HHSC: Joint Committee on Access and Forensic Services, October 21st, 2020

The Joint Committee on Access and Forensic Services develops recommendations for the bed day allocation methodology, the bed day utilization review protocol including a peer review process and advises on a comprehensive plan for coordination of forensic services

Jim Allison General Counsel for the County Judges and Commissioners Association of Texas Austin **Bill Alsup** Texas Municipal League **Shannon Carr** Austin Area Mental Health Consumers, Inc **Sherri Cogbill** Texas Department of Criminal Justice Austin **David Evans** Texas Council of Community Centers Austin **Stephen Glazier** Texas Hospital Association Houston **Windy Johnson** Texas Conference of Urban Counties Austin **Judge Robert Johnston** County Judges and Commissioners Association of Texas **Darlene McLaughlin** Texas Municipal League Bryan	**Shelley Smith** Texas Council of Community Centers Big Spring **Sally Taylor** Texas Hospital Association San Antonio **Judge JD "Butch" Wagner** Texas Association of Counties **Dennis Wilson** Sheriff's Association of Texas Groesbeck **Vacant** DSHS Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Abuse Disorders **Vacant** DSHS Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Abuse Disorders **Vacant** DSHS Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Abuse Disorders **Vacant** DSHS Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Abuse Disorders

1.Opening remarks and introductions. The meeting was convened by the Chair, Stephen Glazier. A quorum was not established.

~~**2. Welcome to new Joint Committee on Access and Forensic Services (JCAFS) members (tabled since new members had not been appointed).**~~

3. Approval of minutes from the July 29, 2020, JCAFS meeting. Initially, the minutes could not be approved due to the absence of a quorum. A quorum was later established, and the minutes were approved as written.

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4. Introduction of Chief of Forensic Medicine for State Hospitals. Felix Torres was introduced as the new Chief of Forensic Medicine for the State Hospitals.

Dr. Torres's LinkedIn Profile:

Felix Torres, MD, MBA, DFAPA is the Chief of Forensic Medicine at the Texas Health and Human Services Commission's State Hospital System. Dr. Torres is a Diplomate of The American Board of Psychiatry & Neurology in Psychiatry and Forensic Psychiatry and a Distinguished Fellow of The American Psychiatric Association (APA). He is the former Vice Chair of Acute Care Services and former Director of Electroconvulsive Therapy (ECT) Services for the Department of Psychiatry at Maimonides Medical Center in Brooklyn, NY.

Dr. Torres is a Special Advisor to the APA on the United Nations, tracking issues in the United Nations relevant to the work of the APA and ensuring the inclusion of mental health in UN development goals and agendas.

Dr. Torres received a Bachelor of Arts degree in Psychology from Yale University. He graduated magna cum laude from Universidad Central del Caribe School of Medicine. Dr. Torres completed his general psychiatry residency and forensic psychiatry fellowship at Saint Vincents Catholic Medical Centers in NYC. He holds a Master of Business Administration degree from Johns Hopkins University Carey Business School with a double concentration in Healthcare Management and Leading Organizations.

Dr. Torres is licensed in the States of TX, NY, FL, and CA. He has also served as a forensic psychiatry expert in local and out-of-state civil and criminal cases.

Dr. Torres served as Assembly Representative from the NY County Psychiatric Society to the APA from 2012 to 2019, where he focused on issues relating to global and cultural psychiatry, addressing the delivery of psychiatric care to underserved populations, highlighting the impact of global climate change on mental health, fighting the stigma surrounding mental illness, and supporting the fourth strategic initiative of the APA: Diversity. He served as Secretary of the New York State Psychiatric Association from 2018 to 2019 until his move from New York to Texas.

Dr. Torres is a former member of the APA Council on Minority Mental Health and Health Disparities, where he collaborated with the drafting of the Stress & Trauma Toolkits for Treating Hispanics and Undocumented Immigrants in a Changing Political and Social Environment. He currently sits on the APA Council on Communications and the Board of the APA Political Action Committee.

Dr. Torres serves as a mental health contributor to local, national, and international media outlets.

Dr. Torres speaks English, Spanish, French, and Italian.

5. Election of Chair and Vice-Chair.

Adopting Presiding Officers Election Procedure
The following is the proposed procedure for electing presiding officers. After laying out the procedure, we will entertain a motion for the adoption of this procedure. HHS staff will announce a call for nominations for each officer position. Nominations may be called for prior to the meeting by being sent to a designated HHS staff member before the meeting, accepted on the day of the meeting, or both before and during the meeting. Members will be asked to nominate themselves or another member for chair and/or vicechair. If they so desire, members can submit a nomination anonymously to designated HHS staff on a piece of paper.

