CPPP CENTER for PUBLIC POLICY PRIORITIES
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From Recidivism to Recovery

The Case for Peer Support in Texas Correctional Facilities

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Transforming the relationship between criminal justice and mental health in Texas requires innovative policy and program models that successfully integrate the principles of mental health recovery into the criminal justice system – countering the traditionally punitive criminal justice framework with the recovery-oriented principles of hope, wellness, personal responsibility, and empowered self-direction.

KEY CONCEPTS

- Mental health peer support is a cost-effective, evidence-based practice that improves clinical and social outcomes for individuals with mental illness.
- A substantial share of Texas inmates has mental health needs.
- Peer support re-entry programs can support recovery, improve continuity of care, and reduce recidivism for inmates with mental illness.
- By reducing recidivism, peer support re-entry programs can produce meaningful cost savings for the state and local governments.
- A successful model exists to inform a Texas pilot project.

In this paper, we explore the use of **mental health peer support services** as one way to support recovery, improve continuity of care, and reduce recidivism for inmates with mental illness during the re-entry process. We present a **successful peer support re-entry program model,** established in Pennsylvania, and offer preliminary suggestions for a **Texas pilot project**. We also offer policy recommendations that, if implemented, would broadly improve access to mental health services, ease re-entry transitions for inmates with mental illness, and enhance the viability of peer support re-entry programming. We intend for our recommendations to be a first step toward more extensive stakeholder discussion and research on this issue. It is our hope that this paper will catalyze conversation about the steps Texas must take to integrate recovery into its justice system and provide national policy leadership in a growing field at the pivotal intersection between mental health and criminal justice.

PEER SUPPORT WORKS

Mental health peer support is a recovery-oriented,[1] evidence-based practice in which a "peer," who has a lived experience of mental illness and has gone through a recovery process, provides mentorship and support to another individual with mental illness currently in the process of recovery.[2] Peer support encompasses a broad spectrum of peer-provided services,

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ranging from assisting with community connections and integration to more informal individual or group support sessions. All peer support, however, is founded upon the principles of mutual support, respect, empathy, empowerment, personal responsibility, and the sharing of personal stories.[3] Peers who provide these services may be referred to as peer support specialists or peer providers.

A growing body of evidence indicates that peer support improves quality of life and supports recovery for individuals with mental illness. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) funded a 10-year study from 1998 to 2008 examining the effects of providing peer support services as a supplement to traditional mental health services for individuals with serious mental illness. The study demonstrated that individuals who receive peer support services experience significant **increases in well-being and personal empowerment**, as well as moderate **clinical reductions in symptoms and hospitalizations**, as compared to their counterparts receiving only traditional mental health services.[4] Additionally, a 2012 *World Psychiatry* article cites research showing that peer support specialists can function in conventional mental health service roles at levels of efficacy similar to non-peer mental health service staff.[5]

> Recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."
>
> *U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Working definition of recovery, 2011.*
>
> For justice-involved individuals with mental illness, especially, "it is important to support re-authoring a personal narrative, moving from 'offender' to community citizen as well as from 'patienthood' to personhood. Two critical factors that amplify the need for recovery-oriented care for people involved in the justice system include the level of social exclusion and trauma that a person experiences leading up to and as a result of convictions or incarcerations."
>
> *SAMHSA, Recovery to Practice, "Frequently Asked Questions," 2011.*

Additionally, peer support specialists make contributions to recovery above and beyond what is provided by traditional mental health staff. Three of these unique contributions are: role modeling, street smarts, and empathy.[6] In sharing their personal stories, peer support specialists become *role models* for self-care and instill hope in the consumer that he or she can become the "hero of one's own life journey."[7] Peers also help the consumer use experiential knowledge (i.e. *street smarts*) to navigate day-to-day activities, such as finding housing or accessing health and human services. These functions, importantly, occur within a relationship founded upon *empathy*, trust, and the mutual understanding that comes with shared lived experience. This evidence suggests that **peer support services are not merely a supplement** to traditional mental health services but are actually **complementary to the comprehensive array of services necessary to fully support recovery for individuals with mental illness.**

State and local governments and mental health service provider organizations are increasingly recognizing peer support as a critical component of an integrated mental health service model. At least 36 states nationwide have developed formal peer support training and certification programs, and at least 22 have received approval, or are in the process of acquiring approval, to obtain Medicaid reimbursement for peer-provided services.[8] Peer training and certification programs provide valuable structure and professionalism to peer workforce development efforts by equipping peers with tools and resources to optimize their efficacy as peer providers. The most **vital qualification** that a mental health peer possesses, however, is a **shared lived experience of mental illness and recovery**, which acts as the foundation for effective relationship building, mutual support, and role modeling.

Benefits of Peer Support

Research has shown that recipients of peer support experience reductions in:

- Symptoms
- Hospitalizations
- Use of crisis services
- Substance abuse
- Level of worry
- Life problems

And increases in:

- Quality of life
- Coping ability
- Medication adherence
- Social network and support
- Daily functioning
- Illness management
- Self-esteem
- Rate of employment
- Earnings

Source: Solomon, "Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients," Psychiatric Rehabilitation Journal, 2004.

Peer Support in Texas

While peer support has existed informally in the mental health service community for years, in 2009 Texas established a formal peer support training and certification program, made possible in large part by a 2005 Mental Health Transformation Grant from SAMHSA.[9] The goal of the grant was to foster a mental health services infrastructure that was more "consumer-driven, recovery-oriented and supported through evidence-based and best practices."[10] The Texas Department of State Health Services (DSHS) distributed the grant funding and, with additional financial support from the Hogg Foundation for Mental Health, created the nonprofit ViaHope, which operates Texas' formal Certified Peer Specialist (CPS) training and certification program.[11]

Texas has taken important steps to integrate peer support into its broader array of public mental health services. **Peer support specialists are allowable providers of Medicaid-reimbursable mental health rehabilitative services in Texas.**[12] Provider organizations' ability to secure financial reimbursement for peer-provided services has **enhanced the financial viability of community-based peer support programs** and is further recognition of peer support's clinical efficacy. Currently, all Texas Community Mental Health Centers (CMHCs, also sometimes referred to as Mental Health and Mental Retardation Authorities or Local Mental Health Authorities)[13] employ or are in the process of employing peer support specialists.[14] A 2011 survey of CMHCs found that the most cited benefits of peer support include peers' ability

to form connections with consumers who have similar life experience, promote the recovery model, provide insight on mental health issues to consumers and staff, instill a sense of hope in consumers, and engage consumers.[15] Some Texas state hospitals, such as the Austin and Kerrville State Hospitals, have also begun to offer peer support services in their facilities.[16] Kerrville State Hospital is a forensic facility (i.e. houses individuals not competent to stand trial and Not Guilty by Reason of Insanity) and currently uses peers to assist patients in transitioning from the hospital to the community.[17] Hospitals and CMHCs have both successfully utilized peer support services in their facilities, and there is **growing interest in bringing the benefits of peer support into the criminal justice system** for justice-involved individuals with mental illness.

Texas Inmates with Mental Health Needs

It is often said that Texas correctional facilities have become today's "de facto treatment centers" for individuals with mental illness. While precisely assessing the prevalence of mental illness in our correctional facilities is challenging, all available estimates indicate that the number and percentage of individuals with mental health needs in correctional facilities is high. The most recent **federal surveys**, conducted in 2004 and 2002, **estimated that 49 percent of state prison inmates and 60 percent of local jail inmates**, on average nationwide, **display current symptoms of mental illness**.[18] In Texas, an estimated **35 percent of inmates in state correctional facilities** (operated by the Texas Department of Criminal Justice, TDCJ) have a history of mental illness, illustrated by the number of inmates who have previously received public mental health services (Table 1).[19] **In local Texas county jails**, up to **40 percent of bookings in 2013 (up to approximately 400,000)** were for individuals who had previously received public mental health services.[20]

Table 1. Over One-Third of State Inmates Have a Public Mental Health Service Match (2014)

Correctional Institution Population (TDCJ)	153,453
# of Matches[a]	54,436
% of Population	35%
# in Target Population[b]	18,647
% of Population	12%

[a] Represents all TDCJ Correctional Institution Division inmates served in the public mental health system since 1985.

[b] Represents all TDCJ Correctional Institution Division inmates with a diagnosis of schizophrenia, bipolar disorder, or major depression.

Source: Texas Correctional Office on Offenders with Medical or Mental Impairments, TCOOMMI Services Template, Fiscal Year 2013.

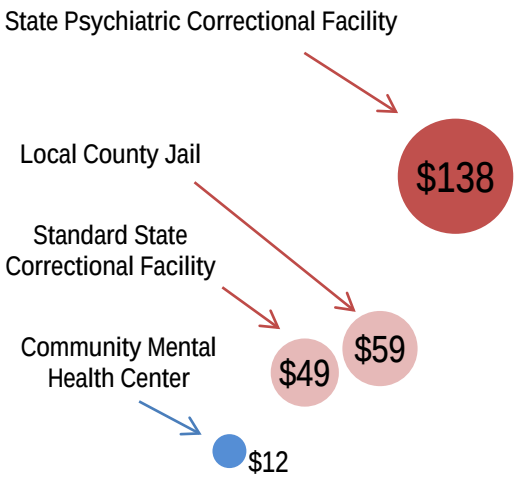
Moreover, due to underreporting and the limited scope of the Texas public mental health system, these data likely *underestimate* the prevalence of mental illness in Texas correctional facilities. In 2012, CMHCs only served one-third of Texas adults estimated to have a service-eligible diagnosis (i.e. schizophrenia, bipolar disorder, or major depression), suggesting that many individuals with mental illness receive treatment elsewhere or go untreated and that the prevalence of mental illness amongst Texas inmates may be significantly higher than estimates

derived from public mental health service match data.[21] Texas correctional facilities have become home to an alarmingly **disproportionate number of individuals with mental health needs**, some of whom have received prior treatment but many of whom have likely gone unidentified and untreated in the community.

At What Cost?

Incarcerating rather than treating individuals with mental illness comes at a high fiscal and human cost. The average cost per inmate in a **standard state correctional facility is between $42 and $49 per day**.[22] This includes the cost of delivering medical and mental health services to inmates residing in those facilities and therefore doesn't distinguish between the cost of incarceration for inmates with and without mental illness. As one point of comparison, however, the average cost per inmate per day in a **state *psychiatric* correctional facility is $138**, illustrating the high end of the cost continuum for incarcerating high-need inmates with mental illness. The Texas Commission on Jail Standards estimates the average cost per **local jail inmate to be approximately $59 per day**, but no aggregate data exist on the cost of jailing individuals with mental illness at the local level, specifically.[23] Correctional mental health services primarily consist of psychotropic medication and the correctional setting lacks the therapeutic environment necessary to promote long-term recovery.

Figure 1. The High Cost of Incarceration: Daily Cost Per Person by Facility



Sources: Legislative Budget Board, 2013; Texas Commission on Jail Standards, 2014; Texas Department of State Health Services, 2012.

The high cost of incarceration becomes even more apparent when compared to the relatively low cost of providing community-based mental health services. In 2012, it cost only **$12 per day to provide an individual with community mental health services**.[24] By any point of comparison, providing treatment in the community is significantly more cost-effective than incarceration, whether in a standard prison facility, a psychiatric prison facility, or a local jail (Figure 1). Outpatient care in a CMHC offers robust, comprehensive, and continuous care, such as rehabilitative services, counseling, and other services that embrace and promote recovery.

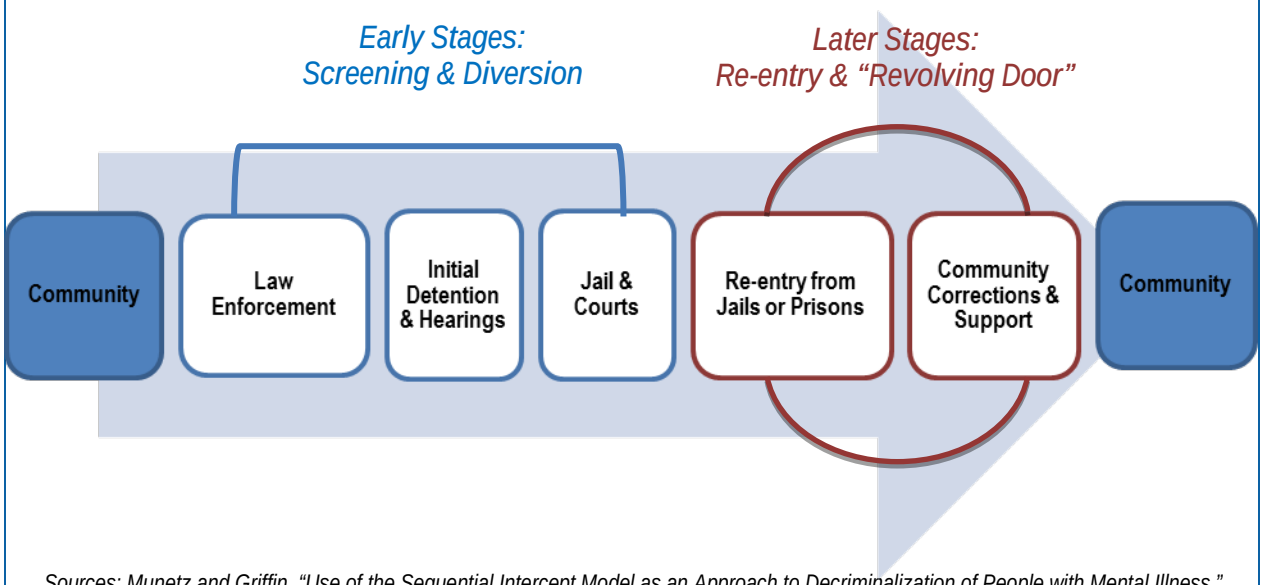
In addition to the fiscal cost incurred by state and local governments, there is tremendous human cost associated with criminalizing mental illness. Advocates across the country, and in Texas, continue to collect stories of individual and family suffering resulting from individuals with

mental illness being funneled into correctional facilities poorly equipped to meet their mental health needs. Stories abound of individuals' functioning and mental health deteriorating while incarcerated due to lack of continuity in care or being held in solitary confinement for protracted lengths of time without proper care or supervision.[25] Recently, for example, a local New York jail made national headlines, and garnered substantial criticism, when an inmate with mental illness died from heat exposure while being held in solitary confinement.[26]

Peer support re-entry programming can play an important role in reducing human suffering and containing costs by ensuring that inmates successfully transition from correctional facilities into more cost-effective and clinically appropriate community-based services post-release – keeping individuals in their homes and communities and out of the jails and prisons.

