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A State Mental Health System in Crisis: Recommendations to Reduce the Forensic Mental Health Population in Texas

APPROVED BY
SUPERVISING COMMITTEE:

Supervisor:

____
Cynthia Osborne

Co-Supervisor:

____
Monica Faulkner

A State Mental Health System in Crisis:

Recommendations to Reduce the Forensic Mental Health Population in Texas

by

Cate Graziani, B.A.

Report

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Abstract

A State Mental Health System in Crisis:

Recommendations to Reduce the Forensic Mental Health Population in Texas

Cate Graziani, MSSW, MPAff

The University of Texas at Austin, 2014

Supervisor: Cynthia Osborne

Co-supervisor: Monica Faulkner

The number of forensic psychiatric commitments has drastically increased over the last decade, now surpassing civil commitments in Texas. This uptick is a result in part of two main policy shifts during the middle of the 20th century: deinstitutionalization and over incarceration fueled primarily by the War on Drugs. Although the Community Mental Health Centers Act of 1963 was meant to replace inpatient services, few centers are adequately funded. As highlighted in the news, the combined effect is illustrated in the numbers: 1 million individuals with serious mental health disorders are booked into local jails each year and half of all incarcerated individuals are experiencing a mental health problem of some kind. To address this growing population and to prevent individuals who are criminally court-ordered to receive mental health treatment from lingering in jail for unconstitutional lengths of time, many states including Texas have been forced to find or create new forensic beds, sometimes even building new facilities. This demand for forensic beds has created opportunities for private prison companies to expand into mental health. GEO Group, one of the largest prison corporations in the world, already owns or operates five psychiatric facilities in the U.S., including one in

Montgomery County, Texas, before it was acquired by Correct Care Solutions. Much like in the private prison industry, for-profit private corporations have an incentive to continue to grow the forensic psychiatric population, which contradicts best practices regarding treatment for individuals with mental illness taking place in the least restrictive environment. In order to prevent opportunities where states rely on private prison corporations because of cost savings promises, research and advocacy regarding alternatives for states attempting to curb a growing forensic psychiatric population are needed.

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Introduction

In June 2014, the Texas Sunset Advisory Commission released their comprehensive staff report of the Texas Health and Human Services Department of State Health Services. The report's first recommendation was: "Resolving the Current Crisis in the State Mental Health Hospital System Requires Action, Starting Now." Although problems in the state hospital system are by no means new, identifying it as a crisis creates an opportunity. Enhancing that opportunity, Texas is also undergoing a ten-year state hospital planning process, authorized by Rider 83 of the 82nd Legislative Session, which may potentially overhaul the state hospital system. In order to provide effective solutions to the state mental health system crisis, this report attempts to understand which policies have contributed to the current state of affairs and proposes solutions to improve the system.

Much of our state's mental health hospital crisis is related to a topic that has been commanding national and local headlines lately: jails are the new mental asylums. The number of people with mental health disorders in our jails and prisons is not only staggering, but also presents serious challenges for lawmakers and public officials. The rising population has created a strain on both the criminal justice and mental health systems and is forcing many states to analyze policies, choosing population reduction to offset costs. Although sentencing reform in recent years has begun to curb the population in jails and prisons slightly, the forensic mental health population has not seen the same reductions. In fact, forensic mental health commitments in Texas are on the rise.[1]

Solutions in Texas have been haphazard; using contracting to find community and private beds has been one tactic, but some advocates argue that more state hospital beds are needed. One proposed solution in Texas has been to build new private state hospitals or attempt to privatize existing ones. Allowing private corporations to either manage or own expensive psychiatric hospitals may seem attractive as deep cuts to state budgets have

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[1] Texas Sunset Advisory Commission, *Staff Report with Hearing Material Department of State Health Services,* Austin, TX: 2014, https://www.sunset.texas.gov/public/uploads/files/reports/DSHS%20Hearing%20Material.pdf

forced state agencies to find ways to save money and is being considered in the State Hospital Long-Term Plan. However, ethical and legal questions arise about whether private corporations should turn a profit on legally mandated mental healthcare. Furthermore, robust data is almost nonexistent on outcomes for individuals who receive inpatient mental healthcare. Furthermore, both public and private state hospitals are wrought with problems including improper use of seclusion and restraint that has resulted in patient deaths. Before care is privatized, more study is needed.

This paper will contribute to the knowledge base on the intersection of the criminal justice and mental health systems, focusing on best practices for the management of and reforms to inpatient forensic psychiatric care. First, a historical analysis will highlight policy trends that have contributed to an increase in the number of incarcerated individuals suffering from mental health disorders. Then, by answering the questions listed below, this analysis aims to raise awareness about individuals who receive forensic psychiatric care, the nature of that care and the complexities and challenges at the intersection of these two systems. Finally, this paper will offer recommendations to decrease our forensic mental health population. In doing so, this paper addresses the following questions:

1. How is Texas managing forensic psychiatric care now?
2. Can privatization improve the system and the care individuals receive?
3. What does the research suggest are good solutions, other than privatization?
4. What are the pros and cons of those solutions?

Background and History: A National Perspective

In order to fully understand the contemporary forensic mental health system, a historical analysis is outlined below.

The Rise of Institutionalization

As far back as the mid-800's, Dorothea Dix, a Boston schoolteacher and community advocate, toured the nation's prisons and jails, documenting conditions and advocating for better treatment of prisoners, especially those with serious mental illness (SMI).[2] At a time when women were not allowed to directly address the legislature, she lobbied Congress and successfully petitioned state governments to fund more public mental asylums and hospitals across the country.[3]

In 1848, Dix proposed the "Bill for the Benefit of the Indigent Insane" to the U.S. Congress, which would have granted the proceeds of ten million acres of federal land to states in order to fund public mental asylums. After many years of congressional debate, President Pierce finally vetoed the bill in 1854.[4] Although Dix continued to advocate and lobby at the state level and was successful in championing the creation of 32 asylums across the country, the veto sent a message: The federal government would not be responsible for mental illness or social welfare programs in general, a precedent that would not be challenged until the Great Depression. It would not be until 1963, with the Community Mental Health Act, that the federal government would directly fund mental health services. [5,6]

Despite the lack of federal support, the population of people in asylums grew substantially over the next hundred years: from 41,000 in 1880 to half a million people in

[2] Dorothea L. Dix, *Remarks on prisons and prison discipline in the United States,* (Boston: Sabin Americana, 1845).

[3] Seaton W. Manning, "The Tragedy of the Ten-Million-Acre Bill," *Social Service Review* 36, 1. 1962: 44-50.

[4] Ibid.

[5] Christopher Welsh, "The Debacle of Deinstitutionalization: History and Politics of Community Mental Health Centers," *Iowa Consortium for Mental Health*, November 25, 2008, https://www.healthcare.uiowa.edu/icmh/archives/documents/CommunityMentalHealthCenters_WELSH.pdf

[6] Manning, "The Tragedy of the Ten-Million-Acre Bill."

