Recommendations for the Creation of a Comprehensive Plan for Forensic Services

As Required By
Texas Health and Safety Code Section 532.0131(e)

Joint Committee on Access and Forensic Services
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Executive Summary

Texas Health and Safety Code Section 532.0131 requires the executive commissioner of the Texas Health and Human Services Commission to establish a work group of experts and stakeholders to make recommendations concerning the creation of a comprehensive plan for the effective coordination of forensic services. The work group, identified herein as the Joint Committee on Access and Forensic Services (JCAFS), developed its recommendations with consideration given to information compiled by other state work groups and organizations. As the JCAFS continues to meet over the course of the next several years, it will utilize all available opportunities to provide feedback regarding the development of a comprehensive plan for forensic services that builds upon the framework outlined within this document.

In general, the committee's recommendations focus on the coordination of forensic services within a comprehensive system that allows for appropriate diversion from the criminal justice system as well as access to an array of services and supports along the entire continuum of care. At a more focused level, the committee's recommendations speak to urgent resource needs across the state. Current resource demands include both expanded inpatient hospital bed capacity and community-based services, including access to diversion programs and services, prompt initiation of services for incarcerated individuals, community-based forensic programs, and reentry services for those who are transitioning back to the community.

Between January 2001 and January 2016, Texas' forensic population grew from 16 to 52 percent of the state psychiatric hospital system. This increase in forensic commitments has led to extensive wait times for admission into state hospitals, particularly for those pending admission to a maximum security unit. Extended wait times place significant strains on the county jails and emergency departments that house individuals prior to hospital admission and lead to delays in the start of necessary psychiatric services. In addition, these wait times delay legal processes for those who have been found incompetent to stand trial. To more adequately address the demand for inpatient services, the JCAFS recommends adding 1,800 hospital beds over the next eight years to meet existing needs and accommodate population growth. Given the challenges in adding new hospital bed capacity, the JCAFS consensus is that the most prudent approach would be a significant initial expansion of state-operated and state-funded inpatient capacity, to include additional maximum security beds, followed by a gradual increase in beds to meet both the current and future demand.

While estimates of current and future hospital bed needs are intended to provide sufficient capacity for both civilly and forensically-committed individuals, inpatient resource needs cannot be addressed in isolation. The level of demand for inpatient care depends, in part, upon the array and availability of community-based services. Large numbers of individuals across the state with unmet behavioral health needs are ending up in emergency rooms and jails, disrupting families and communities and straining local resources. Without further investments in community-based services along the entire continuum of care, the need for inpatient resources will continue to increase.

The JCAFS recommends the development of a comprehensive plan for forensic services that takes into consideration the following areas: emergency services, law enforcement, and post-

arrest diversion programs designed to decrease the number of persons with serious mental illness who come into contact with the criminal justice system; forensic services following initial court hearings (e.g., forensic evaluations, commitments, and competency restoration and behavioral health services provided in community and hospital settings); and reentry and community-based services and supports for persons who are ready to transition to less restrictive levels of care. The body of this legislative report contains a number of specific recommendations that speak to each of these areas as well as a number of more general recommendations that address the system as a whole. The committee's recommendations emphasize a system-wide approach to addressing the coordination of forensic services that builds upon the belief that the demands of the forensic population will not be successfully met without the overall public mental health system becoming more proactive in its efforts to provide individuals with access to appropriate services and supports in a timely and effective manner.

Introduction

Texas Health and Safety Code Section 532.0131 requires the executive commissioner of the Texas Health and Human Services Commission (HHSC) to establish a work group of experts and stakeholders to make recommendations concerning the creation of a comprehensive plan for the effective coordination of forensic services. The work group, identified herein as the Joint Committee on Access and Forensic Services (JCAFS), must have not fewer than nine members, with the executive commissioner appointing members.[1] The JCAFS is required to report to the lieutenant governor, speaker of the House of Representatives, and the standing committees of the Senate and the House of Representatives with primary jurisdiction over forensic services no later than July 1, 2016.

The JCAFS began meeting monthly in December 2015, with subcommittees of the larger group meeting more regularly to address the charges outlined in Senate Bill 1507, 84th Legislature, Regular Session, 2015. In developing its recommendations, the JCAFS used information compiled by other state work groups and organizations.[2] The information presented in this document represents the JCAFS initial recommendations regarding the creation of a comprehensive plan for the coordination of forensic services. As the JCAFS continues to meet, it will utilize all available opportunities to provide feedback regarding the development of a comprehensive plan for forensic services that builds upon the framework outlined within this document.

Background

Forensic services include forensic evaluations, competency restoration services, and behavioral health services provided to persons found incompetent to stand trial or not guilty by reason of insanity. Effective statewide coordination of forensic services is impacted by the rate at which persons with serious mental illness come into contact with the criminal justice system as well as by the variability of resources available across the state. Additional factors, such as program capacity at all levels of care and the service needs of special populations (e.g., juveniles, persons with intellectual disabilities, persons with co-occurring substance use disorders, or those with geriatric and neuropsychiatric needs) add further complexity to the delivery of forensic services.

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[1] Texas Health and Safety Code Section 532.0131 requires membership of the JCAFS to include: a representative of HHSC; a representative of the Texas Department of Criminal Justice; a representative of the Texas Juvenile Justice Department; a representative of the Texas Correctional Office on Offenders with Medical or Mental Impairments; a representative of the Sheriff's Association of Texas; a superintendent of a state hospital with a maximum security forensic unit, a representative of a local mental health authority (LMHA); a representative of the protection and advocacy system of this state established in accordance with 42 U.S.C Section 15043, appointed by the administrative head of that system; and additional members as needed to comply with the number of members selected by the commissioner, who must be recognized experts in forensic individuals or persons who represent the interests of forensic individuals, and who may be advocates, family members, psychiatrists, psychologists, social workers, psychiatric nurses, or representatives of hospitals licensed under Chapter 241 or 577.

[2] Information considered in the development of this report included the work of the Advisory Panel developed out of House Bill 3793, 83rd Legislature, 2013; the Analysis for Ten-Year Plan for the Provision of Services to Persons Served by State Psychiatric Hospitals (SPHs) prepared for the Department of State Health Services in November 2014; and the Sequential Intercept Model developed by the Substance Abuse and Mental Health Service Administration's GAINS Center for Behavioral Health and Justice Transformation.

