Form O: Consolidated Local Service Plan

The Texas Health and Human Services (HHSC) requires all local mental health authorities (LMHA) and local behavioral health authorities (LBHA) submit the Consolidated Local Service Plan (CLSP) for fiscal year 2025 by **December 31, 2024** to Performance.Contracts@hhs.texas.gov and CrisisServices@hhs.texas.gov.

Introduction

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

The CLSP asks for information related to community stakeholder involvement in local planning efforts. The Health and Human Services Commission (HHSC) recognizes that community engagement is an ongoing activity and input received throughout the biennium will be reflected in the local plan. LMHAs and LBHAs may use a variety of methods to solicit additional stakeholder input specific to the local plan as needed. In completing the template, please provide concise answers, using bullet points. Only use the acronyms noted in Appendix B and language that the community will understand as this document is posted to LMHAs' and LBHAs' websites. When necessary, add additional rows or replicate tables to provide space for a full response.

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Section I: Local Services and Needs

I.A Mental Health Services and Sites

In the table below, list sites operated by the LMHA or LBHA (or a subcontractor organization) providing mental health services regardless of funding. 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, adolescents, and children (if applicable).

- Screening, assessment, and intake
- Texas Resilience and Recovery (TRR) outpatient services: adults, adolescents, or children
- Extended observation or crisis stabilization unit
- Crisis residential or respite unit, or both
- Diversion centers
- Contracted inpatient beds
- Services for co-occurring disorders
- Substance use prevention, intervention, and treatment
- Integrated healthcare: mental and physical health
- Services for people with Intellectual or Developmental Disorders (IDD)
- Services for veterans
- Other (please specify)

Table 1: Mental Health Services and Sites

Operator (LMHA, LBHA, contractor or sub-contractor)	Street Address, City, and Zip	Phone Number	County	Type of Facility	Services and Target Populations Served
ACCESS	1011 College Ave Jacksonville, Tx 75766	903-589-9000	Cherokee	Outpatient Clinic	Screening, assessment, & intake; TRR outpatient services: adults, adolescents & children; MAT, Jail Based Competency Restoration, substance abuse prevention, intervention or treatment; MCOT; YES Waiver Services; Services for individuals with IDD; co-located mental and physical health services.
ACCESS	3320 South Loop 256, Palestine, TX 75801	903-723-6136	Anderson	Outpatient clinic	Screening, assessment, & intake; TRR outpatient services: adults, adolescents & children; MAT, Jail Based Competency Restoration, substance abuse prevention, intervention or treatment; MCOT; YES Waiver Services; Services for individuals with IDD; co-located mental and physical health services
ACCESS	913 N. Jackson Street, Jacksonville, TX 75766	903-586-3175	Cherokee	Services for kids and families	Skills training and family integration/support services for Youth enrolled in FAYS (Family and Youth Success Services)
ACCESS	804 S. Main Street, Jacksonville, TX 75766	903-284-8424	Cherokee	Veterans Services	Veteran Services/Lone Star Military Group – current & former members of the US military & their families

Operator (LMHA, LBHA, contractor or sub-contractor)	Street Address, City, and Zip	Phone Number	County	Type of Facility	Services and Target Populations Served
Palestine Regional Medical Center/ Psych Services	4000 S. Loop 256 West Campus, Palestine, TX 75801	903-731-5143	Anderson	Inpatient Acute Psychiatric Care	In-patient psychiatric treatment for adults; 42-bed competency restoration unit for adults
HMIH Cedar Crest Hospital	3500 S IH-35, Belton, Tx 76513	(254) 939-2100	Bell	Inpatient Acute Psychiatric Care	In-patient psychiatric treatment for adults, children 5 to 12, and adolescents 13 to 17
UT Tyler-North Campus	11937 U.S. Highway 271, Tyler, TX 75708	(903) 877-7000	Smith	Inpatient Acute Psychiatric Care	In-patient psychiatric treatment for adults
Medical Behavioral Hospital of Clear Lake	16850 Buccaneer Lane, Houston, TX 77058	(833) 971-2356	Harris	Inpatient Acute Psychiatric Care	92-bed psychiatric facility for acute inpatient care.
Avail	3310 E. 5th Street, Tyler, TX 75701	(800) 510-7730	Smith	Crisis Hotline	24/7 Accredited Crisis Screening Hotline
Cherokee County Peer Support Group	410 Tilley Street Jacksonville, TX 75766	(903) 586-3786	Cherokee	Peer Support and Peer Services	Peer-run support groups, socialization, and skills training

I.B Mental Health Grant Program for Justice-Involved Individuals

The Mental Health Grant Program for Justice-Involved Individuals is a grant program authorized by in Chapter 531, Texas Government Code, Section 531.0993 to reduce recidivism rates, arrests, and incarceration among people with mental illness, as well as reduce the wait time for people on forensic commitments. The 2024-25 Texas General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023, (Article II, HHSC, Rider 48) appropriated additional state funding to expand the grant and implement new programs. The Rural Mental Health Initiative Grant Program, authorized by Texas Government Code, Section 531.09936, awarded additional state funding to rural serving entities to address the mental health needs of rural Texas residents. These grants support community programs by providing behavioral health care services to people with a mental illness

encountering the criminal justice system and facilitate the local cross-agency coordination of behavioral health, physical health, and jail diversion services for people with mental illness involved in the criminal justice system.

