Executive Summary

Among the most difficult policy issues facing Texas legislators are inmate safety and inmate health care. After 25 years of litigation involving these issues, and the expenditure of hundreds of millions of dollars to improve prison conditions, the state still faces the possibility of ongoing court supervision of the Texas prison system. Allegations of deficiencies in the system abound, but most state officials who have experience in investigating anecdotes about prison conditions find it difficult to identify reliable data. It is simply not easy to tell what is true, what is false, and what remedies are appropriate in addressing prison safety issues.

Nevertheless, constitutional and humanitarian requirements are clear. Offenders in the prison system have rights and it is the state's responsibility to meet their needs. Offenders are sent to prison **as** punishment, not **for** punishment. Incarceration should not involve abuse of any sort and should provide for the offender's basic medical needs.

The Senate Interim Committee on Criminal Justice finds that Texas is meeting its constitutional obligations with regard to inmate safety and medical care. However, despite the implementation of multiple systems designed to improve prison safety and health care, there is a clear need for fine-tuning within the Texas Department of Criminal Justice (TDCJ). In particular, various divisions of TDCJ play an important role in prison management, but they do not work together when it comes to the kind of events and conditions that everyone would agree are the most serious.

All parties would agree that the most serious problems inside the Texas prison system are those that result in serious injuries to either offenders or staff. For purposes of clarity, this Report defines serious injuries as those that require more than first aid to the person affected. The Committee focuses on these injuries because they represent the most serious threats to safety and because they are the least subject to legitimate dispute. Whereas there may be legitimate doubts about who started a fight or who overreacted in a given situation, there is little doubt **whether** someone was seriously injured.

The serious injuries that occur inside Texas prisons have many causes. They include workplace accidents, assaults of various types, and medical mistakes among others. Many of these injuries are preventable. The Committee recommends the implementation of a more comprehensive method of reporting and investigating these events. Better reporting and investigation of dangerous conditions in prison will make it easier for prison officials to identify remedies for these problems.

The other Interim Charges deal primarily with the implementation of policies promulgated in the last few years. On balance, the TDCJ is adjusting to the dramatic growth of the system in the last few years. New policies have generally not had time to prove their worth, but are proceeding according to established plans.

Included among the Committee's charges are several discrete issues that should be considered together. Prison capacity, alternatives to incarceration, and the treatment of impaired offenders (whether the impairment is mental or physical) deserve joint consideration. Recent accounts in the press have emphasized the extent to which the prison population across the country is aging. This is also true in Texas. Physically and mentally impaired offenders are filling Texas prisons. They constitute not only the most expensive inmates in terms of medical care, but also the offenders who are most susceptible to exploitation behind the walls. Many of these offenders no longer constitute a danger to public safety. Many others (no one knows how many) simply require structured living to keep them out of trouble.

Texas has not yet explored the extent to which alternatives to incarceration—nursing homes, assisted living, sheltered work environments, and related programs—might reduce the burden of housing these offenders in traditional prisons. Aggressive pursuit of alternatives to incarceration for these offenders may save the state money in the long run. By utilizing federal programs in conjunction with seed money from the Texas criminal justice system, it will be possible to stretch resources to meet the needs of these offenders and promote long term fiscal goals.

Public safety is always the primary goal of the criminal justice system. Therefore, even impaired offenders should be reviewed in the normal parole process to determine their suitability for release to any alternative setting.

In general, the Texas prison system is working well. Prison populations are stabilizing, parole policies are becoming more rational, efforts to combat recidivism are being tested, and the relationship between the state prison system and local government has reached equilibrium after a contentious period marked by litigation. Texas prisons continue to operate efficiently and lawfully. Therefore, this Report will recommend certain efforts to fine-tune and monitor the progress of the system, without abandoning policies that remain untested.

The Texas criminal justice system has undergone immense policy changes in the last few years. Now is the time to exercise patience and vigilance to see if these changes are having the desired effect.

Sunset Review

(The Committee is mindful of the fact that TDCJ, the Board of Pardons and Paroles, the Correctional Managed Health Care Advisory Committee, and the Private Sector Prison Industries Oversight Authority are being reviewed by the Sunset Advisory Commission. Committee staff has worked with Sunset throughout the interim, as well as coordinating with the State Auditor's Office and other agencies interested in criminal justice matters. Many of the issues that might have been examined by the Committee, particularly those involving the structure of the agencies under review, are being handled by Sunset and will not be a part of this report.

In particular, Sunset has recommended a more consistent parole process, improvements in prison industries, a more business-like approach to the production of goods within the prison system, and the integration of prison agriculture and food delivery to inmates. These recommendations are designated as S2, S4, S5 and S6 in the July 1998 Sunset report (see bibliography attached). The Committee endorses these recommendations.)

Interim Committee Charge #1:

Study the safety conditions for correctional personnel and prisoners while on the premises of Texas Department of Criminal Justice (TDCJ) facilities, and if legislative or regulatory action is needed make recommendations. Among other matters, the study should consider effectiveness of guard training and the appropriateness of security measures for inmates.

The Committee is charged with the responsibility of reviewing corrections officer training and safety conditions inside Texas prisons. The charge includes both corrections officer safety and inmate safety.

The Committee held a hearing on September 16, 1997 in Austin to determine the status of efforts in the Texas prison system to ensure the safety of offenders and staff. TDCJ officials and inmate family groups testified about problems within the system and remedial measures taken.

Ensuring the safety of inmates and staff is an immense challenge for prison officials, given the nature and size of the prison population. Many of the inmates housed at TDCJ have demonstrated a strong propensity for violence. All of them have a clear history of violating established rules and norms set by society. Nevertheless, the basic responsibility of TDCJ is to house offenders in an environment that is secure. This security includes an obligation to prevent physical harm to inmates wherever possible.

The two keys to safety inside Texas prisons are the promotion of professionalism among TDCJ staff and the implementation of systems designed to remedy problems. Professionalism among staff members begins with training—both before hiring and in-service—and ends with accountability of each guard for his or her actions. Systems designed to remedy problems are more diverse. They include accurate reporting of incidents behind the walls, addressing genuine grievances, and establishing clear criteria under which inmates can be classified according to their danger to staff and other offenders.

Background

The Texas Department of Criminal Justice has expanded more than threefold in the last eight years. The prison population grew from 40,736 in 1990 to 143,495 in 1998. This rapid growth came about with the revision of the Texas Penal Code, the implementation of the new state jail system, and the imposition of dramatically

increased sentences. These changes have taxed all systems within Texas prisons—construction, programming efforts, and training of corrections staff have been challenged by the expansion of the prison system.

A serious ongoing problem for TDCJ is the recruitment, training, and retention of qualified staff. A strong economy and the rural location of most prisons have made it difficult to attract a qualified workforce. Competition in the job market for good employees remains an issue for prison officials. By all accounts, the duties of a corrections officer are stressful and sometimes dangerous, making hiring of staff even more challenging.

The Legacy of *Ruiz* Litigation

Even before the rapid build up of Texas prison capacity, TDCJ underwent a period of reform and reorganization. Many of these changes were in direct response to issues of inmate safety. Mainly in response to *Ruiz* litigation, TDCJ officials changed core prison policies and established procedures to address inmate and staff disputes. Chief among these changes was the abolition of the "building tender" system in which inmates supervised, disciplined, and controlled the behavior of other inmates. Under that system, guard-to-inmate ratios were very low and building tenders had tremendous, unwarranted discretion in prison management. Abuses were rampant. In addition, in the absence of a comprehensive grievance system, these abuses could go on indefinitely without remedial action by prison management.

During the period of *Ruiz* litigation, TDCJ officials implemented a number of reforms that remain intact. Today inmates do not participate in the management of the system, every inmate has access to a grievance system, and TDCJ has a clear policy on the appropriateness and degree of physical force used on inmates. The Internal Affairs Division of TDCJ is independent of the general management chain of command and reports directly to the Board of Criminal Justice. This division reviews every major "use of force" against inmates, all events in which there is an allegation of retaliation by a guard against an inmate, and any claim that a criminal law has been violated behind the walls of the prison system. Even within the prison system, incidents are subject to quasi-independent review.

