HHSC: Joint Committee on Access and Forensic Services, July 29th, 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. Members appear below. There are several vacancies.

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

Opening remarks and introductions. The meeting was convened by Stephen Glazier, Chair.

Approval of minutes from January 29, 2020 committee meeting. The minutes were approved as drafted.

Introduction of Health and Human Services Commission (HHSC) Forensic Director. Jennie M. Simpson, Ph.D. Forensic Director. Her vita includes:

- Senior Policy Advisor, U.S. Department of Justice, Bureau of Justice Assistance as well as Senior Advisor for Criminal Justice, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

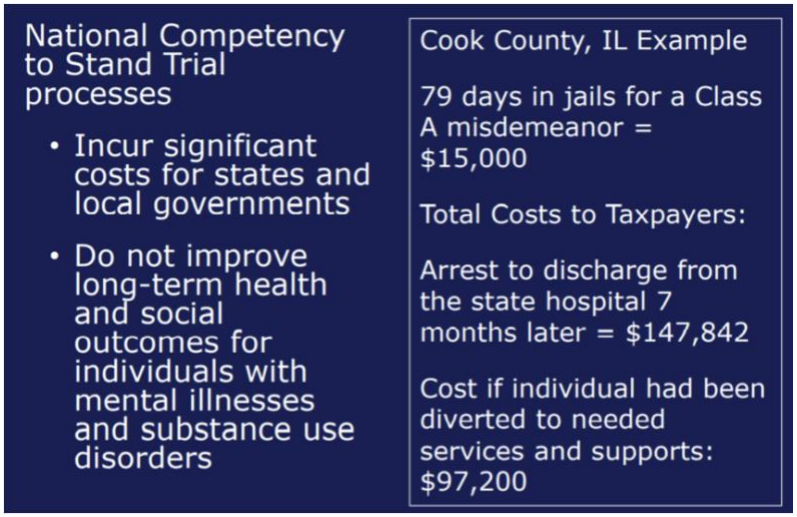
Vision: Comprehensive and Coordinated System of Forensics and Diversion that involves:

- a statewide effort
- Multi-system coordination
- State and local governments
- All three branches of government
- Sequential Intercept Model as a framework
    - Six intercepts to divert individuals with mental and substance use disorders from the criminal justice system or provide specialized services in the criminal justice system

Key Principles:

1. A full continuum of care- from diversion to competency restoration to reentry and supervision is needed to for an efficient and effective forensic mental health system.
2. The social determinants of health are also drivers of justice-involvement and should inform prevention, intervention, and diversion strategies.
3. Peers are valuable contributors to the behavioral health workforce and should be part of all efforts that address forensic and diversion services.
4. Disparities should be evaluated in forensic and diversion efforts to ensure state resources improve health and reduce justice-involvement.
5. The stigma of mental illness, as well as justice-involvement should be actively addressed through cultural change in the behavioral health and criminal justice systems.

We know what doesn't work.



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We know what works! How do we tailor to Texas?

Intercept 0	**JCAFS Recommendations**
• Crisis services, psychiatric emergency programs • Crisis receiving and stabilization centers • Mobile crisis response • Housing • Comprehensive services and supports	• Expanding resources for a range of housing options for independent living and structured facility residences • Early and easy access to services and supports. • A robust system of peer services within each local service are • Community-based options for individuals with co-occurring intellectual and developmental disabilities and behavioral health disorders.

What Works:

Intercept 1 and 2	**JCAFS Recommendations**
• Collaborative law enforcement and behavioral health prearrest/pre-booking diversion programs • Law-enforcement friendly crisis receiving centers • Prosecutorial diversion programs • Mental health public defenders • Specialized pre-trial programs • Universal screenings at booking • Jail diversion at booking	• Continue to study and identify those LMHA's with Jail Outreach programs that are working and where pilot programs have been implemented. Identify best practices from those programs expand them to other areas of the state. • Request funding to expand and implement jail diversion, outpatient and jail outreach programs and best practices across the state and align these recommendations with the report associated with SB 633
Competency process • JBCR and OCR • Qualified evaluators and quality evaluations • Triage system for forensic waitlist • Prioritizing appropriate individuals for CST; diversion and dismissal as first options • Data to drive accountability and efficiency	**JCAFS Recommendations** • Continue and fully implement the "562 review process" • Implement throughout the state hospital system the new Competency to Stand Trial report template • Establish and implement a mechanism to monitor the timeframes for each of the six steps of the competency restoration process

