate a full-time felony mental health court . . . to prevent some offenders from "recycling" through the system."[19]

The cost of setting up a mental health court depends on the model chosen to develop it.[20] For example, some models have a larger target population, require new staff, and require new treatment programs while other mental health courts do not.[21] Merrill Rotter, the Medical Director and Co-Project Director of the Bronx Mental Health Court, mentioned that some of the programs "cost as little as $150,000 while others cost multiples of that."[22] It is possible to have a mental health court with no funding at all.[23] Clements noted that the actual court session amounted to volunteer time during lunch one day a week.[24] The idea was to make offenders follow through on services already available to them.[25] It is important to note that much of the setup cost can be a transfer of existing resources.[26]

Mental health courts have also proven effective for juveniles. The Travis County Collaborative Opportunities for Positive Experiences (COPE) program is part of the Travis County Juvenile Mental Health Court and is designed to divert youths who have committed an offense with a mental health disorder from a residential setting and further involvement in the justice system. It is the first pre-adjudication juvenile mental health court program in the state. Participating youths are on deferred adjudication. To complete the deferred adjudication successfully, the youth must fulfill all phases of the program, as well as any conditions of basic deferred adjudication, such as restitution to the victim.

The key elements of the COPE mental health court program are:

- A judicially supervised, community-based treatment plan is developed for each youth participating in the court, which a team of court staff and mental health professionals design and implement.
- Participants receive needed mental health services, such as psychiatric evaluation, medication management, and individual and family therapy conducted both in and out of the home.
- The team assigned to the youth consists of the mental health court judge, the assistant district attorney, the juvenile public defender, the mental health court project coordinator, two deferred prosecution officers dedicated to COPE cases, the director of assessments, and a psychologist from the Travis County Juvenile Probation Department who participates as needed.
- Juveniles progress through the program based on a level system with decreasing levels of supervision.
- Participants are held accountable through a contract and regular reviews before the judge. Sanctions may be imposed by the court for non-compliance. Examples of sanctions are requiring the juvenile to write a paper related to an incident, community service hours, and being retained longer on a level of supervision. Positive incentives such as gift cards are also offered for exemplary compliance.
- Based on compliance, the program lasts a minimum of six months and a maximum of one year.
- A team member engages with the school district to ensure the youth receives appropriate educational services.

Of the participants, 58 percent are 10 to 14 years old, 21 percent are 15, 19 percent are 16, and 2 percent are 17. The majority—58.2 percent—have committed a misdemeanor. Most of these misdemeanants—41.8 percent—committed a violent offense; the others committed a drug, property, or other offense. Approximately half of the felony participants committed a violent offense. Bipolar disorder afflicts 29.1 percent of participants, depressive disorder 23.6 percent, and major depression 10.9 percent. The remaining participants have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), anxiety disorder, autism, or another mental illness.

Of the 2008 participants in the program during 2008, 69.1 percent have completed the program and 65 percent of those discharged in 2008 have not committed another offense.[27] This recidivism rate is significantly lower than the baseline one year re-offense rate of 66 percent for the state Special Needs Diversionary Program that targets mentally ill youth offenders, who may typically be more likely to recidivate.[28]

In February 2009, Harris County began a juvenile mental health court, with procedures similar to those in Travis County. All types of youth offenders whose conduct is a result of a serious emotional disturbance are eligible. Some 50 percent of detained youths in Harris County have symptoms of mental illness.[29] One of the conditions for entering the program is parental consent. Upon entry, systems of care coordinators, who are part of the mental health court team, refer the families for the services and treatment needed. Services are provided through either the local Mental Health and Mental Retardation Agency (MHMRA) or private providers. Therapists may meet with the youth and family up to four times a week. Medications are financed primarily through Medicaid, so there is no additional cost attributable to the mental health court. The parent and child must meet with the judge every two weeks to discuss their progress. The program lasts a minimum of six months, and this period may be extended if the youth and family demonstrate a need for further intervention. Of the 20 initial juveniles in the program:

- 15 have successfully graduated or are slated to graduate[30]
- Three have been placed in therapeutic residential facilities for more intensive services[31]
- One has been removed from the program due to failure to comply with court conditions[32]
- One has moved out of state[33]

In other states, juvenile mental health courts have produced positive results. For example, the Santa Clara Juvenile Mental Health Court in California reports a reduction in recidivism from 25 percent for probation youths to 7 percent for program participants.[34]

While mental health courts for misdemeanants are an excellent tool for reducing the recycling of mentally ill offenders through county jails, the state should focus its limited resources on mental health courts that handle felony offenders and divert an appropriate group of these offenders from state prisons and jails who can succeed through the extensive judicial oversight and accountability and coordinated treatment that mental health courts provide.

