Department of State Health Services

Form Y
Consolidated Local Service Plan (CLSP)

for Local Mental Health Authorities

October, 2015

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Introduction

The Consolidated Local Service Plan (CLSP) encompasses all of the service planning requirements for LMHAs. The CLSP has three sections: Local Services and Needs, the Psychiatric Emergency Plan, and Plans and Priorities for System Development.

Local planning is a collaborative activity, and the CLSP asks for information related to community stakeholder involvement in planning. DSHS recognizes that community engagement is an ongoing activity, and input received throughout the biennium will be reflected in the local plan. LMHAs may use a variety of methods to solicit additional stakeholder input specific to the local plan as needed.

The Psychiatric Emergency Plan is a new component that stems from the work of the HB 3793 Advisory Panel. The panel was charged with assisting DSHS to develop a plan to ensure appropriate and timely provision of mental health services. The Advisory Panel also helped DSHS develop the required standards and methodologies for implementation of the plan, in which a key element requires LMHAs to submit to DSHS a biennial regional Psychiatric Emergency Plan developed in conjunction with local stakeholders. The first iteration of this Psychiatric Emergency Plan is embedded as Section II of the CLSP.

In completing the template, please provide concise answers, using bullet points. When necessary, add additional rows or replicate tables to provide space for a full response.

Section I: Local Services and Needs

I.A. Mental Health Services and Sites

- *In the table below, list sites operated by the LMHA (or a subcontractor organization) that provide mental health services regardless of funding (Note: please include 1115 waiver projects detailed in Section 1.B. below). Include clinics and other publicly listed service sites; do not include addresses of individual practitioners, peers, or individuals that provide respite services in their homes.*
- *Add additional rows as needed.*
- *List the specific mental health services and programs provided at each site, including whether the services are for adults, children, or both (if applicable):*
    - *Screening, assessment, and intake*
    - *Texas Resilience and Recovery (TRR) outpatient services: adults, children, or both*
    - *Extended Observation or Crisis Stabilization Unit*
    - *Crisis Residential and/or Respite*
    - *Contracted inpatient beds*
    - *Services for co-occurring disorders*
    - *Substance abuse prevention, intervention, or treatment*
    - *Integrated healthcare: mental and physical health*
    - *Other (please specify)*

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
Center for Health Care Services (CHCS)	Paul Elizondo Clinic 806 S. Zarzamora St. San Antonio, TX 78207	Bexar	• Population: Adults • Screening, assessment, and intake • TRR outpatient services • Services for co-occurring disorders • Jail Diversion
Center for Health Care Services (CHCS)	Legacy Oaks 5372 Fredericksburg Rd., Building F San Antonio, TX 78229	Bexar	• Population: Adults • TRR outpatient services • Services for co-occurring disorders • Integrated healthcare • High utilizer integration • ACT

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
Center for Health Care Services (CHCS)	Harvard Place Clinic 1920 Burnet San Antonio, TX 78202	Bexar	• Population: Adults • TRR outpatient services • Services for co-occurring disorders
Center for Health Care Services (CHCS)	Packard Clinic Mental Health & Specialty Programs 1123 N. Main, Ste. 203 San Antonio, TX 78212	Bexar	• Population: Adults • TRR outpatient services • Services for co-occurring disorders • Waiver Projects • Mental Health Court • IOPC
Center for Health Care Services (CHCS)	Forensic Court/OCR 2711 Palo Alto Rd. San Antonio, TX 78211	Bexar	• Population: Adults • Screening, assessment, and intake • TRR outpatient services • Services for co-occurring disorders • Jail Diversion • Forensic Court • OCR • NGRI • TCOOMMI (Texas Correctional Office on Offenders / Medical & Mental Impairments)
Center for Health Care Services (CHCS)	Restoration Center 601 N. Frio San Antonio, TX 78207	Bexar	• Population: Adults • Screening, assessment, and intake • TRR outpatient services (LOC 5) • Services for co-occurring disorders • Substance abuse prevention, intervention or treatment • Extended observation and Crisis Stabilization Unit 24 hours a day, 365 days a year • Mobile Crisis Outreach Team • Crisis Transitional/Residential Services • Detox

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
			• Drug Court • OATS • MOMMIES
Center for Health Care Services (CHCS)	Josephine Recovery Center 711 E. Josephine St. San Antonio, TX 78208	Bexar	• Population: Adults • Screening, assessment, and intake • Crisis Residential
Center for Health Care Services (CHCS)	HIV Prevention, Intervention, & Outreach Programs 1219 McCullough San Antonio, TX 78212	Bexar	• Population: Adults with or at-risk for HIV/AIDS • Screening, assessment, and intake • Assertive Outreach, free testing, education and counseling • Intensive Case Management
Center for Health Care Services (CHCS)	Prospects Courtyard 1 Haven for Hope Way San Antonio, TX 78207	Bexar	• Population: Adults • Screening, assessment, and intake • TRR outpatient services • Services for co-occurring disorders • Supported Housing • Wellness Treatment Program – Dormitory for homeless adult males • PATH • Homeless shelter
Center for Health Care Services (CHCS)	Long Term Care 8155 Lone Shadow Trail Converse, TX 78109	Bexar	• Population: Adults and Children • Home and Community Based Services • Summer Youth Program • Respite • Adult Day Habilitation Services • Employment Assistance • Nursing and Community Living Support Svcs.
Center for Health Care Services Center	Drexel Clinic 227 W. Drexel	Bexar	• Population: Children • Screening, assessment, and intake

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
for Health Care Services (CHCS)	San Antonio, TX 78210		• TRR outpatient services • Services for co-occurring disorders • Respite • Crisis Residential
Center for Health Care Services (CHCS)	Children's Campus 6812 Bandera Rd. San Antonio, TX 78238	Bexar	• Population: Children • Screening, assessment, and intake • TRR outpatient services • Services for co-occurring disorders • Waiver Program
Center for Health Care Services (CHCS)	Children's Clinic 5802 S. Presa San Antonio, TX 78223	Bexar	• Population: Children • Screening, assessment, and intake • Early Childhood Intervention Services • Waiver Program
Center for Health Care Services (CHCS)	Children's Clinic 104 Story Lane San Antonio, TX 78223	Bexar	• Population: Children • Screening, assessment, and intake • Early Childhood Intervention services • Waiver Program
NIX Health System	4330 Vance Jackson San Antonio, TX 78230	Bexar	• Population: Adults • 15 contracted inpatient bed capacity
Southwest General Hospital	7400 Barlite Blvd. San Antonio, TX 78224	Bexar	• Population: Adults • 15 contracted inpatient bed capacity
Clarity Child Guidance Center	8535 Tom Slick San Antonio, TX 78229	Bexar	• Population: Children • Contracted inpatient beds for children 3-11 y.o.