If a member is nominated by someone else, staff will verify that the nominee is willing to accept the nomination for that position. Once all nominations for chair and/or vice-chair have been received, each nominee will be given two minutes to inform members of their qualifications for presiding office, if they so desire. If chair and vice-chair are elected at different times, include: Nominations and election for chair/vice-chair will be conducted at today's meeting and the same process will be followed for the nomination and election for chair/vice-chair at a later meeting.

ROLL CALL VOTE ACCO staff will call each voting member's name one at a time. The member will then state the name of his or her candidate. ACCO staff will record each vote. Once all votes have been recorded for each position, the nominee receiving the most votes will be announced.

SINGLE NOMINEE If only one person is nominated for Chair or Vice Chair and after ensuring that, in fact, no members' present wish to make further nominations, ACCO staff can call for a motion to be made for the nominee to be elected by unanimous consent or "acclamation" and conduct a voice vote [or a roll call vote for voting members that have called in via teleconference]. 2 Texas Health and Human Services ● hhs.texas.gov NOTE: A roll call vote will need to be conducted for a single nominee when a meeting is being conducted in a virtual setting.

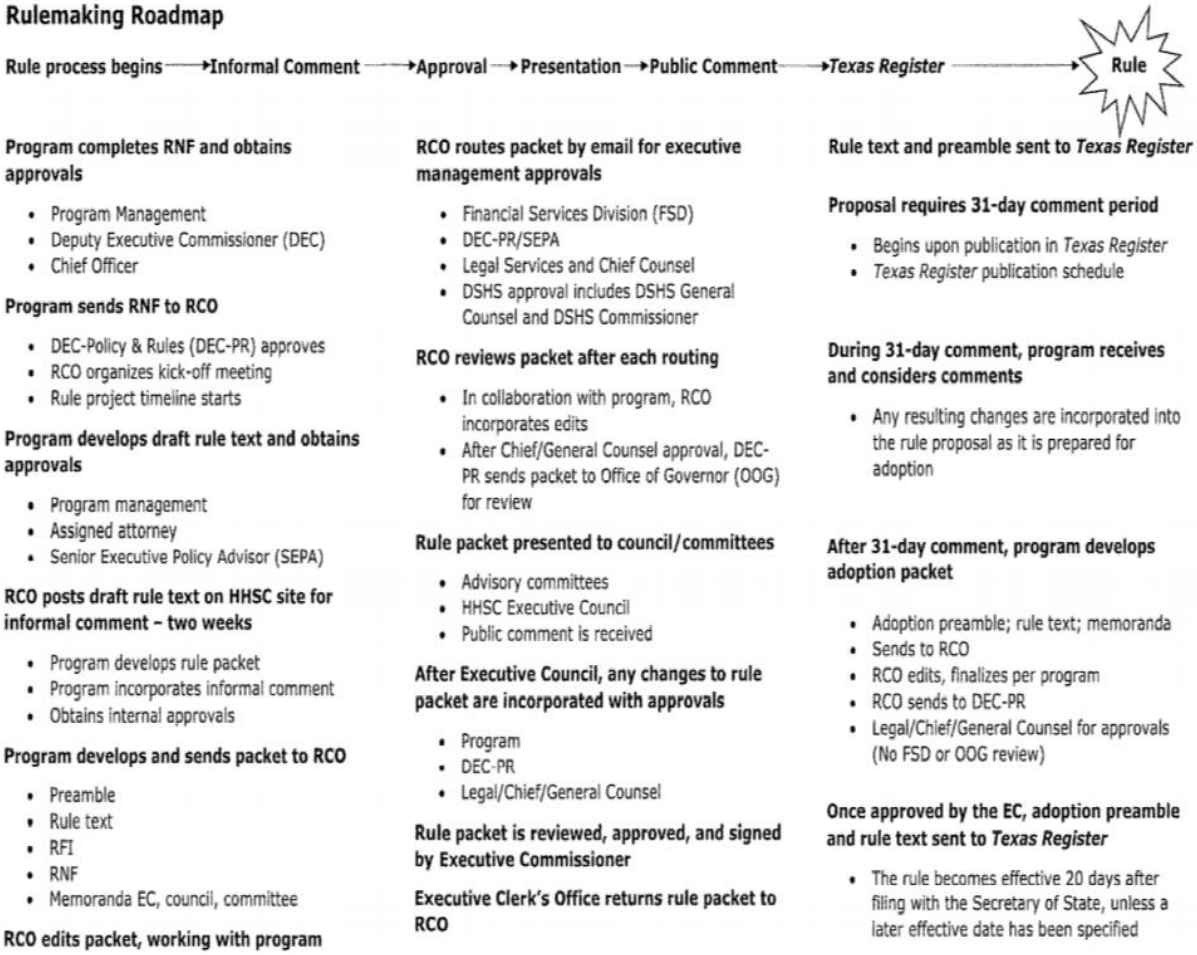
IF MEMBERS ARE ALLOWED TO PARTICIPATE/VOTE BY PHONE INCLUDE: Voting members unable to be present at the meeting but are participating via teleconference call may submit their votes via email during the meeting in writing to designated staff during the voting period. Members submitting their vote through email will be allowed up to 10 minutes to cast their vote.

