



Interim Report

to the 84th Legislature

House Committee on
County Affairs



January 2015

**HOUSE COMMITTEE ON COUNTY AFFAIRS
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2014**

**A REPORT TO THE
HOUSE OF REPRESENTATIVES
84TH TEXAS LEGISLATURE**

**GARNET F. COLEMAN
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Committee On
County Affairs

January 12, 2015

Garnet F. Coleman
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P.O. Box 2910
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The Honorable Joe Straus
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on County Affairs of the Eighty-third Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighty-fourth Legislature.

Respectfully submitted,

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Garnet F. Coleman

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Joe Farias
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Ana Hernandez

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EXECUTIVE SUMMARY

Interim Charge #1 - Examine population growth in Texas counties and the impact the growth has had on housing, available land resources, businesses in Texas, as well as the impact of growth on the state's economy. Evaluate Texas's preparedness to respond to future growth and ensure economic stability.

The Committee met to discuss this interim charge in hearings and individual meetings. In order to give this charge proper respect and insight, it is necessary to continue research on population growth in order to make recommendations that will benefit Texas counties. Therefore, the Committee will continue to study in-depth population growth and make recommendations based on our findings.

Interim Charge #2 - Continue oversight of the Texas Commission on Jail Standards and issues jails currently face, including the mental health of those in jail, and make recommendations for refinement or improvement of processes and programs.

General Oversight

Texas Commission on Jail Standards

BACKGROUND

The Texas Commission on Jail Standards (TCJS) conducts annual on-site inspections of county jails to verify compliance with minimum jail standards in Texas. Currently there are 245 jails that fall under the jurisdiction of TCJS. The policy-making body consists of nine Commission members appointed by the Governor. The Commission operates with 16 full time employees, four of which are jail inspectors, with an annual budget of \$910,000. TCJS requires administration of inmate population reports from jails, and it investigates and resolves inmate grievances. The Commission meets quarterly to discuss any issue that needs to be addressed concerning the various county jail issues under their purview.¹

TCJS's work with the county jails has increased as technology and population issues have evolved. TCJS works directly with the local jails to help them obtain and maintain compliance with minimum standards. Due to the multitude of ever-changing issues that the jails face, the workload experienced by TCJS has increased, thereby creating a need for an additional full-time administrative staff person. The Commission has requested in their Legislative Appropriations Request to the 84th Legislature additional funding for one FTE to perform administrative duties necessary to allow the Commission to keep fulfilling their mission.

RECOMMENDATION

- 1. The 84th Legislature should provide the Texas Commission on Jail Standards with additional appropriations to add one additional full-time employee to perform clerical duties.**

Issues Local Jails Face

Issue 1

Prison Rape Elimination Act

BACKGROUND

The Prison Rape Elimination Act (PREA) is a federal statute that Congress passed unanimously in 2003 intended to prevent sexual assault and victimization in prison. Representative Coleman passed House Bill 1944 in the 80th Legislature (2007) to eliminate sexual assaults in Texas prison facilities. Currently, all federal facilities are required to implement and maintain compliance with PREA standards. State and local facilities are mandated to maintain compliance with the federal standard, but currently no enforcement mechanism exists. Noncompliance could result in litigation. Many of the standards required by PREA were already enforced by Texas Commission on Jail Standards.

Texas has one of the highest rates of prison rape in the United States, with reported rapes and unwanted sexual advances totaling almost four times the numbers reported nationwide. Texas reports 550 alleged incidents per 1,000 inmate population. This is a 3.95 average with other states reporting a 1.05 average. Additionally, locally and privately run facilities reported higher rates of incidents with an average of 3.22 per 1,000 inmate population as compared to an average of 1.22 per 1,000 inmate population in the state prison systems and an average rate of 1.33 in federal prisons. Texas also has one of the lowest resolution rates in the nation.²

Many of the PREA requirements still pose a challenge to our county run facilities. These challenges include but are not limited to cross-gender viewing, sexual harassment, housing of certified juveniles, and restrictions and implementation regarding policies and procedures.

RECOMMENDATIONS

1. The Texas Commission on Jail Standards board members, the Sheriff's Association of Texas, and the Texas Association of Counties have reviewed many of these standards and decided upon some minor changes that would allow smaller, more rural facilities to maintain PREA compliance. These standard changes include
 - **Allowing for sheriff discretion to designate who performs the searches**
 - many small counties may only have one staff on duty at any given point in time
 - **Allowing staff to perform searches, and**
 - **Giving county government flexibility on how to address these standards in order to maintain compliance.**
2. **The Texas Commission on Jail Standards should continue to provide assistance to other facilities to incorporate PREA guidelines in local operations upon request.**

Issue 2

Inmates with Mental Illness

BACKGROUND

Recently, interested parties have noted that "jails are the new state hospitals." County jails have quickly become the default to house someone experiencing a mental health crisis. This is often due to the lack of available state hospital beds and a lack of secure facilities to house people detained that may pose a risk to themselves or others. County jails are the only secure facility that cannot turn away someone. This is not only a drain on county resources; it also does not provide a conducive environment that promotes treatment.³

Criminalization of mental illness has become the trend due to lack of available outpatient services. Many mentally ill Texans have been jailed due to their lack of treatment in community-based facilities and therefore continue to deteriorate while in jail awaiting trial. This not only poses a risk to both the inmate and the jail staff as well as creates a higher cost to taxpayers.

Inmates suffering from mental illness have higher rates for recidivism in the jail system. Additionally, they are one of the highest emergency room utilizers. This may be due to the decline in prescription medication use or mental health treatment post-release for inmates. Quite often, the inmate has not received any treatment prior to their encounter with law enforcement and will have difficulty maintaining this treatment after release. Inmates suffering from mental illness have a disproportionately higher number of physical diseases such as asthma and arthritis. Communicable diseases, such as HIV, tuberculosis, and Hepatitis B and C are more prevalent in the jailed mental health population as well.

Throughout the years, counties have created diversion tools to address population growth and overcrowding in local jails. However, these tools are not being utilized to their full potential. In 1989, Texas implemented its first drug court and in 1997 implemented its first mental health court. These specialty courts are available to counties to divert people whose underlying mental illness or substance abuse caused them to commit an offense. However, when Texas created these courts, they did so on an opt-in basis and did not provide funding. Counties that have created specialty courts are seeing positive results in reducing recidivism rates.

Additionally, the implementation of additional mental health crisis training, mobile diversion teams and Peer Specialists are tools that counties are exploring to help those needing treatment obtain care instead of taking them to jail.

RECOMMENDATIONS

- 1. When incarcerated in a county jail, Texas should maintain Medicaid benefits instead of suspending them so those with mental illness can obtain or maintain medical**

treatment.

2. **Establish a peer support re-entry program to ensure inmates with mental illness successfully transition from jail to community-based care.**

Issue 3

Certified Juveniles

BACKGROUND

Prior to 2011, any juvenile that had been certified as an adult to stand trial was required to be housed in an adult county jail. However, this mandate created many challenges for jails due to previously determined housing standards. These standards required separate searches for certified juveniles as well as complete separation of sight and sound. The 82nd Legislature passed Senate Bill 1209 which required the juvenile board to create policies that allow for certified juveniles to be housed in juvenile detention facilities while awaiting trial.

Certified juveniles continue to be a major issue for county jails, specifically when it comes to issues of separation from the adult population and additional staff requirements. For large urban areas, these requirements create a significant burden due to high numbers of certified juveniles. In rural areas, this creates additional challenges for those smaller jails.

Not only does housing certified juveniles in adult jail facilities present burdensome structural and financial hardships for counties, those juveniles that are certified as adults and transferred to county jails still fall under the guidance of the Texas Family Code which views them as children until they reach age seventeen. Jails must, therefore, provide a higher level of supervision and programming suitable for children, such as educational requirements. Juveniles certified as adults present an additional layer of challenges for meeting PREA guidelines due to conflicts between the state and federal definitions of “adult” and “juvenile.”⁴

RECOMMENDATION

1. **The 84th Legislature should raise the age of maximum juvenile jurisdiction from 17 years old to 18 years old.**

Issue 4

Blue Warrants

BACKGROUND

When an inmate has completed their minimum jail sentence they become eligible for parole. A blue warrant is an arrest warrant used when a parolee commits a violation of their parole

agreement. The term "blue warrant" comes from the blue jacket that the warrant is placed in.

A "true" blue warrant is issued when someone commits another crime while on parole. However, a blue warrant can be issued when someone violates a technical aspect of parole. Often there are terms and conditions associated with their parole such as obtaining a job, reporting to a parole or designated supervisor, drug testing, and more. If a person violates any of the terms and conditions associated with their parole, this is considered a technical violation.

Blue warrant inmates consist of approximately 5,000 total inmates in our jail population. Approximately 3,000 of these inmates are parole violators that have committed a crime. This number tends to remain steady. The other approximate 2,000 blue warrant inmates have violated the technical terms of their parole. This number tends to vary. This inmate population is often referred to as state inmates in the county jails. TCJS does not receive information on which crimes are committed by people on parole who re-offend.⁵

RECOMMENDATIONS

- 1. Board of Pardons and Paroles should not issue a blue warrant until the decision to revoke and return a defendant to state confinement has been made.**
- 2. On the arrest of a Texas parolee for new criminal charges the Board of Pardons and Paroles should not issue a blue warrant until the time that the new local charge is finally adjudicated.**
- 3. Certain parole violators with new charges may be allowed to make bond under the same court of jurisdiction as that of the new charge.**

Issue 5

Paper-Ready Inmates

BACKGROUND

When an inmate is convicted at the local level and sentenced to serve their time in the state prison system, a paper packet is compiled and sent to the Texas Department of Criminal Justice (TDCJ). Once accepted by the TDCJ, the inmate becomes "paper-ready". The term "paper-ready" is derived from the paper packet sent to TDCJ.

In the 1990's, multiple counties filed a lawsuit against the state regarding wait times for the state to pick up paper-ready inmates from the local jail and transfer them to the appropriate facility to serve their sentence. At this time, there was no mandatory time limit for TDCJ to accept and transfer paper-ready inmates. Nor was there any form of reimbursement to the counties for housing these inmates. As a result of this lawsuit, the state statute now mandates that TDCJ has 45 days to transfer the inmate from the county jail to the state facility.

This remains a concern among many of the counties regarding their paper-ready inmates. Two of the TDCJ facilities have shut down, causing concern about TDCJ's ability to accept and transfer inmates out of the local jails. Currently, TDCJ averages about 18 days for acceptance of paper-ready inmates. Upon the two facilities shutting down, TDCJ's average jumped to 23 days. Since then, TDCJ has made the appropriate changes necessary and has now returned to the 18 day average for acceptance.⁶

RECOMMENDATION

- 1. The Texas Commission on Jail Standards should continue to closely monitor the Texas Department of Criminal Justice population and facility closures.**

Issue 6 ***Veterans***

BACKGROUND

As military service men return home, many are having a hard time transitioning into a civilian lifestyle. In Texas there is a 9.7% unemployment rate among veterans and roughly a third of them suffer from Post-Traumatic Stress Syndrome (PTSD) or some other form of mental illness. As a result, veterans across the state are encountering the criminal justice system more frequently, often attributed to self-medicating and lack of employment. It is important to note that many jails report that they are encountering more Vietnam veterans than previously.

The issues surrounding veterans continue to affect our county jails. Identifying an inmate as a veteran can prove to be quite difficult. During the initial booking, inmates are asked if they have performed military service. The language was drafted in the manner to get veterans to self-identify, but many veterans will not self-identify if they never saw active duty. However, VA services are available to all veterans regardless of their job while serving in the military.⁷

RECOMMENDATION

- 1. The 84th Legislature should pass legislation that allows local jails to perform a database search in the Veteran Re-Entry Search Services on inmates to see if they have served in the military.**

Interim Charge #3 - Monitor the health advisory panel stemming from HB 3793 (83R).

Issue 1

Shortage of Mental Health Beds in Texas

BACKGROUND

In 2013, an estimated 499,389 adults in Texas were living with a serious and persistent mental illness, and there were an estimated 175,137 children with severe emotional disturbance. Additionally, the state population increased by 3.6 percent between 2010 and 2012, more than double the national average. This has caused many interested parties to note that the number and location of inpatient beds the state can make available is not adequate to meet statewide patient needs without resorting to long distance transport of patients, local jail placements, and uncompensated hospital care stays.

National and statewide trends show an increased need for forensic beds to provide competency restoration treatment for persons who are arrested but found by a court to be incompetent to stand trial, and, with a finite number of inpatient beds in the state, those persons who are not under arrest or court-ordered placement have diminished access to civil inpatient beds. As a result, the state cannot currently meet and will continue to fail to meet the need for appropriate placements for the care, treatment, and restoration of many persons needing inpatient mental health services.

House Bill 3793, passed in the 83rd Legislative Session, requires the Department of State Health Services, in conjunction with the Health and Human Services Commission, to work with the advisory panel created from the legislation to develop a plan to allocate outpatient mental health services and beds in state hospitals to two specified groups of patients: civil and forensic.

Challenges in the mental health system:

1. Demand exceeds resources.
2. Growing needs.
3. Sustainability of the 1115 Healthcare Transformation Waiver projects.
4. Changes to the Prescription Assistance Program (PAP).
5. Workforce shortages.
6. Lack of affordable housing.
7. Inadequate supply of substance abuse treatment and other health services.
8. Limited transportation.
9. Priorities and perspectives in the legal system.

As detailed in HB 3793, there are four key elements that must be addressed in the report to the 84th Legislature:

(1) A determination of the needs for outpatient mental health services of the two groups of patients

Every local service area should provide access to an array of essential services and supports. These services should be readily available, robust, and easily accessible. However, regional variation and resource limitations may limit the degree to which this goal can be achieved. Local service areas may also identify the need for specific programs, such as recovery-oriented day programs or walk-in medication clinics.

(2) A determination of the minimum number of inpatient beds that the state hospital system must maintain to adequately serve the two groups of patients

In fiscal year 2013, the publicly funded mental health service delivery system had insufficient capacity to meet the demand for community and hospital services. Because serious mental illness is often a chronic condition, there is also an urgent need for an extended provider base in the community to allow individuals to transition out of the state's mental health delivery system without losing access to needed services.

(3) A statewide plan for and the allocation of sufficient funds for meeting the outpatient mental health service needs of and for the maintenance of beds by the state hospitals for the two groups of patients

(4) A process to address and develop, without adverse impact to local service areas, the accessibility and availability of sufficient outpatient mental health services provided to and beds provided by the state hospitals to the two groups of patients based on the success of contractual outcomes with mental health service providers and facilities under Sections 533.034 and 533.052

In addition to expanding capacity, the following strategies will be used to improve access and availability.

Access to care is one of the biggest barriers for people involved in the mental health system. Currently, there are 11 state operated psychiatric hospitals throughout the state. These hospitals have a limited capacity and do not always allow patients to be close to their community when receiving treatment. It has been proven that patients receiving treatment have a higher rate of success upon reentry when treated in their own community and familiar surroundings.⁸

The Committee concurs with the following recommendations made by the HB 3793 Health Panel.

RECOMMENDATIONS

Inpatient Recommendations (State Hospital and Contract Beds):

- 1. The HB 3793 advisory panel concurred that an additional 1,500 beds are needed to meet current needs, plus an additional 60 beds each year to address population growth. The HB 3793 advisory panel recommends a surge of 40 percent of the 1,500 needed beds (600 beds) to begin to meet current needs plus 60 beds for each year of the biennium to address population growth for a total of 720 beds in the 2016-17 biennium. Over the following six years, the panel recommends adding an additional 1,280 beds to meet current needs and to accommodate for population growth. The panel believed that, once sufficient outpatient capacity and other services like jail diversion were in place, the need for state hospital beds may decrease. However, development of those outpatient resources will take time and, as the Sunset Commission report states, the current system is in crisis.**
- 2. Eliminate forensic commitments from the State Hospital Allocation Methodology (SHAM)**
- 3. Replace the current State Hospital Allocation Methodology committee with a more diverse, statewide stakeholder group. Provide monthly utilization reports to LMHAs/NorthSTAR and stakeholder group.**

Outpatient Recommendations:

- 1. Increase outpatient treatment capacity by 1.8% per year for population growth.**
- 2. Expand the scope of the stakeholder group charge to include community-based services.**
- 3. Until an alternative methodology is determined by the proposed expanded stakeholder group, DSHS will allocate civil/voluntary beds on a per capita basis using the existing methodology.**
- 4. Use new funding to achieve equitable distribution of resources as permitted by legislation.**

Access and Availability Recommendations:

- 1. Develop a state-level waitlist for civil and voluntary patients in need of a bed.**
- 2. Develop a process to monitor utilization of community-based alternatives to inpatient care.**
- 3. Enhance stakeholder education by providing the following:**
 - Create a list of available resources for information, training and technical assistance.**
 - Provide training and information to judges and attorneys.**
 - Provide technical assistance to state hospital and LMHA staff on effective engagement with the criminal justice system.**

-
- **Work collaboratively to increase the number of clients transitioning from forensic to civil commitments.**
 - **Simplify nomenclature related to crisis alternatives.**

The Committee makes the additional following recommendation not recommended by the HB 3793 Health Panel.

RECOMMENDATION

Officer Training Recommendation:

1. **The 84th Legislature should increase the number of mental health training hours peace officers are required to complete from eight to 12 through the Texas Commission on Law Enforcement Officer Standards and Education training.**

Interim Charge #4 - Determine which counties have implemented a cite-and-summons policy, whether the policy has been effective in lessening overcrowding in county jails, and whether those cited by peace officers comply with the policy.

Issue 1

Cite-and-Summons

BACKGROUND

After overcrowding issues continued to plague our county jails, resulting in a violation of the minimum jail standards, it became apparent that population reduction measures are needed. In 2007, House Bill 2391 was passed in the hope that not only would this decrease the inmate population in the county jails but that jails would also see a significant cost savings from not housing low-level offenders.⁹

HB 2391 gave counties the ability to cite and release offenders of Class A and Class B misdemeanors, subject to the discretion of the officer. Offenses that allow for cite-and-release consideration include:

Class A and Class B misdemeanor possession of marijuana up to four ounces

- Class B criminal mischief up to \$500 in damages
- Class B graffiti
- Class B theft between \$50-\$500 in stolen property
- Class B driving with an invalid license (Note: Class C misdemeanor for first time offenders, Class B misdemeanor for repeat offenders or if offender has suspended license due to driving while intoxicated)
- Contraband in a correctional facility

However, the policy is widely unused by the majority of law enforcement entities in the state. Currently Hays, Travis, Caldwell, Bastrop, and Midland counties use the policy. Both Austin and San Marcos implement the policy as well.

Although the law's intentions were positive, it lacks necessary enforcement mechanisms for those cited and released to appear in court. Furthermore, the cite-and-summons program does not allow for law-enforcement officers to run background checks on someone to determine whether the person has a criminal background. Additionally, in order for someone to be eligible for cite-and-summons versus incarceration, they must be a resident of the county in which they committed the offense. This largely eliminates many minor offenders from eligibility. Without refinement of the policy to allow law-enforcement to make informed decisions, the policy most likely will remain widely unused.¹⁰

RECOMMENDATIONS

1. The 84th Legislature should change the cite-and-summons policy to allow law enforcement officers to book an offender at a booking facility and then release immediately on bond.
2. Further research on this policy should be conducted with the House Committee on Criminal Jurisprudence to examine additional recommendations on misdemeanor classifications.

Interim Charge #5 - Study the implementation of SB 462 (83R). Examine which counties currently have veterans courts, as well as veterans courts in other states, and determine how those programs are working and whether these courts provide additional services or resources for veterans. Make appropriate recommendations. (Joint charge with the House Committee on Defense and Veterans' Affairs)

Issue 1

Veteran Treatment Courts

BACKGROUND

The Veterans Treatment Court program first began in Texas in December 2009 in Houston, TX under the Honorable Marc Carter. Today there are 20 Veterans Court programs in Texas, operating out of Bexar, Cameron, Collin, Dallas, Denton, El Paso (2 programs), Galveston, Guadalupe, Harris, Hays, Hidalgo, Nueces, Smith, Tarrant, Travis, Webb (with 3 programs), and Williamson counties. These programs have made a significant and positive impact on the lives of its participants and their loved ones. Rather than focusing on a traditional incarceration method, Veterans Treatment Court programs look to reduce recidivism rates by requiring active participation in self-improvement programs designed to address the root issues leading to the high number of Veteran arrests.

During the 83rd legislative session, Senate Bill 462 authored by Senator Joan Huffman was passed, revitalizing many elements of the Veterans Court Program. Under SB 462, Texas statutes on specialty courts were consolidated for the first time under a new Subtitle K. This action allows for better oversight of specialty courts, requiring that they register with the Criminal Justice Division (CJD) in the Office of the Governor and follow pragmatic best practices as an incentive to receive state and federal grants.¹¹

Each current Veterans' Treatment Court (VTC) operates under varying levels of autonomy. Court ordered individualized treatment plans are offered in each court; however due to the varying nature of the programs and funding opportunities available to them, the services they provide can differ drastically. The program is lacking in supportive funding, and would benefit from a standardization of procedural methods such as where, when, and how to approach a Veteran about participation in the program. Additional items of consideration include setting a shared standard for who is eligible for participation.

RECOMMENDATIONS

- 1. Provide permanent, specified funding for Veterans courts. Lack of funding has been repeatedly expressed to be one of the primary barriers to the program across counties.**
- 2. Make the requirement for eligibility more inclusive to include all military members who were/are eligible for combat, whether deployed or not.**

-
- 3. Encourage all counties to inquire if an arrestee has ever had prior military service in order to determine Veteran status, and promote the usage of a data system such as Veteran Re-entry Search Services to track such information.**
 - 4. Grant VTC judges the authority to transfer jurisdiction of cases if all parties involved are consenting.**
 - 5. Support creation of Justice for Veterans grants.**
 - 6. Veterans not eligible to participate in a Veteran Treatment Court should be referred to a mental health court as appropriate.**

Interim Charge #6 - Conduct legislative oversight and monitoring of the agencies and programs under the committee's jurisdiction and the implementation of relevant legislation passed by the 83rd Legislature. In conducting this oversight, the committee should:

- a. consider any reforms to state agencies to make them more responsive to Texas taxpayers and citizens;
- b. identify issues regarding the agency or its governance that may be appropriate to investigate, improve, remedy, or eliminate;
- c. determine whether an agency is operating in a transparent and efficient manner; and
- d. identify opportunities to streamline programs and services while maintaining the mission of the agency and its programs.

Issue 1

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

BACKGROUND

Texas was approved for a five-year demonstration waiver to take place from 2011-2016. The goal of the waiver is to allow for the expansion of managed care while protecting hospital supplemental payments under a new payment methodology at the same time incentivizing the delivery system improvements to enhance access and coordination of services and providers.