Community Re-entry and the Revolving Door

Figure 2. Strategic Points of Intervention: Re-entry is Key to Addressing Recidivism



Sources: Munetz and Griffin, "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Mental Illness," Psychiatric Services, 2006; SAMHSA, GAINS Center for Behavioral Health and Justice Transformation, "Developing a Comprehensive Plan for Mental Health & Criminal Justice Collaboration: The Sequential Intercept Model."

Individuals with mental illness would ideally be diverted away from incarceration at early stages in the justice process, such as at the initial point of contact with law enforcement or during initial detention and court hearings.[27] However, due to a lack of coordination between the mental health and criminal justice systems in many communities, a significant number of individuals have already moved past early points of intervention and entered the correctional facilities – as evidenced by the high prevalence of mental illness in correctional populations discussed previously (Table 1). While **jail diversion initiatives** redirect individuals with mental illness away from jails as soon as possible, or at least significantly reduce time spent in a correctional facility, **re-entry initiatives** enable the successful "transition of offenders from prisons or jails

back into the community" (Figure 2 depicts the sequential continuum of strategic intervention points).[28] Effective re-entry combats the "revolving door" effect wherein inmates cycle continuously between the community and correctional facilities.

Closing this "revolving door" for inmates with mental illness is an important challenge for Texas. **Texas inmates with mental illness are more likely to recidivate** (i.e. experience repeat interactions with the criminal justice system, such as rearrest or reincarceration) than inmates without. One study conducted in Texas state prisons between 2006 and 2007 found that the **odds of previous incarceration** for an inmate with mental illness **are 1.7 times greater** than for an inmate without, and that more than half of prison inmates with a major psychiatric disorder have been incarcerated more than once.[29] On the most extreme end of the continuum, for an inmate with bipolar disorder, the **odds of having had four or more incarcerations are 3.3 times greater** than for an inmate with no major psychiatric disorder. At the local jail level, a 2002 federal survey found that **over 75 percent of local jail inmates with mental illness** have been previously incarcerated, or sentenced to probation, at least once while **nearly one in five** have been previously incarcerated, or sentenced to probation, six or more times.[30] Importantly, only **32 percent of local jail inmates with mental illness can be classified as "violent recidivist"** (i.e. having multiple convictions wherein at least one has been for a violent offense, whether current or previous). Nearly three quarters of local jail inmates with mental illness are incarcerated for non-violent crimes such as property, drug,

Justice Jargon

Local Jail
A locally operated correctional facility that primarily houses inmates awaiting trial or serving out short-term sentences for misdemeanor convictions (with some exceptions). Texas is home to 245 local county jails.

State Prison
A state-operated correctional facility that primarily houses inmates serving longer-term sentences for more serious felony convictions. In Texas, TDCJ operates 50 state prisons, 15 state jails (a minimum security state facility), and a number of specialized state correctional facilities such as Substance Abuse Felony Punishment Facilities.

Probation (i.e. Community Supervision)
The placement of an individual who has been convicted of a crime into structured community supervision as an alternative to incarceration. In Texas, probation is called "community supervision" and is the responsibility of local Community Supervision and Corrections Departments (CSCDs). Typically, inmates are released on probation from local jails following a pre-trial waiting period (if convicted during trial), or as part of a split sentence.

Split Sentence
A combination sentence that includes a period of incarceration followed immediately by a term under probation.

Parole
The conditional release of an inmate from prison allowing the inmate to serve the remaining portion of his or her sentence in the community under some form of supervision (distinct from probation).

Sources: Bureau of Justice Statistics, "Terms and Definitions: Corrections" accessed 16 June 2014 at http://www.bjs.gov/index.cfm?ty=tdtp&tid=1; Texas Commission on Jail Standards, "Abbreviated Population Report for 1/1/2014," 17 January 2014; Texas Department of Criminal Justice, "Unit Directory," accessed 23 May 2014 at http://tdcj.state.tx.us/unit_directory/; Texas Department of Criminal Justice, "Community Justice Assistance Division," accessed 23 May 2014 at http://www.tdcj.state.tx.us/divisions/cjad/index.html.

or public order violations.[31] Recognizing that the majority of local jail inmates with mental illness **do not pose a violent threat to community safety** can help us better tailor policy solutions to transition these inmates into more clinically appropriate and cost-effective community-based treatment.

The high risk of recidivism for inmates with mental illness points to the difficulties associated with transitioning from a correctional facility back into the community. Barriers to successful community re-entry can include a lack of continuity in mental or physical care as well as difficulty establishing access to basic services such as housing or transportation. A study conducted in Texas and Ohio found that state prison inmates with mental illness experience a **decline in mental health treatment and use of prescription medication** following release. It also found that **60 percent of former prison inmates with mental illness are uninsured** at eight to ten months post-release, and that **more than one-third utilize emergency room** services at some point during the post-release period (see pull-out box below).[32] The study suggests that, while former inmates with mental illness may be able to obtain "episodic, acute care for physical or mental problems," they are often unable to maintain continuous and regular treatment for their mental health conditions.[33] Maintaining consistency in medical and mental health treatment and access to medication is critical to supporting an individual's progress toward recovery. Interruptions in continuity of care are a major barrier to effective re-entry for inmates with mental illness and are often compounded by a lack of access to housing, employment, and other critical support systems.

With thousands of inmates with mental illness cycling through Texas correctional facilities every year, this lack of continuity in care and the associated "revolving door" of recidivism pose a real and significant challenge to reducing the population of inmates with mental illness in our state and local correctional institutions.

Barriers to Successful Community Re-entry

Between 2004 and 2005, the Urban Institute conducted a study on health and re-entry in Texas and Ohio state prisons. The study showed that, in the period following release from prison, former inmates with mental illness experience:

- Decline in **mental health treatment**
- Decline in **prescription medication use**
- High **uninsured rate**

Compared to former inmates *without* mental illness, those with mental illness also experience:

- Higher rate of **emergency room use**
- Higher rate of **homelessness**
- Higher rate of **unemployment** and
- Less financial and **emotional support** from family members

Source: Mallik-Kane and Visher, Health and Prisoner Re-entry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration, Urban Institute Justice Policy Center, 2008.

Forensic Peer Support: A Growing Field

State and local governments, and community organizations, are beginning to integrate peer support services into the criminal justice system as a way to address the unique challenges faced by inmates with mental illness. Peer support provided *to* and *by* justice-involved individuals with mental illness is called **forensic peer support** and is a young, but growing, field. Forensic peer specialists are individuals who share a lived experience of mental illness with the consumer as well as, ideally, a history of involvement in the criminal justice system, such as a past experience of incarceration.[34] Doctors Larry Davidson and Michael Rowe, faculty members at the Yale University School of Medicine's Program for Recovery and Community Health, report that "in the limited number of settings in which they have been supported, **case studies clearly suggest using Forensic Peer Specialists is a promising cost-effective practice.**"[35] Richard Baron, of the Center for Behavioral Health Services and Criminal Justice Research at Rutgers University, identifies Forensic Peer Specialists as an emerging workforce uniquely positioned to offer a range of supportive services to individuals with criminal justice involvement. Forensic Peer Specialists are able to provide the "**day-to-day supports persons with mental illness, who have been released from prison, need to live successfully in the community.**"[36]

> "Forensic Peer Specialists effectively embody the potential for recovery for people who confront the dual stigmas associated with serious mental illness and criminal justice system involvement. Forensic peer specialists are able to provide critical aid to persons in the early stages of re-entry, in much the same way that peer specialists who support peers with mental illness alone (i.e., without criminal justice system involvement), have been able to engage into treatment persons with serious mental illnesses."
>
> Larry Davidson, Ph.D. & Michael Rowe, Ph.D.
> *Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists*
> CMHS National GAINS Center, 2008

Peer Support Throughout the Criminal Justice System

A multi-state survey conducted by CPPP staff found that state and local governments and community organizations are using forensic peer support in a variety of criminal justice settings:

- Specialty courts
- Jail diversion programs
- Jail-based competency restoration units
- State prisons and local jails
- Forensic units in state hospitals
- Jail "in-reach" re-entry programs
- Community-based re-entry services

For more information on the CPPP forensic peer support survey, see Appendix A.

In light of this unique potential, organizations and agencies across the United States are pioneering **forensic peer support programs *in correctional facilities*** as an innovative tool to support recovery for current inmates with mental illness as well as to enhance continuity of care and reduce recidivism post-release. CPPP staff, during the course of a multi-state forensic peer

support survey, identified only a handful of states currently home to a peer support program operating in a correctional facility (see Appendix A for a more detailed discussion of the survey and its results). However, program contacts in 12 states with no current programming indicated that their state is *actively considering* expanding peer support services into state or local correctional facilities. In this paper, we explore a promising **peer support *re-entry* program** established at the local county level in Pennsylvania that may provide a model for similar programming in Texas. **Texas has a significant opportunity not only to improve continuity of care and reduce recidivism for Texas inmates with mental illness but to provide national leadership and policy innovation in the growing field of forensic peer support.**

Driving Innovation: Peer Support Re-entry Programming with Peerstar, LLC

One of the leading forensic peer support programs identified during the survey process was a **peer support *re-entry* program** established by a private provider organization called Peerstar, LLC.[37] Operating primarily at the local county level in Pennsylvania, the program boasts a growing body of evidence showcasing positive participant outcomes, a robust partnership with the Yale School of Medicine, and an expanding number of counties served since its inception in 2010. We propose that Peerstar's successful program model can inform future forensic peer support policy and program efforts in Texas.

Peer Support and Criminal Justice in Pennsylvania

Like Texas, Pennsylvania:

- **Has a formal Certified Peer Specialist (CPS)** training and certification program.
- Established its CPS program through funding from a **Mental Health Transformation Grant** awarded in 2004.
- In 2007, received approval to include **CPS services as a Medicaid-reimbursable** component of mental health rehabilitative services.
- Has a **two-tiered correctional system**, with the centralized Pennsylvania Department of Corrections (DOC) operating facilities at the state level and autonomous counties operating jails at the local level.

Source: Pennsylvania Department of Corrections, Pennsylvania's Department of Corrections: Certified Peer Support Specialist Program.

Peerstar utilizes a **"peer in-reach" program model** wherein trained and certified Forensic Peer Specialists (FPSs) go into local correctional facilities to provide peer support to inmates with mental illness prior to their release as part of the re-entry process. FPSs act as powerful liaisons between the inmates and community-based service organizations. This re-entry program model provides inmates with mental illness an **opportunity to access the clinical and social benefits of peer support** *while incarcerated* and equips them with the **mutual support** and **practical case management assistance** necessary to effectively transition into a community-based model of care *following their release* from the correctional facility.

What is Peerstar?

Peerstar, LLC is a private peer support service provider in Pennsylvania. The company provides community-based peer support services as well as peer support re-entry services in local

Pennsylvania county jails in an effort to establish continuity of care and reduce recidivism post-release for inmates with mental illness. The company launched its peer support re-entry program in July, 2010.

Program Model

- **Peerstar Forensic Peer Specialist (FPSs)** go into local Pennsylvania county jails 30 - 90 days prior to inmates' release and provide individualized peer support services to inmates in preparation for community re-entry.
- **The FPS provides the inmate with mental and emotional support** and mentorship, as well as personalized case management assistance and release planning. In some counties, the FPS may also provide group classes to inmates in the county jail.
- **Upon the inmate's release from the jail**, the FPS meets the former inmate at the exit and they attend the first Peerstar community appointment together.
- **At the community appointment,** the FPS helps perform an eligibility assessment for medical benefits and begins connecting the consumer to community-based services.
- **Peerstar operates a peer support program in seven Pennsylvania county jails** and recently obtained a contract to provide re-entry services in a state prison facility.
- **In most participating counties, one FPS provides services in the jail once per week.** In some larger counties, the Peerstar FPS provides services in the jail five days a week, serving a caseload of approximately 20 inmates at a given time.

Client Criteria

Jail inmates participating in the re-entry program must meet a determination for serious mental illness, possess a release date that is 30 – 90 days away, and meet any additional service eligibility criteria established by the county jail.

