The Mentally Ill and the Criminal Justice System: Ideal Categories for Creating Successful Identification and Diversion Programs for Mentally Ill Offenders

By

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ABSTRACT

The past decade has seen an explosion of the inmate population in Texas. The number of individuals incarcerated in correctional facilities has increased from approximately 49,000 to 160,000. With the increasing number of inmates, the criminal justice system has begun to focus on particular inmate populations. This focus has uncovered a finding that professionals in the mental health field and those at the local level have suspected for quite some time; the number of mentally ill offenders in the criminal justice system accounts for a growing percentage of inmates.

The purpose of this paper is to explore policies that deal with mentally ill offenders in the criminal justice system at the county level in Texas. The following categories were used to assess county approaches to dealing with mentally ill offenders.

Mental health law enforcement training
Jail intake screening
Coordination between law enforcement and mental health professionals
Access to mental health and community treatment programs

A survey of Texas Sheriffs in counties with jail capacities between 250-1000+ beds was used as the methodology for assessing policies for dealing with mentally ill offenders in Texas. The responses indicated that there is a need to more aggressively encourage the implementation of existing statutes and multi-disciplinary cooperation.

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Chapter One

INTRODUCTION

Texas Criminal Justice System

The past decade has seen an explosion of the inmate population. The number of individuals incarcerated in Texas correctional facilities has increased from approximately 49,000 to 160,000.[1] This explosion has created a number of problems for the criminal justice system. One of the most important problems is correctional capacity. With the increasing number of inmates, the criminal justice system has begun to focus on particular inmate populations. This focus has uncovered a finding that professionals in the mental health field and those at the local level have suspected for quite some time; the number of mentally ill offenders in the criminal justice system accounts for a growing number of inmates.

This is a concern for several reasons; the population of persons with mental illnesses is one that law enforcement, for the most part, is not adequately trained to deal with and is prohibitively more expensive to incarcerate. Mentally ill offenders tend to be low level misdemeanants that cycle through the criminal justice system.[2]

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[1] Texas Department of Criminal Justice inmate population increases have put the state of Texas in the top tier of incarceration rates in the country.

[2] While some reports contradict this statement, a majority of the research finds that many of the mentally ill offenders that cycle through the criminal justice system are located at the county level and are not serious offenders. See for example Ditton, Roche, and Ventura

These offenders are an identifiable segment of our incarcerated population that would benefit from treatment alternatives and jail diversion programs.

An example of this problem was recently chronicled in the state of Mississippi. Police chief Willie Huff of Natchez, Mississippi acknowledges that there have always been persons with mental illnesses in the community, but that they were usually sent off to institutions that offered treatment. Since the deinstitutionalization movement of the 1960's more of these individuals have become a concern for law enforcement.

A twenty-five year old Mississippi state law allows mental patients to be kept in jail when no other place can be found for their supervision. In the seven years since chief Huff took office, five people have either killed somebody or committed suicide while waiting for a bed at Mississippi State Hospital. It has become evident that jails need the ability to divert these type of offenders to appropriate programs or facilities to ensure the adequate application of public safety. (Roche, 2000: pp. 8283)

Research Purpose

The purpose of this research is four-fold. The first purpose is to describe laws and policies regarding the screening and diversion of mentally ill offenders and how they are implemented around the country. The second purpose is to identify ideal

categories for jail screening and diversion of mentally ill offenders. The third purpose is to assess the current policies of the thirty-nine largest county jails measured against the ideal categories to identify best practices. The final purpose is to make recommendations for ways to improve those policies.[3] The literature used in the research for this paper identifies the ideal categories that serve as a framework for model policies.

Chapter Summaries

Chapter two reviews the literature on the mentally ill offenders in the criminal justice system. The chapter reviews the historical settings that contributed to the problem of increasing numbers of mentally ill offenders in county jails. The literature review chapter also discusses approaches that the criminal justice system can use to deal with the problem of mentally ill offenders based on insight from the literature.

Chapter three, the settings chapter, looks at what Texas has done in the way of dealing with persons with mental illnesses in the criminal justice system. Texas is considered a national front-runner in setting policies for the identification and diversion of mentally ill offenders in the criminal justice system. The settings chapter also provides an overview of the policies of identification and diversion that

[3] It is important to remember for purposes of this report the focus will be on jail inmates. Jail is the front door to the criminal justice system and this report will focus on the mentally ill at this point.

have been put in place in Texas and highlights best practices of selected counties in the state. Finally, the chapter develops a practical ideal type conceptual framework that organizes into categories, policies that are most useful in successfully screening and diverting mentally ill offenders.

Chapter four, the methodology chapter, operationalizes the ideal categories by developing a survey. The survey aims to explore the policies of county jails with regard to mentally ill offenders. The survey pulls together the ideal categories that are identified throughout the literature as necessary for good jail diversion policies and measures them against what is actually being done in county jails in Texas.

Chapter five measures the results from a survey mailed to Sheriffs in the thirty-nine largest counties in the state. The survey results help identify how many of the ideal categories particular jails employ in their operations.

In chapter six, the findings are summarized and suggested recommendations for enhancing jail policies are developed.

Chapter Two

LITERATURE REVIEW

Introduction

The purpose of this chapter is to review the historical settings that contributed to the problem of increasing numbers of mentally ill offenders in county jails. This chapter also discusses approaches that the criminal justice system can use to deal with the problem of mentally ill offenders based on insight from the literature.

It is important to take a look back to understand current policies. Institutionalization of persons with mental illnesses dates back to the seventeenth and eighteenth centuries. Over time, institutionalization shifted to deinstitutionalization and finally, to incarceration of persons with mental illnesses. Today, the criminal justice system must face the dilemma of what to do with this growing segment of our jail population.

Brief History

Persons with mental illnesses have not always been seen as an important societal problem. In the seventeenth and eighteenth centuries, the mentally ill- or as they were known "distracted or "lunatick"- persons were not highly visible.

Society was predominately rural and agricultural, with communities that were small and scattered. Mental illnesses were perceived to be an individual rather than a social problem to be handled by the family of the disordered person and not by the state. (Grob, 1994: p. ***5)***

The proportionately small number of "distracted persons did not warrant the creation of special facilities; therefore, they were cared for on an informal basis. The care of the insane remained a family responsibility; as long as its members could provide the basic necessities of life for afflicted relatives. If the family could not provide adequate care, the community would assist. Early colonial laws were based on the (poor laws) English principle that society had a corporate responsibility for the poor and dependent. Local communities were required to make provisions for various classes of dependent persons. (Grob, 1994: pp. ***5,6***)

The colonial poor law policies worked well because a "care for your own community" philosophy was relatively easy to implement in the rural, sparsely populated society. By the early eighteenth century, however, institutionalization of the insane in the colonies began to appear. The population growth in colonial towns led to an increase in the number of sick and dependent persons. The informal manner in which communities had once cared for such persons was no longer adequate. The increase in illness and dependency ultimately moved

community leaders to support the creation of institutions for dependent persons.[4] (Grob, 1994: pp. 17,18)

In the nineteenth century, care was shifted to confinements in state run hospitals. The concept of mental illness was viewed as a traditional medical condition requiring a physicians care. By the second half of the nineteenth century, there had been a rapid increase in the number of state mental hospitals. In 1880, a total of 91,959 insane persons were identified in the United States. Among the 58,609 individuals in jails and prisons at the time, only 397 of them were said to be mentally ill. (Torrey, 1999: p. 10)

A policy of institutionalization continued to grow and soon consumed large amounts of state and county money. When the problems of overcrowding and poor conditions began to overwhelm mental hospitals, the federal government attempted to address them. The belief that severe mental illness could have a biological or psychological basis developed in the early twentieth century and created the movement away from institutional care in favor of less restrictive community care. (Breakey, 1996:15) By the middle of the twentieth century, there was a movement to shift care from hospitals to institutions such as jails and homeless shelters, which were not intended for persons with mental illnesses. (Kuhns, 8, 1998)

[4] This precipitate the contemporary movement that moved from confinement in state hospitals to deinstitutionalization.

Deinstitutionalization

In 1961, President John F. Kennedy appointed an interagency committee to prepare legislative recommendations to deal with the problem of institutionalization. President Kennedy's final report included the recommendation of the National Institute of Mental Health that 2,000 "community mental health centers" (one for every 100,000 people) be built by 1980. The President signed the Community Mental Health Centers Act on October 31, 1963. The number of patients in state and county mental hospitals peaked in 1955 at 558,922 and has declined every year since then, to 61,722 in 1996. But the goal of building 2,000 community mental health centers did not materialize. By 1980, only 482 had received Federal construction funds. (Moynihan, 1999)

The 1961 policy recommendations were the catalyst for deinstitutionalization of persons with mental illnesses. Deinstitutionalization was the process whereby many mentally ill patients in state/public hospitals were released to the care of community facilities, to their families, or without supervision. Economic factors, humanitarian concern for persons with mental illnesses, and the emergence of psychotropic drugs were additional reasons for the move to deinstitutionalize. (Aderibigbe, 1997: p.128)

When Medicaid and Medicare were first implemented in the 1960's, federal of cials feared the states would try to use the money to cover costs of state mental

hospitals. In addition to the push to deinstitutionalize, the federal government implemented the Institution for Mental Disease exclusions (IMD), which made the state mental hospital ineligible for federal funds except under very limited circumstances. The changes forced the states to re-prioritize the already shrinking number of state mental hospital beds.

Advocates fought for changes in commitment laws that encouraged the discharge of mentally ill patients. Involuntary commitments of severely mentally ill persons to a hospital thus became exceedingly difficult. Additionally. the development and improvement of anti-psychotic medications enabled patients to function outside a hospital setting. (Torrey, 1999: p. 12-13) Based on the philosophy set by the Kennedy administration and the changes in public opinion, the belief that persons with mental illnesses were better served in the community flourished. Unfortunately, without sufficient community resources to treat persons with mental illnesses, county jails have become the alternative treatment centers for a growing number of these individuals.

The rationale behind the deinstitutionalization of the non-violent mentally ill patients in the 1960's was laudable. Those who supported release back into the community heralded the benefits of the resultant down-sizing of mental health institutions and the development of new drug therapies. The money saved by hospital closings could be used in outpatient community programs. Unfortunately,

the money did not go to the community. Instead, states re-budgeted the savings, and many mentally ill people found themselves without treatment services. (Vickers, 2000: p. 3)

One of the results of the deinstitutionalization movement was a rise in the number of mentally ill homeless people. The failure to provide effective services to the mentally ill released from the hospitals left many of these patients to unsuccessfully fend for themselves wandering the streets homeless. (Atwood, 15, 1999)

Mentally I11 Offenders

The idea that jails are not the place for people with mental illnesses is not new. As early as 1843, Samuel Girdley Howe, abolitionist and social reformer, observed: "The jailers and keepers of houses of correction, may be men of humanity; but they do not know how to treat insanity any more than they know how to treat scarlet fever; nor have they the means to do so." (Torrey, 1994: p. 10) The continual rise in the number of mentally ill offenders and the problems they present to the criminal justice system illustrate Samuel Howe's concerns, made more than 150 years ago. At midyear 1998, an estimated 283,800 mentally ill offenders were incarcerated in the Nation's prisons and jails. In a recent survey completed by the Bureau of Justice Statistics, 16% of those in local jails reported either a mental

condition or an overnight stay in a mental hospital. (Ditton, 1999: p. 1)

People come into contact with the criminal justice system for many reasons. Only a portion of them have an identified mental illness. This group, however, demands a disproportionate amount of attention, both because of their special needs and because of the problems they pose for the criminal justice system.

One of the most prevalent myths about persons with mental disorders is that they are prone to violence. Even though some studies have indicated that offenders with mental illnesses were more likely to have committed a violent offense, most are not violent and commit less serious crimes such as disturbing the peace, vagrancy, and trespassing.[5] Persons with mental illnesses are more likely to be held without criminal charges and are more likely to be charged with minor crimes. (Steadman, 1994: p. 10) Jails have increasingly become a poor substitute for community-based mental health services.[6]

Because jails have a constitutional duty to provide mental health treatment to individuals who require it, and a responsibility to provide a safe and secure environment for both staff and inmates, it is in the best interest of all concerned to stabilize persons who have mental illnesses.

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[5] A 1999 study by the Bureau of Justice Statistics found that state prison inmates with a mental illness were more likely than other inmates to be incarcerated for committing a violent offense **53-**46% (Ditton: 1999) However, as mentioned earlier, county jails were more likely to have mentally ill offenders that committed less serious crimes.

[6] This is a result of poor identification and diversion policies in jails.

Institutional Response

Jail mental health services can be most effective when law enforcement and mental health professionals are encouraged to spend a specific amount of time in on-site training in jails. The essential mental health services of screening, evaluation, crisis intervention, and discharge planning must be available to persons who are appropriate for jail diversion. Community-based facilities must function as an integral part of the social and health service system, when diversion programs are developed to avoid inappropriate detention of persons with mental illnesses. (Steadman, 1994: p. 11)

Mental Health Law Enforcement Training

Effective law enforcement response to citizens with mental illnesses requires cooperation and the exchange of knowledge, resources, and services between law enforcement, mental health, and social agencies. In particular, the efforts of local law enforcement are bolstered when training programs emphasize learning to identify symptoms of mental illness and knowing how the local mental health system works. Mental health crisis intervention training allows local law enforcement to assess an individual and determine if they might be served more effectively by diversion to the mental health system.

The State of Tennessee uses what they call a "Specialized Team Approach."

A specialized team is comprised of trained law enforcement officers who are able to address mental health issues in the community. The officers are trained to determine when diversion is appropriate and have the option to divert individuals for mental health evaluation and referral to community resources prior to booking. This training is coordinated through the Tennessee Corrections Institute, an independent jail training and inspection agency. (Criminal Justice Task Force Report, 2000)

The development of crisis intervention programs is another recommended component for law enforcement training. For example, the Memphis Police Crisis Intervention Team (CIT) is a partnership between the Memphis Police, the Memphis Chapter of the Alliance for the Mentally 111, mental health providers, and two local universities. These groups have worked together to organize, train for and implement a specialized unit to respond to crisis events involving persons with mental illnesses. Results have included a significant decrease in officer injury rates and increased access to mental care by people with mental illnesses. According to Vickers (2000, pp 4-5) the program keeps people with mental illness out of jail, minimizes law enforcement time spent on calls, and maintains community safety.[7]

[7] The Tenneeeee programs have been widely cited as models for addressing the identification of mentally ill offenders.