However, testimony before the Committee indicated that these systems are not perfect. Inmate assaults have not dropped during this period (see Attachment 1). The Committee heard many inmate families testify that inmates are still subject to abuse at the hands of both guards and other inmates. Even if the increase in reported assaults is the result of better reporting systems, some remedial measures are justified.

The Public Safety Implications of Prison Safety

Beyond the explicit danger to guards and offenders at TDCJ, there is another potential hazard to public safety that became apparent in Committee hearings. Testimony before the Committee and the Interim Committee on Gangs and Juvenile Justice indicated the possibility of a growing connection between prison gangs and free world gangs. An inmate who has no gang affiliation may become associated with a prison gang if he fears for his safety. Letters to the Committee from concerned family members confirm that offenders who genuinely fear for their safety will seek "protection" offered by prison gangs.

Clearly, the offender who has joined a gang inside prison is more likely to carry that affiliation with him after he leaves prison. In this way, the fear for one's safety in prison can foster inappropriate associations and illegal gang conduct after release. Prison officials can help break this connection by making inmates safe and keeping prisons from incubating a gang mentality.

Reporting of Incidents within TDCJ: Accountability Support Systems Grievance, Internal Affairs, Ombudsman, and Related Divisions

Testimony at the Committee hearing demonstrated that there are multiple systems within Texas prisons for reporting incidents or conditions that require upper management attention. TDCJ officials testified about the Inmate Grievance system, the Internal Affairs Division, the Office of Patient Liaison, Chaplaincy, and the Ombudsman's Office. Independent entities (the press, state legislators, and the courts) also play a part in overseeing prison conditions.

Inside TDCJ, various divisions have distinct responsibilities in dealing with problems in the prison system. The following is an overview of these divisions.

The Inmate Grievance Process

The grievance system operates through the normal chain of command. As part of inmate orientation, offenders are given an explanation of their right to complain of conditions or events. Every offender has access to the forms required to file a grievance. Every grievance is reviewed by unit staff not associated with the event or condition complained of. (Attachment 2, Inmate Grievance Process Overview; Attachment 3 Inmate Grievance process flowchart)

The grievance process has two stages. The Step 1 review of inmate grievances takes place on the unit where the offender is incarcerated. If the inmate is not satisfied with the result, the appeal is forwarded to the TDCJ district level (Step 2). This grievance process is the system that is often lampooned in describing the coddling of inmates. There are many accounts of inmate grievances based on the unavailability of "crunchy" versus "creamy" peanut butter and other frivolous complaints. Unfortunately the volume of inmate grievances—over 400,000 per year—makes it difficult to cull real problems from imaginary ones.

In fact, many of the grievances are valid and the grievance system brings these complaints to the attention of management. In about 11 percent of Step 1 grievances the allegations of the inmate are upheld. Approximately 7 percent of Step 2 appeals are also sustained. According to the director of the Institutional Division, who supervises the majority of all offenders,

> "TDCJ has an interest in maintaining an effective grievance procedure because it serves as a barometer of staff and operational problems and provides an internal mechanism for resolving them." (Affidavit of Gary Johnson in support of State's Motion to Terminate Discovery and for Final Judgment, *Ruiz* litigation July 23, 1998)

The majority of all grievances (57%) come from 13 facilities[1] (out of a total 107 units). The units logging the highest number of grievances are the most populous in the system and the units that house offenders in the highest security classifications. Traditionally offenders classified as "administrative segregation" and "close custody" file and pursue the largest number of grievances. (See Report on Offender Grievance Procedure, TDCJ Report to the Interim Committee)

The grievance process is also significant to inmates because they must exhaust their administrative remedies in the grievance system before they can pursue either state or federal litigation.

[1]Allred, Beto, Clements, Coffield, Connally, Estelle, Hughes, Michael, McConnell, Robertson, Stiles, Telford, and Terrell units.

Internal Affairs

The Internal Affairs Division of TDCJ serves as a quasi-independent entity that investigates specific kinds of problems that arise in Texas prisons. Its mission is to review:

* major "uses of force" against inmates,
* alleged criminal activity by guards or inmates, and
* retaliation by guards against inmates.

The Division reports directly to the Board of Criminal Justice and is not a part of the rank-and-file corrections staff supervised by the Executive Director.

"Use of force" includes any physical contact with an offender by a TDCJ employee in a confrontational situation to control behavior or enforce an order. It includes placement of hands upon an offender, but does not include those situations when an inmate is simply being escorted. A use of force incident is classified as a "major use of force" if:

* restraints are used,
* chemical agents are used,
* batons, water hoses, or other instruments make contact with an offender,
* if there is offensive or defensive contact made with the offender, or
* an injury occurs (including bruises/contusions or wounds).
  (See full definition in TDCJ Use of Force Plan)

The Internal Affairs Division reviews every major use of force and completes a full investigation on those events where there is an allegation that excessive force has been employed. A finding that a guard has used excessive force subjects the guard to disciplinary action. Failure to report a use of force, of any sort, also subjects the corrections officer to disciplinary action.

Under TDCJ rules a corrections officer is authorized to use force to gain control or compliance with lawful orders. **The rules authorize only the minimum amount of force necessary to gain compliance and forbid the use of force to intimidate, coerce, punish, or extract revenge.**

In an average year Internal Affairs reviews approximately 7,500 major uses of force. In FY 1996 and 1997 the Division sustained allegations of excessive force or other rules violations in 426 cases. Of these cases, 60 involved both excessive force

and rules violations (e.g. failure to report an incident). These cases are forwarded to the appropriate authority. In some cases that may be TDCJ management; in others the case may be referred to either a local district attorney or the Special Prosecutor's office.

There were 366 disciplinary cases lodged against guards. These resulted in approximately 72 firings or resignations by corrections officers. Other cases involved lesser disciplinary action. The total number of criminal prosecutions is not known because other authorities prosecuted those cases.

The Committee requested reports on the activities of the Internal Affairs Division and received detailed accounting of the cases investigated by the division. Reports are broken down by uses of force in units, regions and types of facility. Despite the detail provided in these reports, it is difficult to determine what they really show. Important questions remain:

* How many injuries occurred because of uses of force?
* How many serious injuries to staff vs. offenders?
* In how many cases was an offender seriously injured and the Division found no excessive use of force?
* Is there a correlation between excessive force and serious injury?
* Is there a correlation between the filing of multiple grievances and subsequent injury to the complaining offender?

This last question was raised many times during testimony before the Committee. Family members alleged that an inmate filed repeated grievances, fell in disfavor with corrections staff, and was subsequently injured by intentional conduct of the staff. The particular allegations sometimes involved handcuffed inmates being tripped while being transported.

Ombudsman

The office of the Ombudsman is a recent development at TDCJ. The Ombudsman acts as a clearinghouse providing information to the public about policies, events, and procedures in TDCJ. This office was created under the current administration at TDCJ.

As most state officials know, victim's rights groups, inmate families and other interested parties have a strong interest in prison issues. The Ombudsman provides them with a point of contact for information about various aspects of prison policies

and occurrences that was not readily obtainable in the past. The Ombudsman has no independent authority to investigate or discipline, but promotes the flow of information about offenders and the issues that concern them and their families.

Because of the newness of the office, its function is not yet well known to the general public. Committee staff has found it useful to refer offender families to the Ombudsman for a variety of complaints and concerns. In addition, this office may serve as a useful tool for prison officials as a feedback mechanism. Offenders may be more candid with outsiders than they would be with prison officials. Therefore, genuine concerns about conditions or events within the prison system might be more readily transmitted to family members than through the normal TDCJ channels. TDCJ should use information gleaned from the Ombudsman's office to inform its policies on offender management.

Regular reports from the Ombudsman to upper management may prove to be as useful a barometer of prison conditions as the grievance process reports. Data from the office about public perception of prison policies should provide a useful snapshot of public opinion to the agency.

Emergency Action Center

The Emergency Action Center alerts prison management of serious problems in the prison system. The Emergency Action Center separates emergencies into two classes: Level 1 emergencies are reported to upper management within 3 hours of the event; Level 2 emergencies are reported within 12 hours of the event. Level 1 emergencies include assaults to staff involving serious injuries. They also include natural disasters and attempted escapes. Level 2 emergencies include threatened assaults. However, in monthly reports, staff assaults involving serious injuries are combined with other assaults (and even threatened assaults), rendering the reports less valuable in determining the real nature of emergencies within the prison system.

