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Not Guilty by Reason of Insanity Finding (NGRI): Inpatient Commitment and Treatment

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Agenda

- NGRI Overview and Inpatient Trends
- NGRI Verdict
- State Hospital Treatment
- Planning for Discharge
- Transitioning to an NGRI Outpatient Commitment

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NGRI Overview and Inpatient Trends

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46C: Not Guilty by Reason of Insanity (NGRI)

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What is NGRI?

- **Insanity**: At the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong. Texas Penal Code Sec. 8.01
- If found NGRI, the individual is *acquitted* of the offense charged: *not considered a person charged with an offense.* CCP Art. 46C.155(a)

46C: NGRI Definition in Practice

While individuals found NGRI are not guilty and are no longer considered charged with an offense, they remain under the criminal court's jurisdiction if the court makes a finding of dangerous conduct.

Additionally, while they are not guilty, legally the individual is admitting that they have committed the offense *because* of their mental illness, thus as a result,

they will be court ordered to receive treatment because they have been found likely to cause serious harm to another due to mental illness.

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NGRI Verdict

- Individual is acquitted not guilty by reason of insanity.
- Judge orders a CCP 46C commitment to a state hospital.

State Hospital Treatment

- The state hospital must admit and evaluate the acquitted person and make a report to the court within 30 days of the acquittal.
- The commitment order expires after 181 days unless renewed by the court.

Outpatient Management Plan

- The state hospital has a continuing responsibility to notify the court if the treatment team determines that the acquitted person can be safely treated through outpatient or community-based treatment and supervision.
- A clinical team will have a violence risk assessment completed to help inform this determination. If indicated, the team will work with the LMHA to begin drafting an outpatient management plan (OMP).

Discharge

- If clinically indicated and approved by hospital leadership including the Forensic Consultation Committee (FCC) and Superintendent, the state hospital submits the OMP to the court for consideration.
- If in agreement, the court will approve the OMP and begin the discharge process for the individual.

Community Services

- The individual then transitions to a 46C outpatient commitment which expires after one year unless renewed. For court monitoring to fully cease, the court must formally terminate jurisdiction.

NGRI Inpatient Trends: Admissions, Discharges and People Served (1 of 2)

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Numbers and Percentages of NGRI Admissions, Discharges, and Average Daily Census	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26*
NGRI Admissions	183	161	125	105	99	131	107	111	101
% of NGRI Admissions	2.6%	2.6%	2.6%	2.8%	3.1%	3.1%	2.3%	2.4%	3.0%
NGRI Discharges (DC)	55	53	63	57	46	41	44	55	41
% of NGRI DCs	0.8%	0.9%	1.3%	1.6%	1.4%	1.1%	1.1%	1.3%	1.4%
Length of Stay at DC	711	580	758	710	929	1,054	1,066	1,406	1,302
Average Daily Census (ADC)**	247	273	289	288	289	306	325	353	378
% of NGRI ADC**	**11.7%**	**12.9%**	**14.5%**	**16.6%**	**19.5%**	**19.9%**	**17.5%**	**18.1%**	**19.3%**

Discharge data (#, % and LOS) exclude transfers to Other State Hospitals, Private and State Funded Psychiatric Hospitals, State Supported Living Centers, and deaths.
*FYTD2026 data 9/1/2022 - 5/31/2026
**ADC 9/1/2025 – 3/31/2026

NGRI Inpatient Trends: Admissions, Discharges and People Served (2 of 2)

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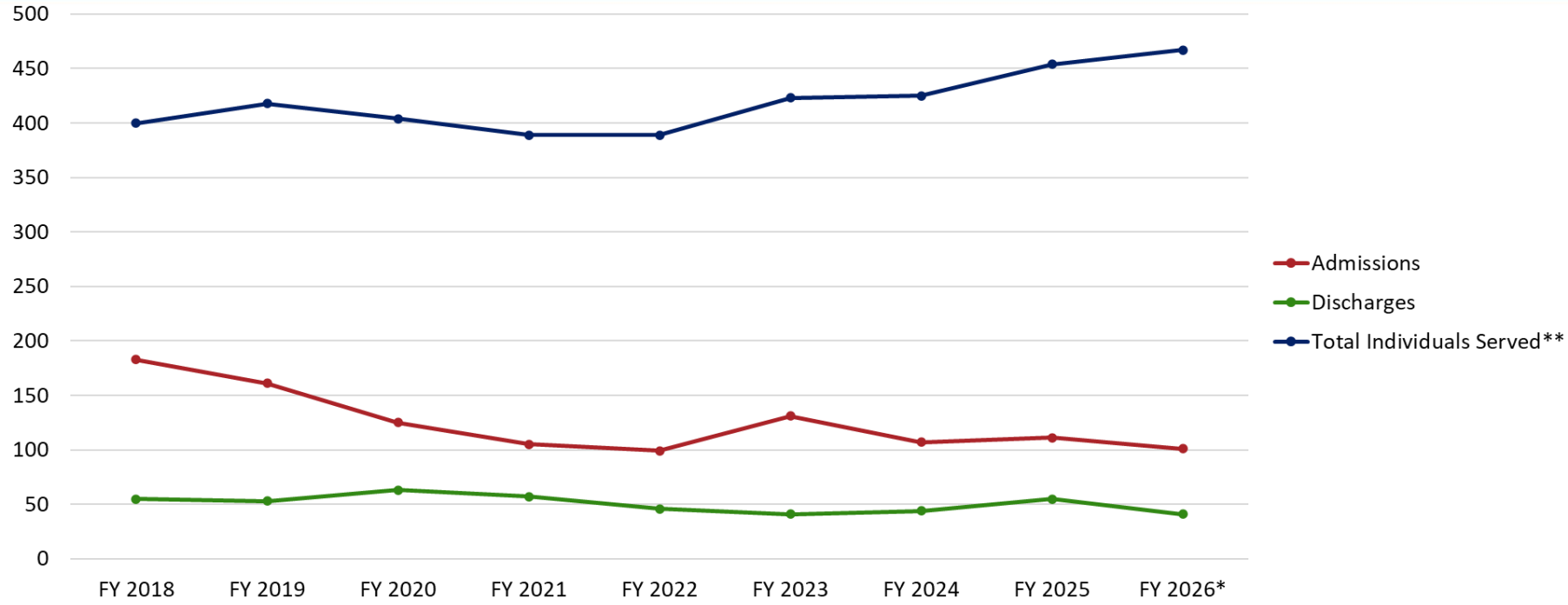

Admissions, Discharges and Total Individuals Served	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026*
Admissions	183	161	125	105	99	131	107	111	101
Discharges	55	53	63	57	46	41	44	55	41
Total Individual Served	400	418	404	389	389	423	425	454	467

Discharge data exclude transfers to Other State Hospitals, Private and State Funded Psychiatric Hospitals, State Supported Living Centers, and deaths.
*FYTD2026 data 9/1/2022 - 5/31/2026
**Total individuals served on NGRI commitments in state hospitals

