Continuity of Care Task Force

Final Report
August 2010

Contents

Acknowledgements

The Continuity of Care Task Force would like to thank for support and development of this project the Department of State Health Services. They would also like to thank for their assistance in hosting and publicizing the Continuity of Care Task Force meetings and public forums: Superintendent Carl Schock and his staff at Austin State Hospital, Superintendent Sonia Hernandez-Keeble and her staff at Rio Grande State Center, Superintendent Ed Moughon and his staff at Big Spring State Hospital, Austin Travis County Integral Care, Bluebonnet MHMR, North Texas Behavioral Health Authority, Dallas County Health & Human Services, the Department of Public Safety, the Texas Council of Community MHMR Centers, Tropical Texas Behavioral Health, and West Texas Centers for MHMR. The Task Force is especially grateful to all of the stakeholders who attended our public forums and provided us with invaluable feedback.

About the Author

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Executive Summary

The Texas state psychiatric hospital system is nearing or already over capacity. Lack of sufficient capacity of both inpatient and outpatient treatment resources for individuals with behavioral health disorders is a public health concern in Texas. Significant numbers of Texans are unable to access services for mental illnesses for a variety of reasons. This, in the context of a growing Texas population with the highest percentage of medically uninsured in the nation, signals a convergence of factors impacting all sectors of our state environment.

To help address these issues, the Texas Department of State Health Services (DSHS) convened the Continuity of Care Task Force (COCTF) composed of representatives from various state and local stakeholder groups. DSHS charged the Task Force with examining the overall continuum of care for individuals with behavioral health disorders who move through multiple state, local and other provider systems, and prioritizing recommendations to improve continuity and capacity of care between systems. The COCTF met four times in the process of developing recommendations included in this report. Additionally, five public hearings were held across the state of Texas to solicit public opinion about a variety of issues related to this important work. The COCTF prioritized data development and analyzed global service system issues in making the recommendations included here.

Recommendations

Recommendations span four dimensions: policy and practice; statutory; clinical; and recommended interim work.

Policy and Practice Recommendations

- The COCTF recommends expansion of Permanent Supportive Housing (PSH) statewide. PSH is a national best practice that will address the needs of some individuals who are frequently hospitalized or at risk of hospitalization because of criminal justice involvement with alleged low-level offenses.

- The Texas behavioral health service system lacks alternative “step down” levels of care, including residential care and assisted living. Advocates urged us to give priority to alternative levels of care in smaller rather than large institutional settings.

- The COCTF recommends a shift in DSHS and legislative attention to “non-crisis services” to complement crisis services.

- COCTF endorses a flow chart developed by an ad-hoc committee of the Texas Council of MHMR Centers around considerations for law enforcement officers about medical clearance before transporting individuals from their local communities to the state’s psychiatric inpatient facilities.

- Law enforcement agencies across the state, both at COCTF meetings and public hearings, advocated strongly for DSHS to develop emergency overflow bed capacity mechanisms to alleviate the need for long and unwieldy transports to access available psychiatric hospital beds out of their traditional catchment area.

- Training for professionals involved in the criminal justice/mental health interface was a key recommendation, including suggestion of online peer support for judges and lawyers in rural settings for collaboration on forensic legal issues.

- Four urban pilots of outpatient restoration of competency to stand trial have been successful. The COCTF recommends expansion of these programs as well as the development of other local restoration of competency options.

Statutory Recommendations

- Many of the recommendations in this report relate to amendments of Chapter 46B of the Texas Code of Criminal Procedure:

    - Allowing the court to rescind an order for competency evaluation at any time, if the parties agree that a pre-trial detainee's competency is no longer an issue after jail treatment;

    - Clarifying and modifying maximum time commitments for misdemeanant offenders, and restricting recommitments for individuals found not likely to be restored to competency. We believe that this will encourage courts to identify alternative strategies to forensic re-commitment;

    - Allowing easier patient flow between inpatient and outpatient settings for restoration of competency without the necessity of a hearing, unless there is objection by either party.

- The COCTF gave consideration to modification of outpatient civil commitment laws. The COCTF recommends:

    - Judicial outpatient civil commitment should include the option of ordering individuals to take psychotropic medications, but with specific provisions that relate to capacity to refuse medications, criteria for modification to inpatient commitment, and methods used to compel;

    - The development of criteria for a certain subset of individuals who might be better served by a longer initial outpatient commitment period to allow for better treatment planning.

- The COCTF urges DSHS to support legislation for suspension, rather than termination of benefits for individuals with Social Security Disability Income (SSDI) during periods of incarceration or forensic hospitalization.

Clinical Recommendations

Continuity of Care Task Force members encouraged state officials to develop incentive programs throughout a variety of training settings to enhance clinical competencies for professionals who choose to serve individuals with severe and persistent psychiatric illness.

While the principles around trauma informed care have been increasingly implemented in recent years, the Task Force recommended expanding those efforts. Peer support is another nationally accepted best practice that could be codified and funded in our public system of care in Texas. A stronger emphasis to help identify residual neuro-developmental disabilities would better serve individuals who, in addition to their mental

illness, have difficulty organizing, planning, and completing activities, particularly those requiring multiple steps and/or sustained mental efforts. It is important to include psychometric testing to firm up diagnostic impressions and assist in treatment planning. Cognitive rehabilitation service options would greatly enhance clinical outcomes for individuals with co-occurring levels of need.

Recommended Interim Work

Texas Mental Health Code

The COCTF recommendation most resoundingly reinforced in both the Task Force meetings and public hearings was an interim study to modify the Texas Mental Health Code.

Medicaid Waiver of Choice

Medicaid funded services are far more flexible for individuals with intellectual disabilities in Texas (served by the Department of Aging and Disability Services) than they are for individuals with behavioral health disorders. The COCTF recommends application for a Medicaid waiver similar to the 1915(c) to better accommodate the need for flexible funding for individuals with psychiatric illness in Texas.

Forensic Conditional Release

This report recommends implementing Forensic Conditional Release programs that allow individuals who have been found not competent to stand trial or not guilty by reason of insanity by criminal courts to move from inpatient psychiatric hospitals into the community.

Health Care Reform

Implementation of federal health care reform measures in Texas has the potential to be problematic for individuals with severe psychiatric illness. Services such as case management and rehabilitation, generally not covered by traditional health insurance plans, might be eliminated from general revenue funding sources because these individuals with the highest levels of need will be deemed to “have insurance.” Additionally, new Medicaid eligibility categories may bring more individuals into the public mental health system.

Continuity of Care Task Force Report

Background

The Texas state psychiatric hospital system is stretched to capacity. In FY 2009, one or more state hospitals were at or beyond full capacity each day. This often means that individuals in local jails who have been found incompetent to stand trial are waiting for long periods for admission to psychiatric hospitals for treatment. Communities have also had to find alternative community-based solutions to address the needs of civil commitments.

Insufficient treatment resources for individuals with behavioral health disorders in Texas is a public health challenge:

- Anyone can have a mental illness, regardless of age gender race or socioeconomic level.
- In established economies, mental illnesses cause more disease burden than all cancers.[1]
- Mental Illness can occur at any age.
- An estimated 26.2 percent of Americans over the age of 18 suffer from a diagnosable mental disorder, with an estimated 2.6 percent suffering from a serious mental illness.[2]
- An estimated 1,037,883 adult Texans have a serious mental illness.[3]
- 7.5 million children are affected by mental, developmental or behavioral disorders.[4]
- Nearly two-thirds of all people with a diagnosable mental disorder do not seek treatment.[5]

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[1] Murray, C.J.L., & Lopez, A.D., Eds (1996). *The global burden of disease and injury series, volume 1: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press.

