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
Emergence Health Network (EHN) – Crisis Emergency Services	1601 E. Yandell El Paso, TX 79902	El Paso County	• Population: Adults and Children/Adolescents • Screening, assessment for Adults and Children/Adolescents
EHN – Central Outpatient	1601 E. Yandell, Suite A El Paso, TX 79902	El Paso County	• Population: Adults • Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services
EHN- Extended Observation Unit	1601 E. Yandell, Suite B El Paso, TX 79902	El Paso County	• Population: Adults • Extended Observation
EHN – Centro San Vicente Wellness Center for EHN	1600 Montana, 1st Floor El Paso, TX 79902	El Paso County	• Population: Adults • Integrated healthcare: mental and physical health

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
EHN-Justice Involved Programs	1600 Montana, 2nd Floor El Paso, TX 79902	El Paso County	• Population: Adults • Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services
EHN-West MH/Primary Care Clinic	725 S. Mesa Hills Bldg. 1, Suite 1 El Paso, TX 79912	El Paso County	• Population: Adults • Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services • Integrated healthcare: mental and primary care health
EHN-Northeast Outpatient MH Clinic	9555 Diana El Paso, TX 79924	El Paso County	• Population: Adults • Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services
EHN-East Valley Outpatient MH Clinic	2400 Trawood, Suite 301A El Paso, TX 79936	El Paso County	• Population: Adults • Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services
EHN-Champs	8500 Boeing Dr. El Paso, TX 79925	El Paso County	• Population: Children and Adolescents • Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services
EHN-Mental Health	9009 Dyer El Paso, TX 79904	El Paso County	• Population: Adults • Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services
EHN-Military Veteran Peer Network	9565 Diana El Paso, TX 79904	El Paso County	• Military Peer Network

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
Atlantis Health Services	10501 Gateway Blvd W El Paso, TX 79925	El Paso County	• Population: Adults • Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services
La Familia Del Paso	1511 E. Yandell El Paso, TX 79902	El Paso County	• Population: Adults • Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services
Homeward Bound (Trinity)	8716 Independence El Paso, TX 79907	El Paso County	• Crisis Residential • Crisis Respite
El Paso Behavioral Health System	1900 Denver El Paso, TX 79902	El Paso County	• Rapid Crisis Stabilization

I. B Texas Healthcare Transformation and Quality Improvement Program 1115 Waive

r 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 clients that can be served at a single point in time.*
- *Enter the number of clients 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

1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity	Number Served/ Year
15	Extended Observation Unit- 10 bed unit, serving individuals in a behavioral health crisis to provide rapid, 48-hour, stabilization through telemedicine.	3	165 (monthly)	2111
15	Westside Clinic- Behavioral health clinic serving Medicaid, low-income and uninsured individuals.	1	350-400 (yearly)	600
15	Expand Behavioral Health Providers- recruitment program to hire behavioral health providers.	3	N/A	N/A
15	Systemic, Therapy, Assessment, Respite, Treatment (START)- Crisis resolution program for individuals with an intellectual or developmental disability.	3	200 (yearly)	381
15	Crisis Respite Center- 8-bed unit, allowing for continuation of crisis treatment for an extended 7-day stay, most commonly after EOU release.	3	43 (monthly)	560
15	Multisystemic Therapy- Providing wraparound therapy services to justice involved youth.	3	50 (yearly)	117
Numbers served since February 2016.				

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
☒	Consumers	☒	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 consumer-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.

• Expansion of criminal justice and behavioral health services as it relates to pretrial and reentry linkage
• Reduction in emergency department behavioral health admissions.
• Provider shortage.
• Lack of comprehensive inventory of behavioral health services in the region.
• Better coordination of healthcare for foster children.
• Better coordination with managed care companies for healthcare of children.

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 consumers 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

Emergence Health Network is a key partner of the El Paso Community Behavioral Health Consortium (BHC) in El Paso County. The BHC convened to examine the El Paso community behavioral health system in preparation for future service needs and funding trends. Its actions are informed by community leaders and available data including an El Paso County behavioral health system assessment conducted in 2014. Stakeholder representation including the necessary service levels of an ideal behavioral health system, approach and methods, planning findings and recommendations are covered extensively for the intended audience of this CLSP by visiting the following site: http://www.pdnhf.org/who_we_are/initiatives/el-paso-behavioral-health-consortium

II.B Crisis Response Process and Role of MCOT

1. How is your MCOT service staffed?
    a. During business hours

- Staggered eight-hour shifts throughout the day starting at 0700 with a new eight hour shift starting every two hours. A QMHP is on call at all times for additional support as needed.

b. After business hours

- One QMHP scheduled per eight to twelve hour shifts that vary at 1500 and 2300 with overlap from the day shifts until 2200. A QMHP is on call at all times for additional support as needed.

c. Weekends/holidays

- Three staggered twelve-hour shifts, at 0700, 1100 and 1900. A QMHP is on call at all times for additional support as needed.