In the table below, describe projects funded under the Mental Health Grant Program for Justice-Involved Individuals, Senate Bill 1677, and Rider 48. Number served per year should reflect reports for the previous fiscal year. If the project is not a facility; indicate N/A in the applicable column below. Add additional rows if needed. If the LMHA or LBHA does not receive funding for these projects, indicate N/A and proceed to I.C.

Table 2: Mental Health Grant for Justice-Involved Individuals Projects

Fiscal Year	Project Title (include brief description)	County(s)	Type of Facility	Population Served	Number Served per Year
	N/A				

I.C Community Mental Health Grant Program: Projects related to jail diversion, justice-involved individuals, and mental health deputies

Section 531.0999, Texas Government Code, requires HHSC to establish the Community Mental Health Grant Program, a grant program to support communities providing and coordinating mental health treatment and services with transition or supportive services for people experiencing mental illness. The Community Mental Health Grant Program is designed to support comprehensive, data-driven mental health systems that promote both wellness and recovery by funding community-partnership efforts that provide mental health treatment, prevention, early intervention, or recovery services, and assist with people transitioning between or remaining in mental health treatment, services and supports.

In the table below, describe Community Mental Health Grant Program projects related to jail diversion, justice-involved individuals, and mental health deputies. Number served per year should reflect reports for the previous fiscal year. Add additional rows if needed. If the LMHA or LBHA does not receive funding for these projects, indicate N/A and proceed to I.D.

Table 3: Community Mental Health Grant Program Jail Diversion Projects

Fiscal Year	Project Title (include brief description)	County(s)	Population Served	Number Served per Year
	N/A			

I.D Community Participation in Planning Activities

Identify community stakeholders that participated in comprehensive local service planning activities.

Table 4: Community Stakeholders

	Stakeholder Type		Stakeholder Type
☒	People receiving services -Prudence Hughs	☐	Family members
☒	Advocates (children and adult) -CASA -Crisis Center -The Hope Station -Highway 69 Missionary	☐	Concerned citizens or others
☒	Local psychiatric hospital staff (list the psychiatric hospital and staff that participated): -Palestine Regional -Cedar Crest	☒	State hospital staff (list the hospital and staff that participated): -Rusk State Hospital
☒	Mental health service providers -Dr. Kenta Etem	☒	Substance use treatment providers -Texas Treatment Centers -ETCATA -Cenikor
☐	Prevention services providers	☐	Outreach, Screening, Assessment and Referral Centers
☒	County officials (list the county and the name and official title of participants): -Cherokee County Sheriff's Dept -Anderson County Sheriff's Dept -Rusk PD -Alto PD -Palestine PD -Jacksonville PD -County Judge, Cherokee County -County Judge, Anderson County	☒	City officials (list the city and the name and official title of participants): Joe Tinsley- Elkhart ISD Joe Williams- Jacksonville PD Dana Young- City Attorney

	Stakeholder Type		Stakeholder Type
☒	Federally Qualified Health Center and other primary care providers -SHR -Family Circle of Care -Crossroads	☒	LMHA LBHA staff **List the LMHA or LBHA staff that participated:* Dennis Steelman, Program Manager Karen Pate, CAO Ted Debbs, CEO Donna Thomas, CPO Debbie Hamilton, CFO Rick Matthews, Crisis Supervisor Shavonne Minor, IDD Manager Lynsie Fisher, MH Manager
☒	Hospital emergency room personnel -Palestine ER Director -CMF ER Director	☐	Emergency responders
☒	Faith-based organizations -Dr. Hackney	☒	Local health and social service providers -Dr. Etem
☒	Probation department representatives -Cherokee County Adult -Cherokee County Juvenile -Anderson County Juvenile	☒	Parole department representatives -Cherokee County
☒	Court representatives, e.g., judges, district attorneys, public defenders (list the county and the name and official title of participants): -Judge McKinney -Judge Davis	☒	Law enforcement (list the county or city and the name and official title of participants): -Rusk PD -Alto PD -Jacksonville PD -Palestine PD -Cherokee County Sheriff -Anderson County Sheriff
☐	Education representatives	☐	Employers or business leaders
☐	Planning and Network Advisory Committee	☐	Local peer-led organizations
☒	Peer specialists -Lindsey Sifers	☐	IDD Providers
☐	Foster care or child placing agencies	☒	Community Resource Coordination Groups -Cherokee County CRCG -Anderson County CRCG
☐	Veterans' organizations	☐	Housing authorities

	Stakeholder Type		Stakeholder Type
☒	Local health departments -Cherokee County Health Dept	☐	Other: _____

Describe the key methods and activities used to obtain stakeholder input over the past year, including efforts to ensure all relevant stakeholders participate in the planning process.