MOTION: *The election process was - adopted.*

Mr. Glazier was the sole nomination and his election of chair prevailed.

Sheriff Dennis Wilson was nominated as chair and his election prevailed.

6. Update on the JCAFS proposed rules



HHSC's Rulemaking Process

Background

Administrative rules – within government

- Federal government starting place (Constitution, federal regulations, APA)
- State statutes and regulations; system of agencies for matters of public interest
- Agencies have administrative rules, policies and procedures
- Texas Administrative Code (TAC)
- *Texas Register*/Secretary of State

Administrative rules – within agencies

- Implement, interpret or prescribe law or policy; or describe the procedure or practice requirements of a state agency
- Window into state government: notice of rulemaking; public comment; transparency
- How initiated at HHSC? Response to statute; internal or external directive; litigation
- How managed at HHSC? Rules Coordination Office (RCO) under Deputy Executive Commissioner Policy & Rules and Chief Policy & Regulatory Officer
- Where viewed at HHSC? HHSC Executive Council, advisory committees; website

Winter 2020

Rulemaking Phases

Two phases of rulemaking

1. Proposal
2. Adoption

Six stages

1. **RNF (Rulemaking Notification Form)**
   - RNF with program approvals submitted to RCO; kick-off; draft for informal comment
2. **Rule packet development**
   - Preamble
   - Rule
   - RFI (Rulemaking Fiscal Impact form)
   - RNF (Rulemaking Notification Form)
   - Memos and Council items
3. **Rule packet approvals**
   - Program management
   - Executive management
   - Office of the Governor
4. **Council review** – advisory committees (MCAC) and HHSC Executive Council
   - Reviewed, approved and signed by Executive Commissioner

Texas Register

5. ***Texas Register* – Proposal**
   - 31-day public comment period
   - Rule and preamble prepared for adoption; comments; approvals
6. ***Texas Register* – Adoption**
   - Rule effective 20 days (or more) after filing
   - Program may designate later effective date

Notes:

7. JCAFS vacancies

	A	B	C
1	JCAFS - Member Organizational Information		
2	**Agency/Organization**	**Number of Representatives Required for Joint Committee**	**Member**
3	Texas Department of Criminal Justice	1 Representative	Sherri Cogbill, TDCJ Reentry and Integration Division Deputy Director over TCOOMMI
4	Texas Association of Counties	1 Representative	Judge J.D. (Butch) Wagner, Terry County Judge
5	County Judges and Commisioners Association of Texas	2 Representatives - (1) Must be a presiding judge of a court with jurisdiction over mental health matters	Judge Robert Johnston, Anderson County Judge and Jim Allison, General Counsel for the County Judges and Commissioners Association of Texas
6	Sheriffs' Association of Texas	1 Representative	Sheriff Dennis Wilson
7	Texas Municipal League	2 Representatives - (1) Must be a municipal law enforcement official	Darlene W. McLaughlin, MD, an Associate Professor of Medicine at Texas A&M School of Medicine and Board Certified in Psychiatry and Bill Alsup, Director of Health, Richardson, Tx.
8	Texas Conference of Urban Counties	1 Representative	Windy Johnson, Program Manager for the Texas Conference of Urban Counties
9	Texas Hospital Association	2 Representatives - (1) Must be a physician.	Sally Taylor, M.D. Senior Vice President and Chief of Behavioral Medicine at University Health System, San Antonio and Steve Glazier, FACHE
10	Texas Council of Community Centers	2 Representatives - (1) Urban Service Area; (1) Rural Service Area	David Evans, Executive Director, Integral Care and Shelley Smith, CEO, West Texas Centers
11	DSHS' Council for Advising and Planning for the Prevention and Treatment for Mental and Substance Use Disorders.	4 Representatives - (1) Chair of the Council; (1) Representative who is a consumer of or advocate for mental health services; (1) Representative who is a consumer of or advocate for substance abuse treatment; (1) Representative who is a family member of or advocate for spersons w/MI & SA	4 Vacancies
12	Austin Area Mental Consumers, Inc.	1 Representative	Shannon Carr, Executive Director, Austin Mental Health Consumers, Inc.