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

- All types of crises meet criteria for MCOT deployment, including, but not limited to: suicidal/homicidal ideations; suicide/homicide attempts and gestures; decompensation of psychiatric symptoms; emotional, financial, housing, substance use- and abuse-related crises; aggressive/erratic behaviors related to psychiatric disorder or suspicion thereof; etc.

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.

- MCOT and crisis hotline operate under the LMHA facilitating the flow of communication and a speedier response to crisis hotline calls necessitating MCOT response. MCOT provides crisis intervention and resolution (when possible) and a recommendation for inpatient placement, transitional services, or follow up (when crisis resolution is reached)

with the LMHA is provided upon completion of the crisis outreach. MCOT provides face-to-face follow up via ongoing crisis intervention services for individuals pending inpatient admission in the community.

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 has an established response time of 1 hour for emergent crises and 8 hours for urgent crises.
- Law enforcement: Yes. MCOT responds to all law enforcement requests for deployment and these requests are treated as emergent crises requiring a 1 hour response time.

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

- Emergency rooms: Lethality assessments, crisis intervention and resolution, placement in appropriate level of care as needed (including inpatient psychiatric treatment, Extended Observation Unit, Crisis Residential Unit, Respite Care Center), initiating communication between holding and receiving facilities when placement is determined to be necessary, as well as facilitating follow up by LMHA.
- Law enforcement: Lethality assessments, crisis intervention and resolution, placement in appropriate level of care as needed, ensuring documentation is delivered and received by admitting facilities when placement is determined to be necessary, arranging for client transportation, as well as facilitating follow up by LMHA.

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?

   a. Describe your community's process if a client needs further assessment and/or medical clearance:

- For individuals needing further assessment, a referral is made to the Extended Observation Unit for evaluation by a Registered Nurse and Psychiatrist/Psychiatric Nurse Practitioner. Any client in need of medical clearance

is referred to a local emergency department of their choice, once medical clearance is established, MCOT deploys and a recommendation is provided.

b. Describe the process if a client needs admission to a hospital:

- MCOT initiates the communication between the holding facility (if applicable) and the receiving facility, securing a bed for the patient. Report is given to the admissions department in the receiving facility via telephone, and documentation required for admission is transmitted for review and placement. Once documentation is reviewed the facilities conduct doctor-to-doctor and nurse-to-nurse communication the transfer process is initiated, or report is provided to admitting doctor and/or nurse at the receiving facility and client is provided transportation to admitting hospital once cleared for admission.

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

- MCOT staffs each individual case with a qualified LMHA practitioner provider on call to provide a recommendation for placement. If a client is determined to need facility-based crisis stabilization, report is given to the receiving facility via telephone and pertinent documentation transmitted to them securely. After documentation is reviewed by the facility's Physician or Registered Nurse and the client is accepted into the receiving facility, transportation is arranged for client to ensure safe arrival.

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

a. During business hours

- Request MCOT dispatch through the crisis hotline.

b. After business hours

- Request MCOT dispatch through the crisis hotline.

c. Weekends/holidays

o Request MCOT dispatch through the crisis hotline.

7. If an inpatient bed is not available:

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

o A lower level of care is utilized in these situations, mostly the Extended Observation Unit, until a bed is available, to prevent overutilization of Emergency Departments. In the event that a client presents with exclusionary criteria for Extended Observation Unit, the client is transported to or remains in a safe environment (mainly local Emergency Department) until a bed becomes available.

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

o MCOT

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

o MCOT routinely conducts re-assessments to determine if the client continues to need inpatient level of care, or can be diverted to lower level of care if appropriate.

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

o MCOT provides transportation via secure company vehicle or local non-emergency ambulance services.