1955.[7] The model that Dix advocated, called 'moral therapy', required a small group of patients who could develop a strong bond with the supervising doctor. Although it did show limited positive results in the late 1800's, moral therapy also shifted the responsibility for recovery onto the individual.[8] This shift in attitudes about individuals with mental illness produced conflicting outcomes: on the one hand individuals were no longer considered unable to recover, rather, recovery was achieved through their own inner moral fortitude.[9]

By the turn of the century, asylums were losing resources, resulting in high patient-therapist ratios and low quality of care.[10] Asylums were largely ignored and avoided by society at this time; they were primarily places of custody or confinement, not treatment and recovery.[11,12,13] Average lengths of stay for most people in asylums lasted years, often their entire lives, and by 1955 institutionalization was at its peak with approximately 560,000 people in psychiatric hospitals.[14,15,16]

Deinstitutionalization

Despite early advocacy efforts, national mental health policy was not codified until President Truman signed the National Mental Health Act in 1946 and the National Institute of Mental Health was founded in 1949, with no federal budget.[17] [By comparison, the Department of Justice was established in 1870]. Advancements in drug treatments for SMI and mental health workforce needs exposed during and after WWII,

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[7] Bernard E. Harcourt, "Reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s," *Ohio State Journal of Criminal Law* 9,1. 2011: 53-88. http://ps.psychiatryonline.org/article.aspx?articleid=83880

[8] Jess P. Shatkin, "The History of Mental Health Treatment," *New York University School of Medicine.*

[9] Ibid.

[10] Ibid.

[11] Harcourt, "Reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s."

[12] Shatkin, "The History of Mental Health Treatment."

[13] Welsh, "The Debacle of Deinstitutionalization: History and Politics of Community Mental Health Centers."

[14] Lisa Davis, et al., "Deinstitutionalization? Where Have All the People Gone?" *Current Psychiatric Rep* 14. 2012: 259–269.

[15] Harcourt, "Reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s."

[16] Shatkin, "The History of Mental Health Treatment."

[17] U.S. Department of Health and Human Services, National Institutes for Health, National Institute for Mental Health, *Important Events in NIMH History,* August 6, 2013, http://www.nih.gov/about/almanac/organization/NIMH.htm.

contributed to the growth of academic fields of psychology and psychiatry during that time.[18,19] As a national awareness grew during the 1950's and 60's, mental asylums were the target of much negative press and exposure.[20,21,22] Ken Kesey's *One Flew over the Cuckoos Nest* was published in 1962, exposing his experiences working in a state mental health hospital and causing public outcry. The general public began to protest and so began what people commonly call 'deinstitutionalization.'

A driving policy force in the deinstitutionalization movement was the passage of the Community Mental Health Centers Act by President Kennedy in 1963. The Act, in conjunction with an increase in inpatient commitment standards and Medicaid implementation, drastically reduced the psychiatric hospital population and, for the first time in history, provided direct federal funding for mental health services.[23,24] President Kennedy's commitment to mental health stemmed largely from personal experience; his sister Rosemary, who had a developmental disability, was the victim of a lobotomy at the age of 23 and lived the rest of her life in a private facility.[25] The timing of a sympathetic president was fortuitous as negative public opinion and economic incentives aligned to support a shift in mental health services to community-based approaches.[26,27] Medicaid and Medicare were passed a few years later in 1965, which also contributed to community-based care's popularity. In fact, Medicaid provided a better reimbursement for nursing home care than for mental hospitals.[28]

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[18] Davis, et al., "Deinstitutionalization? Where Have All the People Gone?"

[19] Harcourt, "Reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s."

[20] Davis, et al., "Deinstitutionalization? Where Have All the People Gone?"

[21] Harcourt, "Reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s."

[22] Welsh, "The Debacle of Deinstitutionalization: History and Politics of Community Mental Health Centers."

[23] Davis, et al., "Deinstitutionalization? Where Have All the People Gone?"

[24] Harcourt, "Reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s."

[25] Welsh, "The Debacle of Deinstitutionalization: History and Politics of Community Mental Health Centers."

[26] Seth J. Prins, "Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?" *Community Mental Health Journal*, 47, 2012: 716–722.

[27] Davis, et al., "Deinstitutionalization? Where Have All the People Gone?"

[28] Welsh, "The Debacle of Deinstitutionalization: History and Politics of Community Mental Health Centers."

In 1981, President Reagan signed the Omnibus Budget Reconciliation Act (OBRA) and retracted much of the momentum community mental health services had garnered during the 1960's and 70's. OBRA of 1981 marked the end of an eighteen-year period of direct federal financial support for mental health, the only period of its kind. The 1980's and 90's left most community mental health centers underfunded and overwhelmed, and waiting lists started to grow.[29,30]

The War on Drugs and Mass Incarceration

At the same time that community mental health resources faded, the War on Drugs began to target low-income African American communities. Additionally, due to the high prevalence of substance use among people with mental illness, the War on Drugs further criminalized mental illness.[31] The War on Drugs was part of a much larger policy shift that has led to over-incarceration, especially among communities of color; between 1970 and 2005 the population of individuals in jails and prisons increased by 700percent.[32]

What is now considered to be a largely ineffective and overly harsh campaign, the War on Drugs began over 40 years ago when President Nixon declared a war on America's "public enemy number one" in 1971. [33] Although President Eisenhower had begun to address increased drug use in the 1950's, it wasn't until rumors of heroine use among deployed troops spread that the White House made it an explicit policy priority. [34] In 1982, President Reagan coined the phrase "The War on Drugs." That decade saw the rise of Nancy Reagan's "Just say no" campaign and the Drug Abuse Reduction Education (D.A.R.E.) program.[35] Then, in 1988 President Reagan signed the Anti-Drug Abuse Act

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[29] Davis, et al., "Deinstitutionalization? Where Have All the People Gone?"

[30] Welsh, "The Debacle of Deinstitutionalization: History and Politics of Community Mental Health Centers."

[31] Josiah D. Rich, Sarah E. Wakeman and Samuel L. Dickman, "Medicine and the Epidemic of Incarceration in the United States," *The New England Journal of Medicine* 364, 22. 2011: 2081-2083.

[32] Michelle Alexander, *The New Jim Crow: Mass incarceration in the age of colorblindness*, (New York: New Press, 2010).

[33] Claire Suddath, "The War on Drugs: Brief History," *Time*: March 25, 2009, http://content.time.com/time/world/article/0,8599,1887488,00.html

[34] Ibid.

[35] National Public Radio, "Timeline: America's War on Drugs," *NPR.org*. 2007, from http://www.npr.org/templates/story/story.php?storyId=9252490

into law, dramatically changing the criminal justice system, creating large disparities in sentencing. Most notably, under the new law, possession of five grams of crack cocaine could earn a mandatory five-year prison sentence, while the same sentence would only be issued in the case of 500 grams of cocaine.[36] This act also disqualified individuals convicted of drug related crimes from federal public assistance, including what is now Temporary Assistance to Needy Families (TANF), public housing and the Supplemental Nutrition Assistance Program (SNAP).[37] It is clear from sentencing disparities and arrest rates in low-income communities that people of color were disproportionately affected by the War on Drugs. As a result, some have suggested that police brutality and racial profiling became the norm, further damaging communities already dealing with poverty and unemployment.[38]

Mental Illness and Incarceration

In recent years the increasing numbers of incarcerated individuals experiencing mental illness has garnered national attention. By some estimates, one million individuals with SMI are booked in local jails across the nation every year.[39,40] In 2006, the Department of Justice (DOJ) reported that more than half of incarcerated individuals were experiencing mental health problems nationally. The DOJ study, which used self-reported data, is reported in Table 1.