I. B Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver Projects

- *Identify the RHP Region(s) associated with each project.*
- *List the titles of all projects you proposed for implementation under the Regional Health Partnership (RHP) plan. If the title does not provide a clear description of the project, include a descriptive sentence.*
- *Enter the number of years the program has been operating, including the current year (i.e., second year of operation = 2)*
- *Enter the static capacity—the number of individuals that can be served at a single point in time.*
- *Enter the number of individuals served in the most recent full year of operation. If the program has not had a full year of operation, enter the planned number to be served per year.*
- *If capacity/number served is not a metric applicable to the project, note project-specific metric with the project title.*

1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity	Number Served/ Year
6	PCY Integrated Clinic: provides behavioral health and primary care services to homeless individuals residing at Prospect's Courtyard.	2	175	DY4/125 DY5/175
6	In House Women's Wellness Program (IHWWP): provides behavioral health services for adult females experiencing homelessness. Program was approved on 09/09/2013 and began operating on 11/04/2013.	2	58	DY3/ 96 DY4/134
6	Expanded Outpatient Capacity: established to extend operating hours at a select number of Local Mental Health clinics or other community-based settings, in areas of the State where access to care is likely to be limited.	3	250**	1,317
6	Hospital Diversion Recovery Services: developed and implemented crisis stabilization services to address the identified gaps in the current community crisis system.	3	16 beds	468
6	Integrated Primary Care: services within existing	3	3 exam	1,795

1115 Waiver Projects				
RHP Region(s)	**Project Title (include brief description if needed)**	**Years of Operation**	**Capacity**	**Number Served/ Year**
	Behavioral Health Care Services for substance abuse and HIV population within one location.		beds/providers	
6	Coordinated Community Integrated Care Responses for Super-Utilizing Individuals: Expand and Enhance Pilot Project: designed, implemented, and evaluated research-supported and evidence-based interventions tailored towards individuals in the target population.	4	150**	178
6	Deferred Institutionalization Program: designed, implemented, and evaluated research supported and evidence-based interventions tailored towards individuals in the target population.	4	240**	444
RHP6	Children's Behavioral Health Campus.	5	230	115/DY4 230/DY5*
RHP6	Crisis Respite Residential Center (CRRC) for children and adolescents (5 to 17 years of age) with severe emotional disturbance.	5	16 Beds (12 licensed by TDFPS)	164/DY4 150/DY5*
RHP6	Dual Diagnosis Clinic Expansion (children and adults with co-occurring Intellectual Developmental Disability (IDD) and mental illness.	5	87	81/DY4 87/DY5*
	*Quality and Process Improvement required.			
	**Capacity calculated by staffing during 10/1/2014 – 9/30/2015 (corresponding to Number Served/Year) and numbers indicate caseload to case managers/therapists/providers as applicable.			

I.C Community Participation in Planning Activities

Identify community stakeholders who participated in your comprehensive local service planning activities over the past year.

	Stakeholder Type		Stakeholder Type
☒	Individuals	☒	Family members
☒	Advocates (children and adult)	☒	Concerned citizens/others
☒	Local psychiatric hospital staff	☒	State hospital staff
☒	Mental health service providers	☒	Substance abuse treatment providers
☒	Prevention services providers	☒	Outreach, Screening, and Referral (OSAR)
☒	County officials	☒	City officials
☒	FQHCs/other primary care providers	☒	Local health departments
☒	Hospital emergency room personnel	☒	Emergency responders
☒	Faith-based organizations	☒	Community health & human service providers
☒	Probation department representatives	☒	Parole department representatives
☒	Court representatives (judges, DAs, public defenders)	☒	Law enforcement
☒	Education representatives	☒	Employers/business leaders
☒	Planning and Network Advisory Committee	☒	Local individual-led organizations
☒	Veterans' organization		

List the key issues and concerns identified by stakeholders, including unmet service needs. Only include items that were raised by multiple stakeholders and/or had broad support.

• Sustainability planning: Continue to look at various funding opportunities for program sustainability after waiver funds are no longer available, the limitations to qualifying for the Affordable Care Act (ACA), and the denial of Medicaid Expansion in the State of Texas.
• Additional adult and child psychiatrists, Advanced Practicing Nurses, Clinical Practitioners, and Therapists are needed in Bexar County as a whole.
• Constraints and requirements of Health Insurance Portability and Accountability Act (HIPAA) have presented challenges with data collection and information sharing.
• Lack of affordable housing creates additional struggles for individuals transitioning back into the community.
• Lack of insurance and increase medication costs are barriers to adequate treatment.
• Mental health outpatient services continue to exceed capacity.
• Telemedicine not being covered by Medicaid if it is used at Patient's home
• Increased services for individuals with a Dual Diagnosis: Mental Health & Intellectual Developmental Disability

Section II: Psychiatric Emergency Plan

The Psychiatric Emergency Plan is intended to ensure that stakeholders with a direct role in psychiatric emergencies have a shared understanding of the roles, responsibilities, and procedures that will enable them to coordinate their efforts and effectively use available resources. The Psychiatric Emergency Plan entails a collaborative review of existing crisis response activities and development of a coordinated plan for how the community will respond to psychiatric emergencies in a way that is responsive to the needs and priorities of individuals and their families. The planning effort also provides an opportunity to identify and prioritize critical gaps in the community's emergency response system. Planning should consider all available resources, including projects funded through the 2015 Crisis and Inpatient Needs and Capacity Assessments.

The HB 3793 Advisory Panel identified the following stakeholder groups as essential participants in developing the Psychiatric Emergency Plan:

- Law enforcement (police/sheriff and jails)
- Hospitals/emergency departments
- Judiciary, including mental health and probate courts
- Prosecutors and public defenders
- Other crisis service providers
- Users of crisis services and their family members

Most LMHAs are actively engaged with these stakeholders on an ongoing basis, and the plan will reflect and build upon these continuing conversations, including those related to the 2015 Crisis Needs and Capacity Assessment.

Given the size and diversity of many local service areas, some aspects of the plan may not be uniform across the entire service area. If applicable, include separate answers for different geographic areas to ensure all parts of the local service area are covered.

II.A Development of the Plan

Describe the process you used to collaborate with stakeholders to develop the Psychiatric Emergency Plan, including:

- Ensuring all key stakeholders were involved or represented
- Ensuring the entire service area was represented
- Soliciting input

- CHCS has organized multiple stakeholders, task forces, advisory boards and subcommittees to examine and recommend improvements to existing crisis services. Included are the Medical Directors Roundtables, the Adult & Child CIT Committee, and the Jail Diversion Oversight Committee. Those attending have reflected significant diversity, representing individuals of all ages, family members, and advocates, mental health services providers, emergency health care providers, the public health system, law enforcement, probation and parole departments, the judiciary, substance abuse providers, and private foundations. Active ad hoc work groups meet as full committees and in

subcommittees at least monthly. Progress reports are provided for specific emphasis areas or priorities and new work assignments are made, as needed. The group continues to meet until their work plan has been accomplished. Policy councils, like the Medical Directors Roundtables, generally are permanent and meet every month.