The waiver divided Texas into 20 regions known as Regional Healthcare Partnerships (RHP's) to partner together, pool funds, and provide coordinated services to their area. Under the waiver, Upper Payment Limit (UPL) funds and new funds are distributed to hospitals and other providers through two funding pools: Uncompensated Care (UC) Pool and Delivery System Reform Incentive Payments (DSRIP) Pool. Under the waiver, the UC pool totals \$17.6 billion, all funds, and the DSRIP pool totals \$11.4 billion, all funds.¹²

RECOMMENDATIONS

- 1. Texas should continue to allow the Health and Human Services Commission to work with all Regional Healthcare Partnerships to ensure that DSRIP projects show measureable improvements to healthcare access and outcomes.**
- 2. Texas should support renewal of the waiver.**

Issue 2
Healthy Community Collaboratives

BACKGROUND

Senate Bill 58, Section 2 (83rd Legislature, Regular Session, 2013) requires Department of State Health Services to establish or expand community collaboratives that provide services to individuals experiencing issues related to mental health and homelessness. The bill allows for a maximum of five grants in municipalities located in counties with a population of over 1 million. The state will provide dollar for dollar matching funds provided by private community sources for the purposes of a community collaborative. In order to be eligible for the grant, awardees must provide evidence of significant coordination and collaboration among providers of these services.¹³

Five municipalities were eligible for the grant. All were awarded the grant.

- Coalition for the Homeless Houston/Harris County
- City of Dallas (the Bridge)
- Tarrant County MHMR
- Austin Travis County Integral Care
- Haven for Hope (San Antonio)

Project Overviews

1. City of Dallas (The Bridge): \$5.18 million GR funds (FY 14/15) / \$ 5.18 million private matching funds
2. Haven for Hope (San Antonio): \$3.58 million GR funds (FY 14/15) / \$3.58 million private matching funds
3. Coalition for the Homeless Houston / Harris County: \$6.96 million GR funds (FY 14/15) / \$6.96 million private matching funds
4. MHMR Tarrant County: \$4.34 million GR funds (FY 14/15) / \$4.34 million private matching funds
5. Austin Travis County Integral Care (ATCIC): \$3.48 million GR funds (FY 14/15) / \$3.48 million private matching funds.¹⁴

RECOMMENDATION

1. **The 84th Legislature should expand grant eligibility to include additional municipalities.**
2. **Texas should place equal emphasis on addressing mental health needs and homelessness.**

Issue 3

County Emergency Response Preparedness

BACKGROUND

Due to counties obligation to maintain the safety of its residents, Chairman Coleman held a legislative hearing to discuss Dallas County's response to a patient in their hospital diagnosed with Ebola. The purpose of this hearing was to discuss publicly Dallas County's emergency response to such a crisis and discuss options available to other counties should another patient present with the Ebola virus.

The Texas Local Government Code, Chapter 418.102 states " Each county shall maintain an emergency management program or participate in a local or interjurisdictional emergency management program that, except as otherwise provided by this chapter, has jurisdiction over and serves the entire county or interjurisdictional area. The county program is the first channel through which a municipal corporation or a joint board shall request assistance when its resources are exceeded. Requests that exceed the county capability shall be forwarded to the state as prescribed in the state emergency management plan." Additionally, under the Texas Government Code, the County Judge is deemed the emergency management director for the county in which they serve. The County Judge has the authority to declare a local disaster in both the incorporated and unincorporated areas of the county.

Communication is key amongst providers to ensure that the most accurate and up-to-date information is received and implemented. Additionally, taking a patient's history regarding recent travels, allergies, family medical history, etc., plays a key role in illness diagnosis. Finally, having a plan of action to implement should such an emergency occur helps prevent the spread of communicable diseases and minimize threats to the community at large. Harris County takes a "3-C" approach: communicate, collaborate, and coordinate. In order to uphold the "3-C" model, Harris County employs the following:

- Maintain a comprehensive emergency management plan.
- Activate an Emergency Operations Center to respond to and recover from disasters.
- Deliver effective public outreach and preparedness programs.
- Provide information for elected officials, the media, residents and other stakeholders.
- Train, educate and prepare for emergencies through extensive drills and exercises.¹⁵

Overall, it is of the utmost importance to coordinate with all healthcare entities to maintain an emergency response plan.

RECOMMENDATION

- 1. Counties, hospitals, and healthcare workers should maintain an active emergency response plan to guarantee preparedness for the highest level threat of the most easily transmitted communicable diseases to ensure diseases such as Ebola, H1N1 or Bird Flu are identified and contained promptly.**

INTRODUCTION

At the beginning of the 83rd Legislative Session, the Honorable Joe Straus, Speaker of the Texas House of Representatives, appointed nine members to the House Committee on County Affairs: Garnet F. Coleman, Chair; Joe Farias, Vice Chair; Lois Kolkhorst; Todd Hunter; Ana Hernandez; David Simpson; Matt Krause; Mary Gonzalez; and Jonathan Stickland.

The House Rules adopted by the 83rd Legislature as House Resolution 4 on January 14, 2013, give the House Committee on County Affairs its jurisdiction. Rule 3, Section 6 reads as follows:

The committee shall have nine members, with jurisdiction over all matters pertaining to:

- (1) counties, including their organization, creation, boundaries, government, and finance and the compensation and duties of their officers and employees;
- (2) establishing districts for the election of governing bodies of counties;
- (3) regional councils of governments;
- (4) multicounty boards or commissions;
- (5) relationships or contracts between counties;
- (6) other units of local government not otherwise assigned by these rules to other standing committees; and
- (7) the following state agency: the Commission on Jail Standards.

During the interim, the Speaker assigned charges to the Committee.

1. Examine population growth in Texas counties and the impact the growth has had on housing, available land resources, businesses in Texas, as well as the impact of growth on the state's economy. Evaluate Texas's preparedness to respond to future growth and ensure economic stability.
2. Continue oversight of the Texas Commission on Jail Standards and issues jails currently face, including the mental health of those in jail, and make recommendations for refinement or improvement of processes and programs.
3. Monitor the health advisory panel stemming from HB 3793 (83R).
4. Determine which counties have implemented a cite-and-summons policy, whether the policy has been effective in lessening overcrowding in county jails, and whether those cited by peace officers comply with the policy.
5. Study the implementation of SB 462 (83R). Examine which counties currently have veterans courts, as well as veterans courts in other states, and determine how those

programs are working and whether these courts provide additional services or resources for veterans. Make appropriate recommendations. (Joint charge with the House Committee on Defense and Veterans' Affairs)

6. Conduct legislative oversight and monitoring of the agencies and programs under the committee's jurisdiction and the implementation of relevant legislation passed by the 83rd Legislature. In conducting this oversight, the committee should:
 - a. consider any reforms to state agencies to make them more responsive to Texas taxpayers and citizens;
 - b. identify issues regarding the agency or its governance that may be appropriate to investigate, improve, remedy, or eliminate;
 - c. determine whether an agency is operating in a transparent and efficient manner; and
 - d. identify opportunities to streamline programs and services while maintaining the mission of the agency and its programs.

The Committee on County Affairs held the following hearings:

- March 10, 2014, Polk County Commerce Center Room A, Livingston, Texas
- May 5, 2014, Capitol Room E2.016, Austin, Texas
- May 14, 2014, 111 East Pecan Street, San Antonio, Texas
- May 15, 2014, Capitol Room E2.016, Austin, Texas
- June 11, 2014, Capitol Room E2.016, Austin, Texas
- October 20, 2014, Capitol Room E2.016, Austin, Texas
- October 27, 2014, The University of Texas - Pan American

The Committee thanks each of the agencies, associations, and individuals who contributed their time, testimony, and information to this report.

The Committee on County Affairs has completed its hearings and has adopted the following report.

Interim Charge #1 - Examine population growth in Texas counties and the impact the growth has had on housing, available land resources, businesses in Texas, as well as the impact of growth on the state's economy. Evaluate Texas's preparedness to respond to future growth and ensure economic stability.

The Committee met to discuss this interim charge in hearings and individual meetings. In order to give this charge proper respect and insight, it is necessary to continue research on population growth in order to make recommendations that will benefit Texas counties. Therefore, the Committee will continue to study in-depth population growth and make recommendations based on our findings.

SUMMARY OF COMMITTEE ACTION

Committee Hearings

March 10, 2014, Polk County Commerce Center, Livingston, Texas

October 20, 2014, Capitol Room E2.016, Austin, Texas

Witnesses

March 10, 2014, Polk County Commerce Center, Livingston, Texas

- Shaun Davis (South East Texas Regional Planning Commission)
- Walter Glenn (Self)
- John Martin (Southeast Texas Groundwater Conservation District)
- Tommy Overstreet (East Texas)

October 20, 2014, Capitol Room E2.016, Austin, Texas

- Jim Allison (County Judges and Commissioners Association)
- John Carlton (Texas State Association of Fire and Emergency Districts)
- Hugh Coleman (Self; Denton County Precinct 1)
- Richard H. Dolgener (Andres County, Texas)
- Sarah Eckhardt (Self)
- Stephen Floyd (Tom Green County)
- Daryl Folwer (County of DeWitt, County of Karnes, County of Gonzales)
- Bob Hebert (Fort Bend County)
- Timothy Irvine (Texas Department of Housing and Community Affairs)
- Ron Moellenberg (Travis Co. Emergency Services District No. 2)
- Gary Painter (Self)
- Bruce Todd (Travis County, Precinct 2)

Interim Charge #2 - Continue oversight of the Texas Commission on Jail Standards and issues jails currently face, including the mental health of those in jail, and make recommendations for refinement or improvement of processes and programs.

SCOPE OF THE CHARGE

This charge explores a multitude of issues local jails face on a daily basis. This includes the Prison Rape Elimination Act (PREA), inmates suffering from mental illness, veterans that enter our criminal justice system, diversion tools available, certified juveniles, paper ready inmates, and peer to peer specialist. Additionally, the Committee continued to monitor the Texas Commission on Jail Standards.

SUMMARY OF COMMITTEE ACTION

Committee Hearings

March 10, 2014, Polk County Commerce Center, Livingston, Texas

May 5, 2014, Capitol Room E2.016, Austin, Texas

October 20, 2014, Capitol Room E2.016, Austin, Texas

Witnesses

March 10, 2014, Polk County Commerce Center, Livingston, Texas

- Diana Claitor (Texas Jail Project)
- Mathew Simpson (ACLU of Texas)
- Carter Tarance (Self)
- Denis Wilson (Sheriff's Association of Texas)
- Brandon Wood (Texas Commission on Jail Standards)

May 5, 2014, Capitol Room E2.016, Austin, Texas

- Diana Claitor (Texas Jail Project)
- Lynda Frost (The Hogg Foundation)
- Catherin Giles (Self)
- Greg Hansch (National Alliance on Mental Health (NAMI) Texas)
- Elizabeth Henneke (Texas Criminal Justice Coalition)
- Christopher Kirk (Self; Sheriff's Association of Texas)
- Megan Randall (Center for Public Policy Priorities)
- Matt Simpson (ACLU of Texas)
- Dennis Wilson (Self; Sheriff's Association of Texas)
- Brandon Wood (Texas Commission on Jail Standards)

October 20, 2014, Capitol Room E2.016, Austin, Texas

- Adrian Garcia, (Harris County Sheriff's Office)

-
- AJ Louderback (Sheriff's Association of Texas)
 - Brandon Wood (Texas Commission on Jail Standards)
 - Ana Yanez-Correa (Texas Criminal Justice Coalition)

General Oversight

Texas Commission on Jail Standards

BACKGROUND

The Texas Commission on Jail Standards (TCJS) conducts annual on-site inspections of county jails to verify compliance with minimum jail standards in Texas. Currently there are 245 jails that fall under the jurisdiction of TCJS. The policy-making body consists of nine Commission members appointed by the Governor. The Commission operates with 16 full time employees, four of which are jail inspectors, with an annual budget of \$910,000. TCJS requires administration of inmate population reports from jails, and it investigates and resolves inmate grievances. The Commission meets quarterly to discuss any issue that needs to be addressed concerning the various county jail issues under their purview. It is the duty of the Commission to establish written rules and procedures establishing minimum standards, inspection procedures, enforcement policies and technical assistance for:

1. the construction, equipment, maintenance, and operation of jail facilities under its jurisdiction;
2. the custody, care and treatment of inmates;
3. programs of rehabilitation, education, and recreation for inmates confined in county and municipal jail facilities under its jurisdiction.

Additionally, TCJS conducts annual on-site inspections of county jails to verify compliance with minimum standards. Currently there are 245 jails that fall under the jurisdiction of TCJS. The policy-making body consists of nine Commission members appointed by the Governor. The Commission operates with 16 full time employees, four of which are jail inspectors, with an annual budget of \$910,000. TCJS requires administration of inmate population reports from jails and investigates and resolves inmate grievances. The Commission meets quarterly to discuss any issue that need to be addressed concerning the various county jail issues under their purview.

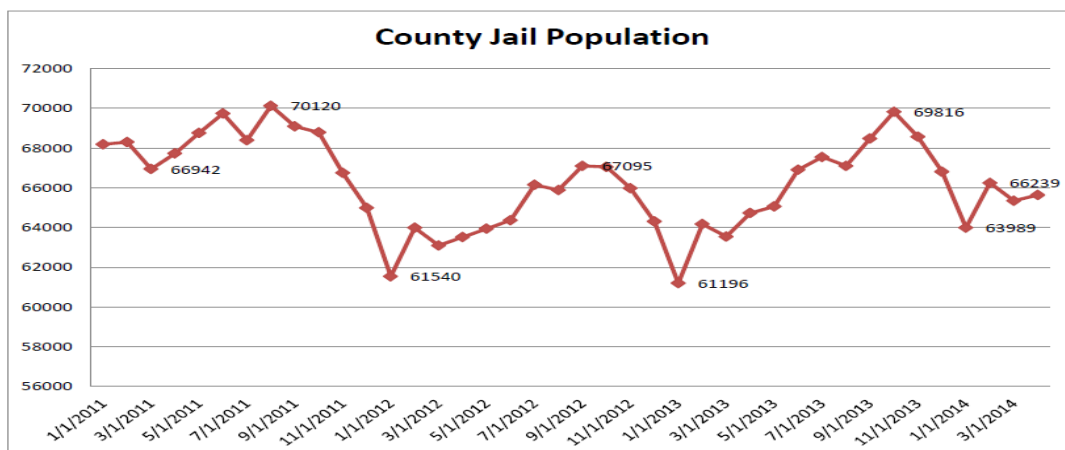
As part of the statewide standards established by the Commission, TCJS requires each county jail or facility under their purview establish a Health Services plan submitted and approved in writing. The Health Services Plan must provide inmate medical, dental, and mental health services. According to the Texas Administrative Code, each plan shall:

- 1) provide procedures for regularly scheduled sick calls;

- 2) provide procedures for referral for medical, mental, and dental services;
- 3) provide procedures for efficient and prompt care for acute and emergency situations;
- 4) provide procedures for long-term, convalescent, and care necessary for disabled inmates;
- 5) provide procedures for medical, mental, nutritional requirements, special housing, appropriate work assignments, and the documented use of restraints during labor, delivery and recovery for known pregnant inmates;
- 6) provide procedures for the control, distribution, secured storage, inventory, and disposal of prescriptions, syringes, needles, and hazardous waste containers;
- 7) provide procedures for the distribution of prescriptions in accordance with written instructions from a physician by an appropriate person designated by the sheriff/operator;
- 8) provide procedures for the control, distribution, and secured storage of the over-the-counter medications;
- 9) provide procedures for the rights of inmates to refuse health care in accordance with informed consent for certain treatments and procedures (in the case of minors, the informed consent of a parent, guardian, or legal custodian, when required, shall be sufficient);
- 10) provide procedures for all examinations, treatments, and other procedures to be performed in a reasonable and dignified manner and place; and
- 11) provide that adequate first aid equipment and patient evacuation equipment be on hand at all times.¹⁶

FINDINGS

The following chart provides the county jail population for the previous three years. Historically county jail populations have fluctuated, typically significantly increasing in the summer months and significantly decreasing in January. Additionally, there have been isolated incidents of overcrowding that the Texas Commission on Jail Standards (TCJS) and interested parties have worked to address and correct.



The Texas Commission on Jail Standards investigates all grievances filed by inmates and/or inmate's family members. The most common grievances filed are regarding the medical care inmates are receiving in the local jails. On average, TCJS receives between 120 to 150 grievances per month. Of these, on average about 60 of those complaints are regarding medical care. Upon investigation, on average between three and four complaints per month result in a violation of the county jail. TCJS works with families and inmates to ensure their understanding of the requirements of the jail to provide medical care.

Medical (care) is one of the biggest and most costly issues that county jails face. TCJS requires that all jails maintain at least the minimum standards of medical, dental, and mental health care required by the Texas Constitution. Additionally, TCJS requires that all jail and local facilities comply with medical orders issued by a doctor for the proper inmate care.

TCJS's work with the county jails has increased as technology and population issues have evolved. TCJS works directly with the local jails to help them obtain and maintain compliance with minimum standards. Due to the multitude of ever-changing issues that the jails face, the workload experienced by TCJS has increased, thereby creating a need for an additional full-time administrative staff person. The Commission has requested in their Legislative Appropriations Request to the 84th Legislature additional funding for one FTE to perform administrative duties necessary to allow the Commission to keep fulfilling their mission.¹⁷

RECOMMENDATION

The 84th Legislature should provide the Texas Commission on Jail Standards with additional appropriations to add one additional full-time employee to perform clerical duties.

The Texas Commission on Jail Standards operates with a significantly less staff than most state agencies. In their legislative appropriations request, TCJS requested additional funding to hire one additional full-time employee to perform clerical duties. The Texas Commission on Jail Standards provides significant oversight of the county jail system and works hard to be an agency that works with the jails to overcome their obstacles. There is a need for TCJS to continue oversight of the jail system. Currently, all employees take part in the clerical work associated with TCJS' responsibilities. In order to ensure that they maintain focus on their responsibility, an additional FTE to perform clerical duties would provide TCJS the needed assistance.

Issues Local Jails Face

Issue 1

Prison Rape Elimination Act

BACKGROUND

The Prison Rape Elimination Act (PREA) is a federal statute that Congress passed unanimously in 2003 intended to prevent sexual assault and victimization in prison. Federal statute defines "prison" as any confinement facility, including jails, police lockups, and juvenile facilities. The definition of "rape" is inclusive of a variety of unwanted sexual activity. Currently, all federal facilities are required to implement and maintain compliance with PREA standards. State and local facilities are mandated to maintain compliance with the federal standard but currently no enforcement mechanism exists thus noncompliance could result in litigation.

PREA has four main goals:

1. Data Collection - Section four of PREA requires the collection of statistics on the occurrence of sexually violent incidences while in custody in state, local, and federal facilities by the Bureau of Justice Statistics.
2. Training and Technical Assistance - Section five of PREA gave funding to the National Institute of Corrections to provide training and technical assistance to the corrections field and to administer a clearinghouse nationwide on sexual violence while in custody.
3. Grants to States that implement PREA standards - PREA authorized a grant program to provide funding to states implementing and maintaining compliance standards.
4. Establishment of National Standards - On June 20, 2012, the Department of Justice adopted a set of national standards for PREA.

As a part of PREA's creation, Congress established a National Prison Rape Elimination Commission (NPREC). NPREC was directed to complete a comprehensive study on penological, physical, mental, medical, social, and economic impacts of prison rape in the United States. Based on their findings, NPREC was instructed to report to the Attorney General on national standards for detection, protection, prevention, reduction, and reprimand inmates committing rape in prison.

FINDINGS

Many of the standards required by the Prison Rape Elimination Act (PREA) were already enforced by the Texas Commission on Jail Standards. State facilities and local facilities with federal contracts must comply with PREA standards. Furthermore, as part of PREA compliance, a state who's Governor does not certify full PREA compliance is subject to lose 5% of any Department of Justice grant that would be used for prison purposes. Although PREA does state

that county facilities must comply with standards, there is no enforcement mechanism. Local facilities not in compliance with PREA standards are not subject to a 5% loss of any DOJ grant as they are not a state-run facility. However, civil suits may be filed against facilities for noncompliance arguing noncompliance is a violation of their constitutional obligation and making them vulnerable to significant litigation.

As part of PREA's four goals, grants are administered by the federal government to provide assistance to states trying to meet compliance standards. As of 2013, the federal government had issued a total of \$54,376,459 to the states with Texas has receiving the largest monetary amount, totaling approximately \$3.5 million.

Several Texas counties have already received PREA-related grants:

- Dallas County Juvenile Department (\$88,942)
- Travis County Juvenile Probation Department (\$100,000)
- Atascosa County Juvenile Probation Department (\$300,000)
- Harris County, Texas (\$237,693)
- Webb County, Texas (\$250,000)

Texas has one of the highest rates of prison rape in the United States, with reported rapes and unwanted sexual advances totaling almost four times the numbers reported nationwide. Texas reports 550 alleged incidents per 1,000 inmate population. This is a 3.95 average compared to other states reporting a 1.05 average. Additionally, locally and privately run facilities reported higher rates of incidents with an average of 3.22 per 1,000 inmate population as compared to an average of 1.22 per 1,000 inmate population in the state prison systems and an average rate of 1.33 in federal prisons. Texas also has one of the lowest resolution rates in the nation.

During the study and ultimate creation of PREA standards, the Bureau of Justice Statistics conducted a nationwide survey and found that five of the 10 state prison facilities that reported the highest incidents of sexual assaults were located in Texas. Furthermore, it was found that 15.7% of inmates surveyed reported they had experienced a sexual assault either by another inmate or staff person.

The following chart reflects the number of sexual assaults reported in 2007 in state prisons around the nation.

Table 4. Prison facilities with the highest prevalence of sexual assault, by another inmate or staff and by level of force and injury, National Inmate Survey, 2007

Facility name	Total prevalence ^a	Inmate-on-inmate sexual assault			Staff-on-inmate sexual assault			
		Physically forced	Pressured	Injured ^b	Physically forced	Pressured	Reported as willing	Injured ^b
U.S. total	4.5%	1.3%	1.7%	0.5%	0.9%	1.5%	1.7%	0.3%
Estelle Unit, TX	15.7	5.1	7.9	2.0	0.9	4.4	5.2	0.4
Clements Unit, TX	13.9	1.7	3.3	1.0	4.1	6.8	5.6	3.1
Tecumseh State Corr. Inst., NE	13.4	0.0	1.2	0.0	7.5	11.8	5.9	3.9
Charlotte Corr. Inst., FL	12.1	0.6	1.1	0.0	2.6	6.1	5.7	0.0
Great Meadow Corr. Fac., NY	11.3	1.0	2.8	0.0	6.0	6.3	2.8	2.0
Rockville Corr. Fac., IN ^c	10.8	6.5	7.5	3.7	0.5	1.1	0.9	0.6
Valley State Prison for Women, CA ^c	10.3	4.7	5.9	1.5	1.5	3.3	3.3	0.9
Allred Unit, TX	9.9	3.6	3.2	3.3	2.8	3.2	2.3	0.9
Mountain View Unit, TX ^c	9.5	7.5	6.8	2.7	0.7	3.0	1.4	2.1
Coffield Unit, TX	9.3	2.1	3.9	0.0	0.4	1.4	4.3	0.0

Note: Detail may add to more than totals because victims may report more than one type of victimization, injury, and type of force.