There are four vacancies and three of those are in the process of being filled. Once the EC approves these, there will be one vacancy for a consumer to be nominated for that position. The three positions are in the final stage of approval and should be made for the next meeting.

8. Subcommittee reports: Access-Utilization Review Protocol

1. The Access Subcommittee met on Sept 23, 2020. The subcommittee began work on the FY 21 UR Protocol which includes:

- Sending the revised JCAFS dashboard to the LMHAs instead of the HBAR. The dashboard now has the two new tabs that were included in the approved UR Protocol.

One tab for data related to bed day utilization by LMHA and one tab for readmissions by LMHA.

- Surveying LMHAs that were listed in the top 3 and bottom 3 in bed day utilization in FY 19 prior to COVID. The bottom 3 LMHAs in utilization will be asked to identify the best practices that they used in 2019 to maintain their low bed utilization rate. The top 3 LMHAs will be asked to identify the factors that drove their high utilization rates in 2019.
- Surveying the top 10 and bottom 10 LMHAs interviewed in 2018 and the current state hospital superintendents regarding readmission rate issues. The LMHAs and superintendents will be asked to review and comment on the 2018 summary of findings regarding readmission rates, provide input on new factors contributing to readmission rates that were not identified in 2018 and provide suggestions for actionable items that might help reduce readmissions.
- Surveying the State Hospital Leadership Team to gather their feedback on the 2019 recommendations for reducing length of stay in the forensic population. We will also be working with them to gather data on timeframes in the steps in competency restoration programs recommended in 2019.
- The Access subcommittee continues to be alarmed at the growing number of individuals on the waiting list for Maximum and non-Maximum beds throughout the state. The subcommittee will continue to work with HHSC on mitigating this continued rise and reducing the number of individuals on the list, as this is a growing concern for counties as more individuals wait for admission into a finite number of beds.

2. The next Access subcommittee is scheduled for November 5, 2020. During the next meeting the subcommittee will be discussing possible forensic data points that can be tracked that may be contributing to the forensic waitlist.

9. New and Ongoing State Hospital Issues. The speaker commented on the impact of COVID-19 on the system. They identified their first case on April 4th. There have been 330 patients recovered since then. They had to slow admissions down to create isolation spaces. They have been proactive on the admissions side. They have protocols for known positive individuals. They cannot provide support for people on a ventilator and they have been looking at the treatment regimens each patient is following. The impact to admissions and discharges showed a decrease in the throughput. The admissions are starting to stabilize, and they are looking for the wait list to come down. They have realized there is a need for long-term isolation space. They have started using rapid antigen testing. They have purchased some PCR testing capability. Another thing being done is the after action/inaction review and planning. They are looking at how COVID-19 impacts the system, comparing it to flu data. They are trying to identify best practices.

Questions/Answers/Comments

At their hospital, they test every admission; is there any rule before a patient can transfer to the state hospital regarding testing? HHSC stated that the test must be done within the shortest period of time prior to admission.

What is the capacity in the system if they were completely staffed? HHSC stated that 2,268 beds are available, but that does not include the 180 beds included if renovations were to happen. HHSC said last week that 1,734 staffed beds were available. Mr. Evans commented on the need for purchase of beds out of the hospital system. HHSC stated that the civil bed need has not been impacted by COVID-19.

There are some civil patients that did not present during this time. So the estimate of need may be understated. As the capacity drops, that feeds the forensic pipeline.

LMHAs have been locked out of using state hospitals for civil patients, so they are looking to other resources in the community. They do not feel they have access to civil beds. HHSC stated that early on with COVID-19, they tried to make civil beds a priority and the population did not show up.

The data on the civil beds is available on the dashboard.