Challenges and Opportunities include:

- Coordinated strategy

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- Collaboration and partnerships
- Statewide reach and scaling of policies and programs, especially to rural areas
- Education and awareness
- Culture change

Focus:

- Strategic plan--Prioritize transition points and cross-system coordination and support
- Building partnerships
- Scaling evidence-based and best programs and practices
- Data, performance outcomes, efficiencies, and effectiveness (including cost effectiveness)
- Training and technical assistance

Considerations:

- How does HHSC achieve a coordinated and comprehensive strategy for forensics and diversion?
- What is the role of HHSC and other state agency partners in the diffusion and uptake of evidence-based and best practices at the local level?
- What key activities are necessary to support uptake of evidence-based and best practices at the local level?
- What is the role of HHSC in these key activities?
- What resources are needed to support statewide systems change?

Questions/Answers/Comments

Include evidence-based practice of peer support.

There should be a dashboard so actions can be tracked. There needs to be a good basis for looking at the data.

There has been work with the Meadows Foundation on elements at the local level and the intercept model. Housing is an issue and has to be a focus. Simpson stated she comes from a housing first background.

Update on the Joint Committee on Access and Forensic Services (JCAFS) proposed rules. The existing rules in Texas Administrative Code (TAC) Title 25, Chapter 411, Subchapter A, relating to Joint Committee on Access and Forensic Services, are being repealed entirely. New rules relating to the Joint Committee on Access and Forensic Services are being proposed in 26 TAC Chapter 1, Subchapter A. The rules will be considered at the Executive Council. The rules will be available for comment.

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JCAFS vacancies

JCAFS - Member Organizational Information		
Agency/Organization	**Number of Representatives Required for Joint Committee**	**Member**
Texas Department of Criminal Justice	1 Representative	Sherri Cogbill, TDCJ Reentry and Integration Division Deputy Director over TCOOMMI
Texas Association of Counties	1 Representative	Judge J.D. (Butch) Wagner, Terry County Judge
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
Sheriffs' Association of Texas	1 Representative	Sheriff Dennis Wilson
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.
Texas Conference of Urban Counties	1 Representative	Windy Johnson, Program Manager for the Texas Conference of Urban Counties
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
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
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
Austin Area Mental Consumers, Inc.	1 Representative	Shannon Carr, Executive Director, Austin Mental Health Consumers, Inc.

BHAC has some vacancies and HHSC will be working with BHAC to fill those positions.

Schedule for election of JCAFS officers. The Chair and Vice Chair will expire in October 2020 and a nomination process will be coordinated by HHSC. The current officers are eligible to continue for one more year.

Timeline for HHSC and JCAFS deliverables.

Timeline for JCAFS and HHSC Deliverables

Due Date	Originator	Recipient	Content
08/31/20	HHSC in conjunction with JCAFS	HHSC Leadership	Draft report containing recommendations regarding the bed day allocation methodology, utilization review protocol and policy recommendations.
11/1/20	JCAFS	Executive Commissioner, Lt. Governor, and Speaker of the House	Annual report including proposal for bed day allocation methodology, utilization review protocol and committee recommendations.
12/1/20	HHSC in conjunction with JCAFS	State Leadership	Finalized report on allocation methodology and utilization review protocol and policy recommendations.

Texas Forensic Implementation Team (TFIT) (Description for the JCAFS)

HHSC would like for the JCAFS to be aware of a forensic initiative that has been taking place over the past year with SAMHSA's GAINS Center. In 2019, Texas was competitively selected by the Substance Abuse and Mental Health Services Administration as one of 6 states to participate in a Competency Restoration Community of Practice. This Community of Practice gives Texas and the other states that were selected an opportunity to receive free technical assistance from the GAINS Center and an opportunity to collaborate with other states regarding ways to improve our competency restoration procedures in Texas. There Sixteen leaders were selected as members for what we call the Texas Forensic Implementation Team, also known as TFIT. Representatives were specifically selected that have a direct involvement in various aspects of the competency restoration system in Texas including LMHA's, NAMI, Judicial Commission on Mental Health, the Sheriff's Association of Texas, Texas Commission on Jail Standards, Texas Indigent Defense Commission, Texas County and District Attorneys Association, Texas Department of Criminal Justice, Office of the Court Administrator, and Texas Tech University. HHSC leadership included DECs Maples and Gaines and ACs Ita, Bray and Harvey.