Response:

Key Methods and Activities to Obtain Stakeholder Input

Over the past year, ACCESS employed a variety of strategies to gather input from stakeholders, ensuring representation from all relevant groups in the planning process. These efforts included:

1. Community Meetings and Forums

- **Open Forums:** ACCESS hosted quarterly community forums to solicit input from stakeholders, including service recipients, family members, law enforcement, healthcare providers, and educators.

2. Surveys and Questionnaires

- **Email Surveys:** Distributed surveys to stakeholders via email to collect quantitative and qualitative feedback on service needs, gaps, and priorities.
- **Post-Service Feedback:** Collected feedback from service recipients and their families through satisfaction surveys distributed after crisis interventions, outpatient services, and peer support programs.

3. Stakeholder Advisory Committees

- **Advisory Group Meetings:** Convened stakeholder advisory groups regularly, including representatives from law enforcement, healthcare providers, educators, and community leaders, to review service plans and discuss emerging needs.
- **Veteran and Peer Support Input:** Included veterans and peer support specialists in advisory meetings to ensure their unique perspectives informed service development.

4. Collaborative Planning Attempts

- **Focus Groups:** ACCESS made efforts to organize focus groups for specific populations, such as veterans, individuals with lived experience, and families of individuals with mental health challenges, to understand their unique needs and perspectives.
- **Planning Workshops:** Initiated planning workshops with key stakeholders to collaboratively identify strategies for improving crisis response and service coordination. While turnout was lower than expected, the insights gathered were valuable.

Efforts to Ensure Broad Participation

1. **Accessibility:** Ensured that all forums and surveys were accessible, providing options such as virtual participation, translated materials, and accommodations for disabilities.
2. **Targeted Outreach:** Proactively engaged historically underserved groups, such as rural residents, individuals with co-occurring disorders, and families of justice-involved individuals.
3. **Follow-Up Invitations:** Extended multiple invitations to encourage participation in focus groups and planning workshops.

Outcomes

Despite challenges in participation for focus groups and workshops, these methods resulted in valuable stakeholder feedback that informed service development and identified unmet needs for future planning.

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

Response:

Key Issues and Concerns Identified by Stakeholders

The following key issues and unmet service needs were identified through stakeholder input over the past year. These reflect concerns raised by multiple stakeholders or those with broad community support:

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1. Gaps in Transitional and Intermediate Levels of Care

- Stakeholders identified a lack of an intermediate service array, such as Intensive Outpatient Programs (IOP) or Partial Hospitalization Programs (PHP), to adequately support individuals between crisis stabilization and outpatient care.
- They also noted delays in service transitions for individuals discharged from inpatient or crisis services, highlighting the need for improved continuity of care.

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2. Transportation Barriers

- Rural residents face significant challenges accessing behavioral health services due to a lack of affordable and reliable transportation.
- Stakeholders in both Anderson and Cherokee counties reported that transportation issues are a major barrier to care.

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3. Housing Shortages for Behavioral Health Clients

- Unmet demand for supported housing options for individuals with severe mental illness, especially for justice-involved individuals and those transitioning from inpatient care.
- Housing instability was identified as a key contributor to repeated crises and hospitalizations.

4. Behavioral Health Workforce Challenges

- While ACCESS maintains strong employee retention, there is difficulty filling open positions, particularly in rural areas and specialized roles.
- Stakeholders noted that workforce shortages contribute to service delays and limited capacity for expansion.

5. Insufficient Substance Use Treatment Options

- ACCESS provides services for individuals with co-occurring disorders, but stakeholders emphasized the need for additional treatment options and specialized substance use treatment centers.
- A lack of nearby detox facilities and integrated care centers was highlighted as a significant gap.

6. Need for Enhanced Data Sharing and Coordination

- Stakeholders emphasized the lack of a centralized data-sharing system, leading to inefficiencies in service coordination and gaps in continuity of care.
- Improved communication and collaboration across agencies were identified as priorities.

7. Absence of Crisis Stabilization Beds

- Stakeholders noted that there are no crisis stabilization beds available in the local service area, leading to reliance on emergency departments for acute care needs.
- This gap highlights the need for alternatives to hospital care that can provide timely, community-based stabilization services.