Developing a comprehensive plan for the coordination of forensic services begins with an understanding of the current landscape, to include the prevalence of serious mental illness in the justice system and the complexity of the adult and juvenile populations coming to the attention of law enforcement. In an ideal scenario, the needs of persons with serious mental illness and co-occurring substance use disorders will be addressed before they ever come into contact with law enforcement. However, the number of individuals with serious mental illness who are incarcerated each year suggests that work is still needed to help divert individuals from the system.

Looking at prevalence, over two million people with serious mental illness are booked into jails each year.[3] The prevalence of serious mental illness[4] among incarcerated persons (i.e., approximately 14 percent of men and 24 percent of women[5]) far exceeds the general adult population, where it is estimated that 4.2 percent of all adults in the United States experience a serious mental illness.[6] In addition, the majority of adults with serious mental illness who are booked into jails each year also present with a co-occurring substance use disorder.[7] The presence of a co-occurring substance use disorder adds to the complexity of individual treatment needs, and integrated treatment plans that address both mental illness and substance use are often necessary to successfully achieve improved outcomes and reductions in recidivism.

Among the juvenile population, approximately 50-70 percent of those who come into contact with the juvenile justice system meet criteria for a mental health disorder and 60 percent meet criteria for a substance use disorder.[8] In addition, approximately 90 percent of detained youth report a history of traumatic exposure.[9] For both the juvenile and adult populations, individuals with intellectual disabilities are overrepresented within the justice system. While persons with intellectual disabilities represent approximately 2-3 percent of the general population, the

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[3] Council of State Governments Justice Center. New Efforts to Reduce the Number of People with Mental Disorders in Jails Set the Stage for Unprecedented Change. Council of State Governments Justice Center. https://csgjusticecenter.org/mental-health/press-releases/new-efforts-to-reduce-the-number-of-people-with-mental-disorders-in-jails-set-the-stage-for-unprecedented-change/. Published December 9, 2014. Accessed March 16, 2016.

[4] Serious mental illness for persons ages 18 and older is defined as "having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities." Substance Abuse and Mental Health Services Administration (SAMHSA). Mental and substance use disorders. SAMHSA. http://www.samhsa.gov/disorders. Accessed April 15, 2016.

[5] SAMHSA. Criminal and Juvenile Justice Overview. SAMHSA. http://www.samhsa.gov/criminal-juvenile-justice. Accessed April 19, 2016.

[6] The National Institute of Mental Health (NIMH). Serious mental illness (SMI) among U.S. adults. *NIMH*. http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml. Accessed March 16, 2016.

[7] Council of State Governments Justice Center. New Efforts to Reduce the Number of People with Mental Disorders in Jails Set the Stage for Unprecedented Change. Council of State Governments Justice Center. https://csgjusticecenter.org/mental-health/press-releases/new-efforts-to-reduce-the-number-of-people-with-mental-disorders-in-jails-set-the-stage-for-unprecedented-change/. Published December 9, 2014. Accessed March 16, 2016.

[8] SAMHSA. Criminal and Juvenile Justice Overview. SAMHSA. http://www.samhsa.gov/criminal-juvenile-justice. Accessed April 19, 2016.

[9] The National Center for Mental Health and Juvenile Justice (NCMHJJ) and the Technical Assistance Collaborative. Strengthening our future: Key elements to developing a trauma-informed juvenile justice diversion program for youth with behavioral health conditions. NCMHJJ. http://www.ncmhjj.com/wp-content/uploads/2016/01/traumadoc012216-reduced-003.pdf. Published 2016. Accessed April 21, 2016.

estimated rate in the prison population is between 4 and 10 percent, with even greater numbers presenting in jails and juvenile facilities.[10]

The Sequential Intercept Model

The Sequential Intercept Model, developed by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, is a well-researched and widely accepted conceptual framework for identification, assessment, and diversion of people with mental illnesses from the criminal justice system.[11] The Sequential Intercept Model identifies five intercept points at which action can be taken to prevent persons with mental illness from becoming more deeply involved with the criminal justice system. While a number of individuals will continue to penetrate the criminal justice system due to the presence of criminogenic risk factors that need to be addressed, there are opportunities to divert individuals at each of the five intercept points identified within the Sequential Intercept Model. The five intercept points are incorporated into the narrative below as a means of demonstrating movement through the criminal justice system. While a comprehensive review of the entire system using the Sequential Intercept Model is outside the scope of this report, this narrative serves as a backdrop for the JCAFS recommendations for a comprehensive plan for the coordination of forensic services.

Intercept 1: Law Enforcement/Emergency Services

The initial intercept point, which includes emergency services and pre-arrest diversion efforts, highlights the need for access to emergency and crisis response services, linkages to the right provider services, and specialized training for law enforcement. Community-based crisis response services at this level include crisis hotlines and Mobile Crisis Outreach Teams[12] as well as services such as the ones offered through Psychiatric Emergency Service Centers (PESC). PESCs are designed to stabilize crisis situations and to serve as stepdown options and alternatives to hospitalization and incarceration. The array of PESC programs available in a service area is based on the local needs of the community and is dependent upon Local Mental Health Authority (LMHA) funding.

Descriptions of PESC programs include the following:

- Extended Observation Units provide up to 48 hours of emergency services in a secure and protected, clinically staffed, psychiatrically supervised environment with immediate access to urgent or emergent medical and psychiatric evaluation and treatment.
- Rapid Crisis Stabilization Beds provide short-term (i.e., up to 3 to 10 days) of rapid crisis stabilization in psychiatrically staffed local hospital settings.

[10] Davis LA. People with Intellectual Disabilities in the Criminal Justice Systems: Victims & Suspects. The Arc for People with Intellectual and Developmental Disabilities. http://www.thearc.org/document.doc?id=3664. Accessed March 16, 2016.

[11] Munetz MR, Griffin PA. Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psych. Services*, 2006; 57: 544-549.

[12] Mobile Crisis Outreach Teams provide immediate responses to psychiatric crises by going to the location where a crisis is occurring; this service is available 24 hours a day, with medical and mental health professionals responding to calls from multiple sources (e.g., homes, schools, clinics).