Jail Intake Screening

Initial detention is an activity that has major implications for the person detained, for the facility, for the criminal justice system, and for the system of mental health care. Although the period of initial detention is usually brief, there is no other time in the course of an incarceration of greater importance to the detainee's health and well being.[8]

Proper intake and classification procedures are essential, both to protect the jail and to ensure that legal requirements and the rights of the individual are met. The booking/admissions officer performs critical functions during these procedures, including screening out critically injured or ill persons, or obtaining immediate medical attention for them. Admission is generally viewed as the first step in classification and is the point at which the jail assumes responsibility for the health and mental health care of those detained. (Jemelka, 1990: p. 37)

The function of jails necessarily dictates a short length of stay and a high turnover rate. As jail populations increase and capacities are taxed, the screening and booking process is the first point at which the impact is evident. Many jails are now holding inmates well in excess of their rated capacity. American Correction Association (ACA) standards recommend that jails operate at 90% of capacity to allow room for population fluctuations. The Bureau of Justice Statistics reports

[8] It is at intake, where identification and diversion of mentally ill offenders can have the most positive impact on the criminal justice system.

that nationally, jails are exceeding the recommended standards. (Jemelka, 1990)

Coordination Between Law Enforcement and Mental Health Professionals[g]

In an effort to link services between law enforcement and mental health professionals, jails across the country are adopting case management techniques. Case management is a service delivery approach developed by mental health and social services workers to suit the needs of a variety of the criminal justice populations. While strategies and practice vary from one setting to another, traditional case management consists of a social or mental health worker who secures and coordinates with law enforcement for continued social, mental health, and other services for clients.

The increase in mentally ill offenders in county jails brought on by deinstitutionalization has required mental health and social workers to develop new ways to connect clients to community social service agencies and to monitor client's use of services. A common model for mentally ill offenders is "assertive case management," which involves delivery of services aggressively to the client, rather than passively offering services in a centralized office setting. Assertive case management may require case managers to seek out the client in his or her home, job, or community, for meeting and counseling or to locate branch offices that

[9]See for example McDonald, Wisconsin Correctional Service Program and Conly, Maryland Community Criminal Justice Treatment Program.

provide services in the communities where clients reside. (Healey, 1999: pp.2-3)

Ventura et al, examined the relationship between the intensity of case management and the criminal recidivism of a select group of mentally ill offenders released from jail and tracked for three years. It was hypothesized that after demographic, criminal history, and diagnostic variables were controlled, recidivism would be inversely related to the amount of case management received inside and outside of jail.

Case managers linked offenders to community based services and prepared treatment plans which included housing and medications. Offenders were referred to case managers to help them follow through with treatment plans. Individuals that received case management tended to be younger and more severely mentally ill. This study found those that continued to receive community case management. were significantly less likely to be re-arrested. (Ventura et al, 1998: p. 1330)

Mentally ill offenders typically pass through the jails and courts during processing by the criminal justice system, and interactions between these institutions can be particularly significant. Of the jails surveyed in 1997 by Steadman and Veysey, all sites had developed at a minimum, relatively routine means for dealing with the courts in response to the special needs of mentally ill offenders. The Forensic Clinic, created in 1985 at the New Hampshire County Jail for example, provides detainees with the services of a psychiatrist, psychologist, and

social workers on site. The major strengths of jail programs stem from their location within the jails and the availability of immediate treatment response.

In Shelby County, Tennessee, a multi-agency memorandum of understanding provides that each of the participating agencies appoint a contact person to act as liaisons with all other social service agencies and service providers. The staff at pretrial services reports the legal status and court dates of those with severe mental illness to the appropriate agencies and assists in expediting court dates. The public defender's office cooperates with pretrial services in communicating the legal status of cases involving persons with severe mental illnesses.[10] (Tennessee Criminal Justice Task Force, 2000)

According to Steadman and Veysey, the key to the success of cooperative agreements is open communication and cooperation among all parties. The support, contribution, and input of all involved parties are necessary for the proper functioning of this type of program. Jails interested in devising mental health services specific to their institutional needs should consider convening a working group that includes criminal justice, social services, mental health, and political leaders to develop a community-wide response. (Steadman & Veysey, 1997: p. 5-7)

Contracting with Community Mental Health and Treatment Programs

[10] This form of cross agency cooperation will prove to be a very significant component to a successful mentally ill offender program.

Another factor affecting both law enforcement and local corrections authorities is the status of local mental health services. The availability, accessibility, organization and quality of local mental health and state hospital services will have a significant impact on the number of new jail admissions designated as "mentally ill." Dispositional alternatives available to admission and booking personnel and pretrial services staff providing services to the jail, also reflect the effectiveness of the local mental health care delivery system.

Because criminal justice is the system that cannot say no, the impact of inadequate mental health care and increased homelessness is often felt first by police, sheriff, and jail admissions personnel. In addition to inadequate funding, some community mental health care providers are reluctant to provide mental health services to mentally ill offenders. In fact, some agencies use a history of incarceration or prior felony convictions as exclusionary criteria when screening for program eligibility. (Jemelka, 1990: p. 35-39)

Approximately 670,000 mentally ill individuals are admitted to U.S. jails each year. Many of them have committed nonviolent offenses such as disturbing the peace, vagrancy, and trespassing. A 1996 research brief conducted by The Center on Crime, Communities, and Culture cited three reasons why more diversion programs for mentally ill offenders were needed:

> Community treatment programs provide a public safety benefit by reducing the likelihood that a mentally ill offender will be re-arrested.

Community treatment programs provide a management benefit by enabling jails to operate more efficiently, to focus on keeping dangerous offenders off the streets, and to more effectively ensure the safety of jail staff and other detainees.

Community treatment programs provide more effective mental health treatment through an array of integrated services that most jails cannot offer.

Diversion of mentally ill offenders into community based treatment programs helps ensure greater public safety and protection for the community and the criminal justice system. Since most of these offenders are misdemeanants, it also helps jails keep beds open for the more dangerous criminals in the community. Diversion of mentally ill offenders into appropriate treatment programs results in better long term prognosis of the individual and lessens the likelihood of recidivism. (Research Brief. 1996: p. 1)

Communities can use creative means to secure funds to run treatment facilities and programs. Both public and private sector programs can be tapped for funds. The Maryland Department of Health and Mental Hygiene has teamed up with other state officials to establish a multi-agency collaborative program that provides services for mentally ill offenders. The Wisconsin Correctional Service (WCS), a private not-for-profit organization in Milwaukee, has established a community support program. These are two examples of the options available to communities attempting to address mentally ill offenders in their jails.[11]

[11] By thinking outside the box cooperative groups across multiple agencies have been able to put together programs that are tailored to their community.

The Maryland Community Criminal Justice Treatment Program (MCCJTP) is a multi-agency collaboration that provides shelter and treatment services to mentally ill offenders in the communities where they live. The MCCJTP operates in 18 of the state's 24 local jurisdictions and is notable among programs across the nation for its strong collaboration between state and local providers.

Two factors place the MCCJTP at the forefront of efforts to aid in diverting mentally ill offenders. These factors are strong collaboration between state and local providers, and transitional case management services that link detainees with community based services. Counties are usually left to address the needs of their jailed mentally ill offenders. The integration of funding streams at the different levels of government and the ongoing commitment by state officials involved, make the program unique. Case management services that link detainees, on release, to community services are seldom provided in jails. (Conly, 1999: pp. 10,11)

The MCCJTP targets individuals 18 and older who have a serious mental illness. The target population requires a continuum of care that is coordinated at both the state and local levels. Agency participants include local mental health and substance abuse treatment providers, local hospital professionals, housing providers, local law enforcement, mental health advocates, and representatives of the criminal justice system. Local communities are in the best position to plan and implement responses to meet the needs of mentally ill offenders in their

communities. The MCCJTP aims to improve the identification and treatment of mentally ill offenders and to increase the chances of successful independent living. (Conly, 1999: p.12)

The Wisconsin Correctional Service (WCS), a private not-for-profit organization in Milwaukee, has established an innovative Community Support Program (CSP) that adopts a "carrot and stick" approach to managing mentally ill offenders in the community by tying program support to adherence to the program. The program was developed in 1978, when WCS noticed the growing number of mentally ill persons coming into the Milwaukee courts and jails. (McDonald, 1994: p.2)

The community support program does not depend on unique conditions in Milwaukee for its existence. The program takes advantage of organizations already in place and benefits from private rather than government operating authority. One of the organizations already in place is pretrial screening. Pretrial screening assesses defendants likelihood of appearing at trial, and also provides a convenient point for identifying persons who might be mentally ill. Identification at the pretrial stage can increase the chances for jail diversion. By functioning under a private operating authority, the CSP has more discretion in deciding how to allocate their funds. (McDonald, 1994: pp. 9-10)

Chapter Three

SETTING

*According to a **1995** study by the American Probation and Parole Association and the National Coalition for the Mentally Ill in the Criminal Justice System, Texas is at the forefront of dealing with mentally ill offenders. Texas is credited with being one of the few states that target appropriations for mentally ill offenders and has specific legislation addressing the needs of offenders with mental impairments. (APPA **1995**)*

Persons with Mental Illnesses and the Criminal Justice System in Texas

Texas has been a national front-runner in setting policies for the identification and diversion of mentally ill offenders in the criminal justice system. While Texas has been aggressive in setting these policies, implementation at the county level is still a work in progress. The settings chapter provides an overview of the policies of training, identification, and diversion put in place in the state.

Four policies are instrumental in setting the framework for addressing the needs of mentally ill offenders in the criminal justice system. Law enforcement mental health training, jail intake screening, coordination between law

enforcement and mental health professionals[12] , and contracting with local mental health authorities are all pieces of the puzzle that put Texas at the forefront of addressing persons with mental illnesses in the criminal justice system.

Table 3.1 Criminal Justice Policies for Persons with Mental Illnesses

Ideal Categories
Mental Health Law Enforcement Training
Jail Intake Screening
Coordination between Law Enforcement and Mental Health Professionals
Contracting with Community Mental Health and Treatment Programs

Law Enforcement Mental Health Training

One of the most important issues in dealing with mentally ill offenders is early identification. The Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE) has worked to improve early identification of mentally ill offenders through mental health training since the early 1990's. In 1995, TCLEOSE worked to support legislation that created a Mental Health Officer Certification Program.

The efforts of TCLEOSE include the following training requirements for peace officers:

[12] The term used for this concept in Texas policy implementation is, Memorandums of Understandings (MOU's)

6.5 hours of pre-service training on dealing with persons with mental illnesses and other disabilities.

- 2.0 hours of in-service training on mental health for continuing peace officer certification.

40 hours of training for specialized mental health deputy certification. To date, more than 2,500 peace officers have completed the specialized mental health officer training program.

TCLEOSE has also developed a long distance education program for peace officers who wish to complete the specialized mental health deputy program, but are unable to attend a training academy class due to proximity or travel difficulties.

As a result of these efforts, trained peace officers are more prepared to identify and appropriately respond to situations involving offenders with mental illnesses or other special needs. Trained peace officers are also more likely to identify suspects with mental illnesses who could be diverted to more appropriate treatment alternatives.

Jail Intake Screening

While well trained peace officers are important, it is equally important to have a system of screening at the local jail level. Since law enforcement is only involved with a suspect for a short period of time, and circumstances may prohibit or hide the identification of a mental illness, jail staff must have tools to help assess the arrestee.

Prior to 1997, the only standard required by the Texas Commission on Jail Standards (TCJS) for screening in county jails was suicide screening. This screening proved to be fairly effective and resulted in Texas having one of the lowest jail suicide rates in the country. As part of an ongoing process, the TCJS formed a task force to develop a screening instrument for mental health and mental retardation. This task force was comprised of jail staff, psychiatrists, psychologists, and advocacy groups for persons with mental illnesses and mental retardation. The group spent over a year developing a screening instrument that was easy to administer and could help determine if further assessment was needed. In 1998, the revised screening instrument was adopted by the Jail Commission. (Appendix A, Jail Screening form)

Coordination Between Law Enforcement and Mental Health Professionals

In 1993, the Legislature established a Continuity of Care System for offenders with mental illnesses. At the time, Texas was the only state in the country to have a statutory provision for a continuity of care system for offenders with mental illnesses and other special needs. The provisions found in Chapter 614.013, Health and Safety Code, stipulate that the state and local criminal justice, mental health, and other health and human service agencies, as well as regulatory agencies for law enforcement and local jails, develop interagency agreements

establishing each agency's role and responsibility in the continuum of care.

Section 614.016, Continuity of Care for Certain Offenders by Law Enforcement and Jails, speaks directly to the issue of providing services through local coordination. The statute requires the TCJS and TCLEOSE to institute a continuity of care service program for offenders with mental impairments. While not specifically enumerated in the statute, coordination with local mental health entities that provide a continuum of care are implemented through local MHMR facilities as provided for in 614.013 of the Health and Safety Code."[13]

While the requirements for Memorandums of Understanding are formally in place, little has been done to ensure that they are implemented across the state. Recommendations include reporting requirements that tie continued funding to implementation of an MOU.[14]

Contracting with Community Mental Health and Treatment Programs

The Texas Department of Mental Health and Mental Retardation (TDMHMR) ensures the provisions of services through performance contracts with local mental health and mental retardation authorities. The board of TDMHMR designates entities as local mental health and mental retardation services within a

[13]Health and Safety Code Chapter 614.013-016.
[14]While the Continuity of Care System is specifically addressed in statute, there is little being done to ensure its enforcement. The proposed recommendations provide an incentive for counties to abide by the statutes.

given area of the state. The board may also delegate its authority for planning, policy development, coordination, resource development and allocation to local authorities.