[2] Kessler, R.C., Chiu, W.T., Demler, O., & Walters, E,E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, Jun;62(6):617-27.

[3] Substance Abuse and Mental Health Services Administration. (1999). *Estimation Methodology for Adults with Serious Mental Illness (SMI)*. Federal Register, Vol. 64, No. 121, Pages 33890-33897.

[4] NAMI, Texas, *Basic Facts About Mental Illness*. Retrieved August 5, 2010 from http://www.namitexas.org/mental_illness/

[5] Ibid.

- Increasing numbers of uninsured and underinsured Texans, as well as decreasing capacity in the private psychiatric system—both inpatient and outpatient—have a significant impact upon the public behavioral health system and undermine the financial viability of the remaining local private psychiatric hospitals; and

- Behavioral health disorders are chronic conditions, much like diabetes and hypertension, with similar levels of ensuing disability, meaning that individuals are likely to need long-term care.

In FY 2009, more than 190,000 Texans received mental health treatment services funded by DSHS at community mental health centers, and over 15,000 persons were admitted to state mental health facilities. This, in the context of a growing Texas population, will have an impact in all sectors of our state environment.

The Department of State Health Services convened the Continuity of Care Task Force (COCTF) to address this crisis. Participants included representatives from Local Mental Health Authorities (LMHAs), State Hospitals (SHs), consumers, family members, advocates, attorneys, judges, and other interested parties, a full roster of which is included in the appendices below. It was acknowledged at the outset of the work of the COCTF that lack of capacity in the state hospital system as well as the public outpatient system reflects issues across the entire behavioral health system in Texas. Task Force Goals were to:

- Examine the overall continuum of care for individuals with behavioral health disorders who move through multiple systems;

- Analyze barriers to discharge for individuals in State Hospitals with extended lengths of stay; and

- Make and prioritize recommendations to address system issues.

Process

The COCTF met four times in the process of developing the recommendations included in this report. In addition, five public hearings were held across the state of Texas to solicit public opinion about a variety of issues related to their work. The last meeting of the COCTF was held on June 18, 2010, so that members could consider all of the input obtained during public hearings. A full list of meeting and public hearing schedules and locations is available in Appendix 2. A series of individual interviews with key stakeholders were conducted during the development of the COCTF recommendations. (A list of the individuals interviewed is available in Appendix 3).

Environmental Perspective and Data Development

The COCTF prioritized data development in making recommendations and analyzed global service system issues. We noted that, while the total number of admissions and civil commitments to State Hospitals have decreased in recent years, there has been a corresponding increase in forensic commitments (those for individuals found incompetent to stand trial or not guilty by reason of insanity), and that forensic commitments generally involve much longer lengths of stay. (Available in Appendix 4). We discussed whether this is a positive or negative development, and, interestingly, found it to be both--likely reflecting both increased sensitivity to behavioral health issues for those involved in the criminal justice system, but also a lack of intermediate care

options to prevent criminal justice system involvement for individuals with behavioral health disorders.

Similarly, we examined the complex clinical issues involved in providing care to persons with severe and persistent mental illness. Most have co-occurring primary care issues and substance use disorders, and many have brain injuries, personality disorders and intellectual disabilities. Our current service system does not adequately reflect or address these co-morbidities.

The Task Force also directly addressed the enormous disparities in resources and practices between urban and rural communities in Texas, which makes statewide recommendations more challenging.

Overview

Recommendations span four dimensions. The Task Force first addresses issues related to public policy and practices. Second, the Task Force outlines specific recommendations related to Texas statutes. Third, we identify needed areas of clinical attention. Finally, we outline recommendations for interim work to ameliorate the crisis and move the service system forward from a longer-term perspective.

Recommendations

Policy and Practice Recommendations

Housing

Affordable housing options with needed supports was immediately noted as a significant gap in the overall service system. It has been well documented nationally that individuals with behavioral health needs who have housing instability are much more likely to also be involved with the criminal justice system and utilize psychiatric emergency and inpatient services at higher rates.

While an estimated 1% of the Texas population is homeless, between 2.4—2.9% of the individuals served by the LMHAs are homeless.

Permanent supportive housing (PSH) is permanent, affordable housing linked to a range of support services such as Assertive Community Treatment (ACT) or intensive case management, that enable vulnerable tenants, especially the long-term homeless, to live independently and participate in community life. A similar model employed in Colorado demonstrated a drastic 80 percent decrease in overnight hospital stays and a 76

percent decrease in nights in jail.[6] PSH can help people with psychiatric disabilities, people with histories of addiction, formerly homeless people, frail seniors, families, young people aging out of foster care, individuals leaving correctional facilities, and people living with HIV/AIDS. (An exploration of LMHA homelessness data can be found in Appendix 5).

For these populations, PSH is a highly effective intervention. Research indicates that among residents of permanent supportive housing:

- More than 80% stay housed for at least one year;
- Rates of arrest and days incarcerated are reduced by 50%;
- Emergency room visits decrease by 57%;
- Emergency detoxification services decrease by 85%;
- Nursing home costs decrease by 50%; and
- There is a 50% increase in earned income.[7]

We believe that statewide expansion of PSH will decrease both incarceration of individuals with behavioral health disorders, and the need for hospitalization for those in acute crisis. DSHS has submitted an Exceptional Item Request to the Texas Legislature to support this recommendation.

"Step Down" Levels of Care

As part of our data development, we analyzed barriers to discharge for individuals with the longest lengths of stay in our state facilities, a full analysis of which is included in Appendix 6.

In November of 2009, there were approximately 600 individuals in Texas State Hospitals who had been continuously hospitalized for more than 365 days.

In our discussions of that data, we noted that a certain subset of those individuals did not clinically need hospitalization, but were also not currently capable of independent community living. This reflects one of the gaps we identified in our service system analysis: the lack of alternative "step down" levels of care, including residential care and assisted living. Advocates urged us to give priority to alternative levels of care in smaller rather than large institutional settings. Discussions also revolved around "repurposing" some empty units in our current state hospitals to allow for an intermediate and more cost effective level of care below full hospitalization status.

We recommend that the Texas Department of State Health Services consider alternative levels of care for individuals who need supports that are less than state hospitalization, but more than

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[6] Wortzel, H., Binswanger, I.,Martinez, R., Filley, C.M., & Anderson C.A. (2007), Crisis in the Treatment of Incompetence to Proceed to Trial: Harbinger of a Systemic Illness, *Am. Acad. Psychiatry Law*, 35:357–63. Retrieved from http://www.jaapl.org/cgi/reprint/35/3/357

[7] Lewis, D., Corporation for Supportive Housing, *Permanent Supportive Housing Program & Financial Model for Austin/Travis County, TX, 2010*. Retrieved August 5, 2010 from http://www.caction.org/homeless/documents/AustinModelPresentation.pdf

community living. Preference should be given to smaller rather than larger institutional settings.