- Crisis Stabilization Units (CSU) are licensed facilities that provide short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected, clinically staffed, psychiatrically supervised environment.
- Crisis Respite Units provide up to seven days of short-term, crisis care for individuals with low risk of harm to self or others.
- Crisis Residential Units provide up to 14 days of crisis services in a clinically staffed, safe residential setting for individuals with some risk of harm to self or others.

Initiatives such as the utilization of Crisis Intervention Teams aim to reduce the need for justice system involvement. Crisis Intervention Teams consist of specially trained law enforcement officers who work to safely and effectively address the needs of persons with mental illness while linking them to appropriate services and potentially serving as a diversion from the criminal justice system.[13]

Intercept 2: Post Arrest - Initial Detention/Initial Court Hearings

Following arrest, actions such as screening for mental illness and suicidality in the jails, utilizing pre-trial diversion programs, and connecting people with comprehensive, evidence-based services are all steps that can be taken to reduce continued involvement with the criminal justice system. At this stage, there are also opportunities to educate justice professionals on how to identify persons with mental illness and to respond in ways that minimize potential for trauma and maximize opportunities for intervention.

Intercept 3: Post Initial Hearings - Jails/Prisons, Courts, Forensic Evaluations, and Forensic Commitments

Intercept 3 includes specialty courts, such as mental health courts, jails and prisons, forensic evaluations, and forensic commitments. At this intercept point, there is a need for expanded access to treatment services for mental health and substance use disorders, utilization of evidence-based interventions and programs, and linkages to comprehensive services and supports. For the purposes of this report, detailed information regarding the types of forensic commitments and the state's forensic waiting list for inpatient hospital admission is provided in a separate section. This is to allow for a more in-depth overview of the processes associated with the forensic population and to highlight the current forensic demand on the state hospital system and the subsequent impact this has on local jails and the broader community.

Intercept 4: Reentry from Jails, State Prisons, and Forensic Hospitalization

With respect to reentry, there is a need for easy access to an array of community-based programming for individuals transitioning to less restrictive levels of care, regardless of where they reside in the state. Community-based services and supports, such as intensive case management, supportive housing and employment, psychosocial rehabilitation services, and peer support services can assist in promoting successful reentry from correctional or hospital settings. However, justice-involved individuals face considerable challenges accessing many community

[13] Watson AC, Fulambarker AJ. The Crisis Intervention Team model of police response to mental health crises: A primer for mental health practitioners. *Best Pract Ment Health*. 2012; 8: 71-81.

supports, such as housing and employment. Supportive services that assist individuals with securing and maintaining permanent housing are crucial to the success of those returning to the community.

Intercept 5: Community Corrections/Community Support Services

Effective interventions require ongoing collaboration and communication between justice professionals and those providing behavioral health treatment and other supports. Case management services and community supports allow for continuity of care and assist individuals in maintaining compliance with conditions of probation or parole.

Types of Forensic Commitments

As described above, intercept 3 is the point at which forensic commitments occur. The two types of forensic commitments (i.e., incompetent to stand trial and not guilty by reason of insanity) and their associated processes are described below.

Persons Found Incompetent to Stand Trial

The complex procedures for determining whether an individual charged with a criminal offense is competent to stand trial are outlined in Texas Code of Criminal Procedure (CCP) Chapter 46B. The standard for determining competency in Texas mirrors the standard set forth by the United States Supreme Court in *Dusky v. United States* (362 U.S. 402 (1960)), a landmark case that found that a criminal court cannot proceed against defendants who do not understand the charges against them and are unable to assist their lawyers in mounting a defense. Under the CCP, a "person is incompetent to stand trial if the person does not have: (1) sufficient present ability to consult with the person's lawyer with a reasonable degree of rational understanding; or (2) a rational as well as factual understanding of the proceedings against the person.[14]" The issue of competency may be raised by defense, prosecution or the court and applies in cases where an individual is charged with a felony or misdemeanor punishable by confinement. The CCP also sets forth the procedures for evaluating the individual's fitness to proceed.

There are several options available to criminal courts to attempt to restore the individual's competency to proceed. Individuals may be committed to an inpatient mental health facility or residential care facility (state supported living center) or released on bail and restored to competency in an outpatient setting. The Legislature also authorized the creation of two jail-based competency restoration pilot programs during the 83rd session (Senate Bill 1475). To date, no individuals have been served under the pilot. The CCP also sets forth procedures if the individual is incompetent to stand trial and determined unlikely to be restored in the foreseeable future.

An individual found incompetent to stand trial may be released on bail and ordered to participate in an outpatient treatment program if the court determines the individual is not a danger to others, may safely be treated on an outpatient basis, and if necessary treatment is available in the community. If each of these criteria are met, the court has discretion to release an individual

[14] Texas Code of Criminal Procedure 46B.003(a).

charged with a felony on bail. Release of a defendant charged with a misdemeanor on bail is mandatory, subject to consideration of public safety and the availability of treatment. Texas currently has 12 outpatient competency restoration programs operated by LMHAs across the state[15]. These programs, which were first authorized by the Legislature in 2007, have helped to decrease pressure on the state hospital system. Currently, the outpatient competency restoration programs have the capacity to serve a target of 324 individuals across the twelve LMHAs.

With respect to inpatient competency restoration, an individual charged with an offense specified in CCP Article 17.032 (a) (e.g., capital murder, aggravated robbery, and others) or with an offense not listed in Article 17.032(a) but involving use or display of a deadly weapon or firearm, will first be committed to a Maximum Security Unit (MSU) of a state hospital. Currently, the MSU programs are located at North Texas State Hospital (NTSH)-Vernon Campus and Rusk State Hospital. Individuals with an intellectual disability charged with an offense as described above are first admitted to the MSU at NTSH-Vernon Campus for treatment. When the individual is deemed not manifestly dangerous[16] by a review panel, they are then transferred to the designated forensic facility for persons with intellectual disabilities. An individual who is not charged with an offense requiring MSU admission will be committed to a non-maximum security facility (i.e., a state hospital, contracted facility or state supported living center) for restorative treatment.