II.B Crisis Response Process and Role of MCOT

1. How is your MCOT service staffed?

   a. During business hours

   - During business hours the MCOT team consists of 7 staff members. There are 5 QMHPs and 2 LPHAs. There is also an RN and a Medical Provider on call for the MCOT team 24/7 at the Crisis Care Center.

   b. After business hours

   - After business hours MCOT has 2 members which include 1 QMHP and 1 LPHA. There is also an RN and a Medical Provider on call for the MCOT team 24/7 at the Crisis Care Center.

   c. Weekends/holidays

   - Weekends and Holidays MCOT has 4 team members which include 2 QMHPs and 2 LPHAs. There is also an RN and a Medical Provider on call for the MCOT team 24/7 at the Crisis Care Center.

2. What criteria are used to determine when the MCOT is deployed?

- MCOT is deployed for all incoming calls that are Urgent, Routine, Community, or State Bed Authorization. Law Enforcement is deployed for Emergent calls. Calls are screened and labeled by the Harris County Crisis Hotline. Upon arrival, Law Enforcement will notify Harris County of the Emergent situation and Harris County in turn will notify MCOT.

3. What is the role of MCOT during and after a crisis when crisis care is initiated through the LMHA (for example, when an individual calls the hotline)? Address whether MCOT provides follow-up with individuals who experience a crisis and are then referred to transitional or services through the LMHA.

- Once Crisis Care is initiated MCOT does not take a lead role. The staff at the Crisis Care Center (CCC) will attempt to resolve the crisis and admit the individual to the crisis stabilization unit where appropriate. CCC staff provides the 24 hour follow ups with each discharge from the CCC. MCOT is on a referral basis. If an individual calls the Hotline, MCOT is deployed to provide Crisis Intervention and Crisis Outreach Services to the individual. Upon resolution of the crisis, MCOT will provide a 24 hour follow up with the individual.

4. Describe MCOT support of emergency rooms and law enforcement:

    a. Do emergency room staff and law enforcement routinely contact the LMHA when an individual in crisis is identified? If so, is MCOT routinely deployed when emergency rooms or law enforcement contact the LMHA?

- Emergency rooms: Yes, MCOT will be deployed to the hospital for screening for determination of eligibility for a private psychiatric bed (PPB).
- Law enforcement: Yes, Law Enforcement will call MCOT workers to accompany them on a community call to assist in crisis intervention and to determine the appropriate level of care or least restrictive environment for the individual.

b. What activities does the MCOT perform to support emergency room staff and law enforcement during crises?

- Emergency rooms: Eligibility screenings for private psychiatric bed (PPB) are performed for ER/Hospital staff.
- Law enforcement: Assist in crisis intervention and to determine the appropriate level of care or least restrictive environment for the individual in coordination with the Crisis Care Center.

5. What is the procedure if an individual cannot be stabilized at the site of the crisis and needs further assessment or crisis stabilization in a facility setting?

c. Describe your community's process if an individual needs further assessment and/or medical clearance:

- Further assessment or medical clearance may be provided at the Crisis Care Center for MCOT or Law Enforcement.

d. Describe the process if an individual needs admission to a hospital:

- If an individual needs admission to a hospital they will be transported by either the LMHA or Law Enforcement. A provider to provider contact will be initiated between the LMHA and the hospital provider to coordinate the case.

e. Describe the process if an individual needs facility-based crisis stabilization (i.e., other than hospitalization–may include crisis respite, crisis residential, extended observation, etc.):

- Seeking the least restrictive environment, individuals may be brought to the Crisis Care Center and admitted for up to 48 hour crisis observation.

6. What steps should emergency rooms and law enforcement take when an inpatient level of care is needed?
    a. During business hours

- If the individual is unfunded, they call Crisis to determine eligibility for a private psychiatric bed. If the individual is funded they may be taken to a hospital in the community.

    b. After business hours

- If the individual is unfunded, they call the Crisis to determine eligibility for a private psychiatric bed. If the individual is funded they may be taken to a hospital in the community.

    c. Weekends/holidays

- If the individual is unfunded, they call the Crisis to determine eligibility for a private psychiatric bed. If the individual is funded they may be taken to a hospital in the community.

7. If an inpatient bed is not available:

    a. Where is an individual taken while waiting for a bed?

- If a private psychiatric bed is not available, the person will be admitted to the closest hospital that provides inpatient psychiatric care.

    b. Who is responsible for providing continued crisis intervention services?

- LOC5 team will provide a 90 day authorization for crisis intervention services and case management. The individual will then be referred to outpatient services where appropriate.

c. Who is responsible for continued determination of the need for an inpatient level of care?

- Provider

d. Who is responsible for transportation in cases not involving emergency detention?

- LMHA

Crisis Stabilization

8. What alternatives does your service area have for facility-based crisis stabilization services (excluding inpatient services)? Replicate the table below for each alternative.

Name of Facility	Crisis Care Center
Location (city and county)	San Antonio, Bexar County
Phone number	210-225-5481
Type of Facility (see Appendix B)	Crisis Stabilization Unit
Key admission criteria (type of patient accepted)	All patients that present to the Crisis Care Center are screened and assessed. Admission to the Observation Unit is determined upon medical clearance and no need for higher level of care.
Circumstances under which medical clearance is required before admission	Open wound, infectious diseases
Service area limitations, if any	Individuals who display violent behaviors cannot be served
Other relevant admission information for first responders	None
Accepts emergency detentions?	Yes

Inpatient Care

9. What alternatives to the state hospital does your service area have for psychiatric inpatient care for medically indigent? Replicate the table below for each alternative.

Name of Facility	Nix Specialty Hospital
Location (city and county)	San Antonio, Bexar County
Phone number	210-579-3800
Key admission criteria	Suicidal, homicidal, exacerbated deterioration in functioning
Service area limitations, if any	15 bed capacity
Other relevant admission information for first responders	Contact the CHCS Mobile Crisis Outreach Team for potential admission recommendation
Name of Facility	Southwest General Hospital
Location (city and county)	San Antonio, Bexar County
Phone number	210-921-2000
Key admission criteria	Suicidal, homicidal, exacerbated deterioration in functioning
Service area limitations, if any	15 bed capacity
Other relevant admission information for first responders	Contact the CHCS Mobile Crisis Outreach Team for potential admission recommendation
Name of Facility	Clarity Child Guidance Center
Location (city and county)	San Antonio, Bexar County
Phone number	210-616-0300
Key admission criteria	Suicidal, homicidal, exacerbated deterioration in functioning
Service area limitations, if any	Children 3-11 y.o. or when the State Hospital is at capacity
Other relevant admission information for first responders	Contact the Children's Mobile Crisis Outreach Team for potential admission recommendation

II.C Plan for local, short-term management of pre- and post-arrest patients who are incompetent to stand trial

10. What local inpatient or outpatient alternatives to the state hospital does your service area currently have for competency restoration?

    a. Identify and briefly describe available alternatives.