Peer Criteria

All Peerstar forensic peers have a lived experience of mental illness, and many have a lived experience of incarceration. Peerstar recruits forensic peers both with and without a history of incarceration because some Pennsylvania county jails prohibit individuals with prior criminal convictions from providing services in the jail. Peerstar considers it a best practice, however, to employ forensic peers with a lived experience of *both* mental illness and incarceration, where possible. Peerstar maintains its own internal list of prior criminal convictions that would disallow an individual from gaining employment as a CPS with Peerstar. The

> "Peer support is about having a heart—caring a little bit. Just showing that little glimmer of hope to a person who is completely down and out can make a world of difference. When everyone is putting them down and yelling at them, whether it's to get in their cell, or telling them when to eat or when to shower, having that one person come in and say, 'It will get better.' There is nothing more gratifying than that."
>
> Thad Koelle,
> Certified Peer Specialist
> Forensic Peer Specialist, Peerstar, LLC
>
> *Source: Telephone Interview, April 2014.*

company strives to strike a careful balance between mitigating risk for the organization and its clients and providing opportunities for individuals with prior criminal convictions to share valuable life experience as forensic peers**.** Peerstar requires *all peers* to obtain Pennsylvania CPS certification and all *forensic* peers to undergo additional specialized forensic peer support training provided by Peerstar.

Spotlight on the Pennsylvania Department of Corrections (DOC)

In 2011, the Pennsylvania DOC launched a forensic peer support program in state prisons **training and certifying prison inmates to provide peer support to fellow inmates.**

The Pennsylvania DOC **now employs peer specialist inmates in 18 of its 25** correctional institutions.

For more information on this innovative program, see Appendix B.

Forensic Peer Specialist Training Curriculum

Peerstar's proprietary forensic peer support training program was developed in partnership with the Yale School of Medicine's Program for Recovery and Community Health in 2009. The Peerstar curriculum also incorporates elements of a forensic peer support training model developed by Drexel University with state grant funding in 2010.

Funding and Cost

Peerstar currently operates half of its peer support re-entry programs as free pilot programs. It funds the remainder of its county re-entry programs on a contract basis with each individual county, with costs varying by county. The company funds its community-based peer support services through Pennsylvania Medicaid. The Delaware County jail houses one of Peerstar's larger programs, serving approximately 20 inmates at any given time. The cost to the county for this program is approximately $100,000 annually. County costs include compensation for one full-time FPS to provide daily services in the jail, as well as compensation for peer supervision, peer training, and operating expenses. There is an additional annual program cost of $315,000 funded by Pennsylvania Medicaid, which covers community-based peer support services and other program operating expenses. The Medicaid-funded portion of the program supports four full-time FPSs in the community in addition to the remaining supervision, administrative, and operating expenses.

Human Stories, Human Success

Thad Koelle, an FPS with Peerstar, said that he has personally observed a reduced rate of reincarceration amongst individuals whom he has helped transition back into the community. Thad emphasized the importance of recovery for him and his clients**: "**For me, recovery is about getting my self-identity back. A lot of people lose themselves and there is nothing more degrading than being incarcerated…and for someone with mental illness, it is ten times harder for them to overcome that…I like to see people succeed. I like to walk into a place and see someone that I haven't seen in two years and have them come up to me and say, 'I'm back now. I have a job, I have a baby on the way. I am getting married.' Stuff like that. I go to bed at night and know that I made a difference in someone's life."[38]

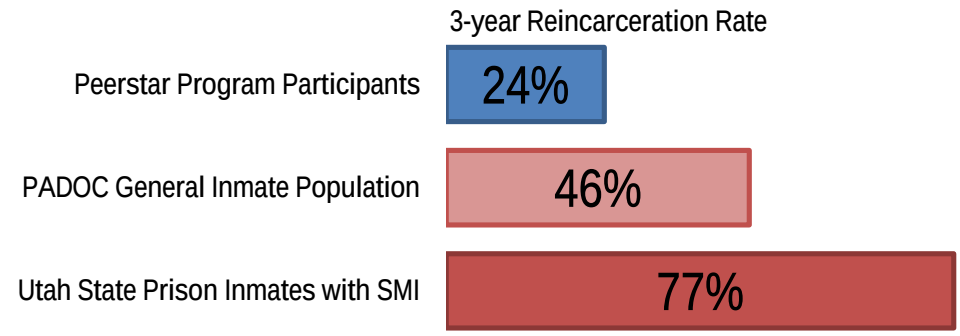
From High Risk to High Reward: Tracking Peerstar's Success

A preliminary program evaluation recently performed by the Yale School of Medicine's Program for Recovery and Community Health found a reduction in recidivism amongst former county jail inmates with serious mental illness (SMI) who participated in Peerstar's re-entry program. While data is not currently available for a formal control group, the preliminary evaluation suggests that the reincarceration rate of 24% amongst Peerstar program participants is significantly lower than estimated rates for similar populations (Figure 3).

Moreover, the **300 local jail inmates who participated** in the **2010 - 2013 program evaluation** were at high risk for recidivism:

- **Approximately 63%** were at medium-to-high risk for recidivism according to the Pennsylvania Department of Corrections Risk Screen Tool.
- **86%** had been incarcerated previously.
- **35%** had five or more prior incarcerations.
- **Nearly one third** had been hospitalized within the past year.
- **55%** had previously received mental health treatment.
- **Approximately 70%** reported using drugs in the past year.
- **41%** had previously received substance abuse services.

Figure 3. Preliminary Program Evaluation: Peerstar Reduces Reincarceration Rate



Note: SMI refers to "Serious Mental Illness," and PADOC refers to "Pennsylvania Department of Corrections."

Source: Chyrell D. Bellamy and Michael Rowe, Yale School of Medicine Program for Recovery and Community Health, Re: Peerstar LLC Forensic Peer Support Program Research, 16 December 2013.

The Texas Re-entry Landscape for Inmates with Mental Illness

An analysis of Texas' current re-entry landscape for inmates with mental illness reveals a need for additional continuity of care programming at the point of community re-entry. A re-entry peer support program, modeled after Peerstar's successful peer in-reach program, can fill gaps where services are limited or unavailable. A more detailed examination of Texas re-entry

programming and policy for special needs inmates is located in Appendix C, and we encourage readers desiring additional detail to reference that section.

Continuity of Care in Texas

In Texas, local CMHCs, local probation departments (i.e. CSCDs), and TDCJ are required to provide continuity of care programming for Texas inmates with mental health needs.[39] These agencies must **work together to maintain continuity of care** for individuals with mental illness at multiple stages throughout the criminal justice process, from arrest to re-entry. The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) is a sub-unit of TDCJ and coordinates the continuity of care programs, in partnership with CMHCs and CSCDs. TCOOMMI offers **three tiers of re-entry assistance to inmates with mental illness:** *Continuity of Care*, *Adult Transitional Case Management*, and *Adult Intensive Case Management* (Table 2).

Mental Health Screening in Local Jails

The mental health screening process in local jails is designed to identify inmates with mental health needs early on. At the point of inmate booking, local jails are required to:

- **Run a Continuity of Care Query** (CCQ) to determine if the inmate has previously received public mental health services.
- **Perform a mental health screening** using a standardized screening form containing staff observation and self-report questions.
- **Notify a magistrate within 72 hours** if the inmate is displaying signs or symptoms of mental illness.

For more detailed information, see Appendix C.

Program Eligibility and Service Limitations

Importantly, state and local agencies are only required to provide continuity of care services to individuals who are released on probation or parole.[40] Therefore, **TCOOMMI re-entry assistance is minimal or nonexistent** for inmates with mental illness who have completed a full sentence and who are **released directly into the community without supervision** (i.e. flat discharge). Local jail inmates being released on flat discharge are ineligible for TCOOMMI programming entirely.

Moreover, **local jails are not required to participate in interagency continuity of care programs** or provide re-entry assistance to inmates with mental health needs. While local jails *are* required to perform a mental health screening for each inmate at intake, they are *not* required to provide a minimum amount of medication to inmates upon release or contact the local CMHC when an inmate with a public mental health service history is released into the CMHC service area.[41] In many counties across the state, local jail inmates with mental illness are ineligible for TCOOMMI re-entry services and are reportedly released from jail at midnight, with no care referral, and without access to medication or transportation.

Table 2. TCOOMMI Re-entry Programs for Inmates with Mental Illness				
	Limited Continuity of Care[a]	Continuity of Care	Adult Transitional Case Management	Adult Intensive Case Management
Time available post-release[b]	90 days	90 days	1 year	2 years
Minimum # of face-to face contact hours with CMHC staff per month	0	1	1.5	3.5
Linking to natural and community supports	✓	✓	✓	✓
Medication assistance	-	✓	✓	✓
Assistance with benefits applications	-	✓	✓	✓
Case management	-	-	✓	✓
Nurse services	-	-	✓	✓
Psychiatrist services	-	-	✓	✓
Skills training and group services	-	-	✓	✓

[a] TCOOMMI technically only offers one Continuity of Care program. However, inmates who do not possess a target diagnosis of schizophrenia, bipolar disorder, or major depression do not qualify for service referrals to CMHCs, where the majority of Continuity of Care services are provided. To reflect this reality, we have created the "Limited Continuity of Care" designation to illustrate the level of services which individuals with non-target diagnoses are likely to receive.

[b] For all programs, extensions may be granted based on client need.

Sources: TCOOMMI, "TCOOMMI Refusal of Services, TCOOMMI Case Management and Continuity of Care Service Eligibility;" also Program Guidelines and Processes for Continuity of Care (COC), Program Guidelines and Processes for Adult Intensive Case Management, and Program Guidelines and Processes for Adult Transitional Case Management; and April Zamora, TCOOMMI, Personal and Telephone Interviews, March and May 2014.

TCOOMMI program eligibility is limited and not all former inmates with a mental health need receive services (Table 4). For example, the **TCOOMMI case management model is highly effective** at reducing recidivism for former inmates who have access to the program, but only a miniscule share of former inmates with mental health needs have access to these services. In 2012, the **three-year recidivism rate** for TCOOMMI case management participants was **13 percent** -- substantially lower than the 23 percent recidivism rate for the general Texas prison population released under supervision.[42] However, the **5,228 individuals served by TCOOMMI case management programs in 2013** constitute only **25 percent** of the current probation and parole population with a target diagnosis of schizophrenia, bipolar disorder, or major depression (Table 3). Therefore, only one in four individuals on probation or parole with a history of serious mental illness is actively receiving case management services. It is possible that some of the probationers and parolees not currently receiving services *have* received TCOOMMI case management services in their past and have successfully transitioned out of those programs. The statistic offers only a rough proxy for need versus service availability, and it appears that a significant number of former inmates with a history of mental illness, including a sizeable number with target diagnoses, are not currently receiving TCOOMMI services.

Table 3. Only a Small Share of Former Inmates Currently Receive TCOOMMI Services			
		CARE Match[a]	**Target Diagnosis[b]**
Total number in Texas parole and probation with:		59,871	20,974
TCOOMMI Re-entry Program	**Number Served in Program**	**As a % of Parole and Probation Population with CARE Match**	**As a % of Parole and Probation Population with Target Diagnosis**
Continuity of Care	8,724	15%	42%
Case Management	5,228	9%	25%
All Programs	13,952	24%	67%

[a] Represents all parole and probation clients served in the public mental health system since 1985.
[b] All parole and probation clients diagnosed with schizophrenia, bipolar disorder, or major depression.

Source: Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, TCOOMMI Services Template, Fiscal Year 2013, March 2014 CARE match and fiscal year 2013 re-entry program data.

Barriers to TCOOMMI Service Eligibility

Inmates with mental illness may be ineligible for TCOOMMI re-entry services for a variety of reasons:

- **Non-target diagnosis.** Inmates without a target diagnosis are ineligible to receive a care referral to the CMHC and are ineligible for TCOOMMI case management programs.
- **Released on flat discharge** from a local jail. No TCOOMMI services are available for this group.

For the more robust case management programs, specifically, barriers include:

- **Low-level conviction.** Inmates with a misdemeanor conviction, a population housed exclusively in local jails, are less likely to qualify for case management services.
- **Low level of criminal risk.** Only inmates with high criminal risk and high clinical need can receive case management services.
- **The local CSCD does not participate**. Only 70 out of 122 local CSCDs maintain an agreement with TCOOMMI to support TCOOMMI case management caseloads.
- **Being released on flat discharge** whether from a state or local facility. Case management is only available to inmates released on parole or probation.

For more information, please see Appendix C.

Many of the inmates falling through the various TCOOMMI program eligibility cracks are those who are released from local jails. Many local jail inmates, whether due to their manner of release (i.e. flat discharge), mental health diagnosis, type of criminal conviction, or residence in a nonparticipating county, are ineligible to receive the level of services they may require, and in some cases receive none at all. This reality is compounded by the lack of transitional support from the local jail. TCOOMMI, with its limited resources, appropriately focuses its case management programs on the highest risk and highest need individuals. The state of Texas, however, in failing to provide sufficient re-entry support to individuals in local jails, is missing an opportunity to mitigate recidivism for primarily non-violent inmates at early stages of their

involvement with the criminal justice system. A peer support re-entry program can help fill this need in a cost-effective and evidence-based manner. Ensuring adequate re-entry support for inmates with mental illness at the both the state and local level will be critical to reducing recidivism, reining in local and state correctional costs, and enhancing health and wellness for individuals with mental health needs.