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36 Jamie Fellner, "Race, Drugs, and Law Enforcement in the United States," *Stanford Law and Policy Review,* 20, 2. 2009: 257-292.

37 Maggie McCarty, et al, "Drug Testing and Crime-Related Restrictions in TANF, SNAP, and Housing Assistance." *Congressional Research Service, Library of Congress.* 2013: 1-32. Retrieved from. http://www.fas.org/sgp/crs/misc/R42394.pdf

38 Alexander, *The New Jim Crow.*

39 Davis, et al., "Deinstitutionalization? Where Have All the People Gone?"

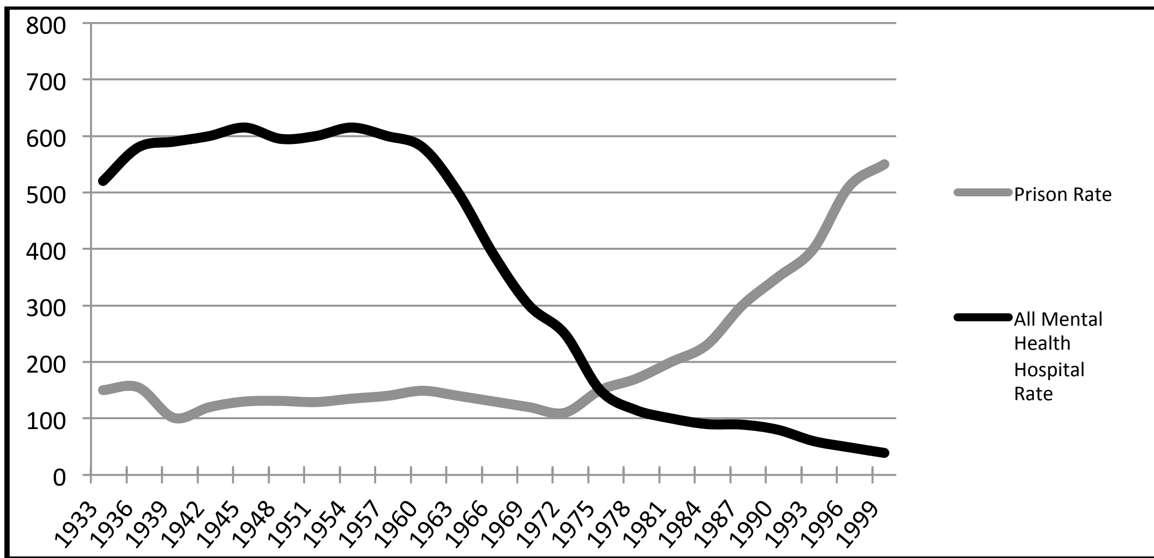
40 Prins, "Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?"

Table 1: National Prevalence of Mental Health Symptoms for Incarcerated Individuals[41]

	Local Jails	State Prisons	Federal Prisons
Mania	50%	40%	53%
Depression	40%	23%	15%
Delusions/Hallucinations	35%	16%	10%
Received treatment	16%	30%	25%
Women	75%	73%	61%

The combined effect of deinstitutionalization and over incarceration has directly impacted the number of individuals with mental health diagnoses in jails and prisons, as shown in Figure 1. The large increase in this population has placed a serious strain on public services, especially in the area of forensic mental health.

Figure 1: Rates of Institutionalization per 100,000 adults, 1934-2000[42]



41 Lauren E. Glaze and Doris J. James, "Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates," U.S. Department of Justice, Bureau of Justice Statistics, 2006.

42 Harcourt, "Reducing mass incarceration: lessons from the deinstitutionalization of mental hospitals in the 1960s."

Race and Incarceration

Although the prevalence of mental illness among inmates across races is comparable, the disproportionate number of people of color who are incarcerated is alarming. This is due the well-documented disproportionate effects of the War on Drugs on poor people of color.[43] Although all races and ethnic groups use drugs at approximately the same rate, African American are more than twice as likely to be arrested for a drug crime.[44] One reason for the disparity stems from sentencing laws, as mentioned above. The Anti-Drug Abuse Act of 1988 established a 100:1 ratio between crack cocaine and powder cocaine.[45] In 2002, a national report found that during the time the 100-1 ratio was in place, 85 percent of individuals sentenced were African American. [46] Although the Fair Sentencing Act reduced the ratio to 18:1 in 2010, the sentencing difference still exists today.

In 2012 the DOJ reported that 35 percent of all inmates are white, 38 percent are African American and 21 percent are Latino. The alarmingly high rate of incarceration for people of color can be traced to policing and sentencing policies targeting black and brown communities.

Mental Illness and Substance Use

Individuals with mental illness can be also diagnosed with co-occurring substance use disorder. In fact, people experiencing mental health problems are more likely to use drugs than those without mental illness. In these cases treatment and recovery are more complex. National studies report that a quarter of people with mental illness also have a

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43 Glaze and James, "Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates."

44 Race and the Drug War | Racial Discrimination in Drug Law Enforcement | Drug Policy Alliance. (n.d.). Retrieved from http://www.drugpolicy.org/race-and-drug-war

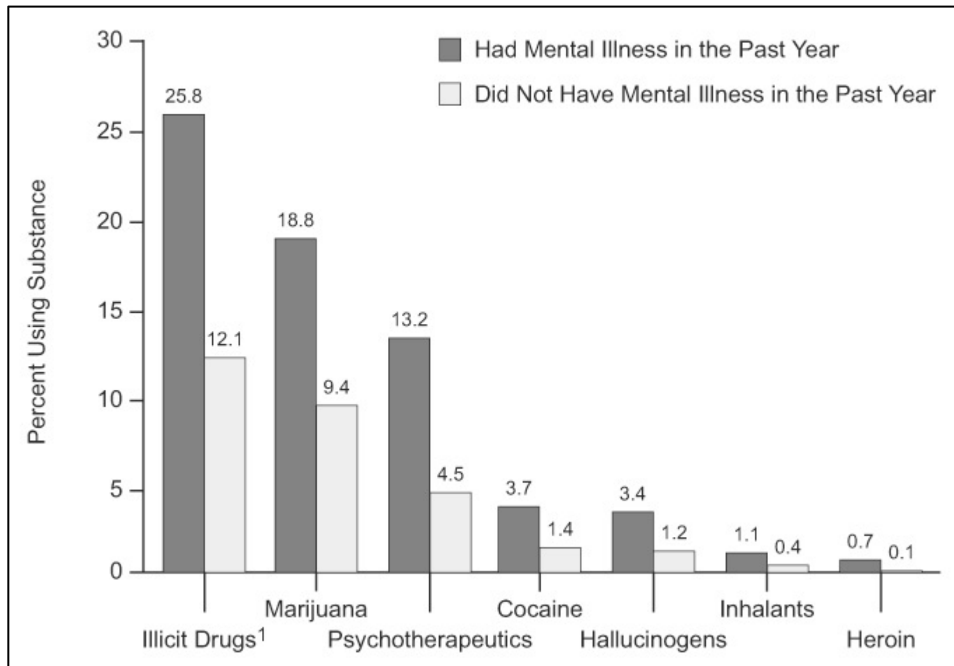
45 The U.S. Sentencing Commission. (2009). The Crack Sentencing Disparity and the Road to 1:1. Published online at: http://www.ussc.gov/Education_and_Training/Annual_National_Training_Seminar/2009/016b_Road_to_1_to_1.pdf