The initial competency restoration period is a maximum of 60 days for misdemeanors and a maximum of 120 days for felonies. The head of the facility providing competency restoration treatment may request one 60-day extension of the restoration order for individuals charged with a felony or misdemeanor if the treatment team believes competency is achievable within 60 days of the expiration of the initial commitment. Following an initial competency restoration commitment, an individual who has not attained competency and whose charges are still pending may be placed on an extended commitment for continued competency restoration services, but only if the individual meets civil commitment criteria. The CCP incorporates the civil commitment standards set forth in the Health and Safety Code when addressing the issue of extended commitments for persons with a mental illness or intellectual disability. The maximum period of restoration is determined by the maximum term of confinement for the underlying offense. For individuals charged with a misdemeanor, the maximum term of restoration is two years.

[15] The 12 outpatient competency restoration programs are operated by the following LMHAs: Austin Travis County Integral Care; Center for Health Care Services; MHMR Tarrant County; NorthStar/ValueOptions; Starcare Specialty Health System; Emergence Health Network; Andrews Center Behavioral Healthcare System; Tri-County Services; Behavioral Health Center of Nueces County; Spindletop Center; Community Healthcore; and Heart of Texas Region MHMR Center.

[16] The term manifestly dangerous is used to describe an individual who, despite receiving the appropriate level and type of treatment, remains a danger to others and requires placement in an MSU to continue treatment and protect the public. It is important to note that in addition to those on forensic commitments who are admitted to an MSU as described in this report, there are also individuals on civil commitments who are deemed manifestly dangerous by a review panel and admitted to an MSU until determined to no longer be manifestly dangerous.

Individuals Found Not Guilty by Reason of Insanity

The procedures for determining whether an individual is not guilty by reason of insanity (NGRI) are found in CCP Chapter 46C. The term insanity is defined in Texas Penal Code Section 8.01 as an "affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong." The term 'mental disease or defect' specifically excludes "an abnormality manifested only by repeated criminal or otherwise antisocial conduct."

Individuals found NGRI are acquitted of the underlying offense. However, if the offense for which a person is found NGRI involved serious bodily injury, imminent threat of serious bodily injury, or threat through the use of a deadly weapon, the criminal court retains jurisdiction of the case until either the court discharges the person and ends its jurisdiction or the cumulative total of inpatient, outpatient, and community-based supervision equals the maximum term provided by law for the offense for which the person was acquitted. If the person is acquitted for an offense involving non-dangerous conduct, the criminal court determines whether the individual may be a person with mental illness or intellectual disability. If so, the criminal court then transfers the case to the appropriate court overseeing civil commitment proceedings and the individual can only be further detained if they meet civil commitment criteria.

In cases involving serious bodily injury, imminent threat of serious bodily injury or threat through use of a deadly weapon, individuals are initially admitted to an MSU (currently NTSH-Vernon or Rusk State Hospital) for a period of not more than 30 days for the purposes of evaluation and treatment. A disposition hearing is then held to determine whether the acquitted person has a severe mental illness or intellectual disability; whether he or she is likely to harm someone as a result; and whether treatment and supervision can be safely and effectively provided in the community. Under CCP Article 46C.256, "the court shall order the acquitted person committed to a mental hospital or other appropriate facility for inpatient treatment or residential care if the state establishes by clear and convincing evidence that: (1) the person has a severe mental illness or intellectual disability; (2) the person, as a result of that mental illness or intellectual disability is likely to cause serious bodily injury to another if the person is not provided with treatment and supervision; and (3) inpatient treatment or residential care is necessary to protect the safety of others." Commitment orders to inpatient or residential care expire on the 181st day following the date the order is issued, and the court determines annually whether to renew the order of commitment. Commitment orders may be modified by the court to allow for outpatient or community-based treatment and supervision if it is determined that the individual can safely and effectively receive treatment and supervision in an outpatient setting.

All individuals committed to an inpatient mental health or residential care facility are initially committed to an MSU. However, unless the individual is determined to be manifestly dangerous by a DSHS review board, the individual must be transferred to a non-secure state hospital or state supported living center within 60 days.

Following acquittal, outpatient or community-based treatment may be ordered under the following circumstances under CCP Article 46C.257: if the state established by clear and convincing evidence that the individual has a severe mental illness or intellectual disability and,

as a result, is likely to cause serious bodily injury to another if not provided with treatment and supervision, and the state fails to establish by clear and convincing evidence that inpatient treatment or residential care is necessary to protect the safety of others. The order for outpatient care expires on the first anniversary of the date it was issued, but may be renewed in certain circumstances.

An individual initially committed to an inpatient facility or residential care facility can be ordered to receive continued treatment and supervision in the community following an inpatient stay if the court finds that the individual does not present a public safety risk and the court receives and approves an outpatient treatment and supervision plan. These plans are generally developed and overseen by LMHAs and the criminal court retains jurisdiction over the individual. Outpatient commitment orders may be modified or revoked in certain circumstances and must be renewed annually.

For individuals found NGRI, the term of commitment to a state hospital, residential facility, or outpatient or community-based treatment program cannot exceed the maximum term of the offense for which they were acquitted. Further confinement following the expiration of an individual's maximum term can only occur under civil commitment proceedings. For some individuals found NGRI, there are limited options for placement outside of the hospital setting. This may be due to long-term housing and specialized care needs that cannot be met with currently available community-based programming.

The Forensic Waitlist

DSHS provides inpatient psychiatric services in nine state hospitals. The maximum security units for the state hospitals are located at NTSH-Vernon Campus and Rusk State Hospital. DSHS contracts with Montgomery County Mental Health Treatment Facility for 94 forensic beds. In addition, Harris Center for Mental Health and IDD subcontracts with Harris County Psychiatric Center for 23 forensic beds; and, most recently, Anderson Cherokee Community Enrichment Services subcontracts with Palestine Regional Medical Center for 20 forensic beds. While there have been additions to the number of contracted community hospital beds available in the state, DSHS has not increased its number of state-operated psychiatric hospital beds. Rather, DSHS has experienced a decrease in the number of available state-operated psychiatric beds due to issues such as facility maintenance and repair needs and mental health professional staffing shortages.

Between January 2001 and January 2016, the forensic population grew from 16 to 52 percent of the total state psychiatric hospital population.[17] This population increase has been accompanied by a sharp rise in the forensic waitlist for state psychiatric hospital services. This waitlist results in individuals waiting in county jails pending a state psychiatric hospital admission. As of April 20, 2016, there were 395 individuals waiting in local jails pending admission to a state psychiatric hospital. Of the 173 individuals waiting for a non-maximum security bed, 77 had been waiting over 21 days. Of the 222 individuals waiting for a maximum security bed, 180 had been waiting over 21 days.