^aPercent of inmates reporting one or more incidents of sexual victimization involving another inmate or facility staff in the past 12 months or since admission to the facility, if shorter. (See *Methodology* for definitions.) Weights were applied so that inmates who responded accurately reflected the entire population of each facility on selected characteristics, including age, gender, race, time served, and sentence length. (See *Methodology* for nonresponse and post-stratification weighting procedures.)

^bInjuries included knife or stab wounds, broken bones, anal or rectal tearing, teeth chipped or knocked out, internal injuries, knocked unconscious, bruises, black eyes, sprains, cuts, scratches, swelling, or welts.

^cFemale facility.

Many of the PREA requirements still pose a challenge to our county run facilities. These challenges include but are not limited to cross-gender viewing, sexual harassment, housing of certified juveniles, and restrictions and implementation regarding policies and procedures.¹⁸

RECOMMENDATIONS

The Texas Commission on Jail Standards board members, the Sheriff's Association of Texas, and the Texas Association of Counties have reviewed many of these standards and decided upon some minor changes that would allow smaller, more rural facilities to maintain PREA compliance. These standard changes include:

- **Allowing for sheriff discretion to designate who performs the searches**
 - many small counties may only have one staff on duty at any given point in time
- **Allowing staff to perform searches**
- **Giving county government flexibility on how to address these standards in order to maintain compliance**

By implementing these changes, county jails will reduce the risk of litigation for noncompliance with PREA standards.

The Texas Commission on Jail Standards should continue to provide assistance to other facilities to incorporate PREA guidelines in local operations upon request.

Federal facilities or local facilities with a federal contract are the only entities required to comply with Prison Rape Elimination Act guidelines. Texas county jails have resources and tools in place to meet constitutional minimum standards for housing and treatment of inmates which, in many cases, exceed the guidelines contained in the Prison Rape Elimination Act. PREA does not mandate local compliance unless the local facility has a federal contract.

Issue 2

Inmates with Mental Illness

BACKGROUND

Criminalization of mental illness has become the trend due to lack of outpatient services available. Many have been jailed due to their lack of treatment in community-based facilities and therefore continue to mentally deteriorate while in jail awaiting trial. This not only poses a risk to the inmate but to the jail staff as well. Additionally, incarceration is costly to the tax payers, especially an inmate with mental illness or other chronic medical conditions.

Studies show that inmates suffering from mental illness have higher rates for recidivism in the jail system. As well, they are one of the highest emergency room utilizers. This may be due to the decline in prescription medication use or mental health treatment post-release for inmates. Quite often, the inmate has not received any treatment prior to their encounter with law enforcement and will have difficulty maintaining this treatment after release. Inmates suffering from mental illness have a disproportionately higher number of physical diseases such as asthma and arthritis. Communicable diseases, such as HIV, tuberculosis, and Hepatitis B and C, are more prevalent in the jailed mental health population as well.

The Texas Correctional Office of Medical and Mental Impairments (TCOOMMI), under the Texas Department of Criminal Justice, does provide re-entry services inmates in some county jails, however, due to limited state funding TCOOMMI primarily serves inmates from the state prison or jail facilities.¹⁹

FINDINGS

Recently, interested parties have noted that "jails are the new state hospitals." County jails have quickly become the default to house someone experiencing a mental health crisis. This is often due to the lack of available state hospital beds and a lack of secure facilities to house people detained who may pose a risk to themselves or others. County jails are the only secure facilities that cannot turn away someone. However, this is not only a drain on county resources, it also does not provide a conducive environment that promotes treatment.

County jails continue to house low-level offenders. It is estimated that 75% of offenders suffer from co-occurring conditions of substance abuse and mental illness. This is often due to self-medicating because of a lack of treatment. Many of these inmates are arrested and booked into county jails on misdemeanor offenses.

People suffering from mental illness would be better served in community treatment facilities where the environment promotes recovery. Recovery is not simply treatment of the substance

abuse or the mental illness, it is a multitude of issues being addressed to ensure the person receiving treatment can be re-integrated into society and live a normal life. These factors include: substance and mental health treatment, job assistance, housing assistance, counseling, and any other issues that need to be addressed. It is important the person receiving treatment is in a supportive environment surrounded by things that are familiar to them.

Medical treatment is the biggest and most costly issue county jails face. National data indicates that approximately 50% of adult inmates suffer from mental illness. Of those, 75% have a co-occurring substance abuse problem. Although studies vary, it is estimated that at least 25% but up to 87% of inmates nationwide have some form of traumatic brain injury. Additionally, 89% of men and 95% of women participating in a jail diversion program reported a traumatic experience or sexual abuse.²⁰

Throughout the years, counties have created diversion tools to address population growth and overcrowding in local jails. However, these tools are not being utilized to their full potential. In 1989, Texas implemented its first drug court and in 1997 implemented its first mental health court. These specialty courts are available to counties to divert people whose underlying mental illness or substance abuse caused them to commit an offense. However, when Texas created these courts, they did so on an opt-in basis and did not provide funding. Counties that have created specialty courts are seeing positive results in reducing recidivism rates.

Crisis Intervention Training

Currently, law-enforcement officers receive a minimum of eight hours in Crisis-Intervention Training. This training equips law-enforcement officers with the knowledge on how to recognize a person experiencing a mental health crisis as well as how to de-escalate an immediate situation. This allows the officers to understand what action is necessary in an immediate crisis situation to maintain the safety of the officer and the offender involved. This training also informs law-enforcement on the available treatment options and allows the offender to be diverted into treatment rather than detained in the local jail.²¹

Mobil Crisis Intervention Teams

One tool that many counties are using is a Mobile Crisis Intervention Team. These teams provide the communities with a great resource to divert those experiencing a mental health crisis into treatment rather than into the local jail. Not only does this provide for a healing environment, it also saves the jail money and allows law enforcement to stay on patrol. Sheriff Chris Kirk of Brazos County created a Mobile Crisis Intervention Team modeled after Williamson County in 2006. Since its creation, Brazos County officials have diverted 1,000 people into local treatment facilities.

Peer Support Programs

As previously stated, once released from a correctional facilities inmates with mental illness, in comparison to other inmates, are more likely to experience higher rates unemployment, homelessness, emergency room use, and rearrests, which is very costly to the state and local

budgets. Several Texas counties have implemented innovative re-entry programs to help transition inmates with mental illness from jail to the community such as the Jail-in Reach project in Harris County. However, currently in Texas, there is no statutory requirement for jails to provide any type of continuity or coordination of care post-release for inmates.

A Pennsylvania organization has successfully used certified peer support specialist to help inmates with mental illness to successfully transition into the community by connecting to community mental health services and treatment. Peer support programs use peer-to-peer specialist with lived experiences of mental illness to befriend inmates suffering from mental illness. The peer-to-peer specialist usually reaches out to the inmate between 30-90 days prior to release to communicate and coordinate wrap-around services for inmates once they are released.

The Pennsylvania peer support programs has proven to be an effective tool in helping inmates receive the wrap-around services needed once released from a jail facility resulting in reduce emergency room utilization and recidivism rates in areas where they are used.

Inmates suffering from mental illness continue to be one of the largest drain on community resources in our local jail facilities. As the stigma surrounding mental illness lessens and acceptance of mental illness as an illness increases, it is imperative that care continues after an inmate is released from jail.²²

Wrap-Around Services

Continuity of care is essential to not only reducing recidivism in our jails, thus lessening the financial burden on tax payers, but also providing those suffering from these illnesses with the tools available to allow them to live a healthy life. Community-based services not only include mental health and substance abuse treatment, they also connect people with housing, transportation and employment services. In the 83rd Legislative Session, the Legislature provided more funding for community-based treatment facilities. From this funding there is evidence that waitlists for treatment have reduced, more people are in supportive housing, and there are more crisis-intervention tools being used.

However, there are obstacles facing these treatment facilities. For example, location of the facilities does not always coincide with where the demand for treatment exists, and often patients lack transportation. Therefore, it is important to have facilities strategically placed so the demand for services can be met. Furthermore, Texas continues to suffer from a serious healthcare provider shortage. This shortage impacts all medical facilities, including community-based treatment facilities. As well, community-based treatment facilities are working on adopting evidence-based best practices for treatment. This ensures that patients treatment has a known success rate.

Medicaid

Currently, if a person who receives Medicaid is incarcerated, Texas immediately suspends their

benefits. This is problematic for someone who suffers from a physical or mental illness upon their release. Often these people need to obtain medical services or treatment post-release from jail. Unfortunately, due to their suspension of Medicaid benefits, they are unable to obtain the proper medication and treatment needed to maintain competency. This factor largely contributes to recidivism rates due to the person's inability to obtain and maintain post-release treatment.²³

RECOMMENDATIONS

When incarcerated in a county jail, Texas should maintain Medicaid benefits instead of suspending them so those with mental illness can obtain or maintain medical treatment.

Currently, when an inmate enters the county jail, their Medicaid benefits are suspended. Upon release, these inmates often are in need of medication and treatment but are unable to obtain them due to suspension or even loss of their Medicaid benefits. If their Medicaid benefits were maintained during incarceration, they could continue to receive proper treatment upon release and reduce recidivism rates.

Establish a peer support re-entry program to ensure inmates with mental illness successfully transition from jail to community-based care.

Texas currently has an established peer support infrastructure in place to train and certify peers to work in community mental health centers and state hospitals. In an effort to maintain a continuity of care for individuals with mental illness, a few state hospitals use certified peer support specialists to assist patients in transition from the hospital to the community. There is growing interest nationwide and in Texas to use peer support specialists within the correctional system. In fact in Bexar County, the county jail and community mental health center just developed a program using peers within various roles to support inmates with a mental illness in county jail. Therefore, Texas should develop a pilot Peer Support Re-Entry program with a local county jail.

Issue 3
Certified Juveniles

BACKGROUND

Prior to 2011, any juvenile that had been certified as an adult to stand trial was required to be housed in an adult county jail. However, this mandate created many challenges for jails due to previously determined housing standards. These standards required separate searches for certified juveniles as well as complete separation of sight and sound. The 82nd Legislature passed Senate Bill 1209 which required the juvenile board to create policies that allow for certified juveniles to be housed in juvenile detention facilities while awaiting trial.

FINDINGS

Certified juveniles continue to be a major issue for county jails, specifically when it comes to issues of separation from the adult population and additional staff requirements. For large urban areas, these requirements create a significant burden due to high numbers of certified juveniles. In rural areas, this creates additional challenges for those smaller jails. First, many of rural areas do not have adequate staff to meet the requirement of having separate staff for juveniles. Second, many of jails were built prior to the separation of sight and sound requirements therefore the physical structure of these jails does not meet these requirements. The Commission works with each of these facilities to address these issues and most are attempting to meet the required standards.

Since the Legislature passed Senate Bill 1209, which allows for certified juveniles to remain in juvenile facilities while awaiting trial, it does eliminate some stress for facilities that do not have the ability or capacity to house certified juveniles.

Not only does housing certified juveniles in adult jail facilities present burdensome structural and financial hardships for counties, those juveniles that are certified as adults and transferred to county jails still fall under the guidance of the Texas Family Code, which views them as children until they reach age seventeen. Jails must, therefore, provide a higher level of supervision and programming suitable for children, such as educational requirements. Juveniles certified as adults present an additional layer of challenges for meeting PREA guidelines due to conflicts between the state and federal definitions of "adult" and "juvenile."

Increasing the age of juvenile jurisdiction would mean a shifting of probation caseloads from the adult probation department, primarily supported with state funds and defendant fees, to the local juvenile probation departments. Currently, counties provide a statewide average of about 65% of funding for the operation of local juvenile probation departments through the county general fund (property taxes). An increase in caseloads and population in juvenile

detention facilities would require additional staffing and an anticipated higher level of supervision, treatment, and diversion programs for older defendants.²⁴

RECOMMENDATION

The 84th Legislature should raise the age of maximum juvenile jurisdiction from 17 years old to 18 years old.

By raising the age for juveniles to 18 years old, this allows them to remain in a juvenile facility with the correct level of staffing required.

Issue 4

Blue Warrants

BACKGROUND

When an inmate has completed their minimum jail sentence they become eligible for parole. A blue warrant is an arrest warrant used when a parolee commits a violation of their parole agreement. The term "blue warrant" comes from the blue jacket that the warrant is placed in.

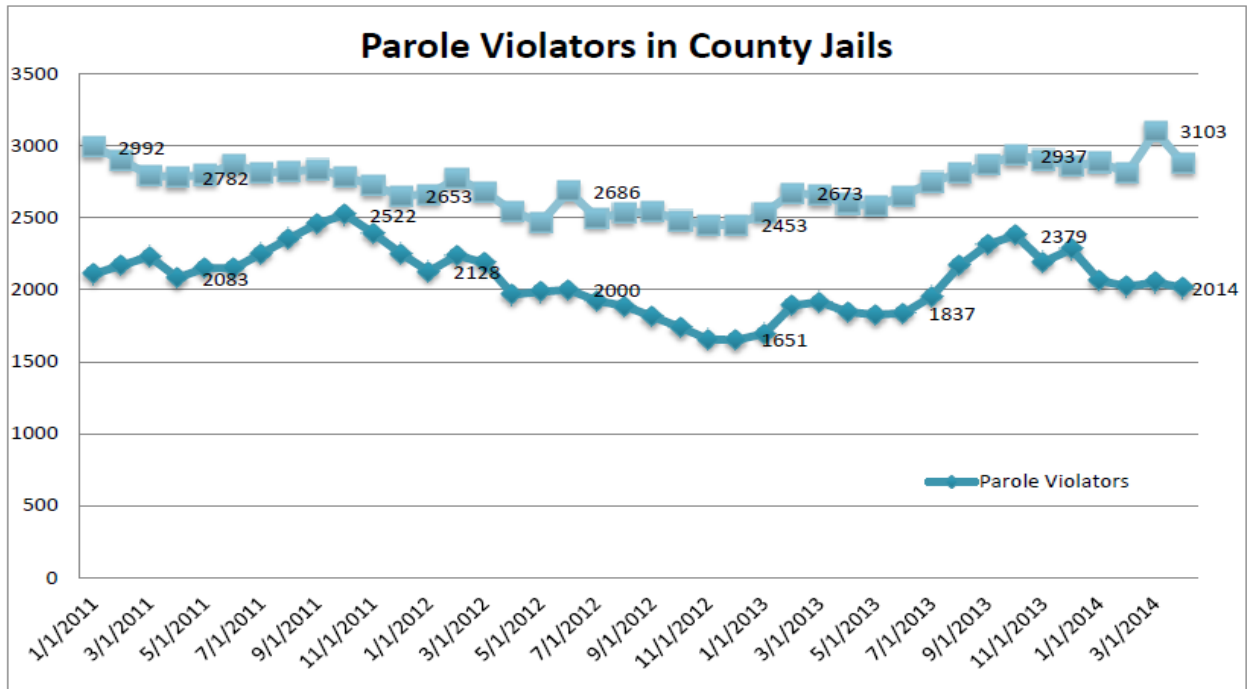
A "true" blue warrant is issued when someone commits another crime while on parole. However, a blue warrant can be issued when someone violates a technical aspect of parole. Often there are terms and conditions associated with their parole such as obtaining a job, reporting to a parole or designated supervisor, drug testing, and more. If a person violates any of the terms and conditions associated with their parole, this is considered a technical violation.

FINDINGS

Blue warrant inmates consist of approximately 5,000 total inmates in our jail population. Approximately 3,000 of these inmates are parole violators that have committed a crime. This number tends to remain steady. The other approximate 2,000 blue warrant inmates have violated the technical terms of their parole. This inmate population is often referred to as state inmates in the county jails. TCJS does not receive information on which crimes are committed by people on parole who re-offend.

Blue warrant inmates may not bond out while awaiting trial.

The following chart provides the population of parole violators that are housed in county jails for the past three years. The top line of the charge represents the true blue warrant inmate population (those that committed a new crime while on parole). The bottom line represents those that were issued a blue warrant due to a technical violation.



In the 2012 calendar year the Brazos County Jail reported an Average Daily Population (ADP) of 550 inmates which translates to 200,750 bed days for incarcerated inmates. During that same time an average of 70.2 inmates daily were being held in the Brazos County Jail on parole issued Blue Warrants which amounts to 25,632 bed days for incarcerated inmates. The operational cost of confinement for one inmate in the Brazos County Jail is \$47.83 per day. At that rate the total incarceration expense to Brazos County in 2012 for the inmates held on Blue Warrants was \$1,225,979. Extrapolation of the total incarceration expense for all Texas county jails to hold inmates on Parole issued Blue Warrants could be \$80,000,000 annually.²⁵

RECOMMENDATIONS

Board of Pardons and Paroles should not issue a blue warrant until the decision to revoke and return a defendant to state confinement has been made.

This would solve the problem of the state using the county for “jail therapy” which increases jail population and places additional financial burden on county budgets, with the result of the parole violators being released back into the communities.

On the arrest of a Texas parolee for new criminal charges the Board of Pardons and Paroles should not issue a blue warrant until the time the new local charge is finally adjudicated.

Exceptions would apply in cases where the new charges are felonies, offenses under Title 5 or Chapter 49 Penal Code, an offense involving family violence as defined in the Family Code or if the defendant would be a public threat.

Certain parole violators with new charges may be allowed to make bond under the same

court of jurisdiction as that of the new charge.

If the defendant arrested on a new charge is eligible for a bond on that charge then there should be a provision for the Blue Warrant to have a bond. Exceptions would apply in cases where the new charges are felonies, offenses under Title 5 or Chapter 49 Penal Code, an offense involving family violence as defined in the Family Code or if the defendant would be a public threat.

Issue 5

Paper-Ready Inmates

BACKGROUND

When an inmate is convicted at the local level and sentenced to serve their time in the state prison system, a paper packet is compiled and sent to the Texas Department of Criminal Justice (TDCJ). Once accepted by the TDCJ, the inmate becomes "paper-ready". The term "paper-ready" is derived from the paper packet sent to TDCJ.

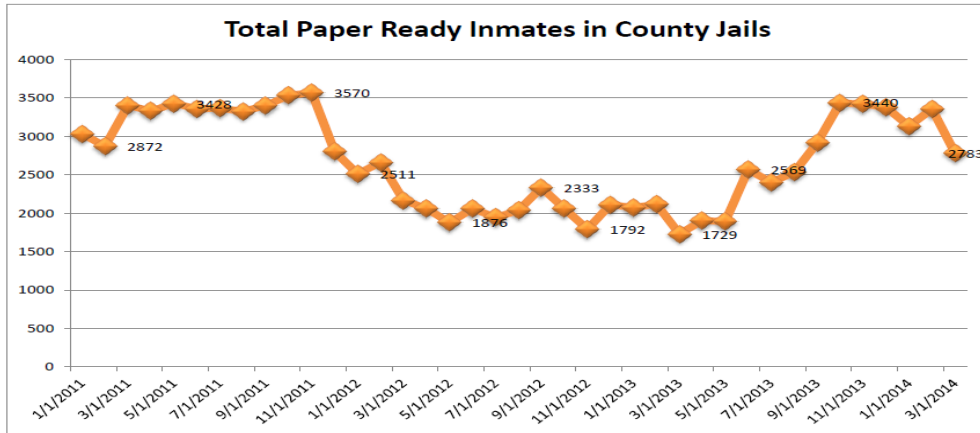
In the 1990's, multiple counties filed a lawsuit against the state regarding wait times for the state to pick up paper-ready inmates from the local jail and transfer them to the appropriate facility to serve their sentence. At this time, there was no mandatory time limit for TDCJ to accept and transfer paper-ready inmates. Nor was there any form of reimbursement to the counties for housing these inmates. As a result of this lawsuit, the state statute now mandates that TDCJ has 45 days to transfer the inmate from the county jail to the state facility.

FINDINGS

This remains a concern among many of the counties regarding their paper-ready inmates. Two of the TDCJ facilities have shut down, causing concern about TDCJ's ability to accept and transfer inmates out of the local jails. Currently, TDCJ averages about 18 days for acceptance of paper-ready inmates. Upon the two facilities shutting down, TDCJ's average jumped to 23 days. Since then, TDCJ has made the appropriate changes necessary and has now returned to the 18 day average for acceptance.

Additionally, there is a remaining concern that if the state prison system's population rises, TDCJ's acceptance rate will once again spike and thus create a burden for the local jails.

The following chart represents the paper-ready inmate population for the past three years.



RECOMMENDATIONS

The Texas Commission on Jail Standards should continue to closely monitor the Texas Department of Criminal Justice population and facility closures.

It is necessary to monitor TDCJ facilities and the impact any increases have on transfer backlogs in local county jails.

Issue 6

Veterans in Local Jails

BACKGROUND

As military service men return home, many are having a hard time transitioning into a civilian lifestyle. In Texas there is a 9.7% unemployment rate among veterans and roughly a third of them suffer from Post-Traumatic Stress Syndrome (PTSD) or some other form of mental illness. As a result, veterans across the state are encountering the criminal justice system more frequently, often attributed to self-medicating and lack of employment. It is important to note that many jails report they are encountering more Vietnam veterans than previously.

Healthcare Costs for Veterans in Perspective

In Texas, there are over 1.7 million veterans. The VA provides health insurance to veterans. Veterans are divided into categories based on a multitude of factors that include income, disability, military service, location of conflict engagement, etc. This allows Congress to adequately fund each category based on the perceived medical cost with groups 1,3, and 5 being the largest groups.

Group 1 is comprised of veterans who are considered to be 50% disabled or more. In 2013, the average medical treatment cost for a veteran insured by the VA in Group 1 was \$11,598 per veteran. Group 3 consists of veterans who are Former Prisoners of War (POWs), veterans

awarded a Purple Heart medal, veterans with disabilities of 10-20%, and veterans awarded special eligibility classification under Title 38, U.S.C., §1151. The annual cost of medical treatment provided by the VA for veterans in Group 3 is \$5,546 per veteran. Lastly, Group 5 is comprised of veterans who are non-service connected veterans with a 0% disability rating but are Medicaid eligible. The annual cost to the VA for providing medical treatment to Group 5 is \$8,386 per veteran.

It is the obligation of the local jail to provide medical care to all inmates, including veterans. Veterans eligible for VA assistance would provide a significant cost savings to the county when providing medical treatment.

FINDINGS

Identifying Veterans

The issues surrounding veterans continue to affect our county jails. Identifying an inmate as a veteran can prove to be quite difficult. During the initial booking, inmates are asked if they have performed military service. The language was drafted in the manner to get veterans to self-identify, but many veterans will not self-identify if they never saw active duty. However, VA services are available to all veterans regardless of their job while serving in the military.

Once a veteran self-identifies, if the county has a veteran's court in place, the court can then sync the veteran up with services already provided by the VA. These services include mental health treatment, substance abuse treatment, employment assistance, housing assistance, and more. By syncing veterans up with services, this allows them to receive proper treatment and has proven to reduce recidivism rates for veterans in the local jails.