10. **Review the JCAFS data dashboard**. Please follow the link to access the spreadsheet. The monthly data points are more precise than the year-to-date numbers. It is calculating the funded capacity minus any beds that have been closed. Beds cannot be determined in the 2,269 number, and it included both civil and forensic. They do not really have a civil and forensic capacity; the beds can float between populations in the MSU table. Changes to the table should be run past Texas Council so they know the changes have occurred from the Hospital Bed Day Allocation Report HBAR.

Do we need to add in the beds not currently included in the dashboard? There was consensus that the next meeting can look at the tables for suggested changes.

11. **Update from Health and Human Services Commission (HHSC) Forensic Director**
A group will be pulled together to develop a forensic strategic plan for the state. As part of the process, there will be a sequential intercept model summit. As part of this, there will be a statewide mapping, and members of this committee will be invited to participate.

> The Sequential Intercept Model (SIM) details how individuals with mental and substance use disorders come into contact with and move through the criminal justice system.
>
> The SIM helps communities identify resources and gaps in services at each intercept and develop local strategic action plans. The SIM mapping process brings together leaders and

different agencies and systems to work together to identify strategies to divert people with mental and substance use disorders away from the justice system into treatment.

A SIM mapping workshop is available through SAMHSA's GAINS Center for communities to:

- Plot resources and gaps across the SIM.
- Identify local behavioral health services to support diversion from the justice system.
- Introduce community system leaders and staff to evidence-based practices and emerging best practices related to each intercept.
- Enhance relationships across systems and agencies.
- Create a customized, local map and action plan to address identified gaps.

The Texas Police Chief's Association convened the Pathways Mental Health Committee and they have been invited to make a presentation in January to the JCAFS.

The Chair stated that it would be good to include this strategic plan in the overall strategic plan for the state.

12. Approval of JCAFS 2020 Legislative Report

These recommendations and the narrative are very similar to the report that was approved by this group for submission to the Executive Commissioner for their report.

Joint Committee on Access and Forensic Services 2020 Annual Report

Introduction and Background. JCAFS formed in 2015 by combining two statutorily-required advisory bodies: the state bed day allocation advisory panel established pursuant to House Bill 3793, 83rd Legislature, Regular Session, 2013, and the forensic workgroup authorized by Senate Bill 1507, 84th Legislature, Regular Session, 2015. Prior to Transformation, the Department of State Health Services combined the advisory panel and workgroup to form the JCAFS because of shared membership and similar charges. The forensic workgroup's authority expired in November 2019; however, the JCAFS will not be abolished so long as its establishing legislation codified in Texas Health and Safety Code Sections 533.051 and 533.0515 remains in effect. Currently the JCAFS is statutorily charged with developing and making recommendations to the HHSC Executive Commissioner or department, as appropriate, and monitoring the implementation of updates to a bed day allocation methodology. The methodology allocates, to each designated region, a certain number of state-funded beds in state hospitals and other inpatient mental health facilities for voluntary, civil, and forensic patients. The JCAFS is further charged with making

recommendations for the implementation of a bed day utilization review protocol including a peer review process. The bed-day allocation methodology uses a poverty-weighted population to allocate state-funded beds to local authorities rather than a standard per capita formulation. The utilization review protocol includes a flexible framework that allows the process to be tailored to the specific focus of review. Rather than focusing exclusively on the number of bed days used by a local authority, the protocol is designed to understand and address the factors driving patterns of utilization.

Meetings and Activities. The JCAFS met 3 times in 2020 during the months of January, July and October. The April meeting was cancelled due to the outbreak of the COVID-19 pandemic. Following the cancellation of the April meeting the JCAFS was able to resume virtual meetings using Microsoft Teams. The JCAFS Access subcommittee completed one cycle of utilization review in 2019. The review focused on length of stay for individuals with 46B Incompetent to Stand Trial commitments. The committee's ability to complete utilization review activities in 2020 was impacted by the COVID-19 pandemic; these activities will be carried out through fiscal year 2021. The Access subcommittee will implement a revised utilization review protocol to include 1): the use of a JCAFS data dashboard for reporting and analyzing state hospital bed day utilization; and 2) a reassessment of the utilization review studies done in 2017, 2018, and 2019 to evaluate factors that impact bed day utilization, readmissions, and length of stay.

