ASH Redesign Phase III
Competency Restoration Workgroup Recommendations

The ASH Redesign Competency Restoration Work Group met throughout Phase III to focus further on the restoration process and determine recommendations to assist with the most appropriate and efficient use of a new ASH. This work group included members throughout the service area with a wide range of expertise to collaborate on solutions (Appendix A). The group made four recommendations.

Recommendation #1: Competency Restoration Continuum of Care in ASH region

The Austin State Hospital Redesign presents an opportunity to establish a model for a continuum of competency restoration and mental health treatment, providing the right care at the right time in the right place. As part of that continuum, the ASH Redesign Competency Restoration Work Group recommends establishing one or more less-restrictive step-down facilities on campus that can serve counties throughout the region (prior to individuals returning to their home communities) and represent a model of care to eventually be distributed across Central Texas. The goal of these facilities would be to provide a less restrictive, clinically more appropriate and less expensive transitional environment from the main hospital to provide or continue competency restoration in people who need it. Having it on campus could facilitate care continuity (e.g. a common formulary with ASH) prior to people returning to their home counties.

Historically the Texas State Hospital system has been the only statutory location for competency restoration for criminal court defendants and remains the typical default choice of many courts. Changes to the Code of Criminal Procedure in the last 20 years created options for restoration outside a secure hospital including unlocked residential facilities or outpatient community-based restoration. While these changes improved options for counties in the ASH region, they have not significantly decreased the use of ASH, in large part because the alternative restoration options lack sufficient resources to meet demand. As of the writing of this report, there are 397 people waiting for a bed at ASH for competency restoration. This wait list has continued to grow throughout the years rather than decrease, a trend that was compounded by the impact of COVID-19 and staffing shortages.

There are several problems that communities encounter that limit the use of alternatives to ASH. Less populated jurisdictions do not have the volume of appropriate defendants to justify the expense of an unlocked residential facility. Defendants who are homeless or unable to live with family members in these jurisdictions end up waiting for a secure hospital bed even though they may be appropriate for community-based restoration. In the

ASH Region there is a single residential community-based restoration program run by Integral Care for Travis County residents. Williamson County has an outpatient competency restoration program, but only for defendants that have a place to reside in the community. These options, although important for beginning to build out the continuum, are consequently very limited.

Many defendants are so acutely ill at the time they are adjudged incompetent that they cannot be safely treated in an unlocked residential facility. While most defendants improve enough to be able to be transferred to a residential program after initial inpatient treatment, some may not; these latter individuals need alternative long-term care facilities of varying acuity levels. For example, part of this population of defendants could be transferred from the high level of care in a secure hospital setting to a secure, but less restrictive step-down facility for continued restoration. This option might be especially useful for individuals charged with serious felony offenses such as murder, sexual assault, or aggravated assault, in which the charges require ongoing locked housing, whereas the clinical need no longer requires an acute care inpatient setting. Judges and prosecutors are reluctant to release these defendants into a community-based restoration setting and indeed the Texas Legislature has limited the use of personal bonds (which are required for community-based restoration) for such defendants.

Recommended Continuity of CR facilities:

Hospital: The new ASH will remain the most restrictive locked facility for the highest level of care as it was prior to the new build. Consequently, it is also the most expensive level of care due to staffing ratios and care rotations. There is no less restrictive residential setting on campus or substantially in the region.

Hospital Step-down: We propose a facility on campus that is less restrictive than the hospital, but still a locked facility, with a cost structure reflecting the lower level of care acuity. In the Phase I ASH Redesign Report such a 48-72 bed facility was recommended, but at the time the Legislature opted for a fully funded state of the art hospital without the additional facility for lower level care. Through a review of a rough escalation of costs, based on Phase I, a facility this size is estimated to cost $30-$90M on the campus. This committee recommends this facility be built upon completion of the hospital. A Step-Down facility can also be used as a direct commitment from local jails if hospital level care is not needed, but a locked environment is (i.e., because of charges). An evaluation could be made upon admission to ASH as to the least restrictive setting required both clinically and legally. A current example from Travis County that supports a Step-Down facility is from June 2022, where there are 23 people in ASH and 13 of which are currently on extended commitments that would potentially benefit from a step-down unit. By offering a Step-Down facility for these 13 individuals, the hospital would create a more efficient process for all individuals utilizing the hospital and increase the functional bed capacity of ASH.