- Assertive Community Treatment (ACT): psychiatric medication management, psychosocial rehabilitative services, and comprehensive support for individuals with frequent psychiatric hospitalizations.
- Forensic Assertive Community Treatment Forensic Court Unit: comprehensive mental health services for individuals found incompetent to stand trial or not guilty by reason of insanity.
- Involuntary Outpatient Commitment Program (IOPC): civil court ordered program designed for individuals who are chronically non-compliant with psychiatric treatment and would otherwise require inpatient hospitalization.

    b. What barriers or issues limit access or utilization to local inpatient or outpatient alternatives? If not applicable, enter N/A.

- Barriers that might limit access include severity of offense, history of compliance with medications, and level of dangerousness of the individual.

    c. Does the LMHA have a dedicated jail liaison position? If so, what is the role of the jail liaison? At what point is the jail liaison engaged?

- We do not have a dedicated jail liaison position; however we do have available Clinical Practioners that will coordinate services as needed. The jail social workers will distribute a weekly list of individuals currently receiving their services and we review that list to determine if any of the individuals have been served by CHCS in the past year. In addition, we are able to determine if any of the individuals are being transferred from

a state mental health facility (SMHF). If any individuals are identified on the weekly list, the Clinical Practioners will visit the jail to provide information, complete assessments, and will attend court on their behalf if requested.

- In addition, if any court ordered defendant was arrested, we are available to assist with medications and educate the individual about competency disposition before a trial date is set.

If the LMHA does not have a dedicated jail liaison, identify the title(s) of employees who operate as a liaison between the LMHA and the jail.

- We have one Clinical Practioner I and two Clinical Practioner IIs.

d. What plans do you have over the next two years to maximize access and utilization of local alternatives for competency restoration? If not applicable, enter N/A.

- To increase the mental illness and competency awareness and education, to avoid the revolving door phenomenon & minimizing mentally ill individuals from acquiring new criminal charges due to lack of treatment.

11. Does your community have a need for new alternatives for competency restoration? If so, what kind of program would be suitable (i.e., Outpatient Competency Restoration Program, inpatient competency restoration, jail-based competency restoration, etc.)?

- Existing Outpatient Competency Restoration programs are a great alternative for keeping Incompetent to Stand Trial defendants incarcerated if they are good candidate based on assessments. Also, an Inpatient Competency Restoration Program would be a more suitable venue for severe offenders.

12. What is needed for implementation? Include resources and barriers that must be resolved.

- Closer supervision to inmate in order to detect early sign of mental illness and quick referral for competency evaluation and treatment. One of the barriers is refusal of dismissing TBI/ABI, dementia, Alzheimer disorder/cases with 2nd or 3rd degree felonies. Defendants who suffer from these neurocognitive or chronic disorders are just being warehoused and will never be restored to competency.

II.D Seamless Integration of emergent psychiatric, substance use, and physical healthcare treatment

13. What steps have been taken to integrate emergency psychiatric, substance use, and physical healthcare services?

- The Restoration Center provides emergency psychiatric, substance use, and physical healthcare services all in one location at 601 N. Frio, San Antonio, Texas.

14. What are your plans for the next two years to further coordinate and integrate these services?

- Other funding sources to expand physical health care services to provide all services to more individuals are being researched.

II.E Communication Plans

15. How will key information from the Psychiatric Emergency Plan be shared with emergency responders and other community stakeholders? Consider use of pamphlets/brochures, pocket guides, website page, mobile app, etc.

- CHCS will share this information via its website www.chcsbc.org and through its social media platform (Facebook and Twitter). Additionally, the Center publishes and distributes over 30 different brochures and flyers listing crisis

facilities, locations, and hotline numbers for mental health and substance use disorders. The Center also utilizes a mobile app *Mental Health and You* to disseminate information regarding mental illness. The app provides a direct connection to our Crisis Hotline so that those in acute psychiatric distress are provided with prompt assessment and treatment.

16. How will you ensure LMHA staff (including MCOT, hotline, and staff receiving incoming telephone calls) have the information and training to implement the plan?

- MCOT and LMHA staff participates in staffings and informational meetings where they participate in education on the plan and the goals of CHCS in assisting individuals with mental illness in the community.

II.F Gaps in the Local Crisis Response System

17. What are the critical gaps in your local crisis emergency response system? Consider needs in all parts of your local service area, including those specific to certain counties.

Counties	Service System Gaps
Bexar	• Coordination and communication of services and responsiveness of all first responders to include police, fire and EMS first responders. Coordination has begun with a project for all first responders and the LMHA to meet monthly to identify barriers and develop solutions.

Section III: Plans and Priorities for System Development

III.A Jail Diversion

Indicate which of the following strategies you use to divert individuals from the criminal justice system. List current activities and any plans for the next two years. Include specific activities that describe the strategies checked in the first column. For those areas not required in the DSHS Performance Contract, enter NA if the LMHA has no current or planned activities.

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☒ Co-mobilization with Crisis Intervention Team (CIT) ☒ Co-mobilization with Mental Health Deputies ☐ Co-location with CIT and/or MH Deputies ☒ Training dispatch and first responders ☒ Training law enforcement staff ☒ Training of court personnel ☒ Training of probation personnel ☒ Documenting police contacts with persons with mental illness ☒ Police-friendly drop-off point ☒ Service linkage and follow-up for individuals who are not hospitalized ☒ Other: Co-location with Bexar County Law Enforcement and Bexar County Pre-Trial Services.	• Law enforcement, CIT, and MHD will meet at location but staff does not travel together. • If and when law enforcement transports an individual to our crisis facility or a local hospital, staff travels behind to ensure safe arrival and then provide service linkage to resources depending on disposition. • Provides Law Enforcement with an easily accessible drop off point for individuals being transferred to the Crisis Care Center. • All staff encounters with law enforcement, on behalf of the individuals, are documented. • MCOT staff provides CIT training for dispatch, first responders, Law Enforcement staff, court personnel, and probation personnel. • Co-location of Clinical Practioner at the Bexar County Central Magistrate Dept. to screen,

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
	assess, and divert to outpatient mental health Jail Diversion program, sobering or detox unit or H4H Dormitory Housing pilot program. • The LOC5 team will provide wrap around services, case management and crisis intervention for those individuals that are not hospitalized.