Another issue regarding veterans is the lack of a statewide database. This prohibits the jails ability to identify veterans who have not self-identified. Currently, there is a statewide database that houses information on individuals who have received mental health treatment from a state-run facility. This database is known as the Continuity Care Query, or the CCQ. The CCQ thus enables the jail to notify the local mental health authority or the state an inmate has previously received services is in their custody.

The Texas Commission on Jail Standards has worked with other interested parties to create a similar model for veterans. This would sync veteran inmates with services already available to them through the VA. However, federal roadblocks at that time prevented creation of the database.

Since then, the federal government has created a pilot program, known as the Veterans Reentry Search Service, that provides a database to allow a county jail to do a real-time search for veterans.

RECOMMENDATION

The 84th Legislature should pass legislation that allow local jails to perform a database search in the Veteran's Re-entry Search Service on inmates to see if they have served in the military.

The ability to perform a real-time search in a live database to find out if someone has prior military service will open the door for the veteran to be linked with services already available to them through the VA.

Interim Charge #3 - Monitor the health advisory panel stemming from HB 3793 (83R).

SCOPE OF THE CHARGE

Under this charge, the Committee monitored the health advisory panel created from House Bill 3793 in the 83rd Legislative Session.

SUMMARY OF COMMITTEE ACTION

Committee Hearings

March 10, 2014, Polk County Commerce Center, Livingston, Texas

May 5, 2014, Capitol Room E2.016, Austin, Texas

October 20, 2014, Capitol Room E2.016, Austin, Texas

Witnesses

March 10, 2014, Polk County Commerce Center, Livingston, Texas

- Jim Allison (County Judges and Commissioners Association of Texas)
- Daniel Burkeen (Limestone County; Texas Association of Counties)
- Clifford Gay (Self)
- Lee Johnson (Texas Council of Community Centers)
- Donald Lee (Texas Conference of Urban Counties)
- Michael Maples (Department of State Health Services)
- Susan Rushing (Burke Center)
- Dennis Wilson (Sheriff's Association of Texas)

May 5, 2014, Capitol Room E2.016, Austin, Texas

- Jim Allison (County Judges and Commissioners Association of Texas)
- Liza Jensen (Methodist Healthcare System of San Antonio)
- Lee Johnson (Texas Council of Community Centers)
- Lauren Lacefield Lewis (Department of State Health Services)
- Donald Lee (Texas Conference of Urban Counties)
- Charzetta McMurray-Horton (Ben Taub General Hospital)
- Dennis D. Wilson (Self; Sheriff's Association of Texas)

October 20, 2014, Capitol Room E2.016, Austin, Texas

- Lauren Lacefield Lewis (Department of State Health Services)
- Donald Lee (Texas Conference of Urban Counties)
- Gyl Switzer (Mental Health America of Texas)
- Dennis Wilson (Self; Sheriff's Association of Texas)
- Stacy Wilson (Texas Hospital Association)

Issue 1

Shortage of Mental Health Beds

BACKGROUND

In 2013, an estimated 499,389 adults in Texas were living with a serious and persistent mental illness, and there were an estimated 175,137 children with severe emotional disturbance. Additionally, the state population increased by 3.6 percent between 2010 and 2012, more than double the national average. This has caused many interested parties to note that the number and location of inpatient beds the state can make available is not adequate to meet statewide patient needs without resorting to long distance transport of patients, local jail placements, and uncompensated hospital care stays. These inpatient beds can be used either as forensic beds for people who are receiving court-ordered mental health services or as civil inpatient beds for people who are in need of inpatient mental health services for safety reasons. National and statewide trends show an increased need for forensic beds to provide competency restoration treatment for persons who are arrested but found by a court to be incompetent to stand trial, and, with a finite number of inpatient beds in the state, those persons who are not under arrest or court-ordered placement have diminished access to civil inpatient beds.

As a result, the state cannot currently meet and will continue to fail to meet the need for appropriate placements for the care, treatment, and restoration of many persons needing inpatient mental health services. Interested parties contend that this situation places a strain on local law enforcement manpower, jail space, and medical and monetary resources because law enforcement personnel are frequently tasked with providing transportation for persons who may not have committed a crime but pose a safety risk to the community. The people law enforcement encounter in these situations have behavioral health issues and are a danger to self or others, which indicates need for hospitalization or community-based services in a mental health facility. Stakeholders contend that access to care could be improved for this population if the length of inpatient stays could be lowered in state hospital facilities and if additional inpatient and outpatient resources were more readily available across service delivery settings in both rural and urban areas of the state.

House Bill 3793, passed in the 83rd Legislative Session, requires the Department of State Health Services, in conjunction with the Health and Human Services Commission, to work with the advisory panel created from the legislation to develop a plan to allocate outpatient mental health services and beds in state hospitals to two specified groups of patients. The bill sets out requirements for the plan and provides for an advisory panel to assist the department in developing the plan. The bill establishes a deadline for the department to begin implementing the plan and to submit a related report to the legislature and governor. The bill requires the department to make every effort to contract with certain mental health services providers and facilities to ensure services and beds for the two groups of patients. The bill also requires the department to develop and implement a procedure to inform courts of commitment options.

Membership on the mental health advisory panel includes:

- Texas Department of Criminal Justice (1 Representative)
- Texas Association of Counties (1 Representative)
- County Judges and Commissioners Association of Texas (2 Representatives; 1 must be a presiding judge of a court with jurisdiction over mental health matters)
- Sheriff's Association of Texas (1 Representative)
- Texas Municipal League (2 Representatives; 1 must be a municipal law enforcement official)
- Texas Conference of Urban Counties (1 Representative)
- Texas Hospital Association (2 Representatives; 1 must be a physician)
- Texas Catalyst for Empowerment (1 Representative)
- Texas Council of Community Centers (2 Representatives; 1 urban service area, 1 rural service area)
- Texas Department of State Health Services (DSHS) Council for Advising and Planning for the Prevention and Treatment of Mental Health and Substance Use Disorders (CAP) (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 or advocated of substance abuse, representative who is a consumer of or advocate for substance abuse treatment, 1 representative who is a family member of or advocate for persons with mental illness and substance abuse).²⁶

Challenges in the mental health system:

1. Demand exceeds resources. The state's mental health service delivery system is unable to meet existing needs. Approximately 2.6 percent of adult Texans are living with serious and persistent mental illness, but less than one third of these individuals are served in DSHS-funded community mental health services. About five percent of Texas children have severe emotional disturbance, but just over one quarter are receiving DSHS-funded services. Although the Legislature has approved substantial funding increases in recent sessions, local service areas continue to face significant challenges in securing adequate resources. Every local service area struggles to meet demand.
2. Growing needs. These existing challenges are compounded by the state's rapidly growing population. Between 2010 and 2012, the state population increased by 3.6 percent, more than double the national average. Furthermore, Texas has the highest rate of uninsured in the nation, with approximately 6 million uninsured residents. This exacerbates the current lack of access to services and puts a strain on an under-resourced, fragmented system of care.
3. Sustainability of the 1115 Healthcare Transformation Waiver projects. The state's 1115 Healthcare Transformation Waiver has created opportunities to significantly increase service capacity, but project outcome data is just now being reported. Thus it is difficult to determine what impact the projects are actually having. Additionally the five-year waiver demonstration period ends in 2016, and, although the Health and Human Services Commission intends to submit a request for waiver renewal, it is not yet clear whether and how those services will be continued in subsequent years.

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4. Changes to the Patient Assistance Program (PAP). PAP is a program offered by pharmaceutical manufacturers that supplies free medication to medically indigent patients. PAP currently provides the majority of funding for medication within the DSHS-funded system, but implementation of healthcare reform and the transition of a number of drugs to generic status could substantially reduce access to medication through PAP. This would require the medications to be purchased, significantly increasing pharmaceutical expenditures and diverting dollars from other services.
 5. Workforce shortages. Texas has a shortage of mental health professionals, particularly psychiatrists. There are 585 designated Mental Health Professional Shortage Areas in Texas, including 202 entire counties. Peer specialists and family partners are emerging as a vital part of the workforce, and continued work is needed to recruit, train, and integrate them throughout the service system. Across the state, organizations serving the indigent population find it increasingly difficult to recruit and retain qualified staff. Until these issues are appropriately addressed, the state's ability to both meet current needs and expand access to services in the future will be limited by workforce shortages, and it will become increasingly difficult to provide timely access to services.
 6. Lack of affordable housing. Many communities, particularly in fast-growing areas, face severe shortages of affordable housing. This is compounded by barriers individuals with mental illness or a criminal record often face when they seek housing, particularly in a competitive environment when landlords can be more selective.
 7. Inadequate supply of substance abuse treatment and other health services. There is a dearth of substance abuse providers in many areas, with detoxification and residential services in particularly short supply. There are also shortages of primary care and dental services for low income individuals.
 8. Limited transportation. Many areas lack a public transportation system, and additional options are needed to ensure access to services within the community and in more distant locations.
 9. Priorities and perspectives in the legal system. Judges, prosecutors, and defense counsel have major roles in directing the flow of court-ordered patients in and out of the system, and they must consider the safety of their communities and the rights of individuals involved in the court system. Many view state hospitals as the only setting that can provide an adequate level of security and protection for individuals requiring commitment, and they are often reluctant to place individuals in less restrictive community alternatives. Without a net increase in the number of state beds, an increasing number of forensic commitments crowd out civil commitments and access to state hospital beds by voluntary patients is non-existent.

Contract with CannonDesign

DSHS contracted with CannonDesign to help in the creation of the ten-year plan. CannonDesign performed a needs assessment in Texas for the number of beds needed currently and based on population projections for the next 10 years. The valuation of the number of beds was used by the HB 3793 panel members to determine their recommendations as well.

Background information on CannonDesign report

The report from CannonDesign includes:

- A description of key themes that resulted from an extensive assessment of operations, planning, real estate, and infrastructure related to the provision of inpatient psychiatric services and alternatives to hospitalization in the State of Texas;
- A description of the results of a visioning session with DSHS leadership and key stakeholders designed to inform the development of a ten-year vision and model of care for DSHS inpatient hospital services;
- A current and future demand forecast that describes the future need for state psychiatric hospital services in Texas, based upon the future model of care, and including a description of the methodology and tool to allow DSHS to periodically update the forecast at its discretion;
- An assessment of the condition of existing facilities (three representative state psychiatric hospitals were selected for this in-depth assessment), including deferred maintenance vs. replacement costs; and
- Recommendations that result from research related to best practices in inpatient hospitalization practices across the country; extensive Texas stakeholder input through focus groups and an e-survey; and assessment of the current and future need for services and infrastructure for the state-operated psychiatric hospital system.

The CannonDesign report will be used by DSHS to inform and support the development of the state hospital ten-year plan, which will be submitted to the legislature in December 2014.

CannonDesign is an architectural and engineering services firm established 65 years ago that includes an in-house healthcare consultancy. The healthcare consultancy includes clinicians, operational, industrial engineering, and facility infrastructure professionals. CannonDesign has expertise in the following key areas: behavioral healthcare facility design and conditions assessment, strategic master planning, performance optimization, and community needs assessment.

To complete this project, CannonDesign also contracted with several subcontractors.

The Innova Group: International healthcare planning consultancy headquartered in Austin, Texas that specializes in operational and facility planning.

RH2: A Texas-based consultant group that has designed and facilitated hundreds of focus groups and other stakeholder outreach activities for clients large and small including the Texas Health and Human Services Commission.

Pacheco Koch: A full-service civil engineering, land surveying and landscape architecture firm offering services to both public and private sector clients.

VAI Architects, Inc.: A full-service architecture firm consulting practice in the Dallas-Ft. Worth

area.

Pape-Dawson Engineers: A professional civil engineering firm with offices in San Antonio, Austin, Houston and Ft. Worth that specializes in the planning and design of education, commercial, industrial and residential land development and construction.

West End Design: A San Antonio-based architectural and design firm.

CRBE Valuation Group: Headquartered in Los Angeles and is the world's largest commercial real estate firm and offers strategic advice and execution for property sales and leasing.

The contract is for \$ 1,081,747 to complete the reports for both DSHS and DADS and the two agencies are sharing the costs of the contract equally. Payment will be made to CannonDesign after the state accepts the final reports.²⁷

FINDINGS

The following standards which should be present in the mental health system have been developed by the HB 3793 Advisory Panel:

Capacity

1. DSHS will have a sufficient number of state-funded inpatient beds of the correct type to admit all forensic, civil, and voluntary patients requiring inpatient services without delay or diversion.
2. As part of the continuum of care, DSHS will have sufficient outpatient capacity to provide the appropriate level of care to all forensic, civil, and voluntary individuals referred to or seeking services without delay or diversion.
3. Fund and maximize utilization of hospitalization prevention programs at the local level that are person centered, recovery based, and utilize peer services.

Allocation

Sufficient resources are allocated and managed efficiently, effectively, and collaboratively.

Maintaining Access and Availability

The needed level of care—inpatient, transitional and long-term residential, crisis, or outpatient—is available without delay or diversion to every eligible individual, including individuals seeking services voluntarily and those on civil and forensic commitments.

The initial HB 3793 plan provides a framework that will be revised as new information becomes available through the community assessment and the ongoing work of the HB 3793 Advisory Panel. It is intended to guide the community assessment and the development of standards and methodologies appropriate for the varied delivery systems within Texas. DSHS began implementing the plan August 31, 2014. Panel members have noted, however, that even after

that point the plan may need to be revised as new information becomes available. In December 2014, DSHS will submit a report to the legislature and governor that includes the plan, the status of the plan's implementation, and the impact of the plan on the delivery of services.

As detailed in HB 3793, there are four key elements that must be addressed in the report to the 84th Legislature:

- (1) A determination of the needs for outpatient mental health services of the two groups of patients*
- (2) A determination of the minimum number of inpatient beds that the state hospital system must maintain to adequately serve the two groups of patients*
- (3) A statewide plan for and the allocation of sufficient funds for meeting the outpatient mental health service needs of and for the maintenance of beds by the state hospitals for the two groups of patients*
- (4) A process to address and develop, without adverse impact to local service areas, the accessibility and availability of sufficient outpatient mental health services provided to and beds provided by the state hospitals to the two groups of patients based on the success of contractual outcomes with mental health service providers and facilities under Sections 533.034 and 533.052*

Below are excerpts from the initial plan that address each key element required by HB 3793 (for the full initial plan, go to <http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=35959&id=8589980499&terms=HB+3793>)

- (1) A determination of the needs for outpatient mental health services of the two groups of patients*

Every local service area should provide access to an array of essential services and supports. These services should be readily available, robust, and easily accessible. However, regional variation and resource limitations may limit the degree to which this goal can be achieved. Local service areas may also identify the need for specific programs, such as recovery-oriented day programs or walk-in medication clinics.

1. Outpatient mental health services
 - Texas Resilience and Recovery (TRR) services. Texas Resilience and Recovery is a patient-centered system of care designed to promote resilience and recovery. It offers evidence-based and promising practices. Services are provided through defined levels of care based on an assessment of individual needs. Each level of care provides an array of services and supports, such as engagement, medication and

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- pharmacological management, medication training and support services, skills training, counseling, psychosocial rehabilitation, supported housing and employment, and peer support services. Services are provided where needed and may be delivered in an office, via telemedicine, or in the client's home or other community setting.
- Appropriate living environments - Safe, secure, and affordable housing is essential for successful recovery and stability in the community;
 - Employment assistance;
 - Peer support services and recovery supports - Peer-provided services are an integral part of the full continuum of services in a recovery-oriented system of care, including hospital services. Recovery supports help individuals become meaningfully involved with their communities and develop natural support systems;
 - Service coordination.
2. Other health services.
- Recovery requires a holistic approach to services. Individuals living with mental illness die many years earlier than the general population, usually from untreated and often preventable chronic diseases. In addition, a significant portion also struggle with substance abuse problems. These are critical issues that can only be addressed through strong and effective partnerships that span service system boundaries. Robust, collaborative, and integrated care models are needed to provide access to essential services and ensure care is effectively coordinated. Sound financing models will be required to ensure healthcare is both available and affordable.
3. Local crisis stabilization and hospital alternatives.
- To avoid unnecessary hospitalization, communities must have a range of local alternatives for both adults and children, including options for crisis stabilization and longer-term settings for individuals transitioning out of a hospital setting. The front door to local crisis services must be convenient and easily accessible to law enforcement and other community partners. The role of peers is particularly important in time of crisis and transition from the hospital, so peer providers should be an integral part of the service delivery team.
4. Hospital services
- Hospital beds must be available when clinically or legally necessary for voluntary, civil, and forensic patients.
 - State hospital beds. The state operates psychiatric hospitals that provide acute and long-term inpatient psychiatric services for voluntary, civil, forensic, and residential patients.
 - State funded community beds. The state also purchases beds from the private sector through contractual arrangements with service providers.
 - Indigent care beds. In addition to the state-funded hospital capacity, local hospitals

provide indigent care through general and psychiatric beds.

Forensic Population

Timely access to appropriate services in the community is the first strategy for avoiding forensic involvement. However, additional strategies are needed to prevent inappropriate involvement with the criminal and juvenile justice systems and address the needs of individuals who do become involved.

1. Jail diversion

To avoid unnecessary and inappropriate incarceration, every community must have a comprehensive plan for mental health and criminal justice collaboration. All LMHA's have implemented jail diversion plans, as required by HB 2292 (78th Legislature). But these efforts could be enhanced through more consistent application of the Sequential Intercept Model. This model identifies five points of diversion where individuals with mental illness can be targeted within the criminal justice system, and suggests strategies for effective intervention.

- Intercept 1: Law enforcement. Strategies may include training, Crisis Intervention Teams, Mental Health Deputy programs, and police-friendly drop-off points.
- Intercept 2: Initial Detention/Initial Court Hearings. Strategies may include on-site screening at jails and courts and pretrial release with linkage to community services.
- Intercept 3: Jails/Courts. Strategies may include specialized courts, court liaisons, and jail-based services.
- Intercept 4: Re-entry. Strategies may include joint discharge planning and specialized re-entry programs.
- Intercept 5: Community Corrections. Strategies include screening all individuals under community supervision, Forensic ACT teams, and developing graduated responses and modification of conditions of supervision.

2. Forensic alternatives

While forensic clients can sometimes be served in the same programs and settings as civil and voluntary clients, specialized programs must also be available to avoid unnecessary hospitalization for individuals committed to treatment through criminal courts. These programs include risk assessment and approaches to address modifiable criminogenic factors that contribute to forensic involvement.

- Outpatient competency restoration (OCR). These programs provide services for individuals found incompetent to stand trial that includes intensive mental health services and legal training in non-restrictive community settings. Patients can be committed to an outpatient program on the initial court order. In addition, patients on an inpatient commitment can have their orders modified to an outpatient commitment once they are stable enough for treatment in a less restrictive setting.

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- Community-based options for individuals found Not Guilty by Reason of Insanity (NGRI). The average length of stay for individuals found NGRI is 370 days. When patients have been appropriately stabilized, their commitments can be modified to outpatient commitments once courts have confidence that risks have been sufficiently mitigated.
 - Intensive community-based programs for individuals with a history of forensic involvement. The Intensive Case Management program provided through the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) is one statewide program that addresses modifiable criminogenic risk and clinical needs to extend community tenure and reduce acute symptom expression, hospitalization, and recidivism. It uses a hybrid service delivery model increasing collaboration with criminal justice supervision authorities and clinical care providers in community centers.
 - Supervised living environments. Outpatient alternatives to forensic hospitalization may be underutilized when secure, supervised living environments are not available.
 - Engagement with the legal system.
 - Engagement and with local officials. Increased outreach is needed to ensure judges, prosecutors, and defense attorneys are informed about and have confidence to use existing statutory alternatives to inpatient commitment.

(2) A determination of the minimum number of beds that the state hospital system must maintain to adequately serve the two groups of patients

In fiscal year 2013, the publicly funded mental health service delivery system had insufficient capacity to meet the demand for community and hospital services. Because serious mental illness is often a chronic condition, there is also an urgent need for an extended provider base in the community to allow individuals to transition out of the state's mental health delivery system without losing access to needed services.

1. Capacity Needs

1.1. Community Services.

- Outpatient services. In August 2013, an average of 110,583 adults and 33,418 children received services in a full level of care through the DSHS-funded mental health service system. With additional funds appropriated by the 83rd Legislature, it is anticipated that services will be provided to approximately 6,700 more adults and 900 more children.
- Local crisis facilities. Currently, DSHS funds 456 Crisis Residential beds, 127 Crisis Respite beds, 60 Extended Observation beds, 32 CSU beds, and 259 Rapid Crisis Stabilization beds.
- Forensic programs. There are eleven state-funded Outpatient Competency Restoration (OCR) Programs. In 2013, 291 individuals were served in these programs; and 158 of them were discharged. However, a number of these programs are currently

underutilized.

1.2. Hospital Services

- State-Operated beds. the current capacity of the state-operated hospital system is 2,503 beds, with approximately 893 beds designated for the forensic population. However, because DSHS is under a court order to accommodate for all forensic patients, the beds assigned to the forensic population at any given time may exceed the designated number. Of the 2,503 beds, 204 are designated as residential beds for individuals who no longer need hospital-level care but have no appropriate community alternatives available.
- State-funded beds. The current number of purchased beds is 427. This includes community hospital beds, private psychiatric hospital beds, and the Montgomery County Mental Health Treatment Facility.

2. Projected Needs.

- Initial plan based on available data. This initial plan includes preliminary estimates of current needs based on available prevalence and utilization data. However, these data sources have significant limitations and must be supplemented with information at the local level to provide a more complete picture of needs across the state.
- Capacity is changing. The needs reflected in 2013 data will be significantly affected by new resources and initiatives entering the system in 2014. Additional funding may be needed to ensure an appropriate array of services is available in each region of the state. This determination is contingent on a number of factors, including new funding appropriated by the 83rd Legislature and the 1115 Healthcare Transformation Waiver projects currently in development. While these new resources add much-needed capacity, planning should recognize that ongoing funding for projects established under the 1115 Transformation Waiver is not assured.
- Need for outpatient mental health services. In 2013, an estimated 499,389 adults in Texas were living with a serious and persistent mental illness, and there were an estimated 175,137 children with severe emotional disturbance. Only 31.4 of these adults and 26.9 percent of children were served in DSHS-funded community mental health services.
- Goal for community capacity. Local service areas will have sufficient capacity to ensure that services are available on demand.
- Need for inpatient mental health services. Based on long-term trends in the DSHS hospital utilization data, a preliminary estimate is that the DSHS-funded system will need to add approximately 17 beds per year simply to keep pace with current utilization trends. In 2020, this would equate to 3,056 total state-funded beds. However, the available data has significant limitations, and can only reflect current capacity and practices—if individuals are not admitted, they cannot be counted. The data does not, therefore, capture the true demand or unexpressed need. Advisory Panel members describe a substantial unmet need for acute care that is severely impacting local emergency services, hospitals, and jails.