[17] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support, February 2016.

Factors contributing to wait times include current state hospital bed capacity, effective recruitment and retention of a qualified workforce, and suitable discharge options, including housing, for those who are ready to stepdown to a less restrictive level of care. Longer lengths of stay may also contribute to wait times by decreasing the number of beds available for new admissions. Between 2001 and 2014 the number of individuals residing in a state psychiatric hospital for over a year grew from under 400 to over 700.[18] Some individuals who have been hospitalized for a long period of time no longer require hospital-level services but appropriate support is not available in the community; moving such individuals to less restrictive settings would free up additional bed capacity for new admissions.

Strengths of the Current System

There are a number of strengths within the current system that should be considered when building a comprehensive plan for forensic services. Many professionals, paraprofessionals, and other staff members at the state psychiatric hospitals who work with individuals deemed incompetent to stand trial or NGRI have a high level of expertise with the forensic population, and some state hospitals have programs that specialize in working with specific populations. Additionally, there has been a shift across the state to operate from a more recovery-oriented, person-centered approach. Such an approach supports the use of evidence-based practices that assist people in living in a physically and emotionally healthy way. Statutory provisions in Texas support diversion, and all LMHAs have jail diversion plans and activities. With 12 outpatient competency restoration programs across the state, Texas is a national leader in outpatient competency restoration services,[19] which help decrease costly hospitalization of individuals who do not require an inpatient level of care. Additionally, in many rural areas where traditional outpatient competency restoration programs are not available, an increased focus on early identification and initiation of psychiatric services in the jails has proven effective. The Texas Department of Criminal Justice's Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) provides a continuity of care system through statewide agreements with LMHAs for persons adjudicated to the juvenile justice system, adults sentenced to probation, and those released from prison to the community who have a severe or persistent mental illness. Additionally, TCOOMMI, in partnership with several LMHAs, initiated Jail Diversion programs for those arrested with a mental illness in an effort to divert individuals from further engagement with the criminal justice system. Finally, there has been a move across the state towards using certified peer specialists with forensic populations. Peer specialists can be incorporated along the entire continuum of forensic services to support diversion from the system as well as successful reentry into the community. Building upon strengths such as the ones listed here will be essential to the success of a comprehensive plan for the coordination of forensic services.

[18] Department of State Health Services, Division of Mental Health and Substance Abuse Services, Office of Decision Support, April 2016.
[19] Hogg Foundation for Mental Health. Texas outpatient competency restoration programs. Hogg Foundation for Mental Health. http://utw10282.utweb.utexas.edu/wp-content/uploads/2015/09/EvaluationReport_091815.pdf. Published August 2015. Accessed March 31, 2016.

Limitations of the Current System

The current system does not have sufficient capacity or the array of services and supports for the mental health and substance use treatment necessary to meet the demands of the forensic population; and the state is currently at a crisis point with respect to its hospital bed shortage. This shortage results in extensive wait times in jails for those pending inpatient admission, thus taxing the resources available through the local jails and delaying receipt of necessary psychiatric services. Facility repair needs, professional workforce shortages and potential inefficiencies in hiring processes contribute to the current hospital crisis by reducing the number of beds available for use. When one considers the state's overall population growth and the more specific growth of the forensic population within the state system over the past 15 years, the state's inability to keep pace with the forensic demand becomes even more alarming.

Addressing the needs of the current system will require focused attention on the capacity issues at state-operated hospitals (i.e., an increase in bed capacity) as well as more general attention to the ability of the public mental health system as a whole to provide the necessary services and supports for persons with serious mental illness and co-occurring substance use disorders. Texas has a high percentage of adults with mental illness who are medically uninsured; and those who are uninsured have few, if any, alternatives for care other than the public health system, which is one of the lowest per capita funded in the nation. The current system has limitations in its capacity to adequately assess and intervene for the purposes of crisis stabilization and early intervention. Furthermore, the current system is limited in its ability to address the needs of populations such as geriatric populations and those with intellectual disabilities who have specialized treatment and service needs. As an example, forensically-involved individuals who present with significant cognitive impairments or brain injuries that require long-term treatment and supports are difficult to place outside of the hospital setting due to a lack of available programs designed to meet their needs. Transitioning from the state hospitals to the jails, one finds disparate drug formularies and continuity of care issues impacting individuals returning to jails following competency restoration; this disparity can lead to decompensation and renewed need for competency restoration. Finally, those reentering the community following incarceration or hospitalization may experience barriers to community supports such as housing and employment that impede their opportunities to transition successfully.

Recommendations for a Comprehensive Plan for the Coordination of Forensic Services

Several key issues were identified by the JCAFS in the development of this report. Among these, was the recognition that the needs, resources, and expertise available across the state vary significantly; thus, a singular approach to forensic care simply will not work. With this in mind, the JCAFS recommends the development of a plan that acknowledges the variable needs and resources across the state. Pressing issues related to resources are at the forefront of the JCAFS concerns. As such, specific recommendations related to increasing resource capacity are presented first and are followed by recommendations the committee believes are necessary for the overall development of a comprehensive plan for the coordination of forensic services. These recommendations cover three broad areas: emergency services, law enforcement, and post-arrest diversion from the criminal justice system (intercepts 1 and 2); forensic services following initial court hearings (intercept 3); and reentry and community services and supports (intercepts 4 and

5). Finally, the committee's recommendations for a comprehensive plan for the coordination of forensic services conclude with a series of recommendations that are relevant across all intercept points and should serve to impact the system as a whole.

Resource Recommendations

It currently appears that the public mental health system has serious limitations at all levels of care, both in capacity and in the array of services and supports available to address the needs of Texas residents and achieve positive clinical and recovery outcomes. These deficiencies have led to unintended consequences, such as an overreliance on emergency and inpatient services and criminal and juvenile justice involvement. Although recovery is optimal and possible, serious mental illnesses tend to be chronic conditions requiring ready access and ongoing availability of an array of services responsive to individual needs.