Plans for the upcoming two years:

- Through the support of the DASH grant, CHCS will be building partitioned access to individual information in order to increase collaboration with Law Enforcement and expedite access to care with the entire team.
- Create 24/7 screening/assessing availability by CHCS clinical personnel at the Bexar County Central Magistrate Dept. Currently, there is a lack of funding and infrastructure to operationalize 24/7. At this time, only Crisis Care Center and MCOT provide "real-time" services in the community with local Law Enforcement on the Intercept 1 level.
- Continue with existing programs and services, continue working with criminal justice partners
- Continue educating about competency & mental illness. Encourage lawyer to research the psychiatric background of their individual to direct to the right source and avoid long time incarceration and neglect with exacerbation of mental illness symptoms.
- Incorporate the mental health crisis response needs of the Local Service Area (Bexar County) with existing coordination efforts such as the Southwest Texas Regional Advisory Committee which coordinates the County response to physical health care emergencies.
- Continue to educate existing programs and services, our criminal justice partners, the community, other medical providers, and those we serve about competency, mental illness, and access to treatment.

Intercept 2: Post-Arrest: Initial Detention and Initial Hearings	
Components	**Current Activities**
☒ Staff at court to review cases for post-booking diversion ☒ Routine screening for mental illness and diversion eligibility ☒ Staff assigned to help defendants comply with conditions of diversion ☒ Staff at court who can authorize alternative services to incarceration ☒ Link to comprehensive services ☐ Other: Click here to enter text.	• Potential individuals for outpatient, sobering/detox or H4H Dormitory Housing pilot program are screened and assessed at the Bexar County Magistrate Dept. by CHCS Clinical Practioners for jail/magistrate diversion into mental health services or other diversions. • Provide screening and assessment for referred probation, parole and pre-trial referrals in all settings as needed, including the Municipal Court.
Plans for the upcoming two years: • Expand ability to complete intake assessments into community based outpatient mental health jail diversion programs to include later hours and possibly even Saturdays for weekend jail diversions/releases. • Continue to support the Magistrates Division to identify and divert individuals arrested for violations who have mental illnesses.	

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☒ Routine screening for mental illness and diversion eligibility ☒ Mental Health Court ☒ Veterans' Court ☒ Drug Court ☒ Outpatient Competency Restoration ☒ Services for persons Not Guilty by Reason of Insanity	• Attend hearings and advocate within criminal justice system for behavioral health interventions for existing and potential individuals. • Currently CRP (Community Reintegration Program) and DIP (Deferred Institutionalization Program) can accept

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☒ Services for persons with other Forensic Assisted Outpatient Commitments ☐ Providing services in jail for persons Incompetent to Stand Trial ☐ Compelled medication in jail for persons Incompetent to Stand Trial ☐ Providing services in jail (for persons without outpatient commitment) ☒ Staff assigned to serve as liaison between specialty courts and services providers ☒ Link to comprehensive services ☐ Other:	individual referrals from the following: ➢ Diversion at Central Magistration level when individuals are first brought in for arrest or tickets. ➢ In outpatient based upon referrals from Community Supervision programs such as Pre-Trial, Probation and Parole. ➢ Individuals screened by specialty Pre-trial officer co-located in the Bexar County Adult Detention Center (local jail) that can request a conditional bond release to outpatient Jail Diversion program from presiding judge in either the district or county courts within the first 5-7 days or admission to local jail. ➢ CRP and DIP can usually provide an intake/screening appt. within 3-4 business days and access to prescriber services within 7-10 business days. • Ensures defendant is evaluated for competency if needed. Take a close look to the competency evaluation report; advocate for Outpatient Competency restoration services as first choice to avoid incarceration or inpatient referrals.

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
Plans for the upcoming two years: • County personnel (judges, district attorneys, administrators, etc.) require further education to decrease stigma of mental illness being treated in the community and increase their knowledge on the array of outpatient mental health services available to individuals being served.	

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
☐ Providing transitional services in jails ☒ Staff designated to assess needs, develop plan for services, and coordinate transition to ensure continuity of care at release ☒ Structured process to coordinate discharge/transition plans and procedures ☒ Specialized case management teams to coordinate post-release services ☐ Other:	• Provide advocacy and services in the jail throughout incarceration to ensure individual has coordination during transition back into the community. • Provide intensive case management that coordinate wraparound services to ensure needs are met following release. • Currently CRP (Community Reintegration Program) and DIP (Deferred Institutionalization Program) can accept individual referrals from jails and prisons. • CHCS works with Bexar County MH Dept., Judicial Services (and associated programs), Adult Probation and State Parole Depts. to provide timely access for screening & intake into jail diversion and probation programs usually within 5 - 7 business days of referral received and access to prescriber services within 7-10 business days. CHCS can provide

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
	services to individuals that are re-entering the community from both jail and prison settings. • Provide continuity of care to offenders releasing from prison/jail to be linking in to needed treatment programs. • LMHA operates a Forensic Assertive Community Treatment (FACT) Team to provide post release services to people with mental illnesses who have been released from jails.
Plans for the upcoming two years: • Would like to hire an additional court liaison that could interface with more district and county courts and specialty officers to increase referrals and streamline the process of individuals accessing needed programs/treatment.	

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
☒ Routine screening for mental illness and substance use disorders ☒ Training for probation or parole staff ☒ TCOOMMI program ☒ Forensic ACT ☒ Staff assigned to facilitate access to comprehensive services; specialized caseloads ☒ Staff assigned to serve as liaison with community corrections ☒ Working with community corrections to ensure a range of	• Individuals are referred to CHCS by individual probation/parole officers or specialized county or district units in the community once it is determined that individual needs or could benefit from MH treatment. Individuals referred by their POs or specialized units for screening and assessment into DIP or Specialty Court Programs (CRP or CC-12) will usually receive a screening and intake appt. within 5-7 business days of referral received. Different

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
options to reinforce positive behavior and effectively address noncompliance ☐ Other:	counties and district courts of Bexar County can also transfer individuals into Specialty Courts. • Provide screening and assessment for referred probation, parole and pre- trial referrals. • Work directly with Parole and Probation officers. • Work in co-located facilities with criminal justice staff. • Educate lawyers about mental illness, its effects, and available treatment. • LMHA operates a Mobile Crisis Outreach Team that is available 24/7/365 to routinely screen for mental illnesses and substance abuse disorders. The MCOT team assists various community organizations in training SAPD officers and Bexar County Sheriff's Deputies in Crisis Intervention Training (CIT). CIT is 40 hour week long training in crisis intervention and de-escalation techniques. CIT training is being provided at both Law Enforcement training academies and other first responder organizations.
Plans for the upcoming two years: • Expand Jail Diversion services to increase capacity and hire another psychiatric prescriber.	