Emergency Action reports are useful because they express the agency's priorities for immediate action. Attempted escapes and natural disasters (both Level 1 events) are significant occurrences that require the immediate attention of upper management. But neither of these events necessarily involves an injury to any party. For this reason the Emergency Action reports are not particularly helpful in evaluating safety issues behind the walls.

Risk Management Office

The Risk Management office within TDCJ provides excellent reports of dangerous events within the prison system. These reports are submitted to upper management on a monthly basis. The reports are broken down into useful categories:

who was injured (staff or offender),
what they were doing when they were injured,
what caused the injury, and (even)
what part of the body was injured.

After months of trying to get a handle on real problems inside the prison system, the Risk Management report shows the most promise of identifying dangerous conditions and trends in the prison system. Beyond the complaints of inmates and the reassurances of prison officials, this report at least attempts to quantify and categorize the injuries suffered by inmates and staff. Risk management reports should form the core of the serious injury report that the Committee recommends below. Risk management reports contain some details about injuries suffered by both staff and offenders populations. However, there are three important factors that should be added to this report in order to better identify hazardous conditions in prison.

First, the reports do not specify the seriousness of the injury. Any injury that involves lost work time and medical care—even simple first aid—is included. The existing reporting structure combines very minor injuries with very serious injuries. This is not helpful in evaluating the nature of reported injuries.

Second, the Risk Management reports exclude certain serious injuries. Injuries or alleged injuries suffered during medical treatment are not included in the reports. A consolidated report of **all** serious injuries—segregated from minor injuries—is essential to good prison management.

A third shortcoming of the Risk Management report is that it does not involve an investigation of underlying causes of injuries. For purposes of identifying dangerous conditions for staff and offenders, it is essential that there be some follow-up analysis of the events that led up to the injury.

Summary of Incident Report Shortcomings

The need for a comprehensive reporting system can be illustrated by a single type of injury that was described by several witnesses at the Committee's first hearing. An offender is being transported from one place to another in a prison unit.

He is handcuffed with his hands behind his back. He falls and suffers significant injuries to his head and face. He is treated sometime later and an accident report is filed.

How would this event be investigated? If the offender files a grievance there is no remedy, because the guard states it was an accident. If he files a report with Internal Affairs and that division cannot obtain independent verification of a claim of excessive or unauthorized force, the claim would not be sustained. In addition, since this does not qualify as a "use of force" there is no requirement for an Internal Affairs investigation at all. The Ombudsman's office will not even hear of the event unless a family member or other outsider registers an inquiry. In any case, the Ombudsman has no independent investigatory authority. The Emergency Action Center has completed its job when it reports the event to management. No further action is required. The Risk Management Office will report that an offender suffered an injury to his head, while being transported in a hallway, and place the event in appropriate category by unit, region, and type. However, there is no follow up to determine the exact cause of the injury, or the extent of the injury, or potential relationship to other events.

If the offender had filed ten grievances about bad food, and gradually inspired the anger of the staff, no one will know. If the guard tripped the offender, no one will know that either. If the offender waited in his cell for two days for medical attention, the health care providers have no authority to discipline those who delayed treatment.

Whether this type of event is endemic (as witnesses alleged) or isolated, cannot be determined under the existing reporting system. Events like these may simply fall between the cracks of the various reporting systems within TDCJ.

Whether an offender or staff member is seriously injured as a result of accident or intentional conduct, it is important for upper management to respond appropriately. Even if the event described above happened 107 different times in 107 different units, it might not be readily apparent to upper management. Therefore the event would not be subject to remedial action. This type of case can remain invisible to the system despite the fact that remedial action could be simple and effective: implementation of a policy that inmates must be supported by staff if they are handcuffed behind their backs while being moved.

The problems associated with the lack of a reliable system for reporting serious injuries became apparent in testimony before the Committee. Family members of

offenders and groups interested in inmate safety came before the Committee and chronicled many events wherein inmates were subjected to substandard and dangerous conditions. Injury reports tell us that some of these accounts are true.

Enough injuries take place in the prison system to warrant remedial action. However, in the absence of a clear accounting of injuries, it is impossible for policy makers and prison managers to specify where remedial measures are most needed and where they are most likely to be effective. Systemic problems and dangerous trends are impossible to remedy if they have not been specifically identified. There is a clear need for a tool that will enable prison managers to look beyond anecdotal evidence to determine where prison conditions are unnecessarily dangerous.

Conclusion Regarding Serious Injury Reports

There is no single report produced by prison officials that combines data from different divisions about all serious injuries suffered by persons in the prison environment. Effective management of prison hazards requires a comprehensive serious injury report. By focusing on reports of serious injuries, upper management can focus on real problems, rather than imaginary problems and minor events. Whereas the Grievance System, Internal Affairs and other TDCJ divisions provide a glimpse of problems in the prison system, a consolidated report on serious injuries would bring to light the most significant dangerous conditions.

Each TDCJ division that currently reports on problems in the prison system has a built-in shortcoming. The shear volume of grievances filed by inmates precludes complete investigation of every complaint. "Use of force" reports, reviewed by Internal Affairs, do not deal with offender-on-offender assaults. Other accountability support systems have similar deficiencies. They either lack the jurisdiction to investigate certain types of problems or the authority to implement changes in conditions or procedures.

In general, safety issues in the prison system are intrinsically difficult to deal with. The offender population is a vocal—and often unreliable—source of information. Well meaning prison officials can become numb to complaints because of the nature and volume of many inmate grievances. But a reliable, comprehensive system of reporting genuinely serious injuries will help identify the conditions and events that jeopardize the safety of people who work and live behind the walls. These reports will confirm or debunk allegations of systemic problems in the prison system.

Response to the Committee from Interested Groups

After the September hearing Committee staff solicited comments from interested groups concerning inmate safety. Of the 13 groups who testified, and whose comments were solicited, three responded. The comments are summarized in Attachment 4.

Video Monitoring

TDCJ officials were questioned about the possibility of using video monitors placed at strategic locations inside prison units to provide an objective view of in-prison activities. The problem with this suggestion was the cost of these units. There was an indication from TDCJ that video monitors would be employed in some locations on a pilot basis. One pilot project is being tested at the Luther Unit.

The Committee believes that there is a compelling need for this type of monitoring. In order to be effective there need not be a guard assigned to watch the monitor at all times. These cameras would not take the place of surveillance cameras, but would provide an independent view of events after the fact, if required to assist an investigation. The mere existence of a tape that could be reviewed by Internal Affairs, the Grievance system, or other parties would provide valuable data and help validate existing processes. Internal Affairs should review the tapes from these video monitors in conjunction with its normal investigations, as well as reviewing random samples, to determine the nature and extent of unreported violations of prison policy.

Training Issues

Testimony at the September hearing indicated that there are discrepancies between the training provided by TDCJ and that conducted by the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE). TCLEOSE trains and certifies applicants for employment in Texas county jails. There may be reasons why training for county employees should differ from that required of state employees, but this issue has not been explored fully. In fact, testimony from TDCJ and TCLEOSE officials illustrated that there is little if any coordination between their respective curricula. For example, TCLEOSE requires a psychological assessment before an applicant is granted certification as a corrections officer. TDCJ has no such requirement. TDCJ officials have determined that the value of these assessments does not justify their cost.

In response to the challenge posed by the increase in prison population and the

need for additional guards, TDCJ lowered the period of training from 240 hours to 160 hours. This enabled TDCJ to place guards in service more quickly without overburdening the training facility in Beeville. TDCJ also hires guards who have been trained to TDCJ specifications in various institutions of higher education, generally community colleges.

TDCJ training meets the standards set by the American Corrections Association. TDCJ trains approximately 400 guard applicants each month at its Beeville facility. With the stabilization of the inmate population and concurrent stabilization of staffing needs, TDCJ anticipates that this number will decrease in the next few years. This should make it possible to use the training facility for additional in-service training for guards on an ongoing basis.

Administrative Segregation, Close Custody, and High Security Beds

One of the most effective tools available to prison officials to ensure safety is the use of classification systems that isolate or partially isolate offenders who pose a danger to staff and other offenders. Administrative segregation, close custody, and high security beds can be very effective in reducing the opportunity for dangerous contact. TDCJ has pioneered the development and use of high technology prison units designed for safety. In the most restrictive of these units, an inmate has virtually no opportunity to attack other offenders or staff.