NGRI Inpatient Trends: Length of Stay

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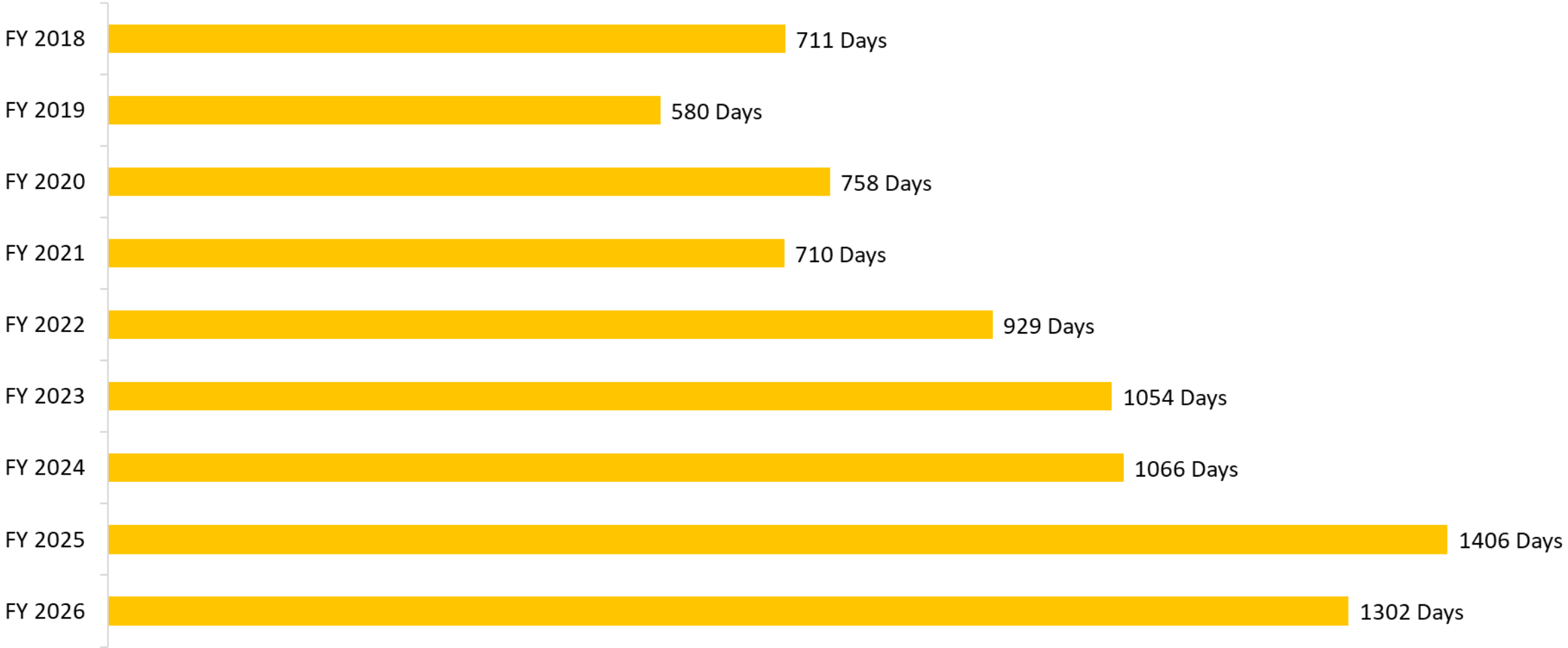

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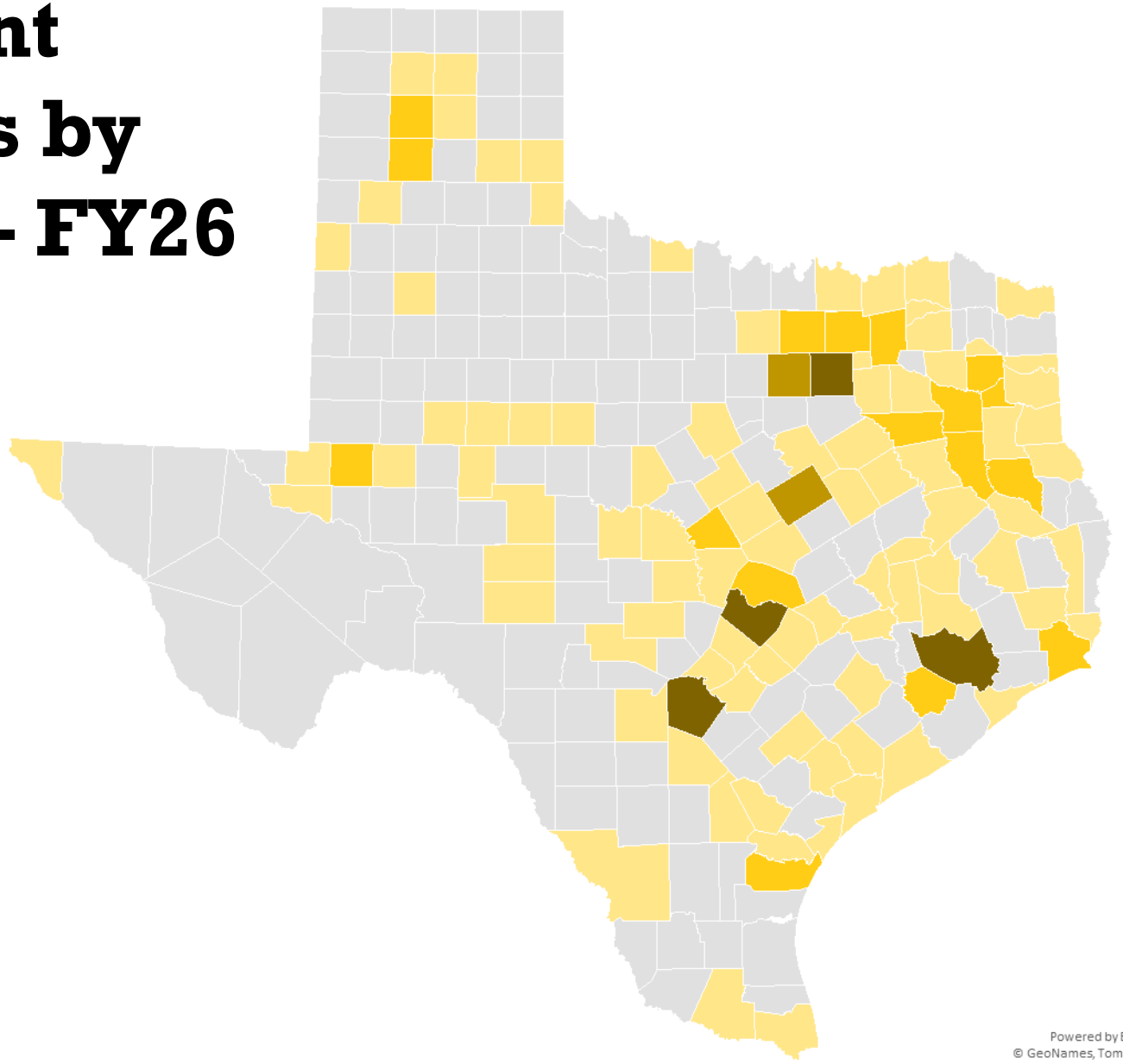
NGRI Inpatient Commitments by County FY18 – FY26