46 Ibid.

substance dependence or abuse, as show in Figure 2 below; conversely, half of people with substance use disorder also have a mental illness.[47]

Although it is difficult to know with certainty, there are several factors that contribute to the high rate of substance use among people with mental illness. First, the lack of affordable and accessible quality care means that many individuals may not receive any treatment for their drug use or mental illness. Additionally, drugs and alcohol can be a form of self-medication, especially for those unable to access services, but at the same time can worsen a person's condition.[48]

Figure 2: Prevalence of Mental Illness and Substance Use[49]



47 U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667, Rockville, MD: 2012, http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm#4.1

48 National Alliance on Mental Illness, "Dual Diagnosis Fact Sheet," 2013, http://www.nami.org/Template.cfm?Section=By_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=23049

49 U.S. Department of Health and Human Services, *Results from the 2010 National Survey on Drug Use and Health.*

People with SMI are not only more likely to use drugs, but they are also more likely to be arrested on drug related charges, especially African American men. [50] A 2007 study of drug-related charges among a sample of individuals with serious metal illness over ten years found that approximately 63 percent of all the charges were for one of the following: cocaine or opium possession; marijuana or phenobarbital possession; or possession of or being around drug paraphernalia.[51] These convictions can bar individuals from public benefits, including TANF, SNAP and Section 8 housing, for a lifetime.

Mental Illness, Homelessness and Race

In 2009, a national study reported that mental illness was the third most commonly cited reason for an individual to be experiencing homelessness.[52] A 2012 study by the Institute of Children, Poverty and Homelessness (ICPH) revealed alarming racial disparities in the homeless population. They concluded that African Americans are seven times more likely than whites to seek shelter due to homelessness.[53] Even more alarming, race is regularly omitted from research and discourse about homelessness. In fact, the U.S. Department of Housing and Urban Development's 2013 Annual Homeless Assessment Report to Congress does not mention race at all. Unfortunately, further gaps in the research exist regarding the overlap of race, mental illness and substance abuse. Table 1 highlights disparities among individuals experiencing homelessness by race, serious mental illness and substance use disorder, but further analysis is needed to understand the demographics of this group.

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[50] William H. Fisher, et al, "Drug-Related Arrests in a Cohort of Public Mental Health Service Recipients." *Psychiatric Services* 58, 11. 2007: 1448-1453.

[51] Ibid.

[52] National Coalition for the Homeless, "Mental Illness and Homelessness: A Factsheet," 2009, http://www.nationalhomeless.org/factsheets/Mental_Illness.html

[53] Institute for Children, Poverty and Homelessness USA, "Intergenerational Disparities Experienced by Homeless Black Families," March 2012, http://www.icphusa.org/filelibrary/ICPH_Homeless%20Black%20Families.pdf

Table 2: Race, Serious Mental Illness and Substance Use among Homeless[54,55]

	Anytime Homeless	Chronic Homeless	General Population
White, non-Hispanic	41.6%	Not given	63%
Hispanic	9.7%	28.7%	16.9%
African American	37%	56.6%	13.1%
Serious Mental Illness	26.6%	30%	6%
Substance Use Disorder	34.7%*	50%**	4.7%**

*Co-occurring not indicated
** Co-occurring mental illness and substance use

Mental Illness, Homelessness and Incarceration

National data suggests that mental illness, homelessness and incarceration are intimately connected. Incarcerated individuals are 7.5 times more likely to have been homeless immediately prior to arrest than the general population. Of inmates with mental illness, 20 percent were homeless before arrest. The overrepresentation of homelessness among inmates may be related to policing practices, especially when drug use is present. Arrest rates for homeless individuals double with substance use; 20 percent of the homeless

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[54] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Homeless Resource Center: July 2011, http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf

[55] U.S. Census Bureau: State and County QuickFacts. *Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.* Last revised Nov. 2013. http://quickfacts.census.gov/qfd/states/00000.html

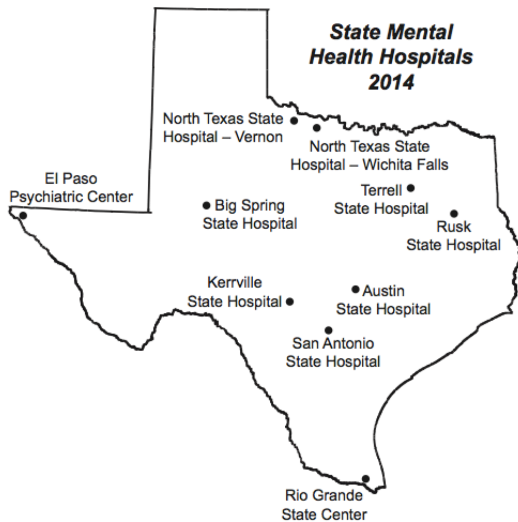
population with substance abuse have been arrested compared to 10 percent of the homeless population without.[56]

56 Daniel K. Malone, "Assessing criminal history as a predictor of future housing success for homeless adults with behavioral health disorders." *Psychiatric Services* 60, 2. 2009: 224-230.

Background and History: A Texas Perspective

Texas' state hospital system mirrors national trends. The first mental health hospital, the Texas State Lunatic Asylum, opened its doors in 1861 (now Austin State Hospital, or ASH).[57] Rusk State Hospital, built in 1919, was originally converted from a state prison to treat the "Negro Insane." In 1968, at the height of institutionalization, ASH served as many as 3,313 patients and Rusk served more than 1,800.[58,59] Since its inception, the state hospital system has undergone many changes, both in population and management; Texas currently operates ten adult inpatient facilities as shown in Figure 3. The state also contracts with Montgomery County to operate a privately run facility, the Montgomery Mental Health Facility in Conroe, TX. Geo Care operates that facility, a company that will be discussed further below.

Figure 3: Public Mental Health Hospitals in Texas[60]



57 Texas Health and Human Services Commission, Department of State Health Services. "History of the Austin State Hospital." April 8, 2011 https://www.dshs.state.tx.us/mhhospitals/AustinSH/ASH_About.shtm

58 John G. Johnson, "AUSTIN STATE HOSPITAL," *Handbook of Texas Online* (http://www.tshaonline.org/handbook/online/articles/sba07), accessed July, 15 2014. Uploaded on June 9, 2010. Published by the Texas State Historical Association.

59 James W. Markham, "RUSK STATE HOSPITAL," *Handbook of Texas Online* (http://www.tshaonline.org/handbook/online/articles/sbr03), accessed August 10, 2014. Uploaded on June 15, 2010. Published by the Texas State Historical Association.