Community mental health and mental retardation centers (CMHMRC) are units of local government authorized in Subchapter A, Chapter **534** of the Health and Safety Code. CMHMRC's are constituted and operated by a county, municipality, hospital district, school district, or any organizational combination of the two or more entities of those local agencies in accordance with a center plan approved by the TDMHMR Board as laid out in Section **534.001,** Health and Safety Code.

Historically, CMHMRCs are given preference as designated local authorities, and performance contracts have focused primarily on effective provision of services. An emerging model focuses on the local authority as an organizational unit for administering the delivery of community-based services through which the policies of the state authority can be enforced effectively at the local level. Currently, the contractual relationship between the department and each local authority provides the mechanism for disbursement of department funds and defines expectations for outcomes by setting targets, requiring adherence to "best practice" models, and establishing non-compliance sanctions and procedures for recoupment of unexpended funds.

Texas Public Mental Health System and its Relationship to Criminal Justice

The Criminal Justice Policy Council released a report entitled *The Public Meittal Health. Systein in Texas and its Relationship to Criminal Justice*. The report focuses on identifying how the operations of the mental health system impact the criminal justice system. It also outlines the funding structure of the Texas Department of Mental Health and Mental Retardation and how it functions in the communities.

The Texas Department of Mental Health and Mental Retardation (TDMHMR) provides funding to its facilities for the care and treatment of individuals diagnosed as severely mentally ill or mentally retarded. Texas funds community services through its Local Mental Health Authorities (LMHAs).

There are 40 LMHAs, and TDMHMR provides 70% of the funding for them. The rest of the funding is provided by statute sought at the local level. Funding for the LMHAs is based on service area population and limited resources for inpatient services. LMHAs provide multiple outpatient services for severely mentally ill individuals. Access to public mental health money is limited to a designated "priority population" identified by TDMHMR. Those that need services but fall outside the priority population designation may be served by local MHMR authorities with grant funds or funds from outside the agency. (Fabelo, 2000)

TDMHMR estimates that the annual prevalence of mental illness among the adult population in Texas is approximately 20% or 2.8 million. Of that number, only 403,393 meet the priority population threshold for services. Many of the people in the priority population experience barriers to receiving and completing treatment. For this reason, Texas continues to explore ways to broaden the availability of treatment for this segment of the criminal justice system. (Fabelo, 2000)

Best Practices"

While researching county jail policies regarding mentally ill offenders, three programs identified as best practices by experts in the field of law enforcement and mental health continually surfaced. The three counties were Lubbock, Galveston and Harris. Each of these counties relied on strong leadership and a desire to make use of available resources to create structured model programs.

These jails set standards for what are considered to be "Best Practices" for addressing inmates with mental impairments in jails. Those practices included the following:

- Specialized mental health deputies were employed to handle crisis calls involving persons with mental illnesses. These deputies play a pivotal role in

"Justification for best practice examples comes from both research and testimony provided by mental health experts to the Senate Committee on Criminal Justice during interim hearings in the spring and fall of 2000.

diverting persons with mental illnesses from jail to more appropriate treatment alternatives.

- Written agreements or MOU's were developed that outlined the local jails, criminal justice, and mental health agencies' role and responsibilities for offenders with mental illnesses. These agreements included guidelines for communication, identifying designated contract staff to respond to issues, and created mechanisms for transitioning inmates from jail to the community.

- Regular meetings were held between jail and mental health agencies to discuss issues and concerns. These meetings allowed for ongoing communications between local entities on a pro-active rather than reactive basis. (TCOMI, 2000)

Lubbock County

The Lubbock County jail, like other jails across the state, was incarcerating a disproportionate number of persons with mental illnesses. Many of these offenders could have been treated more appropriately by the local MHMR center, but there were no formal procedures to determine who was responsible for the treatment. Representatives from the local jail, MHMR and the jails medical contract agency, jointly developed a written MOU to define each entities role and responsibility in the identification, transport and treatment of defendants with mental illnesses. This collaboration also involved the prosecutors office in order to ensure cooperation at the court level.

While the process took considerable time and effort, the result is a written document that clearly and succinctly defines the responsibility of each party. More importantly, the MOU is routinely monitored by the participating agencies to

address gaps or problems which need to be modified or corrected. (Appendix B, Lubbock Regional Mental Health Mental Retardation Center Memorandum of Understanding)

Harris County

Harris County also represents one of the model programs in the country in the identification, in-jail treatment, pre and post-release planning and aftercare treatment for offenders with mental illnesses. The provisions of funding by the county have greatly contributed to the effectiveness of the system. Harris County has also written agreements between the jail, pre-trial, MHMR and Harris County Community Supervision and Corrections Department (CSCD) that contribute to the overall success of the community's response to offenders with mental illness.

State funding, provided through a contract between the Texas Council on Offenders with Mental Impairments (TCOMI) and Harris County MHMR, provides a community based treatment program targeted specifically for offenders with mental impairments. Unlike general revenue funding for mental health, TCOMI funds stipulate the offenders compliance to treatment as a condition of release from incarceration, whether on a pre-trial or community supervision basis. (Appendix C, Harris County Mental Health and Mental Retardation, Community Supervision and Corrections Department Memorandum of

Understanding)

Galveston County

The Galveston County Sheriffs Departments' Mental Health Deputy Program is widely cited as a model program. In Galveston County, deputy sheriffs certified as Texas peace officers, emergency medical technicians, and mental health specialists staff a special program that runs a 24-hour response unit.

This program aimed to increase the level of communication among county departments and community groups handling persons with mental illnesses; specifically, the Gulf Coast Center, the University of Texas Medical Branch Hospital and the municipal police agencies in the county. The program also aimed to establish a special operations unit to deal with persons with mental illnesses through crisis intervention, special screening, and information and referral to determine the client's needs for psychiatric evaluation and to meet their social needs. Finally, the program aimed to reduce the incarceration and institutionalization of persons with mental illnesses and provide them alternative dispositions. (Appendix D, Galveston County Mental Health Deputy Program)

Conceptual Framework

The research for this paper uses a practical ideal type conceptual framework. The literature pointed consistently to several components that made up successful jail diversion polices. The practical ideal type fit the results of the literature

research by identifying several ideal categories. The categories that are most useful in successfully screening and diverting mentally ill offenders are:

Mental health law enforcement training

Jail intake screening

Coordination between law enforcement and mental health professionals

Access to mental health and community treatment programs.

Table 3.2: Conceptual Framework Ideal Categories

IDEAL CATEGORIES	SOURCE
Mental Health Law Enforcement Training	Lubbock County (1999) Galveston County (2000) Harris County (1999) Vickers (2000)
Jail intake Screening	Crean (1990) Fabelo, Heikes (2000) Veysey (1997) Steadman (1994,1997)
Coordination between Law Enforcement and Mental Health Professionals	Crean (1990) Fabelo (2000) Healey (1999) Steadman (1994, 1997) Ventura (1998)
Contracting with Community Mental Health and Treatment Programs	Conly (1999) Crean (1990) Fabelo, Heikes (2000) Jemelka (1990) McDonald (1994) Research Brief (1996) Steadman (1997) Solomon (1994) Ventura (1998)

These four categories are found throughout the literature and in the policies of model programs. Effective response to the problem of offenders with mental

illnesses requires cooperation and the exchange of knowledge, resources, and services between law enforcement, mental health, and social agencies.

Jail mental health services can be most effective when: Mental health professionals are encouraged to spend time in on-site training in jails; The essential mental health services of screening, evaluation, and crisis intervention are available; They function as an integral part of a community-based social and health service system; and diversion programs are developed and accessible to avoid inappropriate detention of persons with mental illnesses. (Steadman, 1994)

A practical ideal type can be viewed as standard or point of reference. The elements of the ideal type do not have to be rigidly fixed; there may be more than one useful way to envision the ideal. (Shields, 1998: p. 219) The literature consistently suggests that most, if not all of the aforementioned ideal categories should be included in programs targeted at mentally ill offenders.

Chapter Four

METHODOLOGY

Introduction

This chapter describes the methodology used to assess the way Texas jails deal with mentally ill offenders. The chapter describes the development of the survey instrument and the strengths and weakness of survey research study. One factor to keep in mind is the subjectivity of the respondents. Survey responses measure the perception respondents want to portray.

Research Design

The methodology for testing the ideal categories in this paper was a survey. The survey approach was most appropriate for this type of research because it aimed to explore the policies of county jails with regard to mentally ill offenders. Surveys tend to be flexible; many questions may be asked on a given topic which allows for flexibility during analysis. Surveys are particularly useful in describing the characteristics of a large population, in this particular case one that is spread out across the state. (Babbie, 1995)

Survey results help measure how many of the ideal categories particular jails employ in their operations. Jails that have more of the ideal categories should have a higher percentage of identified and diverted mentally ill offenders. A standardized survey questionnaire allows for recording jail policies as they pertain

to the specific categories.

However, a weakness of standardized questionnaires is that they may not identify unique policies and results. Standardized questionnaires often do not focus on the most important aspects of a given topic. By designing questions that are at least minimally appropriate to all respondents, the most important issues may be missed. Babbie described this exercise as the fitting of round pegs into square holes. (Babbie, 1995: 273-274) While the questionnaire will allow for a broad study group, careful analysis of the data is necessary to identify important results that are missed.

A survey was mailed to Sheriffs in counties with jail capacity between 250-1000+ beds. (Appendix E, Jail Survey) Thirty-nine county jails out of a statewide total of two-hundred-thirty-seven meet the population threshold. (Appendix F, Survey Response Chart) A majority of county jails in Texas have less that one-hundred beds and account for only a small percentage of total statewide capacity and bookings; while the survey sample represents 81% of statewide capacity, and 72% of total statewide bookings. (Fabelo, 2000) Survey recipients were given two weeks to compile the requested information and return the surveys.

Survey Development

The development of the survey came from the conceptual framework which was developed from the literature review. The survey pulled together the ideal categories that were identified throughout the literature as necessary for good jail diversion policies. The survey instrument was drafted with the assistance of Joel Heikes, of the Criminal Justice Policy Council, Debbie Fillmore, Deputy Director, Texas Commission on Jail Standards, and Dee Kifowit, Executive Director, Texas Council on Offenders with Mental Impairments. These individuals also aided in the pretesting of the questionnaire and analysis of the results. Table ***2,*** operationalization chart, shows how the ideal categories are operationalized into survey questions and responses for coding.

Table 4.1: Operationalization Chart

CATEGORY	SURVEY ITEM	SURVEY RESPONSE
Mental Health Law Enforcement Training	Are any of your sheriffs deputies required to have specific training to deal with mentally ill offenders? What does your training consist of? Do you face any barriers in requiring or providing deputy mental health training? If so what are they?	(no) (yes) (funding) (personnel constraints) (other _____)
Jail intake Screening	Do you conduct jail intake screening for mentally ill offenders? If yes, please include a copy of your screening instrument Who performs offender intake screening?	(no) (yes) (jailer) (deputy) (other_____)
Coordination between Law Enforcement and	Do you have mental health professionals on-site?	(no) (yes)

Mental Health Professionals	Who conducts the follow-up aseeeement for those screened positive for a mental illness?	(psychiatrist) (psychologist) (nurse) (medical doctor) (social worker) (other_____)
	Do you have a written agreement or memorandum of understanding with the mental health community?	(no) (yes)
Access to Mental Health and Community Treatment Programs	Do you have access to treatment or services for the mentally ill on-site?	(no) (yes)
	Do you divert any of your mentally ill offenders to community treatment programs or pre-trial services?	(no) (yes)
	Do the treatment facilities in your community accept individuals you diagnose with mental illnesses?	(no) (yes)
	Do you contract for mental health services? If yes, please attach a list.	

Chapter Five

RESULTS

Introduction

This Chapter presents the findings of a survey conducted for this report. The survey of the thirty-nine largest county jails in the state of Texas was drafted using the ideal categories identified in the conceptual framework. Each of the four categories was included in the survey to measure its importance in the structure of a successful mentally ill offender jail policy.

The chapter also contains tables summarizing the responses of those who answered and returned the survey. The tables show the level with which each category is addressed. Each category contained several questions to help address how particular jail policies have been implemented.

Response Rate

Of the thirty-nine surveys mailed to sheriffs in the largest counties in Texas, twenty-seven were completed and returned providing for a response rate of sixty-nine percent (69%). According to Babbie, statistical response rates of fifty percent (50%) are considered adequate and sixty percent good, putting this analysis at a fairly high level. (Babbie 1995: 261-262) The findings of the survey conducted for this report are detailed below.

Law Enforcement Mental Health Training

The survey included three questions which sought to determine how many jails employed policies for deputy mental health training. If jails did provide deputy mental health training they were asked to describe their policy. Finally, those who indicated they did not employ training were asked if particular barriers kept them from doing so.

Table 5.1 examined responses to the question of whether deputies were required to have specific mental health training. Of the twenty-seven responses 70% reported having some requirements for deputy mental health training while 30% reported having no requirement for this type of training.

Table 5.1
Deputy Mental Health Training **n=27**

Deputy mental health training	Yes	No
Are your deputies required to have specific mental health training?	19 (70%)	8 (30%)

The relatively high percentage of jails that require some level of mental health training is very encouraging. However, the statutory language that addresses certification of officers for mental health assignments is permissive. Section 1701.404 of the Occupational Code states that TCLEOSE "may" establish minimum requirements for training, testing, and certification of officers for dealing with offenders with mental impairments. Since the training is not statutorily required, the high level of implementation illustrates the importance law

enforcement places on this function.

Results of the survey question requesting respondents to attach a summary of their training policies were not statistically significant and thus not put into a table. State deputy mental health training and certification is provided through TCLEOSE, which developed the curriculum in coordination with TDMHMR, TCJS, and TCOMI. Since this training is standard across the state, there was no need to analyze the results of this particular survey question,

Table **5.2** addresses the issue of barriers to providing deputy mental health training. The survey asked respondents to identify whether barriers to providing training were related to funding, personnel or other constraints. It is interesting to note that of the eight respondents who indicated not requiring special training, not all gave a reason, while several of those that did, cited barriers (presumable to enhancing training).