Bed Day Allocation Methodology. The JCAFS is statutorily charged with developing and making recommendations to the HHSC Executive Commissioner or department, as appropriate, and monitoring the implementation of updates to a bed day allocation methodology. The methodology allocates, to each designated region, a certain number of state-funded beds in state hospitals and other inpatient mental health facilities for voluntary, civil, and forensic patients. The initial recommendations for an updated bed-day allocation methodology and utilization review protocol were submitted in February 2016, adopted by the executive commissioner in May 2016, and implemented in fiscal year 2017. The bed-day allocation methodology uses a poverty-weighted population to allocate state-funded beds to local authorities rather than a standard per capita formulation. In 2018, the JCAFS recommended no changes to the bed day allocation methodology. In 2020, the JCAFS is again recommending no changes to the bed-day allocation methodology.

Utilization Review Protocol. The JCAFS 2020 recommendations related to utilization review are as follows:

1. Continue collection of data for the Hospital Bed Allocation Report (HBAR) but replace that report with the new JCAFS data dashboard as the primary tool for reporting and analyzing state hospital utilization. In addition to the data on the current data dashboard add two data points from the HBAR.
    a. LMHA's above and below their bed day allocation.

b. Readmissions by LMHA

2. Assign responsibility for utilization review activities to the JCAFS Access subcommittee

3. The 2020 utilization review protocol will include a reassessment of the studies done in 2017, 2018, and 2019.

a. Reassess the 2017 UR Protocol

i. Identify the 3 LMHA's that are most above and most below their allocation and compare to those on these lists from 2017.

ii. Identify those new on each list and ask them the same survey questions. (What have been your successful strategies, what drives your higher utilization)

iii. Identify those LMHA's with the largest change in their utilization compared to their allocation (largest increases and largest decreases) and survey them as to what they think caused their changes.

b. Reassess the 2018 UR Protocol

i. Re-survey the top ten and bottom ten LMHS's in terms of readmission rates as well as each state hospital superintendent. Ask them to review and comment on the sub-committee's summary of findings from 2018 and identify any new factors contributing to high readmissions that were not identified in the previous report. Also ask them for any suggestions they have for actionable items that might help reduce readmissions.

c. Readmission rates by LMHA. Reassess the 2019 UR Protocol

i. Ask the State Hospital leadership team for their feedback on the 2019 recommendations for reducing length of stay in the forensic population.

ii. Ask the state hospital team for baseline date on the timeframes in the steps in the competency restoration program recommended by Dr. Faubion and JCAFS last year.

d. Training and technical assistance to LMHAs/LBHAs, courts, jails and law enforcement, including the development of a "learning community" among these institutions to help facilitate the implementation of best practices for each region of the state.

e. Direction and coordination of data analyses to improve efficiencies and identify relevant trends related to the forensic population;

f. Provision of technical assistance and input into contract language and expected outcomes for all HHSC contracted forensic services;

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g. Provision of input into the delivery of forensic services within the state hospital system by serving as a liaison to the state hospital leadership team and by serving as a member of the state hospital governing board;

h. Consultation to ensure coordination and integration between the local courts, jails, law enforcement and state hospitals;
i. Support to the Joint Committee on Access and Forensic Services in the development of policy and legislative proposals for the improvement of forensic services in the state.

2. Develop a comprehensive state-level strategic plan for the coordination and oversight of forensic services in Texas. As of October 2020, the state forensic waitlist has grown to over 1200 individuals, and there is no comprehensive and coordinated plan to address the systemic drivers of this waitlist. A strategic plan would establish priorities, programs, and processes to improve forensic and diversion services, including how to reduce and triage the forensic waitlist; identify measures for quality and effectiveness; and ensure coordination internally and with multiple system stakeholders, external partners, settings, and disciplines. This new Forensic plan should be attached to or incorporated into the Texas Statewide Behavioral Health Strategic Plan. Given the substantial cost to counties of holding individuals in their jail while they are on this waitlist, time is of the essence in resolving the problem of this lengthy waitlist. Therefore the JCAFS would like to request that the Agency present an update on progress toward the development and implementation of this plan at its January 2021 meeting.

3. Expand and contract for diversion programs around the state. Pre-arrest and pre-booking diversion programs have demonstrated success in preventing individuals with mental and substance use disorders from entering the criminal justice system and promoting alternatives to arrest, jails, and emergency rooms for law enforcement. First and foremost, diversion programs should consider mental health care as a medical need and be tailored to the community. Programs may include models based on The Harris Center and Crisis Intervention Teams as well as alternative models that incorporate mental health clinicians at 911 call centers, add clinical expertise to multidisciplinary field teams, and use appropriately shared care data for decision making and care linkages. Diversion programs should also address the need for funding of crisis facilities and inpatient beds when needed at the time of diversion.