60 Texas Sunset Advisory Commission, *Staff Report.*

Forensic Mental Healthcare in Texas

Forensic mental healthcare refers to criminally court-ordered mental health treatment or commitment. In Texas, this applies to the case dispositions Not Guilty By Reason Of Insanity (NGRI) and Incompetent to Stand Trial (IST), which comprise the majority of the state's forensic state hospital population. In the criminal justice system, defendants are found incompetent to stand trial (IST) when they are so functionally impaired as to lack the ability to consult with their attorney or have a rational and factual understanding of the legal proceedings. In this situation, due process requires suspending the legal process until a court finds the defendant competent to stand trial. Restoration to competency is the process used to provide treatment aimed at improving the defendant's functional abilities to the legally required level. This process is one small part of the intersection of mental health and criminal justice, and accounts for 86 percent of all forensic commitments in Texas.[61]

The restoration process historically occurred in state psychiatric hospitals funded primarily with general revenue. As shown above in Figure 3, Texas operates ten adult psychiatric hospitals that served 16,796 adults in 2012.[62] That year, 14 percent of all commitments were forensic. However, due to long lengths of stay for a person who is forensically committed, approximately 37 percent of state hospital beds are allocated for forensic commitments, the majority of which were ruled IST.[63] In fiscal year 2012, the average length of stay for a person who was civilly committed was 36 days compared to 120 days for a person found incompetent to stand trial and 227 days for a person found

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[61] Texas Legislative Budget Board, *Texas State Government Effectiveness and Efficiency Report, Selected Issues and Recommendations*, Submitted to the 83rd Texas Legislature, Austin, TX: 2013, http://www.lbb.state.tx.us/GEER/Government%20Effectiveness%20and%20Efficiency%20Report%202012.pdf

[62] Ibid.

[63] Ibid.

not guilty by reason of insanity.[64] During the same year, the average daily cost for inpatient restoration was $421.[65] Seventy-five percent of defendants found incompetent to stand trial who entered an inpatient competency restoration program were restored.[66]

When the Sunset Commission called for action regarding the state hospital crisis, one primary issue highlighted was its lack of capacity and the rising number of forensic commitments.[67]

Expanding Forensic Mental Health Population

As detailed above, the deinstitutionalization of psychiatric hospitals in the 1960s, paired with inadequately funded community mental health care, has contributed to an increase in the number of people with mental health diagnoses in jails and prisons.[68] Although Texas lacks data on the prevalence of mental illness in its state prisons and local jails, The Center for Public Policy Priorities estimates that in 2013, 35 percent of the state prison population and 40 percent of people booked into local jails had received public mental health services in the past.[69] However, these numbers likely underreport the prevalence of mental illness in jails and prisons because research suggests that few individuals that need services access our state's public mental health services. Furthermore, experts have found that people who do access community mental health services are less likely to become incarcerated. In addition, a survey of adult women in federal and state prisons conducted by the Texas Criminal Justice Coalition found that 56 percent of respondents had been diagnosed with a mental illness.[70] Responses indicated that the most common diagnosis was depression, followed by bipolar disorder; almost 80 percent of respondents

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64 Ibid.

65 Ibid.

66 Texas Legislative Budget Board, *Texas State Government Effectiveness and Efficiency Report.*

67 Texas Sunset Advisory Commission, *Staff Report.*

68 Davis, et al., "Deinstitutionalization? Where Have All the People Gone?"

69 Megan Randall and Katherine Ligon, "From Recidivism to Recovery: The Case for Peer Support in Texas Correctional Facilities." Center for Public Policy Priorities. 2014. Retrieved from http://www.forabettertexas.org/images/HC_2014_07_RE_PeerSupport.pdf

70 Texas Criminal Justice Coalition, "Survey of Incarcerated Women: Preliminary Findings," 2014.

reported having a diagnosis of depression and over 50 percent reported a diagnosis of bipolarity.

Although there has been little research focused on whether people with a mental health diagnosis become involved with the justice system because of circumstances resulting from the mental illness, the prevalence of mental illness in jails and prisons is costly. The Center for Public Policy Priorities reported that the daily cost of incarceration is approximately $49 per person in state prison, $59 per person in a local jail and $138 per person in a forensic inpatient facility.[71]

Data obtained from the Department of State Health Services revealed that the relationship between mental illness, substance use, homelessness and incarceration discussed above is playing out in our state forensic mental health population. Between 2011 and 2013, 618 people charged with criminal trespassing were found incompetent to stand trial and were sent to an inpatient competency restoration program. During the same years, 147 people receiving competency restoration services in a state hospital for a drug possession charge. Between 2011 and 2013, 439 individuals found incompetent to stand trial and committed to a state hospital were charged with assault on a police officer or jailer, and 106 were charged with resisting arrest. These numbers illustrate the need for jail diversion strategies, as well as less costly outpatient competency restoration options for low-level offenses.

Another result of deinstitutionalization and under-funded community mental health services has been an increased demand for forensic psychiatric services. The Texas Department of State Health Services reports that the percentage of forensic commitments to state hospitals in Texas rose 43 percent from 2001 to 2013.[72] As state hospitals attempt to accommodate steadily climbing forensic commitments, fewer and fewer civil beds become available [See Figure 4]. In 2014, forensic commitments for the first time

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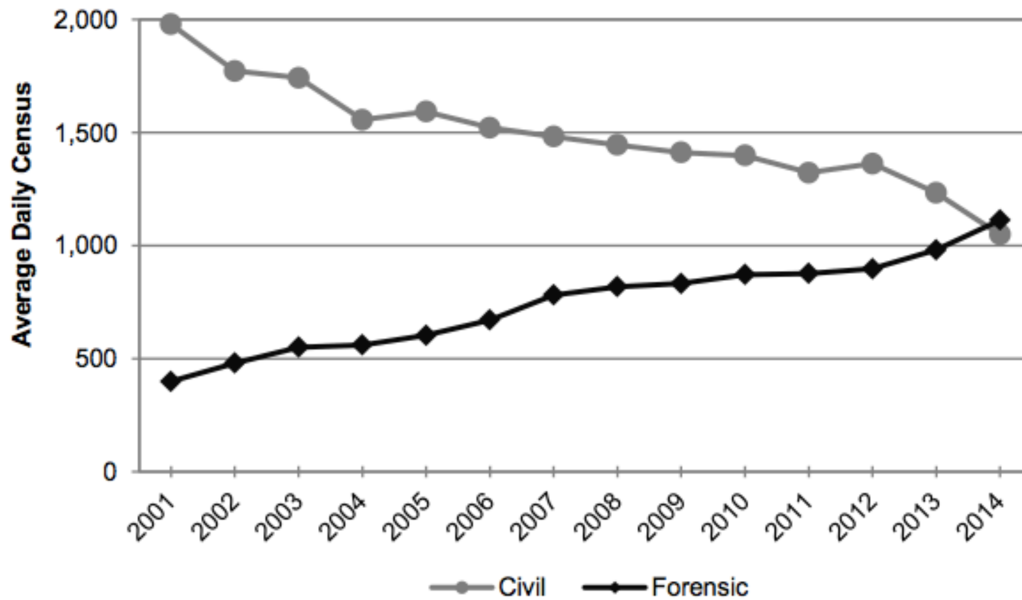
[71] Randall and Ligon, "From Recidivism to Recovery."