Table 5.2
Barriers to **Training** n=27

Barriers to training	**Funding** constraints	**Personnel** constraints	Other
Do you face barriers to providing mental health braining?	5 **(36%)**	5 **(36%)**	4 **(29%)**

***Other equaled "both", and one instance of "time" and "curriculum" constraints**

Jail Intake Screening

The survey questionnaire contained four specific items related to jail intake screening. The first question simply asked if jail intake screening was performed, with a follow-up item asking who performed the screening. The last two items related to the screening process focusing on professional staff on-site and those responsible for follow-up assessments for individuals initially screened for a mental illness.

Table **5.3,** while not demonstrative from a statistical standpoint, illustrates the impact a mandatory statute and certification requirements have on policy implementation. Article **16.22,** Code of Criminal Procedure, speaks to providing evaluations of defendants suspected of having a mental illness. The statute states that not later than 72 hours after receiving evidence that a defendant committed to the sheriffs custody has a mental illness..., the sheriff shall notify a magistrate of that fact.

In addition to statutory requirements, TCJS, which certifies county jails, requires a Mental Disability/Suicide Prevention Plan. This plan requires the sheriff/jail to develop and implement a mental disability/suicide prevention plan, in coordination with available medical and mental health officials, approved by the Commission. For the stated reasons and legal liability concerns, all respondents indicated some level of jail intake screening.

Table 5.3 **Conducting Jail Intake Screening**		
Conducting intake screening	Yes	No
Do you conduct jail intake screening?	27 (100%)	

Table 5.4 identified personnel responsible for the initial screening done at intake. The survey item asked who performs offender intake screenings. Since some of the jails use multiple staff to perform screening, raw numbers were used in the evaluation.[16] The high frequency with which the jailer performed the screenings indicates the desire to maintain responsibility within immediate jail personnel.

Table 5.4 Performing Offender Intake Screening			
Performing Intake Screening	Jailer	Deputy	Other
Who performs offender intake screening?	21	5	7

***Other included Nurse, Social Workers, Booking Personnel, and Medical Personnel**

Table 5.5 evaluated the presence of on-site mental health professionals. The survey asked if the respondents had mental health professionals on-site. Forty-one of the respondents indicated having on-site mental health professionals, while 60% reported not having such personnel. The results of the surveys returned show that the majority of jails with on-site mental health professionals were from larger metropolitan areas with access to a variety of resources. The numbers indicate a

[16]Because **multiple staff performed offender intake the total number of screeners exceeded 27**

need to further study the issue of providing regional assistance to counties outside large metropolitan areas.

Table 5.5 **On-site Mental Health Professional n=27**		
On-site Mental Health Professional	Yes	No
Do you have a mental health professional on-site?	**11** (41%)	**16 (60%)**

Table **5.6** identified personnel responsible for follow-up assessment for those screened positive at intake. The survey question asked the respondents to identify personnel responsible for conducting follow-up mental illness assessments. Since some jails had multiple assessors, raw numbers were used in evaluating the screening. As indicated by table **5.5,** a majority of the jails reported not having on-site mental health professionals, so it must be assumed that the follow-up screenings are done on a roving or contractual basis.

Table 5.6 **Follow-up Assessments for those Screened Positive**						
Follow-up assessment	Psychi	Psychol	Nurse	MD	SW	Other
Screened by?	**11**	8	9	**8**	6	**2**

***Psychi= Psychiatrist Psychol= Psychologist Nurses= Nurse SW= Social Worker MD= Medical Doctor**
Others= counselor and MHMR representative

Memorandum of Understanding

The survey included three items regarding cooperative memorandums of understanding (MOU) between jails and the mental health community. The survey asked if respondents had a written MOU, on-site access to treatment for persons with mental illnesses, or diversion programs such as pre-trial or community treatment programs. The advantages of multi-agency cooperation between law enforcement and the mental health community have been reinforced throughout the literature. As with requirements for jail intake screening, MOUs are required by statute. Section 614.016, Health and Safety Code requires adoption of an MOU that establishes respective responsibilities between law enforcement and mental health to institute a continuity of care and service program for offenders in the criminal justice system that are mentally impaired.

Table 5.7 evaluates all three questions in one table. The "No" responses to whether there was a written MOU with other agencies were surprisingly high. With such detailed statutory requirements, the frequency of respondents having MOUs should have been much higher than 37%.

The second and third items in table 5.7 asked about on-site access to mental health treatment or services, and diversion programs. The high "Yes" response rates for both of these questions, as compared to the low incidences of formal MOUs, indicates that a number of respondents must have some level of informal cooperation with the mental health community.

Table 5.7 Memorandum of Understanding		
Written Memorandum of Understanding (MOU)	Yes	No
Do you have an MOU with other agencies?	10 (37%)	17 (63%)
Do you have on-site access to mental health treatment or services?	19 (70%)	8 (30%)
Do you divert mentally ill offender to community programs?	21 (78%)	6 (22%)

Community Mental Health Contracting

The survey contained two items specifically dealing with community mental health contracting. Table 5.8 shows that results for community mental health contracting and MOUs were similar. A higher percentage of "Yes" responses were reported when a formal contract was not required. Seventy four percent of the respondents indicated that community programs accepted individuals diagnosed with a mental illness, while only **41%** acknowledged any formal contract for services. With the statutory requirements for MOUs, and the apparent informal coordination existing between law enforcement and the mental health community, similar trends were not surprising.

Table 5.8 Community Mental Health Contracting		
Community Mental Health Contracting	Yes	No
Do community programs accept diagnosed mentally ill individuals?	20 **(74%)**	7 (26%)
Do you contract for mental health services?	**11** **(41%)**	**16** **(59%)**

The results of the survey, and analysis of best practices in the settings chapter, provide information on where implementation of jail policies needs the most improvement. The conclusion chapter recaps the survey analysis and makes recommendations on how to improve the process that Texas has been at the forefront in creating.

Chapter **Six**

CONCLUSION

Recommendations

The purpose of this research was to describe the laws and policies regarding the screening and diverting of mentally ill offenders in the criminal justice system. Four ideal categories for implementing policies to address such issues were identified in the literature and developed through a survey and analysis of three best practices examples.

Despite all of the positive activities that have occurred at the state and local level in dealing with mentally ill offenders, continued work is required to aid in implementation of the ideal categories. More progress is needed in:

- Law Enforcement Mental Health Training
- Jail Intake Screening
- Implementation of Memorandums of Understandings
- Access to Mental Health and Community Treatment Programs

With regard to law enforcement mental health training, the results showed that even with permissive statutory language, this category was implemented a majority of the time. However, by making the statute mandatory, and encouraging TCLEOSE to continue improving the content and availability of this training, law enforcement mental health training can be a policy that all jails provide for necessary personnel.

Jail intake screening, as evidenced by the survey respondents requires a

limited amount of attention from policy makers. One area identified in follow-up questions on the survey identified a lack of uniformity or consistency with regard to personnel conducting the screenings. As witnessed in the best practice examples, trained jail personnel in coordination with mental health professionals provides the most comprehensive screening and identification of mentally ill offenders. Broadening the availability of such professionals throughout Texas would provide jails in the less populated areas of the state the ability to better screen and identify these specific offenders.

An additional concern raised in this report involved the implementation of the MOU's required in Chapter **614.013-016,** Health and Safety Code. As indicated by the low survey response rates for MOU implementation, the requirements need to have some teeth added to them. Recommendations have been made to tie funding to the implementation of MOU's, which would provide an incentive for counties to formalize informal agreements that seem to already be in place.

Finally, access to mental health and community treatment programs must come from the local mental health authorities with the help of TDMHMR. Together these groups can provide policy makers with information to expand the current structure of local mental health alternatives and diversions. This includes programs like on-site mental health services and mental health courts.

The diversion of mentally ill offenders has become a higher priority if for no other reason than the realization that correctional capacity must be available to house the most dangerous offenders in our society. With the continued shortage of

correctional capacity the State Legislature will be forced to make some long overdue choices regarding mentally ill offenders. Broadening the use of best practice policies outlined in this paper can serve as a starting point for diverting to treatment the growing number of mentally ill offenders in jails.

Future Research

One item not addressed in this report that could have a dramatic impact on this issue is the lack of data on identification rates of persons with mental illnesses in the criminal justice system in Texas. The MOU's, which have been discussed at length in this report, specifically require state and local criminal justice and mental health agencies to collect data on the number of offenders with mental illnesses in their respective systems. Unfortunately, there are no statutory provisions that stipulate the reporting of such information. By requiring jails to report information on mentally ill offenders either to the TCJS or TCOMI, information on the number of mentally ill offenders can be more readily assessed. Further study of the data collection and reporting processes used by jails to determine the number of mentally ill offenders cycling through the criminal justice system would provide for better planning in the way of diversion programs.

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APPENDIX A:

Mental Disability/Suicide Intake Screening

☐ Was Inmate a medical, mental health, or suicide risk during any prior contact or confinement with department? Yes _____ No _____ If Yes, when? _____

☐ Does arresting or transporting officer believe that the inmate is a medical, mental health, or suicide risk? Yes _____ No _____

A. QUESTIONNAIRE FOR DETAINEE

1. Have you ever received MHMR Services or other mental health services? If Yes, what services?	Yes	No
2. Do you know where you are?	Correct	Incorrect
3. What season is this?	Correct	Incorrect
4. How many months are there in a year?	Correct	Incorrect
5. (a) Sometimes people tell me they hear noises or voices that other people don't seem to hear. What about you?	Yes	No
(b) If Yes, ask for an explanation: What do you hear?" _____		

B. OBSERVATION QUESTIONS

6. Does the individual act or talk in a strange manner?	Yes	No
7. Does the individual seem unusually confused or preoccupied?	Yes	No
8. Does the individual talk very rapidly or seem to be in an unusually good mood?	Yes	No
9. Does the individual claim to be someone else like a famous person or fictional figure?	Yes	No
10. (a) Does the individual's vocabulary (in his/her native tongue) seem limited?	Yes	No
(b) Does the individual have difficulty coming up with words to express him/herself?	Yes	No

B. SUICIDE RELATED QUESTIONS / OBSERVATIONS

11. (a) Have you ever attempted suicide?	Yes	No
(b) Have you ever had thoughts about killing yourself?	Yes	No
If Yes, When? _____		
Why? _____		
How? _____		
12. Are you thinking about killing yourself? Today?	Yes	No
13. (a) Have you ever been so down that you couldn't do anything for more than a week? (If no, go to 14.)	Yes	No
(b) Do you feel this way now?	Yes	No
14. When not on drugs or drinking, have you ever gone for days without sleep or had a long period in your life when you felt very energetic or excited?	Yes	No
15. Have you experienced a recent loss or death of family member or friend or are you worried about major problems other than your legal situation?	Yes	No
16. Does the individual seem extremely sad, apathetic, helpless, or hopeless?	Yes	No

COMPLETED BY: _____ Date _____ Time _____
Booking Technician

COMMENTS _____

_____

_____

Intake Reviewed by Nurse _____ Date _____ Time _____

APPENDIX B:

Lubbock Regional Mental Health Mental Retardation Center
Memorandum of Understanding
(Lubbock Regional MHMR Center – Lubbock County Jail)

THIS MEMORANDUM OF UNDERSTANDING is entered into by and between the agencies shown below.

I. AGENCIES:

The Receiving Agency: Lubbock County Jail
The Performing Agency: Lubbock Regional Mental Health Mental Retardation Center

II. STATEMENT OF SERVICES TO BE PERFORMED:

Services to be provided by the Performing Agency are: I) determining whether detainees referred by the Lubbock County Jail have a mental illness and/or mental retardation diagnosis; 1) development of a service plan for detainees meeting the Texas Department of Mental Health and Mental Retardation priority population definition; and 3) modification of service plans to meet the needs ofdetainees described in #2 above being released from the Lubbock County jail. (See Exhibit A.)

III. OBLIGATIONS OF THE PERFORMING AGENCY

(a) The services to be provided by the Performing Agency will be provided in accordance with the Protocol as set fonh in Exhibit A.

(b) In order to facilitate continuity of care for ACT consumers who are incarcerated, the Performing Agency shall adhere to the Protocol set forth in Exhibit B.

(c) Performing Agency shall be responsible for obtaining psychiatric medication for LRMHMR consumers who are incarcerated. (See Exhibit C).

(d) Performing Agency's Continuity of Care Coordinator shall be responsible for tracking LRMHMR consumers who are incarcerated. (See Exhibit D).

IV. OBLIGATIONS OF THE RECEIVING AGENCY

(a) Receiving Agency shall adhere to the Protocol as set forth in Exhibit A.

in

jb) Receiving Agency shall be responsible for assist g incarcerated LRMHMR consumers and other inmates in need of psychiatric medication obtain the needed medication. (See Exhibit C).

(c) Receiving Agency shall recognize and adhere to ihe definitions set forth in Exhibit E.

(d) Receiving Agency shall be responsible for adhering ro the Admission Authorization Criteria of the Performing Agency, as set forth in Exhibit F.

is) R:cciving Agency ag:cs ro inform LRVHMR consumers of their rights to appeal denials of authorization pursuant to the Performing Agency's appeal process set forth in Exhibit G. Receiving Agency will cooperate with Performing Agency in resolving any appeals or complaints related to its provision of services pursuant to this Agreement.

(f) Receiving Agency shall be responsible For adhering ro the Utilization Management Admission and Continued Sray Criteria of the Performing Agency, as set forth in Exhibit H.

(g) Receiving Agency shall be responsible for adhering to the Performing Agency's Pre-Admission Criteria for consumers referred for admission into Sunrise Canyon Hospital. A consumer must be seen by a physician and transferred to the In-patient hospital unit within 72 hours oithe assessment and diagnosis. (See Exhibit I).

(h) Receiving Agency shall be responsible for assisting with continuity of care during release of Performing Agency's consumers as set forth in Exhibit J.

V. TERM OF AGREEMENT:

This Agreement is to begin August !. 1999, and shall terminate August 31, 2000

THE UNDERSIGNED AGENCIES do hereby certify that. (1) the services specified above are necessary and essential for activities that are properly within the statutory functions and programs of rhe effected agencies and (2) the proposed arrangements serve the interest of efficient and sconomical administration.