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NGRI Verdict

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Process After Individual Found NGRI (1 of 2)

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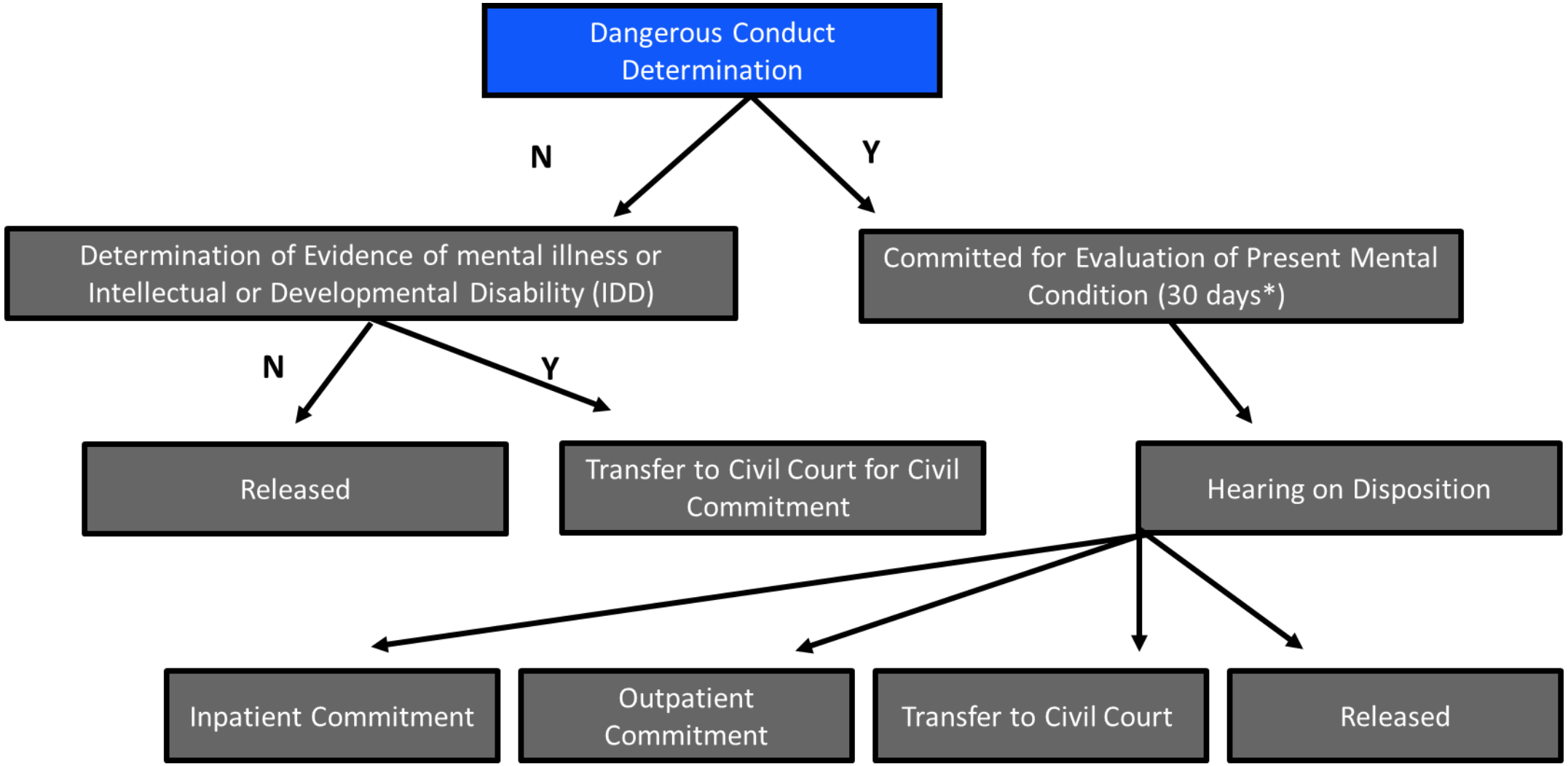

Process After Individual Found NGRI (2 of 2)

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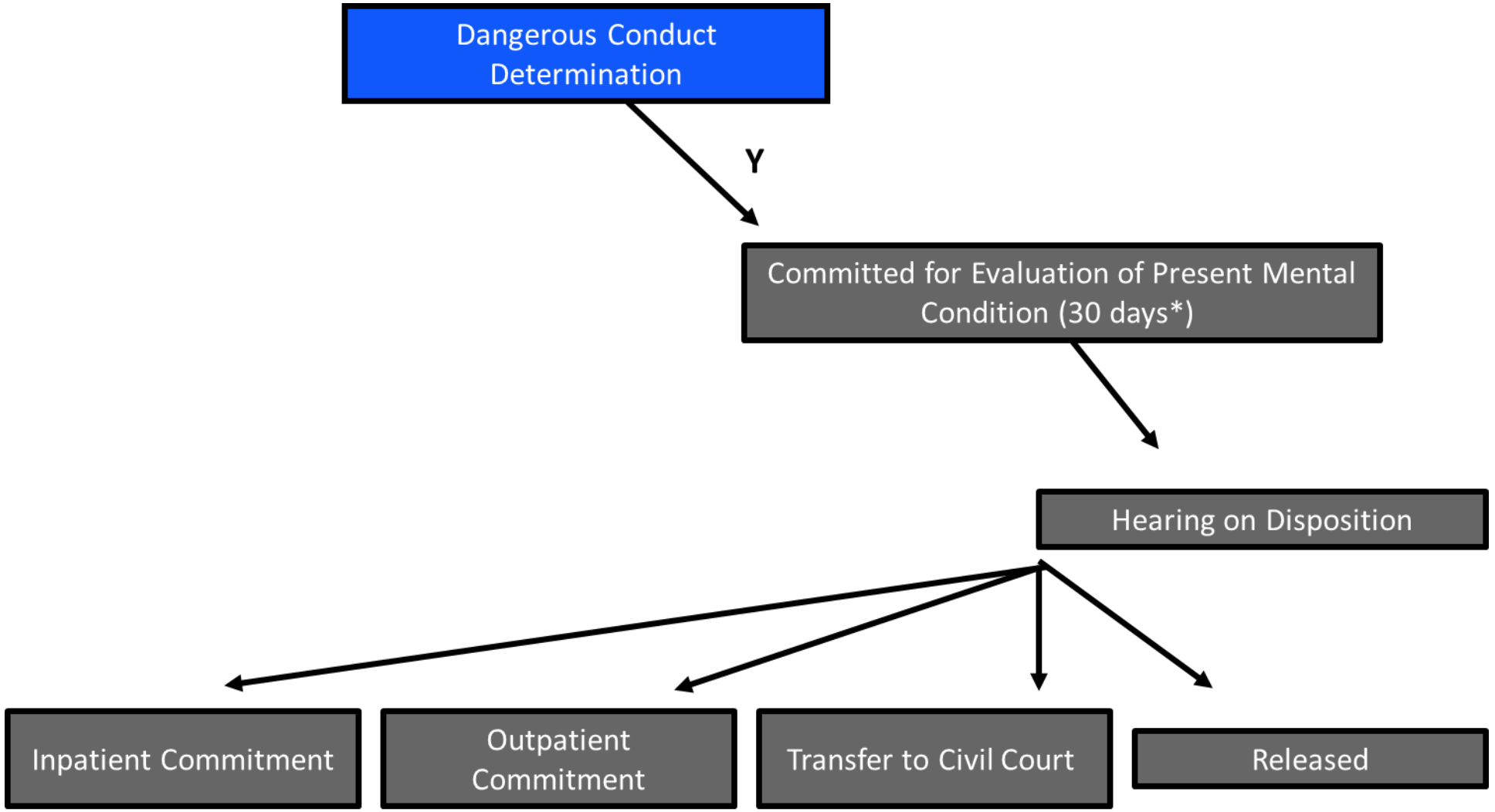