[72] Texas Department of State Health Services, *Self Evaluation Report Submitted to the Sunset Commission*, Austin, TX: September 2013. http://www.hhsc.state.tx.us/sunset/Evaluation-Report.shtml

surpassed civil commitments. For some Texans, this means that it can be easier and faster to receive mental health treatment if charged with a crime than it would be to be voluntarily committed, thus further criminalizing mental illness.

Figure 4: Civil vs. Forensic Census Snapshots on Specified Dates from FY 2001 to 2014[73]



State health departments have also felt the financial impact of the change in the psychiatric hospital population. In 1993, only 10.3 percent of state psychiatric budgets were spent on forensic commitments; in 2007 that number had gone up to 26 percent.[74] As the population in need of forensic psychiatric services swells, privatization may appear to be an attractive option for states working under rigid budget constraints. In fact, in 2013 the Texas DSHS proposed privatization of forensic mental health services as a solution to capacity and budget concerns.[75] This proposed solution is especially alarming

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[73] Texas Sunset Advisory Commission, *Staff Report.*

[74] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Funding and Characteristics of State Mental Health Agencies," 2009. http://store.samhsa.gov/product/Funding-and-Characteristics-of-State-Mental-Health-Agencies-2009/SMA11-4655

[75] Texas Department of State Health Services, *Self Evaluation Report Submitted to the Sunset Commission*. Austin, TX: September 2013, http://www.hhsc.state.tx.us/sunset/Evaluation-Report.shtml

because new research shows for-profit prison corporations are looking for new industries, explained below.[76]

[76] Paula Arnquist, "Preliminary Findings: Correctional Healthcare & Forensic Psychiatric Care Privatization." *Grassroots Leadership*, Submitted May 2014.

Private Prison Corporations Enter Mental Health Care Industry

As sentencing reform has begun to curb the population in jails and prisons, private prison corporations are expanding into new markets. As the data shows, the number of forensic psychiatric commitments has drastically increased over the last decade and demand for inpatient beds has therefore increased. In order to prevent individuals who are court-ordered to receive mental health treatment from lingering in jail for unconstitutional lengths of time, many states including Texas have been forced to create new forensic beds, sometimes even building new facilities. Much like in the prison industry outlined above, for-profit private corporations have an incentive to continue to grow this population, which contradicts best practices regarding treatment for individuals with mental illness in the least restrictive environment.

> Geo Care
>
> Geo Care was founded in 1997 as Atlantic Shores Healthcare, Inc., a subsidiary of Wackenhut Corrections, a private prison corporation. In 2002, through a series of buyouts, Wackenhut Corrections and its subsidiaries adopted the name GEO Group. The subsidiary Atlantic Shores Healthcare became Geo Care. In 2014, Geo Care was acquired by Correct Care Solutions.

Although research in this area is limited, the 2010 Utah State Legislature Executive Appropriations Committee found that the primary driver for cost savings in privatized forensic psychiatric care came primarily from a reduction in overall staff compensation, associated with high turnover rates, putting patient safety at risk.[77] The North Carolina Psychological Association has also voiced strong opposition to the privatization of state-operated forensic psychiatric treatment, specifically by GEO Group. Cost savings, especially over the long term, were presented as unlikely and NC Psychologists expressed concerns over quality of care. [78]

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77 Utah State Legislature, Executive Appropriations Committee, *Feasibility Study on the Privatization of Portions of the Utah State Hospital and the Utah State Developmental Center*, August 2010 www.hendrickson-consulting.com/documents/FeasibilityStudyonthePrivatizationofPortionsoftheUtahStateHospitalandtheUtahStateDevelopment.pdf

78 Glaze and James, "Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates."

Unfortunately, concerns go beyond cost savings. Local and national headlines have exposed multiple scandals perpetrated in private facilities across the country. In August 2012, the Associated Press reported three deaths, including a patient who died in a scalding bathtub, at the South Florida State Hospital operated by a division of private prison corporation GEO Group.[79] In Texas, the same company was fined more than $50,000 after state inspectors found serious violations at the GEO-run Montgomery County Mental Health Treatment Facility.

Montgomery County Mental Health Treatment Facility

Currently, the only privately operated, state-funded mental health hospital in Texas is run by Geo Care, which is now owned by Correct Care Solutions. In 2011, the Montgomery County Mental Health Treatment Facility (MCMHTF) was built in Conroe, Texas, a 100-bed facility with the potential to double in size. In order to address the growing waiting list, a legislative appropriations act during the 81st legislative session authorized 100 additional inpatient beds. Governor Rick Perry signed the appropriation in June 2009 and Montgomery County signed a contract with the state in May 2010.

The new facility was built with $33 million in county bonds and opened in March 2011. Between 2011 and 2013, the facility provided psychiatric services to approximately 1,000 individuals who were found incompetent to stand trial.[80] The facility is the only one of its kind in Texas: the state contracts with the county, who then contracts with Geo Care. Although funded with general revenue, the Department of State Health Services does not list the facility as a state hospital.[81] The original contract amount was $15,000,000, but was increased for the 2014-15 fiscal year to $15,417,450, in order to offer salary raises for certain frontline staff.[82] The facility only serves forensic commitments.

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[79] Associated Press, "Officials reviews deaths at GEO-run FL state hospital," *The San Francisco Chronicle,* July 26, 2012.

[80] Texas Department of State Health Services. "Montgomery County Hospital Population, 2011-2013." [Unpublished data]. Compiled May 2014.

[81] Texas Department of State Health Services, "State Hospitals," March 14, 2014, http://www.dshs.state.tx.us/mhhospitals/

[82] Texas Department of State Health Services, Contract Management Unit, "Montgomery County Mental Health Treatment Facility," [Contract].

In June 2013, the county put out an RFP to sell the facility. Geo Care underbid the county's RFP, offering only $35 Million. In November 2013 the county rejected GEO's bid. Despite conflicting news reports, the facility has not been sold and is not currently pending a decision.