4. Expand, improve and contract for Outpatient Competency Restoration (OCR) programs around the state. To reduce the number of people who, despite diversion programs and community treatment, end up on the waiting list for competency restoration services in state hospitals, OCR and Jail Based Competency Restoration (JBCR) are alternatives. HHSC currently funds some OCR and JBCR programs and should expand capacity across the state. Rigorous analyses of performance data should be conducted to provide oversight, monitor outcomes, and ensure effectiveness. Performance improvement practices may be needed to

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support scaling. Additionally, standards of practice based on demonstrated successful programs should be written into contractual language for these programs.

5. Implement the JCAFS recommendations for the state hospital forensic program. These recommendations are:

a. Continue and fully implement the "562 review process" which is designed to allow the state hospital team to determine whether an individual requires placement in a maximum security bed or a non-maximum security bed.

b. Implement throughout the state hospital system the new Competency to Stand Trial report template that was approved by the System Medical Executive Committee at their November 2019 meeting.

c. Establish and implement a mechanism to monitor the timeframes for steps in the competency restoration process for the state hospitals.

d. Request funding to renovate and operationalize up to 180 beds that have been previously identified as currently unused and feasible to rehabilitate and utilize. In the alternative, if it is determined that it is more cost effective to construct new beds, then request funding for an equal number of new beds.

6. Implement the JCAFS recommendations for jail outreach programs. Collaborative jail outreach programs enable LMHAs/LBHAs (and other agencies providing mental health treatment) to partner with jails to start individuals on medications as soon as possible after arrest, ensure individuals are maintained on medication while they are in jail, re-evaluate these individuals prior to transfer to the state hospital for competency restoration to make sure they are still incompetent, and provide post discharge support in jail after they are restored and returned. These programs are currently piloted at several jails and have been successful in both shortening lengths of stay in competency restoration programs and in removing individuals from the forensic waitlist who are no longer found incompetent to stand trial.

7. Contractually require a forensics and diversion coordinator from each LMHA. Locating a forensic coordinator in each LMHA/LBHA would ensure coordination with the state hospitals, courts, jails, law enforcement, community corrections and community health and mental health providers. This position would also support an efficient flow of individuals through the competency restoration process and improve continuity of care. Although ideally this would be a full-time dedicated position, budget constraints or the size and scope of forensic services within a particular LMHA/LBHA might make that difficult, at least in the near term. If a dedicated position is not already present or is not feasible, then it is recommended the LMHA assign an existing person to be the main point of contact with the new Office of Forensic Services. HHSC should consult with the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) to ensure efforts are not duplicated with their services and that a coordinator fulfills a need not already filled by TCOOMMI staff at each LMHA/LBHA.

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8. In order to get a better idea of which areas of the state are driving the growth of the waitlist, which areas have developed effective alternatives to inpatient competency restoration and where to target the expansion of alternative programing, it is recommended that the new Office of Forensic Services begin to collect and report the following metrics to the JCAFS. Current waitlists (Maximum Security and Non-Maximum Security) broken out by County/Jail

- Number on list (beginning of each month)
- Number on waitlist as a percentage of that jail population
- Number of waitlist as a percentage of that county population
- Waitlist number broken out by charge type
- Waitlist number broken out by arresting law enforcement agency
- Waitlist broken out by available demographic information (to be determined)
- Mean time on list (for the previous month)
- Does this county/jail have any of the following;
    - Jail-based CR program
    - Outpatient CR program
    - Diversion Program

Current waitlists (Max and Non-Max) broken out by court

- Number on list (beginning of each month)
- Waitlist number broken out by charge type
- Mean time on list (for the previous month) Conclusion

Questions/Answers/Comments
This is a very actionable report that will turn around the growth of the wait list. The recommendations are fiscally reasonable.

MOTION: *Approve the plan as proposed - prevailed.*

The Chair stated that the distribution can be the same as the last time and he sought authorization to distribute the report on behalf of the committee.

If it is distributed electronically; it was recommended to distribute to all members of the legislature. Also the report should not be sent out until certification of the election has been accomplished. The Chair stated that they would have to wait until January to send it out. The amended motion was to send out immediately after certification.

