SUBJECT: Revising the state system for care of individuals with mental retardation

COMMITTEE: Human Services — committee substitute recommended

VOTE: 6 ayes — Rose, Darby, Elkins, Hughes, Legler, Naishtat

0 nays

3 absent — Herrero, Hernandez, Walle

SENATE VOTE: On final passage, March 9 — 30-0

WITNESSES: (*On similar House bill, HB 1317:*)
For —Jason Ceyanes, Mexia Independent School District; Todd Clark, Walsh, Anderson, Brown, Aldridge & Gallegos for Mexia Independent School District; Cory Culpepper; Jeff Garrison-Tate, Community Now!; Derrick Osobase, Texas State Employees Union; Susan Payne; Ruth Snyder; Elizabeth Whitlow; (*Registered, but did not testify:* Dennis Borel, Coalition of Texans with Disabilities; Ben Campbell, TORCH; Susan Elrod, Texas Council of Community MHMR Centers; Richard Hernandez, EouCare Community Living, Inc.; Lisa Lewis-Nourzad, Goodwill Industries; Carole Smith, Private Providers Association of Texas)

Against — Beth Mitchell, Advocacy, Inc.; Nagla Moussa, The Arc of Texas; (*Registered, but did not testify:* Tanya Winters, Texas Advocates)

On — Bart Beavers, Texas Health and Human Services Commission, Office of the Inspector General; Anne Heiligenstein and Karl Urban, Department of Family and Protective Services; Colleen Horton, Texas Center for Disability Studies; Angela Lello, Texas Council for Developmental Disabilities; Lee Spiller, Citizens Commission on Human Rights

BACKGROUND: Eligible Texans with cognitive and developmental disabilities may receive care in one of the following settings:

- state schools and centers;
- private intermediate care facilities for the mentally retarded (ICF-MRs) and community MHMR centers; or
- in the community through Medicaid waiver services, including the Home and Community-based Services (HCS) waiver.

The Department of Aging and Disability Services (DADS) operates state schools and licenses and certifies private ICFs-MR. It certifies HCS providers to provide Medicaid long-term services and supports in an individual's own home or family home, a foster care home, or a three- or four-bed group home.

DADS operates state schools and centers with ICFs-MR components providing 24-hour care to residents. These state mental retardation facilities (SMRFs) include 11 state schools (Abilene, Austin, Brenham, Corpus Christi, Denton, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio) and two state centers (El Paso and Rio Grande). In 2008, almost 5,000 Texans diagnosed with mental retardation resided in state schools and centers.

The Department of Family and Protective Services (DFPS) was created to license day-care facilities for adults and children and to protect children, the elderly, and individuals with disabilities living at home or in facilities from abuse, neglect, and exploitation. Human Resources Code, sec. 48.252 and Family Code, sec. 261.404 authorize DFPS to investigate allegations of abuse, neglect, and exploitation of individuals receiving services in or from:

- state-operated mental retardation facilities;
- mental health authorities and mental retardation authorities (community MHMR centers);
- Home and Community-based Services (HCS) and Texas Home Living (TxHmL) programs and their respective contractors; and
- state-operated mental health facilities.

Reports of abuse and neglect in the state school system have led to enhanced state and federal scrutiny, including a U.S. Department of Justice (DOJ) investigation beginning in 2005. The DOJ, in accordance with the Civil Rights of Institutionalized Persons Act (CRIPA), investigates facilities throughout the United States. In the last fiscal year, the DOJ has investigated developmental disability and mental retardation

facilities in Missouri, Nebraska, California, New Jersey, Arkansas, Kentucky, Iowa, and the Commonwealth of Puerto Rico, as well as Texas, and currently monitors conditions in 22 facilities in several states operating under court orders or settlement agreements with the federal government. DOJ investigations generally focus on residents' constitutional rights to reasonable safety, proper medical and mental health care, habilitation, education, and freedom from unreasonable and excessive use of restraints, as well as investigations into allegations of staff abuse and preventable injuries and deaths.

In December 2008, DOJ released a report of its findings on Texas state schools and centers. The report concluded that many conditions and practices within the state school system violated constitutional and federal statutory rights of residents. While differences existed among facilities, the DOJ found systemic failure to provide residents with adequate:

- protection from harm;
- health care;
- behavioral services, habilitation, and freedom from inappropriate restraint; and
- integrated services appropriate to each individual's needs.

DOJ found "serious problems and deficiencies of care" within the state schools and centers, citing 450 reports of abuse and 53 deaths linked to preventable conditions in 2007 and 800 direct-care staff firings or suspensions since 2004. The report referred to the hundreds of reports of abuse and injuries as "disturbingly high" and said more than half of the "state facilities may be in danger of losing Medicaid funding because of care and safety problems." In February 2009, in response to the DOJ report and other highly publicized reports of abuse and neglect, Gov. Perry declared legislation to reform and improve state schools and centers an emergency matter.

Recently, DADS implemented emergency measures in all 13 state schools and centers due to alleged criminal abuse resulting in the arrests of six current or former direct care workers at the Corpus Christi State School. The system-wide emergency measures included assigning additional supervisors to evening shifts, random unannounced inspections by managers during evening and late-night shifts, and the purchase and installation of security cameras.

DIGEST:

CSSB 643 would establish measures for oversight, safety, and the prevention of abuse, neglect, and exploitation of individuals with mental retardation residing in state schools, community and private ICFs-MR, and 1915(c) waiver program or HCS group homes.

A focus of the bill would be changes in state schools, which would be referred to as state-supported living centers (SSLCs), and the ICF-MR component of the Rio Grande State Center (collectively referred to as "state centers" or "SSLCs"). DADS would post surveillance cameras in each state center and perform background checks, fingerprinting, and random drug testing on state center employees and provide additional employee training. The Mexia SSLC would be designated as a separate facility for "high-risk" alleged offenders.

An independent ombudsman would oversee and audit state schools and be a confidential intermediary for residents, clients, family members, or guardians. A toll free abuse hotline would be established and annual unannounced on-site surveys of HCS providers would be required. The role of DFPS, DADS, and the HHSC office of inspector general would change with regard to investigations within state centers, and an independent mortality review system would be created to review the death of any resident or client of a state center or certain other facilities or programs licensed by DADS.