Table 4

TCOOMMI Re-entry Program Eligibility for Inmates with Mental Illness

TCOOMMI Program	Local Jail Inmate					State Jail or Prison Inmate				
	Released on Flat Discharge	Released on Probation[b]				Released on Flat Discharge		Released on Probation[b] or Parole		
		Non-target	Target			Non-target	Target	Non-Target	Target	
			Low CR	High CR					Low CR	High CR
				M[c]	F					
Limited Continuity of Care[a]	-	✓	-	-	-	✓	-	✓	-	-
Continuity of Care	-	-	✓	✓	-	-	✓	-	✓	-
Transitional Case Management	-	-	-	-	AN[d]	-	-	-	-	AN[d]
Adult Intensive Case Management	-	-		-	✓	-	-	-	-	✓

Key: Target = Schizophrenia, Biolar Disorder, or Major Depression Non-target = Other mental health diagnosis

Low CR = Low Criminogenic Risk; at low risk for recurring criminal behavior. M = Misdemeanor conviction
High CR = High Criminogenic Risk; at high risk for recurring criminal behavior. F = Felony conviction

✓= Likely program placement AN = As needed program placement

[a]TCOOMMI only offers one COC program. We have created the "Limited Continuity of Care" designation to illustrate the reduced level of services that individuals with a non-target diagnosis are likely to receive.

[b] All probation departments must participate in Continuity of Care programming, but not all participate in TCOOMMI case management programming. Therefore, not all probation populations in Texas will have access to case management services.

[c] Case management caseloads must consist 80% of felony offenders. Therefore, while some inmates with misdemeanor convictions may be placed into a case management program, they are more likely to be placed into Continuity of Care.

[d] Transitional Case Management primarily serves, on an as needed basis (AN), former inmates with mental illness previously served on the Adult Intensive Case Management caseload (a step-down level of services). The program may also serve some individuals who pose a lower level of criminal risk and have a lower clinical need than the those served under Intensive Case Management. The program has a very small caseload with less than 500 probationers and parolees being admitted into Transitional Case Management in 2013.

Source: TCOOMMI, TCOOMMI Services Template, Fiscal Year 2013; Program Guidelines and Processes for Continuity of Care (COC), Program Guidelines and Processes for Adult Intensive Case Management, and Program Guidelines and Processes for Adult Transitional Case Management; and April Zamora, TCOOMMI, Personal and Telephone Interviews, March and June 2014.

For more detailed information, see Appendix C.

Leading the Way: Designing a Texas Pilot Program

Peer support re-entry programming is an innovative way to address current gaps and insufficiencies in Texas' continuity of care and re-entry services. Texas has an opportunity to make cutting-edge contributions by leveraging our current resources and policies to improve re-entry and support recovery for inmates with mental illness. We recommend that Texas consider developing a **peer support re-entry pilot program in a local county jail** that connects individuals with mental illness to community-based care. Further research and stakeholder discussion will be necessary to understand fully Texas' opportunities and challenges going forward. We hope that the following recommendations will launch a robust stakeholder conversation about how Texas can best design a pilot program and integrate peer support into its criminal justice system.

Toward a Texas Pilot Program: Concepts and Considerations

1. Focus on re-entry
2. Start local
3. Forge community partnerships
4. Integrate with existing systems
5. Leverage existing partnerships
6. Emphasize recovery

1. Focus on re-entry: reduce recidivism and produce cost savings by integrating peer support into the re-entry process.

Texas needs a more robust level of specialized re-entry services for inmates with mental illness, especially at the local level. Lapses in continuity of care at the point of re-entry contribute to heightened recidivism and the avoidable over-incarceration of individuals with mental illness. We recommend designing a pilot program that will leverage the clinical and social benefits of peer support services to transition inmates into community-based services and improve continuity of care at the point of re-entry. This initiative will potentially produce cost savings for state and local budgets by reducing reliance on correctional facilities as the "de facto" mental health service providers and increasing access to more affordable and clinically appropriate community-based care.

2. Start local: fill the gap in local re-entry services, reduce recidivism for non-violent offenders, and build a body of evidence for scalable state-wide programming.

We recommend that Texas implement a pilot program in a local county jail, where re-entry services are reportedly most lacking. Key opportunities at the local county level in Texas include:

Meeting the need for re-entry support

In many areas of the state, local jail inmates with mental illness are released into the community without access to re-entry services. Local jail inmates who do not have access to TCOOMMI's re-entry services and do not receive re-entry support from the local jail may derive significant benefit from a peer support re-entry program. Moreover, a significant share of local jail inmates

with mental illness is incarcerated for nonviolent crimes, yet remains at high risk of recidivism. Providing peer re-entry assistance to these inmates can help mitigate the "revolving door" effect by assisting non-violent individuals with mental health needs successfully transition from the jail into more appropriate community-based care. Peer support re-entry is a cost-effective, practical, and recovery-oriented solution that provides inmates with the powerful benefits of peer support as well as vital release planning services.

Enabling successful peer recruitment

It is important for forensic peers to possess a history of incarceration at a level similar to that of the client population they are serving. For example, a peer with a misdemeanor conviction and history of incarceration in a local jail may not be best-suited to provide services to a felony inmate population in a prison facility. However, peer specialists who possess a history of incarceration in a local jail, as opposed to a state facility, are less likely to possess the type of serious criminal conviction that would trigger an employment bar in a mental health or criminal justice setting (discussed at further length later in this report). Initiating the pilot program in a local jail would therefore better ensure the availability of a peer support workforce appropriate to the needs of the client population. Moreover, county jails maintain a large degree of autonomy and flexibility over their internal operational policies. While some local jails may prohibit individuals with a history of incarceration from providing services in the jail, this is not universal and flexibility may be available on a county-by-county basis.

Building a body of evidence

Local level pilots can help build a body of evidence and support for scalable state-wide programming.

3. Forge community partnerships: identify a community partner with the appropriate infrastructure and resources to administer a peer support re-entry program.

A peer support re-entry program should be housed in an organization able to provide the infrastructure and resources necessary to support the peer workforce. Moreover, launching a pilot program will require recruiting a community partner that can effectively operate in both a community and correctional setting. Further stakeholder discussion, policy research, and examination of available resources will be beneficial to determine the best organizational home for a pilot program in Texas. Two promising ideas, with distinct strengths and limitations, are:

Local CMHC

Currently, all Texas CMHCs offer peer support services as part of their broader array of community-based mental health services.[43] Moreover, in many Texas counties, CMHCs are the primary provider of mental health services in the local jail.[44] There may be an opportunity to leverage the peer support infrastructure and workforce currently in place in a local CMHC, as well as the existing relationship with the local jail, to extend peer support into the jail as part of a collaborative re-entry effort. Operating a program through the CMHC would streamline inmates'

transition directly into the public community mental health system. Additionally, CMHCs have historically been the only provider entities approved to provide Medicaid-reimbursable mental health rehabilitative services.[45] Although recent legislation opened the door for private entities to become approved providers,[46] CMHCs remain the only entities currently approved to obtain Medicaid reimbursement for peer-provided services. One of the pilot's goals should be to transition inmates into the most financially sustainable community-based model of care. As such, it will be important to select a community partner that is also an approved Medicaid mental health rehabilitative service provider.

Private, recovery-oriented community organization

A private organization that has adopted a recovery-oriented model of care as part of its mission and culture may be best able to support peer specialists and justice-involved consumers in their progress toward recovery. Peerstar, LLC is an excellent example of a private, recovery-oriented provider entity. Similar organizations may also exist in the nonprofit sphere. A private organization may have greater autonomy and flexibility with regard to program design and peer support specialist recruitment than a public mental health entity. For example, a private community organization will likely possess greater latitude in their hiring policies and may offer employment opportunities to justice-involved peers with a greater range of prior criminal convictions, whereas CMHCs must abide by strict statutory employment bars (discussed at further length later in this report). However, it is presently unclear whether and when a private organization in Texas will be approved to provide Medicaid-reimbursable rehabilitative services. Obtaining this approval enables providers to obtain compensation for services provided in the community. Medicaid reimbursement is an important component of a program's financial sustainability. Peerstar, for example, funds all of its transitional community-based peer support services through Pennsylvania Medicaid. Despite this potential limitation, opportunities may exist to forge innovative public-private partnerships in this field moving forward.

4. Integrate with existing systems: align the program with successful policies and procedures already in place in local jails.

Texas should take steps to integrate the pilot program with existing continuity of care policies and re-entry systems in local jails. Opportunities exist to leverage the benefits and successes of policies currently in place at little or no increased cost to the state or local governments. For example, it may be possible to use the data and information obtained during the mental health screening and intake process in local jails (i.e. the CCQ and mental health screening form) to identify local jail inmates with mental health needs who would benefit from participation in a peer support re-entry program upon release. Additional research and stakeholder input will be necessary to identify components of the existing procedural landscape that could be successfully integrated with a pilot program.

5. Leverage existing partnerships: work with local and national partners and use the existing peer support training and certification infrastructure to create a forensic peer support curriculum for Texas.

Texas is home to a variety of organizations with valuable knowledge, resources, and national partnerships in the field of peer support. For example, ViaHope operates Texas' peer support training and certification program and maintains partnerships with the Appalachian Consulting Group and Recovery Innovations (private providers of peer support curriculum development and training services), as well as the Yale School of Medicine's Program for Recovery and Community Health.[47] The UT Austin Center for Social Work Research contracts with DSHS and the Hogg Foundation for Mental Health to provide technical assistance and programmatic evaluation for ViaHope.[48] Moreover, nonprofit community organizations and peer service providers across the state (including the CMHCs) are part of the extensive cadre of partners that can provide valuable contributions to program design and development.

Developing a Forensic Peer Support Curriculum

Contracting with either a major university or an existing peer support certification provider can bring credibility and an evidence-based perspective to the forensic peer support curriculum.

- **The Pennsylvania Department of Corrections worked with Recovery Innovations** (a state-approved CPS training provider) to develop a curriculum specific to the state correctional context.
- **Peerstar worked with the Yale School of Medicine's Program for Recovery and Community Health** to develop its internal, proprietary forensic peer support training curriculum.
- **The Pennsylvania Mental Health Consumer Association** developed a forensic peer support training program in partnership with Drexel University, with grant funding from the Pennsylvania Commission on Crime and Delinquency.

Additionally, developing a forensic peer support training curriculum, tailored to the needs of justice-involved individuals and ideally to the unique characteristics of the correctional setting, is one important component of establishing a peer support re-entry program. In developing a Texas curriculum, stakeholders should work with ViaHope to leverage existing partnerships and peer support training infrastructure.

6. Emphasize Recovery: encourage program and organizational practices that support recovery and maximize the efficacy and contributions of peer support specialists.

A recovery-based mental health system includes holistic, integrated, and comprehensive services that embrace self-determination, hope, respect, and family (as well as other ally, e.g. peer) involvement, enabling individuals to play meaningful roles in society and participate in decision-making around their mental health treatment.[49] Peer support specialists are able to maximize their efficacy when the host organization has integrated recovery-oriented values and practices into its organizational culture. To this end, ViaHope provides organizations participating in its peer support initiatives with the *Peer Specialist Integration Workbook*.[50] The workbook provides ideas for practical steps that organizations can take to incorporate recovery into their workplace culture and more effectively support the work of their peer specialists. Practical steps can include conducting staff focus groups on organizational structure and

values, educating non-peer staff about peer support and recovery, and clarifying the distinct roles and responsibilities of clinical staff versus peer support specialists. Representatives from ViaHope expressed that it can be difficult to reconcile the mutualistic, peer-focused, recovery-oriented model of care with the hierarchical provider-patient framework present in many traditional clinical settings. Moreover, this reconciliation may be even more difficult to achieve in the historically punitive environment within correctional institutions. Steps should be taken to overcome these challenges and to equip mental health and criminal justice program partners with the tools necessary to support peer providers. For example, providing specialized training on peer support and the recovery model to correctional supervisors may help staff become more invested in the program and better able to support peer specialists in their work in the correctional facility.[51]

Clearing the Way: Supporting Inmate Re-entry and Forensic Peer Support through Policy

As part of our analysis, we offer policy recommendations to broadly improve access to mental health services and easy re-entry transitions for inmates with mental illness in Texas. In moving forward with a peer support re-entry pilot program, Texas should conduct additional research and, where appropriate, take action on the following policy items affecting the viability of forensic peer support and re-entry programs in Texas.

Policies to Advance Forensic Peer Support and Improve Inmate Re-entry in Texas

1. **Reassess state employment bars** affecting justice-involved peers.
2. **Allocate funding for CMHCs** to serve individuals with mental illness beyond the target diagnoses.
3. **Expand continuity of care standards** to include local jails and inmates being released on flat discharge.
4. **Expand successful TCOOMMI programming** to serve more inmates in more areas of the state.
5. **Accept federal dollars to expand eligibility** for public health care coverage to Texas adults living below the poverty line.

Policy Priority 1: Reassess state employment bars affecting justice-involved peers.

In a forensic peer support survey conducted by CPPP (see Appendix A for more information), employment bars for individuals with prior criminal convictions were the most frequently cited barrier to implementing a forensic peer support program with justice-involved peers.

Texas state policy currently prohibits individuals with certain criminal convictions from employment in state correctional or public mental health provider settings. For example, Texas state law requires TDCJ to maintain strict criminal history clearance policies for its employees, including for medical and mental health service providers in state facilities.[52] Individuals with a felony conviction are ineligible to obtain employment with TDCJ for 15 years following the completion of their sentence.[53] There are currently no state-wide prohibitions against individuals

with a criminal justice history obtaining employment or providing services in a local county jail.[54] Many local jails, however, reportedly maintain internal policies that disallow individuals with a criminal justice history from providing services in the jail.[55] The presence of internal policy barriers in local jails should be examined on a county-by-county basis to better understand the challenges they pose.