MOTION: *(paraphrase) Distribution of the report to Speaker, Governor, and Lt. Governor and Executive Commissioner and staffs and to all members of the legislature as certified by the secretary of state election results - prevailed.*

13. Public Comment.

Written public comments were received and read into the record. The comments are summarized below. Duplicate comments were not repeated.

- Anosognosia is often a severe barrier to treatment
- We need accountability from providers
- Redesign of ASH does not increase the number of beds

Anosognosia. When someone rejects a diagnosis of mental illness, it's tempting to say that he's "in denial." But someone with acute mental illness may not be thinking clearly enough to consciously choose denial. They may instead be experiencing "lack of insight" or "lack of awareness." The formal medical term for this medical condition is anosognosia, from the Greek meaning "to not know a disease."

When we talk about anosognosia in mental illness, we mean that someone is unaware of their own mental health condition or that they can't perceive their condition accurately. Anosognosia is a common symptom of certain mental illnesses, perhaps the most difficult to understand for those who have never experienced it.

- Anosognosia is relative. Self-awareness can vary over time, allowing a person to acknowledge their illness at times and making such knowledge impossible at other times. When insight shifts back and forth over time, we might think people are denying their condition out of fear or stubbornness, but variations in awareness are typical of anosognosia.

What Causes Anosognosia?

- We constantly update our mental image of ourselves. When we get a sunburn, we adjust our self-image and expect to look different in the mirror. When we learn a new skill, we add it to our self-image and feel more competent. But this updating process is complicated. It requires the brain's frontal lobe to organize new information, develop a revised narrative and remember the new self-image.
- Brain imaging studies have shown that this crucial area of the brain can be damaged by schizophrenia and bipolar disorder as well as by diseases like dementia. When the frontal lobe isn't operating at 100%, a person may lose—or partially lose—the ability to update his or her self-image.
- Without an update, we're stuck with our old self-image from before the illness started. Since our perceptions feel accurate, we conclude that our loved ones are lying or making a mistake. If family and friends insist they're right, the person with an illness may get frustrated or angry, or begin to avoid them.
- Early studies of anosognosia indicated that approximately 30% of people with schizophrenia and 20% of people with bipolar disorder experienced "severe" lack of awareness of their diagnosis. Treating mental health conditions is much more complicated if lack of insight is one of the symptoms. People with anosognosia are placed at increased risk of homelessness or arrest. Learning to understand anosognosia and its risks can improve the odds of helping people with this difficult symptom.

Why Is Insight Important?

- For a person with anosognosia, this inaccurate insight feels as real and convincing as other people's ability to perceive themselves. But these misperceptions cause conflicts with others and increased anxiety. Lack of insight also typically causes a

person to avoid treatment. This makes it the most common reason for people to stop taking their medications. And, as it is often combined with psychosis or mania, lack of insight can cause reckless or undesirable behavior.

- Texas lacks step down facilities. Solutions include:
  - More state hospital beds
  - More jail diversion
  - More outpatient treatment
  - Stepdown facilities with each state hospitals
  - Small group homes developed
  - HCBS and AMH program review
  - Transition housing
  - Accountability and transparency for LMHAs
  - Elimination of the IMD exclusion
  - More assisted outpatient treatment
- Personal stories were related to the committee
- Clozapine relieved symptoms and reduced the number of drugs needed
- Medication prescribing has problems along with medication compliance
- We should use empty beds at the SSLC sites
- Premature discharge due to lack of hospital beds
- Forensic involvement is needed before care is provided
- Stepdown housing may be necessary long term

Oral Comments.

Gordon Butler, Pavilion Clubhouse, commented on the clubhouse model. The clubhouse model is very cost-effective. The committee should take a closer look at the clubhouse model, which has been around since the 1940s.

Mathew Lovett, NAMI, stated that 40% of incarcerated individuals have experienced mental illness. He addressed the services for people in jails:

- Continuity of medication must be maintained for justice-involved individuals
- An agreed-upon mental health formulary is necessary
- Improve administration and oversight for competency restoration processes, including an oversight committee
- Expand peer support re-entry program

Sonja Burns, stated that there is a revolving door at the state hospitals. There is a need for an Office of Forensic Services. The civil commitment side of the system is very difficult with many barriers. There is a need to look at the actual charges that are made against an individual. The response to the crisis situation impacts the disposition of the case. We have to see how the services are being utilized. There is an absence of adequate jail diversion and

a need for jail diversion beds. Personal stories were presented. There has to be more opportunity for community feedback. We must expand peer support.

14. Adjourn. There being no further business, the meeting was adjourned.

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