Since last year, the TFIT team has focused on making improvements in four priority areas. Those priority areas are:

1) Proficiency in early identification, assessment and treatment of defendants who are suspected of having a mental illness or an IDD diagnosis,

2) Address deficiencies in the CST examination and quality assurance, waitlist management, treatment, and case disposition,
3) Increase opportunities for competency evaluators, attorneys, judges and competency restoration providers to receive training related to CR trends and best practices and
4) Expand resources for diversion from the criminal justice system. Members of the TFIT team have split into small groups to work on priority areas that they specialize in.

In 2020, Texas continued to be a part of the SAMHSA GAINS Center's Community of Practice as it expanded to 9 states. This summer the GAINS Center has provided training workshops and technical assistance to each of the states in the community of practice, which we shared with this committee. The TFIT team is scheduled to participate in a strategic planning meeting with the GAINS Center on August 26th / 28th to set new goals for the upcoming year.

We want the JCAFS to aware of the work that is occurring with the TFIT team. We expect that there will be opportunities for the TFIT team to provide the JCAFS with information that will help the committee with its recommendations.

The TFIT team members include:

- Dr. Jennie Simpson, HHSC, Forensic Director
- Jim LaRue, Team Lead
- Mike Maples, HHSC, Deputy Executive Commissioner, Health and Specialty Care System
- Sonja Gaines, HHSC, Deputy Executive Commissioner, Intellectual and Developmental Disabilities, Behavioral Health System
- Bill Boyce, Judicial Commission on Mental Health, Commissioner
- Kristi Taylor, Judicial Commission on Mental Health, Executive Director
- Beth Lawson, Star Care Specialty Health System,
- Susan Garnett, MHMR Tarrant
- Scott Ehlers, Texas Indigent Defense Commission
- Bryan Collier, Texas Department of Criminal Justice
- Dennis Wilson, Limestone County Sheriff's Department/Past President of the Sheriffs Association of Texas
- Greg Hansch, National Alliance of the Mentally Ill Texas
- Robert Kepple, Texas County and District Attorneys Association
- David Slayton, Office of Court Administration
- Brandon Wood, Texas Commission on Jail Standards
- Dr. Nancy Trevino, Texas Tech University Health Sciences Center, the Mental Health Institute
- Billy Phillips, Texas Tech University Health Sciences Center, F. Marie Hall Institute for Rural and Community Health

There are a couple things emerging from this process:

- Value of interagency and cross agency planning is valuable

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- Work on subcommittee working on evaluation of competency to stand trial
- Opportunity for technical assistance from two national experts August 12th

JCAFS coordination with Behavioral Health Advisory Committee Housing Subcommittee. There have been many discussions about the critical nature of housing. The BHAC has been meeting regularly and working very hard on this issue. They have looked at gaps and barriers:

- COVID-19 has placed pressure on Jails to get people out
- Life skills training is needed for individuals needing housing
- Housing planning is needed
- Housing needs evolve over time and should be flexible

There is a lack of affordable housing and recommendations include:

- HHSC should partner with entities
- Legislation should be passed to encourage housing
- Funding should be provided
- MCOs should hire a housing specialist and expand housing options
- HHSC should assist TDHCA for housing vouchers
- Support by Medicaid and value-added services by HHSC
- Use Habitat for Humanity approach
- Develop innovation in public funding
- Appropriately trained staff
- Residential treatment (short-term)
- Traditional housing for individuals with MH conditions
- Step-down housing
- Barriers to housing should be addressed
- Certification for Board and Care Homes with an interest-free loan
- Improving HCBS with more training for staff. Allowing the use of GR for people exiting jail; connect people exiting jail with housing options including peer support
- Review the rate structure to look at the full array of housing options
- $16 per hour for staff
- Expanding choices
- Outreach to property managers
- Education on justice-involved individuals
- Fair chance housing practices
- Training for overcoming service barriers
- Increase funding for gaps in the system
- Data-matching efforts should be developed with data-sharing partners
- Substance use needs are still being developed

Subcommittee reports (taken out of order)

Access:

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Approval of Bed Day Allocation Methodology: ***This is the same bed day allocation methodology as previous years.*** The committee felt there was no need to change it. The current methodology allocates bed days based on the poverty-weighted population in each local service area. A poverty-weighted population gives double weight to populations with incomes at or below 200 percent of the Federal Poverty Level (FPL): Poverty-weighted Population = Total Population + Population ≤ 200% FPL The JCAFS's three recommendations related to the allocation of beds are unchanged from 2016.