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
• Hire a court liaison that could interface with more district and county courts and specialty officers to increase streamlined referrals and access to individuals to needed programs/treatment. • Advocate for mentally ill defendants; educate them, their families and the community about mental illness. • Expand coordination and training to all first responders in Bexar County, i.e., SAFD, EMS, etc.	

III.B Other System-Wide Strategic Priorities

Briefly describe the current status of each area of focus (key accomplishments and current activities), and then summarize objectives and activities planned for the next two years.

Area of Focus	Current Status	Plans
Improving continuity of care between inpatient care and community services	• Providing follow-up services to individuals who have been admitted to a psychiatric hospital within 7 days of discharge. • Seen by a Prescriber within 15 days of discharge from the hospital.	• Continue to offer current services in addition to linking individual to a Case Manager within 2 days to complete the first face-to-face meeting 7 days after discharging from the hospital and engage individual. • For existing patients, CHCS will ensure assigned Case Manager sees individual face-to-face within 7 days of discharge or documents that an attempt was made.
Reducing hospital	• LOC 5, ACT Team, High Utilizer's Team all work with individuals	• Work with the High Utilizer's in

Area of Focus	Current Status	Plans
readmissions	who have been or repeatedly have been hospitalized by transitioning them from the moment of their discharge. • Providing follow-up services to individuals who have been admitted to a psychiatric hospital within 7 days of discharge. • Staffing pattern now includes EMT(s). They have been integral, by providing triage care to individuals lacking access or unwilling to access available resources. • IHWWP has contributed in the prevention of unnecessary readmissions by providing compressive treatment to address untreated physical and behavioral health disorders and multiple traumatic experiences. • Utilizing Family Partners and wraparound services to provide timely intervention and necessary supports to avoid crises escalation. • Developed a Process Map to ensure continuity of care and seamless connection to supporting services	introducing Primary Care. • Work on revamping ACT model. • Continue to offer full service array to IOPC individuals to manage community hospital bed days. • Continue providing intensive case mgmt. and med mgmt. • Continue to track and collaborate with hospitals at discharge. • Establish a sustainable plan for expanded EMT services. • To form a cross-continuum team to expand reduction efforts to include local providers such as hospitals, community agencies, behavioral health providers, social service agencies, etc. • Utilize HASA Facts and Alerts to provide enhanced services for children and youth served at the CRRC. • Strengthen collaborative ties with ERs and Psychiatric Hospitals. • Establish complementary clinical services for children at higher risk of being hospitalized. • Have a dedicated staff to handle all Psychiatric Hospitals' referrals, discharges, and follow-ups.

Area of Focus	Current Status	Plans
	for individuals who experience mental health crises and those who are high-utilizers. • Provided training to all clinical staff to address proactive measures to handle crisis and follow-up after hospitalization. • Offering CRRC services to individuals, who do not meet psychiatric hospitalization criteria, require step-down from a Psychiatric Hospital, been seen by CMOT, or referred by ER providers. • Providing planned respite residential services for children and adolescents who have severe emotional disturbance or behavioral issues to prevent escalation of crisis episode. • Participating on the RHP6 Readmissions Learning Collaborative group. • Working with Healthcare Access San Antonio (HASA) to track ER visits and Hospital Admissions for individuals utilizing the Crisis Respite Residential Center (CRRC). • Providing Youth Mental Health	• Implement target interventions for high utilizers and children and youth with special needs e.g. physical comorbidities, academic problems, involvement with the criminal justice and/or foster care systems. • Increase the number of staff certified as a Youth Mental Health First Aid trainer. • Collaborate with the Bexar County Mental Health Department in the development of a single community portal to increase awareness and connect to behavioral health services and resources.

Area of Focus	Current Status	Plans
	First Aid training to raise community awareness and early intervention.	
Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community	• Complete Utilization Reviews on a regular basis. • As the individuals approach discharge readiness, they are linked to services that will assist them in transitioning/ maintaining in the community. • Attends staffings and is available to the State Mental Health Facilities (SMHF) treatment teams on a routine basis. • Forensically committed individuals are linked to the Forensic Court Services Unit as needed.	• Continue current actions, with adjustments made as the State Hospital Allocation Methodology (SHAM) is updated.
Reducing other state hospital utilization	• ABH/ CBH serves individuals per the LOCA, with re-assessments completed as the individuals needs increase/change. • Crisis Services to include MCOT/ CMOT screen potential admissions to SMHFs and makes recommendations to less restrictive alternatives as appropriate.	• Continue current actions, with adjustments made as deemed necessary.

Area of Focus	Current Status	Plans
	• Individuals in Bexar County jail who are known/thought to be experiencing mental health issues are screened and diverted to civil commitments whenever possible to prevent potentially lengthy 46B commitments. • UM department reviews and authorizes any civil SMHF admissions. Those admitted to SMHF are reviewed by Continuity of Care (CoC) for appropriateness for continued stay and linked to services as needed. • UM agreement is followed to include final authorization date and appeal process. Every effort is made to enroll individuals in CHCS on the date of discharge from a SMHF or Private Psychiatric Bed (PPB).	
Tailoring service interventions to the specific identified needs of the individual	• Provide person-centered, recovery focused, trauma informed care. • Moved to a patient centered model that tailors services depending on the need of individual. • Each individual is offered or recommended the parts of our CRP,	• Development of a Community Treatment plan in HASA • Continue with trauma informed care training/enhancement and increase groups offered. Train therapists in DBT and MET. • Continue to developing individualized

Area of Focus	Current Status	Plans
	DIP or other specialty court service arrays that they could therapeutically benefit from or that the court requires of them to fulfill specialty court programming. • Case Managers are trained to identify needed service interventions based on ANSA. • The implementation of Trauma-Informed Care (TIC) and Recovery Oriented Systems of care (ROSC) and other evidence based practice modalities are part of the training curriculum for clinical staff. • Each individual is screened and staff identifies the least restrictive environment for the patient as well as participates in co-planning with the individual to determine specific needs for treatment. • Hired two Patient Navigators. • Provided therapeutic groups for children and youth, concurrent to Parents' Workshops during the Summer and Holiday breaks. • Offering expedited track for Bexar CARES individuals and their families.	recovery plans to address specific needs • Provide ongoing refresher trainings for Case Managers to be able to recognize specific needs and provide appropriate intervention. • Continue providing TIC services • Implement targeted interventions for specialized populations including high-utilizers. • Expand recruitment of Foster Parents to increase planned respite residential capacity. • Establish Model Classroom and Resource Library for Teachers and Counselors.