Jail diversion to mental health crisis centers

Through a Bexar County program, arrested offenders are screened for mental illness and, if not a threat to public safety, released on a mental health bond or to a treatment center. Screenings are

conducted at the Crisis Care Center, a 24 hour facility that provides significantly quicker service at a lower cost than the emergency room. Once stabilized, offenders are released on a mental health bond. Because the wait for a trial date can be as long as six months, outpatient monitoring significantly reduces the utilization of county jail space. Third, follow-up services are provided upon release from jail or prison.

Bexar County's MANOS program for diverting misdemeanants from the jail through intensive case management has been remarkably successful. The intensive case management includes outpatient medication management and counseling.

Of the 371 offenders admitted to the MANOS Program, 23 were re-incarcerated for a 6.2% rate. This compares to a re-incarceration rate of 67% for mentally ill offenders without the intensive case management services offered by the jail diversion program.[35]

Savings from Bexar County's jail diversion program, which also includes the post-booking Genesis program for diverting probationers and parolees discussed below, are estimated at between $3.8 and $5.0 million dollars per year.[36] Similarly, a study of an Ohio jail diversion program found $1 million in savings and an 11.5 percent recidivism rate.[37]

Other counties may be able to achieve similar savings by replicating Bexar County's MANOS program. TCOOMMI had concluded that mentally ill offenders in many counties are kept in jail beyond the 72 hour period after which state law requires them to be released on personal bond.[38] This is partly attributed to a lack of programs for diverting these offenders.

Specialized probation caseloads and individualized case management

Intensive and careful case management reduces the likelihood of the state's having to return a mentally ill probationer or parolee to prison.

With the goal of reducing revocations to prison, the Parole Division and the Community Justice Assistance Division (the division of TDCJ that oversees probation departments) sponsor smaller caseloads for mentally ill offenders: 84 for specialized probation caseloads and 120 for specialized parole. Instead of supervising 90 offenders, each officer supervises only 45. The specialized caseloads cost an additional $3 a day, far less than the cost of prison.

Additionally, about 2,500 mentally ill probationers and 800 mentally ill parolees are assigned case managers funded by TCOOMMI. These case managers provide medication management, counseling, and other services. Each case manager works with approximately 25 offenders.

About 2,500 probationers and 800 parolees participate in this intensive case management initiative at a cost of $2,800 per participant. These offenders are also on a specialized caseload. TCOOMMI reports that the three-year re-incarceration rate for participating probationers is 15.1 percent and 16.0 percent for parolees. These recidivism rates compare favorably to the closest benchmarks. There is an estimated 52 percent re-incarceration rate for mentally ill probationers and parolees who do not receive treatment.[39]

In Texas, the three-year re-incarceration rate for all inmates released from prison is 27.9 percent.[40] A Washington state study found a three-year re-incarceration rate of 43 percent of among mentally ill offenders released from prison without any specialized follow-up compared with 27 percent participating in a program similar to the TCOOMMI initiative.[41] An Iowa study found mentally ill male inmates have a recidivism rate of 54 percent compared to 31 percent for the general prison population.[42]

In their report to the 80th Legislature on TDCJ, the Sunset Commission found that "Offenders receiving services are more likely to be allowed to remain on community supervision, instead of being sent to prison or state jail, saving the State the cost of incarceration."[43]

The public safety imperative to follow up with mentally ill offenders to ensure treatment is illustrated by the potential for a high rate of re-incarceration among these offenders.

National Statistics Show High Rate of Previous Incarcerations Among Mentally Ill Inmates[44]

Previous Incarcerations	≥ 1	≥ 2	≥ 3	≥ 4
Psychiatric Inmates	50.7%	20.1%	7.0%	2.6%
Other Inmates	38.7%	12.2%	3.6%	1.8%

Approximately 3,000 probationers are on intensive case management and a specialized caseload in Harris County called New Specialized Team of Advocates and Rehabilitation Therapists (New START) that is funded with $3 million from TCOOMMI. A portion of these funds allows New START participants to receive medications and counseling through the Harris County MHMR. In 2006 and 2007, 4 percent of probationers on the program were revoked to prison compared with 30 percent of mentally ill probationers not in the program.[45]

Similarly, the Bexar County Genesis program funded through TCOOMMI served 429 mentally ill felony probationers and parolees in 2007. Participating offenders receive psychiatric drugs and counseling through the Center for Health Care Services that is part of the Bexar County MHMR. Of those participating, only 29 were re-arrested. The revocation rate was only 6 percent.[46]

Lawmakers should weigh the public safety benefits from lower recidivism and the potential cost savings from reduced incarceration in considering whether to expand the availability of specialized probation caseloads and individualized case management for mentally ill offenders.