RECEIVING AGENCY AND ITS AGENT further certify that it has rhe authority ro enter into this agreement for rhs above services

PERFORMING AGENCY AND ITS AGENT further certify thar ir has the authority to perform the services specified into this agreement under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended.

RECEIVING AGENCY

Lubbock County Jail

By: David Gutierrez 7/12/99
David Gutierrez Date
Sheriff
Lubbock County Sherrif's Office

Approved as to form by:

Darrell J. Guthrie 7/8/99
Darrell J. Guthrie Dare
Civil Division
Lubbock County Criminal District Attorneys Office

PERFORMING AGENCY

Lubbock Regional MHMR Center

By: [redacted] 7/7/99
Danette Castle Date
Chief Executive Officer

By: Cindy Ann Lucas 7/7/99
Cindy Ann Lucas Date
Director of Administrative Operations

By: Bth A. Moore 7-7-99
Btrh A. Moore Date
Contracts Management Director

EXHIBIT A

PROTOCOL COORDINATING SERVICES FOR DETAINEES WITH SUPSECTED MENTAL DISABILITIES IN THE LUBBOCK COUNTY JAIL

INITIAL CONTACT

- A County Mental Health Officer/Lubbock Sheriff's Officer (LSO) is available to respond to crisis calls in which mental health issues may be a factor both in the Lubbock County jail and in the community.
- In a psychiatric emergency the County Mental Health/LSO communicates with Lubbock Regional MHMR (LRMHMR) Triage staff (740-1414) to obtain relevant information that will assist in getting the individual the appropriate care needed in that specific situation.
- When placing an individual who may be mentally ill into protective custody due to potential harm to self/others or inability to care for self, the County Mental Health Officer/LSO takes the individual to the Lubbock County Jail facility to await an evaluation by a LRMHMR Assessor. Dispatch contacts the LRMHMR crisis line (740-1414) to notify of the need for an evaluation. Once notified by dispatch the LRMHMR Assessor arrives at the Lubbock County Jail within 1 hour to complete an evaluation.
- Upon evaluation, the LRMHMR staff member provides a recommendation for the least restrictive environment to ensure proper treatment of the individual. If the individual is not being hospitalized, transportation is provided back to the individual's residence by LSO unless LSO chooses to book on related charges. If the individual is being hospitalized, the proper medical clearance and admission protocol is followed. LSO transports the individual to the proper facility (Sunrise Canyon Hospital or UMC/ER).

WARRANTS/COMMITMENTS/HEARINGS

All Mental Health Warrants, Commitments, Hearings and Transports are handled with at least 2 officers, more if requested. LSO does not take any unnecessary risks.

- Mental Health Warrants:

1. County Mental Health Officers/LSO who serve Mental Health Warrants ensures that they have all of the information that they need prior to serving the warrant. If any additional information is needed LSO contacts the County Judges office to request a copy of the Information Sheet and Application for Emergency Detention and Mental Health services if it is not attached to the warrant. (LSO has requested that this information be attached for the safety of the LSO so that the LSO may determine what that person's state of mind may be at the time that the warrant is served.
2. The use of handcuffs and restraints is the judgement call of the County Mental Health Officer/LSO. The state of mind and physical condition of the person being detained is taken into account when making this decision. Any problems encountered while serving

the warrant are reported to the mental health professionals upon arrival at the facility. County Mental Officer LSO provides copies of documentation justifying restraint to LRMHMR staff to include with evaluation documentation.

3. The individual is taken to Sunrise Canyon facility or UMC ER, whichever is requested on the Mental Health Warrant. The County Mental Health Officer LSO leaves the hospital a copy of the 'warrant with LRMHMR personnel or UMC ER personnel.
4. If the individual is an identified LRMHMR consumer, LRMHMR staff and LSO staff communicate about the need for LSO to remain at SRC during the evaluation. If the consumer is willing to stay and [here is no danger to [he consumer or staff, then LSO leaves the consumer with LRMHMR staff. If the consumer is unwilling to stay and/or there is a danger to the consumer or staff, LSO remains with the consumer throughout the evaluation process. If the individual is not an identified LRMHMR consumer, LSO remains with the individual throughout the evaluation. lithe consumsr is found nor to meet Sunrise Canyon admission criteria. LSO is responsible for transporting the individual to their residence or other agrerd upon destination.
   The warrant must be executed and taken to the Civil Division. Officers leave the Information Sheet and Application for Emergency Detention and Mental Health Services with the hospital papers so that Hospital staff has as much information as possible.

Commitments

1. individuals are transported to the facility stated on Commitment paperwork (Sunrise Canyon. Charter Plains Hospitai, BSSH, etc.).
2. The use of handcuffs and restraints is the judgement call of the County Mental Health Officer/LSO. The state of mind and physical condition of the psrson being detained is taken into accounr when making this decision. Any problems encountered while serving the warrant are reponed to the mental health proiessionals upon arrival at the facility. County Mental Officer/LSO provides copies of documentation justifying restraint to mental health facility staff to include in hospital chart.
3. Once the individual is turned over to the appropriare personnel along with all necessary paperwork. officers may leave.

- Hearings

The Warrant Division is notified of Mental Health Hearings at least one working day prior to the hearing. At the time of notitication, County Mental Health Officers/LSO are assigned to the hearing.

Counry Mental Health Officers/LSO picks up the individual at the mental health facility and bring that individual to the County Counhouse. The Court is designated by the Counry Judge's Office. Individuals arrive at rhe courthouse 10 minutes prior to the hearing so that the individual may speak with his/her attorney.

3. The use of restraints is handled according to necessity. However. all restraints are removed prior to entering the counroom. County Mental Officer/LSO provides copies of documentation justifying restraint to mental healrh facility staff to include in hospital chart.
4. The County Mental Health Officer/LSO remains in the courtroom with the individual at all times while the proceedings are taking place.

5. When the hearing is over the individual is taken to the location indicated in ihe Judge's orders.
6. Upon arriving ar the designated facility, the County Mental Health Officer LSO iums the individual over to the appropriate personnel along with all necessary paperwork.

BOOKING/INTAKE

- Every individual presented for admission into a detention facility is screened for mental disability during booking. This screening complies with current Lubbock County Jaii protocol.
- All initial screening efforts are described on a Mental Disability/Suicide Intake Screening (MD/SIS) form for each detainee. Each form is forwarded to Lubbock County Hospital District (LCHD) Medical staff by the end of each shift, and :he date and time recorded in the detainee's jail file. LCHD/Medical staff places this form into the detainee's medical file. All individuals identified to be in need of further psychiatric evaluation are forwarded to LCHD/Medical staff immediately.

Evaluation of Objective Information

- During booking jail medical staff may contact LRMHMR to determine whether the oerson receives services from LRMHMR and to determine what medication may be prescribed and other related issues.
- If feasible, the booking officer consults with the officer who transported the detainee to jail ro determine whether the detainee's behavior since encountering law enforcement authorities indicates a possible mental disability, and whether the officer knows that the detainee has a history of mental disability.

Detainee Interview

- Upon notification by the booking department, LCHD Medical staff screens identified detainees.
- Staff indicates on the MD/SIS whether the detainee needs further evaluation by LRMHMR staff.
- Upon determining that further evaluation is appropriate for any detainee, LCHD/Medical staff arranges for evaluation by LRMHMR to be completed within the following time frames. Emergent evaluations are completed within 4 hours. Urgent evaluations are completed within 24 hours. Routine evaluations re completed within 14 days. (See urgent, emergent. routine definitions in attachments.) LCHD/Medical staff faxes a copy of their screening to Triage at 740-1515. When making this referral, LCHD/Medical staff provides the following information:
    1. Legal name
    2. Social security number
    3. Home address and phone #
    4. Date of birth
    5. Sex
    6. Ethnicity
    7. Marital status

8. Family size

- Further evaluation for mental disability consists of an evaluation performed by LRMHMR Assessment staff. This must be performed by a psychiatrist, psychologist, or clinician with a master's or higher academic degree in the behavioral sciences credentialled by LRMHMR. If the detainee is found to meet TDMHMR priority population guidelines at the time of this evaluation, an initial service plan is generated.
- LRMHMR Assessment staff performs these evaluations ar the Lubbock County Jail. Whenever possible several assessments are scheduled rogether. LCHD/Medical staif arranges for rhe assessment. There are no restrictions on the rimes that an assessment may rake place within the Lubbock County Jail.

Access to Mental Health Professionals

- When an evaluarion indicates ihar a detainee meets TDMHMR priority popularion criteria, LRMHMR staff notifies LCHD/Medical iraff that the detainee is opened for LRMHMR services. LCHD Medical staif arranges for jail staff to schedule an appointment wirh a contracted psychiatrist for further examination. The derainee, detainee's family, and detainee's friends must not be notified of appointment rime. A copy of the service plan is given ro LCHD Medical staff for the jail medical record. If the detainee is not found to meet TDMHMR priority population guidelines, this information is provided to LCHD/Medical staff so that the decainee's needs can be met through other jail resources.
- LCHD/Medical staff notifies Lubbock Counry jail administration when a detainee is determined to meet TDMHMR priority popularion. If determined appropriate for diversion, Lubbock Counry jail administration begins to work with the District Attorney's office.
- The detainee is assigned to the LRMHMR/TCOMI Continuity of Care Coordinator (Care Coordinator). If detainee is already a member oirhe ACT team, they continue ro follow. The Care Coordinator works with detainee, jail staff, LCHD/Medical staff. and any assigned LRMHMR provider staff to ensure that service plan is followed and detainee's psychiatric needs are met. The Care Coordinaror ensures thar the detainee has access to all psychiarric medications prescribed by the LRMHMR contracted psychiatrist. Care Coordinaror follows the "Medication ro Lubbock County Jail" prorocol.
- The Care Coordinator also notifies Assessment and suppon sraff of derainee's imminent release so that the Service Plan can be revised to reflect needs of detainee once living in the community and assignment of the detainee can move to community based staff.

Transfers from Lubbock Counry Jail to Sunrise Canyon Hospital

- If during the screening process, the LCHD/Medical staff determines chat a detainee may be in need of inpatient psychiatric services at Sunrise Canyon Hospital, they contact the LRMHMR crisis line ar 740-1414.
- Crisis line staff rakes pertinent information and contacts the LRMHMR Assessor covering emergencies.
- The LRMHMR Assessor evaluates the detainee at the Lubbock Counry Jail within 4 hours of the initial call to the Lubbock Regional MHMR Crisis line. The LRMHMR

Assessor gathers all pertinent information from LCHD/Medical staff. The LRMHMR Assessor completes the "LRMHMR" Inpatient Consultation Assessment".

- If admission to Sunrise Canyon Hospital is authorized. the LRMHMR Assessor contacts :he SRCH physician who makes the final determination for admission. The physician also determines whether medical clearance will be obraincd through UMC/ER or at rhe Sunrise Canyon Facility.
- The LRMHMR Assessor contacts the SRCH charge nurse ro authorize admission. The LRMHMR Assessor also contacts the UM department to notify of admission.

The LCHD/Medical Staff arranges for transport to SRCH and the UMC/ER. if deemed necessary.

EXHIBIT B

PROTOCOL TO PROVIDE PHYSICIAN SERVICES TO INCARCERATED ACT CONSUMERS

The following prorocol has been developed ro facilirate continuity of care For ACT consumers who are incarcerated.

- The assigned ACT physician will see the consumer a minimum of one time per month in Lubbock County Jail.
- The assigned ACT physician will determine the frequency of visits on an individual 'oasis and will see the consumer on an "as needed" basis in Lubbock County Jail.
- ACT staff is responsible for scheduling consume: appointments with Lubbock County Jail stair.
- ACT stiff must contact Lubbock County Jail staff before 10:00 AM to schedule consumer appointments. Appointments are scheduled through Sgt. Putman at (506) 775-1485. If unable to get through to Sgt. Putman, call the front desk at (506) 775-1425.
- If ACT staff is unable to contact Lubbock County jail staff before 10:00 AM ro schedule consumer appointments. ACT staff will make the contact rhe following day to schedule the appointment.

EXHIBIT C

PROTOCOL FOR OBTAINING PSYCHIATRIC MEDICATION FOR LRMHMR CONSUMERS

- If an individual is incarcerated in Lubbock County Jail and is an active client with Lubbock Regional MHMR (LRMHMR), Lubbock Regional MHMR will continue to work with that individual in assisting them in obtaining their medication if the medication has been prescribed by a TTLHSC psychiatrist and is not on the current Lubbock County Jail Formulary. In the event that the medication the individual is currently taking is on the Lubbock County Jail Formulary the Jail will provide the medication to the inmate.

- If an individual is incarcerated in Lubbock County Jail and is not currently receiving services from LRMHMR and has been evaluated by Lubbock County Hospital District (LCHD) and it is determined that psychiatric medication may be needed LCHD/Medical Staff will refer to LRMHMR for assessment following the protocol for "Coordinating Services for Detainees with Suspected Mental Disabilities".

- When an individual has been prescribed medication from LRMHMR/TTUHSC psychiatrist the LRMHMR TCOMI Continuity of Care Coorainaror (Care Coordinator) will assist in obtaining these medications through whatever financial means the inmate has available (e.g. Medicaid, family, United Coalition voucher) and assure medication is delivered to the Lubbock County Jail.

- The Care Coordinator will work with the LCHD/Medical Staff at the Lubbock Count:; Jail to determine which individuals need medication.

EXHIBIT D

PROTOCOL FOR TRACKING OF DETAINED LRMHMR CONSUMERS

- For the purpose of continuity and tracking Lubbock County Jail will provide, on a daily oasis, a list of all current and new individuals in the jail who are receiving services from Lubbock Regional MHMR (LRMHMR). Sharon Bush will supply this list (806) 775-1416.

- The Care Coordinator will meet with detainsss opened to LRMHMR services (new and current) at least once a month to assess current needs (e.g. medication. release date, free world needs). The ACT team will continue to follow their assigned consumers.

- The Care Coordinator will provide the ACT team and Sunrise Canyon Hospital Social Worker with the same list of detainees.

EXHIBIT E

EMERGENT. URGENT, ROUTINE DEFINITIONS

EMERGENT:	Individual presents a danger to self or others, and must be seen within four (4) hours oirequest.
URGENT:	Individual is in danger of decompensation to emergent stare if not seen within 24 hours of request.
ROUTINE:	Individual dos not exhibit signs of emergency or urgency. Must be seen within 14 days of request.