They include:

1. Continue to allocate beds based on the poverty-weighted population within each local service area.
2. Retain the current exclusions for bed days in Maximum Security Units and the Waco Center for Youth.
3. Do not impose any sanction, penalty, or fine for utilization above allocated bed days. As part of the process for developing an updated bed day allocation methodology, Health and Safety Code, Section 533.0515(c) requires an evaluation of factors that impact utilization, including clinical acuity, prevalence of serious mental illness, and the availability of resources in a given region. The JCAFS considered each of these factors in developing its recommendations, with the goal of having an equitable methodology based on consistent, reliable data that can be readily updated to reflect changes over time. Clinical acuity is a key determinant in whether an individual needs inpatient care. However, several factors preclude incorporating a measure of acuity in the allocation of bed days:
    - Clinical acuity is dynamic. Individuals do not exhibit the same level of acuity over time. Even within a single year, a person's acuity may change significantly.
    - There is no source of data to measure acuity among the population living within a local service area. HHSC does measure acuity of individuals receiving services, but this group may not be representative of the larger population.
    - In fiscal year 2017, only 20 percent of individuals admitted to a state-funded hospital bed were receiving ongoing mental health services through a local authority at the time of admission, and only 30 percent had received such services during the prior year.

Similar challenges exist with regard to using prevalence as a factor. Data is not available to directly measure prevalence specific to local service areas. HHSC uses national prevalence data published by the Substance Abuse and Mental Health Services Administration to estimate the number of individuals with mental illness living in the state and within each local service area. The availability of resources can have an impact on the utilization of inpatient beds. Areas with more resources for diversion, such as community-based crisis stabilization and outpatient competency restoration programs, are less reliant on inpatient services. Similarly, a robust system of community services and supports can help individuals maintain stability and avoid crises that require inpatient care.

A wide range of services and supports are relevant to the need for inpatient care, and they are supported with local, state, and national funding sources, both public and private. The availability of such resources changes over time, compounding the challenges of compiling and maintaining a comprehensive and reliable inventory that could be used in an allocation methodology. Moreover, there is no consensus as to how the availability of resources should be considered in allocating bed days. From one perspective, it makes sense to allocate more bed days to areas with fewer resources. However, such an approach could serve as a disincentive for local stakeholders to invest in services and initiatives to reduce the need for inpatient care, leading to greater reliance on state-funded programs.

The committee based its recommendation to continue use of the poverty-weighted population on the following:

- The overwhelming majority of individuals receiving HHSC Behavioral Health Services Section-funded services have incomes at or below 200 percent FPL.
- Since the 84th Legislative session, the Legislature has used the poverty weighted population as the basis for comparing per capita funding among local authorities and appropriating funds to those below the statewide level of per capita funding. Using the same methodology for allocating funding and hospital beds allows for a consistent approach to resource allocation.
- The proposal to move to the poverty-weighted population in the 84th Legislative session was supported by a broad group of stakeholders.

With respect to sanctions or penalties, the JCAFS recommends HHSC not impose sanctions, penalties, or fines on local authorities that use more than the allocated number of hospital bed days. Rather, the bed day allocation methodology should continue to be used as a baseline for analyzing bed day utilization.

MOTION: *Approve Bed Day Allocation Methodology - prevailed*.

Approval of Utilization Review Protocol and additional recommendations. **2020 UR Protocol Wording.** The protocol is different than in the past. 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.
    - LMHA's above and below their bed day allocation.
    - 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
- Identify the 3 LMHA's that are most above and most below their allocation and compare to those on these lists from 2017.
- Identify those new on each list and ask them the same survey questions. (What have been your successful strategies, what drives your higher utilization)
- 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
- 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
- Ask the State Hospital leadership team for their feedback on the 2019 recommendations for reducing length of stay in the forensic population.
- 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. Compile successful and promising strategies identified during utilization review activities for use as a statewide resource

Discussion:
Length of Stay (Forensic and Civil) and correlation to readmissions should be included.

MOTION: *Approve the 2020 UR protocol as amended (Length of Stay) - prevailed.*

New Beds Subcommittee. There was discussion about the forensic population. They proposed a question about what the forensic plan is to move the population out of their county jails—especially under COVID-19 restrictions.

Update on HHSC survey of Texas sheriffs.
This was a request from Sheriff Wilson on "All Texas Access." A survey was sent out in February to understand the challenges to rural mental health. SB 633 required this survey and development of regional plans. Only 16 Sheriff's offices responded.