Funding for "Non-Crisis" Services

The Texas Legislature and the Texas Department of State Health Services have invested a significant amount of attention and funding in recent years to crisis and emergency services. Attention to crisis services was necessary and warranted. The investment by the Legislature and DSHS has allowed quality crisis services to be available across the state. However, the Crisis Services Redesign Evaluation found that the increased enrollment of crisis services users would further tax community mental health caseloads and increase the projected caseloads by 21 percent.[8] The COCTF recommends that attention now be shifted to non-crisis services. Texas justifiably invested resources in what was a fragmented, inadequate crisis system and now should turn its attention to needed capacity and additional types of ongoing services. "Non-crisis" services should be considered a clinically effective part of the continuum of care. Alternative levels of care, particularly supported/supervised living options, could prevent hospital admission from being medically necessary if available early in the deterioration process.

We recommend that future funding strategies prioritize "non-crisis" levels of care to complement crisis services.

Medical Clearance

The Attorney General of the State of Texas issued an opinion on December 28, 2009 which ruled that neither Local Mental Health Authorities nor State Hospitals were statutorily authorized to require medical clearance from a general medical hospital prior to law enforcement transporting individuals to a publicly funded psychiatric hospital. (Attorney General Opinion Number GA-0753 dated December 28, 2009 is included as Appendix 7.)

To address medical clearance issues even prior to the issuance of the Attorney General opinion, a collaborative work group was convened by the Texas Council of Community MHMR Centers composed of representatives of the Sheriff's Association of Texas, Texas Municipal Police Association, Texas Hospital Association, Texas Police Chief's Association, Texas Association of Counties, District and County Attorney's Association, Advocacy, Inc., LMHAs and the Department of State Health Services. The workgroup followed the recommendation of the Medical Clearance Workgroup that sought consensus to develop a Psychiatric Emergency Flow Chart to be used by law enforcement, LMHAs, and State Hospitals as a guide to respond to the Attorney General's Opinion in making the determination when medical clearance might be warranted (attached to this report as Appendix 8). This document may be used as a

[8] Carmichael, D., Jensen-Doss, A., Booth, E., Marchbanks, M. P., Ellis, D. (2010), *Evaluation Findings for the Crisis Services Redesign Initiative—Report to the Texas Department of State Health Services*. Retrieved from Department of State Health Services, Texas Mental Health and Substance Abuse Crisis Services Redesign web site:
http://www.dshs.state.tx.us/mhsacsr/finalreport/CSR%20Final%20Evaluation%20Report.pdf

guide to determine the existence of a medical emergency requiring medical treatment to insure a proposed patient's safety prior to transport to a mental health facility.

The Psychiatric Emergency Flow Chart developed by the Texas Council of Community MHMR Centers Work Group was adopted and endorsed by the COCTF as part of our recommendations.

Emergency Overflow

When state hospitals are full to capacity, law enforcement officers are often asked to travel long distances to access other available state hospital beds outside of their normal catchment area. This creates a tremendous hardship for law enforcement agencies and a public safety risk in potentially taking peace officers off the streets in local communities.

Peace officers from across the state, both at COCTF meetings and public hearings, advocated strongly for DSHS to develop mechanisms for emergency overflow bed capacity at local hospitals under contract to eliminate the need for potentially long and unwieldy transports.

Training

Additional training of judges, prosecutors, defense attorneys, mental health professionals and law enforcement officers is needed. There are significant challenges to accessing larger groups of these professionals. One of the innovative suggestions during COCTF deliberations was the development of an on-line support system for judges and attorneys in rural settings to be able to access peers in more urban areas that have more frequent exposure to cases involving behavioral health issues.

Expansion of Outpatient Restoration of Competency Programs

Over the past biennium, DSHS has funded four pilot sites in urban areas to develop outpatient restoration of competency programs. These programs select certain individuals who are incompetent to stand trial, but who could potentially be restored to competency in community settings. (Outcome Data is included in Appendix 9). Outpatient restoration of competency allows for better management of inpatient beds, can produce better outcomes for individuals who need community supports, and can be done at a fraction of the cost of inpatient services ($140 / day).

Outpatient restoration of competency has been generally successful, and the COCTF recommends expansion of these programs as well as the development of other local restoration options.

In FY 2008-2009, 70% of the individuals who completed the program were either restored to competency or were restored to the court's satisfaction. None of the participants seriously re-offended

Statutory Recommendations

The Task Force also made specific recommendations with regard to possible statutory law changes in Texas.

Chapter 46B, Code of Criminal Procedure

Voluntary Jail Treatment prior to Finding of Incompetency

The COCTF examined data from the Harris County MHMRA 21 Day Stabilization Program. This program allows for 21 days of psychiatric treatment within the jail setting prior to formal evaluation for competency to stand trial. It has been successful in diverting approximately 91 percent of individuals from state hospitals who might otherwise be on the forensic waiting list for beds. (Included in Appendix 10).

In FY 2009, 2307 individuals were hospitalized on forensic commitments for a total of 4696 "episodes." The average length of stay for these individuals was 2.23 years.

Mental health advocates expressed concern, on constitutional grounds, that 21 days was an excessive period of time, and that most jails in Texas do not have the treatment resources to effectively implement such a program. They recommended a maximum of 7 days for jail based competency restoration in our current jail treatment environment.

Consensus could not be reached about the time frame. It was noted, however, that most competency evaluations do not take place within 21 days of the court order, even in Harris County, and that many individuals receiving treatment in local jails are restored to competency prior to the evaluation under current statutory provisions.

The recommendation of the COCTF is to modify Chapter 46B of the Code of Criminal Procedure to allow the court to rescind the order for competency evaluation at any time, based upon the motion of either defense or prosecution. The order would be automatically rescinded without court hearing, unless objection is raised.

Maximum Time Commitments

Data analyzed during COCTF deliberations demonstrated that the Department of State Health Services spent an estimated $11.1 million in hospitalization costs for misdemeanor offenders in FY 2009. 406 persons served on forensic commitments in FY 2009 were classified as misdemeanants. (Available in Appendix 11). Their average length of stay in the hospital was 89 days, for an estimated cost to the state of $11.1 million. Many recommendations address ways to decrease unnecessary hospitalizations for this population:

- ***Limit the maximum time of forensic commitment under 46B of the Code of Criminal Procedure to 90 days for misdemeanor offenses;***
- ***Clarify in statute that the maximum time for forensic commitment under 46B starts at the time of booking and that time credits are consistent among pre-trial detainees regardless of competency status; and***
- ***Include commitment expiration dates in court orders to allow for better discharge treatment planning.***

Individuals Found "Not Likely to Regain" Competency

In the legislative transition from the old Chapter 46.02 of the Code of Criminal Procedure, to the current 46B, provisions that required forensic evaluators to provide an opinion about the likelihood of defendants being restored to competency in

190 individuals had more than five forensic commitments in FY 2009 alone.

the foreseeable future were eliminated. An unintended consequence of this legislative change is that there are a number of individuals being found incompetent to stand trial multiple times for different minor offenses within short time frames. For individuals not likely to be restored to competency, this is a waste of both county and state resources both because of repeat evaluations and unnecessary hospitalizations.