For offenders who have a history of institutional violence, gang involvement, or attempted escape, there are single cells that are electronically controlled and monitored at all times. Recreational time is limited to one hour per day or less. Recreation with other offenders can be limited or forbidden altogether. (These high security units were recently featured in *Nightline* television program.)

TDCJ has approximately 8,000 ad seg beds in operation today and an additional 2,442 have been approved for construction or renovation. With the recent expansion of prison capacity it may seem odd to be constructing additional beds. TDCJ officials have demonstrated the need for these beds for safety purposes. For a detailed analysis of the justification for high security beds the Committee refers the reader to reports from the Criminal Justice Policy Council (May 1998 report listed in bibliography). In general, the expansion of prison capacity included a large number of dormitory style beds. The percentage of cell beds dropped from 72.9% in 1989 to 52.6% in 1997. The new construction is designed to give prison officials the ability to separate the six to seven percent of offenders who require isolation for safety reasons.

The Committee is particularly concerned about some of the implications of confinement in high security facilities. Offenders placed in these units have little opportunity for participation in educational, therapeutic, and vocational programs. Their status also prevents them from getting some "good time" credits. Through this combination of conditions, these offenders may end up completing their sentences by serving day-for-day and being discharged without parole supervision.

The thought of releasing an angry inmate, who has had very little human contact and **no** rehabilitative programming for years onto the streets, is problematic. Those released without parole supervision present a particular danger. For even the most troubling inmate—indeed, especially for that offender—it is important that there be some sort of orderly transition to the free world.

TDCJ has employed a consultant to review the need for and use of high security beds. This final report is pending at this time. The Committee anticipates that TDCJ will review its policies regarding long-term incarceration in high security beds in the context of the consultant's report.

Perspective

It is important to note that there are limits to the efficacy of measures taken to ensure inmate and corrections officer safety. No amount of vigilance can prevent isolated altercations from occurring between physically confined, potentially aggressive individuals. The most effective method for dealing with this challenge is to implement clear rules for both guards and inmates, and to make the consequences of inappropriate behavior swift and fair. The relationship between the safety of guards and inmates cannot be overemphasized. If guards feel safe in their jobs, they are much more likely to respond to difficult situations in an appropriate, measured manner. If inmates feel safe, they are less likely to be aggressive to staff and other inmates.

The Committee heard troubling testimony about various kinds of problems within the prison system. Although much of this testimony was compelling, the fact remains that the Committee—and the Legislature in general—is ill-equipped to adjudicate specific disputes or to determine the veracity of wildly differing accounts of the same event. In this Report, the Committee does not set policy by anecdote, but seeks to establish standards of accountability that will be generally applicable in all situations.

Committee Recommendations to TDCJ and Referenced Agencies Regarding Inmate and Corrections Officer Safety

Reporting Procedures:

- Establish a single protocol utilizing existing reporting systems for reporting incidents of serious injury to staff, offenders or other parties;
- Require TDCJ medical staff and the Correctional Managed Health Care Advisory Committee to define "serious injury" according to accepted medical criteria;
- Include among serious injuries any event or condition arising in prison that required medical attention over and above simple first aid;
- Specify whether the injury was the result of an accident, assault, medical mistake, or other cause;
- Specify any remedial action recommended or taken in response to the event or condition;
- Determine whether there is any correlation between serious injuries to offenders (from any cause) and the filing of grievances by inmates;
- Investigate **every** serious injury to determine possible underlying causes, including substandard medical care, unavailability of timely medical care, industrial/work-related hazards, inherently dangerous procedures used in transporting offenders, and any other threat to safety;
- Combine reports of serious injuries from existing data supplied by:
  - grievance reports,
  - use of force reports,
  - emergency action reports,
  - patient liaison reports,
  - health care provider reports,
  - risk management reports, and
  - all other divisions that may have access to information about injuries;
- Report all serious injuries to the Executive Director of TDCJ, the Correctional Managed Health Care Advisory Committee, the Board of Criminal Justice, the Criminal Justice Policy Council, and the Senate Committee on Criminal Justice at least each fiscal year;
- Report to the Committee by February 1, 1999 on the implementation of these recommendations.

Video monitoring

- Contingent on adequate funding, install video monitoring equipment on units

in locations where there are reported or likely disciplinary or security problems;

- Review Risk Management reports to determine which locations inside prisons are the most dangerous and install video monitors, as appropriate, in those locations;
- Report to the Committee by February 1, 1999 on the implementation of these recommendations.

Training

- Require TDCJ officials and TCLEOSE officials to consult with each other on training curricula;
- Review the extent and adequacy of the respective training of corrections officers to determine whether the current course work sufficiently trains prospective guards for their duties;
- Establish training standards for state, county, and private corrections officer training, including reciprocity for individuals trained under the parallel system;
- Evaluate the need for psychological evaluation and assessment prior to employment as a corrections officer;
- Review contracts with private vendors and determine where the requirements for private vendors differ from TDCJ policies;
- Delete additional requirements imposed on private vendors unless there is a compelling state need to impose these requirements;
- Report the results of these efforts to the Committee by February 1, 1999.

High security units

- Evaluate the classification system to determine whether gang membership alone should entail high security status;
- Determine how many offenders are likely to be released directly from administrative segregation status and make recommendations to the Committee for their supervision or other transition to the free world;
- Review internal policies regarding "graduation" out of high security status and back into the general prison population to ensure efficient use of beds and appropriate classification of offenders subject to imminent release;
- Report the results of these efforts to the Committee by February 1, 1999.

Interim Committee Charge #2:

Review the medical and mental health treatment of inmates while incarcerated in TDCJ facilities and evaluate the effectiveness of mental health treatment for offenders after they have been released. Offer recommendations for any necessary statutory or regulatory changes.

(Mental Health services for offenders will be discussed under Supplemental Charge 1 regarding mental health issues and the identification of mentally impaired offenders in the Texas criminal justice system.)

Medical care for offenders in Texas prisons has undergone a significant change in the last few years. This transformation is still in progress. The biggest change involves the implementation of managed health care for offenders. Managed care includes oversight by the Correctional Managed Health Care Advisory Committee (CMHCAC), delivery of services by the University of Texas Medical Branch (UTMB) and the Texas Tech University Health Sciences Center (TTUHSC), and "gate-keeper" review inside prison units before offenders are referred to physicians.

CMHCAC is composed of six members: two from TDCJ, two from UTMB, and two from TTUHSC. The fiscal connection between these entities is illustrated in Attachment 5. Money is appropriated to TDCJ which contracts with CMHCAC, which in turn contracts with the two academic health care providers for the actual delivery of health care to offenders. UTMB provides health care to offenders in the eastern part of the state. TTUHSC generally contracts with other health care providers in the less populated western part of the state.

The fact that the academic health care providers enjoy a majority on the board that oversees their operations and contracts has been criticized as a "fox guarding a henhouse." The structure (and the acronyms) of health care in Texas prisons can be confusing, but the reasoning behind its implementation was sound. The managed health care system was put in place to control costs and provide quality medical care for offenders by qualified medical personnel. The partnership between TDCJ and the health care providers has accomplished both of these goals.

Previously TDCJ itself provided health care to inmates and contracted with local providers for additional care. This arrangement was unsatisfactory for a number of reasons. TDCJ found it very difficult to hire and retain physicians. For example,

at one point the job of TDCJ medical director went unfilled for over one year. Before the implementation of managed health care, prison health care costs were rising in a consistent manner. Since the advent of managed care health care costs have stabilized. (See Attachment 6)

Nevertheless the current system has not been problem free. The State Auditor issued a report critical of a variety of prison health care activities (see Auditor's Report referenced in bibliography). There are two main concerns raised in this report: fiscal accountability and quality management. Although they did return $12 million to TDCJ in excess funds, the two health care providers were criticized for keeping approximately $25 million in excess appropriations from the latest appropriated amounts. They were also criticized for failing to address quality-of-care issues.