SB 633 amends Chapter 531 of the Government Code to require the Health and Human Services Commission (HHSC) to assign local mental health authorities (LMHAs) that are located in or serve a county with a population of 250,000 or less into regional groups no

later than January 1, 2020. The bill requires HHSC to develop a mental health services development plan for each regional group that will increase the capacity of the LMHAs in the group. The bill requires HHSC to publish each plan,an evaluation of each plan, and a comprehensive statewide analysis of mental health services in counties with a population of 250,000 or less, on its website no later than December 1, 2020. The section of the bill requiring these plans expires September 1, 2021. The bill also amends the Special District Local Laws Code to allow the Midland County Hospital District to impose a sales and use tax.

Transport expenses were collected through the survey as were other costs for incarcerating people with mental illness. The cost of emergency room visits was also collected, and those costs varied. The total exact costs are difficult to determine because of numerous variables. The report will be published on the website December 1st.

This report update can be expanded at the next meeting. The data models are being updated for 2019 data.

Review the JCAFS data dashboard. Please follow the link to review the data from the dashboard.

Highlights:

- There are bed reductions that have changed the census numbers (18 MSU beds offline and 296 non-MSU beds offline (related to COVID-19 issues)
- Waitlist numbers are high but as of June 2020, it appears that we are on track to add 40 fewer patients to the MSU wait list and get 22 additional off the waitlist
- The patients over 365 days is lower this go-round
- We are doing a lot of movement off the wait list

Questions/Answers/Comments

Is there a plan related to COVID-19? There is no plan until we no longer need the quarantine units. There is fluidity required in quarantining an entire unit. Additionally, there is isolation space as well when there have been positive test results.

New and Ongoing State Hospital Issues. COVID-19 is impacting the entire operation. There is no designated COVID-19 hospital. All hospitals have quarantine and isolation space. Counties that have staved off the virus are now seeing positive cases. They are working with the Jail Standards people tracking jail issues and testing. Information is available on COVID-19 infections from HHSC.

For information about COVID-19 cases at State Supported Living Centers (SSLCs) and state hospitals, download this Excel.

The construction is moving along at the hospitals and active construction crews are onsite daily (employing COVID-19 safety protocols). SASH renovations will be opening in September. Demolition is going on at Rusk. Other hospitals are also progressing.

The 562 waiver process is in place. There have been 605 packets and 17 percent have been waived from MSU. There were six waived to SSLCs and the remaining 99 were waived to a state hospital and NGRI were also waived. There has been success in moving people appropriately off the MSU wait list.

Possible work projects for 2021 and discussion on 87th Legislative Session (taken out of order)

Background: Like states across the country, Texas faces a growing crisis in effectively serving Texans with mental illnesses that are involved with the criminal justice system. The number of individuals found incompetent to stand trial and added to Texas' waitlist for competency restoration services continues to increase, with over 1100 individuals on the forensic waitlist and 70% of state hospital beds in Texas currently utilized by the forensic population. A systematic approach to forensic and diversion services is needed to both reduce the number of individuals entering the criminal justice and more efficiently utilize resources for individuals who need them.

Recommendations

1. Create an Office of Forensic Services that is responsible for the coordination and contractual development and management of all forensic services funded by the state. At present, no central body coordinates forensic services across the Health and Human Services Commission (HHSC). A central coordinating office will ensure a comprehensive and strategic systems level approach to forensic and diversion services between community-based services, state psychiatric hospitals, and state supported living centers. An Office of Forensic Services would also help to facilitate the uptake and consistent implementation of demonstrated best practices across the entire state.

2. Develop a comprehensive state-level strategic plan for the coordination and oversight of forensic services in Texas. As of July 2020, the state forensic waitlist has grown to over1100 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. The Texas Statewide Behavioral Health Strategic Plan is a model on which the plan can be based. This new Forensic Behavioral Health plan could potentially be attached to or incorporated into the Statewide Behavioral Health Strategic Plan.

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 promote alternatives to arrest, jails, and emergency rooms for law enforcement. Diversion programs should be tailored to the community and may include models based on The Harris Center, Crisis Intervention Teams, and law enforcement and behavioral health co-responder models.

4. Expand, improve and contract for OCR programs around the state. To reduce the number of individuals waiting for competency restoration services in state hospitals, outpatient competency restoration (OCR) and jail-based competency restoration programs (JBCR) are 2 effective alternatives. HHSC currently funds OCR and JBCR programs and should expand capacity across the state. Additionally, standards of practice based on demonstrated successful programs should be written into contractual language for these programs.