The COCTF seeks to address this issue through the following recommendations:

- ***Restore provisions in Chapter 46B of the Code of Criminal Procedure that evaluators provide opinions about likelihood and timeframe of restoration to competency, assuming appropriate treatment is provided; and***
- ***Add language that discourages/prohibits re-evaluation and/or re-commitment for a new minor offense within 12 months of a finding of not likely to be restored to competency.***

Outpatient Restoration of Competency

While four pilots of outpatient restoration of competency have been successful, there are significant logistical issues in moving this approach statewide largely revolving around movement between inpatient and outpatient settings. One of the lessons learned from the pilots, for example, is that some individuals who may be good candidates for outpatient restoration need a period of time in inpatient settings either at the beginning, or at other times during their commitment. Under the current statute, each one of these modifications requires returning to court for new orders. ***COCTF members recommended allowing modification between inpatient and outpatient settings without a hearing, unless there is objection by either party.***

It was also noted that time frames for inpatient and outpatient restoration of competency to stand trial for misdemeanor charges are widely variant. Under existing law, the time frame for restoration of an alleged misdemeanant on an outpatient basis far exceeds that allowed in an inpatient setting. ***The COCTF recommends amending Chapter 46B of the Code of Criminal Procedure to make inpatient and outpatient restoration of competency time frames parallel for misdemeanants.***

Assisted Outpatient Treatment

Statutory revisions to outpatient civil commitment laws under the Texas Health and Safety Code were also entertained by the COCTF. Data was presented about the successful implementation of Assisted Outpatient Treatment statutes in New York. While there is current statutory authority for a probate court to order outpatient commitment in Texas, it is not used frequently in most areas across the state, as limited resources prohibit effective enforcement. After much discussion, the COCTF made the following recommendations:

- Judicial outpatient civil commitment should include the option of ordering individuals to take psychotropic medications. ***Statutory language around compelling individuals to take medications should mirror language in Chapter 574.106 of the Health and Safety Code, requiring judicial determination that refusal to take psychotropic medications is based upon lack of capacity—i.e., the individual, because of psychiatric illness, does not fully understand the risks, benefits and alternatives to taking the medication. A corollary recommendation is strengthening the language in Chapter 574.106 about the definition of capacity, and consideration of decreasing the statutorily dictated time frame between inpatient civil commitment and court ordered medication hearings.***

- The current outpatient civil commitment statute provides for an initial commitment period of 90 days, with the option of extension to a longer-term commitment of 12 months, but only if the person had also previously been inpatient for 60 consecutive days within the past year. COCTF members believe that there is a subset of individuals in Texas who would be better served by a longer term of outpatient commitment but whom do not meet the inpatient hospitalization criteria for such a term. This would allow for more substantive long term treatment planning and improve the potential success of the commitment. ***The Task Force urged DSHS to work with consumers, professionals and advocates to develop criteria for these longer-term commitments.***

- ***Accompanying amendments should clarify that outpatient commitments cannot be converted to inpatient commitments unless individuals meet the current inpatient criteria, and that compelling medication does not include the use of physical force.***

Medicaid benefits

Under current law, Social Security benefits (SSDI and Medicaid) are terminated after 30 days of incarceration or forensic commitment. This requires re-application for benefits after release from incarceration, which is cumbersome and logistically difficult, particularly for individuals with psychiatric illness. ***The COCTF recommends that DSHS sponsor and/or support legislation to suspend, rather than terminate Medicaid benefits for twelve months during periods of incarceration.***

Clinical Issues

COCTF members also analyzed clinical issues contributing to extended lengths of stay for certain individuals in state hospitals. What, for example, could we as a system do differently from a clinical perspective to decrease the need for this most restrictive level of care? While the principles around trauma informed care have been increasingly implemented in recent years, the Task Force recommended expanding those efforts. Peer support is another nationally accepted best practice that could be more codified and funded in our public system of care in Texas. A stronger emphasis to help identify residual neurodevelopment disabilities would better serve the individuals who in addition to their mental illness have difficulty organizing, planning and completing activities, particularly those requiring multiple steps and /or sustained mental efforts. It is important to include psychometric testing to firm up diagnostic impression and assist in treatment planning.

Of the almost 600 individuals who have been hospitalized for more than a year in our state hospitals, 65 were characterized as suffering from dementia or other cognitive disability.

There is a severe shortage of mental health professionals in Texas. While this is true across the state, it is a specific crisis in public mental health settings, where the demand for professionals who are interested in this type of work far exceeds the supply. Texas' supply of psychiatrists,

psychologists and social workers falls below other regions of the country and the U.S. as a whole. This disparity is even more apparent along the Texas border--the supply rate of licensed professional counselors (LPCs) in Texas per 100,000 residents is 65.5 in urban regions and 40.7 in rural regions, but drops to only 29.4 in urban areas of the border region and is much lower in rural areas of the border.[9] COCTF members encouraged state officials to develop incentive programs throughout a variety of training settings to enhance clinical competencies for those individuals with psychiatric illness who are perhaps the most difficult to serve.

Interim Work

Mental Health Code

The COCTF recommendation most resoundingly reinforced during public hearings was an interim study to revise Chapters 571 - 576 of the Texas Health and Safety Code, known as the Mental Health Code. This set of statutes was last comprehensively overhauled over 25 years ago, in the context of a very different public behavioral health service system. While numerous amendments have been made in the time since its implementation, there is overwhelming consensus that the entire statutory framework should be revisited. This recommendation cannot be implemented before the next legislative session, but should be considered as an interim charge.

In Depth Study of Long Term Hospitalization

A preliminary analysis of barriers to discharge for individuals who have been hospitalized more than 365 days in Fiscal Year 2009 revealed a complex array of clinical and environmental issues. ***The COCTF recommends that DSHS commission an in depth study of these issues in an attempt to make more substantive clinical recommendations for the next legislative session.***

Improved Data Systems

Data necessary to make recommendations about these complex issues was found to be incomplete and inconsistent. This was particularly true with regard to the interface of the criminal justice and mental health data systems. This is another area that the COCTF wants addressed in the interim biennium. ***Better data systems will lead to more effective decision making processes about levels of care and person directed planning, and improved communication between Local Mental Health Authorities, State Hospital Treatment Teams and Criminal Justice entities.***

Medicaid Waiver

Medicaid funded services are far more flexible for individuals with intellectual disabilities in Texas (served by the Department of Aging and Disability Services) than they are for individuals with behavioral health disorders. Largely because of the 1915(c) Medicaid waiver, funding for individuals with intellectual and developmental disabilities "follows the person," rather than being tracked by service provider. There are significant differences

[9] The Hogg Foundation. (2008). *Health Care in Texas: Critical Workforce Shortages in Mental Health*. (May 2008). Retrieved from http://www.hogg.utexas.edu/PDF/Workforce%20Interim%20Senate%20052308.pdf

between these populations, but also similarities in terms of service needs. ***The COCTF recommends that DSHS consider application for a Medicaid waiver similar to the 1915(c) to better appreciate the need for flexible funding for individuals with psychiatric illness in Texas.***

Clarify Judicial Authority over Forced Medications

Task Force members noted that Chapter 46B is not clear about judicial authority to order forced medications under Section 46B.086. Some COCTF members argued that this should be under probate jurisdiction, while others believed that it is logistically more appropriate under criminal court jurisdiction. ***While, in the end, consensus could not be reached about this issue, the COCTF recommended that DSHS further investigate strategies to clarify these provisions.***

Conditional release

Though similar in some respects to Outpatient Commitment, a Forensic Conditional Release Program is a statutorily based mechanism providing for the protection of the public through the prevention and reduction of re-offense by specified forensic patients, notably persons who are either Incompetent to Stand Trial and unlikely to regain competency in the foreseeable future or Not Guilty by Reason of Insanity and whose charges are felony level and typically involve serious bodily harm to others.

