July 2025

Continuity of Care Query Report - SB 1 from 89 (R) 2025 (Pg 644 Item 4)

Background

The Continuity of Care Query (CCQ) was created by Senate Bill 839 in the 80th Legislature and allows jailers to access the Department of State Health Services database through DPS' TLETS system.

The CCQ along with the 16.22 mental health screening mandated by the Sandra Bland Act passed in 2017, was meant to ensure continuity of care in the pretrial detention system. The CCQ notifies a county jailer if a detainee has received prior state mental health services, which should allow the jail to continue the detainee's mental health care. The CCQ check returns an *"exact"* or *"probable"* match if the individual touched the public mental health system in the three years prior to the date of jail booking through state psychiatric hospitalization, crisis care or enrolment in routine mental health services at any of the 39 Local Mental Health Authorities (LMHAs) or Local Intellectual and Developmental Disabilities Authorities (LIDDAs).

The Texas Commission on Jail Standards (TCJS) is required to check a jail's compliance of utilizing the CCQ system as per 271.1(a)(h)(7) and 273.5 (c) (1) of the minimum jail standards.

In FY 2016, the CCQ received 1,076,801 requests. Of the 1 million requests, 7.88 % or 84,862 resulted in exact matches with the DSHS database and 38% or 407,244 were probable matches.

As per testimony provided by the executive director of TCJS to the House Committee on County Affairs on 08 March 2023, in **FY 22 there were 887,404 Inquiries out of which 49,436 were Exact and 252,607 Probable matches**. **Outside of these two testimonies,**

neither counties nor the public have any access to CCQ data. A June 2025 Dallas Morning News article stating that approximately 57 per cent of the overcrowded Dallas county jail's monthly bookings were CCQ positive is the only reporting of CCQ data ever seen in the media.

In the past eight to ten years, the Texas county jail system, currently comprising 237 county jails, has been widely described as the largest mental health system in the state of Texas. It is a fact routinely touted by the Texas Association of Counties, the Texas Jail Association, sheriffs, jailers and elected officials alike based on a preponderance of anecdotal and qualitative data.

Only a couple of county jails such as Harris and Dallas provide a public facing dashboard of their jail population with a breakdown of the psychiatric population. But it is unclear how the psychiatric population is measured since the jails are not required to compile CCQ data or even aggregate the data from 16.22 screenings.

Open records requests filed by Texas Jail Project (TJP) to several county jails have clarified that CCQ data is not aggregated by jails. CCQ data are internally compiled by Health and Human Services but there is no requirement for the data to be made public to either lawmakers or counties which find themselves spending more and more of their limited public safety dollars to counter the growing mental health crisis in their jails.

A 2023 Houston Landing investigation into mental illness related deaths in Houston area jails revealed that despite efforts statewide to develop programs and services that would divert people with mental illnesses away from jails and into mental health care, a review of thousands of public records shows the "death toll of inmates with documented mental health concerns in Texas is far higher than a decade ago."

The non-profit media investigation also found that:

- the number of people flagged as mentally ill who died of unnatural causes in the custody of county jails in 2022 had increased nearly 1,200 percent since 2012, from three deaths to 38 in 2022
- more than half of the 68 people who died of unnatural causes in jail custody across the state in 2022 had been identified as mentally ill at least once since the 1980s
- about 46 percent of the 114 individuals who died of unnatural causes in the custody of Houston area jails (Harris, Fort Bend, Brazoria, Chambers, Liberty, Galveston,

Montgomery and Waller counties) had been flagged as potentially mentally ill at least once since the 1980s.

Additionally, data from Health and Human Services presented in 2024 to the legislatively mandated Intellectual and Developmental Disabilities Advisory Committee (IDDAC) revealed that the largest number of transfers to State Supported Living Centers (SSLCs) of people with I/DD was occurring from county jails. People with I/DD who are clients of the public mental health system can be identified through a mandatory TLETS check (similar to CCQ query) at the time of intake into county jails. However this data is neither collected nor published by jails or the LIDDAs.

Lastly, a 2024 state auditor's report mandated by SB 1677 from 88 (R) on the inefficiencies in the 46 B competency restoration waitlist, stated that **in a five year lookback:**

- **over 10 per cent of the individuals on the waitlist reappeared on new charges**
- **over two thirds of all state hospital admissions came from county jails**
- **54 individuals died while waiting for a state hospital bed**

Objective of Continuity of Care Query Report - Item 4 Rider SB 1 89 (R) 2025 - Pg 644

Texas Jail Project has been collecting qualitative data on individuals who are cycling through the state's public mental health and the county jail systems. But lack of centralized CCQ and TLETS (I/DD) data has created barriers for counties attempting to address the growing mental health crisis in their jails. This CCQ report is the first step toward identifying and measuring the gaps in identifying clients of the public mental health system who touch the county jail system with the intent to improve continuity of care.

Item 4 Rider mandates TCJS:

- To collect and summarize CCQ and TLETS data broken down by county and LMHA and LIDDA
- To study patterns in the revolving door by identifying the highest utilizers of the public mental health and pretrial detention system in the five largest counties and a handful of smaller counties chosen by size and region

- To identify individuals from recorded in-custody deaths who were an "exact match" and the ones who may have been a "probable match" but later determined to have received mental health services from the state
- To measure "probable" matches that triggered further collection of information by a magistrate and determine how many "probable" matches turned into an "exact" match.
- To make recommendations on improving the quality of CCQ matches in order to reduce false positives and ensure that *"probable"* matches are properly investigated to determine if continuity of care is mandated due to prior history of services

Outcome

A final report will be published no later than December 01, 2026