The Committee finds that the quality-of-care delivered to offenders meets constitutionally required norms. The Committee also finds that the basic funding of the managed health care system is appropriate. However, it is important to deal with the legitimate concerns raised by the Auditor's report by requiring CMHCAC to take a more active role in regulating both the monetary efficiency and the quality control aspects of managed care. The Committee defers to the Sunset Advisory Committee on the structural changes that will affect these changes. The Sunset Committee has recommended adding three members to the CMHCAC. This will give prison health care managers fresh eyes to review the expenditure of a $280 million appropriation, designed to deliver good, efficient care to the 145,000 offenders subject to its jurisdiction.

In general, the Committee finds that the current system is doing a good job managing the delivery of care to a difficult population. The Committee finds that fine-tuning this system by providing for additional oversight, structural changes in management, and firm fiscal controls will continue to improve the system. These are the changes recommended by Sunset and endorsed by the Committee.

One of the newest developments in correctional health care is the requirement of co-payment for medical services by offenders who have the ability to pay. Testimony indicated that the advent of co-payment has reduced the number of visits by offenders to medical personnel. This is a viable tool for reducing medical costs in the prison system just as it is in the free world. However, in the prison environment it is important to make sure that indigent offenders are not denied medical care solely on the basis of their inability to pay the modest co-payment. CMHCAC should continue to monitor the delivery of health care to ensure that indigent inmates are not deprived of health care for lack of funds. Current rules do not require co-payment

from indigent inmates or require co-payment in emergency situations. This protocol should remain intact.

Institutional health care providers—who are reputable Texas medical schools—should play a more active role in self-policing quality control. But the CMHCAC should share the responsibility of reviewing compliance with good medical practice. Side issues, like the delivery of care by physicians subject to disciplinary action and the implementation of co-payment by offenders, are best left to the CMHCAC.

CMHCAC should have the authority to set capitation rates (currently at $5.28/inmate/day) and the responsibility of ensuring that excess monies are used appropriately. The recent practice by the medical schools of retaining excess appropriations, and in some cases paying bonuses to individual physicians, should be carefully reviewed by CMHCAC. Contracts between CMHCAC and the health care providers should provide for rebates in situations where these excess appropriations can be identified.

By adding three members to CMHCAC in the next legislative session, prison health care providers will no longer have a majority of voting members. This should help ensure independent oversight of managed health care in the prison system, while at the same time ensuring representation by the stakeholders in the system.

Under current practice, TDCJ is given $280 million to provide health care for offenders. This money is given to CMHCAC which, in turn, contracts with the two medical schools to provide health care. The Sunset Commission has recommended continuing this somewhat roundabout method of control, with the addition of external CMHCAC members. The Committee finds that managed health care in Texas prisons is working according to the general statutory scheme. However, the large appropriations involved—and the newness of the system—justify ongoing vigilance.

Prevention of Health Care Problems in the Prison Environment

The prison population is over 90% male, has an average age of 31 years, and is precluded from drinking alcohol and consuming tobacco. Ordinarily, this would be an ideal target population for a health care provider or health insurer. Unfortunately, inmates have not been the beneficiaries of life-long appropriate health care and many suffer from the effects of substance abuse.

Nevertheless, the offender population should be a model of preventive

medicine, because of the control that the prison system has over the inmates' diet and exercise. Many offenders are serving very long sentences. Given the fact that the state will be responsible for their health care, it makes sense that prison management should focus very strongly on the promotion of offenders' health.

The Committee heard a great deal of testimony about medical care in the prison system. However, there was no indication that the medical experts are involved in developing programs in the prison system to promote inmates' health. The Committee finds that it is in the best interest of the state that health care providers actively participate in developing prison dietary and exercise guidelines that will advance good health among offenders. This will have long-term financial benefits for the state—and may even help offenders' general well-being when they are released.

Committee Recommendations Regarding Health Care in TDCJ:

- Support the Sunset recommendation to expand the CMHCAC by adding three new, independent members;
- Require CMHCAC to be accountable for both quality-of-care and fiscal responsibility for health care within the prison system;
- Require health care providers to report to TDCJ management all instances of medical deficiencies (malpractice, delayed delivery of care, etc.) on at least a quarterly basis;
- Require CMHCAC to include in contracts with health care providers rebates of monies representing excess appropriations;
- Require health care providers to justify the retention of money appropriated for catastrophic care, unforeseen events, and critical care based on actuarial analysis;
- Require CMHCAC to evaluate the efficiency of the health care delivery mechanisms utilized by UTMB and TTUHSC and make recommendations to the legislature for changing healthcare providers, if necessary;
- Require health care providers and CMHCAC to report yearly (January 1 each year) to the Board of Criminal Justice, and the Committee any problems encountered by health care professionals in the prison system including:
    - delays in alerting medical staff about medical needs,
    - inconsistencies between good medical practice and actual practice arising from security or other concerns,
    - trends involving injuries to staff and offenders from any source (referred to above in Charge 1), and

- potential policy changes that could improve the quality or efficiency of health care in the prison system;

- Require health care providers to establish guidelines for offender diet and exercise (taking into account reasonable security requirements);
- Require TDCJ to follow established dietary and exercise programs whenever feasible;
- Require health care providers and TDCJ officials to valuate and implement methods of preventing the spread of serious disease in the prison environment; and
- Report to the Committee by February 1, 1999 on the implementation of these recommendations.

Interim Committee Charge #3:

Continue to monitor the implementation of the Rehabilitation Tier in TDCJ and the Master Facilities Utilization Plan as recommended in the Committee's interim report for the 75th Legislative Session. Study the general capacity needs of TDCJ through the year 2004 and make recommendations for enhanced facility use, construction needs, or alternatives to incarceration.

Alternatives to Incarceration

The dialogue concerning alternatives to incarceration usually centers around the safety and cost effectiveness of probation and parole. Lost in this dialogue is the need to carefully evaluate another part of the offender population. There are many offenders inside the prison system who are the most likely to be abused, the most likely to be exploited, the most expensive to treat medically, and the least likely to re-offend. This population includes offenders who are mentally ill, mentally retarded, physically incapacitated, geriatric, and terminally ill. Clearly there is a pressing need to develop alternatives to incarceration for these offenders.

Recent studies have chronicled the aging of the prison population. With felons serving longer and longer mandatory sentences, it is inevitable that prison systems throughout the United States will house older inmates. Texas shares this problem with every other jurisdiction in the country. In all jurisdictions, health care costs and other costs are much greater for older offenders.

In addition, it is clear that even young offenders can suffer from long-term, pernicious diseases that incapacitate them and make them expensive to incarcerate. The AIDS epidemic, the recent increase of Hepatitis (especially Type C), tuberculosis, and other diseases that affect the general population, also have an impact on the prison population. These diseases result in significant costs in treating old and young offenders alike.

Perhaps the most overlooked population in the prison system is the group of mentally ill and mentally retarded offenders. In the past few years there has been a national trend away from institutionalization of mentally impaired individuals. Texas MHMR has followed this trend. Many of the offenders throughout the criminal justice system—and TDCJ in particular—formerly resided in mental facilities of various sorts. Many of these offenders are in prison, not because they committed violent crimes, but because they cannot cope with the free world. Many have substance abuse problems. Others simply get into trouble when they have no support and no structure

in their lives.

It is not clear how many mentally impaired offenders are in Texas prisons. It is clear that they are very likely to be exploited and abused in prison. These offenders simply fall between the cracks of the state's various support mechanisms. MHMR has its hands full with law-abiding citizens. The Texas Rehabilitation Commission (TRC) does not generally provide for the long-term needs of the offender population.

For the offenders who are incapacitated by physical or mental problems, there is little help in the prison system. In many cases inmates are held in the general population. When they are eligible for parole, a parole plan that calls for release (literally) to the streets cannot be viewed favorably. The one program that provides some assistance is Special Needs Parole (found in 508.146 of the Texas Government Code). Unfortunately, the availability of placements in this program is very limited.

Committee staff visited a pilot project nursing home in Karnes County that houses paroled offenders exclusively. The facility held 27 parolees on the day of the visit, but has capacity for 60. This facility looks like other nursing homes, but the residents are supervised on a regular basis by a parole officer. The walkers, wheelchairs, and oxygen bottles made it evident that these residents are not at great risk to escape.

Committee staff also visited a TDCJ facility for incapacitated offenders in Huntsville. These facilities are remarkably similar to the Karnes County facility in services, medical care, etc. However, the two facilities have widely differing costs to the state. Whereas the facility in Karnes County is operated by a private provider who receives money from Medicare, Medicaid, and related programs, the facility in Huntsville does not. Basically an offender behind bars who is in very bad medical condition can cost the state $250 per day **over** the basic cost of incarceration. An offender in a private nursing home costs the state a small fraction of that amount because federal funds defray most of the cost of medical care.