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- Goal for bed capacity. Currently, there are approximately 11 state-funded hospital beds per 100,000, including state hospital beds and state-funded community beds. The national average for psychiatric hospital beds is 14 per 100,000. To achieve this number, Texas would need an additional 879 hospital beds. Adding 879 hospital beds to the DSHS-funded system would cost \$176.5 million. It is preferable, however, for individuals to be served close to home and in the least restrictive environments possible. Because the availability of local options has a major impact on demand for hospitalization, the total number of beds must be considered when determining the number of beds needed, not just inpatient hospital beds. There will, however, always be individuals who need inpatient care, and more hospital beds are needed to ensure inpatient services are available when needed.
 - Factors influencing need. The number of inpatient beds needed in the state system will depend on steps taken to provide appropriate alternatives close to home and use capacity more effectively, as outlined under Access and Availability. These factors will be considered in the next phase of analysis.

(4) A process to address and develop, without adverse impact to local service areas, the accessibility and availability of sufficient outpatient mental health services provided to and beds provided by the state hospitals to the two groups of patients based on the success of contractual outcomes with mental health service providers and facilities under Sections 533.034 and 533.052

Access and Availability

In addition to expanding capacity, the following strategies will be used to improve access and availability.

Access to care is one of the biggest barriers for people involved in the mental health system. Currently, there are 11 state operated psychiatric hospitals throughout the state. These hospitals have a limited capacity and do not always allow patients to be close to their community when receiving treatment. It has been proven that patients receiving treatment have a higher rate of success upon reentry when treated in their own community and familiar surroundings.

Additionally, many of the beds in the state operated facilities are designated for specific patient types. Currently, the State has 1,196 civil beds (of which 32 are maximum security beds), 281 child/adolescent beds, 854 forensic beds (of which 292 are maximum security beds), 1116 residential beds, 32 intermediate beds, and 22 medical beds. When a patient is in need of a psychiatric bed, they must be placed in a bed from the correct type. Therefore, when a person experiencing a mental health crisis is needing state-level treatment, it is difficult for the first responder to find an available bed. This is not a good use of resources for law enforcement, emergency rooms, nor is it good for the person in crisis. They continue to mentally decompensate while waiting for an available bed.

State Operated Psychiatric Hospitals:

1. Big Spring State Hospital
2. Terrell State Hospital
3. Rusk State Hospital
4. Waco Center for Youth
5. Austin State Hospital
6. Kerrville State Hospital
7. San Antonio State Hospital
8. El Paso Psychiatric Center
9. Rio Grande State Center
10. North Texas - Vernon
11. North Texas - Wichita Falls



1. Community services.

- 1.1. Strengthen key activities. The following activities are critical to ensure individuals receive the services and supports they need to maintain stability in the community, build resilience, and achieve recovery. Strategies will be developed to improve quality and consistency.

- Outreach. Effective outreach consistent with available capacity is needed to identify individuals who need treatment but cannot or do not seek services due to incarceration, illness, stigma, or discouragement.
- Immediate engagement. Many clients who enter service do not become actively involved in treatment. The first step is to quickly establish a relationship with the individual to engage them in services as soon as possible.
- Continuity of care. Clients are also vulnerable when transitioning from one part of the service system to another. Careful continuity planning, a warm hand-off, and close support during the transition are essential.
- Service coordination. Individuals may need access to a range of services and supports to achieve stability and resilience. These may include primary care, housing, substance abuse treatment, transportation, and other services. Active linkages, coordinated planning, and ongoing communication are necessary.
- Crisis response. Prompt and effective crisis intervention services facilitate stabilization and linkage with appropriate services. This can often avoid the need for emergency department visits, hospitalization, or incarceration.

- 1.2. Improve collaboration with the criminal justice system. Local service areas have made progress in implementing the Sequential Intercept Model, but gaps remain. Effective implementation can significantly reduce inappropriate involvement with the criminal and juvenile justice systems and promote appropriate treatment and intervention.

- 1.3. Expand peer support services. Peers have a vital role in all aspects of service delivery, but are especially important in the points of transition identified above.

-
- 1.4. Prioritize services and housing for high-need populations. This includes long-term hospital residents and individuals with a history of repeated hospitalization or forensic involvement.
 - 1.5. Outcome based incentives. 2014-15 General Appropriations Act, S.B . 1, 83rd Legislature, 2013 (Article II, Department of State Health Services, Rider 78) directed DSHS to withhold 10 percent of an LMHA's general revenue to use as a performance incentive. Initial outcome measures were implemented for fiscal year 2014, including measures relating to hospitalization and incarceration. These measures will be reviewed at the end of the year to identify what changes might be appropriate.²⁸

2. Hospital beds.

One overarching strategy frame's all efforts to ensure hospital beds are available when needed: provide timely access to appropriate care at the local level. Individuals requiring short-term acute stabilization should be treated in community-based facilities whenever possible. It is also important to develop long-term residential options for individuals who no longer need hospital care and can be safely discharged to community-based programs. Hospitalization is the most intensive level of care, and the state's limited capacity must be managed effectively to ensure timely access.

- 2.1. Utilization Management. Improving the management of existing capacity will involve two areas of focus.
 - Admission and discharge criteria will be defined based on clinical necessity or legal mandates. The goal is to treat individuals in the hospital only when there are no appropriate clinical or legal alternatives available.
 - A system will be developed to promote appropriate utilization of hospital beds. The goal is to create incentives to maximize utilization of community-based alternatives and reduce inappropriate utilization of hospital beds.
- 2.2. Alternatives for individuals with extended length of stay. In 2013, 701 individuals had been in the hospital for more than one year. A significant number of them no longer need hospital-based psychiatric care and would be more appropriately served in the community. Developing long-term residential alternatives in the community would free up significant hospital capacity. For example, moving 100 long-term patients into the community would provide beds for approximately 745 individuals on civil commitments. The Home and Community-based Services Program being developed through a 1915(i) Medicaid State Plan Amendment will accommodate a subset of the long-term population, but far greater capacity is needed. There are also many individuals in the community who need housing with individualized support services to avoid cycling through homelessness, emergency rooms, hospitals, and the criminal justice system. Attention must also be given to reducing barriers that prevent use of community alternatives, with attention paid to decision-making capacity.

(3) *A statewide plan for and the allocation of sufficient funds for meeting the outpatient mental health service needs of and for the maintenance of beds by the state hospitals for the two groups of patients*

Allocation of Resources

1. Community Services

- Current allocation. Each year, baseline state and federal funding is allocated to local service areas based on the previous year's funding. New funding is distributed in accordance with legislative direction. When permitted, a portion of the funding is used to achieve greater equity in funding.
- Goal. The long-term goal is to achieve equitable distribution of resources.
- Strategy. The plan is to continue to move towards equity in resource distribution while recognizing the need for an adequate local service array in both urban and rural areas. To the extent permitted by legislative direction, equity will continue to be a component of the allocation methodology for all new funds.

2. State funded inpatient services

- Current allocation. Hospital bed days are allocated to local service areas on a per capita basis. A specified number of beds are designated for the forensic population and for the civil/voluntary population, but non-maximum security beds can be used for either population based on demand. Currently, local service areas are not penalized for exceeding their allocated bed days. This allocation plan will continue until a new strategy is developed.
- Goal. All local service areas will have access to hospital services when needed.
- Strategy. The allocation methodology will be reviewed and revised as needed between January and August, 2014. During this period, local service areas will receive regular reports on utilization.

Systemic Barriers

Because DSHS must begin implementation in September 2014, the initial plan is based on existing funding and statutory authority. To fully implement the plan, legislation must be passed in the 84th Legislative Session.

Statutory and regulatory issues

A variety of statutory changes were discussed in the health panel monthly meetings. However, every statutory change proposed burdened other stakeholders and players in the mental health system.

Workforce Issues

- Workforce shortages. Throughout the state, organizations serving the indigent population find it increasingly difficult to recruit and retain qualified staff, including peer specialists and family partners.
- Community providers. Another critical issue is the lack of affordable mental health services outside of the state system. Individuals who have achieved long-term stability

are often unable to leave the publicly funded system because they have no other options for maintaining access to needed services. Strategies are needed to equip and support community providers, including Federally Qualified Health Centers, so individuals can be transferred out of the system, freeing capacity for others who need a more intensive level of care.

Current Implementation of the plan

Needs Assessment and Quantifying the Need for Beds

Through the work done with CannonDesign on the ten-year plan, the needs assessment was completed and the minimum number of beds needed to adequately serve consumers was determined. Gaps were identified and the resources needed to fill them have been quantified.

Efforts to increase capacity:

- 14 beds at UT HSC Tyler were brought online September 1, 2014
- Open enrollment for community hospital inpatient services was announced:
http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=113776

Workforce Issues:

- Converted psychiatric positions to APRN positions
- Benchmarked psychiatrists, PAs, and APRN positions, allowing for increased flexibility in hiring practices
- The 2016-2017 LAR included an exceptional item for an expansion of the psychiatric residency program – 4 additional residency contracted FTEs each year of the biennium in state hospitals and community centers
- 10% pay increase for PNAs was implemented September 1, 2014
- Additional information in the State Hospital Quarterly Staffing Reports and the Report on Mental Health Workforce Shortages posted online:
<http://www.dshs.state.tx.us/Legislative/Reports-2014.aspx>

Substance Abuse Treatment – Integration of MH/SA:

- State hospital leadership has been meeting with Substance Abuse Services regarding developing a residential detoxification program within a state hospital

ANSA/CANS Training:

- Select staff from all 11 hospital sites participated in training for the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) in August 2014

Home and Community Based Services (HCBS):

- During May-July 2014, 96 individuals with extended tenure in SHs were assessed at four different state hospitals across Texas for home and community-based services. The HCBS-AMH program provides an array of services, appropriate to each individual's needs, to enable these individuals to live and experience successful tenure in their

community. Implementation of the HCBS-AMH program is dependent on approval from the Center for Medicare and Medicaid Services. The State Plan Amendment was submitted to CMS in July. CMS has 90 days (October 20) to approve, deny, or request more time to consider the SPA.

Housing:

- LMHAs were required to become Tenant Based Rental Assistance providers. TBRA is a voucher program administered by TDHCA with funds flowing from HUD. It acts as a bridge subsidy to permanent housing. As TBRA providers LMHAs are able to access the reservation system and utilize these dollars.
- Approximately 1,700 individuals received services through the DSHS supported housing program in FY 2014

Utilization management:

- Weekly conference calls with state hospital utilization management staff began in February 2014
 - State Hospitals review and report on the appropriateness of admission and continued stay for patients in the state hospitals.
 - Evaluate state hospital system utilization and reimbursement policies
 - Provide technical assistance for utilization and reimbursement issues to state hospital staff
 - Integrate utilization management and social service functions to improve coordination of care for the patient while inpatient and discharge planning
- Evaluate documentation in the medical record for individual patients to determine need for inpatient hospitalization, continued stay and discharge criteria

The Committee concurs with the following recommendations made by the HB 3793 Health Panel.

RECOMMENDATIONS

Inpatient Recommendations (State Hospital and Contract Beds):

The HB 3793 advisory panel concurred that an additional 1,500 beds are needed to meet current needs, plus an additional 60 beds each year to address population growth. The HB 3793 advisory panel recommends a surge of 40 percent of the 1,500 needed beds (600 beds) to begin to meet current needs plus 60 beds for each year of the biennium to address population growth for a total of 720 beds in the 2016-17 biennium. Over the following six years, the panel recommends adding an additional 1,280 beds to meet current needs and to accommodate for population growth. The panel believed that, once sufficient outpatient capacity and other services like jail diversion were in place, the need for state hospital beds may decrease. However, development of those outpatient resources will take time and, as

the Sunset Commission report stated, the current system is in crisis.

The HB 3793 advisory panel made the recommendation based on population projections and the national standard for mental health beds based on population. Additionally, CannonDesign found a similar capacity need when they completed their assessment. The initial 720 beds will begin to bring Texas up to the current demand for state hospital beds. Based on population growth projections, Texas will need to continue to add 60 new state hospital beds each year (120 each biennium) to accommodate future growth plus an additional 920 to meet the required capacity needs.

Eliminate forensic commitments from the State Hospital Allocation Methodology (SHAM).

The panel recommends that the Department of State Health Services manage the forensic commitment capacity instead of the Local Mental Health Authorities (LMHAs). Currently, Texas mandates that the LMHAs give priority to forensic commitments to the state hospitals. If the patient requires treatment beyond the state's allocated number of days for each forensic patient, the LMHA must provide compensation to the state for the "over utilization" of the state hospital for competency restoration even though the state mandated the forensic patient be committed for treatment. Therefore, the LMHAs are unable to control costs for treatment. (Go to <http://www.dshs.state.tx.us/mhcontracts/HospitalBedDayMehod.shtm> for a full understanding of the State Hospital Allocation Methodology)

Replace the current State Hospital Allocation Methodology committee with a more diverse, statewide stakeholder group. Provide monthly utilization reports to LMHAs/NorthSTAR and stakeholder group.

The current SHAM committee is an informal committee that stemmed from House Bill 2292 passed in the 78th Legislature. Committee make-up consists of representatives from the Department of State Health Services, Texas Council of Community Centers, and representatives from various local mental health authorities. Expansion of the membership of the committee to include representatives from criminal justice entities, law enforcement, county and city management, providers of physical health care, mental health and substance abuse services and consumer advocacy groups. Inclusion of these stakeholders would provide a well-rounded balance of interested parties to come up with a creative alternative to the current SHAM.

Outpatient Recommendations:

Increase outpatient treatment capacity by 1.8% per year for population growth.

As law enforcement along with other crisis intervention teams continue to divert people suffering from a mental illness into the appropriate level of care and out of the local jails, it is predicted that Texas will see an increase in demand for outpatient treatment options. In fact, despite the reduction of waiting lists, there is still need for additional outpatient access to keep people out of crisis, out of local emergency rooms and out of jails. The panel understands that an array of services is needed to ensure that people needing behavioral health services receive the appropriate care, which is not always the state hospital. However, without access to outpatient services, patients end up in higher and more expensive levels of care – or in jail. Therefore, the panel sees the need to increase outpatient options for less acute patients to

receive the services needed and reduce the burden on hospitals, local jails and law enforcement.

Expand the scope of the stakeholder group charge to include community-based services.

By expanding the stakeholder group to include community-based services, the advisory panel can examine all treatment options available in order to ensure that patients receive the appropriate level of treatment in the appropriate treatment setting.

Until an alternative methodology is determined by the proposed expanded stakeholder group, DSHS will allocate civil/voluntary beds on a per capita basis using the existing methodology.

Currently stakeholders are meeting with DSHS to discuss alternative civil and voluntary bed allocation methodology alternatives that better suit the needs of everyone involved.

Use new funding to achieve equitable distribution of resources as permitted by legislation.

Limited resources continues to plague the community-based services system and the state hospital system. As new funding becomes available, equitable distribution of these resources should take place in Texas as permitted.

Access and Availability Recommendations:

Develop a state-level waitlist for civil and voluntary patients in need of a bed.

Currently there is no mechanism in place to track people who are in need of a state hospital bed but due to lack of availability are diverted to alternative treatment options or remain “stuck” in non-state hospitals. It is hard to determine the true need for expanded state hospital beds without first determining how many people needed one and weren't able to obtain one.

Develop a process to monitor utilization of community-based alternatives to inpatient care.

Currently there is no mechanism in place to track people using community-based treatment options. In order to understand how many people needed to be treated in a state hospital bed but weren't able to obtain one due to lack of availability and therefore used community-based treatment options, we must first create a mechanism that tracks the number of people using these options. This, in combination with the state-level waitlist, will help capture the true demand for state mental health beds.

Enhance stakeholder education by providing the following:

- **Create a list of available resources for information, training and technical assistance.**
- **Provide training and information to judges and attorneys.**
- **Provide technical assistance to state hospital and LMHA staff on effective engagement with the criminal justice system.**
- **Work collaboratively to increase the number of clients transitioning from forensic to civil commitments.**
- **Simplify nomenclature related to crisis alternatives.**

By providing these tools, stakeholders can equip themselves to improve their response to

someone experiencing a mental health crisis. Training and understanding what options are available for first responders, judges, and other medical health professionals will reduce the burden on the criminal justice system and community hospitals and will offer the appropriate level of care to the person.

The Committee makes the additional following recommendation not recommended by the HB 3793 Health Panel.

RECOMMENDATION

Officer Training Recommendation:

The 84th Legislature should increase the number of mental health training hours peace officers are required to complete from eight to 12 through the Texas Commission on Law Enforcement Officer Standards and Education training.

As awareness increases surrounding mental health issues, it is imperative that peace officers are adequately equipped to encounter someone experiencing a mental health crisis. The additional hours will assist in providing peace officers with de-escalation techniques and knowledge of diversion and treatment options available within the community.

Interim Charge #4 - Determine which counties have implemented a cite-and-summons policy, whether the policy has been effective in lessening overcrowding in county jails, and whether those cited by peace officers comply with the policy.

SCOPE OF THE CHARGE

Under this charge, the Committee reviewed whether the cite-and-summons policy is fulfilling its intended purpose. Additionally, the Committee examined counties that have implemented the policy, their successes or failures, and why other counties have chosen not to.

SUMMARY OF COMMITTEE ACTION

Committee Hearings

March 10, 2014, Polk County Commerce Center, Livingston, Texas

May 5, 2014, Capitol Room E2.016, Austin, Texas

Witnesses

March 10, 2014, Polk County Commerce Center, Livingston, Texas

- Joseph Ptak (Texans Smart on Crime)
- Scott Walstad (Professional Bondsmen of Texas)
- Dennis Wilson (Sheriff Association of Texas)

May 5, 2014, Capitol Room E2.016, Austin, Texas

- Gary Cutler (Hays County Sheriff's Office)
- Mike Davenport (Hays County Sheriff's Office)
- Shannon Edmonds (Texas District and County Attorneys Association)
- Elizabeth Henneke (Texas Criminal Justice Coalition)
- AJ Louderback (Jackson County Sheriff's Office; Sheriff's Association of Texas)
- Joseph Ptak (Self; Texans Smart on Crime)

Issue 1

Cite - and - Summons

BACKGROUND

After overcrowding issues continued to plague our county jails, resulting in a violation of the minimum jail standards, it became apparent that population reduction measures were needed. In 2007, House Bill 2391 was passed in the hope that not only would this decrease the inmate population in county jails but that jails would also see a significant cost savings from no longer housing low-level offenders.²⁹

HB 2391 gave counties the ability to cite and release offenders of Class A and Class B misdemeanors, subject to the discretion of the officer. Offenses that allow for cite-and-release consideration include

- Class A and Class B misdemeanor possession of marijuana up to four ounces
- Class B criminal mischief up to \$500 in damages
- Class B graffiti
- •Class B theft between \$50-\$500 in stolen property
- Class B driving with an invalid license (Note: Class C misdemeanor for first time offenders, Class B misdemeanor for repeat offenders or if offender has suspended license due to driving while intoxicated)
- Contraband in a correctional facility

The bill passed with the support of numerous county and law enforcement entities such as the Texas Conference of Urban Counties, the Texas Fair Defense Project, the Texas Criminal Justice Coalition, and the Texas Public Policy Foundation to name a few.³⁰

FINDINGS

HB 2391 gave counties the authority to implement the cite-and-summons policy. However, the policy is widely unused by the majority of law enforcement entities in the state. Currently Hays, Travis, Caldwell, Bastrop, and Midland counties enforce the policy. Both the City of Austin and the City of San Marcos implement the policy as well.

Although the legislation was passed with good intentions, there are procedural issues that continue to create hesitation for law enforcement to adopt the policy. First, when an offender is cited and released, there is little incentive for the offender to appear on their court date. Typically when an offender is released from jail prior to their court date, they are released on bond. However, the cite-and-summons policy does not require any form of “bonding out” and therefore there provides no incentive to appear before a magistrate.

There is no ability to render consequences should one fail to appear on their court date. In Travis County, it is estimated that an average of 40% of cite-and-release offenders fail to appear. Once an offender does not appear on their court date, no further action is taken. The offender will only have to address their citation if they are arrested on a separate charge at a later time.

Hays County began implementing their policy in 2008. In 2012, Hays County cited and released 35 people. In 2013, 103 people were cited and released and as of May 5, 2014, 44 people had been cited and released. On average, Has County has experience an average of 25-30% of people failing to appear. Hays County, contrary to other counties, does issue a warrant when an offender fails to appear.³¹

Additionally, when someone is booked into the criminal justice system, they are issued a unique tracking number. This tracking number allows the criminal justice system to identify the offender, create a case number, and follows the offender throughout the process. If an offender is cited and release and then actually appears in court on their court date, they are immediately sent to booking. It is at this point in time that their case essentially begins. The offender is then fingerprinted, a background check is performed, and they are issued their unique tracking number. As well, the offender will have to re-appear before the magistrate at a later date to resolve their case.³²

Furthermore, when an offender is cited and released, no fingerprinting or background check is performed at the time the citation is issued. This information lets the officer know if the person has multiple alias', prior arrests, warrants, etc. Many critics of the policy state there is the potential of citing and releasing an offender that has multiple arrests for the same offense or has current arrest warrants. Without the ability to perform those two functions at the time the citation is issued, law enforcement officers remain hesitant to implement the cite-and-release policy.

In addition, in order to be eligible for the citation, you have to be a resident of the county in which the offense was committed. For counties with large populations of nonresidents, such as San Marcos that has 35,000 students attending Texas State University that are not considered a resident, a student would not be eligible for the citation and will automatically be arrested.

Moreover, people who have been issued a citation cannot simply pay a fine online. Class C misdemeanors allow violators to pay online because there is no possibility of jail time when that ticket was issued. However, with the Class A and Class B misdemeanors included in the cite-and-summons policy, there is a possibility that the offender could receive jail time as the result of a conviction. It is for this reason that online pay for a cite-and-summons ticket is not an option.

Finally, the cost savings assumed would come with the policy's implementation never came to fruition. This could be largely due to the lack of counties enforcing the policy. The amount of cost savings is hard to determine for counties that have implemented the policy due to the multitude of factors that affect law enforcement costs.

RECOMMENDATIONS

The 84th Legislature should change the cite-and-summons policy to allow law enforcement officers to book an offender in a booking facility and then release immediately on bond.

This would entail just a quick processing, finger printing, background check and then immediate release on bond. By making this change, law enforcement can do the proper back ground check on the offender and additionally provide more incentive to the offender to appear in court. As a result, this would assign the unique tracking number to the case and allow for

quicker case resolution.

Further research on this policy should be conducted with the House Committee on Criminal Jurisprudence to examine additional recommendations on misdemeanor classifications.

Without knowing the unintended consequences of reducing Class B misdemeanors to Class C misdemeanors, further research should be conducted to understand the full impact of these reclassifications.

Interim Charge #5 - Study the implementation of SB 462 (83R). Examine which counties currently have veterans courts, as well as veterans courts in other states, and determine how those programs are working whether these courts provide additional services or resources for veterans. Make appropriate recommendations. (Joint charge with the House Committee on Defense and Veterans' Affairs)

SCOPE OF THE CHARGE

The House Committee on County Affairs and the House Committee on Defense and Veterans' Affairs examined the implementation of Senate Bill 462. Both committees looked at Veteran's Courts across the state to determine the success of SB 462.