Area of Focus	Current Status	Plans
	• Supplementing DSHS services by offering therapeutic groups, occupational therapy, and wraparound services through the Children's Campus. • Providing Transitional Psychiatric Follow-up and Medication Clinic to after completing outpatient services to ensure seamless connection to services in the community. • Developing "My Life" Care Coordinated Programs for 1) children and youth with physical comorbidity problems such as depression, anxiety, and mood disorders coupled with obesity, hypertension, high cholesterol, or asthma (My Life, My Health); 2) 17 year old youth who will transition from child to adult mental health services (My Life, My Voice); and 3) children and adolescents who struggle with academic success because of their mental health needs (My Life, My Choices). • Developing the "Velocity" High Utilizer Program for individuals	

Area of Focus	Current Status	Plans
	with a history of recurring psychiatric hospitalizations and crisis episodes related to treatment non-compliance. • Implemented trauma informed specialized training for Foster Parents.	
Ensuring fidelity with evidence-based practices	• Complete CBT, CPT, DBT certification training and supervision ensuring competency. • Case Managers are trained on fidelity based practices. • All programs are aligned with therapeutic intervention protocols to ensure fidelity and adhere to DSHS performance contract metrics, GFC contract requirements, and DIP 1115 waiver metrics. • All clinicians receive ongoing coaching and feedback to ensure fidelity. • LMHA uses the LEAN process with dedicated staff to ensure continuous quality improvement and maintain fidelity with the evidence based practice models used in programs.	• Working with SAMHSA and the PBHCI Grant in ensuring EBP's. • Continue to trend data and look for operational or other reasons/rationale if we are see fidelity become an issue. • Continue utilizing prescribed DSHS and TCOOMMI treatment models. • Continue to train our staff for fidelity based practices and review for quality assurance that such are being implemented. • Continue providing coaching and feedback. • Establish process to provide additional training needed to enhance Clinical Core Competencies. • Implement Core Competencies evaluation, observation, and follow-up processes.

Area of Focus	Current Status	Plans
	• Utilize a Clinical Consultant to provide CBT individual and group supervision, as well as one-on-one coaching. • Provide individual supervision for QMHPs and LPHAs. • Conduct quality assurance reviews and clinical observations. • Developed Core Competencies for Clinical Staff.	
Transition to a recovery-oriented system of care, including development of peer support services and other individual involvement in Center activities and operations (e.g., planning, evaluation)	• Peer integration. • Use of trauma informed therapeutic modalities. • Recovery model based treatment. • Implemented customer satisfaction surveys. • Positions for Peer Support specialist are posted and interviews are scheduled with qualified candidates. • Utilizing Family Partners to provide additional support, connect to services, and develop long-term recovery strategies. • The outpatient clinics are working towards fully implementing the	• Working to increase our Peer Support Services and employees. • Improve outreach to community partners to increase links for potential candidates for Peer Support specialists' positions. • Continue to train and incorporate ROSC strategies. • Provide Wraparound and Motivational Interviewing Staff training.

Area of Focus	Current Status	Plans
	ROSC model. • IHWWP has implemented the ROSC model. • CHCS uses person centered TRR services where the individual plays a co-facilitative role in their treatment. The individual is involved in treatment planning, recovery planning, and personal needs. • Secured a SAMHSA System of Care grant in partnership with the City of San Antonio.	
Addressing the needs of individuals with co-occurring substance use disorders	• Provide substance abuse based rehab services, seeking safety sessions, and staff with LCDC credentialing. • Case Managers are assessing needs for individuals with co-occurring substance use disorders and provide intervention as appropriate or referring to care. • The Integrated Clinic team works in conjunction with our internal Substance Abuse Programs and applies MI interventions to meet the needs of dually diagnosed	• Working on getting a Substance abuse license at one of the mental health outpatient clinics. • Continue to address needs as related to co-occurring mental health and substance abuse disorders. • Continue to grow services for individuals with this need to include development of groups once facilities are approved. • Evaluate the efficacy and utilization of the Substance Abuse groups.

Area of Focus	Current Status	Plans
	individuals. • IHWWP utilizes EBPs integrated treatment interventions to address dual disorders. • There are currently several programs for individuals with co-occurring disorders to participate in including: Opioid Addiction, Co-Occurring SA Disorders, Drug Court, and IOP, In-House Recovery. • Providing substance abuse educational groups.	
Integrating behavioral health and primary care services and meeting physical healthcare needs of individuals.	• Both ACT and ICT are located in an integrated, multidisciplinary clinic. • Provide both behavioral and physical need groups. • Implemented model at outpatient mental health clinic. • Currently addressing the barrier of Integrated Care clinic individuals not having funding or provider not being in network. • Referring individuals to PCP for primary care services • IHWWP works in collaboration with integrated care clinic onsite to provide healthcare treatment as	• Continue to develop true integration model that will meet both the Behavioral Health needs as well as Primary Care. • CHCS/ABH needs to have larger/overarching access to primary care/integrated regardless of funding source or lack of funding. • Continue to assist individual in obtaining benefits to receive both mental health and primary care services. • Continuous quality improvement of services. • Establish a process for utilization of this

Area of Focus	Current Status	Plans
	needed • A primary care clinic staffed by PA, APN, RN and LVN staff is located in the Restoration Services Division. It is available to individuals in the various programs. • Participating on the Primary Behavioral Health Care Integration (PBHCI) Planning and Coordination Committee to explore opportunities to expand services to the Children's Division.	service. • Evolve our services and prescriber panel to include PCP's on site. • Hire a part-time Primary Care provider. • Explore possibility to partner with UTHSC at San Antonio Community Medicine Department to place Family Practice Residents. • Implement targeted interventions for children and adolescent with physical comorbidities such as obesity, high blood pressure, diabetes, and asthma.

III.C Local Priorities and Plans

- *Based on identification of unmet needs, stakeholder input, and your internal assessment, identify your top local priorities for the next two years. These might include changes in the array of services, allocation of resources, implementation of new strategies or initiatives, service enhancements, quality improvements, etc.*
- *List at least one but no more than five priorities.*
- *For each priority, briefly describe current activities and achievements and summarize your plans for the next two years. If local priorities are addressed in the table above, list the local priority and enter "see above" in the remaining two cells.*

Local Priority	Current Status	Plans
Sustainability	• Early planning stages.	• Develop strategic sustainability plan.