Today, the state's public mental health system struggles to meet that goal. The legislature's recent investments in behavioral health services have helped many individuals and communities across the state, but there are still critical resource needs throughout the continuum of care, with significant gaps and limitations in the state's ability to provide timely emergency response and diversion, crisis stabilization, inpatient treatment, and reentry and long-term community services and support. The JCAFS has not had sufficient time to develop specific resource recommendations in each of these areas, but the absence of explicit numbers does not imply that these services are of secondary importance. Large numbers of individuals across the state with unmet behavioral health needs are ending up in emergency rooms and jails, disrupting families and communities and straining local resources. Without further investments in community-based services, the need for inpatient care will remain unchecked. The JCAFS will continue its work in the coming months to quantify the critical needs in these areas.

Inpatient Services

The committee has built upon past work to make specific recommendations regarding inpatient capacity, where the need is both acute and urgent. In 2014, DSHS consultants assisting with the State Hospital System Long Term Plan developed a methodology to capture the unmet need for hospital beds. The forecast methodology incorporates factors that include incidence and prevalence rates, the steady growth in population, changing demographics, trends such as an increase in the forensic population, the future role of the state hospitals, and changes in the continuum of care. Using this model, the CannonDesign consultants suggested a need of about 4,300 state-funded beds in 2014, and an additional 50 new beds per year to address anticipated changes in demand.

The consensus of the JCAFS is that the best available estimate of current need in Texas is about 4,400 beds, which accounts for population growth since 2014. Currently there are about 3,000 DSHS-funded psychiatric beds in Texas, if state hospital beds and purchased community beds are included.[20] Therefore, about 1,400 new beds are necessary to meet the committee's

[20] Note, the actual number of available beds within the state-funded psychiatric hospital system may vary depending upon hospital staffing shortages and issues pertaining to facility maintenance and repair.

consensus recommendation. In addition, the committee agrees that an additional 50 beds will need to be brought online each year to accommodate projected population growth.

The JCAFS recognizes that operating an additional 1,400 beds at the current average cost for state hospital beds may cost over $300 million annually (not inclusive of any potential construction costs). Moreover, there are significant limitations on the state's ability to quickly add state-operated capacity, including staffing challenges and facility deficits, making a substantial increase in state hospital capacity a long-term strategy. But the current demand need not be for state-operated hospital beds alone. DSHS should be able to meet some of this need by contracting for additional acute psychiatric capacity, although the cost per bed day is likely to be higher and the number of beds available for state contracting is not fully known. While this strategy has proven successful in expanding access to inpatient care, it must be recognized that local hospitals are not equipped to treat the many patients with very high acuity and complex needs, including large numbers of forensic patients.

Over the next eight years, the JCAFS recommends adding 1,800 beds to meet the existing need and accommodate population growth. Given the challenges in adding new capacity, the JCAFS consensus is that the most prudent approach would be a significant initial expansion of state-operated and state-funded inpatient capacity, to include additional maximum security beds, followed by a gradual increase in beds to meet both the current and future demand. After the immediate need for substantially greater access to inpatient care is addressed, further investments in other types of beds (such as extended observation, detoxification, and crisis stabilization beds) may prove to be a cost-effective option that reduces the longer-term need for hospital beds. Over the long term, a mix of bed types based on regional needs and ensuring prompt admission to the appropriate level of care may achieve goals related to access at the most efficient cost.

While these estimates of current and future hospital bed needs are intended to provide sufficient capacity for both civilly and forensically committed individuals, inpatient resource needs cannot be addressed in isolation. The level of demand for inpatient care depends, in part, upon the array and availability of community-based services.

Community-based services

Hospital services must be embedded in a community-driven system designed to promote recovery, respond effectively to crises, and reduce the need for inpatient care. Every local service area must offer access to an integrated array of essential services and supports for individuals with behavioral health needs. These include outreach and engagement, outpatient mental health and substance use treatment services, peer support services and recovery supports, a range of appropriate living environments, supported employment services, service coordination, and primary healthcare. Services should be readily available, robust, and easily accessible. With a strong system of services and supports, most individuals can maintain stable lives in the community. When individuals do experience crises, there must be a coordinated emergency response system with law enforcement and mental health professionals working together to divert individuals away from inappropriate forensic involvement. To avoid unnecessary hospitalization, communities must also have a range of local crisis stabilization alternatives for both adults and children.

For individuals who are hospitalized, successful transition back to the community requires prompt connection with ongoing treatment and a stable, appropriate living environment. Such placements can be difficult to find for individuals with lengthy hospitalizations, forensic involvement, or functional impairments. Many of these patients remain in the hospital when they no longer need inpatient care simply because an appropriate placement is not available, while others are discharged to settings that lack the necessary supports, leading to repeated destabilization and crisis. The lack of appropriate long-term community living environments fuels the need for hospital beds.

The demand for inpatient care is increasingly driven by growing numbers of forensic commitments. Timely access to appropriate services in the community is the foundational 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. As described in this report, these strategies include diversion and appropriate services on the front end, prompt initiation of services when individuals are incarcerated, community-based forensic programs, and reentry services for individuals transitioning back to the community.

Emergency Services, Law Enforcement and Post-Arrest Diversion

Consideration must be given to services and supports that are designed to keep individuals from penetrating the criminal justice system. In general, successful diversion from the criminal justice system requires robust community services and programs, to include peer support and peer crisis services; education about mental illness through such evidence-based courses as Mental Health First Aid[21]; opportunities to serve people in the least restrictive settings; adequate capacity for timely service delivery for all levels of care; and adequate supports and resources for local law enforcement and county jails.

Recommendations regarding specific objectives and strategies as they relate to the first two intercept points include the following:

- Increase available services and supports.
    - Building upon existing infrastructure and best practices, explore ways to enhance the exchange of information between law enforcement and mental health service providers.
    - Expand support for jail diversion programs and strategies, including Crisis Intervention Team models, mental health deputy programs, and the utilization of criminogenic risk assessments.
    - Consider providing funding in at least 10 additional communities over the next biennium to replicate law enforcement diversion programs such as Crisis

[21] Mental Health First Aid is an evidenced based training program that teaches individuals about the signs, symptoms and risk factors associated with mental illness and substance abuse and how to respond when faced with a person who is experiencing a mental health crisis. Additional information on Mental Health First Aid can be accessed at http://www.mentalhealthfirstaid.org/cs/.