The Federal government also has programs designed to assist mentally retarded and mentally ill citizens. Generally these programs do not apply to persons who are incarcerated, but they do apply to parolees. Programs include sheltered work places, assisted living environments, and other structured settings appropriate for disabled individuals. The Committee has found no concerted attempt by any state agency to pursue these programs and funds for offenders. Indeed most agencies seem concerned that any attempt to bring offenders under this umbrella would dilute the funds available for law-abiding Texans.

There are over 2,000 geriatric offenders in Texas prisons—and that number is growing dramatically. A typical estimate of the number of mentally impaired offenders in any system is 10%. For Texas that would mean a population of well over 10,000 incarcerated offenders who are mentally impaired.

If some of these offenders can be placed in alternative settings, funded partly by federal programs, TDCJ could save millions of dollars. Obviously this would also provide additional bed space in Texas prisons for offenders who constitute a greater threat to public safety. For example, if only half of the mentally impaired offenders were transferred to structured living environments, the prison system would save $75 million per year in operating expenses (5,000 offenders at about $15,000/year). These numbers would justify using money appropriated to TDCJ to contract for and develop alternative settings for these offenders, without depleting money appropriated to MHMR, TRC and related agencies.

Clearly, parole policies would also have to reflect these changes. Since public safety is always the primary goal of the criminal justice system, the Parole Board should review individuals on a case-by-case basis to determine their danger to society and the appropriateness of proposed placements.

Committee Recommendations (Alternatives to Incarceration)

- Require TDCJ, TCOMI, the TRC, the Texas Department of Human Services (DHS), and MHMR to review all programs to which offenders, parolees, and other persons in the criminal justice system may be entitled;
- Require TDCJ, TCOMI, DHS, TRC, and MHMR to aggressively pursue the development of facilities and programs for offenders who are incapacitated and unlikely to re-offend;
- Require TDCJ and TCOMI to do a comprehensive census of offenders who are mentally ill, mentally retarded, terminally ill, incapacitated, and geriatric;
- Require TDCJ to determine how many of those offenders are non-violent offenders;
- Require the Texas Department of Human Services, TDCJ, TRC, and TCOMI to complete a survey of facilities (including nursing homes, hospitals, etc.) which would be available and appropriate for paroled offenders;
- Require TDCJ, TCOMI, TRC, and the Parole Board to coordinate efforts to find outside placements for appropriate offenders who can be paroled to facilities that are appropriate for their needs;
- Require all referenced agencies to ensure that placements in facilities are

designed to ensure public safety;

- In particular, require referenced agencies to determine how much security can be imposed on nursing home residents while still qualifying for available funds;
- Require the Board of Pardons and Paroles to evaluate potential parolees based on their likelihood of re-offense, their cost to the prison system, and the appropriateness of possible placements; and
- Require referenced agencies to report to the Committee on the implementation of these recommendations by February 1, 1999.

Rehabilitation Tier and Capacity Needs

The Criminal Justice Policy Council (CJPC) has held regular briefings for legislative leaders and produced numerous reports regarding these issues during the past two years. Regarding capacity of Texas prisons, it is clear that the efforts of the state's leadership and voters have provided the state with adequate space to incarcerate felons for the foreseeable future.

Assuming that parole rates and incarceration rates hold steady, TDCJ has the ability to hold Texas felons for the expected term of their incarcerations. TDCJ has implemented an orderly process of contracting with counties to hold inmates when necessary. This is greatly superior to the previous practice of leaving offenders in county facilities without compensation to the counties.

Background on the Rehabilitation Tier

Last Interim this Committee recommended new accountability measures within the prison system regarding rehabilitation efforts. The Committee identified numerous programs and substantial funds that appeared to be dedicated to various rehabilitation efforts. In testimony before the Committee, it became apparent that these programs and funds had goals that were not primarily rehabilitative. Some programs were used primarily to reduce the cost of incarceration by using inmate labor for prison operations. Others were used as inmate management tools, rewarding inmates for good behavior by allowing participation in desirable programs.

In response to the Committee's recommendations, TDCJ identified specific programs that would be evaluated based on their success in reducing recidivism. These programs include the Sex Offender Treatment Program (SOTP), Substance Abuse Felony Punishment Facilities (SAFPs), Pre-release Centers, the In-Prison Therapeutic Community (IPTC), and the Value Based Pre-Release Center. It was agreed that programs that could not be justified based on their success in reducing recidivism would be considered for elimination. The broader goal was to evaluate

TDCJ's ability to establish successful rehabilitative programming for offenders.

The Rehabilitation Tier has also been carefully chronicled by the CJPC. The effort to evaluate the success of rehabilitation within TDCJ is an ongoing exercise. This was anticipated by the last Interim Report from the Senate Committee on Criminal Justice. The Committee refers the reader to the reports issued by the CJPC listed out in the attached bibliography. This effort to evaluate rehabilitation efforts in an objective manner is proceeding in an orderly fashion, and deserves additional time before it is fully evaluated.

Substance Abuse Felony Punishment Facilities (SAFPs)

SAFPs are particularly interesting to state leaders because this program is one of the few efforts that has shown excellent preliminary results in combating recidivism. The CJPC has identified this program as one that is both cost-effective and successful. Unfortunately, its success has brought about a shortfall in available bed space in the program. At several points in the last year the program had a waiting list of hundreds and up to a six-month delay in placement of offenders.

For this reason legislative leaders have urged TDCJ officials to divert resources from other programs and eliminate the backlog. TDCJ management has responded by expanding available SAFP space and cutting the waiting list substantially (see Attachment 7). Again, these efforts are continuing and deserve additional time before they are fully evaluated.

Intermediate Sanction Facilities

Intermediate Sanction Facilities (ISFs) are secure facilities designed to hold offenders who have violated the terms of their parole, but whose violation is not sufficiently severe to warrant full revocation of parole. For example, a non-violent offender who has been on parole for a significant period of time may have a technical violation of parole conditions. This may be a failure to attend counseling or a failure to appear in the parole office at a specified time. The Parole Board reviews these offenders in the normal process of parole revocation review.

If the Parole Board determines that an offender has violated the terms of parole in some minor fashion, it may order the offender to be held in an ISF. This has proven to be an effective tool for bringing offenders into compliance, without the expense of much longer term incarceration in prison. Of course, the Parole Board retains the authority to revoke parole and return the offender to prison if he or she fails to comply with parole conditions in a satisfactory manner.

Committee Recommendations on Capacity Needs

- Direct TDCJ to continue to review the utilization of Substance Abuse Felony Punishment Facilities and Intermediate Sanction Facilities to determine their cost-effectiveness;
- Direct TDCJ to divert resources to SAFPs and ISFs as deemed appropriate based on their overall effectiveness; and
- Direct TDCJ and CJPC to continue to review the implementation of the Master Facilities Utilization Plan and Rehabilitation Tier and alert the Committee and legislative leadership of any problems in their implementation.

Interim Committee Charge #4:

Monitor the implementation of major criminal justice legislation passed by the Legislature during the 1997 regular session including: SB 367, regarding out-of-state inmates and private correctional facilities; HB 1301 and HB 2324, regarding the prison industries program; and HB 1112 relating to parole. Make recommendations for further legislative action, if necessary.

SB 367 Out-of-State Inmates and Private Jail Regulation

SB 367 from the 75th Legislature established a system for regulating the incarceration of out-of-state inmates in Texas jails. The regulatory authority is the Texas Commission on Jail Standards (TCJS). In the last year the population of out-of-state inmates in Texas jails has dropped from 4,367 to 1,625 (as of September 1, 1998). The regulatory framework has worked well with no serious problems since its effective date.

In the September 16, 1997 hearing regarding TDCJ inmate safety issues the Committee heard testimony about a serious disturbance in Brazoria County. The Committee viewed a videotape in which guards and guard dogs assaulted offenders in the Brazoria County Jail. The videotape was shown on many news programs nationwide. In the aftermath, several inmates sued the county and guards were disciplined. The litigation is still pending. This event raised a controversy about the treatment of out-of-state inmates in Texas jails and the conditions in privately operated correctional facilities.