Key Methods and Activities to Obtain Stakeholder Input:

Over the past year, ACCESS employed the following methods and activities to gather stakeholder input and ensure broad participation in the planning process:

1. **Community Listening Sessions**
    - Regularly scheduled sessions were held in Jacksonville and Palestine, allowing stakeholders, including service users, family members, and community leaders, to voice concerns and provide feedback. Sessions were advertised through multiple channels to maximize attendance.
2. **Surveys and Polls**
    - ACCESS distributed annual satisfaction surveys and needs assessment polls to individuals receiving services, family members, and partner organizations. These tools were available in print and digital formats to enhance accessibility.
3. **Stakeholder Advisory Group**
    - ACCESS facilitated quarterly meetings with a diverse advisory group comprising consumers, caregivers, local law enforcement, educators, healthcare providers, and other community representatives. This group reviewed programs and provided targeted recommendations.
4. **Focus Groups for Specialized Populations**

- Focus groups were conducted with youth, veterans, individuals with co-occurring mental health and substance use disorders, and caregivers to explore specific challenges and service gaps.

5. **Direct Feedback Channels**
   - Stakeholders were encouraged to provide feedback via email, phone hotlines, and an online submission form. These channels ensured continuous access to ACCESS leadership for input.
6. **Collaborative Partnerships**
   - ACCESS worked closely with schools, hospitals, and non-profit organizations to collect feedback from underrepresented and hard-to-reach populations, such as rural residents and non-English speakers.
7. **Efforts for Inclusivity**
   - Steps were taken to include marginalized and underrepresented groups, such as offering virtual meeting options, childcare during events, language interpretation services, and transportation assistance to eliminate barriers to participation.

Key Issues and Concerns Identified by Stakeholders:

1. **Unmet Service Needs:**
   - **Access to Crisis Services**: Stakeholders noted limited availability of immediate crisis stabilization services, particularly during evenings and weekends.
   - **Transportation Barriers**: Difficulty accessing services due to a lack of affordable and reliable transportation, especially in rural areas.
   - **Integrated Care**: Stakeholders emphasized the need for more integration between mental health and primary care services.
   - **Veteran-Specific Services**: Concerns were raised about the availability of tailored mental health services for veterans and their families.
2. **Workforce Challenges:**
   - High turnover rates among mental health professionals and the need for culturally competent and trauma-informed staff were identified as significant concerns.
3. **Outreach and Awareness:**
   - Insufficient community awareness about available mental health services and how to access them, particularly for underserved populations.
4. **Support for Co-Occurring Disorders:**
   - A lack of comprehensive services for individuals with co-occurring mental health and substance use disorders was highlighted as a pressing need.
5. **Youth and Adolescent Services:**
   - Stakeholders expressed a strong need for expanded services for youth and adolescents, including school-based mental health programs and early intervention services.
6. **Housing and Social Support:**

- Stakeholders highlighted the need for increased supportive housing options for individuals with severe mental illness and those transitioning from crisis or inpatient care.

7. **Technological Accessibility:**
    - Limited access to telehealth services for stakeholders without internet connectivity or digital devices, particularly in rural areas.

ACCESS is using this feedback to guide service improvements, resource allocation, and strategic planning for the upcoming year.

Section II: Psychiatric Emergency Plan

The Psychiatric Emergency Plan is intended to ensure stakeholders with a direct role in psychiatric emergencies have a shared understanding of the roles, responsibilities, and procedures enabling them to coordinate 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.

The following stakeholder groups are essential participants in developing the Psychiatric Emergency Plan:

- Law enforcement (police/sheriff and jails);
- Hospitals and emergency departments;
- Judiciary, including mental health and probate courts;
- Prosecutors and public defenders;
- Other crisis service providers (to include neighboring LMHAs and LBHAs);
- People accessing crisis services and their family members; and
- Sub-contractors.

Most LMHAs and LBHAs are actively engaged with these stakeholders on an ongoing basis, and the plan will reflect and build upon these continuing conversations.

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 Developing the Plan

Describe the process implemented to collaborate with stakeholders to develop the Psychiatric Emergency Plan, including, but not limited to, the following:

- Ensuring all key stakeholders were involved or represented, to include contractors where applicable;

Response:

Process for Collaborating with Stakeholders to Develop the Psychiatric Emergency Plan:

ACCESS implemented a structured and inclusive process to collaborate with stakeholders in developing the Psychiatric Emergency Plan. This process ensured that all key stakeholders were engaged or represented, including contractors, to create a comprehensive and responsive plan. The steps taken are as follows:

1. **Stakeholder Identification and Outreach:**
    - ACCESS identified key stakeholder groups, including community members, healthcare providers, law enforcement, emergency responders, contractors, and individuals with lived experience of mental health crises.
    - Invitations to participate in the planning process were sent via email, direct outreach, and public announcements to ensure representation from all relevant parties.
2. **Formation of a Planning Workgroup:**
    - A multidisciplinary planning workgroup was formed, comprising representatives from ACCESS leadership, service providers, contractors, and community partners.
    - This group met regularly to discuss goals, review existing protocols, and identify opportunities for improvement.
3. **Inclusive Meetings and Forums:**
    - ACCESS hosted a series of forums and workshops to gather input from stakeholders. These sessions provided an opportunity for attendees to share insights, concerns, and recommendations.
    - Virtual options were offered to ensure participation from those unable to attend in person, especially in rural areas.
4. **Needs Assessment and Gap Analysis:**
    - Feedback from stakeholders was integrated into a comprehensive needs assessment to identify service gaps in crisis response, extended observation, and crisis stabilization.