C. Recommendation #2: Strengthen use of risk and needs assessments and performance measures for treatment programs to better evaluate both recidivism and intermediate outcomes such as performance on validated instruments before and after the program so that existing resources can be maximized by getting the right offender in the right program.

While mental health treatment is critical, there are many different treatment protocols and some programs may work for offenders with a certain profile than others. Furthermore, offenders with mental illness, just like non-offenders, can sometimes be placed in a residential setting that is more restrictive than necessary or medicated with more drugs than necessary, wasting resources and potentially even leading to counterproductive results. The use of a validated risk and needs assessment is vital to better allocate existing resources by matching the type of offender with the program that has proven to produce the best outcomes for offenders that fit this profile in terms of both their mental problems and other characteristics such as substance abuse, risk factors, criminogenic needs, and offense history.

Every program should be evaluated in part based on recidivism, which can include being arrested again, self-reporting, and re-incarceration. However, it often takes considerable time and resources to conduct controlled studies that evaluate long-term recidivism for participants versus non-participants in a program. This is one reason why it is also critical to implement intermediate performance measures that can assess an offender's progress during the treatment program.

The Front-End Diversionary Initiative (FEDI) is a diversion program designed for youth offenders with mental illness that provides an excellent example of how progress is measured both during the course of the program and before and afterwards. The program is currently operating in Dallas, Lubbock, Bexar, and Travis counties with financial support from the John and Catherine T. McArthur Foundation and the *Models for Change:* Mental Health and Juvenile Justice Action Network (MHJJAN). The four sites began implementing FEDI in February 2009. More than 95 youths and families are engaged. The centerpiece of the program is the use of Specialized Juvenile Probation Officers (SJPOs) who are uniquely trained to manage this challenging population. As a pre-adjudication program, FEDI offers successful participants the opportunity to avoid an adjudication on their records that would be detrimental to their future.

Youth arrested for offenses that make them eligible for deferred prosecution are screened to identify those with a significant mental illness, such as major depression or schizophrenia. In Lubbock County, the SJPO assigned to FEDI checks all youth referred-with the Mental Health and Mental Retardation Center (MHMR) to identify entering youths who have had previous contact with the mental health system. Additionally, other youths who are eligible for deferred prosecution are considered for the program if the results of a screening instrument—the Massachusetts Youth Screening Instrument (MAYSI)—indicate a mental health problem. The MAYSI is a 52-question exam that covers seven domains: alcohol/drug use, anger and irritability, depression and anxiety, somatic complaints, suicidal ideation, thought disturbance, and traumatic experience. Also, the intake officer or behavioral health coordinator who meets with youths in the detention center may recommend that they be included in FEDI based on their observations, even though there is no prior contact with the mental health system and no indication of mental illness on the MAYSI.

After a youth is identified for possible participation in FEDI, an SJPO meets with the youth and family. The family's willingness to participate is determined, as it is a precondition for participation. The officer obtains background information on the youth and family and administers the Ohio Youth

Problem, Functioning, and Satisfaction Scales, an assessment that consists of norm-referenced self-reporting measures and behavioral rating scales.[i]

The parent and officer also fill out a version of the Scales. Among the items on the Scales: whether the youth has had behavioral problems within the last 30 days, such as getting into fights, using drugs or alcohol, skipping school, and hurting himself. Other items concern positive behaviors such as getting along with friends and family, caring for health needs, being motivated, completing household chores, and accepting responsibility for actions. Another part of the inventory assesses the level of satisfaction with any mental health services received so far.

In the first of week of FEDI participation, the officer completes an individualized case plan that is discussed with the youth and parent. After any changes are agreed upon, the youth and parents sign the plan and are given a copy. The SJPO coordinates with the local MHMR agency, treatment providers, and school officials to ensure that the youth is receiving appropriate care, complying with medications, and maintaining good attendance and behavior at school. The program consists of three phases:

- Phase I (two months): Contact with the juvenile at least three times a week. Contact with the parent/guardian at least twice a week. Contact with the mental health provider at least once a week.
- Phase II (two months): Contact with the juvenile at least twice a week. Contact with the parent/guardian at least once a week. Contact with the mental health provider at least once a week.
- Phase III (two months): Contact with the juvenile at least once a week. Contact with the parent/guardian at least once a week. Contact with the mental health provider at least once a week.