Local Priority	Current Status	Plans
Reduce preventable ER usage and 30-day readmissions related to behavioral health conditions	• See Above.	• See Above.
Increase Staff of Medical personnel	• Shortage across the state and within CHCS. • Offering practicum experiences opportunities. • Utilizing Telemedicine.	• Increase marketing to Medical Professionals and advocate increasing funding for hire. • Establish partnerships with UTSA, OLLU, and other Accredited Universities to provide opportunities for graduate students' involvement. • Increase utilization of Telemedicine.
Individuals need insurance/benefits	• Many individuals are unfunded and do not have insurance. Thus their MH, Sub. Abuse and Primary Care often goes untreated. • Individuals that do not have an extensive mental health history may not qualify for SSI/SSDI benefits. • Due to being an offender, some might not qualify for insurance benefits and are unable to get the necessary treatment.	• Look at affordable fee for service model that targeted populations can afford. • Increase CBO or insurance employee base. • Continue to assist offenders at obtaining benefits at no cost to them and educating them on the need to get and maintain benefits if they qualify.
Access to quality/safe housing	• Not enough safe boarding homes. No real access to licensed boarding homes, as they charge quite a bit	• Need additional housing options/opportunities. • Need a "halfway house" or residential

Local Priority	Current Status	Plans
	more than the unlicensed homes. • Difficulty placing sex-offenders at most facilities (to include JRC, H4H, and boarding homes).	facility for these populations. Seek a grant for these resources. Without such resources, there cannot be full integration into the community.

III.D Priorities for System Development

Development of the local plans should include a process to identify local priorities and needs, and the resources that would be required for implementation. The priorities should reflect the input of key stakeholders involved in development of the Psychiatric Emergency Plan as well as the broader community. This will build on the ongoing communication and collaboration LMHAs have with local stakeholders, including work done in response to the 2015 Crisis Needs and Capacity Assessment. The primary purpose is to support local planning, collaboration, and resource development. The information will also provide a clear picture of needs across the state and support planning at the state level. Please provide as much detail as practical for long-term planning.

In the table below, identify your service area's priorities for use of any new funding for crisis and other services. Consider regional needs and potential use of robust transportation and alternatives to hospital care. Examples of alternatives to hospital care include residential facilities for non-restorable individuals, outpatient commitments, and other individuals needing long-term care, including geriatric patients with mental health needs. Also consider services needed to improve community tenure and avoid hospitalization.

a. Assign a priority level of 1, 2 or, 3 to each item, with 1 being the highest priority.
b. Identify the general need.
c. Describe how the resources would be used—what items/components would be funded, including estimated quantity when applicable.
d. Estimate the funding needed, listing the key components and costs. For recurring/ongoing costs (such as staffing), state the annual cost.

Priority	Need	Brief description of how resources would be used	Estimated Cost
1	Warm Line	• Establish a Warm Line where 100% State Bed Authorization calls and community informational calls are directed.	• TBD
2	JRC Beds	• Expand JRC beds and open a Substance Abuse wing.	• TBD
2	Detox Beds	• Increase the number of detox beds for Restoration Services.	• TBD
1	Staffing (medical providers & medical/clinical staff)	• Expand the availability of services at the Crisis Care Center.	• TBD
2	Greater building capacity	• Expand Restoration Services. Locate alternative space where we can increase current services (crisis & detox) as well as offer more mental health and substance abuse services to the community.	• TBD

Appendix A: Levels of Crisis Care

Admission criteria – Admission into services is determined by the individual's rating on the Uniform Assessment and clinical determination made by the appropriate staff. The Uniform Assessment is an assessment tool comprised of several modules used in the behavioral health system to support care planning and level of care decision making. High scores on the Uniform Assessment module items of Risk Behavior (Suicide Risk and Danger to Others), Life Domain Functioning and Behavior Health Needs (Cognition) trigger a score that indicates the need for crisis services.

Crisis Hotline – The Crisis Hotline is a 24/7 telephone service that provides information, support, referrals, screening and intervention. The hotline serves as the first point of contact for mental health crisis in the community, providing confidential telephone triage to determine the immediate level of need and to mobilize emergency services if necessary. The hotline facilitates referrals to 911, the Mobile Crisis Outcome Team (MCOT), or other crisis services.

Crisis Residential – Up to 14 days of short-term, community-based residential, crisis treatment for individuals who may pose some risk of harm to self or others, who may have fairly severe functional impairment, and who are demonstrating psychiatric crisis that cannot be stabilized in a less intensive setting. Mental health professionals are on-site 24/7 and individuals must have at least a minimal level of engagement to be served in this environment. Crisis residential facilities do not accept individuals who are court ordered for treatment.

Crisis Respite – Short-term, community-based residential crisis treatment for individuals who have low risk of harm to self or others and may have some functional impairment. Services may occur over a brief period of time, such as 2 hours, and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons for whom they care to avoid mental health crisis. Crisis respite services are both facility-based and in-home, and may occur in houses, apartments, or other community living situations. Facility based crisis respite services have mental health professionals on-site 24/7.

Crisis Services – Crisis services are brief interventions provided in the community that ameliorate the crisis situation and prevent utilization of more intensive services such as hospitalization. The desired outcome is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse. (TRR-UM Guidelines)

Crisis Stabilization Units (CSU) – Crisis Stabilization Units are licensed facilities that provide 24/7 short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected, clinically staffed, psychiatrically supervised, treatment environment that complies with a Crisis Stabilization Unit licensed under Chapter 577 of the Texas Health and

Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code. CSUs may accept individuals that present with a high risk of harm to self or others.

Extended Observation Units (EOU) – Emergency services of up to 48 hours provided to individuals in psychiatric crisis, in a secure and protected, clinically staffed, psychiatrically supervised environment with immediate access to urgent or emergent medical and psychiatric evaluation and treatment. These individuals may pose a moderate to high risk of harm to self or others. EOUs may also accept individuals on voluntary status or involuntary status, such as those on Emergency Detention. Individuals on involuntary status may receive preliminary examination and observation services only. EOUs may be co-located within a licensed hospital or CSU, or be within close proximity to a licensed hospital.

Mobile Crisis Outreach Team (MCOT) – Mobile Crisis Outreach Teams are clinically staffed mobile treatment teams that provide 24/7, prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up, and relapse prevention services for individuals in the community.

Psychiatric Emergency Service Center (PESC) and Associated Projects – There are multiple psychiatric emergency services programs or projects that serve as step down options from inpatient hospitalization. Psychiatric Emergency Service Center (PESC) projects include rapid crisis stabilization beds within a licensed hospital, extended observation units, crisis stabilization units, psychiatric emergency service centers, crisis residential, and crisis respite. The array of projects available in a service area is based on the local needs and characteristics of the community and is dependent upon LMHA funding.

Psychiatric Emergency Service Centers (PESC) – Psychiatric Emergency Service Centers provide immediate access to assessment, triage and a continuum of stabilizing treatment for individuals with behavioral health crisis. PESCs are staffed by medical personnel and mental health professionals that provide care 24/7. PESCs may be co-located within a licensed hospital or CSU, or be within close proximity to a licensed hospital. PESCs must be available to individuals who walk in, and must contain a combination of projects.

Rapid Crisis Stabilization Beds – Hospital services staffed with medical and nursing professionals who provide 24/7 professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute behavioral health crisis. Staff provides intensive interventions designed to relieve acute symptomatology and restore the individual's ability to function in a less restrictive setting.