Services are highly individualized, underpinned by a Comprehensive Violence Risk Assessment, corresponding Violence Risk Management Plan, and include provisions for ongoing community supervision. Patients in the program must agree to follow a treatment contract designed by treatment providers, the outpatient supervisor and approved by the committing court. Violation of the terms of the release contract may result in preventive revocation of outpatient status and re-hospitalization. In such cases re-hospitalization is not viewed as a punitive response, rather as an opportunity for treatment intervention in an effort to prevent criminal recidivism, and revocation would have to comply with current state statutes around forced medications.

The aim is to clinically address the factors contributing to revocation of outpatient status and to return the person to community based care. Given the dual emphasis on community based treatment and supervision, forensic conditional release will afford many long term forensic inpatients an opportunity to transition out of the hospital, while protecting the safety and security interests of the larger community.

Broader consideration of conditional release provisions is another interim recommendation of the COCTF.

Health Care Reform

The prospects of positive developments as a result of health care reform in terms of more coverage for mental illness are encouraging. However, COCTF members reflected that implementation of these reform measures in Texas has the potential to be highly problematic for individuals with severe psychiatric illness. Services such as case management, for example, which are generally not covered by traditional health insurance plans, might be eliminated from general revenue funding sources, because these individuals with the highest levels of need “have insurance.” Additionally, the insurance industry does not have experience with the complex needs of individuals currently in the public system. Health care reform needs to be analyzed to determine the full impact, positive or negative.

The COCTF strongly recommends an analysis of the impact of the implementation of health care reform to the public behavioral health system in Texas.

Conclusions

The Continuity of Care Task Force is a dedicated and broad based group of individuals from a variety of settings that considered issues on a number of levels related to the continuum of care in Texas that impacts State Hospital service system capacity. Recommendations in this report span across policy, practice, statutory, clinical and long range planning. The developing challenges of the public mental health system, if not reversed through expansion/enhancement of clinically appropriate services and supports, will likely have a significant impact on a broad array of Texas organizations and entities, both public and private.

Appendices

Appendix 1: Continuity of Care Task Force Member Roster

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State Director of Nursing, Office of Academic Linkages, Texas Department of State Health Services

Emilie Attwell Becker, M.D.
Behavioral Health Medical Director, Texas Department State Health Services

Eulon Ross Taylor M.D.
Clinical Director, Austin State Hospital

James E. Smith, LCSW, DCSW
Superintendent, North Texas State Hospital

Jeanette Kinard, J.D.
Director, Travis County Mental Health Public Defender's Office

Joseph Penn, M.D.
Director, Mental Health Services CMC University of Texas Medical Branch

Judge Brent A. Carr
Tarrant County Criminal Court

Judge Guy Herman
Travis County Probate Court

Lauren Parsons, M.D.
Clinical Director for Operations, North Texas State Hospital

Leon Evans
Executive Director, Center for Health Care Services

Michael D. Maples
Assistant Commissioner, Mental Health and Substance Abuse Division, Texas Department of State Health Services

Mike Halligan
MHPAC Representative

Robin Peyson
Director, NAMI Texas—MHPAC Representative

Ross Robinson
Program Director, Mental Health Substance Abuse Division, Texas Department of State Health Services

Shelley Smith
Chief Executive Officer, West Texas Centers for MHMR

Stan Parker
Sheriff, Howard County

Steven Schnee, Ph.D.
Executive Director, MHMRA of Harris County

Sylvia Muzquiz, M.D.
Mental Health Medical Director, MHMRA of Harris County

Ted Debbs
Superintendent, Rusk State Hospital

Appendix 2: List of Continuity of Care Task Force Meetings

Task Force Meetings

February 5, 2010 - Austin, Texas
10 AM — 12:45 PM
Austin State Hospital Canteen Conference Rooms A, B, & C

February 19, 2010 - Austin, Texas
10 AM – 2 PM
Austin State Hospital Canteen Conference Rooms A, B, & C

March 26, 2010 - Austin, Texas
10 AM— 2 PM
Austin State Hospital West Auditorium

June 18, 2010 (Rescheduled from April 16, 2010) - The Woodlands, Texas
10:30 AM— NOON
Waterway 2 Ballroom
Marriott Woodlands Waterway Hotel & Convention Center

Public Forums

March 3, 2010 – La Grange, Texas
Rural Strategies for Jail and Hospital Diversion Conference
Czech Heritage Hall
1:45 PM—3PM

May 7, 2010 – Harlingen, Texas
Rio Grande State Center Auditorium
12:30 PM—2PM

May 11, 2010 – Dallas, Texas
Room 627, Dallas County Health and Human Services Building
1 PM—3 PM

May 21, 2010 – Big Spring, Texas
Big Spring State Hospital Auditorium
12:30 PM—2 PM

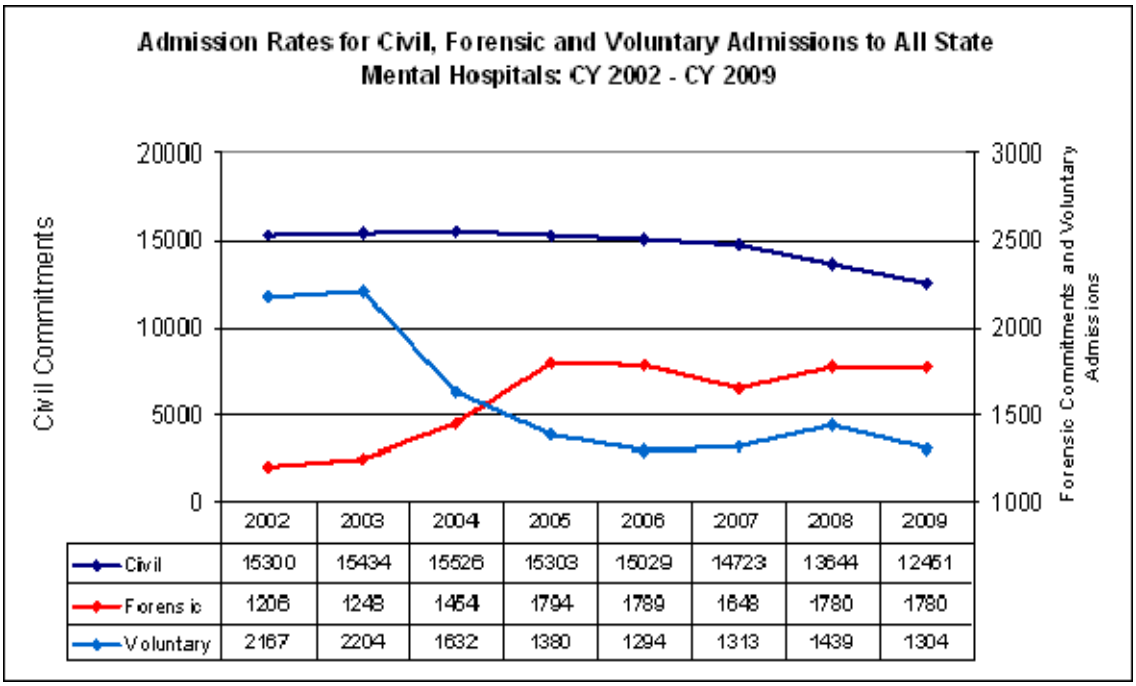
May 27, 2010 – Austin, Texas
Conference Room of Criminal Law Enforcement, Bldg E
1 PM—3 PM

Appendix 3: Individual Interviews

Susan Stone conducted individual interviews with key stakeholders:

- Beth Mitchell, Senior Managing Attorney, Advocacy Incorporated;
- Kat Lewis, Attorney and Policy Specialist, Advocacy Incorporated;
- Dee Wilson, Director, Texas Correctional Office on Offenders with Medical or Mental Impairments;
- Gyl Switzer, Policy Director, Mental Health America of Texas; and
- John Theiss, Board Member, Mental Health America of Texas.