**State-supported living centers and center directors.** Under CSSB 643, state school superintendents would be referred to as "center directors." Their powers and duties would include current duties of state school superintendents, but would be expanded under the bill to include:

- ensuring that the civil rights of center residents and clients were protected;
- ensuring the health, safety, and general welfare of center residents and clients; and
- monitoring the arrival and departure of individuals to and from the center as appropriate to ensure the safety of residents.

**Video surveillance.** DADS would install and operate video surveillance equipment in state centers. The department would not install or operate video cameras in "private spaces," including bedrooms, bathrooms, medical services areas, or places where residents or clients may privately meet with visitors or make phone calls.

**Criminal background checks and fingerprinting.** The bill would require DADS and the Department of State Health Services (DSHS) to perform criminal background checks on all agency employees, volunteers, or applicants for employee or volunteer positions who would be placed in direct contact with residents or clients. Submission of Texas Department of Public Safety (DPS) or Federal Bureau of Investigation (FBI) quality fingerprints also would be mandatory. The bill would require that DPS provide electronic updates of arrests and convictions for any person on whom the agency previously ran a background check and who remained an employee or volunteer in direct contact with residents or clients.

HHSC would be required to have all employee background checks completed by September 1, 2010. Employees would be dismissed if the criminal history check revealed a conviction that would bar employment under ch. 250, Health and Safety Code, which includes murder, kidnapping, sexual offenses, robbery, terroristic threats, injury to a child, elderly or disabled person, and cruelty to animals. Lesser offenses such as assault, burglary, and disorderly conduct would bar employment for five years from the date of conviction.

**Person ineligible for license.** A person or entity would be ineligible for a license to operate a private, licensed ICF-MR if the applicant, an administrator, chief financial officer, or other "controlling person" with respect to the applicant had a conviction for an offense that would bar employment at the facility. A "controlling person" would include anyone, including a management company or other business entity, with the ability to directly or indirectly influence the management, expenditures, or policies of a facility or person who operated a facility.

**Drug testing.** CSSB 643 would require random drug testing for all SSLC employees and would allow drug testing of a center employee upon reasonable suspicion of the use of illegal drugs by the employee. Any employee who knew or reasonably suspected that another center employee was illegally using or was under the influence of a controlled substance would have to report this knowledge or reasonable suspicion to the center director. Employees could be terminated on the basis of a single positive drug test, but could appeal the decision.

**Center employee training.** Before a center employee performed duties without direct supervision, the department would provide appropriate training and instruction related to the employee's job, including the

uniqueness of the individuals the center serves, the health and safety of individuals with mental retardation, and conduct expected of employees.

General instruction would include:

- an introduction to mental retardation, autism, mental illness, and dual diagnosis;
- the rights of individuals with mental retardation who are served by the department;
- respecting personal choices made by residents and clients;
- the safe and proper use of restraints;
- recognizing and reporting evidence of abuse, neglect, or exploitation, any unusual incidents, and any reasonable suspicion of drug use, violence, or sexual harassment;
- preventing and treating infection, first aid, and CPR; and
- information regarding home and community-based services, including the principles of community inclusion and the community living options information process (CLOIP).

Staff would be trained in the interdisciplinary treatment program (ITP) for each resident for whom an employee provided direct care and specific techniques for target populations, such as aging clients, residents with mobility issues or visual or hearing impairments, and the prevention and management of aggressive behavior.

DADS would develop new training no later than January 1, 2010, and employees would receive new training no later than September 1, 2010.

An SSLC could provide training to employees of private ICFs-MR or HCS waiver program group homes or other professionals involved in the care of individuals with mental retardation. DADS would evaluate and determine the types of training needed and the legislation or actions needed to ensure that the right training was received and would report its findings to the governor and legislative leaders by December 1, 2010.

**Forensic state-supported living center.** CSSB 643 would create a forensic SSLC for the care of high-risk alleged offender residents apart from other clients and residents at the Mexia state center. DADS would hire additional forensic center employees and provide training specific to the care of high-risk alleged offender residents to direct care staff.

In establishing the center, an interdisciplinary team (IDT) would determine whether each alleged offender residing in a state center on the effective date of the bill was "high risk," or at risk of inflicting substantial harm to another. A current alleged offender resident classified as high risk would be entitled, before being transferred to the forensic SSLC, to:

- an administrative hearing with the department to contest the determination and classification;
- bring suit to appeal the determination and classification in district court in Travis County, upon exhausting administrative remedies with DADS; and
- an administrative hearing to contest the proposed transfer or discharge.

DADS could not transfer a current alleged offender resident while the resident was pursuing any administrative remedies. Alleged offender residents determined not to be high risk and non-alleged offender residents in the Mexia SSLC could choose to remain at the facility, housed separately from the high-risk alleged offender population, or could request a transfer to another SSLC.

DADS would have to place all new alleged offender residents, when they initially were committed to the SSLC system, in the forensic SSLC until a risk determination was completed. Within 30 days of a new alleged offender resident arriving at the forensic SSLC and annually thereafter, an IDT would determine whether the alleged offender was high-risk. The IDT would document all evidence collected in making the determination and present the documentation to the department, center director, independent ombudsman, alleged offender resident, the resident's legally authorized representative (LAR), and a parent if the resident were a minor.

An individual who was deemed to be a high-risk alleged offender would be entitled to an administrative hearing to contest the determination and classification and could file an appeal by trial de novo in a district court in Travis County within 30 days of the administrative hearing determination.

DADS would collect data on the commitment of alleged offender residents to the forensic SSLC and would submit this information annually in a report to the governor and various legislative leaders. The report could contain no identifying information.

**Office of Independent Ombudsman.** CSSB 643 would create an Office of Independent Ombudsman to investigate, evaluate, and secure the rights of residents and clients of SSLCs. The governor would appoint as ombudsman an individual with at least five years of experience managing and ensuring the quality of care and services provided to individuals with mental retardation, no later than September 1, 2009. Although administratively attached to DADS, the office would act independently of the department. The role of the ombudsman would be to evaluate how centers investigated, reviewed, and reported unusual incidents and injuries and to evaluate center services to ensure the rights of residents and clients were protected and that sufficient unannounced patrols were conducted.