- Stakeholders contributed data on local challenges, such as transportation barriers, workforce shortages, and service accessibility.

5. **Contractor Involvement:**

    - Contractors providing crisis services, extended observation, or respite care were directly involved in developing protocols and aligning their practices with ACCESS's emergency response framework.

6. **Collaboration with First Responders:**

    - Regular consultation meetings were held with law enforcement and EMS agencies to ensure their needs and perspectives were included.

    - MCOT participated in developing strategies for seamless coordination during psychiatric emergencies.

7. **Integration of Community Feedback:**

    - Input from consumers, family members, and advocacy groups was solicited through surveys and focus groups to ensure the plan was person-centered and culturally competent.

8. **Draft Development and Review:**

    - A draft of the Psychiatric Emergency Plan was created based on the input received. The draft was shared with all stakeholders for review and feedback.

    - Revisions were made collaboratively to address concerns and incorporate suggestions, ensuring broad consensus on the plan's content.

9. **Training and Dissemination:**

    - Once finalized, the plan was shared with all stakeholders, including contractors, through training sessions and informational materials to ensure consistent implementation across all service providers.

10. **Ongoing Stakeholder Engagement:**

- ACCESS established mechanisms for ongoing stakeholder feedback to refine the plan as needed. This included regular check-ins, quarterly reviews, and an open feedback channel.

By actively engaging stakeholders throughout the planning process, ACCESS ensured that the Psychiatric Emergency Plan reflects the needs and priorities of the community while fostering collaboration among all relevant parties.

- Ensuring the entire service area was represented; and

Response:

Ensuring the Entire Service Area Was Represented:

ACCESS took deliberate steps to ensure that stakeholders from the entire service area were adequately represented during the development of the Psychiatric Emergency Plan. The following methods were implemented:

1. **Geographic Inclusivity in Outreach:**
    - ACCESS divided the service area into regions to identify and reach out to stakeholders from all geographic locations, including urban, suburban, and rural areas.
    - Specific efforts were made to engage stakeholders in underserved and remote areas, ensuring their unique challenges and needs were considered.
2. **Localized Stakeholder Meetings:**
    - Meetings and forums were held at accessible locations across the service area, including Jacksonville and Palestine, to encourage local participation.
    - Virtual meeting options were also provided to accommodate stakeholders unable to travel due to distance, transportation barriers, or scheduling conflicts.
3. **Partnerships with Regional Organizations:**

- ACCESS collaborated with local organizations, schools, hospitals, and community groups throughout the service area to collect input and ensure regional representation.

- Partner organizations helped amplify outreach efforts and facilitate communication with stakeholders in their respective communities.

4. **Representation from Key Populations:**

    - Efforts were made to include diverse voices from various populations within the service area, such as veterans, individuals with co-occurring disorders, youth, and families.

    - Feedback channels were tailored to accommodate linguistic and cultural differences, ensuring inclusivity.

5. **Stakeholder Feedback Surveys:**

    - Surveys were distributed throughout the entire service area, both online and in paper format, to gather input from stakeholders unable to attend meetings.

    - Surveys included questions specific to regional challenges and gaps in psychiatric emergency services.

6. **Dedicated Rural Engagement:**

    - ACCESS recognized the unique challenges faced by rural communities in accessing emergency psychiatric services and prioritized targeted engagement with stakeholders from these areas.

    - This included listening sessions focused on transportation barriers, telehealth options, and crisis response times specific to rural regions.

7. **County-Level Representation:**

    - Stakeholders from each county in the service area, including Cherokee and Anderson counties, were invited to participate in the planning process to ensure a comprehensive understanding of county-specific needs.

8. **Data Collection Across the Service Area:**

- ACCESS reviewed service utilization data from all regions within the service area to identify trends, gaps, and high-need areas. This data was presented to stakeholders for validation and further discussion.

By employing these strategies, ACCESS ensured that stakeholders from the entire service area were represented and that their input shaped a Psychiatric Emergency Plan that addresses the needs of all communities served.

- Soliciting input.