Intervention Response Teams and Law Enforcement Assisted Diversion[22] as well as adaptations that have proven successful in rural areas.
    - Provide funding to replicate community PESC[23] programs in at least 10 additional communities over the next biennium.
        - Consider funding for additional crisis centers in rural and urban areas that allow police to directly transport those in crisis. These centers could be strategically located around the state to expand available options beyond local jails or hospitals. Individuals could be held in such settings on an emergency detention and evaluated for risk of harm to self or others.
- Provide additional training and professional oversight.
    - Provide education and training to law enforcement, courts, and attorneys:
        - Services provided by the LMHAs and hospitals, to include capacity limits;
        - Programs designed to serve as alternatives to incarceration and hospitalization; and
        - Existing statutes pertaining to the criminal competency and civil commitment processes and legal ethics.
    - Evaluate minimum training standards for law enforcement and explore opportunities to enhance current training efforts using best practices.

Forensic Services following Initial Court Hearings

For those under the umbrella of criminal justice, special attention must be paid to those for whom the question of competency has been raised, those found incompetent and not likely to be restored in a reasonable time period, and those deemed NGRI. In addition, attention and focus must be given to persons with cognitive impairments, intellectual disabilities, or brain injuries as well as juveniles and those who have reached a reduced level of functioning due to age and/or health condition. Each of these groups presents its own set of challenges when seeking access to behavioral health services and supports.

Interventions and supports for the forensic population (i.e., those found incompetent to stand trial or not guilty by reason of insanity) includes inpatient and outpatient competency restoration and behavioral health services. While hospital-based services are an important part of the continuum of care for some individuals, effective treatment necessitates adequate community-based resources so that individuals can be served in the least restrictive environment and close to home whenever possible. This includes earliest possible access to appropriate medications and comprehensive treatment and supportive services.

Recommendations regarding specific objectives and strategies for individuals as they relate to intercept 3 include the following:

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[22] Law Enforcement Assisted Diversion (LEAD) is a pre-booking diversion program that utilizes a harm reduction framework for approaching substance use, with participants offered immediate access to treatment services. Additional information on LEAD can be found via the following resource: Drug Policy Alliance. Law Enforcement Assisted Diversion (LEAD): Reducing the Role of Criminalization in Local Drug Control. Drug Policy Alliance. http://www.drugpolicy.org/sites/default/files/DPA%20Fact%20sheet_Law%20Enforcement%20Assisted%20Diversion%20%28LEAD%29%20_%28Feb.%202016%29.pdf. Published February 2016. Accessed May 3, 2016.

[23] An overview of PESC projects is provided on pages 5 and 6 of this document.

- Increase state hospital bed capacity and improve service delivery for individuals at hospital and community-based levels of care.
    - As noted previously, unless action is taken, the forensic population detained in Texas county jails and court-ordered to receive services in a state psychiatric hospital will continue to grow. Local tax payers pay for holding this population in county jails without reimbursement from the state. The entire process from commitment to admission takes an extensive length of time and subsequently impacts not only those who are waiting for a forensic bed but also those who are waiting for a bed following a civil commitment. With these concerns in mind, the state must increase the number of inpatient forensic beds in the state psychiatric hospital system. However, it is important to maintain civil beds capacity. As such, the increase in forensic beds must be in addition to, and not in lieu of, civil beds.
    - Using available data, evaluate the capacity for forensic patients moving through the system with a specific focus on the flow of individuals through the MSU and the delays that occur in accessing and transitioning from this particular setting.
    - Consider strategies to expand the use of alternative restorative treatment for individuals based on charges and criminogenic risk.
- Assure that controlling laws and agency regulations permit outpatient competency restoration programs that include a community-based residential component.
- Explore ways to better meet the housing and employment needs of justice-involved individuals, including those in outpatient competency restoration programs.
- Consider a system for qualitative oversight of competency evaluations completed by practitioners in the field.
- Address the needs of specific populations.
    - Explore ways to support specialization of services and opportunities to build expertise with specific populations, to include treatment of juvenile offenders.
    - Identify alternatives to effectively address the needs of individuals with intellectual disabilities.
    - Individuals with intellectual disabilities charged with offenses that require MSU admission currently go to NTSH-Vernon Campus and then to the Mexia State Supported Living Center or San Angelo State Supported Living Center after being found not manifestly dangerous. This flow creates a backlog for individuals with intellectual disabilities requiring admission to an MSU. Consideration should be given to reviewing offenses listed in Article 17.032(a) CCP, to determine whether any of those offenses may be exempted from the requirement to commit an individual with an intellectual disability to an MSU.
- Explore ways to support county jails in addressing the behavioral health needs of persons incarcerated and include county sheriffs and jail administrators in program development efforts when establishing behavioral health programs in county jails.
- Address the disparate formularies and continuity of care issues present following restoration and return to jail. The transition from the state hospital system to the jails following competency restoration raises concerns about access to necessary medications. In some instances, individuals transitioning back to jail following competency restoration do not have access to the specific medication they received while in the state hospital due to disparities in the drug formularies utilized by the two systems. This lack of access to medications that have proven effective can lead to disruptions in care or, potentially, to a

need for readmission to the state hospital for renewed competency restoration. Addressing this concern may be accomplished by capitalizing on formularies currently utilized by state hospitals and LMHAs while taking into consideration the unique circumstances and needs of the different systems. In addition, it is important to support county jails in this area, as they should not assume the cost of paying for needed medications not on their formulary.

Reentry and Community Services and Supports

Following incarceration or hospitalization, it is particularly important to establish strong aftercare or community plans that incorporate necessary services and supports. Access to an array of services and supports that engage those with serious, complex conditions (i.e., mental health, substance use and significant medical conditions) is necessary to reduce recidivism and increase likelihood of success in the community. This is particularly true for those who are impoverished or homeless. Without appropriate living alternatives, individuals cannot successfully engage in services over time. In addition, opportunities within the area of reentry include the possible provision of transitional services through regional programming and the training and utilization of peer support specialists.