Under the bill, the ombudsman would refer complaints of:

- possible abuse, neglect, or exploitation to DFPS;
- unusual incidents to the inspector general; and
- ICF-MR standards violations or employee misconduct that did not involve abuse, neglect, or exploitation to the regulatory division of DADS.

The ombudsman would not investigate alleged criminal offenses or alleged abuse, neglect, or exploitation of a resident or client. However, the ombudsman would investigate complaints involving a possible systemic issue in a developmental center's services and could apprise a person who was interested in a resident's or client's welfare of the respective rights of the individual. The ombudsman would take action upon determining a resident, client, family member, or LAR was in need of assistance, including advocating with an agency, provider, or other person in the best interests of the resident or client and making appropriate referrals.

CSSB 643 also would require that the independent ombudsman:

- conduct an annual audit of each center's policies, practices, and procedures to ensure that each resident and client was encouraged to exercise his or her rights, including the right to file a complaint and the right to due process; and
- prepare and deliver an annual report regarding the findings of each audit to various state leaders and agencies.

The independent ombudsman would hire assistant ombudsmen, with the same degree of experience, to be stationed at each SSLC to perform the

same duties as the ombudsman. A person could not serve as ombudsman or as an assistant ombudsman if the person or the person's spouse was employed by or had any interest, directly or indirectly in any business entity or organization receiving funds from DADS or was a lobbyist on behalf of a profession related to the department.

The ombudsman would submit a biannual report to the governor and various legislative leaders describing the results of any reviews or investigations conducted by the ombudsman's office and any recommendations for systemic improvements. The report could contain no information allowing the identification of an individual.

CSSB 643 would require the independent ombudsman to immediately report to the governor, the lieutenant governor, and the speaker of the House any particularly serious or flagrant:

- case of abuse or injury of a resident or client;
- problem with the administration of a center program or operation; or
- interference by a center, DADS, or HHSC with an investigation conducted by the independent ombudsman.

Any resident or client, family member, or other interested party could communicate with the independent ombudsman or an assistant ombudsman, and it would be confidential and privileged. The department or a SSLC could not retaliate against an employee or another person who in good faith made a complaint or cooperated in an investigation with the ombudsman.

The independent ombudsman could make investigation reports public upon completion of the investigation if all identifying information of a resident or client, family member or authorized representative of a resident or client, or SSLC or center employee were removed from the report and it remained confidential.

**Toll-free number.** The independent ombudsman would promote awareness of the services provided by the office and how it could be contacted. The office would establish a permanent, toll-free number to report a violation of a resident’s or client’s rights. The toll-free number would be prominently displayed in common areas, and residents, clients,

LARs, and developmental center employees would have confidential access to a telephone to call the toll-free number.

**Consumer rights employees.** On the effective date of the bill, a DADS employee who performed duties primarily related to consumer rights and services at state centers would be required to reapply for a position with the department and could apply for a position as an assistant ombudsman.

**New agency roles and procedures; private facilities.** The bill would require DADS to notify each resident, parent, or other adult family member of a resident in a state center of any incident involving the abuse, neglect, or exploitation of a resident occurring in the center.

The bill would add facilities licensed under Health and Safety Code, ch. 252, and private ICFs-MR licensed by DADS to the list of private facilities DFPS would investigate regarding allegations of abuse, neglect, or exploitation. In giving DFPS the authority to investigate these facilities, the bill would repeal several sections of the Health and Safety Code on the private facilities' or DADS' current role in investigations.

The bill would require private facilities to prominently post a notice of how to contact DFPS to report allegations. Private ICFs-MR also would be required to report employee misconduct of abuse, neglect, and exploitation for purposes of listing in the Employee Misconduct Registry.

CSSB 643 would require that DFPS would, within one hour of receiving a report of abuse, neglect, or exploitation in a state center:

- notify the center in which the individual was receiving services of the allegations;
- forward a copy of the initial intake report to the OIG for evaluation and investigation; and
- place the DFPS investigation on hold.

DFPS could assist the OIG during an investigation, including by conducting interviews but otherwise would proceed with and complete an investigation only if, within 24 hours of forwarding the report to the OIG, the OIG notified DFPS that no cause for criminal investigation was found.

The HHSC executive commissioner would adopt rules regarding investigations in private ICF-MR facilities licensed by DADS to ensure

that all investigations relating to elderly and disabled individuals were as consistent as possible.

Changes in law made by the bill relating to investigations of abuse, neglect, or exploitation in state centers or private ICFs-MR would apply only to reports made on or after January 1, 2010.

**Office of Inspector General (OIG).** CSSB 643 would establish additional duties for the HHSC Office of Inspector General for criminal investigations of abuse, neglect or exploitation of residents or clients of state centers and for filing reports relating to investigations.

Upon receipt of a report from DFPS or the ombudsman regarding an unusual incident or possible abuse, neglect, or exploitation of a resident, the inspector general immediately would begin an evaluation to determine if a criminal investigation was warranted. If, within 24 hours, the OIG determined that a criminal investigation was not warranted, a report of that determination would be provided to DFPS or the ombudsman as appropriate for further investigation by the agency.

If the OIG determined within 24 hours that there was cause for a criminal investigation or if the OIG was unable to make a determination within 24 hours, then the inspector general would conduct or assist a law enforcement agency in conducting an investigation of the report.

In making a determination or conducting an investigation, the OIG would:

- within one hour of determining the identity of a perpetrator of abuse, neglect, or exploitation, notify the center and DADS;
- within one hour of determining that cause existed for a criminal investigation within a center, notify local law enforcement and provide appropriate information and assistance;
- within five days of receiving a report of abuse, neglect or exploitation, provide an unredacted investigation report to the state center involved, and within 14 days provide a report to DFPS, DADS, the SSLC, and its assistant ombudsman;
- if a criminal prosecution was warranted, refer the investigation findings to the local prosecuting attorney or to the attorney general if the local prosecutor did not proceed within 30 days of receiving the evidence from the OIG; and

- refer any evidence of employee misconduct not involving abuse, neglect, or exploitation to DADS.