SUMMARY OF COMMITTEE ACTION

Committee Hearings

March 10, 2014, Polk County Commerce Center, Livingston, Texas

May 14, 2014, Wyndham San Antonio Riverwalk Hotel, San Antonio Ballroom, 111 East Pecan Street, San Antonio, TX 78205

- The Committee met with the House Committee on Defense and Veterans' Affairs in a joint hearing to investigate Interim Charge #5

Witnesses

March 10, 2014, Polk County Commerce Center, Livingston, Texas

- Deece Eckstein (Travis County, Texas)
- Jackson Glass (Travis County Veterans Court)
- Thomas Palladino (Texas Veterans Commission)

May 14, 2014, Wyndham San Antonio Riverwalk Hotel, San Antonio Ballroom, 111 East Pecan Street, San Antonio, TX 78205

- Sheila Allen (Nueces County Veterans Treatment Court)
- Angie Juarez Barill (Charge 4/ El Paso Veterans Court Program)
- Christopher Burnett (Criminal Justice Div. Office of the Governor)
- Eliseo Cantu (Texas Veterans Commission)
- Wayne Christian (Bexar County Veterans Treatment Court)
- Dominique Collins (Self; Dallas Veteran's Court, Crim Dist. Court #4)
- Mike Denton (Vet Court - Travis County)
- Ryan Ellis (Veterans Treatment Court; County of Galveston, TX)
- Vonda Freeman (Dallas County Veterans Court)
- Jackson Glass (Travis County Veterans Court)
- Oscar Hale (Self)
- Mark Henry (Galveston County)
- Marianne Horne (North Texas Addiction Counseling and Education Inc.)

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- Brian Klas (Williamson County Veterans Court)
 - Robert Maier (Williamson County Veterans Court)
 - Jason Molina (Nueces County CSCD)
 - Steve Morrison (Williamson County Community Supervision & Corrections Dept.)
 - Charlie Overstreet (Tarrant County Veterans Court)
 - Thomas Palladino (Texas Veterans Commission)
 - Beckie Palomo (Self)
 - Randall Parker (Bexar County Veterans Treatment Court)
 - Kathy Pierce (Williamson Co. Veterans Court)
 - Jude Prather (Hays County & City of San Marcos)
 - Ryan Randolph (Tarrant County Veterans Court)
 - Leon Reed Jr. (Tarrant County Veteran's Court)
 - David Sanchez (Self)
 - Mark Skurka (Nueces County District Attorney)
 - Guy Williams (Nueces County Veteran's Court)
 - Tim Wright (Williamson Co. Veterans Court)
 - Courtney Young (Tarrant County Veteran's Court)

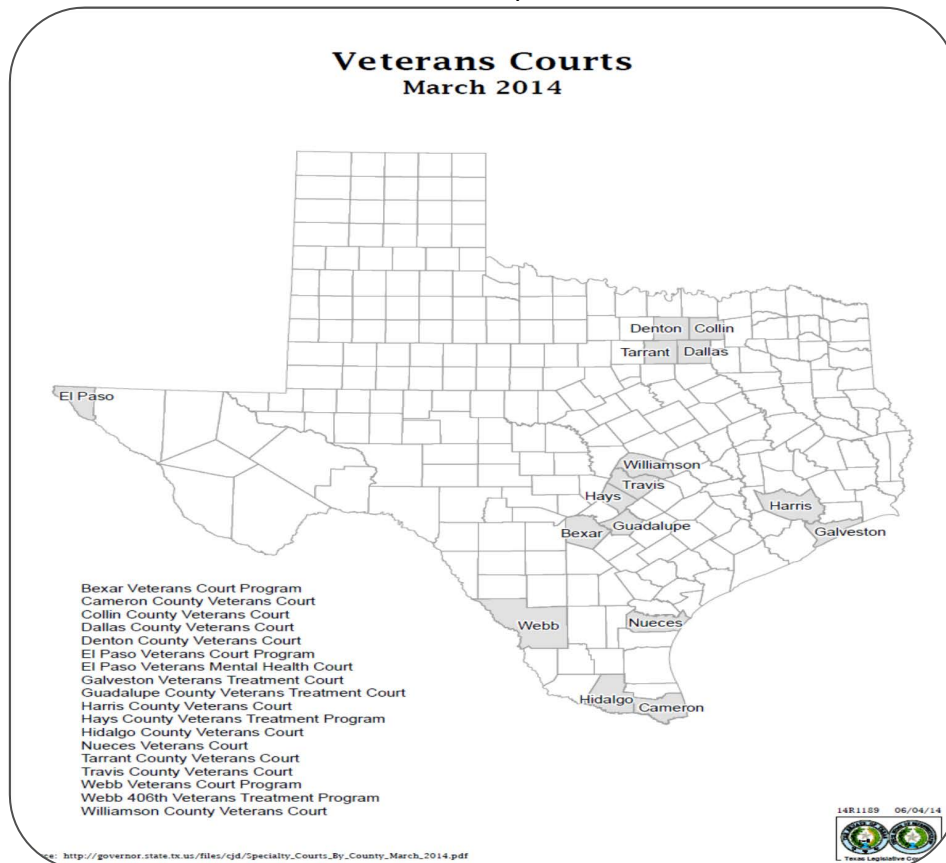
Issue 1

Veteran Treatment Courts

BACKGROUND

The Veterans Treatment Court program first began in Texas in December 2009 in Houston, TX under the Honorable Marc Carter. Today there are 20 Veterans Court programs in Texas, operating out of Bexar, Cameron, Collin, Dallas, Denton, El Paso (2 programs), Galveston, Guadalupe, Harris, Hays, Hidalgo, Nueces, Smith, Tarrant, Travis, Webb (with 3 programs), and Williamson counties. These programs have made a significant and positive impact on the lives of its participants and their loved ones. Rather than focusing on a traditional incarceration method, Veterans Treatment Court programs look to reduce recidivism rates by requiring active participation in self-improvement programs designed to address the root issues leading to the high number of Veteran arrests. Consistent positive results are demonstrating the successful endeavor of these courts to give Veterans a needed second chance, rather than placing them into a system that will likely lead to repeat offenses.

Each current Veterans' Treatment Court (VTC) operates under varying levels of autonomy. Court ordered individualized treatment plans are offered in each court; however due to the



varying nature of the programs and funding opportunities available to them, the services they provide can differ drastically. Relationships with external organizations such as TVC, the VA, and local non-profits offer expansion opportunities for the variety of services available, as well as community service opportunities for participants in the program.

*Map is missing Smith County VTC

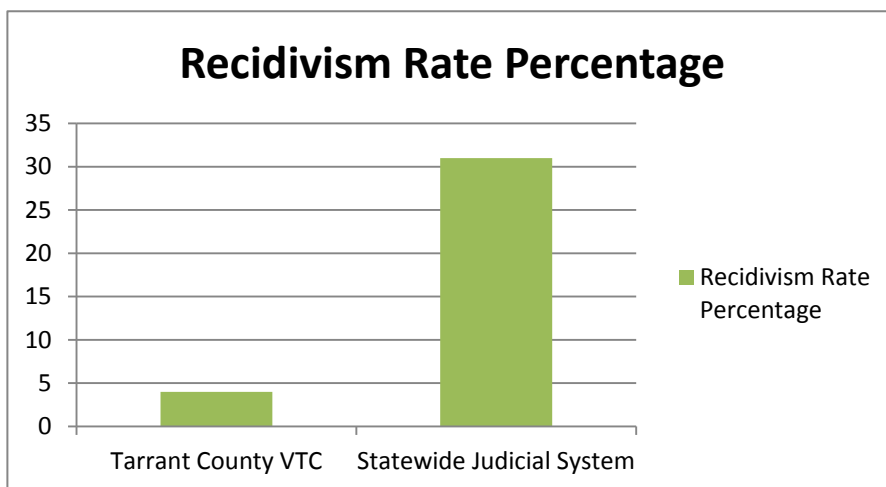
During the 83rd legislative session, Senate Bill 462 authored by Senator Joan Huffman was passed, revitalizing many elements of the Veterans Court Program. Under SB 462, Texas statutes on specialty courts were consolidated for the first time under a new Subtitle K. This action allows for better oversight of specialty courts, requiring that they register with the Criminal Justice Division (CJD) in the Office of the Governor and follow pragmatic best practices as an incentive to receive state and federal grants. This led to many valuable changes outlined in the bill, which helped solidify the structure of many operational procedures of the courts.

FINDINGS

Much more can be done in support of these courts. In order for the Veteran Treatment Court program to reach its full potential, it must be offered increased legitimacy and more detailed organization. The program is lacking in supportive funding, and would benefit from a standardization of procedural methods such as where, when, and how to approach a Veteran about participation in the program. Additional items of consideration include setting a shared standard for who is eligible for participation.

These programs are a well-placed use of our state's dollars. Not only do they offer fresh avenues for our Veterans to successfully get their lives back on track, they ultimately save the taxpayer money. This is due to the low recidivism rate seen in the currently operating Veterans' Treatment Court programs. According to a 2014 report by the Tarrant County VTC program, of those admitted from January 2010 to August 2014 (122 Veterans), 86% successfully graduated, and the program experienced a 4% recidivism rate.³³ When compared with the statewide average recidivism rate, which fluctuates within the low to mid 30% range, this program is hugely successful. A 2009 study done by the Veterans Intervention Project found that of those Veterans arrested during a 90 day trial, 32% were re-arrested at least once during the trial period.³⁴ When compared to the previously stated 4% recidivism rate, the successful nature of the VTC program is made clear. By lowering the recidivism rate, taxpayer dollars that would ultimately go towards re-incarceration are being saved. While this study contained only a small sample, it illustrates the benefits that can come of paring treatment programs, court monitoring, and individuals who are willing participants in the process of breaking negative behavioral cycles and habits.

The chart provides an illustration on the recidivism rates for the VTC



program versus the statewide average.

Program Implementation

Due to the financial status of VTCs, and to their focus on connection to community, many of these courts have strong external relationships to a variety of organizations and groups. The VA, TVC, and CJD have been providing state-level support through a variety of roles which include funding, serving as treatment providers, and offering employment services and assistance. By utilizing local support structures, the courts are able to fulfill their treatment and service functions. These local groups include the local county Veterans Service Officer, coalitions of Veterans support organizations, homeless shelters, mental health programs (both residential and through treatment centers), and other such organizations. Depending on the county, the court will have relationships with varying numbers of the aforementioned groups. Encouraging a continued growth of this communal commitment to VTCs would be in the best interest of the program and the Veterans it serves. In order to best support this, currently operating VTCs have discussed the numerous benefits that a state-level funding mechanism would bring to the program.

Drawing on information received in a survey issued to currently operating Veterans' Treatment Courts by the Committee on Defense and Veterans Affairs, several goals for these courts have been determined. They are outlined below, along with the reasoning behind them and possible future action to address them.

Funding

At present, each court is funded through a wide variety of organizations and grants, with some using entirely volunteer based staff doing the work pro bono. Many of the grants used are provided by different Veterans organizations, with TVC and CJD rising repeatedly to the top of the list (although several courts surveyed mentioned that CJD did not approve their request for grant money). Through discussions with the VTCs, it is clear that a formalized and steady form of funding needs to be put into place. The CJD is currently providing grant funding to eight counties, however this funding is limited in size and scope, focusing primarily on the initial establishment costs of those eight courts.

Many of these courts have special costs associated with them due to the nature of the program; a Veteran participant may be required to attend alcohol and substance abuse classes multiple times a week. If the court cannot assist the Veteran with the fees associated with the class, the Veteran participant will be forced to cover the costs him or herself if they wish to proceed in the VTC program. Many participants are already experiencing financial difficulty, and this places an undue burden on them. They are already putting forth an impressive effort towards self-improvement, and adding cost burdens on top of the time commitment VTCs require can make participation difficult for some willing participants. Such concerns were voiced by Craig A. McNeil, Assistant District Attorney for the Veterans Court of the Dallas County Criminal District Attorney's Office in his response to the VTC survey. Mr. McNeil stated that it would help his court if there was more funding for "equipment (SCRAM devices, interlock

devices, urinalysis testing), money to compensate counties for the time used by prosecutors, judges, community supervision officers, CATS evaluators, court reporters, and bailiffs used in Veterans Court. Although the statute permits Veterans Courts to charge a fee to participate, the Committee does not believe that such a fee is appropriate if a Veteran has met the very high standards necessary to be admitted to Veterans Court."³⁵

Developing a specific and reliable funding mechanism for VTCs is a positive investment of state dollars. VTC programs ultimately save the state money due to their lowered recidivism rate which results in a saving of taxpayer dollars that would otherwise have been spent on costs associated with incarceration. Veterans involved in the VTC program are required to participate in a variety of court-ordered individualized treatment plans, from substance abuse to family counseling. Focusing efforts into treating the root cause of an individual's negative behaviors ultimately diminish the long-term treatment costs that would arise if the situation were not addressed as early as possible. By addressing these issues through VTCs, the state sees a savings in funds that would be otherwise spent on incarceration costs and emergency room visits. For example, Veterans comprise a significant portion of the incarcerated (10% in Harris County), creating VTCs for them to participate in instead would ease the burden on the judicial system.³⁶ This applies to both current offense and potential future offenses, as participation in

			Fee Amount	Revenue Estimates
		JP Civil	\$ 2.00	
		County Civil	\$ 2.00	
	Est. Rev per \$	District Civil	\$ 2.00	
		Appellate Civil	\$ 2.00	
		Supreme Court	\$ 2.00	
JP Civil	\$ 418,209			\$ 836,418.00
County Court Civil	\$ 190,728			\$ 381,456.00
District Court Civil	\$ 395,428			\$ 790,856.00
Courts of Appeals	\$ 4,891			\$ 9,782.00
Supreme Court	\$ 990			\$ 1,980.00
TOTAL				\$ 2,020,492.00

VTCs dramatically lower the probability of repeat offenses.

The Texas Veterans Commission has also cited funding as being a significant concern for the expansion of VTC programs. One possible way of funding these much needed programs would be to add a court fee to all civil court filings that would directly fund VTCs. This can be done in a 60/40 split, as

seen in Drug Courts, in which 60% of the funds would stay in the county received, while the remaining 40% would go to the state.

This money could then be reapplied for by the county, if the additional money was needed for their VTC. This could be created for Veterans Courts largely by drawing directly from language found in the Code of Criminal Procedures Article 102.0178 as it relates to a similar program style, that of the drug court program.

These funds could then be deposited by the comptroller directly to the credit of the county's VTC account in the Criminal Justice Division's grant account. This money would then be appropriated solely for distribution to the county's VTC program.

Using House Bill 2302 (83R) as a reference for the language used in the collection of court fees, the money for the 60/40 split could be found through implementing a standard \$2 civil court filing fee at all levels of court. As seen in the chart, this would generate an estimated \$2,020,942 annually.

By instigating this fee, another issue would be addressed, which is the cost of participating in the VTC program. Some counties such as Webb County ardently believe that there should be no cost to participate once the Veteran has been approved, while Nueces County charges a fee of \$1,000. Such a fee could potentially dissuade Veterans from using the program, lessening its ability to make a pronounced impact on the community.

This funding is urgently needed by VTCs. While some are able operate at full capacity, many are relying on the willingness of staff to work these cases for free, in addition to their paid case-loads. Almost every Veterans Treatment Court office that responded to the survey mentioned funding issues.³⁷ This has led many to be understaffed, and in some cases to waitlists of Veterans hoping to get into these programs. If VTCs are to reach their full potential, they need to be permanent judicial structures. The current level of funding is inadequate and ultimately takes away from the levels of effectiveness that these treatment courts could reach, and thereby from the lives it could save. VTCs work to break negative behavioral patterns that endanger not only the lives of Veterans served, but also the well-being of their loved ones and those around them. Successful VTCs take a burden off the judicial system as they assist in changing the negative cycles that landed these individuals in the judicial system in the first place.

The funds generated in this 60/40 split would be advantageous to the counties and to the state. Using civil cases as a potential funding source is imagined to be a proactive step in the judicial process. Many of the cases taken on by VTCs have negatively affected the family life of the arrestee. Their actions have often already resulted in degraded relationships with those around them. While the offenses taken on by VTCs are under the purview of the criminal court, they can often result in later civil court concerns, such as divorce. Through the use of VTCs such behaviors can be altered through treatment, resulting in improved home-life conditions and easing the burden the criminal justice system is currently under.

Automatic Record Expunction

According to SB 462, there is the strong possibility of record expunction upon successful completion of the VTC program. However, this process may be lengthy and potentially full of more obstacles than many defendants are equipped to deal with. It is often associated with complicated judicial procedures as well as steep filing costs to be paid by the Veteran. Automatic expunction of the recorded criminal activity for which the defendant was initially arrested will better incentivize participation in VTCs and streamline the expunction process (thereby making it easier for those who are working these cases). VTC programs are significantly more time consuming (up to two years rather than a few days or weeks in a jail holding cell), and being able to inform potential participants that they would receive an automatic record expunction following program completion would increase initial participation. All current VTCs expressed that once the word got out about the program, they become a popular option for Veterans in their area.

Automatic expunction enables the Veteran to employ the skills they have been working to improve upon throughout the duration of the program. If they graduate the program but do not have the resources to request an expunction, their employment options are severely restricted. When legitimate employment options are restricted to those with a criminal background, they may likely be forced into illegitimate means of securing an income. Living with a criminal background places significant restrictions upon an individual. It can create a huge roadblock in apartment or home rentals as many agencies will automatically refuse an application from someone with a criminal background. By expunging the record of successful participants of a VTC program, the opportunity to continue pursuing a life of normalcy in the civilian world can be better achieved. Our Veterans deserve a chance to succeed.

It is recommended that upon completion of the VTC, an order of expunction will be issued for the offense no later than the 30th day after the date of program completion. Once the order of expunction is issued, it would be beneficial if the court required all state agencies that had previously sent information concerning the arrest to a central federal depository to request that the depository return all record and files subject to the order of expunction. This could be done without holding separate hearings but simply as a standard procedure of the expunction process, thereby ensuring the full expunction of the record.

It should be noted that if the return of records or files is impractical, all portions of it that identify the individual should be obliterated. This expunction should close all court records concerning the expunction to everyone except the VTC program participant. However, if a repeat offense occurs, there should remain the possibility of this record being brought to light.

In order to track recidivism and success rates, VTCs should be allowed the right to retain a file holding the names of those who have completed their program. This is necessary as it enables the court to track repeat offenders, and monitor the progress of the program overall.

Authority of Veteran Treatment Court Judges

At present, there is significant discrepancy as to what cases a VTC judge may or may not preside over. Most VTCs have defaulted into accepting only misdemeanor cases. Using Nueces county as an example, one of their general qualifications for participation is that the defendant cannot have been charged with the following: "Any first or second degree felony; murder or any type of criminal homicide; any crime including abuse of children or child pornography; any crime against children, elderly, or disabled; any crime of a sexual nature."³⁸ While some regulatory stipulations such as these may be necessary, many of the charges currently being brought to the Nueces court, such as Possession of a Controlled Substance, are closely linked to felony charges. Opening up the degree of crime that can be adjudicated by a VTC judge will help to expand program participation. This helps both the Veteran and tax-payer, as participation in the program opens up space in our traditional correctional facilities. Criminal charges such as Possession of a Controlled Substance, Criminal Trespass, Theft, and Aggravated Assault are common accusations seen by these courts, but can drastically vary in level or degree. Depending on the amount or type of drug, a Possession charge can dramatically alter the life of a Veteran and under current stipulations could bar them from participation in a VTC. If a VTC judge had the authority to take a higher degree Possession case (or other charge) the number of Veterans that could be reached and assisted would be greatly expanded. This authority is not intended to be a requirement that such cases be taken on by a judge, but simply to give them the authority to do so, should they wish to.

Of the VTCs surveyed, DWI was cited by 100% of responding VTCs as one of the top offense currently being accepted, with Assault and Possession of a Controlled Substance following close behind.³⁹ These leading offenses are in-line with statistics from 2009, illustrating a holding trend in top offenses. These offenses are at the misdemeanor level, although charges such as Possession can quickly and easily turn into felony offenses. It was determined that being cited as a felony level offense should not stop a Veteran from being reviewed for the VTC program. While there may be circumstances in which a judge does not feel that the Veteran should be allowed to participate due to gravity of offense, such as sexual crimes or crimes against children, judges should nonetheless have the power to make that call without concern that they are overstepping their jurisdiction. Due to the prevalence of Aggravated Assault and Possession of a Controlled Substance (strongly related to narcotics abuse) as seen in the survey responses, that VTCs will serve to prevent future problems such as domestic violence, divorce, and continued behavioral patterns of Assault or DWI/DUI. This results in these courts acting in a preventative role, addressing the root cause of criminal actions before they manifest in civil cases or in increasingly severe criminal behaviors.

Determination of Veteran Status

At present, there is no standardized way of determining if a defendant is a Veteran or not.

When a county determines if an arrestee is a Veteran varies county by county, from the initial



moment of arrest to weeks later. This can dramatically affect how and when Veterans are referred to the VTC system. The sooner these individuals can be made aware of their choices for legal recourse, the better. In some counties Veterans are referred to VTCs by the police, while in others it is through the DA or even a separate court. A significant number of the VTCs are currently operating under a referral system to recruit potential members to the program.

The appropriate time and manner in which to make this personal inquiry into the Veteran status of an individual, as well as the subsequent steps to direct a potential participant to the VTC program need to be formally addressed. How Veterans are referred, and when this takes place must become standardized.

This will create unity in the program, and will prevent Veterans who may have wished to participate from falling through the cracks.

It would be of substantial benefit if information on a Veteran's status was entered into a data system that could be accessed by all Texas correctional facilities. HB 634 calls for the use of the Public Assistance Reporting Information System to verify a Veteran's status and to then use that information to assist Veteran inmates in applying for federal benefits. However the PARIS system, is not kept up-to-date in real-time, an essential element for the effective use of such a program. TVC recommends a statewide implementation of the VA's Veteran Re-entry Search Services (VRSS), which connects the inmate registries of jails and court systems. Again, coordination of information would result in ultimate benefit to both the state and the Veteran, creating a more efficient process for determining Veteran status and what appropriate steps should be followed at that point. Initial investments of time and money to set up these VTC support structures will result in a strong return in investment through state-levels savings.

Jurisdiction of Veteran Treatment Court Judges

Judges of VTC wishing to transfer jurisdiction of a Veteran who is attempting to participate in

the diversion program are only able to do so using non-standardized methods. Judges have discussed a need to have the specified authority to transfer the jurisdiction of a given individual's case to a different judge and district. This would be beneficial to numerous Veterans hoping to participate, in particular the homeless Veteran population. The transportation concerns of homeless Veterans can impede their participation in the VTC program. For example, there was a recent case of a homeless Veteran who was arrested in Travis County but had no transportation methods to get to his VTC-mandated meetings with his parole officer and with his presiding judge. His sister who lived in Dallas offered to let him live with her if he could continue the VTC program there; unfortunately there was no authorized method to transfer his case. It would be advantageous to all involved and to the overall success of the program if Veterans cases could be easily transferred from one county to another if the judges of both courts and the DA were willing. If a Veteran cannot fully participate in the program, they are expelled. If judges were to be granted the authority to legitimately transfer jurisdiction of a Veteran's case, it would expand the population of Veterans who could participate as well as streamline the transferal process, making it more efficient and effective.