Texas regulations also prohibit individuals with certain convictions from being employed in public mental health service facilities, including CMHCs.[56] Additionally, Texas Medicaid providers of mental health rehabilitative services (including private provider entities) are required to conduct a criminal history clearance on contractors and employees delivering services through their organization.[57] Provider entities must ensure that clients do not come into contact with or receive services from an individual who has a conviction for any of the criminal offenses outlined in the Texas Health and Safety Code.[58]

These prohibitions may prevent justice-involved peers with valuable lived experience from providing services in criminal justice and public mental health settings. Regulations affecting the employment of individuals with a criminal justice history should strike a balance between ensuring public safety, mitigating risk, and providing individuals with criminal justice histories an opportunity to provide clinically and socially beneficial assistance to justice-involved consumers. Peerstar maintains an internal list of employment bars for its peer support workforce that may serve as an initial point of reference for how to negotiate this balance effectively. Texas should evaluate and reassess current policies that would prohibit peer specialists with a history of incarceration from being able to provide services within a correctional, state institution, or community mental health center setting.

Policy Priority 2: Allocate funding for CMHCs to serve individuals with mental illness beyond the target diagnoses of schizophrenia, bipolar disorder, and major depression.

Texas currently has a two-tiered eligibility system for public community mental health services provided to adults through local CMHCs.[59] The first service eligibility tier, originally established in 2003, mandates that funding for public community mental health services be limited to adults with schizophrenia, bipolar disorder, or major depression. This first eligibility tier is called the "Target Population."[60] However, the spectrum of mental health needs is much larger than these three diagnoses. Therefore, a second tier was established by the legislature in 2013, permitting CMHCs to provide clinically appropriate treatment services, where funding is available, to adults with mental illnesses when their psychological, social, and occupational functioning deteriorates.[61] This second eligibility tier is called the "Priority Population." Although the intent of establishing the second eligibility tier was to ensure that all individuals with mental illness, regardless of a specific diagnosis, are able to access services, the legislature has not allocated sufficient funding to serve this broader population of individuals, and services continue to be limited to the Target Population in most areas of the state.

The selective eligibility and limited funding for adult community-based mental health services creates an obstacle to ensuring continuity of care for inmates with mental health needs after they return to the community. A former inmate with a non-target diagnosis, such as post-traumatic stress disorder, may have received treatment for his or her mental illness in the correctional setting, but be cut off from services post-release if the local CMHC lacks sufficient funding to expand services to the broader Priority Population. According to TDCJ public service match data, 35 percent of inmates in TDCJ correctional institutions have a public mental health service match, but only 12 percent fall into the Target Population, illustrating the gulf between potential need and existing service eligibility.[62] Eligibility for TCOOMMI's re-entry case management services, and for post-release service referral to a CMHC, is limited to the target diagnoses since TCOOMMI's re-entry services must connect inmates to the public community mental health system. While providing peer support re-entry services to inmates with a broader spectrum of diagnoses may help bridge this service gap, individuals who do not meet public mental health service eligibility criteria will continue to experience difficulties accessing community-based treatment post-release. Moreover, if Texas elects to house a peer support re-entry program in a CMHC, the transition from a correctional setting to community-based care will remain compromised for individuals with a non-target diagnosis. Funding CMHCs sufficiently to serve a broader population of adults with mental illness will better enable former inmates to maintain continuity of care at the re-entry stage.

Policy Priority 3: Expand continuity of care standards to include local jails and inmates being released on flat discharge.

There are no standards requiring local jails to provide continuity of care services to inmates with mental illness during the re-entry process. For those local jail inmates with mental illness who do not qualify for or have access to TCOOMMI services, this lack of standards poses a serious challenge to maintaining continuity of care. An opportunity exists to extend at least minimal continuity of care standards to local jails at relatively low cost by expanding existing systems and procedures. For example, data obtained from the CCQ data match and mental health screening process (already required of all jails) may be used to identify inmates with mental health needs at the point of re-entry and provide them with some minimal level of care coordination. The jail may be able to coordinate with CMHCs, for example, to ensure that CMHCs receive an electronic notification when a former client is released into the community. At minimum, Texas should consider requiring jails to participate with other state and local agencies in designing and implementing the continuity of care programs. Having more uniform continuity of care and re-entry standards in place at the local level would make additional local programming more readily scalable across the state. Additionally, continuity of care standards should be expanded to include inmates with mental illness being released on flat discharge, whether from state or local facilities. Services are currently minimal to non-existent for this population.

Policy Priority 4: Expand successful TCOOMMI case management programming to serve more inmates in more areas of the state.

Texas should expand access to and funding for TCOOMMI's successful case management programs to help reduce recidivism. Currently, case management is primarily available to individuals with a felony conviction, leaving much of the local misdemeanor population with access to only a minimal level of services, regardless of clinical need. Moreover, only 70 of 122 local probation departments participate in the TCOOMMI case management program, which means that many local probation populations lack access to adequate services. Texas should expand access to and funding for programs that are known to reduce recidivism. At a later point, the state may consider integrating peer support services into TCOOMMI's broader array of successful re-entry programming.

Policy Priority 5: Accept federal dollars to expand eligibility for public health care coverage to Texas adults living below the poverty line.

Expanding eligibility for public health insurance coverage (i.e. funded through Medicaid) to adults living below the federal poverty line would allow more inmates with mental illness to obtain health insurance at the point of community re-entry. Obtaining quality and affordable health care coverage at the point of re-entry would support continuity of care for inmates with mental health needs as well as enhance the financial sustainability of re-entry programs connecting inmates with community-based services. Peerstar funds its community-based peer support programs through Pennsylvania Medicaid, and this funding mechanism allows Peerstar to obtain financial compensation for serving a high-need population while reducing recidivism rates and producing cost savings for local communities. Since peer providers are allowable providers of Medicaid-reimbursable mental health rehabilitative services in Texas, expanding access to Medicaid would dramatically increase the population of re-entry clients for whom ongoing funding of cost-effective care is available.

Next Steps: Engage, Establish, Explore

The program concepts that we have presented here should be developed in greater depth following more extensive research into the Texas criminal justice and mental health landscape. Texas has an opportunity to transform the relationship between criminal justice and mental health in our state. Peer

What's Next?

- **Engage** stakeholders.
  Encourage ongoing dialogue amongst stakeholders in the mental health and criminal justice communities.
- **Establish** partnerships.
  Establish relationships between community partners, such as local jails, CMHCs and other recovery-oriented provider organizations. Consider developing mutually beneficial public/private partnerships.
- **Explore** funding and legislative opportunities.
  Incorporate best practices and stakeholder feedback into a concrete program proposal. Seek out public or private funding opportunities. Consider possibilities for filing legislation in the 2015 Texas Legislative Session.

support re-entry programs integrate the principles of hope, recovery, and well-being into the criminal justice system while reducing recidivism, promoting cost savings, and enhancing health and wellness for justice-involved individuals with mental illness. The road map forward involves additional stakeholder deliberation, cross-community learning, and collaboration and we hope to play a role in convening and supporting that ensuing discussion.

Appendix A: CPPP Forensic Peer Support Survey

About the Survey

To learn more about the existing landscape of **peer support programming *in correctional facilities***, CPPP staff conducted an informal **36-state telephone and e-mail survey**, drawing primarily from the universe of states that, like Texas, have formal peer support certification programs. The survey was conducted using an informal snowball sampling method, initially drawing from program and agency contacts identified in the *Peer Specialist Training and Certification Programs* report, published by the Center for Social Work Research at the University of Texas at Austin in 2012.[63] The survey was conducted between November, 2013, and March, 2014. **CPPP staff conducted informal phone and e-mail interviews with contacts at public agencies or consumer-focused community organizations in 31 states** (we were unable to reach contacts in five states), asking the agency or organization representative whether he or she was aware of any forensic peer support initiatives operating in the state and whether he or she was aware of any programs operating in a correctional setting, specifically. Given the informal sampling and survey methods employed, as well as the limited knowledge and lack of centralized information that exists on forensic peer support, it is **possible (and even likely) that additional forensic and correctional peer support programs exist that CPPP staff did not identify.** The CPPP survey was intended to provide a preliminary overview of where the recognized leaders in correctional peer support are located and lay the foundation for future research on this topic.

Survey Findings

Of the **31 states** for which CPPP collected data, **five are home to a peer support program that operates in a correctional facility.** Only one state, Pennsylvania, is home to a large state-level public initiative as well as programming at the local county level. In **12 of the surveyed states**, forensic peer support is available in some **other criminal justice context** (e.g. mental health courts, see pull-out box on page 9). Additionally, **12 of the surveyed program or agency contacts** indicated that their state is actively considering **expanding its peer support programming into state or local correctional facilities**.

In addition to Peerstar, LLC, whose county-level peer support re-entry program is featured in the body of this paper, CPPP staff identified several states and organizations providing peer support in a correctional setting. See a brief description of these programs below.

Douglas County Jail, Nebraska

The Douglas County jail employs at least one peer support specialist in the Intensive Pre-Release and Transitional Services program.[64] The program focuses on providing pre- and post-release peer support services to 18-24 year old inmates who identify as having experienced mental illness, substance abuse, or homelessness. The inmate receives both intensive case management and peer support services. The peer begins by helping to develop a treatment

plan while the inmate is incarcerated, focusing on self-identified issues and goals, including where he or she will go upon release. Post-release, the peer continues to meet with the consumer in a place that is appropriate for his or her needs, and assists with issues related to recovery and wellness including rides to and from appointments, 12-step meetings, and job searches, for example.

Howie the Harp, New York

Howie the Harp (HTH) is a consumer-operated nonprofit based in New York that trains and certifies peer support specialists with a focus on recruiting justice-involved peers.[65] The organization operates two small-scale peer support programs in correctional facilities. The first is a peer support specialist internship program called the Riker's Island Project. HTH peers are required to complete an internship as part of their peer training and certification process, and a small number of trainees choose to complete this requirement by providing peer support services in the New York City Riker's Island Jail. The second program is called Project Renewal and operates in the state Bedford Hills Correctional Facility. For Project Renewal, HTH employs one peer support specialist to provide peer support services, discharge planning, and group work once a month to inmates in the prison. Services are also provided to inmates post-release to help them connect with community support services with the goal of reducing recidivism.

Oklahoma Department of Corrections (DOC) & Department of Mental Health (DMH)

The Oklahoma DOC utilizes forensic peer support services in two programs.[66] First, as part of an inmate re-entry program operated in partnership with the Department of Mental Health (DMH), a team of DMH employees provides intensive case management services 3 - 9 months prior to release for inmates with mental illness. *Following release*, inmates are paired with intensive care coordination teams, which include a certified case manager as well as a state-certified Recovery Support Specialist (RSS, i.e. a peer provider) who work with the inmate in the community for up to a year. Second, the Oklahoma DOC has a peer inmate training initiative (similar to the Pennsylvania DOC program discussed in Appendix B). The Oklahoma DOC program, launched in 2009, trains and certifies state prison inmates to provide peer services to fellow inmates. The first peer inmate class graduated in 2010, and approximately 20 inmates received RSS certification. The training and certification component of the program is currently suspended. However, inmates who graduated from the program continue to perform RSS services in the prisons. Oklahoma is currently examining how best to reinstitute the training and certification component of the program.

Pennsylvania Department of Corrections (DOC)

The Pennsylvania DOC operates a peer inmate training and certification program similar to the Oklahoma DOC program. The Pennsylvania DOC program is currently active and operating at a larger scale than the Oklahoma program. See additional details about the Pennsylvania DOC program in Appendix B.

Wisconsin Resource Center, Wisconsin

The Wisconsin Resource Center (WRC) is a specialized health facility established as a prison which employs two peer support specialists who also share a history of incarceration and who provide services to inmates at the center.[67]

Appendix B: The Pennsylvania Department of Corrections Peer Inmate Training Program

In 2011, the Pennsylvania Department of Corrections (DOC), in collaboration with the state's Office of Mental Health and Substance Abuse Services, as well as the multi-stakeholder Pennsylvania Commission on Crime and Delinquency launched a forensic peer support program in state correctional institutions**.** The program trains and certifies inmates to provide peer support to fellow inmates.[68] The Pennsylvania DOC launched the program in August, 2011. By June 2013, the PADOC had trained and certified 264 peer inmates in 13 different state prison facilities, provided peer supervision training to approximately 60 correctional staff members, and trained four correctional staff to conduct forensic CPS trainings for future classes of peer inmates. As of January, 2014, the PADOC had trained and certified peer inmates at 18 out of 25 state correctional facilities.

Program Goals

To improve internal operations in state correctional facilities; to support recovery and stabilize symptoms for inmates with mental illness; to support successful community re-entry by equipping inmates with job skills and a recognizable professional credential.

Program Model

- **The PADOC provides Certified Peer Specialist (CPS) training and certification** to inmates in state correctional facilities.
- **The PADOC employs certified peer inmates to provide peer support services** to inmates in Special Needs Units of state correctional facilities.
- **The peer inmate provides peer support services** include facilitating personal hygiene and recovery wellness sessions, giving presentations on peer support, assisting with school homework, and speaking with fellow inmates one-on-one.
- **Upon the inmate's release into the community**, the PADOC works with the state's Office of Mental Health and Substance Abuse Services to provide job leads and connect former inmates with opportunities to work as peer support specialists in the community.