MHMR

Lubbock Regional Mental Health Retardation Center
Sunrise Canyon Hospital
Policies and Procedures

EFFECTIVE DATE: November 25. 1996

Title: *Admission Criteria, Authorization and Procrdurer*

Policy

Only persons who have been assessed by a MHA Assessor and deemed to meet the following admission criteria are authorized a bed at Sunrise Canyon Hospital:

A. Because of a psychiatric disorder?remaining in a less restrictive non-specialized setting will lead to deterioration in the ability to function independently.

B. Because of a psychiatric disorder, the person presents a danger to self or others through their actions or statements of intended actions.

These criteria include:

1) Individuals who do not have a major mental illness, but are in crisis; and
1) Individuals who have a serious mental illness;

Purpose

To ensure that consumers are served in the least restrictive environment and that resources are appropriately used.

Procedure

1) The MHMR Assessor notifies the SRC hospital Charge Nurse and the admitting physician that an admission is authorized.

2) The admitting physician contacts the SRC Charge Nurse to give orders for admission. For transfers from another facility the admitting physician notifies the transferring facility of acceptance.

3) The SRC nurse contacts the transferring ER, if applicable, and requests a *Nurse-to-Nurse* report.

4) The SRC nurss receives the admission orders over the phone and makes entries on-[he orders as appropriate (medications. lab. precautions. etc.) and signs and dates the orders as verbal order or telephone order. If the physician is present on the unir. the physician documents. signs. and dares the ***Physician's Order Sheet***.

5) The nurse transcribes orders on the Cardex and the *Medication Sheet* ai appropriate.

6) Tine Unit Clerk Nurse transcribes orders on the lab request form and makes referrals/other appointments as ordered.

7) If the consumer arrives by ambulance, EMS personnel take the consumer to the seclusion area door on the north side of the Nurses' Station.

8) If the consumer is hostile/aggressive, nursing staff may implement procedures of seclusion and restraint if necessary, prior to taking the person into the unit.

9) The nurse initiates the Nursing Assessment at the time of admission, and documents information on the *Nursing* ***Assessment*** form. The nurss completes an assessment for suicide and assault precautions.

10) Nursing staff take the consumer's vital signs, and document this information on the ***Daily Activity Flowsheer*** and on the *Nursing Assessment* form.

11) lilab work has been ordered, the RN performs venipuncture or obtains other specimens in exam room.

12) Nursing staff request the person's cooperation with a search of his/her person and all person?! belongings. If the consumer refuses to cooperate with the search, the nurse contacts the physician for an order to search and documents the order on the ***Physician's Order*** form. (See Policy and Procedure for Personal Belongings Inventory).

13) Nursing staff place valuables in the safe. If the consumer wishes to keep valuables, he/she is asked to sign a statement that valuables have been retained. If he.she refuses to sign, nvo staff members sign the form (See Policy and Procedure for Personal Belongings Inventory).

14) Other personal belongings and contraband are placed in the personal belongings closet. Contraband is not released to the consumer during admission.

15) A staff member reviews the ***Consent to Treatment*** form and ***the Client Handbook and Rights*** with the consumer and obtains his/her signature on the ***Consent to Treatment*** and ***Client Rights Acknowledgment*** form.

16) A staff member gives the consumer a tour of the unit and provides information about unit policies, schedules and activities.

17) If the consumer has a roommate, the staff member introdcces him/her to rhr roommate.

18) The Unit Clerk/Nurse places the person's name on the Client Roster marker board. enters the name on the ***Code Number List***, and on ***the Administrative Log.***

19) Service Coordinators are notified of weekday admissions by the social worker. Tine nurse notifies the Service Coordinaror of weekend admissions by calling their mobile phone and leaving a message that one of the persons they serve has been admitted.

20) The admission process is complete once all steps on the ***Admission Checklist*** have been done. The person completing each task on the ***Admission Checklist*** indicates completion ***by*** initialing die task. The ***Admission Checklist*** is then placed in the person's chart.

EXHIBIT G

Protocol for LRMHMR Appeal Process

All appeals for LRMHMR will be handled by the Utilization Management Department. An appeal may be made to the UM Department regarding any Adverse Determinations. These may include determinations in which consumers:

- Are found to be ineligible for services during the eligibility determination process
- Have been terminated from service
- Have had an involuntary reduction in their level of service
- Have been denied access to a service they wish to receive

An Appeal must be filed within 30 days of notification of the Adverse Determination. An Appeal may originate from a Consumer, a Provider, or anyone else a Consumer allows to advocate for them. An appeal may be made in person, by telephone, or by mail. To file an Appeal, Consumers may call Eileen Coonrod in the UM Department at 740-1543. She is located at: Sunrise Canyon. Any correspondence by mail may be sent to the following address:

P.O. Box 2328
Lubbock, TX 79408-2828
UM Department

Attn: Eileen Coonrod

There are three stages in the Appeal Process.

RECONSIDERATION

First, a Consumer may request a Reconsideration of the Adverse Determination with the UM Department. If a Reconsideration is able to be granted, then the Adverse Determination is overturned.

LEVEL 1

If a request For Reconsideration may not be granted, then the request becomes a Level 1 Appeal. The UM Department/ Eileen Coonrod is responsible for gathering all data necessary to make a determination. This may include, but is not limited to, chart reviews, interviews with the Consumer, Authority and Provider staffconsultations. She then makes her recommendation regarding the case. All information is forwarded to Dr. Jim Van Norman in Austin for a final determination. The UM Department has3 business days to respond to an Appeal regarding Routine Services. Once all data is forwarded to Dr. Van

Norman, he will have 3 business days to make a determination regarding Appeals for Routine Services. Consumers will be notified of the determination by Certified mail. In the case of Appeals regarding Emergency Services, a completed determination must occur within 4 hours once the Appeal has been filed. Consumers will be notified of the determination verbally, and by Certified mail.

LEVEL 2

If the Consumer disagrees with the Level 1 determination, there is 3 second level of Appeal that may be utilized. The Consumer will have 14 days from notification of the Level 1 determination to file a second Appeal. This Appeal may be filed in the same manner as the Level 1 Appeal. The Consumer, the Provider, or the Consumer's designated advocate nay contact the UM Department/Eileen Coonrod in person, by telephone, or by mail to file the Appeal. The UM Department will gather all data pertinent to the Appeal and forward that data to our internal Authority Medical Director Dr. Lim. This may include, but is not limited to, chart reviews, Consumer interviews, Authority and Provider staff consultations. Dr Lim is responsible for making the final determination regarding the Appeal. The UM Department will have two business days to respond to Appeals regarding Routine Services. Dr. Lim will nave two business days to make her determination regarding Appeals for Routine Cervices. The Consumer will be notified of the determination by Certified mail. Any Appeals regarding Emergency Services will be completed within 4 hours from the time the Appeal is initiated. The Consumer will be notified of the determination verbally, and by Certified Mail. There is no further mechanism for Appeal following rhe Level 2 Appeal.

EC 6-5-98

EXHIBIT H

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

P.O. Box 12668
Austin, Texas 78711

UTILIZATION MANAGEMENT GUIDELINES

Fall/1997

Acute Inpatient Treatment

I. Definition of Service

Hospital services staffed with medical and nursing professionals which provide 24-hour professional monitoring, supervision and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff provide intensive interventions designed to relieve acute psychiatric syptomatology and restore client's ability to function in a less restrictive setting.

II. Standard o i Practice

A physician's order is required

Must be a licensed facility

III. Admission Criteria

A. Must meet all of the following criteria:

1. Meets TDMHMR criteria for priority population.

2. Treatment at a lower level of care has been attempted or ruled out.

3. Where applicable, dangerousness must be a direct product of the principle DSM-IV Axis I or II diagnosis.

B. Must be exhibiting at least one of the following:

1. Loss of ability to perform activities of daily living due to severely impaired judgment, impulse control or cognitive/perceptual abilities arising irom:

a. Acute psychiatric condition;

b. Acute exacerbation of a chronic psychiatric condition. or,

c. Significant decrease in functioning as measured against baseline functioning over the preceding year.

NOTE: This service does not apply to those individuals whcse existing condition will not stabilize or reverse with inpatient rreatment.

Loss of ability to perform ADL's should be considered a criterion only if it endangers self or others, or causes marked agitation and violence.

2. Danger to self as evidenced by:
   a. Significant life-threatening attempt to harm self within the past 24 hours with csntinued imminent risk; or

   b. Specific plan to harm self withclear intention, high lethality and availability of means; or

   c. A level of suicidality that cannot be safely managed at a lower level of care; or

   d. Suicidality accompanied by a rejection of or lack of available sociallherapeutic support.

3. Danger to others as evidenced by:

   a. Significant life-threatening action within past 24 hours with continued imminent risk:

   b. Specific plan with clear intention, high lethality and availability or means, or

   c. Dangerousness accompanied by rejection of or lack of available sociallherapeutic support.

4 Danger to property where such danger includes:

   a. Recent and significant damaging action to property with conrinued imminent risk; or

   b. Specific plan to take damaging action to property with clear intention, potential serious effect and availability of means; or

   c. Dangerousness accompanied by rejection of or lack of available social/therapeutic support.

5. High risk psychiatric procedures that require intensive observation by medical personnel.

IV. Continued Stav Criteria

A. Must meet all of the following criteria.

   1. Priority population diagnosis.

   2. Reasonable likelihood of substantial benefit from active medical intervention, which requires the acute inpatient setting.

B. Must meet at least one of the following criteria:

1. Continuation of symptoms and/or behaviors that required admission and continue to meet admission guidelines; less intensive level of care would be insufficient to stabilize the client's condition.

2. Appearance of new problems meeting admission guidelines.

V. Discharge Criteria

A. No longer meets admission or continued stay guidelines; or

B. Meets criteria for another level of care and plans for continuation at another level of care have been implemented.

VI. Estimated Length of Service

Adults and children: 4-10 days

VII. Authorization Parameters

Initial: Within 24 hours of emergency admission for which pre-authorization was not obtained; 3 days for pre-authorized admissions

Subsequent: Up to 72 hours by UM

See Authorization Guide, Inpatient Room and Board

VIII. Related Services

A. Inpatient physician services are authorized and billed separately under the Medicaid card when not included in the per diem.

See Authorization Guide

Hospital Admission
Daily Inpatient Care
Hospital Discharge
Inpatient Consultation

B. Psychological testing is authorized and billed separately under the Medicaid card when not included in per diem.

See Authorization Guide; Psychological Testing

MENTAL STATUS: (check all that apply)

ORIENTATION: ( ) day ( ) date ( ) month ( ) year ( ) person ( ) place

LEVEL OF CONCIOUSNESS: ( ) alert ( ) confused ( ) lethargic ( ) unresponsive
Other:_____

APPEARANCE/HYGIENE: ( ) dressed appropriately ( ) inappropriately dressed ( ) groomed
( ) unkempt ( ) odor

SPEECH: ( ) rapid ( ) loud ( ) pressured ( ) slurred ( ) slow ( ) soft ( ) mute
( ) stuttering ( ) neologisms

MOOD: ( ) euthymic ( ) euphoric ( ) sad ( ) angry ( ) depressed ( ) labile
Other:_____

AFFECT: ( ) congruent ( ) flat ( ) apathetic ( ) hostile ( ) blunted ( ) euphoric
( ) bright ( ) animated ( ) tearful ( ) suspicious ( ) incongruent
Other:_____

MEMORY: ( ) intact ( ) poor remote ( ) poor recent ( ) poor immediate
( ) confabulation Other:_____

THOUGHT PROCESSES: ( ) organized ( ) goal directed ( ) flight of ideas ( ) loose associations
( ) tangential ( ) concrete ( ) perservation ( ) blocking ( ) circumstantial
Orhcr:_____

THOUGHT CONTENT: ( ) coherent ( ) obsessions ( ) phobias ( ) ideas of reference
( ) depersonalization ( ) hypochondriasis ( ) magical thinking
( ) rumination Orhcr:_____

Delusions: ( ) N/A ( ) grandiose ( ) paranoia
( ) thought broadcasting ( ) thought insertion
Other:_____

PERCEPTIONS: Hallucinations: ( ) N/A ( ) auditory ( ) visual ( ) tactile ( ) olfactory
( ) gustatory ( ) command
Other:_____

CLIENT'S LEVEL OF COMPLIANCE & RESPONSE TO TREATMENT _____

_____

DISCHARGE PLAN: _____

_____

PROJECTED DISCHARGE DATE: _____

= DAYS REQUESTED:_____

AUTHORITY USE ONLY

UM DETERMINATION:

Continued stay approved? ___Yes ___No # of days___ From (date)_____ Thru (date)_____

If not approved, reason for denial_____

_____

Date next review due_____

Issues to address during next review: _____

UM Review Signature_____ Date_____

Memorandum of Understanding
BHMHMR – Lubbock County Jail

EXHIBIT I

PRE-ADMISSION MEDICAL EXAM

TITLE: Sunrise Canyon Hospital Procedures
Pre-Admission Medical **Exam** by Physician

DATE: April 20, 1998

POLICY: A physician provides a face to face assessment and physical examination of each person referred for hospital admission, no more than *72* hours prior to the admission. in order to determine need for psychiatric hospitalization and level of medical clearance needed.

PCRPOSE: To protect the rights of persons served; to ensure the health and well-being of persons served.

PROCEDURE:

I. MONDAY - FRIDAY 8:00 A.M. TO 5:00 PM

A. ADMISSIONS FROM TTLHSC CLINIC:

1. At the time of assessment, the clinic physician completes the attached "Sunrise Canyon Hospital Pre-Admission **Exam** by Physician" form.

2. If the findings documented in the medical examination indicate a need for general medical treatment and stabilization prior to admission, the person is transferred to University Medical Center.

3. If the findings documented in the medical examination indicate that there is not a need for general medical treatment and stabilization prior to admission, lab specimens are obtained by UMC personnel and the person is transferred to Sunrise Canyon Hospital.