Recommendations regarding specific objectives and strategies as they relate to intercepts 4 and 5 include the following:

- Establish a statewide advisory psychiatric review board to provide state hospitals with consultation regarding the release of long-term forensic individuals from facilities; this board would include representation from the community.
- Consider a regional model for transitioning individuals out of the state hospital system.
    - Explore ways in which the 1915(i) Home and Community-Based Services Medicaid Waiver may be utilized to help establish the services and supports needed in a regional transitional program.
- Consider methods for providing LMHAs with incentives for developing post-discharge placements. If a state hospital or facility recommends discharge, LMHAs should seek appropriate placement for the individual and present this to the court. At a minimum, LMHAs should be expected to articulate the steps taken to find an appropriate placement. Moving forward, these efforts could serve to help highlight specific areas of need and support the development of increased placement options for persons with criminal histories and co-occurring medical or specialized treatment needs.
- Examine community-based programming needs and opportunities. Five areas of importance that must be considered when exploring options for reintegration are: housing, employment, transportation, medical needs, and peer support.
    - Consider services and supports for community living for individuals with long-term medical or neuropsychiatric needs who no longer require inpatient hospitalization.
    - Identify ways to support individuals in gaining access to benefits when getting out of county jails so they can continue with any healthcare treatment regimen that has been successful for them.
    - Evaluate the need for expansion of community-based programming for individuals on probation and parole with behavioral health needs.

    - Address the quality of care provided at personal care homes that are utilized as transitional or stepdown facilities as well as the level of oversight in these homes across the state.
- Evaluate the need for a statutory conditional release program designed to provide community support and treatment. Forensic conditional release programs are typically designed for use with individuals who have been found NGRI.
- Develop a mechanism to track recidivism for NGRI individuals and those who have been restored to competency and discharged from state hospitals. This can be accomplished by identifying the total population of NGRI and restored individuals discharging from state hospitals within the fiscal year of study using representative samples. Each case would then be researched to determine whether individuals were subsequently hospitalized within three years of discharge. The recidivism rate reported in one fiscal year (i.e., 2015) refers to the fiscal year sample of discharged individuals three years prior (i.e., 2012). The total number of recidivates who returned to the state hospital system within three years of discharge would then be divided by the total number of the sample and multiplied by 100 to obtain the three year recidivism rate.
- TCOOMMI programs address continuity of care needs for those released from incarceration and those released from the hospital if they are on supervision. Continue to support collaborations with TCOOMMI in response to continuity of care and diversion activities for those clients released from prison or on probation.

General Recommendations for the Coordination of Forensic Services

The JCAFS identified several recommendations that are relevant at all or multiple points along the continuum. Specific recommendations that address the system as a whole include the following:

- Conduct a functional inventory of forensic programs, services, available expertise, and academic partnerships. This would allow for better understanding of the limits and potential of the state's forensic system, to include the state's juvenile system. Using the Sequential Intercept Model to evaluate the five intercept points in each region of the state would allow for a systematic evaluation of the needs and gaps of the current system. This would also provide consistency when considering the varying needs that exist throughout the state (e.g., the needs in rural versus urban areas) and create opportunities to draw on regional strengths when addressing the needs of the system. Included in this inventory, and in all work done to enhance the coordination of forensic services, there should be an overarching direction to work with best practices and with fidelity to the models utilized.
- Expand the use of certified peer specialists, recovery coaches, and family partners along the entire continuum of care. Increasing access to peer support services along the service continuum is a cost-effective strategy for supporting engagement and improving outcomes.
- Track the progress of pilot programs and other emerging models of care.
- Support ongoing statewide recruitment and retention efforts and academic partnerships to help address workforce shortage issues. The 2014 Legislative Report entitled *Mental*

Health Workforce Shortage in Texas[24] offers specific suggestions for addressing the mental health workforce shortage across the state. These suggestions serve as a solid foundation for addressing issues pertaining to statewide recruitment and retention efforts.

- Given that state psychiatric facilities are unique in the DSHS system (e.g., they are open 24 hours a day, seven days a week and employ a high percentage of all DSHS employees), the department should be tasked with conducting a review of work processes for the purpose of identifying opportunities to improve effectiveness and efficiency with regards to staff recruitment and retention.
- Explore ways to more efficiently and more fully utilize existing laws and authority as well as current best practices, to include expanding the use of outpatient competency restoration.
- Support the use of telemedicine and/or sharing of expertise between state systems to assist with immediate needs. Provide an additional funding pool to support infrastructure needs for acquiring necessary, state-of-the-art telemedicine equipment.

In addition to the recommendations for a comprehensive plan for the coordination of forensic services listed above, the JCAFS encourages the legislature to consider forming a taskforce to review relevant statutes, including the Mental Health Code, Chapter 55 of the Texas Family Code, and Chapters 46B and 46C of the Code of Criminal Procedures to identify potential changes. To support such an effort, the JCAFS will begin to highlight areas in relevant statutes related to forensic services that may benefit from updates or changes. Specific examples of some potential changes that may serve to improve the overall flow and coordination of forensic services include the following:

- Courts in several jurisdictions, including Texas, have found that substantial waits in jail for a hospital bed following a determination of incompetency violates the constitutional rights of pre-trial detainees. Texas should consider a statutory cap on the number of days an individual can be housed in jail after an order for restorative treatment in an inpatient facility is issued.
- Consideration should be given to statutory changes that would allow the state to better serve persons with intellectual disabilities who are on forensic commitments as outlined in CCP Chapter 46B.

Conclusion

Effective coordination of public mental health and forensic services should divert appropriate low level offenders and reduce delays in the legal process as well as increase access to treatment at the appropriate level of care, reduce wait times for inpatient psychiatric services, and increase statewide use of community-based alternatives and diversion programs. The JCAFS recommends developing a plan for the coordination of forensic services that utilizes the research base and structure of the Sequential Intercept Model to successfully address the needs of Texas' forensic population. Such a plan should be flexible enough to meet the variable needs of the different regions of the state while allowing for overall coordination and support of the forensic service delivery system. In addition, this plan must consider the impact of increased forensic

[24] DSHS Legislative Report. Mental Health Workforce Shortage in Texas. As required by House Bill 1023, 83rd Legislature, Regular Session. September 2014.

commitments on the state psychiatric hospitals, the urgent need to address the current shortage of available hospital beds, and the need to address gaps in the current service delivery system.

As a comprehensive plan for forensic services develops, further exploration of the forensic programs, services, expertise, and academic supports available across the state may prove beneficial as a means of highlighting existing gaps and identifying potential opportunities within the state's forensic system. In addition to the recommendations for forensic services outlined in this report, the JCAFS encourages the legislature to consider forming a taskforce to examine relevant statutes, including the Mental Health Code, Chapter 55 of the Texas Family Code, and Chapters 46B and 46C of the Code of Criminal Procedures for potential changes.