GEO operates another facility in Conroe - the Joe Corley Detention Center, built in 2008. That facility was part of a federal investigation regarding the procurement process and construction financing because Montgomery County officials financed the $33 million dollar Corley facility in part through federally tax-exempt bonds.[83]

Violations of Patient Rights

The MCMHTF has also received scrutiny from the state. Within its first year of operation, Geo Care was fined $53,000 after state inspectors found serious violations, including unauthorized restraint and seclusion of patients, incomplete medical records, failure to show patient consent for medications, and failure to report serious injuries to the state.[84]

Racial Disparity

There is an over-representation of African Americans receiving treatment inside the MCMHTF, as shown in Figure 1. The disparity is likely due to a combination of racial profiling and discrimination in the criminal justice system paired with the over-diagnosis and confinement of African Americans in the mental health system.[85] There is emerging research on how African Americans charged with a crime are less likely to receive a competency evaluation than their white counterparts, but research is limited. However,

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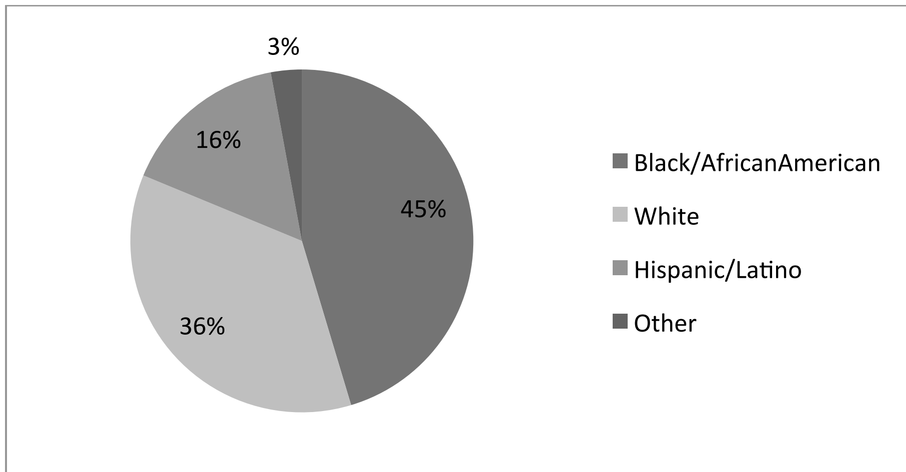
[83] Nancy Flake, "Montgomery County's mental health facility gets $53K in fines," *The Courier of Montgomery County*, July 20, 2012.

[84] The Office of Alan B. Sadler, Montgomery County Judge. *Montgomery County Commissioner's Court,* March 2013, http://www.mctx.org/dept/departments_c/commissioner_s_court/docs/Full_Document_Package_031113.pdf

[85] Jonathan M. Metzl, *The Protest Psychosis : How Schizophrenia Became a Black Disease*, (Boston: Beacon Press, 2010).

when evaluated for competency, African Americans are more likely to be found incompetent.[86]

Figure 5: Racial and Ethnic Makeup of Commitments MCMHTF, 2013[87]



Attempts to Privatize State Hospitals

Despite limited research, serious concerns from advocates and instances of abuse at the MCMHTF, in 2011, the Texas Legislature authorized the privatization of one state hospital. Rider 63 of House Bill 1, 82nd Legislature allowed for one of the state's mental health hospitals to be privatized. Through an RFP process, five companies requested information: MHM Services, Inc., El Paso MHMR, and Liberty Healthcare Corporation (Liberty), Vodastra Solutions and Geo Care, Inc.[88] Ultimately, only Geo Care submitted a proposal.

Amidst these concerns regarding their Montgomery County facility, Geo Care's 2012 proposal to take over the Kerrville State Hospital met challenges. In a letter to Governor's office, DSHS Commissioner David Lakey rejected GEO's proposal noting

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[86] Karen L. Hubbard, Patricia K. Zapf and Kathleen A. Ronan, "Competency Restoration: An Examination of the Differences Between Defendants Predicted Restorable and Not Restorable to Competency." *Law and Human Behavior* 27, 2. 2003: 127-139.

[87] Texas Department of State Health Services. *Montgomery County Hospital Population, 2011-2013***.**

[88] Rider 63, HB 1, 82nd Legislature, *Report on Privatization of a State Mental Health Hospital*, 2012, Texas Department of State Health Services,
http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589962374

that the company would have cut overall staffing facilities by 21 percent and psychiatric nursing assistant levels by 27 percent. GEO's proposal, Lakey wrote, would not "ensure a safe environment for patients and staff." The proposal received a score of only 64 out of 100. In June 2014, during a tense Sunset review process and highly critical Sunset staff report, DSHS issued an Request for Proposals to privatize Terrell State Hospital. Although Health and Human Services Commissioner Janek has extended the timeline for awarding the contract, Geo Care has already expressed interest.[89]

Mental health experts across states warn against privatization of forensic psychiatric treatment, echoing similar concerns surrounding quality of care. Although public state hospitals may also provide poor quality care, the level of oversight is usually greater, creating more opportunities for intervention. Advocates instead recommend an expansion of jail diversion programs and community outpatient services that are more effective, less costly, and result in fewer people being involuntarily confined. [90,91] These recommendations can also result in fewer inpatient mental health commitments overall, reducing the strain on the system and also keeping people out of both public and private inpatient facilities. The Sunset Staff Report echoes these recommendations and will be discussed at greater length below.

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[89] Staff Report. "Four potential bidders express interest in taking over Terrell State Hospital." *The Terrell Tribune,* June 24, 2014.

[90] California Judicial Council Task Force for Criminal Justice Collaboration on Mental Health Issues, *Final Report: Recommendations for Changing the Paradigm for Persons with Mental Illness in the Criminal Justice System*, Judicial Council of California, Administrative Office of the Courts, Center for Families, Children and the Courts, April 2011, http://www.courts.ca.gov/documents/Mental_Health_Task_Force_Report_042011.pdf

[91] Texas Department of State Health Services, Council on Sex Offender Treatment, *Civil Commitment of the Sexually Violent Predator - Inpatient vs. Outpatient SVP Civil Commitment,* April 2010, www.dshs.state.tx.us/csot/csot_ccinout.shtm

Strategies to Reduce the Forensic Mental Health Population

As previously discussed, privatization of forensic mental health care became attractive to policymakers because of capacity shortages and financial limitations. Although some states have studied the impact of privatization and decided it is not in their best interest, there is already ample support for privatization in Texas. Therefore, best practices include population reduction strategies to ease the strain the large population has had on the state and the justice system, but also because advocates and clinicians agree that confinement, either in jails, prisons or psychiatric facilities, is not optimal; providing services in the least restrictive environment is best.

Jail Diversion

Jail diversion strategies include three-tiers: pre-booking jail diversion; post-booking jail diversion; and reentry services to prevent recidivism. [92,93] In addition, law enforcement is commonly unprepared to address mental health issues when responding to a call or completing an arrest and therefore, training regarding mental health for law enforcement is often considered a component of jail diversion. When provided together, these intervention strategies are referred to as the Sequential Intercept Model (SIM), which is a comprehensive set of diversion tactics that, together, should result in far fewer individuals with mental disorders involvement in the justice system.

Pre-booking Jail Diversion

In order to prevent individuals with a mental health disorder from ever entering the justice system, a number of jail diversion strategies have been employed. One prominent program involves training law enforcement to effectively respond to public safety concerns perpetrated by someone with a mental health diagnosis. This training alone can

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[92] Henry J. Steadman and Michelle M. Naples, "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders." *Behavioral Sciences & the Law* 23, 2. 2005: 163–170.

[93] Henry J. Steadman, Suzanne M. Morris, and Deborah L. Dennis, "The Diversion of Mentally Ill Persons from Jails to Community-Based Services: A Profile of Programs." *American Journal of Public Health* 85, 12. 1995: 1630-5.

prevent charges from ever being brought against these individuals, but paired with crisis intervention centers and accessible community mental health services, a comprehensive diversion and treatment program is preferred.