The department or a SSLC could not retaliate against an employee or any other person who in good faith made a complaint or cooperated in an investigation with the OIG. The OIG would deliver the summary report to various state leaders and human services agencies. It would be confidential and not subject to disclosure, discovery, or subpoena, to anyone other than the OIG agents involved in the investigation, DFPS, the attorney general, the State Auditor's Office, and law enforcement agencies.

The OIG would prepare an annual status report, including non-identifying information aggregated and disaggregated by individual center, on the number and types of:

- alleged offenses investigated by the office;
- alleged offenses involving center employees;
- investigations conducted that involved suicides, deaths, or hospitalization of center residents or clients; and
- completed investigations resulting in findings of confirmed, unsubstantiated, or inconclusive allegations and reasons supporting the findings.

The annual status report would be public information and would be provided by the OIG to various state leaders and human services agencies.

The OIG would employ and commission peace officers, no later than December 1, 2009, for the sole purpose of assisting state or local law enforcement in the investigation of a criminal offense involving a resident or client of a state center.

**Mortality review.** CSSB 643 would create an independent mortality review system to review deaths of individuals with developmental disabilities who at the time of the death were:

- a resident in or received services from a state center, an ICF-MR operated or licensed by DADS, or a community center;
- a resident in a 1915(c) waiver program group home serving three or more developmentally disabled individuals, and in which the waiver program provider had a property interest.

This review would be in addition to, and upon the completion of, any investigation or review conducted by the facility in which the individual resided or received services.

The executive commissioner, no later than December 1, 2009, would be required to contract with an independent, federally certified, patient safety organization (PSO) to conduct mortality reviews. The PSO's contract would require that the mortality review team include a physician, a registered nurse, and a clinician with expertise in the treatment and care of individuals with mental retardation. Health care providers and others would not be civilly or criminally liable for providing information in good faith to assist the PSO or HHSC during the investigation.

The findings of the mortality review would be submitted to DADS, DFPS, the independent ombudsman, and the OIG. The PSO would submit a report semi-annually to the governor and certain legislative leaders containing aggregated data regarding deaths, trends in the causes of death, and any recommendations for system-wide improvements.

Information from the review could be used by the department only to advance statewide practices in the treatment and care of individuals with mental retardation or other disabilities or as a summary or statistical compilation containing no identifying information of individuals involved. Information and records acquired by the PSO in the course of the investigation would be confidential and exempt from disclosure under open records law.

**Memorandum of understanding (MOU).** A "Memorandum of Understanding" would be required between HHSC, DFPS, DADS, the independent ombudsman, and OIG by December 1, 2009, regarding investigations of abuse, neglect, or exploitation in state centers and delineating the responsibilities of each agency. It could be amended as necessary.

**Assistant commissioner of state-supported living centers.** The DADS commissioner would hire an assistant commissioner of SSLCs. The assistant commissioner would report directly to the commissioner and would be selected based on education, training, experience, and ability.

The assistant commissioner's duties would include:

- supervising the operation of the SSLCs;
- verifying that quality health and medical services were being provided;
- verifying and certifying qualifications for employees of SSLCs;
- working with the commissioner to create administrative guidelines for proper implementation of federal and state statutory law and judicial decisions; and
- consulting with DSHS to ensure that individuals with dual diagnosis residing in state centers were provided with appropriate care and treatment.

When an assistant commissioner of SSLCs was employed, the current position of section director over state schools would be eliminated.

**Electronic database.** DADS, in consultation with DFPS and the OIG, would develop and maintain an electronic database to collect and analyze information on the investigation and prevention of abuse, neglect, and exploitation of individuals with mental retardation residing in publicly or privately operated ICFs-MR or in HCS group homes, other than foster homes, and the results of the regulatory investigations or surveys performed by DADS on those facilities or providers.

The information in the database would be detailed, easily retrievable, and include information on abuse, neglect, and exploitation investigations and regulatory investigations. At a minimum, the database would have to include:

- the number of allegations of abuse, neglect, or exploitation received about a facility or group home, other than a foster home;
- the number of allegations about a facility or group home, other than a foster home, substantiated through an investigation; and
- findings on failure to comply with regulatory standards directly related to the prevention of abuse, neglect, or exploitation in a facility or group home, other than a foster home, aggregated and disaggregated by home, provider, and facility.

**Increased penalties.** CSSB 643 would increase the penalty for failure to report the abuse of a child from a class B misdemeanor (up to 180 days in jail and/or a maximum fine of $2,000) to a class A misdemeanor (up to

one year in jail and/or a maximum fine of $4,000). If at trial it was shown that the child was a person with mental retardation who resided in a state center and the actor knew the child had suffered serious bodily injury from the abuse or neglect, the penalty would be a state-jail felony (180 days to two years in a state jail and an optional fine of up to $10,000).

The penalty for knowingly failing to report the abuse, neglect, or exploitation of an elderly or disabled person is a class A misdemeanor (up to one year in jail and/or a maximum fine of $4,000). CSSB 643 would increase the penalty to a state-jail felony (180 days to two years in a state jail and an optional fine of up to $10,000) when the disabled person was a person with mental retardation residing in a state center or a private ICF-MR and the actor knew that the disabled person suffered serious bodily injury as a result of the abuse, neglect, or exploitation.

The bill would increase the penalty for intentionally and knowingly committing an injury to a disabled individual if the disabled individual resided in a state center or ICF-MR and the actor was a direct-care employee for the victim. The penalty for the offense would increase from a third-degree felony (two to 10 years in prison and an optional fine of up to $10,000) to a second-degree felony (two to 20 years in prison and an optional fine of up to $10,000).