Maximum-Security Unit vs. Non-Maximum- Security Unit

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Maximum Security Unit (MSU)

- Increased level of security – security staff frequently present on units
- More restrictions on movement around facility and environment
- Perimeter fencing and metal detectors
- Serves persons who have higher assessed violence risk
- More focus on treating immediate risk factors

Non-MSU

- Security present on campus but only on units when needed
- Less restrictive environment with greater independence
- Serves persons with lower assessed violence risk
- Focus shift to long-term or complex risk factors

Commitment for Evaluation

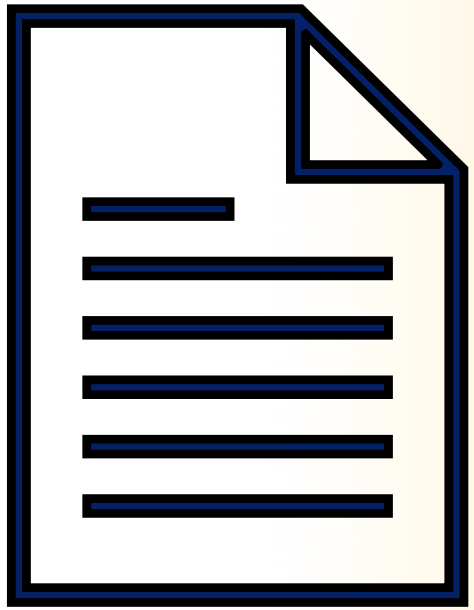
- Court orders a commitment for evaluation of present mental condition and for treatment to a facility designated by HHSC
- 30-day commitment to
  - Evaluate *current* mental condition
  - Recommendation(s) for next steps
- Provide a Written Report to the Court

CCP Art. 46C.251

Written Report to Court

Report must address:

- Whether the person has mental illness (MI) or IDD and whether it is severe;
- Whether, as a result of severe MI or IDD, the individual is likely to cause serious harm to another;
- Whether the individual is subject to a commitment under Health and Safety Code Chapters 574 or 593;
- Prospective treatment and supervision options; and
- Whether treatment and supervision can be safely and effectively provided as an outpatient or community-based treatment or supervision.



CCP Art. 46C.252

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Inpatient Commitment Criteria

- Person has severe MI or IDD;
- Person, as a result of severe MI or IDD, is likely to cause serious bodily injury to another if the person is not provided with treatment and supervision; and
- Inpatient (hospital) or residential (SSLC) care is necessary to protect the safety of others.

CCP Art. 46C.256

Inpatient vs. Outpatient Setting

If stabilized on a treatment regimen + no longer likely to cause serious harm to another, inpatient treatment or residential (SSLC) care may be found necessary to protect the safety of others ONLY IF :

- Likely to cause serious harm to another *if* the person fails to follow a court-ordered outpatient treatment regimen; AND
- Likely to fail to comply with a court-ordered outpatient treatment regimen, as determined by:
  - the person's insight into the need for medication,
  - the number, severity, and controllability of side effects,
  - the availability of support and treatment programs from community members,
  - other appropriate considerations.

CCP Art. 46C.254

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State Hospital Treatment

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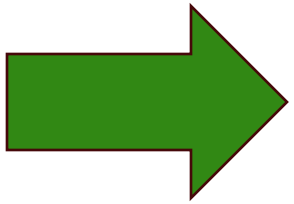
NGRI- Treatment Goals

What the statute says:

- CCP Art. 46C.258(b) speaks to the responsibility of the inpatient or residential care facility in caring for a person under an NGRI commitment.
- The head of the facility must notify the committing court and seek modification of the order of commitment if the person:
  - no longer has a severe mental illness or intellectual disability;
  - is no longer likely to cause serious harm to another; or
  - can be safely and effectively provided outpatient treatment and supervision



In practice:

- The primary goal is to promote long-term recovery and safe community reintegration.
- This is accomplished by providing treatment tailored to the clinical needs of the individual as well as treatment targeted to address the individual's specific risk factors for future violence and/or recidivism.
- In order for courts to make the most informed decision regarding release of an individual, we must provide clinical evidence on the person's risk of harm to others; recidivism; and whether treatment and supervision can be safely and effectively provided in a less restrictive setting.

So, how do we do that in the hospital?

Medications and Stabilization

- Many individuals are already stabilized on medications at admission to inpatient services
- Focus shifts from acute stabilization to maintenance of functioning
  - What that looks like:
    - The individual needs to have a baseline understanding of
      - WHY medications are prescribed
      - WHAT medications are prescribed
      - HOW medications impact them
- Psychoeducation and skill building to facilitate communication with treatment team members

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Structured Clinical Formulation in NGRI Hospitalization