An example of a comprehensive program is found in Massachusetts where a first responder team is made up of both police and mental health professionals in order to prevent escalation and booking and promote access to treatment. This model also uses a Comprehensive Community Intervention Team (CCIT) and all first responders are trained in effective responses to public safety concerns that involve individuals with mental disorders. Initial outcomes of this model illustrate effective jail diversion for individuals who interacted with members of a CCIT.[94]

Post-booking Jail Diversion

Ideally, individuals with mental health diagnoses will never enter the justice system, but trends in the system show that unfortunately, they are not diverted nearly enough. Furthermore, for individuals who commit more serious and/or violent offenses, involvement in the justice system is usually unavoidable. However, once charged with a crime, there are a few avenues to hold them accountable, but also keep them from being incarcerated in a setting that will only worsen their condition, i.e. most jails and prisons. First, a psychiatrist or psychologist must evaluate each person to ensure they are competent to stand trial; if found incompetent, the individual must be transferred to a competency restoration program. If found competent, another opportunity for intervention is a mental health court or docket.

A 2007 study evaluated the outcomes of a mental heath court in San Francisco. The study found that graduates of the mental health court program went longer periods of time after

[94] U.S. Substance Abuse and Mental Health Services Association. National GAINS Center for Behavioral Health and Justice Transformation, Technical Assistance and Policy Analysis Center. *Department of Mental Health Forensic Mental Health Services Report on DMH-operated pre-arrest jail diversion programs 7/1/06 to 10/1/09*. Massachusetts Department of Mental Health: 2009, http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.mass.gov%2Feohhs%2Fdocs%2Fdmh%2Fforensic%2Fjail-diversion-program.doc&ei=bAXoU_n4A6rX8AGswoGQBw&usg=AFQjCNH6kmXNie1yPDvdx5qEgPF6_1us5Q&sig2=j37RE_oO4ho4q7MIDlrivA&bvm=bv.72676100,d.b2U

completion before another arrest and were less likely overall to re-enter the justice system. These findings further improved when completion was paired with follow-up contact within a year. [95]

Outpatient Treatment Options

If neither of the aforementioned programs or interventions succeeds in keeping individuals with a mental health diagnosis from being incarcerated, there is one last option. For those that have been charged with a crime, but found incompetent to stand trial, an outpatient competency restoration can be effective. For those convicted of a crime, some states are testing the efficacy of condition release for certain severely impaired individuals. Texas operates the largest outpatient competency restoration (OCR) program in the country. Twelve programs across the state served 1,607 individuals by the end of 2013. Initial evaluation data reveals that OCR is more cost effective with comparable outcomes to inpatient competency restoration, however further research is needed.

Some states, including Texas, are also considering jail-based competency restoration. The Dallas community will implement a jail-based competency restoration pilot program this year. Jail-based competency restoration refers to medication and treatment that is administered to an individual while still in jail, rather than transferring them to an inpatient or outpatient program. Unfortunately, there is little evidence documenting the outcomes of jail-based competency restoration. The Texas Legislative Budget Board reported that there were considerable savings in a California county that contracted with a private company, Liberty Healthcare, but the average length of stay was 54 days.[96] However, advocates point out that individuals requiring mental health services should not be held in the jail environment for such an extended period of time.

Reentry

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[95] Dale E. McNiel and Renee L. Binder, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence." *American Journal of Psychiatry* 164, 9. 2007: 1395-1403.

[96] Texas Legislative Budget Board, *Texas State Government Effectiveness and Efficiency Report.*

Supports and services for individuals with a mental health or substance use disorder leaving jail and prison have also showed promising results. The Center for Public Policy Priorities' recent publication, *From Recidivism to Recovery: The Case for Peer Support in Texas Correctional Facilities,* recommends utilizing peer support specialists to assist in transitioning back into the community. A peer support specialist is someone who has lived experience with mental illness and has gone through a recovery process. The report research suggests that recidivism rates for individuals with serious mental health disorders that receive peer support services during reentry are approximately 24 percent, as compared to 77 percent of state prisoners with serious mental health disorders who do not.[97] Reentry services are considered an integral part of a comprehensive jail diversion strategy.

[97] Randall and Ligon, "From Recidivism to Recovery."

Additional Recommendations

The Texas Sunset Commission Staff Report addressed the forensic mental health population in its first set of recommendations.

Department of State Health Services Sunset Staff Report Recommendations[98]

1.1 Require DSHS to work with the Court of Criminal Appeals to develop training to inform the judiciary about alternatives to inpatient mental health treatment.

1.2 Direct DSHS to develop a guide for alternatives to inpatient mental health treatment in the state mental health hospital system.

Although the Sunset review process highlighted the need for alternatives to inpatient mental health treatment, it did not provide a vetted list of those alternatives. The strategies outlined above could be considered by the state in developing alternatives to inpatient treatment, especially regarding the forensic mental health population.

Support population reduction strategies

Jail diversion strategies can be used to dramatically reduce the forensic mental health population, and the number of people with mental health diagnoses involved in the justice system. These efforts can be paired with prison population reduction strategies, such as sentencing reform and increasing options for community supervision to reduce the overall number of incarcerated individuals, with and without a mental health diagnoses.[99]

Increase funding for community mental health programs

For jail diversion tactics to have meaningful, long-term impact, efforts should be paired with increased funding for community mental health. Jail diversion will be no more

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98 Texas Sunset Advisory Commission, *Staff Report.*

99 Judith Greene and Marc Mauer, "Downscaling Prisons: Lessons from Four States." *The Sentencing Project:* 2010. http://www.sentencingproject.org/doc/publications/publications/inc_DownscalingPrisons2010.pdf

effective than deinstitutionalization if affordable and quality mental health services are not also readily available. When the Community Mental Health Act of 1963 was signed, the intent was to open adequately funded mental health centers in every community. The Patient Protection and Affordable Care Act offers some opportunities, however without Medicaid expansion, Texas will forego billions of dollars for mental health and substance use disorder services.

Conduct more research that includes people who have been affected by these systems

Research conducted for this paper did not find any studies that surveyed or interviewed individuals with lived experience with these systems. Although some studies include limited outcome measures of recidivism, employment, or treatment compliance, available literature fails to present opinions and ideas of those individuals themselves. The social work profession calls for practice informed research and research informed practice; considering this population represents some of the most marginalized members of our society, their inclusion in research and policy making is paramount.

Conclusion

Unfortunately, it does not appear that we have come much farther since Dorothea Dix was championing the cause of incarcerated individuals with mental health disorders in the 19th century. That is partly because reforming the criminal justice and mental health systems is no easy feat, but also because changes to one system do not adequately address the diverse array of needs of the most affected individuals. In modern times, we now face the added challenge of for-profit prison companies operating publically funded mental health hospitals. However difficult, the state hospital planning initiative and the Sunset report create an opportunity to make meaningful changes.[100] The policies in the forensic mental health system are not limited to criminal justice or mental health; housing policy, public benefits, and education are all part of a larger societal context. Therefore, although this paper analyzes forensic mental health care, the above recommendations must be part of a larger reform effort.

[100] Texas Sunset Advisory Commission, *Staff Report.*

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