Appendix 4: Admission Rates for Civil, Forensic, and Voluntary Admissions to All State Mental Hospitals: 2002—2009



	2002	2003	2004	2005	2006	2007	2008	2009
Civil	15300	15434	15526	15303	15029	14723	13644	12451
Forensic	1206	1248	1454	1794	1789	1648	1780	1780
Voluntary	2167	2204	1632	1380	1294	1313	1439	1304

Appendix 5: Homelessness Data

Housing Instability based on First TRAG in the Fiscal Year (FY) for each Adult Assessed (including NorthSTAR)

Housing Instability Score	FY2008	FY2009	% FY2008	% FY2009
1 - None	70,065	75,250	47.6163	47.89211
2 - Low	36,408	36,468	24.74294	23.20969
3 - Moderate	30,769	35,098	20.91067	22.33777
4 - Significant	5,507	5,809	3.742567	3.69708
5 - High	4,396	4,499	2.987529	2.863344
Total	147,145	157,124		

Housing Instability based on Last TRAG in the Fiscal Year (FY) for each Adult Assessed (including NorthSTAR)

Housing Instability Score	FY2008	FY2009	% FY2008	% FY2009
1 - None	75,797	79,224	51.3979	50.2802
2 - Low	36,463	36,462	24.72554	23.14093
3 - Moderate	27,082	32,877	18.36429	20.86567
4 - Significant	4,456	5,197	3.021611	3.298321
5 - High	3,673	3,805	2.490659	2.414876
Total	147,471	157,565		

Housing Instability Definitions

This dimension examines the person's housing situation according to whether they experience no or minimal housing instability, or whether they are marginally or literally homeless.

1 – None—Person has no housing instability as indicated by stable housing for over two years.

2 – Low—Person has minimal housing instability as indicated by safe and decent housing that is in an integrated setting, but is paying more than 30% of their monthly income towards rent.

3 – Moderate—Person experiences episodic financial difficulties in meeting other basic needs such as paying for food, medicine or health care, and has moderate housing instability as indicated by an inability to afford housing, or to find safe, decent and affordable housing.

4 – Significant—Person is marginally homeless in that they are at imminent risk of becoming homeless as indicated by being in a temporary or transitional living situation that is either basically unstable or about to be terminated, causing the person to be literally homeless.

5 – High—Person is literally homeless in that they are actually without shelter, except for emergency shelter provided by such organizations such as the Salvation Army, is most frequently found in shelters or streets, and is unable to find safe, decent and affordable housing.

Appendix 6: Demographic Data – Barriers to Discharge

Demographic Data (as of 11/30/2009) for persons residing in the State Hospitals for over 365 days

GENDER

Male	476
Female	138
Total	614

RACE/ETHNICITY

Asian or Pacific Islander	11
Black/African American	199
Hispanic	179
White	224
Other	1
Grand Total	614

PSYCHIATRIC DIAGNOSIS

Diagnosis Category	Total
Adjustment reaction	1
Alcohol induced mental disorder	5
Delusional disorder	7
Dementias	2
Disturbance of conduct	3
Depressive NOS	1
Drug dependence	1
Drug induced mental disorder	1
Episodic mood disorder	52
Mild mental retardation	1
Other nonorganic psychoses	46
Other specified mental retardation	1
Other suspected mental condition	2
Persistent mental disorder	31
Personality disorder	1
Schizophrenic disorder	441
Specific nonpsychotic mental disorder due to a brain injury	4
Transient mental disorder	14
Grand Total	614

MEDICAL DIAGNOSES

Endocrine/Metabolic	30%
Circulatory	14.3%
Supplementary Class Factors	13.4%
“Ill-Defined Conditions”	8.3%

BARRIERS TO DISCHARGE

Psychotic/Aggressive/Risk	272
Dementia/Cognitive	65
Manifestly Dangerous	54
Withdrawn/Catatonic	20
Appropriate Services Unavailable	13
Court Restriction	13
Not US Citizen/No Funding	11
Waiting List for Services	10
Noncompliant	10
Medical	9
Head Injury	9
Guardianship Issues	8
Self-Injurious	7
Not Ready for Community Placement	5
Unknown/Other	18

Appendix 7: Texas Attorney General Opinion No. GA-0753

ATTORNEY GENERAL OF TEXAS

GREG ABBOTT

December 28, 2009

Ms. Ilse Bailey
Acting Kerr County Attorney
County Courthouse, Suite BA-103
700 Main Street
Kerrville, Texas 78028

Opinion No. GA-0753

Re: Whether a peace officer who has taken a person into custody under chapter 573 of the Health and Safety Code may be required to transport that individual to a medical facility for evaluation prior to taking that person to a mental health facility (RQ-0809-GA)

Dear Ms. Bailey:

The Texas Mental Health Code, codified as subtitle C of title 7, Health and Safety Code (consisting of sections 571.001 through 578.008) pertains to the care and treatment of mentally ill individuals. *See* TEX. HEALTH & SAFETY CODE ANN. chs. 571–578 (Vernon 2003 & Supp. 2009). Chapter 573 provides for the emergency detention of a person who is believed to be mentally ill and a risk to him or herself or to others. *See id.* ch. 573. You ask whether a peace officer who takes a person into custody under chapter 573 may be required to transport that person to a medical facility for a medical evaluation prior to taking that person to a mental health facility.[1] You explain that the local "inpatient mental health facilities require that proposed patients be 'medically cleared' before they will accept the person for mental health treatment." Request Letter at 1.

A peace officer may take custody of and transport a person under chapter 573 in two circumstances. First, chapter 573, subchapter A, authorizes a peace officer to take a person into custody, without a warrant, in narrow, specified circumstances. *See* TEX. HEALTH & SAFETY CODE ANN. § 573.001(a) (Vernon 2003). The peace officer taking a person into custody under section 573.001 is required to "immediately transport the apprehended person to: (1) the nearest appropriate

[1]Request Letter at 1 (*available at* http://www.texasattorneygeneral.gov) (original request from Honorable M. Rex Emerson, former Kerr County Attorney).

inpatient mental health facility;[2] or (2) a mental health facility[3] deemed suitable by the local mental health authority, if an appropriate inpatient mental health facility is not available." *Id.* § 573.001(d) (footnotes added). The peace officer is then required to "immediately file an application for detention after transporting a person to a facility." *Id.* § 573.002(a).