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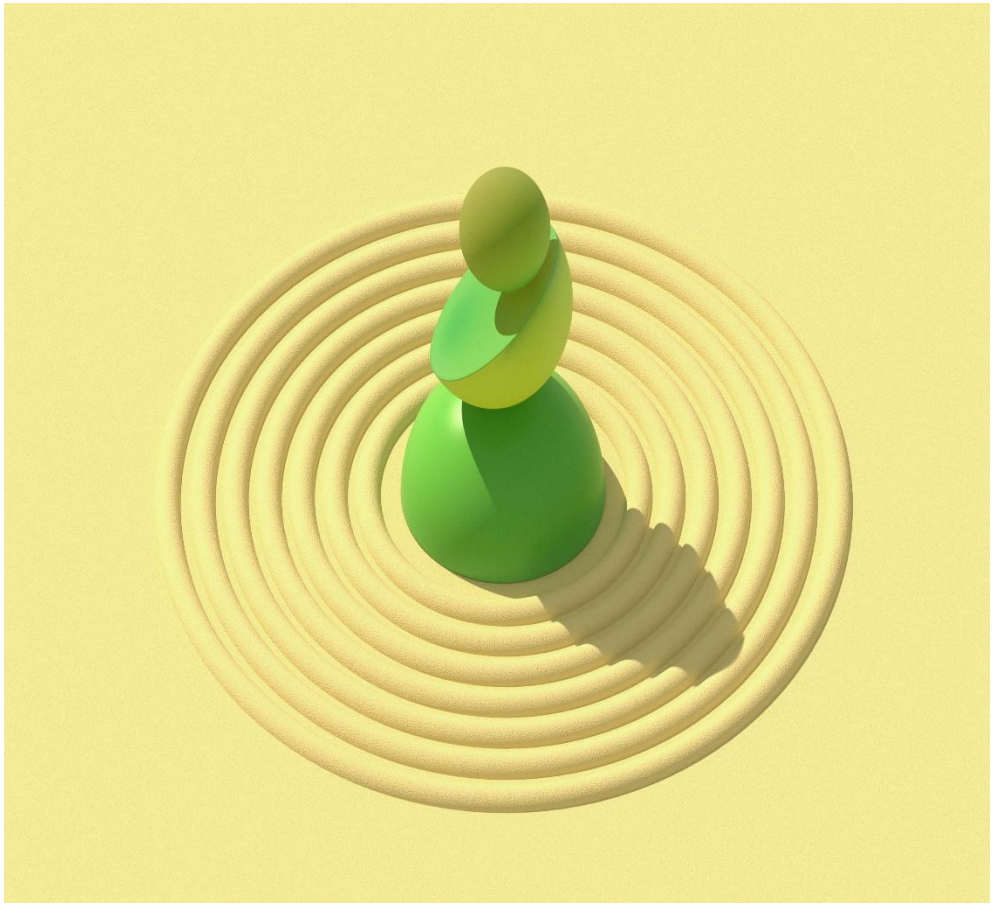
Mental Illness/Intellectual Disability	• Specific diagnosis and personal presentation • Individualized treatment • Increased self monitoring and responsivity
Triggers	• Including emotional, physical, and situational • Why they exist and how to avoid them • What to do when they cannot be avoided
Patterns of Thoughts & Behavior	• Insight into their thoughts, beliefs, and interactions • Can include family members, friends, or peers • Typical responses under stress
Strengths & Limits	• Recognizing individual strengths and limitations • Build and reinforce healthy coping strategies • What to do when they are nearing their limit
Help-Seeking Ability	• Recognize the need for assistance • Willingness to engage identified supports • Capacity to access supports in real time

Understanding the Offense: An In-depth Analysis



The individual needs to be able to discuss the event and understand how it got to that point.

- Precipitating Risk Factors
  - Physical, psychological, and environmental
- The Offense
  - What do they remember, what emotions do they have surrounding the event
- The Victim (if applicable)
  - Are there any patterns, characteristics, or features which lead to the involvement of the victim
- Consequences and Aftermath
  - Understand the consequences from the offense
  - Managing guilt and trauma from the event

Understanding why the offense happened and what comes after helps prevent future episodes of violence.

NGRI Treatment (1 of 5)

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Clinical Assessments and Therapeutic Engagement

- Individual and group therapy focused on insight, accountability, and wellness
- Violence risk and other psychological testing

Education and Skill Building

- Psychoeducation on the NGRI commitment goals and expectations, mental illness, medication adherence, and relapse prevention

Community Readiness

- Participation in life skills training, volunteer work, and structured community outings
- Access to vocational programs, on-campus jobs, and leadership roles to build responsibility and autonomy

Collaborative and Extensive Discharge Planning

- Coordination with outpatient providers and legal stakeholders for step-downs and eventual transition to a community-based setting

NGRI Treatment (2 of 5)

Clinical Assessments and Therapeutic Engagement

- Clinical assessments & psychological testing identify risk factors.
- Therapeutic Engagement seeks to address those needs by developing insight, accountability, wellness, and recovery management skills

Clinical Assessments are completed at the following times during treatment:

- Within 30 days of admission
- As clinically indicated to measure progress or request authorization for off-unit or campus programming
- Prior to pursuing outpatient modification, a full violence risk assessment is completed

During hospitalization, individuals will engage in:

- Individual/Group/Experiential Therapy
- Substance Use Treatment
- Peer Support

NGRI Treatment (3 of 5)

Education and Skill Building

- Through psychoeducation groups, individuals learn about the NGRI commitment, treatment goals, mental illness, and recovery.
- Skill building groups allow individuals to develop coping and adaptive skills for their recovery and prepare for community transition.

Educational Groups:

- Mental Health
- Medication Management
- Symptom Management
- Mental Wellness
- Recovery Management
- Relapse Prevention
- Nutrition
- NGRI Commitment

Skill Building Groups:*

- Coping skills
- Anger management
- Life skills
- Mindfulness
- Social skills

*Skill building can also be supplemented through recreational and occupational therapy.

NGRI Treatment (4 of 5)

Community Readiness

Individuals utilize skills and knowledge via unique programming and activities to demonstrate their community readiness.

- NGRI treatment seeks to help individuals build skills and demonstrate their readiness to return to the community.
- One method for helping build evidence of readiness is providing opportunities to individuals to engage in programming off unit and, with court approval, off hospital grounds with more responsibility, less supervision, and lower restrictions.
- Initial opportunities can include:
  - **Leadership Roles**
  - **Worker programs**
  - **Off-unit programming**

NGRI Treatment (5 of 5)

***All off-ground activities are reviewed by an internal hospital committee and have to be approved by HHSC Executive Leadership, SH Central Administration and the committing court.**

- One of the final opportunities afforded to individuals to work towards and demonstrate community readiness is by participating in therapeutic events and activities off hospital grounds* (often referred to as off-campus passes).
- While accompanied by staff, individuals engage in passes independently with minimal assistance.
- These activities can include
  - **Volunteer opportunities** (ex: food pantries, animal shelters, or local shelter/church)
  - **Life skills practice** (ex: grocery store trips; utilizing public transportation)
  - **Discharge preparation** (ex: obtaining identification; opening bank account)
  - **Therapeutic family outings** (used to assess family interactions prior to discharge)
  - **Therapeutic programming** (ex: recovery/12-step meetings)

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Planning for Discharge

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Roadmap to Discharge

Adjudicated NGRI

01 Engagement in Treatment

Individual works with team to meet goals:

- *Medications*
- *Group/Individual Programming*
- *Insight*
- *Time*

02 Ordering a Violence Risk Assessment

Once goals are met, a VRA is ordered to determine if the individual could be managed safely in a less restrictive environment

03 Discharge Planning

Social Worker (SW) creates a formal & comprehensive discharge plan:

- *Access to medications*
- *Housing*
- *Financial Support*
- *Wrap around services*
- *Mitigating Risks*

04 Complete Internal Process

- Home Community-Based Services Initial Recovery Plan Meeting
- Step Down Meetings
- FCC

05 Modification Hearing

Testimony may be required
Judge will order:

- *Modification to outpatient*
  or
- *Recommitted back to inpatient*

06 Physical Discharge

If approved:

- SW-Coordinates discharge details with placement and outpatient provider
- Psychiatry- Enter discharge orders
- Designated Hospital Staff- Transport individual and ensure they are safe in placement
- Outpatient provider (LMHA, LBHA, or other provider) are notified to ensure services outlined in outpatient commitment are initiated.

Outpatient Commitment

Violence Risk Assessment (VRA)

- An evidence-based, comprehensive assessment conducted by an independent evaluator to assess the likelihood that a person will commit a future violent act through the identification of risk factors, protective factors and preventative management strategies.
- The goal of the VRA is to identify salient factors that may contribute to an individual's violence risk and make recommendations for management strategies to allow the individual to reside in the least restrictive environment (LRE) possible.