There is potential to use elements of language found in Article 5 Section 8 of the Texas Constitution to state that upon agreeing to participate in a VTC program, the jurisdiction of that given Veteran's case may then be automatically transferred to the Veterans Court closest to the participant's primary residence or county of choice, rather than staying within the jurisdiction in which the offense was committed. The provision for a county of choice may be necessary due to the fact that many Veterans are homeless, but perhaps have the opportunity to stay with relatives or friends if they participate.

Expanding Eligibility

Under SB 462, those eligible to participate in VTCs must demonstrate that they are, as stated in the bill, "a Veteran or current member of the United States Armed Forces, including a member of the Reserves, National Guard, or State Guard; and suffers from a brain injury, mental illness, or mental disorder, including post-traumatic stress disorder, that: resulted from the defendant's military service in a combat zone or other similar hazardous duty area; and materially affected the defendant's criminal conduct at issue in the case."⁴⁰

The previously stated eligibility requirement is proving to be problematic. If a Veteran does not have written documentation of the aforementioned issues at time of trial, it can be difficult to materially prove that they are indeed suffering. Even if such documentation exists, elements of an individual's military record may be difficult to attain. Additionally, and of greater scope, is the concern that any participation in the military has the potential to be "hazardous". 3% of all military members are reported as developing PTSD simply by participating in the military. Jackson Glass, Veteran's Court Manager for the Travis County VTC expressed concern that this constraint will prevent Veterans from participating who are suffering from trauma from sexual assault within the military, rather than from a specific combat experience. Mr. Glass stated that "unfortunately, there are many women (and men) who are the victims of sexual assault while in the military. If they were not deployed and their condition is not related to their

deployment, then they are not eligible for Veterans Courts. I feel strongly that they should be".⁴¹ Military Sexual Trauma is a horrific event, and one that occurs far too often, resulting in severe trauma that has nothing to do with combat status. As such, it would be prudent to expand eligibility to include all servicemembers who were either confirmed as deployment-ready or had been deployed. This would open up eligibility to more servicemembers, regardless of the existence of documented combat experience, brain injury, other mental ailment. Additionally, a 2009 report by the Travis County Veterans Intervention Project found that of the Veterans arrested during a 90 day trial period, 54% of the Veterans arrested had served in non-combat zones.⁴² While it is quite possible that a similar survey done today would show higher levels of combat exposure among our incarcerated Veterans, this statistic illustrates the need for expanded eligibility language.

El Paso County and Webb County have expressed a desire to solidify the definition of who is eligible, for at present much is still at each individual judge's discretion. Webb County has also suggested that VTCs clearly state that their services are available to the Reserves and National Guard, due to the fact that depending on the nature of their service, these components may or may not be eligible for full Veterans status and VA benefits, and therefore may not know if they can receive the services of a VTC.



Judicial Immunity for Veteran Treatment Court Judges

Judicial Immunity is a common law practice given precedent in *Stump v Sparkman* 435 US 349, 355 (1978) which drew on *Bradley v Fisher*, 13 Wall, 335, 347, 20 Led2d (1872). This immunity protects a judge from having a suit brought against them due to a prior ruling. While there are some exceptions to this, it generally holds that "The scope of the judge's

jurisdiction must be construed broadly where the issue is the immunity of the judge. A judge will not be deprived of immunity because the action he took was in error, was done maliciously, or was in excess of his authority; rather, he will be subject to liability only when he has acted in the 'clear absence of all jurisdiction'.⁴³ Such immunity has not yet been established for judges of Veterans Treatment Courts and would provide safety for the livelihood of the judge handing down the ruling.

CONCLUSION

Addressing these needs of Veterans Treatment Courts would better enable them to assist our Veterans and by doing so would ease the strain the Texas criminal justice system is under. Through their use of a combination of rigorous programs which revolve around personal

accountability and treatment for substance abuse and/or mental health disorders, VTCs are producing progressive and constructive results. Success is being seen in breaking cycles of drug use and criminal behavior which is resulting in lower recidivism rates being seen in program participants than in those who go through the traditional criminal justice system. It would therefore seem prudent both financially and civically to promote the continuation of the programs and offer greater assistance to that goal. Vets served our country, so it is our country's turn to serve them.

RECOMMENDATIONS

Provide permanent, specified funding for Veterans courts. Lack of funding has been repeated expressed to be one of the primary barriers to the program across counties.

This could be done partially through support of Justice for Veterans grants (done through partnership between the Supreme Court of Texas and TVC). This would be administered by the FVA and given solely to Veteran Treatment Courts.⁴⁴

Make the requirement for eligibility more inclusive to include all military members who were/are eligible for combat, whether deployed or not.

Hazards exist simply through engaging in military activity. Keeping in mind the tragic rates of military sexual trauma and other such factors, the importance of expanding VTC eligibility becomes clear.

Encourage all counties to inquire if an arrestee has ever had prior military service in order to determine Veteran status, and promote the usage of a data system such as Veteran Re-entry Search Services to track such information.

This will expedite the process for law enforcement officials, and will put more Veterans into contact with VTCs more quickly and effectively

Grant VTC judges the authority to transfer jurisdiction of cases if all parties involved are consenting.

In order to reach all Veterans who are willing to participate in the program, VTC judges need the authority to transfer jurisdiction of cases. This will particularly benefit Veteran population that is either homeless or in transitional housing, a demographic that often gets caught up in the justice system and struggles to get out.

Support creation of Justice for Veterans grants.

The Texas Supreme Court asked for \$4 million in their Legislative Appropriation Request for the 2016-17 biennium which would be used in a matching funds partnership with the TVC to create the Justice for Veterans grant program.

Veterans not eligible to participate in a Veteran Treatment Court should be referred to a mental health court as appropriate.

For Veterans with offenses that make them ineligible for the Veteran Treatment Court, they

should be transferred to a mental health court so they may be referred to mental health treatment services.

Interim Charge #6 - Conduct legislative oversight and monitoring of the agencies and programs under the committee's jurisdiction and the implementation of relevant legislation passed by the 83rd Legislature. In conducting this oversight, the committee should:

- a. consider any reforms to state agencies to make them more responsive to Texas taxpayers and citizens;
- b. identify issues regarding the agency or its governance that may be appropriate to investigate, improve, remedy, or eliminate;
- c. determine whether an agency is operating in a transparent and efficient manner; and
- d. identify opportunities to streamline programs and services while maintaining the mission of the agency and its programs.

SCOPE OF THE CHARGE

This section of the Interim Report explores the agencies and programs under the committee's jurisdiction. The committee examined Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, Healthy Community Collaboratives, and County Emergency Response Preparedness as a result from the Ebola patient in the United States. The Texas Commission on Jail Standards is under the jurisdiction of the committee but is examined in Interim Charge #2.

SUMMARY OF COMMITTEE ACTION

Committee Hearings

March 10, 2014, Polk County Commerce Center, Livingston, Texas
May 5, 2014, Capitol Room E2.016, Austin, Texas
May 15, 2014, Capitol Room E2.016, Austin, Texas
June 11, 2014, Capitol Room E2.016, Austin, Texas
October 20, 2014, Capitol Room E2.016, Austin, Texas
October 27, 2014, The University of Texas - Pan American

Witnesses

March 10, 2014, Polk County Commerce Center, Livingston, Texas

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

- Lee Johnson (Texas Council of Community Centers)
- Jim Allison (County Judges and Commissioners Association of Texas)
- Ardas Khalsa (Health and Human Services Commission)
- Katrina Lambrecht (University of Texas Medical Branch (UTMB); Anchor for RHP 2, 1115 Transformation Waiver)
- Susan Rushing (Burke Center)

May 5, 2014, Capitol Room E2.016, Austin, Texas

Healthy Community Collaboratives

- Marilyn Brown (Coalition for the Homeless of Houston/Harris County)
- Mark Carmona (Haven for Hope)
- Jay Dunn (Self; The Bridge Homeless Recovery Center)
- Lauren Lacefield Lewis (Department of State Health Services)

May 15, 2014, Capitol Room E2.016, Austin, Texas

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

- Connie M. Almeida (Self; Fort Bend County, Behavioral Health Services)
- Jeffrey Dane (University Medical Center)
- Ted Day (University Medical Center)
- Evelyn Delgado (Texas Department of State Health Services)
- Daniel Deslatte (UT Health Science Center at Tyler and RHP 1)
- Gary Floyd (Self; JPS Health Network, Region 10 Health Partnership)
- Chuck Girard (HCA - Hospital Corporation of America)
- Dawn Handley (ATCIC)
- John Hawkins (Texas Hospital Association)
- Carol Huber (University Health System, RHP 6)
- Kyle Janek (Health and Human Services Commission)
- Lee Johnson (Texas Council of Community Centers)
- Mallory Johnson (JPS Health Network)
- Shane Kernell (St. Marks Medical Center)
- Lisa Kirsch (Health and Human Services Commission)
- Nicole Lievsay (Harris Health System, Region 3 Anchor)
- Don McBeath (Texas Organization of Rural and Community Hospitals)
- Maureen Milligan (Teaching Hospitals of Texas)
- Eduardo Olivarez (Hidalgo County Health and Human Services)
- Rick Roberts (Community Healthcore)
- Israel Rocha (Doctors Hospital at Renaissance)
- Regina Rogoff (People's Community Clinic)
- Steven Schnee (MHMRA of Harris County)
- Kristi Sherrill Hoyl (Baylor Scott and White)
- Scott Soland (Fort Bend County Sheriff's Office)
- Michael Thompson (Frio Hospital District)
- Sandra Tyson (UT Health, The University of Texas Health Science Center at Houston)
- Christopher Wall (JPS Health Network)
- Patricia Young Brown (Central Health)

June 11, 2014, Capitol Room E2.016, Austin, Texas

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

- Steven Berk (TTUHSC)

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- Oliver Bogler (UT MD Anderson Cancer Center)
 - Andrew Casas (UT Health Houston)
 - Jose Delarosa (TTUHSC at El Paso)
 - Thomas Fairchild (University of North Texas Health Science Center)
 - Gregory Fenves (The University of Texas at Austin)
 - Lewis Foxhall (UT MD Anderson Cancer Center)
 - Francisco Gonzalez-Scarano (UT Health Science Center San Antonio)
 - Tim LaFrey (Seton Healthcare Family)
 - Katrina Lambrecht (The University of Texas Medical Branch)
 - Jeffrey Levin, MD (The University of Texas Health Science Center at Tyler)
 - Bruce Meyer (UT Southwestern Medical Center)
 - Thomas Murphy (UT Health Houston)
 - Paul Ogden (Texas A&M Health Science Center)
 - Lee Ann Ray (Texas A&M Health Science Center)
 - Patricia Young Brown (Travis County Healthcare District dba Central Health)

October 20, 2014, Capitol Room E2.016, Austin, Texas

Counties Emergency Response Preparedness

- Bryan Alsip (University Health System)
- Kirk Cole (Department of State Health Services)
- Mitzi Ressmann (Texas Hospital Association)
- Umair Shah (Harris County Public Health and Environmental Services)
- Mark Sloan (Harris County Homeland Security and Emergency Management)

October 27, 2014 - The University of Texas - Pan American

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

- William Adams (Knapp Medical Center and Harlingen Medical Center)
- Terry Crocker (Tropical Texas Behavioral Health (MHMR))
- Francisco Fernandez (University of Texas Rio Grande Valley School of Medicine)
- Paula Gomez (Texas Association of Community Health Centers; Brownsville Community Health Center)
- Javier Iruegas (Mission Regional Medical Center)
- Eduardo Olivarez (Hidalgo County Health and Human Services)
- Rebecca Ramirez-Stocker (Hope Family Health Center)
- Israel Rocha Jr. (Doctors Hospital at Renaissance)
- Manuel Vela (Valley Baptist Health System)
- Shirley Wells (Self; Texas Occupational Therapy Association)

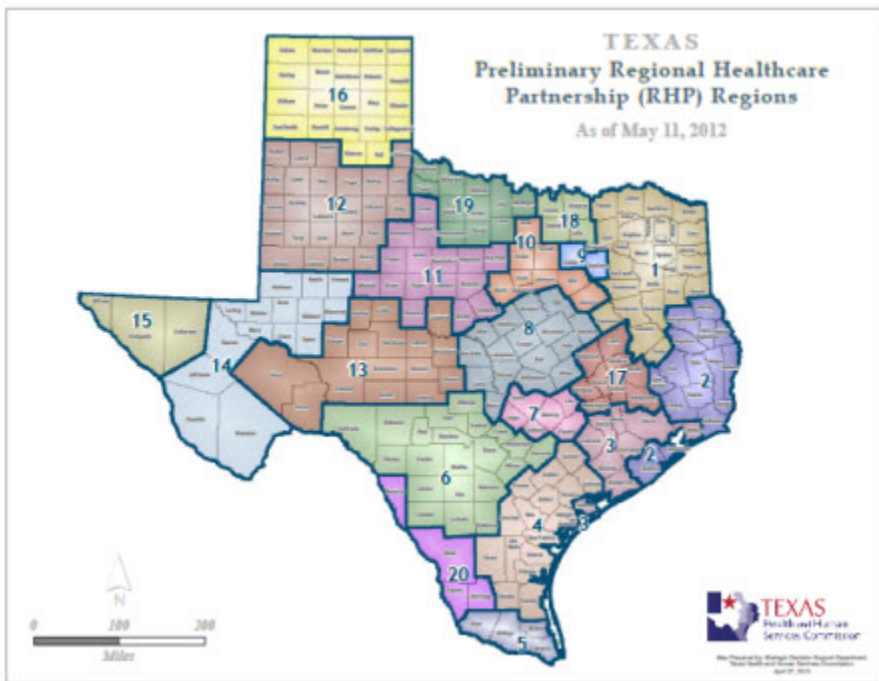
Issue 1

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

BACKGROUND

Overview

Texas was approved for a five-year demonstration waiver to take place from 2011-2016. The goal of the waiver is to allow for the expansion of managed care while protecting hospital supplemental payments under a new payment methodology at the same time incentivizing the delivery system improvements to enhance access and coordination of services and providers. The waiver divided Texas into 20 regions known as Regional Healthcare Partnerships (RHP's) to partner together, pool funds, and provide coordinated services to their area. Each RHP has a designated entity, known as the anchor, that coordinates services and funding throughout the RHP. Under the waiver, previous Upper Payment Limit (UPL) funds and new funds are distributed to hospitals and other providers through two new funding pools: Uncompensated Care (UC) Pool and Delivery System Reform Incentive Payments (DSRIP) Pool.



Uncompensated Care (UC)

The UC pool replaces the former UPL pool and reimburses hospitals for services provided to people with no third party insurance coverage. Under the waiver, the UC pool totals \$17.6 billion, all funds.

Delivery System Reform Incentive Payments (DSRIP)

DSRIP is a new program created

under the waiver to financially support various projects designed and implemented by the RHP's to transform the way healthcare services are provided to the region. These programs must be innovative and transformative of services rendered while reducing costs of services through efficiencies and improvements. These programs are administered through coordination between hospitals, physician groups, community mental health centers and local health departments. Under the waiver, the DSRIP pool totals \$11.4 billion, all funds.

DSRIP participants are eligible to earn \$4.66 billion All Funds for the first three years of the

waiver. While the valuations for the last two years are not final, DSRIP projects for those years are estimated to be valued at over \$5 billion total. For successful submission of the 20 regional plans in the first year of the waiver, RHP anchors and DSRIP providers received almost \$500 million. For project achievements in the second year of the waiver, DSRIP providers received about \$1.6 billion (as of January 2014).

Delivery System Reform Incentive Payment Projects (DSRIP Projects)

Across the 20 RHP's, there are a total of 309 performing providers:

- 232 hospitals (106 public and 126 private)
- 17 physician groups
- 39 community mental health centers
- 21 local health departments

As of December 18, 2014, there are a total of 1,491 approved and active DSRIP projects (1,273 4-year projects and 218 3-year projects). The most common project types include:

- Expand access to primary and specialty care
- Behavioral health interventions to prevent unnecessary use of services in certain settings (e.g. emergency departments, jail)
- Programs to help targeted patients navigate the healthcare system

Most DSRIP projects have completed their initial start-up phase and have successfully reported achievement of the initial project activities. Projects have begun reporting their direct patient impact and established benchmarks for project outcomes. Providers are required under the waiver to report twice each year on project metrics and milestones completed to earn DSRIP payments. For initial approval of the DSRIP projects, providers put in place performance measures. If these measures are not met, providers do not receive DSRIP payments.⁴⁵

FINDINGS

Texas reached the mid-point of the five year waiver on April 1, 2014 and is beginning the process of requesting renewal from Centers for Medicaid and Medicare Services (CMS). Currently, the waiver is set to expire on September 30, 2016. The Health and Human Services Commission (HHSC) must submit a renewal request to CMS no later than September 30, 2015 to extend the waiver. HHSC has begun the discussion process with key stakeholders and obtaining public input for renewal of the waiver.

Delivery System Reform Incentive Payment (DSRIP) Projects

Providers and other DSRIP participants are meeting across the state to work collaboratively to identify best practices, share ways to improve projects, and promote continuous quality improvement. These learning collaboratives are underway in many regions, and a statewide learning collaborative summit for all RHP's took place in September 2014. Common topics for regional learning collaboratives include:

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- Behavioral healthcare, including integrated behavioral/primary healthcare;
 - Care transitions and patient navigation;
 - Chronic care and disease management;
 - Reducing unnecessary emergency room use, potentially preventable readmissions;
 - Primary care/access.

Close to 300 of the approved 4-year DSRIP projects focus on primary care:

- 199 projects to expand primary care capacity, including new clinics, mobile clinics, expanded space, hours and staffing;
- 36 projects to enhance or expand medical homes;
- 27 projects to increase training of the primary care workforce;
- 18 projects to increase, enhance and expand dental services;
- 7 projects to redesign primary care.

About 400 of the approved 4-year DSRIP projects focus on behavioral healthcare:

- 90 interventions to prevent unnecessary use of services (ex. criminal justice system or emergency department);
- 58 projects to enhance behavioral health service availability (house, locations, transportation, mobile clinics);
- 59 projects to develop behavioral healthcare crisis stabilization services;
- 49 projects to integrate primary and behavioral healthcare care services;
- 21 projects to deliver behavioral healthcare care services through telemedicine/telehealth.

Community Center Involvement in the Waiver

Overview of current Mental Health Services provided by Community Centers for Adults and Children:

Statewide

- Crisis Hotline (accredited)
- Mobile Crisis Outreach Teams
- Crisis Transitional Services
- Intensive Ongoing Services
- Jail Diversion Planning
- Medication-Related Services
- Skills Training (psychosocial rehab)
- Case Management
- Cognitive Behavioral Therapy
- Supported Employment
- Supported Housing
- Assertive Community Treatment
- Benefits Assistance

Certain Local Services

- Crisis Stabilization Units
- Extended Observation (23-48 hours)
- Crisis Residential Services
- Crisis Respite Services
- Crisis Step-Down/Local Hospital
- Outpatient Competency Restoration
- Community Hospitals
- Local Hospital Beds
- Substance Use Disorder Services
- Homeless Services
- Peer Support Services

Currently 294 active community center DSRIP 4-year projects and 52 3-year projects:

- Integration of physical and behavioral health care
- Expanded community-based behavioral health services capacity
- Crisis mental health services
- Telemedicine
- Diversion: emergency room and criminal justice
- Peer support services
- Children's mental health services (children only)
- Crisis and expanded services for people with intellectual and developmental disability & co-occurring mental illness.⁴⁶

DSRIP Project Examples

Tropical Texas Behavioral Health serves as the Local Mental Health and Intellectual & Developmental Disability (IDD) Authority for Cameron, Hidalgo and Willacy Counties.

Description: In-House Medical Clearance Evaluations of persons requiring inpatient psychiatric hospitalization (reducing unnecessary use of hospital ERs and law enforcement transports)

Metric	Target	YTD Outcomes
Complete in-house medical clearance evaluations of 27 persons served	27	197

Description: Enhance service availability through Expansion of Behavioral Health Service Capacity of Edinburg, Harlingen and Brownsville Clinics

Metric	Target	YTD Outcomes
Remove 250 additional individuals (above DY2) from waiting list (500 total)	250	941
Hire and train 10 BH staff	10	30
Transport 1,200 individuals identified as low-income or uninsured to appropriate behavioral health services	1,200	2,571

Examples of other promising DSRIP Projects include:

Gulf Coast Center serves as the Local Mental Health and Intellectual & Developmental Disability (IDD) Authority for Galveston and Brazoria Counties.

Description: Crisis Respite Residential provides adult residential psychiatric crisis respite services 24 hour per day, 7 days per week at an 8 bed facility. Serves as an alternative to inpatient psychiatric hospitalization and as a 'step-down' for people discharged from inpatient psychiatric hospitals.

Camino Real Community Services is the Local Mental Health and Intellectual & Developmental Disability (IDD) Authority for Maverick, Dimmit, Zavala, Frio, La Salle, McMullen, Atascosa, Karnes and Wilson counties.

Description: Enhanced Mobile Crisis Outreach Teams respond to emergency behavioral calls at 6 hospitals, 15 police departments, 7 sheriff departments, 24 health clinics, and numerous schools within the Region every hour, every day of the year. Monthly Crisis Task Force meetings are held.

MHMR Services for the Concho Valley serves as the Local Mental Health and Intellectual & Developmental Disability (IDD) Authority for Crockett, Reagan, Irion, Tom Green, Concho, Coke and Sterling counties.

Description: IDD Behavioral Health Crisis Response System to provide community based crisis intervention services to patients with IDD and mental illness in order to prevent hospitalization and inappropriate utilization of local emergency departments or psychiatric hospitals.⁴⁷

RECOMMENDATIONS

Texas should continue to allow the Health and Human Services Commission to work with all Regional Healthcare Partnerships to ensure that DSRIP projects show measureable improvements to healthcare access and outcomes.

In anticipation of waiver renewal, it is imperative that DSRIP projects meet their performance measurements required by CMS in order to obtain renewal. Thus far, HHSC has done a great job of working with providers to ensure that these metrics are met and providing assistance and guidance when needed.

Texas should support renewal of the waiver.

The full benefit of the DSRIP projects has yet to be seen. While performance metrics are in place to ensure that transformation in administering healthcare is taking place, some projects need additional time to see true change and positive impacts on patients. Renewal of the waiver is imperative to see these changes and continue to treat people otherwise unable to receive care.