Response:

Soliciting Input:

ACCESS implemented several strategies to actively solicit input from stakeholders throughout the development of the Psychiatric Emergency Plan. These strategies ensured that all voices were heard and that the plan reflected the diverse needs and priorities of the community. Key activities included:

1. **Direct Invitations:**
    - Invitations to participate in the planning process were sent to identified stakeholders via email, phone calls, and mailed letters. This included community partners, service users, family members, contractors, and representatives from law enforcement and healthcare.
2. **Surveys and Questionnaires:**
    - ACCESS distributed targeted surveys and questionnaires to gather input on specific areas of the Psychiatric Emergency Plan, such as crisis response protocols, service accessibility, and coordination efforts.
    - Surveys were made available online and in paper form, with translation services offered to ensure accessibility for non-English speakers.
3. **Public Forums and Town Halls:**

- Open forums and town hall meetings were conducted in central locations throughout the service area, allowing stakeholders to share their concerns, suggestions, and experiences directly.

- Virtual town halls were also hosted to accommodate those unable to attend in person.

4. **Focus Groups:**

    - ACCESS organized focus groups with key populations, such as youth, veterans, individuals with co-occurring disorders, and caregivers, to explore their unique perspectives and gather qualitative insights.

5. **One-on-One Consultations:**

    - Individual meetings and phone consultations were offered for stakeholders who preferred to provide input in a more private or personalized setting.

    - Contractors and key service providers were engaged in direct discussions to gather detailed feedback on operational and service-related aspects of the plan.

6. **Feedback Through Advisory Committees:**

    - ACCESS leveraged its existing stakeholder advisory committees, which include representatives from community organizations, consumers, and family members, as a primary channel for soliciting structured and actionable feedback.

7. **Suggestion Boxes and Online Submissions:**

    - Physical suggestion boxes were placed at ACCESS's outpatient clinic locations in Jacksonville and Palestine, allowing clients and visitors to submit anonymous input.

    - An online submission form was also available on ACCESS's website for stakeholders to provide suggestions or concerns at their convenience.

8. **Feedback During Service Interactions:**

- Frontline staff, including clinicians and crisis responders, collected real-time feedback from individuals and families who engaged with ACCESS's services. This feedback was documented and integrated into the planning process.

9. **Partner and Contractor Engagement:**

   - Contractors, partner organizations, and other service providers were invited to collaborative planning sessions where they could share their insights on gaps, challenges, and potential improvements.

10. **Regular Updates and Requests for Input:**

    - Stakeholders were regularly updated on the progress of the plan's development through newsletters and email communications, which included requests for additional input and suggestions.

By using these comprehensive strategies, ACCESS ensured that stakeholder input was not only solicited but actively integrated into the development of the Psychiatric Emergency Plan, resulting in a collaborative and well-informed final product.

II.B Using the Crisis Hotline, Role of Mobile Crisis Outreach Teams (MCOT), and the Crisis Response Process

1. How is the Crisis Hotline staffed?
   a. During business hours

   Response:

Crisis Hotline Staffing During Business Hours

The ACCESS Crisis Hotline is managed through a partnership with **AVAIL Solutions**, a contracted provider specializing in crisis hotline services. AVAIL ensures immediate support and high-quality crisis intervention during business hours with the following structure:

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1. Staffing Composition:

- The Crisis Hotline is staffed by **licensed mental health professionals (LMHPs)**, **qualified mental health professionals (QMHPs)**, and **trained crisis support specialists** employed by AVAIL.
- Supervisory staff, including licensed clinicians, are available to oversee operations and assist with complex or high-risk calls.
- AVAIL is **certified by the American Association of Suicidology (AAS)**, demonstrating adherence to nationally recognized standards for crisis services.

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2. Coverage:

- The hotline operates with continuous coverage during business hours, typically **8:00 AM to 5:00 PM, Monday through Friday**.
- Additional staff are scheduled during anticipated high-demand periods or in response to community events or crises.

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3. Training and Competency:

- AVAIL staff receive **initial and ongoing training** in crisis intervention, suicide prevention, trauma-informed care, and de-escalation techniques.
- As an AAS-certified provider, AVAIL adheres to **evidence-based protocols** and meets rigorous certification standards.

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4. Technology Support:

- The hotline is supported by a **secure telecommunication system**, ensuring real-time call tracking, routing, and logging.
- The system is designed to minimize wait times and allows for seamless coordination with ACCESS's **Mobile Crisis Outreach Teams (MCOT)** for in-person interventions.

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5. Coordination with MCOT:

- During business hours, AVAIL staff work closely with ACCESS's MCOT, gathering detailed information to facilitate efficient dispatch of in-person crisis intervention services.
- AVAIL ensures effective communication with ACCESS to support timely and coordinated crisis responses.