Residential/Inpatient: To expand the continuum, we also recommend an unlocked residential competency facility on the ASH Campus to serve the ASH Region. An onsite facility would make transition from the Hospital or Hospital Step-down facilities seamless. Medical treatment could continue to be provided by ASH personnel so that there are no changes in care that could jeopardize restoration or functioning. Defendants from the ASH Region could skip the hospital admission and go directly to this facility if appropriate, thereby reducing the current writ list, opening acute care beds in ASH and saving money. If a higher level of care becomes necessary, then defendants can be transferred to the Hospital or Hospital Step-down. For example, occasionally defendants abscond Residential/Inpatient and these individuals could be returned to campus in a more restrictive facility instead of going to jail. Another benefit of this type of facility is opportunity for community re-integration to begin.

Community based- Outpatient Day Center: To expand the model of care at the ASH campus, with an eye toward expansion across the region, a campus-based day center would be beneficial for persons that have a stable place to stay in the community during the competency restoration process, allowing a person to stay close and engaged with their support system. It could be combined with perhaps temporary housing until the individuals can return to their own county (or as a more permanent solution for Travis County). Successful restoration might be enhanced by providing the defendants with day programming to continue restoration and care. Urinalysis would likely be available to ensure no illicit substance use off campus. For individuals from other jurisdictions in the ASH region from which travel to ASH is impossible or impractical then housing would be provided in the form of supportive housing on campus, as noted previously. Indeed, supportive housing towards the end of restoration and thereafter for a period of time on campus would increase the number of individuals who are able to stay in the community pending case disposition (see housing work groups recommendations). Ultimately, the goal would then be to replicate as much of this model as possible through the counties served by ASH. The Residential/Inpatient recommendation and the community based-outpatient day center could both use vacant buildings on the ASH campus to build the brain health campus platform. HHSC could develop a committee to review previously submitted request for proposal responses and request for further response if there lacks the residential and community based-outpatient day centers as described in this report.

Continuum of Care Beyond the Campus: Successes found through the ASH Campus competency restoration efforts are then situated to be models of best care practices throughout the continuum of care. Already, several Local Mental Health Authorities are developing their own solutions for the intersection of mental health and criminal justice. As the ASH Campus and LMHA partners build their programs, this opportunity creates a continuum of care network for the intersection of mental health and criminal justice. Models can be shared among community providers and the ASH Campus to expand the continuum of care throughout all of the ASH Service Area. As the hospital is completed, is

the work group recommends collaborating for continuum of care services development with the All Texas Access program at HHSC to support each other as the continuum of care services for people in the criminal justice system improve together for the hospital and outpatient systems.

Recommendation #2: Improved working conditions and compensation for ASH social workers and psychiatrists

Statement of Problem: Staff shortages and turnover have been a problem at ASH (and other state hospitals) for a long time. The pandemic exacerbated this problem. Noncompetitive salaries impact the ability of the hospital to hire and retain highly qualified social workers, psychologists, psychiatrists and hospital staff. High turnover means less continuity of care by medical teams and disturbs the community re-entry process. It also raises overall costs of operating the facility, as recruiting and hiring adds expenses. Staff shortages mean that medical staff cannot provide the kind of intensive treatment required to decrease the restoration time periods or increase clinical stability toward less restrictive care. Successful community re-entry can reduce readmissions and increase the likelihood of courts to grant bonds rather than returning defendants to jail.

Furthermore, staff shortages prevent ASH from using all available beds, thereby increasing the wait time on the writ list. Details of the impact on available beds due to staff shortages can be found in the Academic and Area Experts report.

Recommendation: While having a better physical workplace is important, HHSC must pay salaries commensurate with other public agencies to hire and maintain quality staff. Additionally, a partnership with UT Dell Medical School and UT School of Social Work to develop a forensic workforce could improve the availability of trained staff in the region. We support the efforts of the ASH Redesign Academic and Area Experts Workgroup in this regard.

Recommendation #3: Provide access to video communication for defense attorneys and clients as well as the ability to conduct virtual hearings and pleas consistent with the Code of Criminal Procedure.