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Least Restrictive Environment (LRE) for Individuals with Serious Mental Illness (SMI)

- LRE is a setting that provides necessary care with maximum independence and minimum restriction on freedom.
- Focuses on integration, allowing for specialized care, such as Assertive Community Treatment or intensive case management while avoiding unnecessary institutionalization.

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When Is the VRA Completed?

- The recovery team will refer an individual for a VRA once they believe the individual is appropriate for community placement and outpatient treatment
- VRAs may also be completed earlier in an individual's stay at the request of the treatment team to help inform decisions about passes, privileges and/or other treatment recommendations

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A Notable Distinction

A VRA is a comprehensive, multistep assessment that estimates the likelihood of future violence and includes recommendations for risk management.

A risk assessment tool is a specific instrument or checklist designed to standardize the evaluation of risk. It is only one component of a full risk assessment or VRA.

It is important to note this distinction, as the two are not synonymous.

It is not uncommon for the term VRA to be used colloquially when someone is referring to the administration of a risk assessment tool or measure (e.g., HCR-20 v3, PCL-R, VRAG-R), but this misuse of this term often leads to confusion.

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Evidenced-Based Best Practices for Assessing Risk

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- Define the Question – Risk of Future Violence
- Consider Empirically Supported Risk & Protective Factors
- Consider Idiographic Risk Factors
- Link Risk Assessment to Risk Management

Static vs. Dynamic Risk Factors

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Static Risk Factors – Factors that do not change

- History of Violence
- History of Treatment Noncompliance
- Problems with Relationships
- Problems with Employment
- Problems with Major Mental Illness
- History of Substance Use

Dynamic Risk Factors – Factors that can change over time

- Insight into Mental Illness, Violence Risk, and Need for Continued Treatment
- Behavioral/Affective/Cognitive Stability
- Treatment and Supervision Response
- Symptoms of Major Mental Illness
- Violent Ideation/Intent

Components of a VRA

- Review of records
  - Background/Historical Information
  - Course of treatment while hospitalized
- Clinical Interview
  - Insight into mental illness, violence risk, need for treatment
  - Behavioral stability
- Collateral consultation with treatment providers and/or family
- Other psychological testing (if applicable)
  - Intellectual functioning, neuropsychological functioning, personality
- Risk Assessment Tool
  - Gold Standard: Historical Clinical Risk Management-20 Version 3 (HCR-20v3)
- Mitigating/Protective Factors
  - e.g., social support, positive attitudes towards treatment
- Risk Estimates & Proposed Risk Management Plan
  - Risk estimates are valid for a 6-to-12-month period

Risk Management Planning

Outpatient Examples

- Professional services for managing major mental illness, including engagement with the LMHA and routine appointments with a psychiatrist
- Managing stress and reinforcing adaptive coping with services such as individual therapy
- General monitoring for stability through frequent meetings with a case manager and/or referral to a FACT/ACT team
- Living arrangements, including the need for structured and supervised housing (if applicable)
- Strategies to support sobriety, including regular drug testing and/or attendance in AA/NA or SMART recovery programs

Inpatient Examples

- Pharmacological consultation for addressing residual symptoms of mental illness
- Recommendation for use of a long-acting injectable antipsychotic medication in cases where medication adherence has historically been problematic
- Referrals for additional psychological testing to clarify relevant variables in the case
- Engagement in individual and/or group therapy to facilitate insight into mental illness, violence risk, and/or need for continued treatment

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Outpatient Management Plans (OMP)

- Following the completion and review of the VRA, the treatment team will create an Outpatient Management Plan (OMP).
- The goal of the OMP is
  - Discuss how care will be managed in the community to mitigate potential risks in the future as outlined in the VRA
  - Promote recovery in the least restrictive environment while balancing safety in a community setting and legal requirements as required by law
- OMP is a standardized document across all facilities with two primary sections: **Presenting Problem** and **Services/Recommendations.**

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Generating the OMP

- OMP, per the OP, is created following the VRA, but **discharge planning begins on at admission.**
- To comprehensively address the individual's needs in the community, coordination amongst multiple stakeholders is needed.
- Drafting and creating the OMP is primarily driven by the SH social worker

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OMP Challenges

Placement Barriers

- Severity of offense
- Specialized populations that require unique services
  - Ex: geriatric individuals, individuals with an acquitted sex offense, individuals with IDD
- Ineligibility for benefits, such as SSI/SSDI or VA benefits, limits accessibility to structured, therapeutic placements
  - Ex: Individuals with other financial resources

Lack of Appropriate Resources

- Limited supply of supportive, structured, and/or therapeutic housing options
- VRA recommends services or a level of care that the identified outpatient treatment provider cannot be provided
- Additionally, rural counties lack or do not have access to the same level of resources as larger, urban counties

Placement & Coordination Challenges Between County of Commitment vs. Residence

- County stakeholders may resist placements that are outside of the committing county either for resource purposes or concerns regarding supervision across county lines
- Lack of clarity regarding party responsible for supervision, or supervision requirements being requested cannot be fulfilled by LMHA/LIDDA/outpatient provider

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Forensic Consultation Committee (FCC)

- The FCC includes five mental health professionals that review a recovery team's request to recommend an individual be modified to an outpatient commitment.
- The FCC can serve other purposes, such as supporting decision making and communicating to the committing court on complex forensic cases.

- To be impaneled on an FCC, a mental health professional:
  - Must not have been a member of the individual's recovery team within the past 12 months; and
  - Must not have had personal or professional involvement with the individual's hospital treatment in the 12 months preceding the meeting.
- At least one member of the FCC must be a psychiatrist experienced in the care of adults

State Hospital Considerations for Recommendations to Court

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Key Components in Decision Making:

- Treatment progress and compliance
- Clinical evaluation and reports
- Comprehensive violence risk assessment
- Input from treatment team, LMHA/LBHA/LIDDA, outpatient placement/provider (if applicable), individual and legal parties