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	Extended Observation Unit
Location (city and county)	City of El Paso, El Paso County
Phone number	(915) 599-4900
Type of Facility (see Appendix B)	Extended Observation Unit
Key admission criteria (type of patient accepted)	The EOU can accept individuals 18 years and older who are medically eligible, non-violent, and in a mental health crisis.
Circumstances under which medical clearance is required before admission	• Vitals and/or labs outside normal limits or abnormal • Recent sexual assault • Complaints of chest pain, numbness, or weakness • Sudden onset of severe headache, blurred vision, slurred speech and/or unsteady gait • History of stroke and difficulty swallowing • Difficulty breathing or irregular breathing pattern • Diabetes with complications present • Severe pain • Recent, untreated injuries or wounds • Unconsciousness • Recent seizure activity • Recent overdose attempts (within 6 hours) or suspicion of overdose without medical intervention • Medical detox from drugs or alcohol

	• Onset of altered mental status in the last 24 hours
Service area limitations, if any	N/A
Other relevant admission information for first responders	Exclusionary criteria: • Uncooperative, combative or violent behavior in the past 8 hours • 17 years old or younger • Nursing home patients, diagnosis of dementia, Alzheimer's • Patients requiring assistance with activities of daily living • Patients requiring ongoing medical treatment such as dialysis, chemotherapy or radiation treatment • Diagnosis of Autism or Intellectual Disabilities with low functioning First responders can contact (915) 747-3511 to check if an individual qualifies for admission prior to initiating transport.
Accepts emergency detentions?	Yes

Name of Facility	Crisis Residential Unit
Location (city and county)	City of El Paso, El Paso County
Phone number	(915) 772-9111
Type of Facility (see Appendix B)	Psychiatric Emergency Service Center/Crisis Residential
Key admission criteria (type of patient accepted)	The Crisis Residential unit can accept individuals 18 years and older who are voluntarily seeking assistance, medically eligible, non-violent, and in a mental health crisis.
Circumstances under which medical clearance is required before admission	• Vitals and/or labs outside normal limits or abnormal • Recent sexual assault • Complaints of chest pain, numbness, or weakness • Sudden onset of severe headache, blurred vision, slurred speech and/or unsteady gait • Difficulty breathing or irregular breathing pattern

	• Diabetes with complications present • Severe pain • Recent, untreated injuries or wounds • Unconsciousness • Recent seizure activity • Recent overdose attempts (within 6 hours) or suspicion of overdose without medical intervention • Medical detox from drugs or alcohol • Non-mental health related crises (i.e. substance abuse only) • Altered mental status or active psychotic episode
Service area limitations, if any	N/A
Other relevant admission information for first responders	Exclusionary criteria: • Uncooperative, combative or violent behavior in the past 8 hours • 17 years old or younger • Nursing home patients, diagnosis of dementia, Alzheimer's • Patients requiring ongoing medical treatment such as dialysis, chemotherapy or radiation treatment • Diagnosis of Autism or Intellectual Disabilities with low functioning • Involuntary status (EDO, PCO, CME)
Accepts emergency detentions?	No

Name of Facility	Respite Care Center
Location (city and county)	City of El Paso, El Paso County
Phone number	(915) 772-9111
Type of Facility (see Appendix B)	Crisis Respite
Key admission criteria (type of patient	Short-term, community-based, residential, crisis treatment for persons

accepted)	with low risk of harm to self or others and may have some functional impairment who require direct supervision and care but do not require hospitalization.
Circumstances under which medical clearance is required before admission	• Vitals and/or labs outside normal limits or abnormal • Recent sexual assault • Complaints of chest pain, numbness, or weakness • Sudden onset of severe headache, blurred vision, slurred speech and/or unsteady gait • Difficulty breathing or irregular breathing pattern • Diabetes with complications present • Severe pain • Recent, untreated injuries or wounds • Unconsciousness • Recent seizure activity • Recent overdose attempts (within 6 hours) or suspicion of overdose without medical intervention • Medical detox from drugs or alcohol
Service area limitations, if any	Services limited to individuals residing within El Paso County
Other relevant admission information for first responders	Intakes are only competed between the hours of 0700 and 1900 Sunday through Saturday.
Accepts emergency detentions?	No

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	Rapid Crisis Stabilization Unit
Location (city and county)	City of El Paso, El Paso County
Phone number	(915) 544-4000