Statement of Problem: Criminal Defense attorneys practice in multiple jurisdictions/counties, multiple courts within jurisdictions and go to multiple jails to meet with clients. Visiting clients at ASH in person is unnecessarily time-consuming, particularly for attorneys outside Travis County. Transporting defendants from ASH to the court of jurisdiction for purposes of bond hearings, restoration hearings, and pleas interrupts continuity of care and discharge planning when no trial is needed.

Recommendation: While ASH has made videoconferencing available when requested, we recommend a more established and publicized process. ASH could create secure, private videoconference rooms now and use private multiuse rooms in the new hospital for defense communication. Increased client communication will aid the defense in better, more-timely advocacy for their clients, as well as facilitate the restoration process by directly involving the individual charged. Additionally, video-conference rooms can be utilized for certain court hearings and pleas with defense consent.

ASH could have an administrative point person to publicize and assist with scheduling and creation of Zoom or MS Teams links for purposes of defense attorney communication and court processes allowed under the Code of Criminal Procedure.

Recommendation #4: Supportive Housing on Campus

Statement of Problem: There are multiple problems due to the lack of appropriate housing for Defendants who are restored to competency.

- Rearrest post restoration and case disposition
- Return to jail post restoration for court and decompensation in custody
- Decompensation post restoration in the community on bond
- Release to homelessness and decompensation and return on civil commitment
- Retention in hospital setting for lack of appropriate housing

Recommendation: Housing on campus could be considered a part of the continuum of care. Supportive Housing should be built on campus for both temporary and permanent stays, or elsewhere in the ASH region. Temporary supportive housing can provide a bridge to community based permanent supportive housing by providing wrap-around support and training for independent living. Such housing could be available for defendants engaging in outpatient day treatment for restoration. It would also encourage the release of defendants on bond rather than return to jail pending hearings. Permanent supportive housing may be necessary for a small population of individuals with certain mental health diagnoses that cycle through the criminal or civil systems. It is very difficult to establish housing for these individuals in the community due to resistance by neighborhoods. Guardianship is not a practical or useful solution to improving restored Defendants' success in the community. Placing restored Defendants into housing alone is not useful and likely to be a temporary solution when supportive housing is what they require. We support the planning and recommendations of the ASH Redesign Housing Workgroup in this regard.

The Competency Restoration Work Group of Phase III for the ASH Redesign presents the above 4 recommendations for consideration to support the continuum of care and increase the functional bed capacity of the new ASH. As the forensic population within the state hospital system continues to grow, the hope is to better serve the most vulnerable population in Central Texas with a brain health illness or dual diagnosis of substance use and or intellectual developmental disabilities with the above recommendations.

Appendix A: Work Group Members

Name	Organization/Role	Role
Judge Nancy Hohengarten	Travis County Court at Law 5	Co-Chair
John Petrila	Senior Executive VP of Policy, MMHPI	Co-Chair
Karlee Anderson	MHMRA Brazos Valley, TCOOMMI	Member
Lauv Bruner	State Hospital Construction Project Coordinator, Health & Specialty Care, HHSC	Member
Erika Canales	HHSC	Member
Krista Chacona	Mental Health Representative, Austin Criminal Defense Lawyer's Association	Member
Cristyn Cordova	Director of Social Work, ASH	Member
Dawn Handley, M.Ed., LPC	Chief Operations Officer, Integral Care	Member
Judge Guy Herman	Probate Court, Travis County	Member
Chris Lopez	Attorney, Policy Department, HHSC	Member
Tom McClure	Attorney, Policy Department, HHSC	Member
Daniel Owens	Executive Director, NAMI Brazos Valley	Member
Judge Dan Prashner	Associate Judge, Probate Court, Travis County	Member
Jennie Simpson, Ph.D	Forensic Director, Office of Mental Health Coordination, HHSC	Member
Joey Smith, LPC, MBA	Chief Adult Behavioral Health Services and Revenue Development, Center for Life Resources	Member
Reggie Smith	Policy & Community Liaison	Member
Erin Shinn Sreenivasan	Attorney Travis Co	Member
Jason Steans	Mental Health Court Lead, Williamson County Attorney's Office	Member
Steve Strakowski, MD	Associate Vice President of Regional Mental Health, Dell Medical School	Member
Felix Torres, MD	Chief of Forensic Medicine, Health & Specialty Care System, State Hospitals, HHSC	Member