B. ADMISSIONS FROM UMC **ER** OR SMOP **ER:**

1. At the time of assessment, the emergency room physician completes the attached "Sunrise Canyon Hospital Pre-Admission **Exam** by Physician" form.

2. If the findings documented in the medical examination indicate a need for general medical treatment and stabilization prior to admission. the person regains at UMC or SMOP for treatment.

3. If the findings documented in the medical examination indicate that there is not a need for general medical treatment and stabilization prior to admission, lab specimens are obtained by UMC or SMOP personnel and the person is transferred to Sunrise Canyon Hospiral.

C. ALL-OTHER ADMISSIONS:

1. The Mental Health Authority (MHA) Assessor contacts the assigned SRC Resident and relays information about possible admission and authorization.

2. The person is transported to SRC for a pre-admission psychiatric and medical exam in the Exam Room of Building 200, or the Resident travels to the location of the consumer to conduct the pre-admission assessment.

3. The Resident meets the MHA Assessor and person to be evaluated within 30 minutes of notification and completes the attached "Sunrise Canyon Hospiral Pre-Admission Exam by Physician" form.

4. If the findings documented in the medical examination indicate that there is not a need for general medical treatment and stabilization prior to admission, the person is admitted to Sunrise Canyon Hospiral where lab specimens are obtained by SRC personnel and sent to UMC.

5. If the findings documented in the medical examination indicate a need for general medical treatment and stabilization prior to admission, the person is transferred to UMC for treatment.

II. MONDAY - FRIDAY 5:00 P.M. TO 8:00 A.M., SATURDAY AND SUNDAY

A. ADMISSIONS ORIGINATING FROM UMC ER OR SMOP ER:

1. At the time of assessment, the emergency room physician completes the attached "Sunrise Canyon Hospital Pre-Admission Exam by Physician" form.

2. If the findings documented in the medical examination indicate a need for general medical rreatment and stabilization prior to admission. rhe person remains at UMC or SMOP for treatment.

3. If the findings documented in the medical examination indicate that there is not a need for general medical treatment and stabilization prior to admission, lab specimens are obtained by UMC or SMOP personnel and the person is transferred to Sunrise Canyon Hospital.

B. ALL OTHER ADMISSIONS:

1. At the time of assessment, the MHA Assessor ensures that a physician completes the attached "Sunrise Canyon Hospital Pre-Admission Exam by Physician" form.

1. If the findings documenred in the medical examination indicate a need for general medical treatment and stabilization prior to admission. the person is not transferred to Sunrise Canyon Hospital until medical trearment has been received.

3. If the findings documented in the medical examination indicate that there is not a need for general medical treatment and stabilization prior to admission, the Assessor facilitates the physician to physician procedure in order to transier the person to Sunrise Canyon Hospital.

SUNRISE CANYON HOSPITAL
PRE-ADMISSION EXAM BY PHYSICIAN

Within 71 hours prior to admission to Sunrise Canyon Hospirai, a physician must provide a face to face assessment and physical examination in order ro recommend inpatient psychiatric treatment. The Physician must complete the following information in order to make a referral to SRC.

Consumer Name: _____

Date of Exam: _____ Time of Exam: _____

Physician's Name: _____

Name of Facility/Clinic: _____

Physician's Telephone No.: (_____

Findings of Psychiatric .Assessment: _____

_____

_____

_____

Reason for Admission:

_____ dangerousness to self;
_____ dangerous to others;
_____ condition can be expected to deteriorate if not treated in a hospital;
_____ treatment in a less restrictive setting is not indicated;
_____ treatment in a less restrictive setting is not available;
_____ other; please specify: _____

_____

_____

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Findings of Medical Examination:

Does person currently exhibit any of the following?

Fever greater rhan 100.4 with symptoms suggesting bacterial infection?	Yes	No
Acute pain of severe nature and recent onset?	Yes	No
Mental status changes that can nor be attributable to rcccnr substance abuse and appear nor to be psychiatric in nature?	Yes	No
Wounds that are bleeding or appear infected?	Yes	No
Obvious vascular insufficiency or extremity characterized by cyanosis, pain, pallor, or lass of motor function?	Yes	No
Recent or new onset of focal neurological findings, i.e. paralysis, inability to move an extremity or ambulate?	Yes	No
Chronic illness such as diabetes mellitus, stable angina, hypothyroidism, or other chronic problems that has degenerated into an acute one as determined by history of increasing or worsening of symptoms associated with their chronic disease?	Yes	No
Pregnancy with pain, fever, vaginal bleeding, discharged or other symptomatic problems'?	Yes	Yo

A "Yes" answer to any of the above requires general medical treatment and stabilization prior to a imission to Sunrise Canyon Hospital.

Physical Examination:

Pulse: _____

Blood Pressure: _____

Temperature: _____

Respiration: _____

Weight: _____

Pertinent Physical findings: _____

_____

_____

_____

_____

Physician's Signature Date Time

EXHIBIT J

PROTOCOL FOR CONTINUITY OF CARE DURING RELEASE OF LRMHMR CONSUMERS

- When an inmate is scheduled for release by whatever means, the Release Officer will notify Lubbock County Hospiral District (LCHD)/Medical Staff of planned release. LCHD/Medical Staff will notify the Lubbock Regional MHMR (LRMHMR) TCOMI COC worker Gary Vivian at (806) 790-5152 so a follow up appointment can be scheduled with MHMR.

- Whenever possible the jail will call the Care Coordinator in advance to advise on which derainees are being released.

- In the event the detainee's needs are immediate the Care Coordinator will work with rhe LRMHMR Assessors in obtaining a referral for necessary resources.

- On weekends and evenings the LSO can leave a message on the Care Coordinaror's voice mail informing them what detainee(s) have been released and whar problems/needs have been identified.

- For immediate/emergency needs on weekends and evenings the LSO can call the crisis line ar (806) 795-9955.

APPENDIX *C:*

AGREEMENT

THE STATE OF TEXAS §
§
COUNTY OF HARRIS §

THIS AGREEMENT is made and entered into, executed by and between the Mental Health and Mental Retardation Authority of Harris County, a community center and an agency of the State of Texas under the provisions of the TEX. HEALTH & SAFETY CODE ANN. Chapter 534 (the "MHMRA"), as amended, , Harris County, a body corporate and politic under the laws of the Stare of Texas (the "County"), and Harris County Community Supervision and Corrections Department (the "Department"), a department created pursuant to TEX. GOV'T CODE ANN. Chapter 76, as amended, by the district judges trying criminal cases in each judicial district in Harris County, Texas.

1.
SCOPE OF SERVICES

A. MHMRA agrees to do the following:

1. Assign pretrial mental healthimental retardation specialists to work with the staff of the County's Pretrial Services Agency ("PTSA") and Harris County court personnel, including Department personnel ("court personnel"), in identifying and evaluating criminal defendants for mental impairments during the intake/booking stage;

2. Disclose information as requested by PTSA staff, the Harris County Sheriffs Department detention staff, or court personnel to assist them in their decision-making functions, such as, but not limited to, whether a criminal defendant is suitable to receive mental healthimental retardation services, whether such persons who are placed on misdemeanor or felony probation are complying with their conditions of probation, i.e., are receiving mental healthimental retardation services and participating in clinic treatment or counseling programs;

3. Link criminal detainees/offenders to appropriate mental healthimental retardation services;

4. Assist PTSA staff and court personnel in identifying the criminal inmate population most in need of, and most likely to, benefit from community-based alternatives to incarceration;

5. Provide early access to jail-based crisis intervention and short-term therapy to increase the potential for successful pretrial bond compliance in community based mental healthimental rerardation services; and

6. Provide family education, crisis intervention, behavioral counseling and linkage to case management services.

B. County, through PTSA, agrees to do the following:

1 Adjust its intake and pretrial procedures for purposes of identifying criminal defendants with mental impairments and those having a prior history of receiving mental healttdmental retardation services:

2. Provide workspace and other resources necessary for the joint identification of detaineesloffenders' needs for mental health/mental retardation services and preparing reports to the criminal courts;

3. Provide updated lists of detainees so that MHMRA is able to identify current MHMRA clients and arrange linkage on a timely basis to MHMRA's case management system; and

4. Provide sufficient and timely data to enable MHMRA to track client status through the criminal justice system during the pretrial stage.

C. The Departmen: agrees to cooperate with MHMRA and PTSX in tracking criminal defendants placed on probation who have been ordered to submit to outpatient or inpatient mental health/mental re;ardation treatment.

D. Compliance with Law. In performing the obligations and responsibilities under this Agreement, MHMRA, the Department, and the County each agree to observe and comply with all applicable laws, rules, and regulations affecting the services to be performed under this Agreement. The parties specifically agree to keep alcohol and drug abuse patient records confidential in accordance with the regulations set forth in Confidentiality of Alcohol & Drug Abuse Patient Records, 42 C.F.R. Part 2, as amended.

E. Status of Emplovees. It is understood and agreed that no employee, agent, or representative of the County or the Department is an employee of MHMRA and, therefore, is not eligible for any benefits, rights, or privileges accorded to MHMRA employees. It is further understood and agreed that no employee, agent, or representative of MHMRA is an employee of the Court or the Department and, therefore, is not eligible for any benefits, rights, or privileges accorded to County or Department employees.

II.
TERM AND TERMINATION

.4. Term. This Agreement begins on December 1, 1999, and ends on November 30, 2002, unless earlier terminated as provided herein.

B. Termination. Any party may terminate this Agreement, with or without cause, by giving thirty (30) days prior written notice to the other parties.

III.
NOTICES

All notices and communications under this Agreement to be given to the County hereunder may be given by hand-delivery or certified United States mail, postage prepaid, return-receipt requested, addressed to:

Harris County Pretrial Services Agency
1310 Prairie, Suite 170
Houston, Texas 77002
Attention: Director

All notices and communications under this Agreement to be given to MHMRA hereunder may be given by hand-delivery or certified United States mail, postage prepaid, return-receipt requested, addressed to:

Mental Health and Mental Retardation Authority of Harris County
2850 Fannin
Houston. Texas 77002

All notices and communications under this Agreement to be given to the Department hereunder may be given by hand-delivery or certified United States mail, postage prepaid, return-receipt requested, addressed to:

Harris County Community Supervision and Corrections Department
49 San Jacinto Street
Houston, Texas 77702
Attention: Director

Any notice mailed by registered or certified United States mail, return-receipt requested, as hereinabove provided, is deemed given upon deposit in the United States mail.

IV.
MISCELLANEOUS

A. Nondiscrimination. Each party to this Agreement agrees to comply with all federal and state laws, standards, orders, and regulations regarding equal employment which are applicable to each party's performance hereunder.

B. Entire Agreement. This instrument contains the entire Agreement between the parties related to the rights herein granted and the obligations herein assumed. Any oral or written representations or modifications concerning this instrument shall be of no force or effect excepting a subsequent modification in writing signed by both parties hereto.

C. Governing Law and Venue. This Agreement shall be construed and enforced in accordance with the laws of the State of Texas, and venue shall lie in Harris County, Texas.

D. Captions. The captions at the beginning of the paragraphs of this Agreement are guides and labels to assist in locating and reading such paragraphs, and therefore, will be given no effect in construing this Agreement and shall not be restrictive of the subject matter of any paragraph, section, or part of this Agreement.

E. Severability. The invalidity or unenforceability of any term or provision hereof does not affect the validity or enforceability of any other term(s) or provision(s).

EXECUTED in triplicate originals this _____ day of DEC 21 1999, 1999.

APPROVED:

MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY

By _____
STEVEN B. SCHNEE, Ph.D.
Executive Director

11/3/99

APPROVED AS TO FORM:

MICHAEL P. FLEMING
County Attorney

By _____
SIMONE SCOTT WALKER
Assistant County Attorney

HARRIS COUNTY

By _____
ROBERT ECKELS
County Judge

APPROVED:

HARRIS COUNTY COMMUNITY SUPERVISION AND CORRECTIONS DEPARTMENT

By _____ 12/2/99
NANCY PLATT, Director

ORDER AUTHORIZING EXECUTION OF AN INTERLOCAL AGREEMENT BETWEEN THE MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY, HARRIS COUNTY, *AND* HARRIS COUNTY COMMUNITY SUPERVISION AND CORRECTIONS DEPARTMENT

THE STATE OF TEXAS §
§
COUNTY OF HARRIS §

On this the _____ day of DEC 21 1999, 1999, the Commissioners Court of Harris County, Texas, sitting as the governing body of Harris County, upon motion of Commissioner Radack, seconded by Commissioner Fonteno, duly put and carried,

IT IS ORDERED, that the County Judge of be, and is, authorized to execute for and on behalf of Harris County an Interlocal Agreement between Harris County, the Mental Health and Mental Retardation Authority of Harris County ("MHMRA"), and the Harris County Community Supervision and Corrections Department, for the sharing and coordination of information between MHMRA, the Department, the Harris County Pretrial Services Agency, and the Hams County Sheriffs Department, said Agreement being incorporated herein by reference for all purposes as though fully set forth word for word.

ABSTAIN:
JUDGE ECKELS —

Presented to Commissioners' Court

DEC 21 1999

APPROVE_____
Recorded Vol____Page____

HARRIS COUNTY PRETRIAL SERVICES AGENCY

CAROL OELLER
DIRECTOR

DENNIS POTTS
ASSISTANT DIRECTOR

December 14, 1999

Harris County Commissioner's Court
1001 Preston, 9th Floor
Houston, TX 77002

Gentlemen:

The County Attorney's Office prepared an Agreement between Harris County, the Mental Health and Mental Retardation Authority of Harris County, and the Harris County Community Supervision and Corrections Department. It allows Pretrial Services Agency staff, court personnei, Community Supervision and Corrections Depanment employees, Sheriff's Department detention staff, and the Mental Health and Mental Retardation Authority to exchange information about defendants with mental disorders.

I am sending you three originals of the Agreement. Its language mirrors that of two previous agreements that were operational for hree years each. The current documents have already been signed by an Assistant County Attorney, the Executive Director of the Mental Health and Mental Retardation Authority, and the Director of the Community Supervision and Corrections Department. Respectfully, I am requesting that you enter this Agreement.