Second, chapter 573, subchapter B, authorizes any adult to file a written application for the emergency detention of another person. *See id.* § 573.011(a). Upon certain findings by the judge or magistrate regarding a person's mental illness and risk of harm, the "magistrate shall issue to an on-duty peace officer a warrant for the person's immediate apprehension." *Id.* § 573.012(d) (Vernon Supp. 2009). The "person apprehended . . . shall be transported for a preliminary examination in accordance with Section 573.021 to: (1) the nearest appropriate inpatient mental health facility; or (2) a mental health facility deemed suitable by the local mental health authority, if an appropriate inpatient mental health facility is not available." *Id.* § 573.012(e).

As we consider your question, we examine chapter 573 mindful that in construing statutes courts seek first to determine the Legislature's intent. *See Leland v. Brandel*, 257 S.W.3d 204, 206

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[2]"Inpatient mental health facility" means a mental health facility that can provide 24-hour residential and psychiatric services and that is:

> (A) a facility operated by the department [Texas Department of Mental Health and Mental Retardation];
>
> (B) a private mental hospital licensed by the Texas Department of Health;
>
> (C) a community center, facility operated by or under contract with a community center or other entity the department [Texas Department of Mental Health and Mental Retardation] designates to provide mental health services;
>
> (D) a local mental health authority or a facility operated by or under contract with a local mental health authority;
>
> (E) an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of Health; or
>
> (F) a hospital operated by a federal agency.

TEX. HEALTH & SAFETY CODE ANN. § 571.003(9) (Vernon Supp. 2009).

[3]"Mental health facility" means:

> (A) an inpatient or outpatient mental health facility operated by the department, a federal agency, a political subdivision, or any person;
>
> (B) a community center or a facility operated by a community center; or
>
> (C) that identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided.

Id. § 571.003(12).

(Tex. 2008). Courts look to the statute's plain language under the assumption that the Legislature meant what it said and that its words are the surest guide to its intent. *See Fitzgerald v. Advanced Spine Fixation Sys., Inc.*, 996 S.W.2d 864, 865–66 (Tex. 1999). Where language of a statute is unambiguous and its meaning clear, courts give effect to the statute according to its terms. *See id.*

The plain language of subsections 573.001(d) and 573.012(e) directs a peace officer to transport a person in custody under chapter 573 to only two types of facilities: (1) an "inpatient mental health facility;"[4] or (2) a "mental health facility." TEX. HEALTH & SAFETY CODE ANN. § 573.001(d) (Vernon 2003), 573.012(e) (Vernon Supp. 2009). The two subsections contain no grant of authority to an inpatient mental health facility or mental health facility. *See id.* §§ 573.001(d) (Vernon 2003), 573.012(e) (Vernon Supp. 2009). Specifically, neither subsection 573.001(d) nor subsection 573.012(e) authorize such facilities to direct a peace officer in any manner, much less to require a peace officer to transport a person in custody under chapter 573 to a facility other than one authorized under chapter 573. *See id.* §§ 573.001(d) (Vernon 2003), 573.012(e) (Vernon Supp. 2009); *see also generally* TEX. CODE CRIM. PROC. ANN art. 2.13 (Vernon 2005) (setting out duties and powers of peace officers but containing no provision authorizing mental health facilities to direct a peace officer). Moreover, chapter 573 contains no grant of authority allowing an inpatient mental health facility or mental health facility to reject a person transported by a peace officer under chapter 573 for lack of a medical evaluation and clearance. *See* TEX. HEALTH & SAFETY CODE ANN. ch. 573 (Vernon 2003 & Supp. 2009). Because we must give effect to the statute's plain language and because the statute contains no grant of authority to such facilities, we conclude that an inpatient mental health facility or a mental health facility is not statutorily authorized to require a peace officer to transport a person in custody under chapter 573 to a medical facility for a medical evaluation prior to taking that person to the mental facility.[5]

We received several briefs informing us of the potential economic, health, and policy implications of our opinion.[6] We recognize that the transportation of involuntary patients by law enforcement implicates a number of complex issues. While our opinion addresses the narrow legal issue before us, the broader economic, health, and policy matters are appropriately addressed by the Legislature.

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[4]We recognize that the term "inpatient mental health facility" is modified by the words "nearest" and "appropriate." *Id.* §§ 573.001(d)(1) (Vernon 2003), 573.012(e)(1) (Vernon Supp. 2009). Similarly, the term "mental health facility" is limited to one that is "deemed suitable by the local mental health authority." *Id.* §§ 573.001(d)(2) (Vernon 2003), 573.012(e)(2) (Vernon Supp. 2009). Whether a particular "inpatient mental health facility" is nearest or appropriate, and whether a "mental health facility" is deemed suitable by the local mental health authority are questions that involve factual considerations and are thus outside the purview of an attorney general opinion. *See, e.g.*, Tex. Att'y Gen. Op. No. GA-0726 (2009) at 3 ("We cannot find and resolve questions of fact in an attorney general opinion."). These fact questions, however, do not serve to expand the scope of subsections 573.001(d) and 573.012(e) such that the subsections include a facility that is neither an inpatient mental health facility or a mental health facility.

[5]Whether certain situations may trigger powers and duties of a peace officer outside of chapter 573 that would authorize or require the officer to take a person in custody to a medical facility is beyond the purview of your inquiry.

[6]*See* Brief from Kathryn Lewis, Advocacy Incorporated (Aug. 3, 2009); Brief from Sheree Hess, Hill Country Crisis Stabilization Unit (Aug. 7, 2009); Brief from Susan Stefan, Center for Public Representation (Aug. 3, 2009); Brief from Carvan E. Adkins, Texas Council of Community MHMR Centers, Inc. (Aug. 10, 2009) (all on file with Opinion Committee).

S U M M A R Y

An inpatient mental health facility or a mental health facility is not statutorily authorized to require a peace officer to transport a person in custody under chapter 573, Health and Safety Code, to a medical facility for a medical evaluation prior to taking that person to the mental facility.