Although the Committee's charges do not include a review of conditions in county or private facilities, the Brazoria County incident inspired closer scrutiny of these facilities. TCJS commissioners considered a proposal to impose state regulation on county facilities. In particular, TCJS solicited comments from county officials about the possibility of setting statewide policies regarding "uses of force" against offenders. TCJS determined that there was no need for statewide regulation. The commissioners decided against the imposition of state standards in an effort to avoid usurping local authority.

In the last eighteen months there have been no serious incidents of uses of force on out-of-state inmates in private corrections facilities. The Committee finds that there is no immediate need to impose a single state standard on all Texas counties regarding uses of force. However, it is incumbent upon state government—through TCJS—to monitor and regulate local facilities.

Several clean-up issues were raised during the interim that may require legislative action. There was no provision made for the regulation of transportation of offenders. Money collected by TCJS to monitor the incarceration of offenders was not re-appropriated to the agency to defray the cost of these inspections. There was no provision permitting privately employed corrections officers to carry firearms while supervising offenders. (An Attorney General's letter opinion (No. 97-053) indicates that privately employed guards may carry weapons **only while on duty.** However, a statutory change specifying the scope of this authority would be an improvement.)

Finally, the transfer of training responsibilities from the Texas Board of Private Investigators and Private Security Agencies (TBPIPSA) to TCLEOSE may need additional clarification. The Committee recommends these actions.

HB 1301 and HB 2324
Prison Industries Programs

Legislation regarding prison industries has been exhaustively reviewed by the Sunset Commission in its interim report. Sunset has echoed the State Auditor's call for increased oversight of prison industries. The general approach is for prison industry programs to operate in a more business-like fashion, including the implementation of clear cost accounting and development of a mission to train offenders for specific free world jobs.

The legislation created a new reviewing body, the Private Sector Prison Industries Oversight Authority (PSPIOA), to help manage private prison industries. The Governor appointed members to this body and it has begun the process of promulgating rules and guidelines for private prison industries. This body is the umbrella organization for certification of private prison industries in the state, under the federal Prison Industries Enhancement Act (PIE). PSPIOA is doing an excellent job of bringing together industry and corrections facilities to meet common goals. The Committee finds that no dramatic changes to this new entity are needed at this time.

HB 1112
Blue Warrants

In past years, TDCJ left parolees in county jails for extended periods of time, pending the outcome of parole revocation hearings. (Violation of the terms of an offender's parole triggered the issuance of a "blue warrant" authorizing any peace officer to arrest the parolee and transport him to a local correction facility.) Holding parolees during this period constituted a burden on county government, because there

were significant backlogs in the hearing process and many months might elapse between the time of re-arrest and re-incarceration in TDCJ.

HB 1112 sought to remedy this situation by setting time limits for holding parolees in county facilities. Basically, after 60 days TDCJ must transfer parolees to its own facilities to await revocation proceedings. All indications are that this plan is working successfully. The Blue Warrant backlog has dropped, parole decisions are being expedited, and counties appear satisfied with the current system.

Committee Recommendations, Charge 4

- Grant TCJS the authority to regulate the transportation of offenders among county facilities, including out-of-state offenders;
- Re-appropriate to TCJS money charged for the supervision of facilities holding out-of-state inmates;
- Grant private corrections officers the authority to carry firearms while on duty (this is not a recommendation to allow guards to carry weapons while off duty);
- Clarify that training for corrections officers should be conducted by TCLEOSE, TDCJ, or other authorized entities, and that TBPIPSA training or licensing should not be required for corrections officers; and
- Continue to monitor prison industries to enhance performance.

No Committee recommendation on blue warrant issues.

Interim Committee Charge #5:
Evaluate and, if needed, make recommendations for enhancing super-intensive supervision and other parole supervision efforts to ensure that parolees are sufficiently supervised upon release. In its work, the Committee should study technological advances that offer more effective supervision of offenders in a cost-effective manner.

Super-Intensive Supervision Parole (SISP)

This program was developed as an alternative to retroactive abolition of Mandatory Supervision. For offenders who had to be released under previously existing mandatory release laws (and selected parolees) the legislature determined that extraordinary supervision was appropriate. The Parole Board, based on recommendations from the Parole Division of TDCJ, imposes special restrictions on offenders who present a special risk to public safety. The restrictions include placement in secure facilities pending release, electronic monitoring, and high parole officer/offender ratios. **All** of the offenders released under SISP are monitored by electronic means.

The same bill that created Super Intensive Supervision Parole also expanded the definition of electronic monitoring to include whatever new devices technology might bring. Committee staff interviewed contractors who provide various kinds of electronic monitoring devices for parole supervision. Each of the companies touted its system and promised that there would be significant improvements in the near future. The companies, their services, and related costs are included in Attachment 8. The range of these services is substantial—from simple pagers, to voice recognition systems, to Global Positioning Systems that provide a trace of the offenders' movements moment-by-moment.

Although the SISP program is very new, it has already demonstrated its value. Preliminary numbers indicate that **over half of the offenders in the program have already failed to meet its requirements**. These offenders were selected because they were likely to re-offend. The high rate of revocation was anticipated and demonstrates the effectiveness of SISP. The percentage of revocations will increase as other offenders violate the terms of SISP. Of the 1,507 offenders placed in SISP, 793 have had warrants issued for pre-revocation hearings (as of June 30, 1998).

These offenders face revocation of their release, return to prison, and the loss of accrued "good time." The net result is that these offenders will end up serving more

of their full sentences, without regard to previously acquired good time.

A full report on the first fiscal year of SISP will be available from the Parole Division after the issuance of this Report. The program has shown that it is effective in supervising many of the offenders who constitute the greatest threat to public safety. When the full report is made available, it is likely to encourage expansion.

Committee Recommendation Regarding Super Intensive Supervision Parole:

- Continue to monitor the SISP program;
- Direct TDCJ Parole Division to prepare an analysis of offenders in the program;
- Direct the Parole Division to provide the Committee with recommendations by February 1, 1999 for expansion, modification, or other improvements needed in the program**;** and
- Direct the Parole Division to review and employ new technologies for monitoring offenders appropriately (according to their dangerousness) in a cost-effective manner that enhances public safety.

Supplemental Charge 1

Study the state court system to evaluate whether criminal defendants' competency and sanity is appropriately considered prior to the entry of judgment, assessment of punishment, and the execution of capital punishment.

The Committee held a hearing on Supplemental Charge 1 on November 17, 1997. At that hearing Dee Kifowit, Director of the Texas Council on Offenders with Mental Impairments (TCOMI), testified that Texas was frequently cited in a study conducted by the American Probation Parole Association (APPA) as an innovator among states in addressing criminal justice issues related to offenders with mental impairments.

In 1993, Texas became one of two states with legislative provisions and funding targeted specifically for the protection of the rights of offenders with mental impairments. These legislative provisions required the Texas Commission on Law Enforcement Officer Safety and Education (TCLEOSE), the Texas Jail Standards Commission (TCJS), and the Texas Department of Criminal Justice (TDCJ), to develop Memoranda of Understanding (MOUs). The purpose of the MOUs was to specify each agency's role regarding offenders with mental impairments throughout the judicial process. The agencies were also asked to review current procedures for identification of mentally ill or mentally retarded offenders, and take necessary action to improve the process.

Incompetency and Insanity

In examining the issue of whether a defendant's competency and sanity is appropriately considered prior to judgment, the assessment of punishment, and the execution of capital punishment, it is important to clarify the difference between incompetency and insanity. It is also important to review how a finding of incompetency or insanity affects an offender throughout the criminal justice process.

Competency relates to the defendant's condition at the time of trial. A defendant who is not able to assist in his defense is incompetent to stand trial (see 46.02 Texas Code of Criminal Procedure (CCP)). Insanity relates to the defendant's state of mind at the time of the crime (Section 8.01 Texas Penal Code and 46.03 CCP). A defendant who did not know right from wrong at the time of the crime is insane. The relevant statutory provisions follow:

CCP 46.02 Sec. 1.(a) A person is incompetent to stand trial if he does not have:

(1) sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding; or

(2) a rational as well as factual understanding of the proceedings against him.