**Interim select committee.** CSSB 643 would establish the Interim Select Committee on Criminal Commitments of Individuals with Mental Retardation to study the criminal commitment process for individuals with mental retardation who were found incompetent to stand trial or who were acquitted by reason of insanity. The committee's study would include:

- the advantages and disadvantages of the existing system;
- the number of individuals with mental retardation who were criminally committed each year and the number found to be violent or dangerous through the criminal commitment process;
- whether the commitment process should be changed to provide for the commitment of individuals with mental retardation found to be violent or dangerous to a mental retardation facility instead of to a mental health facility; and
- the costs associated with modifying the criminal commitment process.

The committee would include the chairs of various legislative committees and would report its findings to the governor, the lieutenant governor, the House speaker, and legislators by December 1, 2010.

The bill would make various technical and conforming changes, and would apply to dismissals of state center employees hired before, on, or after the effective date of this act**.** If a state agency determined that a federal waiver or authorization was required to implement a provision of the bill, the agency could delay implementation of the provision until the federal waiver or authorization was granted.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2009.

SUPPORTERS SAY:

CSSB 643 would address problems that have played a significant role in the ongoing allegations of abuse, neglect, and exploitation of one of the state's most vulnerable populations—the intellectually and developmentally disabled individuals in state schools, private ICFs-MR, and HCS group homes. The bill would reform the internal operations of state facilities and increase oversight. It would enhance investigation and reporting procedures, institute training, establish safeguards for residents and clients, assist staff, and ultimately initiate change in the current culture of state schools.

**State-supported living centers and center directors.** CSSB 643 would change the name "state schools" to a more accurate and illustrative term. "State school" is a misnomer that leads to confusion because, while state schools do provide some educational services, they are residential settings offering a wide array of services, treatments, and habilitation, primarily to adults. The associated title of "state school superintendent" reinforces the confusion. The bill would require transitioning to the more appropriate terms "state-supported living center" and 'center director."

Center directors would have authority to remove an employee if the director believed residents were at risk, whereas current law requires a state school superintendent to have "good cause" to terminate an employee. The bill would remove the requirement for "good cause" so that a center director could terminate an employee without a review hearing if the director felt it was necessary to protect residents. In specifically addressing the powers and duties of an SSLC director, the bill would

address a December 2008 recommendation by the House Select Committee on Services for Individuals Eligible for Intermediate Care Facility Services.

**Video surveillance.** The use of video surveillance systems would be a deterrent for inappropriate behavior and provide evidence in cases of alleged abuse, neglect, or exploitation. The privacy of residents would be maintained by the bill's limitations on camera use, but cameras in hallways and other common areas would protect residents. Employees would know their movements into and out of residents' rooms were recorded and time stamped and could be evidence should any abuse occur in private.

Cameras already are used to protect other vulnerable populations, including residents in nursing homes. In 2007, the state auditor recommended increasing video surveillance to help secure TYC facilities for the safety of juvenile residents. In a follow-up report in 2009, the auditor noted that increasing the number of video surveillance systems was a factor that increased security and monitoring of the schools.

**Criminal background checks and fingerprinting.** Studies have shown that fingerprint background checks are the most accurate type of background checks. An individual can fake a name but not a fingerprint. Both the state auditor and a Senate interim report recommended this measure.

**Person ineligible for license.** The bill would amend current law restricting an individual from obtaining a license to operate a private ICF-MR if the person had a conviction that would bar the person from employment in a facility. The bill would expand the law to include those who may not have had the license in their names but who were actively involved in the controlling operations and direction of a facility. This would prevent bad actors from remaining in the business of caring for vulnerable residents.

**Drug testing.** A House interim report recommended that current DADS policy allowing employee drug testing only upon reasonable suspicion of drug use be changed to allow random drug testing of all state center employees. This would help protect residents from harm by ensuring that employees were not under the influence of drugs.

**Center employee training.** DOJ findings noted the need for increased training of staff. The training required by the bill would ensure that staff were adequately prepared to care for the specialized needs of intellectually and developmentally disabled individuals. The value-based training recommended by the interim committee and provided by the bill would initiate a philosophical shift and change in state school culture by focusing on valuing each resident as an individual, respecting the needs and abilities of each resident, and recognizing the uniqueness of developmentally disabled individuals, while offering them the highest quality of life.

DADS would be required to provide direct care employees with training on implementing the unique interdisciplinary treatment program (ITP) of each resident for whom the employee would provide direct care. DOJ noted a lack of training on residents' direct care plans and the importance of knowing not just how to care for individuals with developmental disabilities in general, but also how to care for each specific individual under the employee's care. For example, if an employee cared for someone who could communicate only by blinking his or her eyes, then the employee would need that specific training.

CSSB 643 would also address an interim committee recommendation that all staff receive Community Living Options Information Process (CLOIP) training in order to have a full understanding of the service options available to residents and clients.

**Forensic state-supported living center.** Establishing a separate forensic state center would provide more appropriate care for high-risk alleged offender residents and a safer environment for residents of other SSLCs. Currently, alleged offenders, including those deemed to be "high risk," are found throughout the state school system, housed with non-offender populations and cared for by regular direct care staff in the centers. Assigning all high-risk alleged offenders to the designated forensic center would allow those individuals to be cared for by staff specially trained to meet the needs of this unique population.

The bill would ensure that current alleged offender residents were not transferred to the newly designated forensic center until they had been determined to be "high-risk" and all administrative appeals challenging the determination had been exhausted. Therefore, no undue transfer or

disruption would be imposed on current alleged offender residents until a final determination had been made.

Individuals coming into the system on an initial criminal commitment would be entering from the court system, so an interdisciplinary team (IDT) determination could not be made and, even if it were, the only alternative would be to keep them in jail until all administrative appeals were exhausted. The bill would protect these individuals by requiring a determination to be made within 30 days of arriving at the forensic center.

CSSB 643 would provide for annual reviews of all alleged offenders determined to be high-risk so that if someone was determined to no longer be at risk of inflicting substantial physical harm to another, the individual could be transferred out of the forensic center to another SSLC.

**Office of Independent Ombudsman.** An ombudsman would be established as an independent entity focused on the needs of residents and clients. The ombudsman would strengthen oversight and be a confidential intermediary among parents, residents, guardians, and DADS. Assistant ombudsmen would be located at each school to ensure that the rights of residents were upheld and to help residents advocate for their interests.