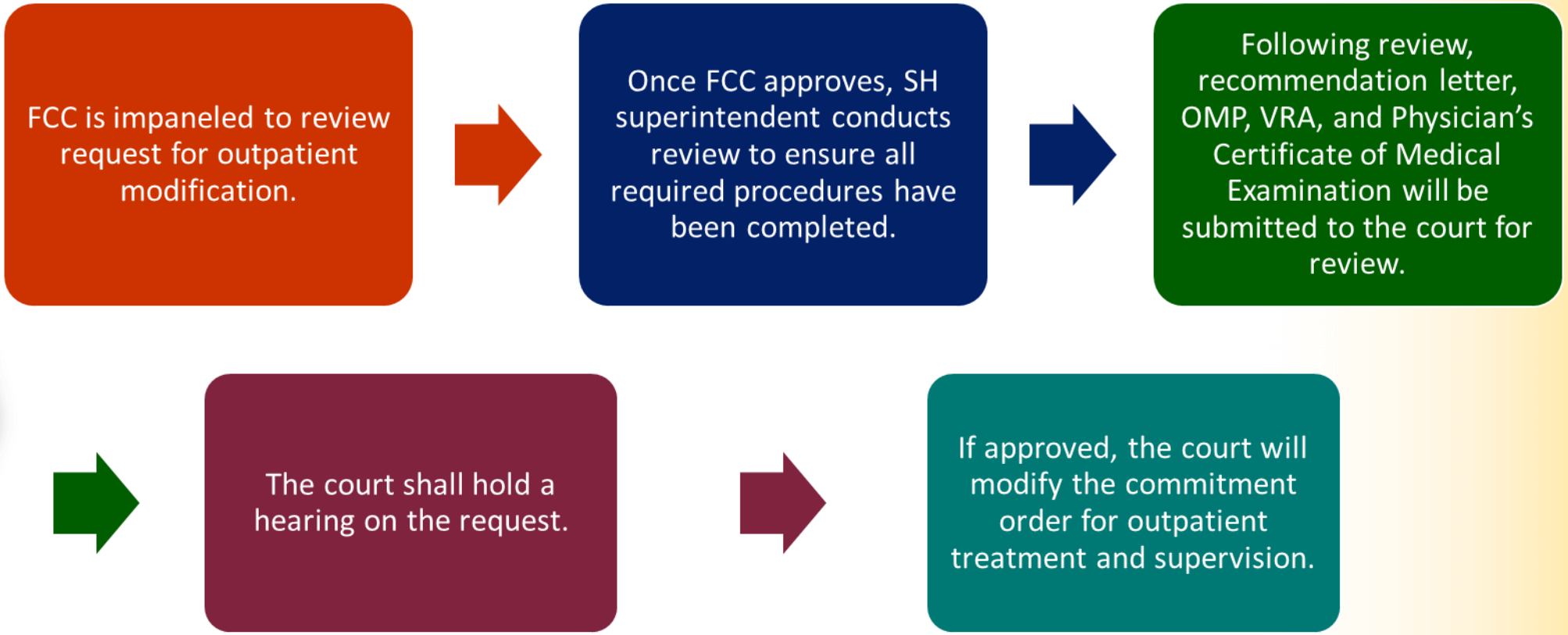
Important Considerations:

- Is the individual stable with treatment?
- Have the identified risks of future violence been mitigated?
- Is there a strong and viable outpatient management plan with commitment from the individual, the outpatient treatment provider, and the individual's support system?

Goal:

Balance public safety with least restrictive and most appropriate level of care

Once OMP is Completed



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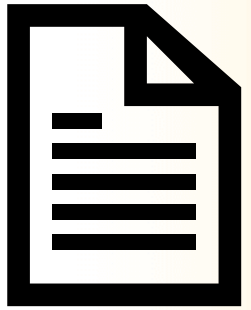
NGRI Commitment Renewal Determination and Potential Outcomes

Court must determine (by recommendation of treatment team) if there is:

- a continued mental illness
- an ongoing risk to self or others
- a need for continued inpatient or supervised care

Possible Outcomes:

- Renewal of inpatient commitment
- Modify conditions (e.g., step-down to outpatient commitment)
- Release from commitment (e.g., terminate jurisdiction)



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How Can Courts Support Successful Community Transition

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During Hospitalization

- Consider approving off-campus supervised passes if/when requested and appropriate. Should there be concerns, collaboration and discussion with treatment team is encouraged.
- When court is notified of potential modification request, communicate specific concerns or needs the court has for community transition to ensure they are addressed in OMP by SH and outpatient treatment provider.

Prior to Approving Outpatient Modification

- Confirm treatment and supervision outlined in OMP can and will be provided to the acquitted person as outlined in Code of Criminal Procedure, Article 46C.263(b)(2).
- Ensure the order identifies the person/party responsible for administrating the outpatient or community-based treatment AND the person/party responsible for supervision as outlined in Code of Criminal Procedure, Article 46C.263(f).
  - ➢ Should there be multiple parties involved in the care and supervision of the acquitted individual, ensure procedures and points of contact are outlined to facilitate communication for both standard reporting and in the event of noncompliance or crisis.

Termination of Court Jurisdiction

- Court no longer has legal authority over the individual
- Ends court-ordered treatment and supervision

Occurs When:

- Maximum commitment period expires; or
- Court determines continued oversight is no longer necessary for public safety

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When Individuals Re-Enter the System after an NGRI Discharge

Possible Pathways Back into the System:

- Revocation of Outpatient NGRI commitment
  - Violation of OMP
  - Failed Placement
  - Clinical Decompensation
- New charge, found incompetent to stand trial (IST)
- New charge, found NGRI a second time and has a new NGRI commitment

Often reflects complex clinical and system factors and is not always indicative of a single point of issue

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Key Drivers of System Re-entry and System Responses

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Potential Contributing Factors

Clinical complexity

- serious mental illness
- co-occurring disorders
- trauma

Medication changes

- non-adherence or decompensation
- community provider adjustments

Substance use

Gaps in community supports or housing instability

Changes in risk over time

Limitations of legal oversight after discharge

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NGRI Outpatient Commitments

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Statutory Criteria for Ordering Outpatient Treatment and Supervision

Statute	Requirement
CCP Art. 46C.263(b)(1)	The court must receive and approve a comprehensive outpatient or community-based treatment and supervision plan.
CCP Art. 46C.263(b)(2)	The court must find that the services described in the outpatient treatment and supervision plan will be available and provided to the acquitted person.
CCP Art. 46C.263(c)	The court order must identify the person(s) responsible for administering an ordered regimen of outpatient or community-based treatment and supervision.
CCP Art. 46C.264(a)	The court *may* order the outpatient or community-based treatment and supervision to be provided in any appropriate county where the necessary resources are available.

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Statutory Responsibilities of NGRI Outpatient Treatment and Supervision Provider(s)

- The court may distribute the responsibilities of treatment and supervision to one party or multiple parties with separate, designated responsibilities. CCP Art. 46C.263(c)-(e) identifies multiple options for supervision providers.
- In accordance with CCP Art. 46C.265, the party or parties responsible for administering a regimen of outpatient or community-based treatment and supervision shall:
  - Monitor the condition of the acquitted person and determine compliance with the regimen of treatment and supervision; and
  - Notify the court and the attorney representing the state if the acquitted person fails to comply with the regimen AND becomes likely to cause serious harm to another.

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NGRI Outpatient Commitments: Stakeholders

Stakeholders involved in an NGRI outpatient commitment include:

- The acquitted person;
- The committing court;
- The attorney representing the state;
- The defense attorney;
- The designated treatment provider;
- The designated supervision provider (if separate); and
- Other outpatient providers of services as identified in the court-approved outpatient treatment and supervision regimen.