(b) a defendant is presumed competent to stand trial and shall be found competent to stand trial unless proved incompetent by a preponderance of the evidence.

Texas Penal Code, Section 8.01

(a) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of a severe mental disease or defect, did not know that his conduct was wrong.

(b) The term "mental disease or defect" does not include an abnormality manifested only by repeated or criminal or otherwise antisocial conduct.

It is also important to recognize that whether a defendant is found incompetent to stand trial or "not guilty by reason of insanity," Texas law specifies that the defendant is not immediately released. On the contrary, mentally impaired persons subject to prosecution are evaluated and detained pending civil process. The flowchart contained in Attachment 9 describes the evaluation process that parallels the criminal justice process. Alleged offenders are evaluated by mental health professionals to determine the nature and extent of their impairment.

Incompetent defendants are held in secure facilities until they become competent to stand trial (if ever). Defendants who are insane, according to the statutory definition, are committed to a mental health facility. In the last ten years, only about 120 defendants have been declared not guilty by reason of insanity in the state of Texas. Ordinarily, the prosecution and the defense agree in these cases, and a jury determines that there is no reason to proceed with the criminal prosecution. There are very few cases in which there is a dispute about the defendant's ability to distinguish right from wrong.

Texas leads the country in its efforts to determine mental impairment within the criminal justice system. For example, the Texas Commission on Jail Standards (TCJS) has promulgated an assessment tool for use in all county jails in Texas. County officials ask individuals who have been arrested a series of questions to determine the individuals level of coherence and understanding. This simple technique, along with other clues that may have arisen during the arrest and booking process, helps officials

determine who requires additional assessment. TCJS has worked for two years to implement a screening process, seeking the input of the Department of Mental Health and Mental Retardation, TCOMI, the National Institute of Corrections, numerous mental health advocacy groups, sheriff's offices, and other concerned individuals. These early detection efforts are a significant improvement over previous practice in which an offender might be diagnosed with a mental impairment only after he reached the diagnostic center at TDCJ.

Various other tools are being employed by law enforcement as part of the effort to identify mentally impaired offenders. For example, peace officers complete six hours of training regarding mentally impaired offenders as part of their normal training. Local MHMR facilities retain data on mentally impaired individuals. This data is now available to law enforcement officials, who can cross-check records on offenders who they believe to be mentally impaired.

Mental Health Issues Prior to the Assessment of Punishment

To maintain a continuity of care, and to assist judges in the sentencing of defendants with a mental impairments, the Community Assistance Division of the Texas Department of Criminal Justice (TDCJ-CJAD) conducts a pre-sentence investigation (PSI) on all defendants in felony cases. PSIs contain information about the crime the defendant has been charged with, restitution necessary to compensate the victim, criminal and social history, and any other information requested by the judge. A copy of the completed PSI is sent to the sentencing judge and any agency that might be involved in the supervision of the defendant to assist these agencies in maintaining continuity of care for the defendant and providing for his or her special needs.

TCOMI Continuity of Care Program

(TCOMI Summary of Testimony and Materials)

Prior to calendar year 1994, there existed no formalized pre-release referral or post-release aftercare system for offenders with special needs who were being released from incarceration upon completion of their sentence (i.e., released on community supervision, paroled, mandatory supervision, or discharge). Without such a system of pre- and post-release planning, offenders with special needs, particularly those with mental impairments, were quite literally falling through the service delivery cracks.

As a result of legislative mandates, by statute and appropriations, TCOMI's coordination with the MOU agencies, embarked on establishing a continuity of care system in 1994. This continuity of care process is designed to identify offenders with special needs who are incarcerated in publicly or privately operated facilities (i.e.,

State Jails, SAFP's, or the Institutional Division) and are in need of aftercare treatment or rehabilitative services upon their release to the community. By identifying and referring such offenders prior to release, the chances for a more successful reintegration into the community are greatly improved. When considering that some local MH/MR's are reporting service delays of up to six months after intake, this pre-release process becomes even more critical. By notifying an MH/MR center, or other service provider, of an offender's projected release date, all necessary applications and eligibility determinations for service can be initiated prior to the offender's return to the community. This in turn ensures that the offender has immediate access to services (e.g., medication, psychiatric monitoring, case management, etc.) upon release.

With the majority of offenders with special needs residing in counties where TCOMI has funded programs targeted exclusively for those offenders, the pre- and post-release process in those counties is a contractual requirement. However, in communities where no such funding is available, the pre- and post-release referral process becomes of paramount importance.

To address this gap, TCOMI in cooperation with the MOU agencies, developed a statewide contact directory that identifies the appropriate criminal justice or health and human service professional who is responsible for responding to referrals or issues related to offenders with special needs. By having a designated contact person in every Texas community, the pre-release referral process can be initiated for every offender with special needs in need of aftercare treatment.

An additional component to the continuity of care process is the post-release follow-up report. For every offender referred to aftercare treatment, TCOMI requires a 30-60-90 day progress report. This report provides information on the offender's participation in required treatment programs and other pertinent information. By following the offender's progress immediately upon release, the offenders chances for a more successful reintegration into the community can be greatly improved.

Mental Health Issues Prior to Execution of Capital Punishment

The Committee examined whether a defendant's competency and sanity are appropriately considered prior to the execution of capital punishment, and found that no new procedures, judicial or otherwise, are necessary in this area. The Committee found that the appeals process, coupled with judicial remedies available prior to the execution of capital punishment, provide adequate opportunities to address the issue.

Conclusion

TCOMI has been charged with assessing the effectiveness of recent efforts to identify offenders with mental impairments. TCOMI will report the results of its study to the legislature in February of 1999. TCOMI is also charged with the responsibility of determining the adequacy of care provided to offenders after they are released from custody. The Committee will review that report to determine whether there are any statutory changes needed.

NO COMMITTEE RECOMMENDATIONS ON MENTAL HEALTH (COMPETENCY/SANITY ISSUES) AT THIS TIME:
AWAITING RESULTS OF COMPREHENSIVE SURVEY OF **TCOMI** REPORT

Supplemental Charge 2

Study inmate access to third parties' personal information obtained while working in the prison industries program. Evaluate the effectiveness of enforcement by prison authorities of current laws prohibiting inmate access, possession, or dissemination of certain information.

In the 74th and the 75th Legislative sessions, the Legislature passed laws to prevent inmates from gaining access to and misusing third parties' personal information. In the 74th Legislative session, the Legislature passed HB 949, which provided penalties for an inmate's misuse of information gained in an inmate work program. The 75th Legislature strengthened the prohibition on misusing information, by making it an offense for an inmate to possess confidential information with the intent to misuse it. Section 38.111 of the Texas Penal Code states:

> (a) An inmate of the institutional division or a person confined in a state jail facility commits an offense if with intent to harm or defraud another the inmate or person possesses a written document or other tangible item that contains personal information about another or discloses or uses personal information about another that the inmate or person has access to by means of participation in a work program operated by or for the institutional division or state jail division.
> (b) An offense under this section is a felony of the third degree.

An inmate who has been convicted of this offense may not participate in an inmate work program that provides access to personal information and may have his good conduct time taken by Director of the Institutional Division. This is stated in Section 498.0041 of the Government Code.

> Sec. 498.0041. Forfeiture for Work Program Violations
>
> If during a term of imprisonment an inmate is convicted of an offense under section 38.111 Penal Code, the director of the institutional division shall forfeit all or any part of the inmate's accrued good conduct time.

In addition to this legislative action, TDCJ has also responded to concerns over this issue. In response to a *Primetime Live* episode which examined the ability of TDCJ inmates to misuse personal information, Executive Director Wayne Scott stated

that since 1996 TDCJ has been "phasing out" inmate work programs which provide inmate access to personal information. The only instance in which offenders have had access to personal information in the last few years was a contract for data entry between TDCJ and the Texas Department of Transportation (TDOT). As of September 1998, all records conversion contracts are terminated. As this Report is being prepared, offenders are finishing up the data entry pursuant to the TDOT contract. In addition to phasing out these contracts, TDCJ has instituted several safety measures to ensure that inmates do not gain access to personal information.

NO COMMITTEE RECOMMENDATIONS REGARDING INMATE ACCESS TO PERSONAL INFORMATION. THIS ISSUE HAS BEEN RESOLVED BY ADMINISTRATIVE AND LEGISLATIVE ACTION.