The office would serve as a check and balance for DADS because it would be authorized to review procedures and services. The bill would keep lines of authority clear, limiting the investigatory powers of the office to non-criminal cases that under the bill would be handled by the Office of Inspector General. Requiring the office to report to the Legislature and to immediately report certain serious or flagrant situations would be yet another check, and allowing the ombudsman to make investigation reports public if all identifying information was removed would provide greater transparency and public oversight of the agency.

**Toll-free number.** Facilities would have to post the ombudsman's toll-free number in common areas where residents could readily view it and provide private telephone service. Although other toll-free numbers currently are posted in facilities, the addition of one more would help residents and might encourage them to call when necessary.

**Consumer rights employees.** The bill would not assume the status quo and would make possible the hiring of new employees in assistant ombudsmen positions by requiring current state school staff employed as

consumer rights officers to resign as of the effective date of the bill. These employees could apply for the position of assistant ombudsman, but the bill would not guarantee their rehire as the required qualifications for assistant ombudsmen would be substantially higher than those for a human or civil rights officer.

**New agency roles and procedures, private facilities.** CSSB 643 would improve oversight of private ICFs-MR and assisted living facilities (ALF) providing services to individuals under the Deaf-Blind with Multiple Disabilities (DB-MD) waiver program. Currently, when an allegation of abuse, neglect, or exploitation is received about a private ICF-MR or ALF, the private institution investigates itself, and DADS follows up to confirm that the investigation was conducted properly and to check for compliance with state and federal licensure and certification standards. The bill would remove the conflict of interest inherent in the current process by providing that reports of abuse and neglect in private institutions be investigated by DFPS, rather than the facility accused of abuse investigating itself.

Placing DFPS in charge of investigations within these facilities would bring consistency to the process so that all providers of services to individuals with intellectual and developmental disabilities were investigated by DFPS for allegations of abuse, neglect, or exploitation.

The bill also would improve the current system of private group home inspection by requiring unannounced on-site surveys of all HCS group homes in the state, other than foster homes. Under the current system, DADS surveys a sample of group homes each year, but not all.

In addition, the bill would provide for more transparency as DADS would be required to notify all residents and family members when an incident of abuse, neglect, or exploitation of a state center resident occurred.

**Office of Inspector General (OIG).** The investigation procedures established by the bill would better protect developmentally disabled residents and better enable state and local law enforcement's ability to criminally prosecute abuse in facilities.

Currently, DFPS decides at the intake level, usually over the telephone, the priority of a report and whether or not a criminal act is involved. Depending upon the initial determination, it may be days before DFPS arrives to investigate. If upon investigation the department realizes that

the incident was more serious than initially thought, or that a crime did take place when previously none was assumed, then it often is too late to obtain a prosecution because evidence is lost in the intervening days.

The bill would ensure that critical evidence was not lost and more prosecutions of abusers could take place by requiring that, within 24 hours, the OIG make a determination on whether a criminal offense had occurred. This would allow a more timely initiation of investigations, resulting in a greater preservation of evidence and more successful prosecutions. The bill would increase the probability of early detection of a problematic situation in a center with the requirement that the OIG analyze each report to detect patterns indicating abuse, neglect, or exploitation within a center.

**Mortality review.** CSSB 643 would require HHSC to employ independent experts to review all deaths of residents in state schools, private ICFs-MR, three or four bed HCS group homes, or individuals in the DB-MD waiver program residing in licensed assisted living facilities, as recommended by the federal Government Accountability Office (GAO). These reviews would help determine whether deaths were preventable, caused by abuse or neglect, lack of adequate care, or natural causes. Mortality reports issued by the patient safety organization would provide regulators, providers, and legislators with trend data and strategies to improve care of this population, yet confidentiality would be maintained to protect residents and clients and encourage cooperation by all parties.

Mortality reviews would increase independence and transparency. Currently, when a death occurs in a state school, DADS handles the incident and reports it only to DFPS or HHSC if DADS believes there is an indication that the death was not due to natural causes. Under the bill, more trust would be instilled in the system because one agency, DADS, would administer the SSLC program; a second, DFPS, would investigate the circumstances of incidents to determine if they were due to abuse, neglect, or exploitation; and a third agency, HHSC, would be responsible for mortality reviews to identify trends and address quality of care.

**Assistant commissioner of state-supported living centers.** The bill would establish the position of assistant commissioner of SSLCs at DADS to create a centralized jurisdiction over issues related to improvement in state centers, as recommended by the House interim report. The assistant

commissioner could work with the commissioner to ensure expedient, effective implementation of the recommendations and improvements specified by the Department of Justice. The position would not add another layer of bureaucracy because it would replace the existing section director of state schools at DADS.

**Electronic database.** The electronic database established by the bill would further protection of intellectually and developmentally disabled individuals by increasing oversight in state centers, private ICFs-MR, and HCS group homes. The database would aid in monitoring trends in the incidence of abuse and neglect so that problems could be immediately addressed, regardless of the setting in which they were taking place.

**Increased penalties.** Abuse and neglect of this population is deplorable, and the increased penalties provided by the bill reflect the seriousness of these crimes.

OPPONENTS SAY:

CSSB 643 would not address major systemic issues cited by DOJ in its report, such as staff-to-client ratios and the lack of mid-level supervision. Security cameras, name changes, and ombudsmen provided by CSSB 643 would not change the culture of state schools, and the culture is the prime cause of the abuse and neglect. When individuals with limited education, training, and skill are given total control over vulnerable individuals' lives, abuse and neglect will occur, and the bill would do nothing to change this basic fact. Living in a large institution involves living by group mentality, and individuality is lost. While oversight and protection legislation is important, the need to reform and rethink the system as a whole, including moving more individuals into the community, is just as important.

**State-supported living centers and center directors.** CSSB 643 would simply waste fiscal resources of the state by changing the name of state schools to "state-supported living centers." The cost of the name change would be $650,000, yet residents and clients would not be better served nor better protected as a result of the name change. People would continue to call them "state schools," as they always have.