Type of Facility (see Appendix B)	Psychiatric Emergency Service Center
Key admission criteria (type of patient accepted)	Individuals 18 years and older who are in a mental health crisis.
Circumstances under which medical clearance is required before admission	• Delirium including substance induced syndromes • Unconsciousness or comma • Uncontrolled seizures • Blood alcohol level of 0.08 or greater • Overdoses with unstable vital signs within the past 12 hours, evidence of improved level of consciousness is required • Unstable vital signs during the last 24 hour period • Temperatures over 101 degrees Fahrenheit • Abnormal labs or outside of normal limits • Uncontrolled diabetes with blood sugar fluctuating below 70 or over 400 during the last 48 hour period • Post-op instability • Cardiovascular disorder with unstable vital signs, chest pain, shortness of breath, unstable arrhythmia, pulmonary edema, congestive heart failure, acute respiratory distress syndrome, or acute asthma within the last 24 hours • Central nervous system instability • Emergent medical conditions requiring medical or surgical care • Recent gastrointestinal bleeding • Acute abdomen syndrome within the past 48 hours • Intubated within the past 24 hours •
Service area limitations, if any	N/A
Other relevant admission information for first responders	Exclusionary criteria: • Specialized cancer care including radiation or chemotherapy • Decubitis, stage 3-4

	• Requiring blood or blood product transfusions • Continuous oxygen or oximetry • Active tuberculosis • Anyone requiring isolation for infection control • Ongoing intravenous therapy • Subclavian lines, arterial lines, hyperalimentation/total parenteral nutrition, suctioning • Individuals requiring dialysis • Individuals requiring peritoneal or hemodialysis treatments • Wounds that require complex care or sterile equipment • Tracheotomy care • Non-ambulatory as a chronic condition • High-risk pregnancy • Any person whose physical infirmities are such that they would be better treated in a medical facility with support and monitoring available appropriate to their medical conditions • Primary diagnosis of substance abuse

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.

o Outpatient Competency Restoration –community based competency restoration services.

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

- N/A

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?

- Yes, jail liaison function is to assist the courts in identifying individuals eligible for diversion, facilitate information between the court, the jail, pre-trial and the psychiatric center.

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.

- N/A

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.

- EHN will continue to utilize and offer OCR services as a suitable alternative to inpatient placement

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.)?

- El Paso County would benefit from jail-based competency restoration services due to the lengthy waitlist for inpatient placement at a state facility.

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

- The need would be increased staffing and related costs for the jails and additional staff. Barriers would be the recruitment of a psychiatrist and psychologist to the area, which has been designated as a HPSA area.

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?

- LMHA has partnered with a local Federally Qualified Health Center (FQHC) to co-locate at one of the LMHA's facilities to which primary care services will be provided effective March 1, 2016 to uninsured clients.
- In May 2015, LMHA established a new Westside integrated primary and behavioral health care clinic on one location. Plans are underway in 2016 to integrate substance abuse services in the same location.
- LMHA has hired a Chief of Addictive Services that has begun the process of securing state required licenses to provide substance abuse treatment and services (not including detox services) to LMHA clients. Completion of licensing requirements is expected for completion in March/April 2016 and services are expected to commence in April 2016.

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

- To expand primary care and substance abuse services at all outpatient mental health sites including relevant IDD programs and sites.

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.

- Information will be shared via EHN website, as well as through emails and ground mail to community stakeholders and emergency response leaders. Communications will also be shared through distribution of fact sheets/brochures. Community stakeholders/groups/emergency responders will also have the option to request an "informational" presentation (Q and A) by EHN.

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?

- Pocket guides, brochures, website page and community training outreaches as well as 24/7 hotline availability for first responders and community stakeholders. Ongoing training and information to be provided to MCOT and hotline staff.

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
El Paso	• **Fragmentation and a lack of substantive programmatic collaboration.** System leaders in El Paso agreed that important steps have been taken in the community to address fragmentation through improved collaboration, most notably the establishment of collaborative bodies such as the El Paso Community Behavioral Health Consortium (BH Consortium), the Brain Trust Committee, collaborative development by Regional Health Partnership 15 of DSRIP5 -funded projects such as the extended observation unit, and reorganization of the leadership of key providers to increase collaboration and effectiveness. Recent efforts to address fragmentation have resulted in the formation of the following leadership councils in the community: 1) Family; 2) Integration; 3) Justice. Additional information on each initiative of the respective leadership councils go to: http://www.pdnhf.org/who_we_are/initiatives/el-paso-behavioral-health-consortium
	• **Develop a crisis continuum for children and families – coordinated with the broader crisis system – that centers on a non-forensic mobile crisis team supported by a continuum of community-based and residential components.** The ideal crisis continuum centers on a dedicated on-call mobile team – separate from but supported by law enforcement- to serve children, youth and their