Throughout the phases of the program, SJPOs hold weekly meetings with the youth and family and utilize motivational interviewing, a method of therapy that identifies and mobilizes the client's intrinsic values and goals to stimulate behavior change. Motivation to change is elicited from the client, and not imposed from without. It is assumed that ambivalence or lack of resolve is the principal obstacle to be overcome in triggering change. In an example of motivational interviewing, an officer may ask a youth questions designed to elicit self-motivational statements such as, "What are you afraid might happen if things continue as they are?" and "What might be some advantages of changing your behavior?"[47] Motivational interviewing has been designated by the National Institute of Corrections as one of eight evidence-based practices that contribute to reduced recidivism.[48]

The SJPO also develops a plan to be used in the event of a crisis. SJPOs maintain small caseloads of 15 youths or fewer in order to provide close supervision. The officers receive intensive, specialized training in supervision of mentally ill offenders. All Texas SJPOs underwent extensive training in

[i] An example of the Scales is available online at: http://www.ct.gov/dcf/lib/dcf/programs_and_services_data_collection_and_reporting_system/psdcrs_forms/ohio/osyouth.pdf.

motivational interviewing, family engagement, crisis intervention, and quality case management from October 2008 through February 2009.[ii]

After six months of deferred prosecution, youths who comply with the individualized case plan are released from supervision, unless the judge orders additional time in the program. The Ohio Scales are completed once again by the youth, parent, and SJPO to document behavioral progress. Aftercare planning is used to prepare the youth and family for transition out of the program.

Youths who engage in delinquent behavior are removed from the FEDI program and referred to formal probation. In Dallas County, 34 youths have gone through the program beginning in February 2009 of whom 17 remain engaged in it. Five of the 17 have violated the conditions of their deferred prosecution agreement.[49] Mr. Griffiths finds the success rate encouraging, given the high recidivism typically associated with mentally ill offenders.[50]

D. Recommendation #3: Redirect a share of savings from reduced incarceration for community-based mental health interventions

Two ways of accomplishing this are particularly promising.

First, the state could create a framework similar to the budget provision that led to the juvenile Commitment Reduction Program though which district attorneys, judges, and other county officials could enter into an arrangement with the state to target a lower level of non-violent commitments to prison in exchange for receiving a share of the savings that could be used for stronger probation, drug and mental health treatment, and other community-based programs and interventions to promote public safety. Such a framework could enable the state to obtain significant savings from closing unneeded prisons.

Second, a key problem in the current system is that all state jail inmates and thousands of prison inmates, including many in each group with mental illness, are released as flat discharged with no parole supervision or reentry supports. This is particularly problematic for mentally ill offenders who may have received treatment and medications in prison but now cannot be supervised or held accountable upon release because they are not under supervision. In fact, the Texas Council on Offenders with Mental Impairments (TCOOMI) recently stopped referring flat discharged inmates to mental health services because the vast majority did not show up for their appointment and no resources or leverage were available to get them to do so. Clearly, when these flatly discharged inmates abruptly discontinue medication and counseling upon release, they may therefore pose a greater danger to the public than if there was a continuity of care and evidence-based supervision. Therefore, public safety could be enhanced and net savings achieved by adjusting the term of incarceration for some of these offenders based on a validated risk and needs assessment and having them complete the remainder of their sentence on probation or parole.

[ii] In December 2009, TJPC began offering training for the Specialized Officer Certificate initiative in conjunction with the Mental Health and Juvenile Justice Action Network (MHJJAN) through the support of the John D. Catherine T. McArthur Foundation.

E. Recommendation #4: Enhance information sharing across agencies

In regard to special needs offenders, it is vital that government entities such as school districts and the Department of Family and Protective Services share information as appropriate with criminal justice agencies and vice versa to the full extent that is permissible under federal and state law governing confidentiality and privacy. Such exchanging of information can improve the level of care and supervision and ensure there is not duplication, such as the same assessment being repeatedly performed on an individual within a short timeframe.

F. Conclusion

While special needs offenders must be held accountable like all others, recognizing and addressing their special needs is vital to protecting public safety, controlling total costs to taxpayers, and restoring victims of crime.

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