In addition, changing the name to "living centers" would not make the facility any more person-centered or allow for more individual self-determination. It simply would establish a politically correct name that would distance itself from the negative connotations associated with "state schools," such as the DOJ report and the hundreds of allegations of abuse

and neglect. Giving state schools a different name would not address the continuing problems occurring there.

**Video surveillance.** The bill's requirement of video surveillance would be costly while failing to achieve a safer environment for residents. The presence of cameras in common areas would not likely reduce the incidence of abuse and neglect because most of it occurs in private, and the cameras actually could cause harm by providing a false sense of security. The fiscal resources allocated for cameras would be better spent on items that would truly produce change, such as adequate staffing, mid-level supervision, and increased pay to attract higher-quality employees.

**Drug testing.** Random drug testing of center employees under the bill would be a good practice for protecting residents from possible mistreatment by a staff member under the influence of drugs. However, individuals with developmental disabilities living in private ICFs-MR and HCS group homes deserve the same protection, and the bill would not provide it to these groups.

**Center employee training.** While increased training is good, the bill would do nothing to address increasing the quality of individuals hired to care for residents, such as establishing higher education requirements or increased pay.

Training in the CLOIP (community living options information process) would not be appropriate for all staff members, just as the CLOIP process is not appropriate for all residents. CLOIP has merit for those who have the capacity to use it, but many state school residents have profound and severe mental retardation and lack the capacity to make decisions about their care. In addition, 60 percent of state school residents do not have a legal guardian. Without a legal guardian, a severely or profoundly mentally retarded individual would not be in a position to properly participate in the CLOIP process, and the process itself would be susceptible to manipulation.

**Forensic state-supported living center.** CSSB 643 should require determinations of "high risk" to be made before an alleged offender was transferred to the forensic SSLC. The bill would require DADS to place all developmentally disabled minors criminally committed under Family Code, ch. 55 into the forensic SSLC with high-risk alleged offenders. Most offenders with mental retardation are arrested for committing

misdemeanors, such as public disturbances or trespassing, as opposed to serious felonies. This would mean that all court-committed children would be placed with high-risk, dangerous individuals before ever being determined to be high-risk themselves. For individuals with developmental disabilities, this would be a sufficient amount of time to learn bad behaviors from others who may in fact be dangerous.

Another reason the determination of high risk should be made before the individual is transferred to the forensic SSLC is that when the routines of individuals with developmental disabilities are interrupted, maladaptive behaviors can intensify. The transfer itself could result in behavior problems that could cause them to be deemed high risk.

The bill would provide for administrative hearings to appeal a determination, but again, this should happen before the classification is final and a transfer has been made. Individuals denied Medicaid benefits continue to receive benefits until the appeals process has been exhausted. The same consideration should be applied to alleged offenders so that no transfer or classification of an alleged offender was made until all due process rights were exhausted.

The bill does not contain provisions by which alleged offenders could return to their communities. CSSB 643 would provide for periodic reviews to determine whether the individual continued to be "high risk" for inflicting substantial harm to another, but would provide no review of the state center placement in general. Under the bill, an individual would be presumed to be guilty based on their intellectual disability and, instead of a time-certain sentence in the criminal justice system, would receive an indefinite sentence to a state center. Given the negative impact of institutionalization on children, the bill should provide specific measures to ensure that any criminally related placement of a child was limited to the minimal time possible.

**Office of Independent Ombudsman.** Creating a new Office of Independent Ombudsman and placing assistant ombudsmen at each facility would be a waste of limited state fiscal resources by needlessly creating another layer of government bureaucracy and would not change anything within the system. “Human rights officers” have been in place in each state school for years. The duties of these officers are virtually identical to those of the ombudsmen that would be created under the bill. In addition, the bill would allow these current state school employees to be

hired as the "assistant independent ombudsmen" as of the effective date of the bill. In fact, as of March 2009, the name of the position of human rights officer in each state school already has been changed to the "ombudsman." The bill simply would change the title of the position and provide a lead independent ombudsman appointed by the governor, which would only serve to politicize the office.

The bill instead should place existing human rights officers, or ombudsmen, under the direction of the existing HHSC long-term care ombudsman, thereby creating just one office of ombudsman that would oversee all HHSC agencies and receive complaints statewide. The office and positions already exist, so this modification would be more efficient and less costly than that proposed in the bill. Alternatively, in order to really change or reform the facilities, the bill should require that assistant ombudsmen have no prior association or relationship with the facility in which they were placed, or even better, no relationship to the system at all.

The bill would not specifically prohibit retaliation against residents or family members. The Senate-passed bill would protect employees from retaliation and the committee substitute added "or other persons," but residents and families should have an equally stated level of protection.

**Toll-free number.** The required toll-free number for the independent ombudsman would do nothing to change the reporting of abuse and neglect. Three toll-free numbers already are posted in state schools for reporting allegations of abuse, neglect, or exploitation:

- DFPS statewide intake number for abuse, neglect, and exploitation;
- DADS office of consumer rights and services; and
- Advocacy, Inc.

One more toll-free number would change nothing.

**New agency roles and procedures, private facilities.** Investigation reports should be provided to the resident and a family member or LAR. They also should be made available to the public, with identifying information redacted. It is doubtful that the current reform of the state schools would even be possible if it were not for public records.

**Office of Inspector General (OIG).** It is unnecessary to make a major change and shift in current roles and duties with regard to investigations.

The OIG does not specialize in investigations of abuse, neglect, and exploitation. DFPS does — investigating abuse and neglect is exactly what DFPS was established to do. The bill could allow OIG to assist DFPS in order to protect potential criminal evidence without completely swapping out powers and duties as the bill would require. The bill would go too far in taking away DFPS' primary investigatory authority. In addition, the HHSC Office of Inspector General is not set up to carry out such statewide investigations, yet the bill would call for greatly expanding the OIG. If DFPS personnel are not consistently handling investigations properly with regard to criminal evidence, staff should be trained properly rather than the agency being stripped of its investigative authority and purpose and greatly expanding the OIG.

**Mortality review.** The bill's mortality review is a much-needed measure, but the system would be further strengthened if the bill did not make records exempt from disclosure under open records practices and instead required mortality reports to be released to the public as long as resident or client names were redacted.

