



**Texas Department of
Criminal Justice**

Number: PGP 01.07

**Date: September
1, 2013**

TCOOMMI

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**Program Guidelines and Procedures
for Adult Transitional Case Management**

**Supersedes: January 3,
2011**

- Subject:** Case Management process for adult offenders on criminal justice supervision who do not require intensive case management services.
- Purpose:** To provide a process to TCOOMMI contract programs for identified offenders who may be considered for, or are receiving, Transitional Case Management services.
- Contents:**
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Guidelines:

I. Referral

- A. At least monthly, the TCOOMMI Program Director and/or designee shall meet with a representative of the Community Supervision and Corrections Department (CSCD) to review possible referrals to TCOOMMI Case Management.
- B. In areas where Parole Case Management is funded, at least monthly, the TCOOMMI Program Director and/or designee shall meet with a representative of the Parole Office to review possible referrals to TCOOMMI Case Management.
- C. When a probationer is determined to be an appropriate referral the CSCD officer will, in counties that have a CJAD funded Initiative Caseload, ensure that the offender is placed on the specialized Mental Health Initiative probation caseload prior to admission to the TCOOMMI program.
- D. Parole referrals may be on Special Needs Offender Program, Sex Offender, or Super Intensive Supervision Program caseloads.
- E. If eligible, offenders shall be admitted to the TCOOMMI program within 7 days of referral.

II. Admission Criteria

The intent of TCOOMMI Transitional Case Management is to provide transitional mental health services to offenders with severe and persistent mental illness who have been served on the TCOOMMI Intensive Case Management caseload and require ongoing services to reduce risk of recidivism, reduce or stabilize symptoms while linking the offender to natural and/or alternative supports. Additionally, TCOOMMI Transitional Case Management may be provided to offenders with a severe and persistent mental illness who present with very little risk of harm and a level of functioning that requires less intensive levels of care to maintain community tenure. The general focus of services is to reduce or stabilize symptoms, reduce the risk of recidivism, improve the level of functioning and prevent deterioration of condition, liaison with the community supervision regarding integrated chronic care needs, increase awareness of and participation with community and natural supports, increase skills in self advocacy and increase ability to participate in independent mental health care. Services focus on maintaining baseline level of functioning, decreasing risk of recidivism, increased use of core community reintegration skills, increase in self reliance, increased independent living skills, as well as, effective peer, community, and family interactions. Therefore:

- A. All offenders admitted to TCOOMMI Case Management shall score a 1 or higher on a minimum of 19 individual criteria comprising the standard dimensions of the Adult Needs and Strengths Assessment.
- B. At least 90% of the TCOOMMI Case Management caseload shall be felony offenders.
- C. An offender with Veteran's Benefits shall not be excluded from TCOOMMI services based solely upon that benefit status.
- D. Review of the Offender's Risk Needs or Parole Guidelines Score shall be used to assist in determining appropriate admission, and establishing a level of care. This review shall be documented in the offender's clinical record.

III. Benefits Assistance

- A. Within five (5) days of the offender's admission into the program, the Case Manager (CM) shall:
 - 1. Ensure that the offender is screened for possible eligibility for local, state, and federal benefits (food stamps, Supplemental Security Income, Medicaid, Medicare, etc.)
 - 2. Ensure that applications have been initiated for applicable benefits.
- B. Within five (5) days of the prescription for psychotropic medications, the CM or designee shall ensure that appropriate Prescription Assistance Program (PAP) application is submitted.
- C. Ensure these services are documented within the clinical record.

IV. Interdisciplinary Team (IDT)

- A. An IDT shall be comprised of at least the following individuals:
 - 1. the offender,
 - 2. the offender's supervising officer,
 - 3. the CM,
 - 4. the Program Director and/or designee, and the
 - 5. psychiatrist, and/or nurse when medical staff is available.
- B. The IDT shall:
 - 1. Provide input on and develop the initial Treatment/Service Plan within thirty (30) days of the offender's admission.
 - 2. Review and/or modify the Treatment/Service Plan every ninety (90) days, or more frequently as indicated by the offender's need.