5. Implement the Joint Committee on Access and Forensic Services (JCAFS) recommendations for the state hospital forensic program. These recommendations are:

- 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.
- 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.
- Establish and implement a mechanism to monitor the timeframes for steps in the competency restoration process for the state hospitals.
- 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 partner Local Mental Health Authorities 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 would ensure coordination with the state hospitals, courts, jails, law enforcement, and community corrections. This position would also support an

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efficient flow of individuals through the competency restoration process and improve continuity of care.

Questions/Answers/Comments

These recommendations are exactly where we need to go. The wait list continues to grow.

There is a lot of work being done with law enforcement and care teams. Some patients on the civil side need admission and that impacts the forensic side. There are payment issues associated with that issue. Diversion is only as good as the places you have to divert to.

How do we get patients who are getting their mental health services at facilities, not engaged with the local MHA?

The closure of private facilities impacts the LMHA, which has to use more of the state beds. This is why we need an office of forensic services that works with the local LMHA.

On contracts, there can be more clarity through the LMHA. Direct contracting with private providers puts the LMHAs in a role where they have to work to make contracts work that they are not directly engaged with. There can be fragmented contracts because of co-occurring substance use disorders.

We need a point of contact to keep moving the population along. (Sheriffs.)

We want to get the ideas into the HHSC report.

We will be producing our own report based on these recommendations and we will forward to HHSC for inclusion in their report if the Committee approves. The edits suggested above will be included in this Committee's report. The document as submitted can still be sent to HHSC for their report that has to be completed by the end of August.

The consensus was to not advance this to HHSC at this time. It will be voted on at the October meeting.

Mr. Chacon suggested that the Chair could provide edits and get input through the JCAFS' email. There can also be a special called meeting to address this issue only.

MOTION: *Approve the recommendations pending the sending out through JCAFS' email for ideas/edits and then verify changes through email for approval. If approval is granted, then submit to HHSC. If no consensus is reached, then a special meeting will be called - prevailed. (Before the end of August).*

Public Comment.

Written public comment was read into the record. A summary of comments appears below:

- Inadequate post-hospital care (medication compliance issue)
- Readmissions are common because of inadequate post-hospital care
- State of art treatment for MI and SMI should be following parity laws
- Hospitals should be built for long-term treatment for those who need it
- Housing for people with behavioral health challenges must be a focus; we do not have enough beds nor enough step-down beds
- We cannot wait another session for key issues to be addressed
- We need specialists to address the most severe cases
- Many gave personal stories illustrating the failure of the system
- Continuum of care with step-down beds and other options are desperately needed

Oral Comments

Frances Musgrove, NAMI Advocate, described the experience of her son. He was dropped from service by the LMHA. She described her son's need for safety.

Krishnaveni Gundu, Texas Jail Project, commented on persons in county jails. A common complaint is that once a family member enters the criminal justice system, the family are treated like criminals. Their organization serves as the bridge between the community and jails. We hear traumatic stories from people who are determined incompetent to stand trial. Some people are spending five months in solitary confinement.

Delilah Reynosa,[1] Community Advocate, described the experience of a friend who was incarcerated. A judge ordered her to a state hospital for competency to stand trial. She has had 15 encounters with law enforcement. She needs step-down facilities.

Anna Harris, Just Us Participatory Defense, stated that we have 95 percent of justice-involved individuals. Convictions are often drug-filled crimes with mental illness. We are constantly in damage control legislation and never address the underlying mental health issues. One in two individuals reoffend. TDCJ does not have the funding for rehabilitation needed for incarcerated individuals and there are no alternatives for incarceration.

Diana Zuniga, Just Us Participatory Defense, described the experience of her husband who passed away in custody.

[1] Spelling uncertain

Sandra Bush, described the experience of her son in the inadequate system. Hospitals should retain patients who need more care.

Sonja Burns, spoke about her brother, describing his traumatic Brain Injury and other diagnoses. There is not a safe discharge capability for him. You should revisit SB 633. We do not want the hospitals to be 100% forensic. Step-down opportunities should be in all state hospitals.

Cindy Pierce, spoke about her family member who does not acknowledge his mental health condition.

Many people testified spoke about 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.

Adjourn. The next meeting is October 21, 2020. There being no further business, the meeting was adjourned.

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