Client Criteria

Services are currently only provided to inmates in Special Needs Units (may include individuals diagnosed with mental illness, emotional instability, mental retardation, or other physical or mental disabilities).[69]

Peer Criteria

In order to be accepted into the training and certification program, an inmate must meet a range of criteria such as having a history of receiving mental health services, possessing a high school diploma or GED, and not having had any assaultive misconducts in the prior year. Importantly, all peer inmates must also secure unanimous approval from correctional staff by way of a vote

sheet before being accepted into the program. This process is important for maintaining buy-in from staff at the correctional institution. Each of the peer inmates receives 80 hours of training followed by a 60 day period of on-the-job training at the correctional facility. Inmates are awarded formal CPS certification. Peer inmates are given opportunities to pursue continuing education in order to maintain their certification.

Forensic Peer Specialist Training Curriculum

The PADOC contracted with Recovery Innovations, one of two state-approved providers of CPS training and certification in Pennsylvania, to develop and administer a curriculum tailored to the state correctional context.

Funding and Cost

The PADOC received approximately $115,000 in federal American Recovery and Reinvestment Act Justice Assistance Grant funding to implement the program through June, 2013. The funding was distributed through the Pennsylvania Commission on Crime and Delinquency. It cost approximately $96,000 to develop the curriculum with Recovery Innovations and administer the initial training for inmates and supervisors at the first six pilot sites. Training initially cost approximately $20,000 per 20 peer inmates. The PADOC dedicated the remaining $19,000 in original grant funding to inmate wages during this initial period until each correctional institution was able to incorporate the cost of peer inmate wages into its internal budget. The PADOC is taking steps to make the program more financially sustainable by training correctional staff to administer the CPS training for future classes of peer inmates.

> "[Peer support] helps me get stuff off my chest. We play chess and we talk. It's like he knows where I am coming from because he is going through it too."
>
> Inmate, SCI-Greensburg
>
> "[Peer Support Specialists] listen. They don't judge. They don't tell me what to do. They help me figure out things for myself. It's really good."
>
> Inmate, SCI-Greensburg
>
> "There are always people in the world who are going to have problems. It's good to be able to help someone. This is a dream job."
>
> Peer Inmate, SCI-Greensburg
>
> Note: SCI refers to "State Correctional Institution"
> Source: Testimonials collected and provided by the PADOC.

Success Stories

The program is currently undergoing evaluation by a research team at Lycoming College and Pennsylvania State University. No data are currently available. However, anecdotal reports from correctional staff and inmates suggest that the program has been successful on a number of fronts. Participating institutions have reportedly observed fewer inmate visits to Psychiatric Observation Cells (where inmates are detained if they are deemed homicidal or suicidal) and staff has observed improvements in peer inmate attitudes and well-being. Anecdotal testimonials from participating institutions suggest satisfaction amongst both inmates and peers. Buy-in from correctional staff is reportedly high, with some institutions and staff members reportedly expressing a desire to have even more peers at their facilities.

Appendix C: Re-entry Programs and Policies for Inmates with Mental Illness in Texas

Below, we outline some of Texas' current re-entry programs and policies for inmates with mental illness in an effort to provide context for future program and policy recommendations.

Continuity of Care Requirements for Inmates with Mental Illness

The Texas Health and Safety Code requires TDCJ, DSHS, the Department of Public Safety (DPS), local CMHCs, and local Community Supervision and Corrections Departments (CSCDs, i.e. local probation departments) to adopt a Memorandum of Understanding (MOU) with one another outlining each actor's respective roles and responsibilities in instituting a "continuity of care" program for Texas inmates with mental health needs.[70] Local jails are not required to adopt an MOU of this nature (see the section on the role of local jails below).

Defining Continuity of Care

The Texas Health and Safety Code defines continuity of care as developing a treatment plan and maintaining provision of care for an individual with mental health needs at any of the following stages of the justice process: [71]

- Time of arrest
- While charges are pending
- During post-adjudication or post-conviction custody
- During post-conviction criminal justice supervision
- During pretrial diversion

According to the above definition, local and state agencies must assist inmates in maintaining continuity of care primarily at early stages in the justice process (i.e. at arrest, pre-trial, and during custody), and are only required to provide continuity of care at the point of re-entry to inmates being released into community supervision or parole (i.e. post-conviction criminal justice supervision). There is no statutory requirement for agencies to provide continuity of care programming to inmates with mental health needs who have completed a sentence and who are being released directly into the community without supervision (i.e. "flat discharge").[72]

Despite the absence of a statutory requirement, continuity of care programming *is* available to some inmates with mental illness released on flat discharge from *state* correctional facilities (see an overview of TCOOMMI re-entry services below).[73] At the local jail level, TCOOMMI re-entry services are only available to individuals being released on probation. Local jail inmates being released on flat discharge are not eligible for services.[74]

What is in the MOU?

The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI, a sub-unit of TDCJ) coordinates and monitors the development and implementation of the interagency MOUs. Each MOU must establish methods for:

- Identifying inmates with mental illness and reporting prevalence data to TCOOMMI
- Developing interagency rules and policies regarding the care and exchange of information for inmates with mental illness by state and local agencies, including local jails and CMHCs
- Identifying services needed by inmates with mental illness to re-enter the community successfully
- Establishing processes to report implementation activities to TCOOMMI

TDCJ, DSHS, local CMHCs, and local CSCDs are responsible for operating the continuity of care programs and TCOOMMI is responsible for coordinating the programs and contracts. Local and state criminal justice agencies are encouraged to, wherever possible, contract directly with local CMHCs to improve the continuity of care services offered to inmates with mental health needs.

The Role of Local Jails

The Texas Health and Safety Code does not require local jails to adopt an interagency MOU to provide continuity of care programming for its inmates. Local jails are encouraged to contract with CMHCs to improve continuity of care for their inmates, but numerous local jails across the state reportedly do not maintain a contract with the local CMHC and do not take proactive steps to ensure continuity of care for inmates with mental health needs being released from their facilities.[75] According to staff at the Texas Commission on Jail Standards, there are currently no requirements in place for local jails to provide specialized re-entry assistance to inmates with mental health needs and this responsibility falls exclusively to local probation departments, CMHCs, and TDCJ.[76]

Similarly, there are no standards in place requiring local jails to provide a minimum amount medication (3 days is common, according to anecdotal reports), or to contact the local CMHC when an inmate with a public mental health service match is being released back into the community (see the section on Mental Health Screening and Intake in Local Jails below).[77] In many counties, local jail inmates with mental illness do not receive TCOOMMI continuity of care services and are reportedly released from jail at midnight, with no community care referral, and without access to adequate medication.

Independent re-entry programming at the local level in Texas varies greatly from county to county. Some jails, such as Harris County, have pioneered innovative jail “in-reach” projects that connect an inmate with a case manager while incarcerated. Standard practice is to release an inmate at night, but through the “in-reach” project, the inmate is released in the morning and into the care of the case manager who connects him or her with services in the community.[78] Anecdotal reports suggest, however, that standard practice in the majority of county jails differs significantly from practices employed by Harris County.[79] There is no centralized source of information available on which local county jails have implemented independent re-entry programs.

Mental Health Screening and Intake in the Local Jails

Though jails are not required to provide continuity of care or re-entry programming to inmates, they are required to complete a mental health screening and identification process upon an individual's booking into the jail.[80] This process is designed to help identify individuals early on who may be eligible for diversion programming due to a mental health need or who require special mental health services while in custody. In 2007, DSHS received a legislative mandate to work with the Department of Public Safety (DPS) to design and implement a data exchange process that would allow personnel at local county jails to obtain real-time public health service match data at the point of an individual's booking into the jail.[81] During this data match process, known as the Continuity of Care Query (CCQ), an inmate's name and other personal identification information is matched against entries in a DSHS database of individuals who have previously received public mental health services in a CMHC or state hospital. The data match process is intended to help identify individuals who have a history of mental illness and who may have mental health needs, and all jails are required to run a data match for each individual booked into the facility.[82] As of 2013, all counties were using the CCQ data match process.[83]

The CCQ is accompanied by a mental health screening that is conducted for every inmate at the point of booking into the jail.[84] The screening instrument, provided by the Texas Commission on Jail Standards (TCJS), is called the **"**Screening Form for Suicide and Medical and Mental Impairments."[85] The form includes staff observations and self-report questions, and TCJS is currently providing training materials to local county jails to help staff recognize mental illness more effectively and complete the form accurately. If the individual is demonstrating signs and symptoms of mental illness, the sheriff must notify a magistrate within 72 hours.[86] Results of the match and screening process are used to help identify individuals who may require mental health treatment or be eligible for diversion programming. However, local jails are not required to utilize this information to connect inmates with community care at the point of re-entry into the community.

TCOOMMI Re-entry Programming

TCOOMMI is broadly charged with coordinating and overseeing interventions that establish continuity of care for inmates with special needs (i.e. serious mental illnesses, mental retardation, terminal or serious medical conditions, physical disabilities, and those who are elderly) at each stage of the criminal justice continuum, from arrest to community re-entry.[87]

As part of its continuity of care directive, TCOOMMI coordinates three tiers of re-entry assistance for inmates with mental illness: *Continuity of Care*, *Transitional Case Management*, and *Adult Intensive Case Management*. For a succinct breakdown of TCOOMMI program characteristics and eligibility see Tables 2, 3 and 4 in the body of this report.

TCOOMMI contracts with 38 local CMHCs (including NorthSTAR) to provide Continuity of Care and case management services to inmates with mental illness being released from local and

state facilities,[88] and maintains MOUs with 70 out of 122 CSCDs to facilitate TCOOMMI case management services, specifically, for local probation caseloads.[89]

Continuity of Care Program

Available to the broadest population of special needs inmates, this program serves all individuals diagnosed with a mental illness (as defined in the Texas Mental Health Code) who are being released on probation, parole, or on flat discharge (flat discharge from state facilities only).[90] However, only inmates who possess one of Texas' three target diagnoses (i.e. schizophrenia, bipolar disorder, or major depression) are eligible to receive a service referral to a local CMHC post-release. Inmates with non-target diagnoses are ineligible to receive services at a CMHC, where the majority of Continuity of Care program services are provided.[91] Inmates with a non-target diagnosis are therefore only eligible to receive TCOOMMI staff services linking them to natural and community supports. On very rare occasions, exceptions are made for inmates with non-target diagnoses, and a referral to a CMHC may be provided. This exception is granted primarily to inmates with psychotic disorders or those in like nature.[92] Inmates with a target diagnosis receive a CMHC service referral as well as a base level of service coordination and face-to-face follow-up post-release.[93] Continuity of Care programming is available for 90 days post-release, though this time period can be extended based on client need, especially if the client has been subjected to a service waitlist following his or her release.[94]

Adult Transitional Case Management Program

Transitional Case Management primarily serves former inmates with mental illness previously served on the Adult Intensive Case Management caseload (see below) who require some level of ongoing services to maintain stability in the community.[95] In this capacity, the program serves as a step-down level of services for former inmates remaining on probation or parole. However, the program may also serve some inmates being released on probation or parole who pose a lower level of criminal risk and have a lower clinical need than those served by Intensive Case Management.[96] For these inmates, the program serves as an intermediate level of services between Continuity of Care and Adult Intensive Case Management. As with the Adult Intensive Case Management program, the Transitional Case Management program only serves inmates or former inmates who possess one of the three target diagnoses, with rare exceptions.[97]

The Transitional Case Management caseload is small. Only 848 parolees and probationers were served in Transitional Case Management in 2013.[98] Eighty percent of the Adult Transitional Case Management caseload must be felony offenders.[99]

Traditional Case Management is available for one year post-release, though this time period can be extended based on client need, especially if the client has been subjected to a service waitlist following his or her release.[100] A former inmate may remain in the program until he or she no longer requires services, can be transitioned onto a standard CMHC caseload, or until he or she has completed the required term of criminal justice supervision.[101]

Adult Intensive Case Management Program

This program is available to a select pool of inmates identified as being at a high level of risk for criminal behavior as well as a high level of clinical need.[102] The program only serves individuals being released on probation or parole.[103] In order to qualify for this program, the inmate must possess one of Texas' three target diagnoses, with rare exceptions.[104] Notably, not all CSCDs maintain MOUs with TCOOMMI to facilitate case management caseloads (either Intensive or Transitional). In fact, TCOOMMI currently only has MOUs with 70 out of 122 CSCDs statewide. Case management, therefore, is not available to probationers in many areas of the state. For those inmates who are able to access the program, more thorough care coordination and post-release service follow-up is provided post-release, including significantly higher requirements for face-to-face contact hours with case managers.

Former inmates can remain in the program for up to 2 years, though this time period can be extended based on client need, especially if the client has been subjected to a service waitlist following admission into the program.[105] A former inmate may remain in the program until he or she no longer requires services, can be transitioned onto a standard CMHC caseload, or until he or she has completed the required term of criminal justice supervision.[106] Eighty percent of the Adult Intensive Case Management caseload must be felony offenders.[107]

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ENDNOTES

[1] For more information on recovery and related terms see United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "SAMHSA announces a working definition of 'recovery' from mental disorders and substance abuse disorders," December 2011, accessed 01 April 2014 at http://www.samhsa.gov/newsroom/advisories/1112223420.aspx; and SAMHSA,"Recovery to Practice Frequently Asked Questions," July 2011, accessed 01 April 2014 at http://www.samhsa.gov/recoverytopractice/RTPFAQ.aspx#faq3.