V. Treatment/Service Plan

- A. Treatment/Service Plans shall:
 - 1. Be developed based upon all areas of the offender's needs.
 - 2. Be individualized for the specific offender.
 - 3. Include goals, objectives, and strategies for achieving the goals and objectives.
 - 4. Initially be developed within thirty (30) days of the offender's admission into the program with input from the IDT.
 - 5. Be reviewed and/or modified by the IDT every ninety (90) days, or more frequently as indicated by the offender's need.
 - 6. Include recognition of barriers, interventions, and goals to move into independent (Non-TCOOMMI) mental health care.

VI. Transitional Case Management Services

- A. The CM shall:
 - 1. If the Case Manager is solely a Transitional Case Manager: Maintain a caseload of no fewer than 50 and no more than 75 offenders at any one time.
 - 2. Coordinate intake and assessments as needed.
 - 3. Facilitate IDT meetings.
 - 4. Identify and coordinate the offender's access to needed therapeutic and mental health services, including inter- and intra-agency resources.
 - 5. Ensure the provision of skills training and service coordination to include:
 - a) A minimum of 1.5 face-to-face contact hours per month.
 - i. Hours can be provided by and met in combination with CM, nurse, psychiatrist, benefits specialist, and/or skills trainer.
 - ii. Hours may be individual or include group.
 - b) Make contact via in person or by telephone with the offender within 24 hours of a no show appointment.
 - c) Make contact via in person or by telephone with the offender's supervising officer within 24 hours of a no show appointment.

- d) Services that assist the offender in coordinating access to necessary care and services appropriate to the offender's needs. Activities with interventions targeted at engagement and education on service value. Skills training and education that addresses severe and persistent mental illness and symptom-related problems that interfere with the offender's functioning and increase the risk of recidivism and deterioration in level of functioning. Skills training and education that provide opportunities for the offender to develop skills needed to function as appropriately and independently as possible in the community and facilitates the offender's community reintegration and/or increases the offender's community tenure.
 - e) Documentation of the offender's progress in developing natural and/or alternative supports, which facilitate the ability to transition out of TCOOMMI services.
 - f) Documentation of barriers to the offender's progress toward transitioning out of TCOOMMI services and development of interventions to address these barriers.
- 6. Ensure crisis intervention is available twenty-four (24) hours per day, seven (7) days per week.
 - 7. Make at least one (1) collateral contact per month in person or by phone with the offender's supervising officer.
 - 8. Document all activities and contacts in the offender's case file and ensure such documentation meets standards for Medicaid reimbursement.

VII. Transition Planning

- A. Planning for the transition out of TCOOMMI services should begin upon admission. The IDT shall:
 - 1. Identify the offender's chronic needs and develop treatment or case management strategies to address these needs, as well as, any barriers.
 - 2. Designate an IDT member (usually the CM) to coordinate necessary transition services.
 - 3. Determine whether an offender should have gradually reduced TCOOMMI services as a transition to non-TCOOMMI services.
 - a) Such determination shall be documented in the offender's Treatment/Service Plan.
 - b) Approval for service contact hours other than those stated in this procedure shall require approval from TCOOMMI.

VIII. Discharge

- A. The offender should be discharged from the program when he/she no longer needs TCOOMMI Transitional Case Management Services, or when:
 - 1. He/She completes required community supervision,
 - 2. Probation or parole has been revoked;

3. He/She moves outside of the Local Mental Health Authority (LMHA) local service area. In such cases, the LMHA shall follow the Continuity of Care procedures outlined in Program Guidelines and Processes (PGP) 01.01.
 4. Has been arrested and remains incarcerated in a county jail for more than 30 days. In such cases, the offender shall be admitted to Continuity of Care and monitored until release or adjudication.
- B. If an offender is enrolled in the program for longer than one (1) year, the IDT shall review the case and determine whether the offender should continue in the program. If continuation is determined necessary:
1. A service extension request shall be submitted to TCOOMMI.
 2. The Treatment/Service Plan should include the necessary goals, objectives, and strategies for stabilizing the offender so that transition to less intensive services can be achieved.

IX. TCOOMMI Web Application (WebApp)

The TCOOMMI Web Application (i.e., WebApp) will be deployed beginning September 2013. The WebApp will replace the Microsoft Access database file required for reporting program activity and service delivery information. All contract providers are required to request and maintain access to the WebApp for a sufficient number of individuals to ensure that referrals are received and acted upon, and that program activity and service delivery information is entered timely and accurately.



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9/1/13

Date