Issue 2
Healthy Community Collaboratives

BACKGROUND

Senate Bill 58, Section 2 (83rd Legislature, Regular Session, 2013) requires Department of State Health Services to establish or expand community collaboratives that provide services to individuals experiencing issues related to mental health and homelessness. The bill allows for a maximum of five grants in municipalities located in counties with a population of over 1 million. The state will provide dollar for dollar matching funds provided by private community sources for the purposes of a community collaborative. In order to be eligible for the grant, awardees must provide evidence of significant coordination and collaboration among providers of these services. Senate Bill 1, Department of State Health Services Rider 90 (83rd Legislature, Regular Session, 2013) allocated \$25 million to award healthy community collaborative grants.

In the County Affairs Interim Report to the 82nd Legislature, the report recommended that healthy community collaboratives be created in populous areas to address these needs.

FINDINGS

Implementation Timeline

On August 16, 2013 the initial request for information was posted.

- A Housing First option was added.

On November 27, 2013 the request for proposal was released.

- Prior to the release of the request for proposal, two conference calls were held to engage potential respondents.

On January 10, 2014 responses were due.

- Proposals were submitted by all five eligible municipalities.

January through April 2014, evaluations were done of the proposals.

- Proposal clarifications and negotiations took place.

July 1, 2014 was the anticipated start date.

Awards

Five municipalities were eligible and awarded for the grant.

- Coalition for the Homeless Houston/Harris County
- City of Dallas (the Bridge)
- Tarrant County MHMR
- Austin Travis County Integral Care
- Haven for Hope (San Antonio)

Over \$23,536,632 in private matching funds was identified.

- Capital Campaign, on-going fundraising activities, United Way and private donations
- Private Foundations include: St. David's NuStar, Fort Worth, Austin Community Seton Healthcare Family, Meadows, Waller Creek Conservancy, Hogg, Arnold, Religious Coalition for Homeless

Total collaborative funding \$47,073,264 million over the biennium.⁴⁸

The Model: Haven for Hope



Haven for Hope in San Antonio was created to assist the homeless population in Bexar County in obtaining income and permanent housing. The Haven for Hope campus was strategically placed in an area of downtown San Antonio where homeless people resided. At the time of inception, this location was a high crime spot. However, the campus has decreased the once crime ridden location and has turned the area into a place for people to seek refuge, treatment, and new beginnings.

Located in downtown San Antonio, Haven for Hope is near the local jail, public hospital system, and public transportation. These factors play a key role in the success of Haven for Hope and allow them to maintain their "no wrong door policy". Mark Carmona, current President and Chief Executive Officer for Haven for Hope testified that this policy allows them "meet people where they are and help them anyway you can."

From the beginning, it was clear that mental illness and addiction treatment were going to be necessary for their target population. In order to address these issues, Haven for Hope established two areas on campus: the Transformation Campus and the Prospects Courtyard.

The Transformation Campus is committed to "transforming lives" provides a multitude of services necessary to meet any and all needs of those committed to transforming their life. These services include but are not limited to: a recovery oriented system of care, intensive case management, employment readiness training, disability/senior services, spiritual services, an in-house recovery program, and aftercare services. It is at this campus where they offer peer support programs. These programs employ those who have a lived experience of mental illness to provide friendship and support to those currently seeking services. Additional services include counseling, therapy, physical fitness, spiritual enrichment, etc.

The Prospects Courtyard (PCY) is a "safe outdoor sleeping area for those unwilling, unable, or waiting to participate in the transformation programs." Since the start of Haven for Hope, over

13,089 individuals have been served in the PCY. On average, there are 524 individuals sleeping in the PCY overnight and 744 individuals being served at the PCY during the day. Between April of 2013 and March of 2014, over 900 individuals had transitioned into higher levels of care. These levels include the services provided at the Transformation Campus and residential care.

As the needs at the PCY evolved, the services offered have evolved as well. The PCY offers basic needs services such as three meals per day, showers, and laundry. As utilization of the courtyard continued, Haven for Hope began to see that a major need of those using the PCY was mental health treatment. Haven for Hope leveraged city and county dollars to provide a behavioral health clinic on the PCY. Psychiatrists employed by the clinic approach people who are clearly suffering from mental illness and engage with them. This is another area in which peer to peer services are utilized. Additionally, Haven for Hope obtained a Centers for Medicare and Medicaid Service grant through their innovation grant series to provide medical care. Recently, they were able to obtain dollars through the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver to integrate the physical and mental health care provided at the PCY.

One centralized intake and triage center provides medical care for both the Transformation Campus and the PCY. Intake staff conduct an initial assessment and refer the patient to the most appropriate program: Transformational Campus tracks, Prospect's Courtyard, In-House Recovery Program (IHRP), Other community housing opportunities such as Emergency, Transitional, Domestic Violence, or Prevention Providers if the person presents as "at risk of homelessness". Medical and wellness care is also provided through hospital outpatient beds, primary health care services, dental, vision, and triage services. Haven for Hope is able to provide these services through public/private partnerships with CentroMed, San Antonio Christian Dental Clinic and Vision Center - I Care San Antonio.

For its creation, Haven for Hope raised \$100 million to construct its campus. Of that, approximately \$60 million was private funds with approximately \$40 million in public funds. Currently only 6% of the funding is spend on administrative costs, with the remaining of the funding going directly to services provided on campus.

Have for Hope has raised funds through various partnerships and fundraisers. NuStar Energy has sponsored the NuHope Golf Tournament and raised \$15 million for Haven for Hope over the past six years. Haven for Hope has partnered with Lucky Duck Race for the last four years. Through this partnership, they have raised over \$58,500 for the Campus. Additionally, Haven for Hope through partnership with local downtown businesses and city attractions, created the Downtown Meter Program which provides funding and creates awareness around Haven for Hope.



Haven for Hope has a total of 39 on-campus partners and 42 off-site partners, with a total of over 200 community business partners.

To date, over 1,445 people have exited the transformational campus and are now living in permanent housing with housing retention of six months at 95% and housing retention of one year at 91%. Additionally the job placement and training programs are proving to be effective with over 1,081 people attaining employment. In the last year, job placements through Haven for Hope have increased 55%. Over 40,000 individuals have received quality medical, dental, and vision care. As of May 2013, approximately 193,000 services were provided with an approximate value of over \$15.7 million. Haven for Hope has built partnerships with 89 agencies to provide 150 different social services. In 2008, Haven for Hope opened the Restoration Center which provides critical sobering and

City and county jails, emergency rooms and court rooms avoided approximately \$50,054,650 in the first five years of operation

detoxification services. Approximately 35,000 individuals have received life-saving services. Additionally, city and county jails, emergency rooms and court rooms avoided approximately \$50,054,650 in the first five years of operation..⁴⁹

Project Overviews

City of Dallas (The Bridge): \$5.18 million GR funds (FY 14/15) / \$ 5.18 million private matching funds

- Centralized intake to serve the entire continuum of care
- Increase case management services
- Increase integrated physical and behavioral services
- Provide permanent supportive housing
- Increase aftercare supports by an additional 6-months of community based care

Haven for Hope (San Antonio): \$3.58 million GR funds (FY 14/15) / \$3.58 million private matching funds

- Centralized intake to serve the entire continuum of care
- Provide permanent supportive housing
- Increase aftercare supports to foster retention
- Increase peer support in all areas of service delivery from outreach, intake, and case management through to aftercare and discharge
- Increase coordination and services for the re-entry population

Coalition for the Homeless Houston / Harris County: \$6.96 million GR funds (FY 14/15) / \$6.96 million private matching funds

- Build a co-located homeless crisis and housing processing services center in the

northeast section of downtown Houston

- Increase the number of permanent supportive housing units
- Increase the access to integrated medical and behavioral health services

MHMR Tarrant County: \$4.34 million GR funds (FY 14/15) / \$4.34 million private matching funds

- Expand outreach and engagement
- Create Homeless Navigator Team with case managers and peer providers
- Provide permanent supportive housing subsidies

Austin Travis County Integral Care (ATCIC): \$3.48 million GR funds (FY 14/15) / \$3.48 million private matching funds

- Create dedicated housing units for the homeless
- Provide permanent supportive housing subsidies
- Provide intensive case management services
- Enhance substance abuse treatment for permanent supportive housing
- Provide supported employment services⁵⁰

RECOMMENDATIONS

The 84th Legislature should expand grant eligibility to include additional municipalities.

There is a significant need for community collaboratives in other areas of the state. As population growth continues to strain resources, the need for a community collaborative in these areas continues to grow as well. Without this tool, counties and municipalities continue to experience pressures on emergency rooms and local jails.

Texas should place equal emphasis on addressing mental health needs and homelessness.

Community collaboratives should maintain their "no wrong door" policy, placing equal weight on treating those suffering from mental illness as well as addressing homelessness.. Haven for Hope sustains a model for addressing all needs for people seeking their services. This should be the model for all community collaboratives.

Issue 3

County Emergency Response Preparedness

BACKGROUND

Due to counties obligation to maintain the safety of its residents, Chairman Coleman held a legislative hearing to discuss Dallas County's response to a patient in their hospital diagnosed with Ebola. The purpose of this hearing was to discuss publicly Dallas County's emergency response to such a crisis and discuss options available to other counties should another patient present with the Ebola virus.

The Texas Local Government Code, Chapter 418.102 states " Each county shall maintain an emergency management program or participate in a local or interjurisdictional emergency management program that, except as otherwise provided by this chapter, has jurisdiction over and serves the entire county or interjurisdictional area. The county program is the first channel through which a municipal corporation or a joint board shall request assistance when its resources are exceeded. Requests that exceed the county capability shall be forwarded to the state as prescribed in the state emergency management plan." Additionally, under the Texas Government Code, the County Judge is deemed the emergency management director for the county in which they serve. The County Judge has the authority to declare a local disaster in both the incorporated and unincorporated areas of the county.⁵¹

West Africa Outbreak

On August 8, 2014, the World Health Organization (WHO) declared the Ebola outbreak in West Africa a Public Health Emergency of International Concern (PHEIC). The countries with the most widespread transmission of Ebola include: Guinea, Liberia, and Sierra Leone. As of October 12, 2014, the Centers for Disease Control and Prevention (CDC) reported a total case count of 8,997 with a total number of deaths at 4,493.

Timeline of Events

On September 30, 2014, the Department of State Health Services (DSHS) and the Centers for Disease Control (CDC) confirmed the first Ebola diagnosis in the United States. This patient had contracted the disease through recent travels to West Africa. Soon after his diagnosis, the patient passed away on October 8, 2014.

A contact investigation was launched once the initial patient was diagnosed to determine those who may have been exposed to the virus while the patient was contagious. At this time it was determined that 48 individuals were identified with a possible exposure; of those, 10 people were considered at high risk of exposure.

On October 12, 2014, the second case of Ebola was diagnosed. This patient was a health care worker who had provided care to the initial Ebola patient. An investigation was again launched

to determine other people who may have been exposed to the Ebola virus while the second patient was contagious. Only one person was identified as at possible risk. This patient was treated at the National Institute of Health and has made a full recovery.

On October 15, 2014, a third case of Ebola was diagnosed. This individual also provided care to the initial Ebola patient. It was determined that three people were at risk of exposure to the Ebola virus once the third patient was determined to be contagious. This patient was treated at Emory Hospital and has made a full recovery.

In total, the CDC asked Texas to monitor approximately 200 individuals that were determined to have possibly been exposed.⁵²

Symptoms of Ebola and How it Spreads

Ebola is a potentially fatal disease, one of several viral hemorrhagic fevers, for which there is no approved vaccine available.

Symptoms include:

- Sudden fever, sometimes with headache and joint and muscle aches
- Nausea
- Weakness
- Diarrhea
- Vomiting
- Stomach pain

Ebola is only contagious when a person is exhibiting symptoms. A person infected with the virus can become symptomatic between two and 21 days after exposure. Transmission of the virus requires direct contact with bodily fluids or through a contaminated object such as a needle. Direct contact for exposure means through broken skin or unprotected mucous membranes.

FINDINGS

Patient History

Ebola symptoms present in the same way the Flu virus presents. It is for this reason that a patient's history is essential to diagnosis of any illness. Taking a patient's history regarding recent travels, allergies, family medical history, etc., plays a key role in illness diagnosis. During the current Ebola outbreak in West Africa, it is of the utmost importance for medical health professionals to take a proper medical history from the patient, including recent travel history, to determine whether concerns regarding possible Ebola symptoms are present or if the patient has the flu.

If a patient identifies that they have been in contact with the Ebola virus, the patient should

immediately be put in isolation and the provider should contact their local health authority. The local health authority will then contact the Department of State Health Services (DSHS) regarding testing for the Ebola virus. DSHS in conjunction with the Centers for Disease Control (CDC) will determine whether testing needs to be administered. If determined that testing needs to be conducted, the sample will be tested at the DSHS facility.

In some cases the patient will need to be re-tested after 72 hours since symptoms of the virus are not immediate. In some cases where patients reported travels to West Africa, test results have come back positive for Malaria.

Minimal Risk to Community At Large

While Ebola is truly devastating West African countries, the population in the United States is at minimal risk of contracting the Ebola virus. The only people who are at risk are those that can identify with **all** of the following three items:

1. People who have traveled to or been in contact with someone who traveled to one of the three countries experiencing the Ebola outbreak within the last three weeks.
2. People who are experiencing Ebola like symptoms such as fever.
3. Those who have had definitive contact with a person confirmed with Ebola or his/her bodily fluids.⁵³

Preparedness and Planning

Mark Sloan, Emergency Management Coordinator for Harris County, provided testimony regarding the Harris County Office of Homeland Security and Emergency Management's preparedness at the county level for any and all types of emergencies. "Harris County is a national model for best practices in homeland security and emergency management." The Harris County Office of Homeland Security and Emergency Management maintains 24 hour readiness with over 100 plans to guide emergency response initiatives. Harris County takes a "3-C" approach: communicate, collaborate, and coordinate. In order to uphold the "3-C" model, Harris County employs the following:

- Maintain a comprehensive emergency management plan.
- Activate an Emergency Operations Center to respond to and recover from disasters.
- Deliver effective public outreach and preparedness programs.
- Provide information for elected officials, the media, residents and other stakeholders.
- Train, educate and prepare for emergencies through extensive drills and exercises.⁵⁴

Communication is key amongst providers to ensure that the most accurate and up-to-date information is received and implemented. Mitzi Ressler, RN, Chief Operating Officer for the Texas Hospital Association and Chief Executive Officer and President for the Texas Center for Quality and Patient Safety, provided testimony regarding Texas Hospital Associations (THA) ability to provide immediate, accurate, and up-to-date information regarding Ebola to hospitals around the state. THA's primary role is to act as a communication HUB for the 400 hospitals they represent across the State and to provide support to the state agencies involved with the Ebola response.

THA has been actively informing hospitals across the State since July 2014 about potential Ebola patients entering the United States. Through various social media outlets, THA has provided hospitals with reports from the American Hospital Association, the CDC, and DSHS to help the hospitals prepare for such an event.⁵⁵

Secondary Transmission Prevention Measures

Bryan Alsip, MD, Senior Vice President and Chief Executive Officer for the University Health System (UHS) in San Antonio, provided testimony regarding measures they have taken to prevent secondary transmission of the virus. UHS activated their Internal Hospital Instant Command Structure which allows for UHS to implement their coordinated planned response. Daily meetings are conducted to ensure the appropriate response and planning regarding logistical and financial issues as they relate to Ebola. Infectious Disease Specialist are on-call 24/7 for the University Health System (includes both hospitals and community centers) as the main point of contact should there be a patient suspected of having Ebola.

Communication amongst the county, police, fire and EMS, community providers, the hospital system and anyone emergency management or healthcare system that may come in contact with the virus to update their emergency plan. This is done by making sure the Ebola virus is recognized and isolated properly while testing is conducted. Published a Ebola checklist to ensure preparedness should someone present with the Ebola virus.

Additional protective gear has been ordered to ensure that they have adequate amounts for training and one-on-one care. Training has been conducted for healthcare workers in the system to ensure the proper donning and doffing of protective gear. The University Health System decided to deploy the same personal protective equipment (PPE) used by the University of Nebraska. This PPE requires a multi-piece suit which, through practice doffing tests, proved to be the most preventative towards spreading infectious diseases. These suits provide the same full coverage as the one-piece suits. However, they were not as effective in preventing transmission of diseases as the multi-piece suits were. Although more time consuming than the one-piece suits, the multi-piece suits are most effective when donning and doffing with a body.

Training is being conducted as well to ensure proper transport, care, isolation, and testing are done on a suspected Ebola patient. Practice runs have also been conducted with the ambulance crews and with the team receiving the suspected Ebola patient.

An internal portal has been created for staff to access information regarding Ebola as well as ask questions regarding Ebola. Town hall meetings are held for hospital and clinic staff to keep them informed on how to care for an Ebola patient and provide up-to-date them with current CDC recommendations as they continue to evolve.⁵⁶

RECOMMENDATIONS

Counties, hospitals, and healthcare workers should maintain an active emergency response plan to guarantee preparedness for the highest level threat of the most easily transmitted communicable diseases to ensure diseases such as Ebola, H1N1 or Bird Flu are identified and contained promptly.

It is imperative that counties be prepared for much more communicable diseases that are more easily transmitted than Ebola. While Ebola is a very scary and deathly virus, there are other viruses that are airborne that are equally as scary and deadly. Therefore, having equipment and an emergency response plan in place is imperative to the health of the community.

ENDNOTES

- ¹ Texas Commission on Jail Standards (www.tcjs.state.tx.us)
- ² Elizabeth Henneke, Policy Attorney at Texas Criminal Justice Coalition, testimony to the House Committee on County Affairs, May 5, 2014
- ³ Lynda Frost, Director of Planning and Programs at Hogg Foundation for Mental Health, testimony to the House Committee on County Affairs, May 5, 2014
- ⁴ Brandon Wood, Executive Director at Texas Commission on Jail Standards, testimony to the House Committee on County Affairs, May 5, 2014
- ⁵ Brandon Wood, Executive Director at Texas Commission on Jail Standards, testimony to the House Committee on County Affairs, May 5, 2014
- ⁶ Brandon Wood, Executive Director at Texas Commission on Jail Standards, testimony to the House Committee on County Affairs, May 5, 2014
- ⁷ Brandon Wood, Executive Director at Texas Commission on Jail Standards, testimony to the House Committee on County Affairs, May 5, 2014
- ⁸ Texas Department of State Health Services website (<http://www.dshs.state.tx.us/mhsa/hb3793/>)
- ⁹ Shannon Edmonds, Staff Attorney and Government Relations for Texas District and County Attorneys Association, testimony to the House Committee on County Affairs, May 5, 2014
- ¹⁰ Joe Ptak, Texans Smart on Crime, testimony to the House Committee on County Affairs, May 5, 2014
- ¹¹ Senate Bill 462, 83R (enacted)
- ¹² Kyle Janek, M.D., Executive Commissioner, Lisa Kirsch, Deputy Director, Healthcare Transformation Waiver Operations, Texas Health and Human Services Commission, testimony to the House Committee on County Affairs, May 15, 2014
- ¹³ Senate Bill 58, 83R
- ¹⁴ Texas Department of State Health Services, Presentation to the House Committee on County Affairs, Lauren Lacefield Lewis, Assistant Commissioner for Mental Health and Substance Abuse Division, May 5, 2014
- ¹⁵ Mark Sloan, Emergency Management Coordinator at Harris County, testimony to the House Committee on County Affairs, October 20, 2014
- ¹⁶ Texas Commission on Jail Standards (www.tcjs.state.tx.us)
- ¹⁷ Brandon Wood, Executive Director at Texas Commission on Jail Standards, testimony to the House Committee on County Affairs, May 5, 2014
- ¹⁸ Elizabeth Henneke, Policy Attorney at Texas Criminal Justice Coalition, testimony to the House Committee on County Affairs, May 5, 2014
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- ²⁰ Lynda Frost, Director of Planning and Programs at Hogg Foundation for Mental Health, testimony to the House Committee on County Affairs, May 5, 2014
- ²¹ Dennis Wilson, Sheriff for Limestone County, testimony to the House Committee on County Affairs, March 10, 2014
- ²² Megan Randall, Health Care Policy Fellow for Center for Public Policy Priorities, testimony to the House Committee on County Affairs
- ²³ T. Michael O'Conner, Sheriff for Victoria County, President of the South Texas Coastal Sheriff's Alliance, testimony to the House Committee on County Affairs, June 11, 2014
- ²⁴ Brandon Wood, Executive Director at Texas Commission on Jail Standards, testimony to the House Committee on County Affairs, May 5, 2014
- ²⁵ Brandon Wood, Executive Director at Texas Commission on Jail Standards, written testimony for the House Committee on County Affairs, May 5, 2014
- ²⁶ House Bill 3793, 83R
- ²⁷ Texas Department of State Health Services website (<http://www.dshs.state.tx.us/mhsa/hb3793/>)
- ²⁸ Lee Johnson, Deputy Director at Texas Council of Community Centers, testimony to the House Committee on County Affairs, March 10, 2014
- ²⁹ Shannon Edmonds, Staff Attorney and Government Relations for Texas District and County Attorneys Association, testimony to the House Committee on County Affairs, May 5, 2014
- ³⁰ Joe Ptak, Texans Smart on Crime, testimony to the House Committee on County Affairs, May 5, 2014

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- ³¹ Gary Cutler, Sheriff for Hays County, testimony to the House Committee on County Affairs
- ³² Dennis Wilson, Sheriff for Limestone County, testimony to the House Committee on County Affairs, March 10, 2014
- ³³ "Tarrant County Overall Veterans Court Statistics as of 4/4/14." *Veterans Court Program Survey Results* (2014): 13.
- ³⁴ Marchman, Judy L. "Veterans Courts in Texas." *Texas Bar Journal* 75.8 (2014): 616-18. Web.
- ³⁵ *Veterans Court Program Survey Results* (2014): 6.
- ³⁶ Banned-Smith, St. John. "New Misdemeanor Court to Help Combat Veterans." *Houston Chronicle*. N.p., 23 Sept. 2014. Web
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- ³⁹ *Veterans Court Program Survey Results* (2014).
- ⁴⁰ Senate Bill 462, 83R., 15-16; Lines 22-3 (enacted). Print.
- ⁴¹ *Veterans Court Program Survey Results* (2014):15.
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- ⁴⁸ Texas Department of State Health Services, Presentation to the House Committee on County Affairs, Lauren Lacefield Lewis, Assistant Commissioner for Mental Health and Substance Abuse Division, May 5, 2014
- ⁴⁹ Haven for Hope, Mark Carmona, President and Chief Executive Officer, Presentation to the House Committee on County Affairs, May 5, 2014
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- ⁵⁴ Harris County Office of Homeland Security and Emergency Management, Testimony, Texas House of Representatives, County Affairs Committee, Mark Sloan, Emergency Management Coordinator, October 20, 2014
- ⁵⁵ Mitzi Ressmann, RN, Chief Operating Officer, Texas Hospital Association, Chief Executive Officer and President, Texas Center for Quality and Patient Safety, Verbal Testimony provided to the House Committee on County Affairs, October 20, 2014
- ⁵⁶ Bryan Alsip, MD, Senior Vice President and Chief Executive Officer for University Health System at San Antonio, verbal testimony to the House Committee on County Affairs, October 20, 2014