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Examples of NGRI Outpatient Treatment and Supervision Provider Options

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Treatment Providers*

- Local Mental or Behavioral Health Authority (LMHA or LBHA)
- Local Intellectual and Development Disability Authorities (LIDDA)
- U.S. Department of Veterans Affairs (VA)
- Private psychiatric provider
- Home and Community-Based Services (HCBS)
- Home and Community-Based Services (HCS)
- State Hospital Step-Down Program

Supervision Providers*

- Local community supervision office
- Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) supervision program
- LMHA, LBHA, or LIDDA
- VA
- Private psychiatric provider
- HCBS, HCS, or other supervised living program
- State Hospital Step-Down Program

***Non-exhaustive list of providers**

Best Practices for NGRI Outpatient Stakeholder Collaboration (1 of 2)

Before ordering an outpatient commitment, stakeholders should establish local processes that:

- Verify that any service or requirement described in the outpatient court order or the court-approved regimen for treatment and supervision will be available and provided to the acquitted person upon entrance into the community.
- Maintain an accurate contact list for all stakeholders involved in each NGRI outpatient commitment.
- Designate roles and responsibilities regarding processes to renew the outpatient commitment, revoke or modify the outpatient commitment, and terminate court jurisdiction (e.g., advance discharge or timeout).
- Proactively plan for how to address issues such as changes in service availability, compliance concerns, crisis episodes, additional legal involvement, or other extraneous factors with risk for occurrence in the community.

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Best Practices for NGRI Outpatient Stakeholder Collaboration (2 of 2)

Stakeholders should establish notification requirements and protocols regarding the acquitted person's compliance with the court-ordered treatment and supervision regimen including:

- Thresholds or triggering events regarding noncompliance or status changes that require notification to the court or other parties (e.g., a specific number of missed appointments, confirmed substance use, medication non-compliance for a specific period, or a change in residence);
- Timeframes to complete notifications based on the triggering event;
- Parties identified to receive notifications of compliance issues; and
- Protocol for requests to modify a court-approved treatment regimen.

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NGRI Outpatient Programming Options and Resources (1 of 4)

Housing and General Programming

- Housing options vary based on several factors (e.g., personal and community resources, treatment planning determinations to support optimal outcomes) and may include:
  - Living with family members
  - Living independently
  - Living in a supervised living facility
- Programming options vary based on treatment determinations and local resources.

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NGRI Outpatient Programming Options and Resources (2 of 4)

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Specialized Recovery Management Services and Supervised Living*

- The **Home and Community-Based Services-Adult Mental Health (HCBS-AMH)** 1915(i) Medicaid program provides specialized supports through the provision of home and community-based services to adults diagnosed with a serious mental illness (SMI) with established eligibility.
- The **Home and Community-based Services (HCS)** program provides individualized services and supports to persons with intellectual disabilities who are living with their family, in their own home or in other community settings, such as small group homes.
- The **State Hospital Step-Down Program (SHSDP)** is an HHSC-funded program designed to identify, assess and facilitate the successful transition of adults with SMI, or a combination of SMI and medical needs exceeding the supports available in traditional settings, who are clinically appropriate for transition to community-based services with proper supports.

***Court must confirm the service(s) or resource(s) can and will be provided.**

NGRI Outpatient Programming Options and Resources (3 of 4)

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Specialized Mental Health Service Delivery Models*

- The **Assertive Community Treatment (ACT)** model provides comprehensive, community-based services which may include intensive case management, psychiatry, nursing, mental health counseling, medication training and support, benefits support, supportive employment, supportive housing, skills training and development, and psychosocial rehabilitative services.
- The **Forensic Assertive Community Treatment (FACT)** model provides ACT service requirements with adaptations to address criminogenic risks, reduce recidivism and increase public safety. Forensic services may include coordination with criminal justice entities, legal advocacy and assistance navigating the criminal justice system.

***Court must confirm the service(s) or resource(s) can and will be provided.**

NGRI Outpatient Programming Options and Resources (4 of 4)

- **Outpatient SUD treatment services** are provided in a community-based setting at a licensed treatment center.
- **Residential SUD treatment services** are provided in licensed facilities where people stay for a short period of time. Treatment includes counseling, case management, education, and recovery skills training.
- **Recovery Support Services** are non-clinical, experience-based services delivered by peer specialists to help individuals initiate and sustain long-term recovery from substance use disorders or mental health challenges. These services are delivered by peer specialists who leverage their own personal lived experience of recovery to provide mentorship, emotional support, and navigation to community resources. Peers provide support before, during and after treatment.

Note: Drug and alcohol testing is a separate monitoring and supervision function, not a component of SUD treatment services.

***Court must confirm the service(s) or resource(s) can and will be provided.**

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Additional Considerations for NGRI Outpatient Requirements

The court and other relevant stakeholders may consider additional requirements to include in the outpatient commitment order. However, all stakeholders must establish how requirements will be implemented and monitored prior to court-ordering. Requirements, if available, may include:

- Court check-ins (e.g., monthly meeting with the committing judge);
- Electronic ankle monitoring;
- Drug and alcohol testing;
- Curfew requirements;
- Restriction of movement (e.g., cannot leave the county of residence without permission, cannot go to the county of original offense, cannot change residence); or
- Restriction of access (e.g., cannot be in contact with minors, cannot be in contact with the victim or the victim's family).

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Key Takeaways

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Key Takeaways (1 of 4)

- **After an NGRI finding, the court must receive information from the state hospital to help them determine the appropriate treatment setting for the acquitted person.**
  Inpatient admission is appropriate when an individual has a SMI or IDD and has been acquitted of specifically defined dangerous conduct. The state hospital is to provide a report to the court outlining their assessment of the person's needs.

- **State hospital treatment is both clinical and public-safety focused.**
  The state hospital's role is not only to stabilize psychiatric symptoms, but also to assess and reduce future violence risk, build insight, support accountability, and document whether the person is ready for a less restrictive setting as required by law.

Key Takeaways (2 of 4)

- **Discharge planning is a structured, collaborative process—not a single event.**
  Safe transition depends on treatment progress, clinical evaluation, violence risk assessment, input from the treatment team and community providers, and a viable Outpatient Management Plan supported by key stakeholders.

- **Violence risk assessment helps connect inpatient clinical progress to practical risk management.**
  A VRA identifies risk factors, protective factors, and management strategies so the team can recommend the least restrictive environment that still protects public safety.

Key Takeaways (3 of 4)

- **Active, coordinated stakeholder involvement is required across the full lifecycle of an NGRI outpatient commitment.**
  This includes coordinated communication and planning regarding inpatient discharge, community reentry and monitoring, outpatient modifications, annual renewals, and preparation for court termination of jurisdiction—with clear local processes and designated responsibilities established in advance.

- **Court oversight is continuous and must be fully supported by verified resources.**
  The court must approve a detailed treatment and supervision plan for both initial release and each outpatient commitment renewal, confirming all required services are available and will be provided to the acquitted person before issuing an outpatient order.

Key Takeaways (4 of 4)

- **Community success depends on clear roles, resources, and ongoing coordination.**
  Once a person transitions to outpatient commitment, designated providers are responsible for treatment and supervision but are dependent upon active court and stakeholder participation. Court requirements can vary significantly across communities and should be based on the established needs of the acquitted person and confirmed availability of resources.

- **Hospital readmission is not necessarily a system failure.**
  Relapse and symptom reemergence are expected for individuals with serious mental illness. Having the proper supports in place to promote treatment adherence and engagement is critical. Readmission is not necessarily a failure, particularly when it prevents a more serious outcome.

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Thank you!

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