Considering DOJ findings regarding mental health services within the state schools, a required member of the PSO team should be a psychiatrist with expertise in psychiatric care and treatment of individuals with mental retardation if the client was prescribed psychotropic medications or died while in restraints.

**Assistant commissioner of state-supported living centers.** CSSB 643 would needlessly grow government bureaucracy by creating the assistant commissioner of SSLC position. DADS currently has a director of state mental retardation facilities who oversees all state schools for DADS. HHSC also has an assistant commissioner of provider services who oversees all provider services for HHSC, including the state schools. One more official overseeing the schools would not change anything. In addition, HHSC and DADS will go through Sunset review next session, so if the Legislature wanted to change the organization of the agencies, that would be the most appropriate time.

**Increased penalties.** The bill would raise the criminal penalties for abuse by a direct care giver and for failure to report abuse or neglect resulting in serious bodily injury of individuals living in state centers or private ICFs-MR, but not for those living in HCS group homes. The bill should address

the entire developmentally disabled population living in group settings and not protect individuals residing in certain facilities over others.

OTHER OPPONENTS SAY:

CSSB 643 would be a good start for addressing needed change in state schools, but a moratorium on all admissions to state schools should be established. The moratorium on admissions should remain in effect until the facilities are free of abuse and neglect, or at minimum for one year, to give DADS time to address the problems and improve the facilities. This was done recently to address issues at the Corpus Christi State School and should be done systemwide.

**Center employee training.** The bill would not go far enough with the training made available to private providers. Making the training available would not mean that the providers would take advantage of it due to logistical inconveniences and costs incurred when arranging and paying for subs so that staff could attend the training sessions. The bill would be stronger and fulfill its intent by requiring the training as part of licensure or certification requirements for private providers.

**Forensic state-supported living center**. CSSB 643 would recognize the dangers that the high-risk alleged offender population would pose to other residents of state centers yet would not address the safety of the students, staff, and community of the Mexia Independent School District (ISD). The bill would provide no assistance to the school district to supervise high-risk alleged offenders while district personnel provide educational services.

Mexia ISD has been in a dispute with the Mexia State School and DADS regarding care, custody, and supervision and whether current alleged offenders should have access to the regular education campuses at Mexia ISD, despite the fact that DADS provides no supervision or assistance to local teachers instructing these state school residents with special needs.

If the state is not going to require the forensic SSLC to provide 24-hour supervision of these high-risk alleged offenders, then the state should appropriate significant resources for the local ISD to provide this state function and provide immunity from any liability to the school district and its employees for having to carry out the duties of a state agency outside of the legally delegated duties of a local school district.

**Over-reaching legislation**. The bill is over-reaching legislation. Much of what it would call for would simply be recreating and renaming existing positions. DADS and HHSC currently are initiating changes to address the DOJ report. The state has increased funding for state schools significantly in fiscal 2008-09 and will continue that in the fiscal 2010-11 budget. The state should continue putting money toward increasing the number, quality, and training of available staff, rather than creating more government under CSSB 643 in an attempt to create a false sense of security.

NOTES:

According to the fiscal note, the cost to the state for CSSB 643 would be about $20 million for fiscal 2010, and about $14 million each fiscal year thereafter. The bill's primary costs would include:

- mortality reviews for each death occurring in a state center, private ICF-MR, or group home;
- funding for DFPS to increase staffing to conduct investigations of private ICFs-MR, and update software;
- funding for DADS to increase staffing to conduct annual unannounced surveys of all HCS group homes and to create a database to track surveys;
- background checks of employees, volunteers, and applicants;
- random drug testing of direct care employees;
- purchase and installation of video cameras and related technology;
- establishment and hiring of ombudsman positions;
- hiring 43 peace officers to conduct investigations and assist law enforcement in criminal investigations in state centers;
- software and system modifications to link DFPS and OIG;
- creating an electronic database for tracking information regarding investigations in state centers, private ICFs-MR, and HCS group homes, other than foster homes.

Other costs could be assumed to be absorbed within existing agency resources.

Provisions in SB 643 as approved by the Senate are largely similar to the House committee substitute. However the House substitute added several provisions, including:

- expanding the role and duties of the inspector general regarding investigations and reports;
- requiring DFPS to place its initial investigation on hold for 24 hours in order for OIG to make a determination;
- enhancing penalties for criminal offenses;
- expanding the application of the mortality review to include reviews of deaths of individuals residing in or receiving services from private ICFs-MR and HCS group homes;
- requiring unannounced on-site surveys of all HCS group homes, other than foster homes, at least once a year;
- requiring that DFPS conduct investigations of reports of abuse, neglect, or exploitation of residents in private ICFs-MR;
- requiring the development of an electronic database;
- allowing private ICF-MR employees or other community programs for individuals with mental retardation to receive training at cost;
- making an individual ineligible for a license to operate a private ICF-MR if a "controlling person" related to the facility had a conviction for an offense that would bar employment in the facility;
- allowing the termination of center employees solely on the basis of a single positive drug test and providing an appeals process;
- requiring a memorandum of understanding between DADS, HHSC, DFPS, the ombudsman, and the inspector general regarding investigations of abuse, neglect, and exploitation;
- establishing an assistant commissioner of SSLCs within DADS;
- requiring the ombudsman to monitor DADS actions relating to problems identified or recommendations made by DFPS or OIG;
- specifying that the ombudsman ensure that each center conducts sufficient unannounced patrols, immediately refer allegations of abuse to DFPS, and report to the OIG any unusual incidents;
- establishing the Interim Select Committee on Criminal Commitments of Individuals with Mental Retardation;
- allowing an alleged offender determined not to be high-risk to request a transfer to another state center;
- designating the Mexia SSLC as the forensic SSLC, while the Senate-passed bill would require DADS to designate an existing center;
- applying changes in law regarding dismissals of state center employees hired before, on, or after the effective date of the bill, while the Senate-passed bill would apply to employees hired on or after the effective date of the bill; and

- renaming “state schools” as “state supported living centers,” while the Senate-passed bill would rename “state schools” as “state developmental centers.”