Sincerely,

Carol Oeller

Enclosure

Presented to Commissioners' Court

DEC 21 1999

APPROVED R/F

Returned

ABSTAIN:
JUDGE ECKELS

1310 Prairie, Suite 170 • Houston, Texas 77002
713-755-5440 • Fax 713-755-2929

Harris County Special Needs Referral

Client's Name: _____ S.S.#: _____

SPN #: _____ Phone: _____

Address: _____

D.O.B. _____ SEX: M F SID NO. _____ Offense: M F B

Disabled? ____ Disability Type: _____ Lang: _____

Physical Health Problem? _____ Problem Type: _____ PH Code: _____

Mental Impairment? _____ Impairment Type: _____ MI Code: _____

On Maintenance Medication? ____ Names(s) of Medication: _____ Med Type: _____

MHMRA Client Now? ____ MHMRA Past? _____ MH Hospitalizations? _____ Last year hospitalized: _____

Defendant wants substance abuse treatment? _____ Substance Abuse type: _____ (Drug, Alcohol, Both)

Personal Contact/Guardian: _____ Phone: _____ Rel to Def: _____

Is Client receiving any of these services at the time of the interview:

Outpatient Substance Abuse Treatment? ___ Outpatient Psychiatric Treatment at MHMR? ___

Outpatient Psychiatric Treatment/Other? ___ Inpatient Psychiatric Treatment? ___

SSI ___ Food Stamps ___ AFDC ___ Medicare ___ Medicaid ___ VA Benefits ___

Social Security ___ TRC ___ Public Housing ___ Halfway House ___

Circle Applicable Observations (from the T _____

1. Does the individual talk or act in a strange manna?
2. Does the individual seem unusually confused or preoccupied?
3. Does the individual talk very rapidly or seem to be in an unusually good mood?
4. D m the individual claim to be someone else like a famous person or fictional figure?
5. D m the individual's vocabulary (in his/her native tongue) seem Limited?
6. Does the individual have difficulty coming up with words to express him/herself?
7. Does the individual seem extremely sad, apathetic, helpless. or hopeless?

Comments/Other Observations:

_____

_____

ACTION REQUESTED	ARREST/COURT ACTIVITY
MI/MR Confirmation _____	PTSA Interview Date/Location _____
Assessment _____	PCH Date and Time _____
MI Conditional Release Options _____	Referral Date/time _____
MI Confirmation Only; Def Released _____	PCH Outcome _____
SN Conditional Release Options _____	Assigned Court Setting _____
SN Notification Only; Def Released _____	Assigned Court/Cause _____
Additional Infor (Ref Before) _____	Other _____
Other _____	Other _____

Adult Mental Health - Forensic Services
MHMRA Pre - Trial Screening

HARRIS COUNTY SPECIAL NEEDS RESPONSE FORM

CLIENT NAME: _____ MHMRA #: _____ SPN #: _____

DOB: _____ AGE: _____ SEX: ____ RACE: B: ___ W: ___ H: ___ Other: _____

REFERRAL SOURCE: _____ CRT: CRT DATE: _____

MENTAL HEALTH TREATMENT

Outpatient Treatment

____ No History Found

Harris Co. MHMRA Last Date Seen: _____ Clinic: _____
Current Status Active: Not Active: ___

____ Other County MHMRA Last seen: _____ County: _____

____ Private Counseling as reported by client Last Date: _____
Service Info: _____

In-Patient Services or Psychiatric Hospitalizations

____ No History Found

Facility City Year Length of Stay Diagnosis

_____

_____

_____

CURRENT DIAGNOSTIC IMPRESSION (subject to Psychiatric Evaluation)

Axis I (P): _____

Axis I (S): _____

Axis II: _____

Axis III: _____

Axis V: Current GAF: _____ Past Year: _____

CURRENT MEDICATIONS: _____

PRELIMINARY SERVICE RECOMMENDATIONS

____ Refer to PreTrial Intensive Casemanager - _____

Refer to Outpatient MHMRA Clinic- _____

Refer to MR assessment - _____

____ Refer to Adult Forensic Unit - _____

____ Refer for Substance Abuse assessment - _____

____ Refer to HCJ medical department - _____

____ Refer to Private Physician - _____

____ Refer to other - _____

____ No mental health intervention needed at this time

____ _____

DATE: _____ Screener: _____

APPENDIX D:

JOE MAX TAYLOR
SHERIFF

Galveston County
715 · 19th Street
Galveston. **Texas** 77550

Area Code 409-766.2300

GALVESTON COUNTY SHERIFF'S DEPARTMENT
MENTAL HEALTH DMSION

JOB DESCRIPTIONS

DAY FIELD INVESTIGATOR

(A) Duties:

1. Responsible for any calls originating during their shift
2. Complete follow-up assignments as .directed by the Division's Lieutenant
3. Record all activities on Daily Investigation Logs
4. Report any problems or progressions to the Division's Lieutenant. (Note: There will be a least one Deputy in the Mental Health office at all times during this shift unless otherwise authorized by the Watch Commander.)

EVENING SHIFT INVESTIGATOR

(A) Duties:

1. Responsible for any calls originating during their shift
2. Complete follow-up as directed by the Division Lieutenant
3. Record all activities on Daily Investigation Logs
4. Report any problems or progressions to the Division Lieutenant

NIGHT SHIFT INVESTIGATOR

(A) Duties:

1. Responsible for any calls originating during their shift
2. Record all activities on Daily Investigation Logs
3. Maintain an on call status during remainder of shift
4. Report any problems or progressions to the Division Lieutenant

TRANSPORTATION AND TRIPS

(A) The Mental Health Deputies are responsible for transporting all MH/MR clients:

1. All State Hospitals
2. From all agencies within Galveston County
3. Private clients within Galveston County at the Doctor's request
4. Forensic Evaluations that are ordered by the Court

ADMINISTRATIVE ASSISTANT/LEGAL INTAKE

(A) Primary Function:

1. Preparation of legal documents pertaining to and inclusive of the original application process pursuant to the civil commitment process.
    a. Interviewing concerned parties (screened)
    b. Preparing appropriate documents
    c. Completion of process procedures (Courts)

(B) Secondary Function:

1. Screening of all contacts for proposed patients
2. Receiving complaints from clients family (Affidavits)
3. General record processing for the Mental Health Division
4. Staff record maintenance and typing reports for Mental Health Division
5. General administrative assistant responsibilities

STANDARD OPERATIONAL PROCEDURE

I. RAPE INVESTIGATIONS

Effective this date, September 16, 1985, the following will be considered departmental policy governing rape investigation.

(A) The field-deputy responding to the reported offense will conduct the preliminary investigation and will be responsible for the original report.

(B) Upon receipt of a rape call the field deputy will consult his supervisor to determine whether the investigator on-call should be called to the scene. In any event, the field supervisor will make the on-call investigator aware of the event under investigation.

(C) The victim will be transported to John Sealy ER by the field supervisor. If the field supervisor is not available, the field deputy will transport the victim.

(D) The victim and transporting officer will be met at John Sealy ER by the MH deputy on-call. The MH deputy will notify his/her supervisor of his/her involvement in the case.

(E) The MH deputy will remain at John Sealy ER until completion of medical examination and will receive from the attending physicians evidence in the form of a "Rape Kit". The "Rape Kit" will subsequently be submitted to the Identification Bureau for storage. The MH deputy will document his/her activities in a concise Supplementary Offense Report which will include (to maintain the "Chain of Evidence") the name of the Identification Bureau staff member receiving the "Rape Kit".

(F) The MH deputy will advise the victim to contact the OCCU (during working hours) within 24 hours following completion of the medical examination.

This procedure will also apply to all other sexual offenses in which medical examinations of the victim is necessary.

COLLECTION OF ***CLIENT*** PROPERTY

I. For Clients Not Under Pending Criminal Charges:

(A) The Mental Health Deputy responding to a request for services for clients under this heading will:

1. Collect all personal property of said client
2. Receive a release form from the hospital for any said personal property which is necessary for said client to possess if hospitalized
3. Properly catalog, report and store as per policy of the Sheriff's Department any and all personal property not necessary for said client to possess if hospitalized (weapons) **(NOTE:** release of the above will be in compliance with the standard property release policy of the Sheriffs Department)

II. For Clients Requiring Emereency Psychiatric Treatment and Who Have Possible Criminal Charges Pending:

(B) The Mental Health Deputy responding to a request for services for Clients under this heading will:

1. Not collect that property which will not be necessary for said client to possess if hospitalized
2. Received a release form from the hospital for that property which is necessary for the client to possess if hospitalized
3. Not release said property to client if said client is not admitted (This property as well as said client will be released back to the original investigating agency)

III. ROUTINE MENTAL HEALTH CONTACTS

(A) If at anytime a request is made concerning an individual who is believed to be manifesting a particular dysfunction, a full intake report shall be made. As has been normal **S.O.P.** in the past.

(B) In addition to the above, the client case history will contain:

a. Copies of the E.A.D. (if used)

b. Any and all information concerning the contact (on intake form)

(C) Make note that the above applies for any and all request for services. Only one copy of all report forms are necessary unless directed otherwise

(D) Complete Criminal history check (enclosed)

(E) All contracts will be submitted to the Program Director for approval.

IV. ALCOHOL CONTACTS:

(A) All alcohol contacts will be submitted to the Gulf Coast Center MHMR.

(B) After completion of a alcohol contacf all information will be submitted to the Gulf Coast Center MHMR.

(C) The copies of the forms will be soned and distributed by the Program Director.

(D) CCH enclosed

V. SUICIDE ATTEMPTS:

If at anytime a request is made to this division for an investigation of the above mentioned category, the following will be the S.O.P.

(A) **Request from an agency other than the S.O.**

1. The officer receiving the original call will make an Original Offense Report.

2. The investigator of the MH Division will complete the following:
   a. Client case history form
   b. Client attempt form
   c. Body diagram
   d. If possible all of the above in duplicate

3. CCH enclosed

(B) Request from the Sheriff's Department

1. The officer receiving the initial call will complete an original Offense Report. The Investigator from the MH Division receiving the request for services under this heading shall:

    a. Complete any and all supplements to the original Offense Report
    b. Complete any and all statements
    c. Complete attempt form
    d. Complete client intakes
    e. All reports shall be submitted to the Program Director for approval and distribution

VI. FORENSIC EVALUATIONS:

(A) Evaluations that are ordered by the Court on an inmate with a felony charge:

a. The MH Officer will transport the inmate for evaluations or elsewhere as directed
b. The MH Officer will remain with the inmate until the evaluation is completed
c. The inmate will be transported back to the jail

VII. DAILY ACTMTY LOGS:

(A) Each MH investigator shall complete a daily activity log which will be submitted to the Program Director at the end of each investigators shift

(B) The above will be in single copy

APPENDIX E:

COUNTY **JAIL** MENTAL HEALTH POLICY SURVEY

DIRECTIONS: Please complete the following questions in ink **and** for applicable questions enclose summary of policies.

COUNTY	PREPARED BY	PHONE #

1. Are any of your sheriffs deputies required to have specific training to deal with mentally ill offenders?

yes no

2. What does your training consist of? (attach summary of policy)

3. Do you face any barriers in requiring or providing deputy mental health training? If so what are they?

funding personnel constraints other_____

4. Do you conduct jail intake screening for mentally ill offenders? If yes, please include a copy of your screening instrument.

yes no

5. Who performs offender intake screening?

jailer deputy other_____

6. Do you have a mental health professional on-site?

7. Who conducts the follow-up assessment for those screened positive for a mental illness?

psychiatrist psychologist nurse medical doctor

social worker other_____

8. Do you have a written agreement or memorandum of understanding with the mental health community? If yes, please include a copy of MOU.

yes no

9. Do you have access to treatment or services for the mentally ill on-site?

yes no

10. Do you divert any of your mentally ill offenders to community treatment programs or pre-trial services?

yes no

11. Do treatment facilities in your community accept individuals you diagnose with mental illnesses?

yes no

12. Do you contract for mental health services? If yes, please attach a list.

APPENDIX F:

Survey Response Chart

COUNTY	Population	Returned Survey	Number of Beds	County Seat
BELL	225,513	YES	709	Belton
BEXAR	1,328,219	YES	3,670	San Antonio
BOWIE	85,499	NO	922	New Boston
BRAZORIA	222,179	YES	1,170	Angleton
BRAZOS	138,985	NO	402	Bryan
CAMERON	318,132	YES	752	Brownsville
COLLIN	386,875	YES	680	McKinney
DALLAS	2,010,655	YES	8,187	Dallas
DENTON	385,957	YES	823	Denton
ECTOR	123,448	YES	667	Odessa
EL PASO	679,842	YES	2,464	El Paso
FORT BEND	308,991	YES	773	Pasadena
	244,447	YES	880	Galveston
GRAYSON	101,707	NO	324	Sherman
GREGG	112,482	YES	394	Longview
HARRIS	3,142,293	YES	9,113	Houston
HAYS	83,599	YES	286	San Marcos
HIDALGO	506,919	YES	597	Edinburg
JEFFERSON	245,452	YES	1,538	Beaumont
JOHNSON	110,825	NO	307	Cleburne
LUBBOCK	233,642	YES	835	Lubbock
MCLENNAN	203,2201	YES	835	Waco
MIDLAND	117,346	YES	306	Midland
	247,970	YES	674	Conroe
MONTGOMERY	60,121	YES	292	Nacodoches
NACAOGDOCHES				
NAVARRO	42,436	YES	290	Corsicana
NUECES	311,543	YES	984	Corpus Christi
ORANGE	85,658	NO	310	Orange
POTTER	101,157	NO	598	Amarillo
SMITH	166,164	NO	755	Tyler
STARR	49,756	NO	275	Rio Grande City
TARRANT	1,322,221	YES	4,244	Fort Worth
TAYLOR	128,041	YES	456	Abiline
TOM GREEN	105,696	NO	265	San Angelo
TRAVIS	668,039	YES	3,021	Austin
VICTORIA	81,695	YES	524	Victoria
WEBB	180,011	YES	475	Laredo
WICHITA	133,008	YES	626	Wichita Falls
WILLIAMSON	203,428	NO	438	Georgetown