Very truly yours,

GREG ABBOTT
Attorney General of Texas

ANDREW WEBER
First Assistant Attorney General

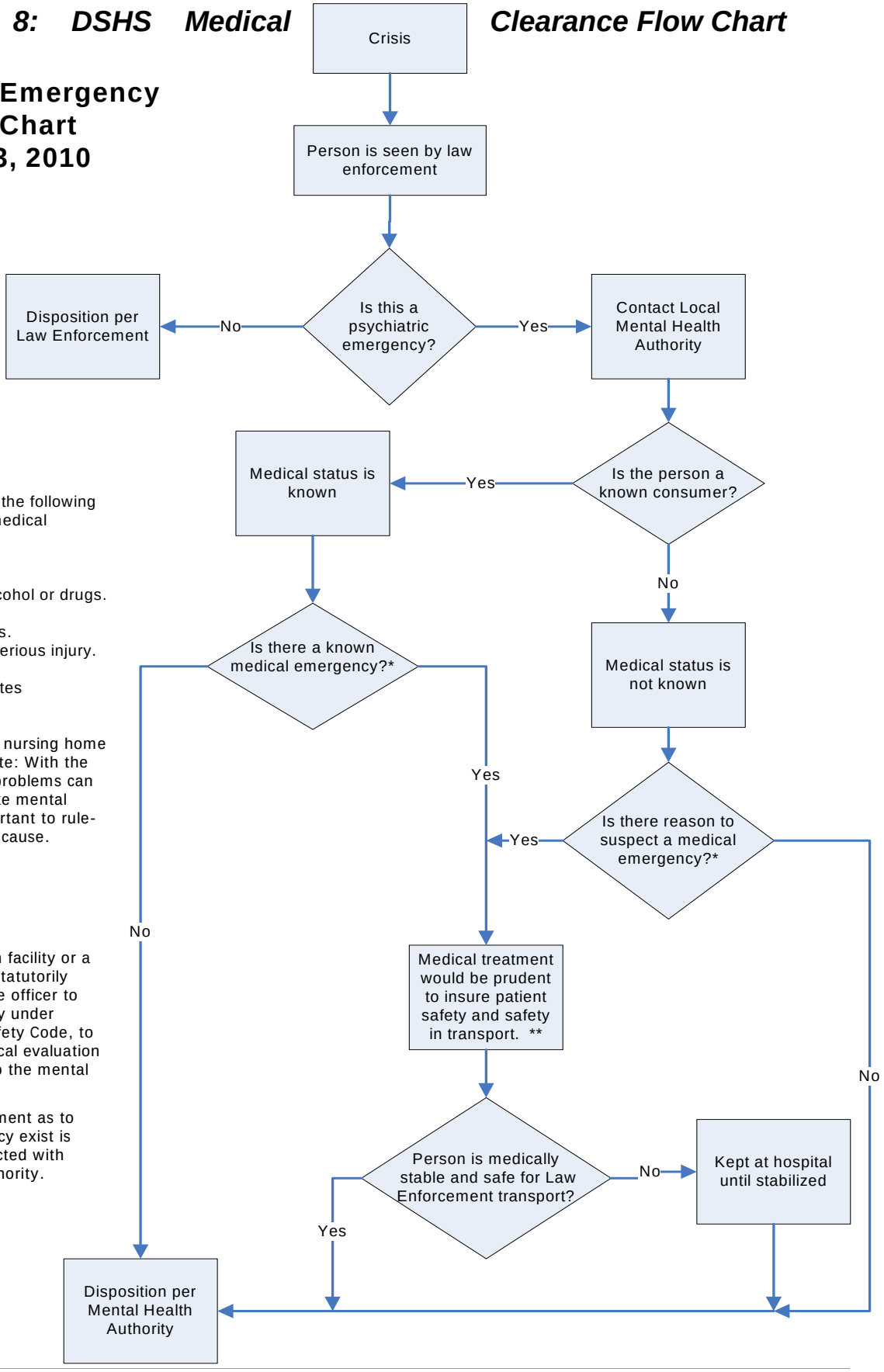
JONATHAN K. FRELS
Deputy Attorney General for Legal Counsel

NANCY S. FULLER
Chair, Opinion Committee

Charlotte M. Harper
Assistant Attorney General, Opinion Committee

Appendix 8: DSHS Medical Clearance Flow Chart

Psychiatric Emergency Flow Chart
April 23, 2010



*The Peace Officer may use the following indicators to determine if a medical emergency exist:

1. Overdose
2. Acute intoxication with alcohol or drugs.
3. Chest pain
4. Fluctuating consciousness.
5. Stab wound, bleeding or serious injury.
6. Seizure activity.
7. Complications from diabetes
8. Injured in assault or fight
9. Victim of a sexual assault
10. Person is a resident of a nursing home or assisted living facility. Note: With the elderly, sometimes medical problems can cause symptoms that look like mental illness but are not. It's important to rule-out medical problems as the cause.

**An inpatient mental health facility or a mental health facility is not statutorily authorized to require a peace officer to transport a person in custody under chapter 573, Health and Safety Code, to a medical facility for a medical evaluation prior to taking that person to the mental health facility.

The opinion of Law Enforcement as to whether a medical emergency exist is final in the screening conducted with the Local Mental Health Authority.

Appendix 9: Outpatient Competency Restoration

During the 80th regular legislative session, the legislature enacted Senate Bill 867. This bill allows courts to commit individuals found incompetent to stand trial and not deemed a danger to self or others to local mental health authorities (LMHAs) to receive outpatient competency restoration services. Four LMHAs began pilots in March 2008, funded by the Texas Department State Health Services.

Outpatient Competency Restoration Information Reported as of March, 2010 N = 310				
Gender				
Male	Female			
73%	27%			
Ethnicity				
Asian	Black	Other	Hispanic	Anglo
3%	46%	2%	20%	29%
Age				
0-21	22-30	31-40	41-64	Over 65
7%	27%	19%	43%	4%
Substance Abuse Diagnosis				
Yes	No			
38%	62%			
Axis I Diagnosis				
Schizophrenia	Major Depression	Bipolar		
48%	4%	18%		
Felony Offense				
Yes	No			
41%	59%			
Homeless prior to OCR admission				
Yes	No			
24%	76%			
Case Status				
Open	Closed			
81%	19%			
Outcome for closed cases				
Absconded	Dismissed	Extended Commitment	Not Restored	Restored
3%	27%	5%	25%	40%

Appendix 10: Harris County Data

Rusk State Hospital Diversion Program Outcomes March 1, 2009 - January 31, 2010

Month	Number of Referrals	State Hospital Transfers		Previous History with MHMRA CARE	Active with MHMRA at Referral	Court		Diverted from State Hospital	Pending Adjudication
		Rusk	Other			Misdm.	Felony		
Mar-09	150	11	3	109	44	44	106	136	5
Apr-09	123	9	5	82	31	29	94	109	10
May-09	121	11	7	87	32	36	85	103	4
Jun-09	152	12	8	98	17	51	101	132	9
Jul-09	164	15	6	110	17	50	114	143	16
Aug-09	128	7	3	76	5	31	97	118	14
Sep-09	118	6	1	67	3	33	85	111	21
Oct-09	125	13	2	88	6	26	99	110	26
Nov-09	129	4	2	55	6	37	92	123	37
Dec-09	95	1	0	52	4	37	58	94	45
Jan-10	103	0	0	56	2	22	81	103	85
Feb-10									
Total	1408	89	37	880	167	396	1012	1282	272
PCT.		6%	3%	63%	12%	28%	72%	91%	19%

Appendix 11: Patients Admitted on Forensic Commitments by Offense

Patients Admitted on Forensic Commitments by Offense Category and by Misdemeanor/Felony for FY 2009

Criminal Offense Category	Unknown	Felony	Misdemeanor	Total
No offense code entered	39	23	6	68
Arson	3	62		65
Assault	7	1012	60	1079
Bribery			2	2
Burglary	3	169	196	368
Dangerous Drugs	1	143	9	153
Escape		9	7	16
Forgery		11		11
Fraud	1	11	2	14
Homicide	6	131		137
Kidnapping		16		16
Larceny	1	47	13	61
Obstructing Judiciary/Legislative	2	18	13	33
Obstructing the Police		20	30	50
Public Order	2	37	37	76
Robbery	1	117		118
Sex Offenses	2	89	11	102
Sex Offenses - Commercialized		20	4	24
Sexual Assault	2	79		81
Stolen Vehicle		21	3	24
Traffic Offenses		15	9	24
Weapons Offense		17	4	21
Total	70	2067	406	2543