[2] This definition is specific to mental health peer support. Peer support service models also exist for veterans, individuals in recovery from substance abuse disorders, and for other populations for whom a mutual support framework may be beneficial. A "peer" in this broader sense is an individual who shares a similar life experience to the consumer. In this paper, we use the term "peer support" to refer to mental health peer support, specifically.

[3] For more information on the principles and benefits of peer-provided service models see United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, C*onsumer-Operated Services: The Evidence*, HHS Pub. No. SMA-11-4633, 2011, p. 11, accessed 15 March 2014 at http://store.samhsa.gov/shin/content/SMA11-4633CD-DVD/TheEvidence-COSP.pdf; and Phyllis Solomon, "Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients," *Psychiatric Rehabilitation Journal* 27.4 (2004), p. 393, accessed 15 March 2014 at http://www.parecovery.org/documents/Solomon_Peer_Support.pdf.

[4] Jean Campbell, *Federal Multi-site Study Finds Consumer-Operated Service Programs are Evidence-based Practices*, Missouri Institute of Mental Health, January 2009, pp. 5 - 8, accessed 15 March 2014 at http://cosp.mimhtraining.com/2010/12/federal-multi-site-study-finds-consumer-operated-service-programs-are-evidence-based-practices/.

[5] Larry Davidson et al., "Peer support among persons with severe mental illness: a review of evidence and experience," *World Psychiatry* 11.2 (2012), p. 124, accessed 15 March 2014 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363389/pdf/wpa020123.pdf.

[6] Ibid.

[7] Ibid.

[8] Laura Kaufman et al., *Peer Specialist Training and Certification Programs*, Center for Social Work Research, University of Texas at Austin, 2012, accessed 01 April 2014 at http://blogs.utexas.edu/mental-health-institute/files/2012/10/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview.pdf.

[9] ViaHope, "History," accessed 19 March 2014 at http://www.viahope.org/about/history.

[10] United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "FY 2010 RFA Grant Application Information (RFA)," accessed 19 March 2014 at http://www.samhsa.gov/grants/2010/SM-10-010.aspx

[11] ViaHope, "History," accessed 19 March 2014 at http://www.viahope.org/about/history.

[12] Peer support, as a general service category, is not Medicaid-reimbursable in Texas. Rather, peer providers are established under DSHS rule as one of several provider types permitted to provide Medicaid-reimbursable mental health rehabilitative services. For more information on the criteria that peer providers must meet, and the types of Medicaid-reimbursable mental health rehabilitative services that they are permitted to provide, see Texas Health and Safety Code §§ 416.3 (35), 416.4(b)(2), and 416.7 – 416.11. DSHS adopted this rule in January, 2014 and the rule constitutes a revision to prior standards for peer providers outlined under former Texas Health and Safety Code §§ 419.451 – 419.459 and 419.461 – 419.470. The new rule has not yet been posted to the online Texas Administrative Code. See the rule adoption order, Texas Department of State Health Services, "Adoption of New Chapter 416, Subchapter A, concerning Mental Health Rehabilitative Services and repeal of Chapter 419, Subchapter L, concerning same," January 2014.

[13] CMHCs are funded by DSHS and provide community-based mental health services primarily to adults in Texas' adult mental health Target Population (i.e. schizophrenia, bipolar disorder, or major depression). CMHCs are also

commonly referred to as Mental Health and Mental Retardation Authorities (MHMRAs), and may be administratively housed within the Local Mental Health Authority (LMHA). For more information on CMHCs and the clients they serve see Texas Department of State Health Services, *Sunset Self-Evaluation Report*, September 2013, p. 137, accessed 10 March 2014 at http://www.dshs.state.tx.us/sunset.aspx.

[14] Texas Council of Community Centers, Personal Interview, July 2014.

[15] Laura Kaufman, Wendy Brooks, and Stacey Stevens-Manser, *Peer Provided Services and Medicaid Billing at the Local Mental Health Authorities in Texas*, Texas Institute for Excellence in Mental Health, Center for Social Work Research, University of Texas at Austin, September 2011, p. 28, accessed 01 April 2014 at http://blogs.utexas.edu/mental-health-institute/files/2013/08/Peer-Provided-Services-and-Medicaid-Billing-at-the-Local-Mental-Health-Authorities-in-Texas-Final-Draft.pdf.

[16] Texas Department of State Health Services, Austin State Hospital, "Services Offered," accessed 13 May 2014 at http://www.dshs.state.tx.us/mhhospitals/AustinSH/ASH_SvcOffered.shtm; LeighAnn Fitzpatrick and Roderick Cruickshank, Kerrville State Hospital, Personal Telephone Interview, April 2014.

[17] LeighAnn Fitzpatrick and Roderick Cruickshank, Kerrville State Hospital, Personal Telephone Interview, April 2014.

[18] Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, Bureau of Justice Statistics, United States Department of Justice, September 2006, p. 1, accessed 01 April 2014 at http://www.bjs.gov/content/pub/pdf/mhppji.pdf.

[19] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *TCOOMMI Services Template***,** Fiscal Year 2013*.* The public mental health service data match system that TDCJ uses is called the Client Assessment Registry system (CARE) match and identifies individuals within the TDCJ system who have previously received state-funded mental health care. The CARE match reflects all clients served in the public mental health system since 1985. The March 2014 CARE match data provided in Table 1 refer to inmates in the TDCJ Correctional Institutions Division.

[20] Texas Commission on Jail Standards, "Request from County Jail by Match Type," 2013. This statistic reflects bookings for individuals with either an "exact" or "probable" Continuity of Care Query (CCQ) match. In 2007, the CCQ match replaced the CARE match process, discussed in footnote 19, in local county jails. The CCQ identifies individuals who have had a previous state hospital admission, or mental health community service encounter, authorization, or assessment since September, 2004. Out of approximately 982,000 bookings in 2013, over 400,000 were for individuals who had an "exact" or "probable" match in the system. While a "probable" service match indicates a likelihood of that match being accurate, further investigation might reveal the match to be false. We have included the qualifier "up to" to reflect this ambiguity in the data. Take note of the unit of measurement and the distinction between "bookings" and "inmates." It is possible for an individual to be booked into a jail on multiple, separate occasions throughout the year. The CCQ data include and do not distinguish between repeat bookings for the same individual. Therefore the statistic "40% of bookings" is not synonymous with "40% of jail inmates" or "40% of people booked into jails."

[21] For the most recent service need estimates in Texas see Texas Department of State Health Services, *Fiscal Year 2014 - 2015 SAMHSA Community Mental Health & Substance Abuse Block Grant Application Needs Assessment*, p. 1, accessed 10 March 2014 at http://www.dshs.state.tx.us/mhsa/blockgrant/. For more information on underreporting and underestimation in public mental health service match data see Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Biennial Report of the Texas Correctional Office on Offenders with Medical or Mental Impairments*, February 2007, pp. 27-28, accessed 10 March 2014 at http://www.tdcj.state.tx.us/documents/rid/TCOOMMI_Biennial_Report_2007.pdf.

[22] Texas Legislative Budget Board, *Criminal Justice Uniform Cost Report Fiscal Years 2010 to 2012*, January 2013, p. 8, accessed 15 April 2014 at http://www.lbb.state.tx.us/Public_Safety_Criminal_Justice/Uniform_Cost/Criminal%20Justice%20Uniform%20Cost%20Report%20Fiscal%20Years%202010%20to%202012.pdf.

[23] Brandon Wood and Diana Spiller, Texas Commission on Jail Standards, Personal Interview, March 2014; Terri T. Burke, "Burke: Jail population needs to shrink, not soar," *Austin Chronicle*, 15 March 2014, accessed 23 May 2014 at http://www.chron.com/opinion/outlook/article/Burke-Jail-population-needs-to-shrink-not-soar-5320629.php?cmpid=opedhphcat.

[24] Texas Department of State Health Services, *FY 2014 – 2015 Legislative Appropriations Request (LAR)*, August 2012, p. 160, accessed 15 April 2014 at http://dshs.state.tx.us/budget/lar/default.shtm.

[25] For personal stories of individuals and families who have interfaced with the local jail system in Texas, see the Texas Jail Project at http://www.texasjailproject.org/.

[26] "NYC official: Mentally ill inmate 'baked to death' in cell," *CBS News*, 19 March 2014, accessed 15 April 2014 at http://www.cbsnews.com/news/new-york-city-official-mentally-ill-inmate-baked-to-death-in-jail-cell/.

[27] The leading model for strategic redirection of individuals with mental illness away from the criminal justice system is known as the Sequential Intercept Model. Developed in 2006 and subsequently adopted by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, the model identifies strategic points of intervention at which an individual with mental illness can be prevented from "penetrating deeper" into the criminal justice system. The model identifies both early-stage points of intervention (such as an individual's first contact with law enforcement or interaction with the court system), as well as later-stage points of intervention (such as re-entry into the community following a term of incarceration) as vital components of a holistic model for reducing criminal justice involvement for individuals with mental illness. See Mark R. Munetz and Patricia A. Griffin, "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Mental Illness," *Psychiatric Services* 57.4 (April 2006), p. 544 - 549, accessed 12 March 2014 at http://ps.psychiatryonline.org/article.aspx?articleid=96593; also see United States Substance Abuse and Mental Health Services Administration, GAINS Center for Behavioral Health and Justice Transformation, "Developing a Comprehensive Plan for Mental Health & Criminal Justice Collaboration: The Sequential Intercept Model," New York, accessed 12 March 2014 at http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf.

[28] United States Substance Abuse and Mental Health Services Administration, "What is Jail Diversion?" accessed 20 May 2014 at http://gainscenter.samhsa.gov/topical_resources/jail.asp; United States Bureau of Justice Assistance, "What is Re-entry?" accessed 20 May 2014 at https://www.bja.gov/evaluation/program-corrections/reentry1.htm.

[29] Jacques Baillargeon et al., "Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door," *American Journal of Psychiatry* 166.1 (January 2009), p.106, accessed 12 March 2014 at http://ajp.psychiatryonline.org/article.aspx?articleid=100490.

[30] Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, Bureau of Justice Statistics, U.S. Department of Justice, September 2006, p. 8, accessed 01 April 2014 at http://www.bjs.gov/content/pub/pdf/mhppji.pdf.

[31] Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, Bureau of Justice Statistics, U.S. Department of Justice, September 2006, p. 7, accessed 01 April 2014 at http://www.bjs.gov/content/pub/pdf/mhppji.pdf.

[32] Kamala Mallik-Kane and Christy A. Visher, *Health and Prisoner Re-entry*: *How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*, Washington, DC: Urban Institute Justice Policy Center, February 2008, pp. 34-43, accessed 12 March 2014 at http://www.urban.org/UploadedPDF/411617_health_prisoner_reentry.pdf.

[33] Kamala Mallik-Kane and Christy A. Visher, *Health and Prisoner Re-entry*: *How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*, Washington, DC: Urban Institute Justice Policy Center, February 2008, p. 36, accessed 12 March 2014 at http://www.urban.org/UploadedPDF/411617_health_prisoner_reentry.pdf.

[34] In some cases, peers with a history of incarceration may be legally unable to obtain employment in criminal justice or human service settings. For this reason, recruiting forensic peers who share a lived experience of both mental illness and incarceration is not always possible. Forensic peer support programs may recruit peers both with and without a history of justice system involvement in order to provide services in those settings where prior criminal convictions are not allowable, though it is considered a best practice to employ peers who share both experiences, where possible.

[35] Larry Davidson and Michael Rowe, *Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists*, May 2008, p. 2, New York: CMHS National GAINS Center, accessed 16 April 2014 at http://www.mhselfhelp.org/storage/resources/tu-clearinghouse-webinars/ForensicPeerGAINSCenter%201.pdf;

[36] Richard Baron, *Forensic Peer Specialists: An Emerging Workforce*, New Brunkswick: Center for Behavioral Health Services and Criminal Justice Research, June 2011, p. 2.

[37] Unless otherwise noted, information on the Peerstar, LLC forensic peer support re-entry program was obtained via e-mail and telephone interviews with Peerstar CEO Dr. Larry J. Nulton, Peerstar Vice President of Operations and Forensic Programs Elissa Gies, and Peerstar Forensic Peer Specialist Thad Koelle, conducted between January and April 2014. Also see the Peerstar, LLC website at http://www.peerstarllc.com/.

[38] Thad Koelle, Peerstar, LLC, Telephone Interview, April 2014.

[39] Texas Health and Safety Code § 614.013, accessed 16 April 2014 at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.614.htm.

[40] Texas Health and Safety Code § 614.001(3-a), accessed 16 April 2014 at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.614.htm

[41] Brandon Wood and Diana Spiller, Texas Commission on Jail Standards, Personal Interviews, March 2014.

[42] Texas Department of Criminal Justice, *Biennial Report of the Texas Correctional Office on Offenders with Medical or Mental Impairments*, 2013, p. 7, accessed 16 April 2014 at http://www.tdcj.state.tx.us/documents/rid/TCOOMMI_Biennial_Report_2013.pdf.

[43] Texas Council of Community Centers, Personal Interview, July 2014.

[44] Brandon Wood and Diana Spiller. Texas Commission on Jail Standards, Personal Interviews, March 2014.

[45] Texas Health and Human Services Commission and Department of State Health Services, *Analysis of the Texas Public Behavioral Health System,* p.28, prepared by Public Consulting Group, accessed 27 May 2014 at http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf.

[46] This is provided by SB 58, passed during the 2013 Texas Legislative Session. For more information see Monica Thyssen, Texas Health and Human Services Commission, "SB 58 Behavioral Health Integration," Presentation at http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/bhiac-docs/behavioral-health-carve-in.pdf.