	families in crisis across systems (mental health, substance abuse, schools, child welfare, and juvenile justice). The team must be integrated within a broader crisis system that includes at least one high quality, respected children's hospital program anchoring an array of brief out-of-home options for children and youth in crisis (with some available up to 30 days), including inpatient care for truly complex cases, crisis residential, respite, therapeutic foster care, and emergency shelter options (EP Community BH Assessment, Final Report: 2014). For additional information regarding crisis gaps in the area the following reference is provided to the CLSP reviewer(s): http://pdnhf.s3.amazonaws.com/documents/files/000/000/044/original/2014_El_Paso_County_BH_Assesssment_-_Full_Report.pdf?1455580360
	• **A dramatic lack of capacity exists in El Paso County for both adult and child behavioral health services.** The bottom line is that need greatly exceeds service capacity at every level of the system, especially crisis care, prescribers, culturally-competent care, and El Paso Community Behavioral Health Assessment Page 17 intensive community-based services to provide ongoing care for those most in need, as well as the supported housing, supported employment, and peer supports needed to foster true recovery over time. Strategies under consideration and review by the local leadership councils would address the need to Prioritize development efforts to (1) stabilize crisis situations and (2) build broader capacity to intervene earlier, particularly with children, in order to break the repeating cycle of dependency on crisis, law enforcement, criminal justice, juvenile justice, and child welfare services and build preventive capacity over time in federally qualified health centers and UMC clinics, primary care and pediatric practices, schools, and local communities. For additional information regarding crisis gaps in the area the following reference is provided to the CLSP reviewer(s): http://pdnhf.s3.amazonaws.com/documents/files/000/000/044/original/2014_El_Paso_County_BH_Assesssment_-_Full_Report.pdf?1455580360
	• State operation of the El Paso Psychiatric Center (EPPC) offers the most cost effective option for expanding adult acute and crisis capacity in accord with local priorities and inclusive of locally operated services co-located at EPPC. DSHS has expressed a willingness and flexibility to partner with the local community to support the development of EPPC programming, including the option of contracting with a local hospital provider to operate the program. Recommendation under consideration and review

	include EPPC to contract existing first floor space to become a full service Psychiatric Emergency Service (PES) that provides not just a basic emergency and diversion function as a front-end to EPPC and other psychiatric inpatient programs in the county, but also the core for a system-wide crisis triage and diversion system for both acute and forensic cases. For additional information regarding crisis gaps in the area the following reference is provided to the CLSP reviewer(s): http://pdnhf.s3.amazonaws.com/documents/files/000/000/044/original/2014_El_Paso_County_BH_Assesssment_-_Full_Report.pdf?1455580360
	• Despite a strong commitment by local law enforcement leadership to robust behavioral health liaisons and mental health training for peace officers, there continue to be significant gaps in the readiness of law enforcement and correctional officers to respond to behavioral health crises. However, two major gaps remain. First, because of the demands on officers for their time (and a lack of resources sufficient to allow officers additional time for training away from their law enforcement duties), there is currently a gap in the area of recertification and training. For additional information regarding crisis gaps in the area the following reference is provided to the CLSP reviewer(s): http://pdnhf.s3.amazonaws.com/documents/files/000/000/044/original/2014_El_Paso_County_BH_Assesssment_-_Full_Report.pdf?1455580360

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: Click here to enter text.	• Current activities include: MHFA training for court personnel and Community Supervision Officers. Additional specialized training has been made available upon request for Pre-Trial and other court personnel.
Plans for the upcoming two years: • Develop CIT or MH Deputy program for the county. Increase utilization of the EOU as a location for law enforcement.	

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.	• On a case by case basis, a court coordinator is available to assist the District Courts and Magistrates with Diversion opportunities.
Plans for the upcoming two years: • Increase community capacity to serve individuals with a MH diagnosis. Increase staffing to enhance presence at court to facilitate services.	

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 ☐ Services for persons with other Forensic Assisted Outpatient Commitments ☐ Providing services in jail for persons Incompetent to Stand	• El Paso has several specialty courts such as the ones listed on the left. In collaboration with the magistrates and the Public Defender's Office, individuals are identified for diversionary services. EHN is the jail MH service provider and therefore is able to provide services comparable to that in the community for identified MH patients. Jail Liaison will link individuals to comprehensive services in the community.