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6. Documentation and Follow-Up:

- All calls are documented in real-time to maintain accurate records of the caller's needs, interventions, and any referrals or follow-up actions.
- AVAIL initiates follow-up protocols for individuals identified as being at ongoing risk, ensuring continuity of care and safety.

b. After business hours

Response:

Crisis Hotline Staffing After Business Hours

The ACCESS Crisis Hotline remains fully operational 24/7, ensuring continuous support for individuals in crisis. After business hours, the hotline is managed in partnership with **AVAIL Solutions**, which provides specialized crisis hotline services. The structure is as follows:

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1. Staffing Composition:

- The hotline is staffed by trained **crisis support specialists** and **on-call licensed mental health professionals (LMHPs)** or **qualified mental health professionals (QMHPs)**.
- Supervisory staff or an on-call clinician is available to provide consultation and oversight for complex or high-risk calls.
- As an **AAS-certified provider**, AVAIL adheres to nationally recognized standards for after-hours crisis services.

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2. Coverage:

- Dedicated after-hours shifts ensure that staff are immediately available to respond to calls throughout the night, weekends, and holidays.
- **Call routing systems** minimize delays by directing incoming calls to the first available staff member.

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3. Training and Competency:

- After-hours staff receive comprehensive training in **crisis intervention**, **suicide prevention**, and **trauma-informed care**, consistent with daytime staff training.
- They are equipped to handle diverse crisis situations, including psychiatric emergencies, substance use crises, and referrals to immediate care resources.

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4. Coordination with Mobile Crisis Outreach Teams (MCOT):

- Hotline staff maintain direct communication with ACCESS's **on-call MCOT personnel** to coordinate in-person interventions when needed.
- Detailed information is gathered by hotline staff to ensure **rapid and effective dispatch** by MCOT.

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5. Technology Support:

- A **secure telecommunications platform** supports after-hours operations, enabling staff to manage multiple calls, document real-time data, and access resources efficiently.
- The system integrates seamlessly with ACCESS's broader crisis response framework to ensure continuity of care.

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6. Documentation and Follow-Up:

- All calls received after hours are documented in detail, including the nature of the crisis, interventions provided, and referrals made.
- Critical information is relayed to **day-shift staff** to ensure continuity of care and timely follow-up for individuals requiring additional support.

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7. Community Collaboration:

- After-hours hotline staff collaborate closely with **local law enforcement, hospitals, and emergency services** to respond to high-risk situations effectively.
- Strong relationships with community partners ensure smooth coordination during emergencies.

c. Weekends and holidays

Crisis Hotline Staffing on Weekends and Holidays

The ACCESS Crisis Hotline operates 24/7, ensuring uninterrupted support for individuals in crisis, including weekends and holidays. The staffing model for these times is structured as follows:

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1. Staffing Composition:

- The hotline is staffed by **trained crisis support specialists** and **qualified mental health professionals (QMHPs)**, with **on-call licensed mental health professionals (LMHPs)** available for clinical oversight and guidance.
- Supervisory staff remain on-call to address escalated or complex cases.

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2. Shift Coverage:

- Shifts are scheduled to ensure **full coverage throughout weekends and holidays**, including peak times when call volumes may increase.
- Staffing adjustments are made as needed based on anticipated demand, particularly during holidays that may trigger heightened crisis activity.

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3. Training and Competency:

- Weekend and holiday staff receive the same rigorous training as weekday staff, ensuring proficiency in **crisis intervention**, **suicide prevention**, and **trauma-informed care**.
- Additional emphasis is placed on addressing holiday-specific stressors, such as **loneliness, grief, or family conflict**, which are common during these times.

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4. Coordination with Mobile Crisis Outreach Teams (MCOT):

- Hotline staff work closely with **on-call MCOT personnel** to assess and dispatch in-person crisis responses as needed during weekends and holidays.
- Detailed information is gathered during calls to facilitate **effective and timely responses** by MCOT teams.

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5. Technology and Infrastructure:

- The hotline is supported by a **secure telecommunications system** that ensures seamless call handling, documentation, and coordination with other crisis services.
- Technology enables minimal wait times and provides access to referral databases for **immediate connection to resources**.

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6. Documentation and Reporting:

- All calls received during weekends and holidays are thoroughly documented, capturing the nature of the crisis, interventions provided, and referrals made.
- **Critical cases** are flagged for follow-up by weekday staff to ensure continuity of care and support.

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7. Community and Emergency Service Collaboration:

- Hotline staff collaborate with **law enforcement, emergency medical services, and local hospitals** to address high-risk situations effectively during weekends and holidays.
- Partnerships with community organizations provide additional support and resources for callers in urgent need.

2. Does the LMHA or LBHA have a sub-contractor to provide the Crisis Hotline services? If, yes, list the contractor.

   Response:

Yes, ACCESS utilizes AVAIL Solutions as the sub-contractor to provide Crisis Hotline services. This partnership ensures high-quality, 24/7 crisis response support for individuals in need.