[47] ViaHope, "Faculty and Partners," accessed 16 April 2014 at http://www.viahope.org/about/faculty-and-partners; Anna Jackson and Dennis Bach, ViaHope, Personal Interview, March 2014.

[48] Ibid.

[49] United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Operationalizing Recovery-Oriented Systems," 17 August 2012, accessed 8 July 2014 at http://www.samhsa.gov/recovery/docs/Expert-Panel-05222012.pdf

[50] ViaHope, *Peer Specialist Integration Workbook Working Draft Version 2,* January 2013; Anna Jackson and Dennis Bach, ViaHope, Personal Interview, March 2014.

[51] The Pennsylvania Department of Corrections adopted a correctional staff training program as part of its peer inmate re-entry program for this purpose. See Appendix B.

[52] April Zamora and Chris Dickinson, Texas Correctional Office on Offenders with Medical or Mental Impairments, Personal Interviews, February and May 2014.

[53] This is for non-correctional officer positions. Texas Department of Criminal Justice, "Basic Eligibility for Non-Correctional Positions," accessed 16 April, 2014 at http://www.tdcj.state.tx.us/divisions/hr/hr-home/nceligibility.html

[54] Brandon Wood and Diana Spiller, Texas Commission on Jail Standards, Personal Interview, March 2014.

[55] Ibid.

[56]Texas Health and Safety Code § 250.006, accessed 16 April 2014 at http://www.statutes.legis.state.tx.us/DocViewer.aspx?DocKey=HS%2fHS.250&Phrases=%22convictions+barring+employment%22&HighlightType=1&ExactPhrase=True&QueryText=%22convictions+barring+employment%22.

[57] Texas Administrative Code § 416.15(a)(2)(iv)

[58] Texas Health and Safety Code § 250.006, accessed 16 April 2014 at http://www.statutes.legis.state.tx.us/DocViewer.aspx?DocKey=HS%2fHS.250&Phrases=%22convictions+barring+employment%22&HighlightType=1&ExactPhrase=True&QueryText=%22convictions+barring+employment%22.

[59] Texas Health and Safety Code § 533.0354, accessed 01 April 2014 at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.533.htm#533.0354.

[60] This target population language was added to the code in 2003 as a result of the passage of HB 2292.

[61] This second service eligibility tier was established by the passage of HB 3793 in 2013.

[62] Texas, Department of Criminal Justice, *Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments*, 2013, p. 10, accessed 10 March 2014 at http://www.tdcj.state.tx.us/documents/rid/TCOOMMI_Biennial_Report_2013.pdf.

[63] Laura Kaufman, et al., *Peer Specialist Training and Certification Programs*, Center for Social Work Research, University of Texas at Austin, 2012, accessed 01 April 2014 at http://blogs.utexas.edu/mental-health-institute/files/2012/10/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview.pdf.

[64] Program information on the Douglas County jail program was obtained from an e-mail interview with Roni Wilder, Certified Peer Support and Wellness Specialist, in December, 2013.

[65] Program information on Howie the Harp was obtained from telephone and e-mail interview with Lynnae Brown, Director, Howie the Harp Advocacy Center, Community Access, in November, 2013.

[66] Program information on the Oklahoma DOC program was obtained from telephone and e-mail interviews with Bob Mann, Administrator of Mental Health Operations, Oklahoma Department of Corrections, and Jill Amos, Coordinator of Recovery Support Services, Oklahoma Department of Mental Health and Substance Abuse Services, from December, 2013, to February, 2014.

[67] E-mail Interview, Laleña Lampe, Community Program Quality Improvement Specialist, Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services, November - December, 2013.

[68] Unless otherwise noted, information on the PADOC peer support program was obtained from telephone interviews and e-mail exchanges with Re-entry Program Manager Mary Finck between November, 2013, and January, 2014. In addition, Mary Finck provided CPPP staff with PADOC grant proposal and reporting documents , which were used as references. Pennsylvania Department of Corrections, *Pennsylvania's Department of Corrections: Certified Peer Support Specialist Program*; Mary Finck, *PADOC Certified Peer Support Specialist Initiative Phase II Summary Report*, 27 June 2013.

[69] Pennsylvania Department of Corrections, "A Handbook for the Families and Friends of Pennsylvania Department of Corrections Prison Inmates," p. 16, accessed 20 May 2014 at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCYQFjAA&url=https%3A%2F%2Fwww.portal.state.pa.us%2Fportal%2Fserver.pt%2Fdocument%2F915546%2Fhandbook_for_families_and_friends_pdf&ei=4qt5U9WMAs6eqAaU5oKQAg&usg=AFQjCNGqzxS7WNDvYJ6jiSjWRG743Qry2w&bvm=bv.66917471,d.b2k&cad=rja.

[70] Texas Health and Safety Code § 614.013, accessed 16 April 2014 at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.614.htm.

[71] Texas Health and Safety Code § 614.001 (3-a), accessed 16 April 2014 at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.614.htm

[72] Texas Health and Safety Code § 614.001(3-a), accessed 16 April 2014 at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.614.htm; Brandon Wood and Diana Spiller, Texas Commission on Jail Standards, Personal Interviews, March 2014.

[73] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Program Guidelines and Processes for Continuity of Care (COC)*, 01 September 2013, p. 10.

[74] Brandon Wood and Diana Spiller, Texas Commission on Jail Standards, Personal Interviews, March 2014.

[75] Ibid.

[76] Ibid.

[77] Ibid.

[78] David Buck, Carlie Brown, and J. Scott Hickey, "The Jail Inreach Project: Linking Homeless Inmates Who Have Mental Illness with Community Health Services," *Psychiatric Services* 62.2 (2011), p 121, accessed 16 April 2014 at http://ps.psychiatryonline.org/article.aspx?articleid=102161.

[79] Brandon Wood and Diana Spiller. Texas Commission on Jail Standards, Personal Interviews, March 2014.

[80] Texas Administrative Code § 273.5(b), accessed 16 April 2014 at http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=37&pt=9&ch=273&rl=5.

[81] This new data match process replaced the prior service match data process which CMHCs were required to perform manually within 72 hours of receiving the inmates' name upon booking. This former process was known as the Client Assessment Registry system (CARE) match process and is still employed within state correctional facilities. The current data match process in local jails is instantaneous and real-time. For more information on the CCQ, see Texas Department of State Health Services, *Mental Health Service Data Exchange Rider 60, 81st Legislative Session*, p. 2, 2010; Texas Department of State Health Services, *Mentally Ill Offender Screening and Information Exchange Rider 43, 83rd Legislative Session*; Texas Department of State Health Services, "Information Item T Data Exchange and Continuity of Care Guidelines," *FY 2012 – 2013 Contract*; and Texas Health and Safety Code § 614.017, accessed 16 April 2014 at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.614.htm.

[82] Texas Administrative Code § 273.5 (b), accessed 16 April 2014 at http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=37&pt=9&ch=273&rl=5.

[83] Texas Department of State Health Services, *Mentally Ill Offender Screening and Information Exchange Rider 43, 83rd Legislative Session.*

[84] Brandon Wood and Diana Spiller, Texas Commission on Jail Standards, Personal Interview. March 2014; and Texas Administrative Code § 273.5 (b), accessed 16 April 2014 at http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=37&pt=9&ch=273&rl=5.

[85] Texas Commission on Jail Standards, "Screening Form for Suicide and Medical and Mental Impairments," accessed 23 April 2014 at http://www.tcjs.state.tx.us/docs/JailScreeningForm.pdf.

[86] Texas Code of Criminal Procedure § 16.22 accessed 23 April 2014 at http://www.statutes.legis.state.tx.us/Docs/CR/htm/CR.16.htm; and Brandon Wood and Diana Spiller, Texas Commission on Jail Standards, Personal Interview, March 2014.

[87] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, "Mission Statement," accessed 22 May 2014 at http://tdcj.state.tx.us/divisions/rid/tcoommi/index.html; Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *How it*

Works Continuity of Care Flow Chart: Adult Criminal Justice System; and April Zamora and Chris Dickinson, Texas Correctional Office on Offenders with Medical or Mental Impairments, Personal Interviews, February 2014.

[88] April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, E-mail and Telephone Interview, April and May 2014.

[89] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, "MHI Caseloads," 04 June 2014.

[90] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Program Guidelines and Processes for Continuity of Care (COC)*, 01 September 2013; April Zamora, Texas Correctional Office on Offenders with Medical and Mental Impairments, Personal E-mail Interview, April 2014.

[91] TCOOMMI aligns its program eligibility and CMHC service-referral eligibility with current public mental health service eligibility criteria. Currently, CMHCs maintain contracts with DSHS that permit CMHCs to provide services only to adults in the Target Population (i.e. those who have a diagnosis of schizophrenia, bipolar disorder, or major depression). However, in line with 2013 legislative changes to public mental health service eligibility criteria, in 2015 CMHCs will update their contracts with DSHS to expand services beyond the Target Population to include the more broadly designated Priority Population, contingent upon availability of funding. In the future, TCOOMMI plans to update its program eligibility criteria and contracts with CMHCs to reflect these eligibility changes. April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Telephone Interview, May 2014.

[92] An out-of-scope allowance can be requested for any inmate who does not meet Target Population criteria. The CMHC performs the assessment and decides whether an exception can be made. These allowances are made only on rare occasions and for severe disorders. April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Telephone Interview, May 2014.

[93] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Program Guidelines and Processes for Continuity of Care (COC)*, 01 September 2013; April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Personal E-mail Interview, April 2014.

[94] Inmates being released into TCOOMMI re-entry programming may be subject to a waitlist if the CMHC maintains one, but they cannot be closed to services. Waitlists can cause service delays, and in these cases TCOOMMI grants extensions to the program duration limitations. The Texas Legislature has recently taken steps to eliminate the waitlist at CMHCs. See Legislative Budget Board, *Fiscal Size Up 2014 – 2015 Biennium*, February 2014, p. 168, accessed 17 June 2014 at http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf; also April Zamora, Texas Correctional Office on Offenders with Medical and Mental Impairments, Telephone Interview, May 2014

[95] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Program Guidelines and Processes for Adult Transitional Case Management,* 01 September 2013.

[96] Ibid.

[97] As with the CMHC referral criteria in the Continuity of Care program, an out-of-scope allowance can be requested for any inmate who does not meet Target Population criteria. The CMHC performs the assessment and decides whether an exception can be made. These allowances are made only on rare occasions and for severe disorders. Additionally, in line with 2013 legislative changes to public mental health service eligibility criteria, in 2015 CMHCs will update their contracts with DSHS to expand services beyond the Target Population to include the more broadly designated Priority Population, contingent upon funding availability. In the future, TCOOMMI plans to update its program eligibility criteria, and contracts with CMHCs, to reflect these eligibility changes. April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Telephone Interview, May 2014.

[98] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *TCOOMMI Services Template*, Fiscal Year 2013.

[99] April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Telephone Interview, May 2014.

[100] Inmates being released into TCOOMMI re-entry programming may be subject to a waitlist if the CMHC maintains one, but they cannot be closed to services. Waitlists can cause service delays, and in these cases TCOOMMI

grants extensions to the program duration limitations. The Texas Legislature has recently taken steps to eliminate the waitlist at CMHCs. See Legislative Budget Board, Fiscal Size Up 2014 – 2015 Biennium, February 2014, p. 168, accessed 17 June 2014 at http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf; Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Program Guidelines and Procedures for Adult Transitional Case Management,* 01 September 2013; April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Telephone Interview, May 2014.

[101] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Program Guidelines and Procedures for Adult Transitional Case Management,* 01 September 2013; April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Telephone Interview, May 2014.

[102] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Program Guidelines and Processes for Adult Intensive Case Management,* 01 September 2013; April Zamora and Chris Dickinson, Texas Correctional Office on Offenders with Medical or Mental Impairments, Personal Interviews, February 2014.

[103] Ibid.

[104] As with the CMHC referral criteria in the Continuity of Care and Transitional Case Management programs, an out-of-scope allowance can be requested for any inmate who does not meet Target Population criteria. The CMHC performs the assessment and decides whether an exception can be made. These allowances are made only on rare occasions and for severe disorders. Additionally, in line with 2013 legislative changes to public mental health service eligibility criteria, in 2015 CMHCs will update their contracts with DSHS to expand services beyond the Target Population to include the more broadly designated Priority Population, contingent upon funding availability. In the future, TCOOMMI plans to update its program eligibility criteria, and contracts with CMHCs, to reflect these eligibility changes. April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Telephone Interview, May 2014.

[105] Inmates being released into TCOOMMI re-entry programming may be subject to a waitlist, if the CMHC maintains one, but they cannot be closed to services. Waitlists can cause service delays, and in these cases TCOOMMI grants extensions to the program duration limitations. The Texas Legislature has recently taken steps to eliminate the waitlist at CMHCs. See Legislative Budget Board, Fiscal Size Up 2014 – 2015 Biennium, February 2014, p. 168, accessed 17 June 2014 at http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp_2014-15.pdf; Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Program Guidelines and Procedures for Adult Transitional Case Management,* 01 September 2013; April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Telephone Interview, May 2014.

[106] Texas Department of Criminal Justice, Texas Correctional Office on Offenders with Medical or Mental Impairments, *Program Guidelines and Procedures for Adult Intensive Case Management,* 01 September 2013; April Zamora, Texas Correctional Office on Offenders with Medical and Mental Impairments, Telephone Interview, May 2014.

[107] April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments, Telephone Interview, May 2014.