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
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:	
Plans for the upcoming two years: • Plans for the future include a Mental Health Court, use of Compelled Medications for persons waiting in jail IST.	

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:	• EHN has staff available at releasing to coordinate care for individuals releasing from the county jail. Services are also coordinated for those released back to the jail from a state hospital. They are subsequently linked back to community based services.

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
Plans for the upcoming two years: • EHN is working to develop a structured process to coordinate discharge and assist inmates transitioning from jail.	

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 options to reinforce positive behavior and effectively address noncompliance ☐ Other:	• EHN currently has a TCOOMMI program that routinely screens for MH services. The TCOOMMI program has specialized caseloads for probation and parole to meet the needs of identified offenders.
Plans for the upcoming two years: • Develop FACT • EHN intends to provide MHFA and other trainings to probation and parole staff.	

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	• EHN currently has liaison staff housed at both of the inpatient psychiatric hospitals to aid in continuity of care and discharge planning	• NA
Reducing hospital readmissions	• EHN currently reviews all inpatient admissions as part of clinical review at each unit. Expanded the ACT team to two teams increase access to services for high utilizers	• Expand ACT services to include the addition of another team.
Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community	• EHN has routine communication with state hospital staff to evaluate the progress and determine their appropriateness for a lower level of care.	• EHN is exploring the HCBS-AMH waiver program to aid in the transition of long-term state hospital patients
Reducing other state hospital utilization	• EHN has improved access and expanding capacity in the community so that individuals can access care in the right setting.	• Enhance services delivered in the outpatient setting to include the implementation of CBT services.
Tailoring service interventions to the specific identified needs of the individual	• EHN is in the beginning stages of implementation of PCRP services.	• 100% implementation of PCRP throughout the service lines.

Area of Focus	Current Status	Plans
Ensuring fidelity with evidence-based practices	• EHN currently maintains Fidelity with its ACT Team, YES waiver and LOC 4 CAD services. EHN also maintains fidelity in the 1115 Waiver MST program	• Explore options for other services or programs that can bring fidelity quality program to the region
Transition to a recovery-oriented system of care, including development of peer support services and other consumer involvement in Center activities and operations (e.g., planning, evaluation)	• Current Pilot of Peer Support Service with two staff members; Current PNAC receiving status reports on operations by EHN staff	• Provision of Peer Services by certified peer providers at all EHN facilities; Development and PNAC strategic plan to increase PNAC involvement at Board of Trustees level and implementation of specific goals related improving consumer and communication knowledge of EHN services.
Addressing the needs of consumers with co-occurring substance use disorders	• Individual counseling addresses both MH and Substance Use Disorders • Currently in process of obtaining substance use disorder facility licensure in order to start an outpatient substance abuse treatment program	• Will have active outpatient substance abuse program for both adults and youths, along with both ambulatory and residential detox
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• EHN currently has integrated primary care services at two locations	• EHN plans to have full integration at all four outpatient service locations.

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
Substance Abuse Services	• Limited access to providers	• EHN expands addiction services
Criminal Justices and Behavioral Health Expansion	• Jail-based Population Services to individuals inside County jail facilities	• Expand services to include 1622 assessments conducted during booking processes
Integrated Healthcare	• Westside Clinic- integrated healthcare model	• Integrate primary, behavioral health and addiction services into one site

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	Crisis Intervention Team (CIT)	• To promote and support collaborative efforts that will create and sustain effective interactions among law enforcement, mental health care providers, individuals with mental illness, their families and the El Paso community.	• $730,000
2	Residential crisis and respite center for children and adolescents	• To establish a 16-bed, residential crisis and respite center for 1,187 children and adolescents with a diagnosis of mental illness who exhibit serious emotional, behavioral or mental health disorders over a three year initial implementation period.	• $2,967,500
3	Crisis Respite Unit (CRU) for individuals with IDD and IDD/MI	• The unit would consist of a total of four (4) beds dedicated exclusively for individuals with IDD. The anticipated number of individuals to be served annually totals 139 individuals per year.	• $879,000
4	NAIP Project-Provider Trainings in Behavioral Health and IDD.	• Train 200 providers from local public hospitals in behavioral health and IDD, conducting 13 trainings in mental health first aid, crisis and local mental health services and IDD crisis prevention.	• $50,000

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.