3. How is the MCOT staffed?
    a. During business hours

    Response:

Mobile Crisis Outreach Team (MCOT) Staffing During Business Hours:
During business hours, the ACCESS Mobile Crisis Outreach Team (MCOT) is staffed by a multidisciplinary team of mental health professionals trained to respond to psychiatric emergencies. The staffing structure includes:

1. **Team Composition:**
    - **Qualified Mental Health Professionals (QMHPs):** Primary responders trained in crisis intervention and mental health assessments.
    - **Licensed Mental Health Professionals (LMHPs):** Clinicians available for consultation, supervision, and direct intervention as needed.
    - **Peer Support Specialists:** Individuals with lived experience who provide additional support and engagement during crisis responses.
2. **Coverage:**
    - MCOT operates with multiple shifts to ensure coverage throughout standard business hours, typically 8:00 AM to 5:00 PM, Monday through Friday.
    - Additional staffing is allocated during periods of high demand or anticipated community needs.
3. **Training and Competency:**
    - All team members are trained in trauma-informed care, suicide prevention, de-escalation techniques, and co-occurring disorder interventions.
    - MCOT staff are also skilled in culturally competent practices to meet the diverse needs of the community.
4. **Coordination with the Crisis Hotline:**
    - During business hours, MCOT works closely with AVAIL Solutions (Crisis Hotline contractor) to receive referrals and information for in-person crisis responses.
    - Hotline staff provide detailed assessments to MCOT for effective deployment.
5. **Crisis Response:**
    - MCOT conducts on-site crisis interventions, including mental health evaluations, safety planning, and referrals to additional services.
    - The team can respond to a variety of locations, such as homes, schools, workplaces, or community settings.

6. **Documentation and Follow-Up:**
    - Team members document all interventions and outcomes in real time, ensuring continuity of care.
    - Individuals served by MCOT are connected to follow-up services, including outpatient care, hospitalization, or other community resources.

This staffing structure allows MCOT to provide timely, professional, and effective crisis intervention services during business hours.

b. After business hours

Response:

After business hours, **MCOT services are provided by AVAIL Solutions**, which operates in consultation with the **ACCESS Crisis Supervisor** or the **on-call Licensed Practitioner of the Healing Arts (LPHA)**. This structure ensures that individuals in crisis receive prompt and professional care during evenings, weekends, and holidays, with direct oversight and support from clinical leadership.

c. Weekends and holidays

Response:

On weekends and holidays, the **normal day shift is covered by ACCESS MCOT staff**, ensuring direct care and crisis response. The **night shift is covered by AVAIL Solutions**, with **oversight from the ACCESS Crisis Supervisor** and the **on-call Licensed Practitioner of the Healing Arts (LPHA)**. This staffing model ensures continuous and seamless support for individuals in crisis throughout weekends and holidays.

4. Does the LMHA or LBHA have a sub-contractor to provide MCOT services? If yes, list the contractor.

   Response: No

5. Provide information on the type of follow up MCOT provides (phone calls, face-to-face visits, case management, skills training, etc.).

   Response:

MCOT provides comprehensive follow-up services tailored to meet the needs of individuals experiencing a crisis. The follow-up services include:

1. **Phone Calls:**

- MCOT staff conduct follow-up phone calls to check on the individual's well-being, assess ongoing needs, and provide support or referrals as needed.

2. **Face-to-Face Visits:**
   - In-person visits are conducted to ensure individuals are stabilized, address immediate needs, and build rapport for continued care.
3. **Case Management Services:**
   - MCOT offers case management to coordinate care, connect individuals to long-term services, and ensure access to resources such as housing, healthcare, and financial assistance.
4. **Skills Training:**
   - Skills training is provided to help individuals develop coping mechanisms, problem-solving abilities, and other tools to manage their mental health and prevent future crises.
5. **Crisis Planning:**
   - MCOT staff assist individuals in creating crisis plans that outline steps to take and resources to access if another crisis occurs.
6. **Referrals to Long-Term Services:**
   - MCOT coordinates referrals to outpatient mental health services, substance use treatment, peer support programs, and other community-based resources to ensure continuity of care.

6. Do emergency room staff and law enforcement routinely contact the LMHA or LBHA when a person in crisis is identified? If so, please describe MCOT's role for:

   a. Emergency Rooms:

   Emergency room staff routinely contact the LMHA or LBHA when a person in crisis is identified. MCOT's role includes:

- **Crisis Assessment:** MCOT responds to emergency room referrals to conduct comprehensive mental health assessments and determine the appropriate level of care.
- **De-escalation:** Providing on-site de-escalation services for individuals experiencing acute mental health crises.
- **Discharge Planning:** Collaborating with emergency room staff to develop a discharge plan, which includes follow-up services, referrals, and crisis safety planning.
- **Coordination of Care:** Connecting individuals to outpatient services or other community-based resources, as there are no crisis facilities available in the area.

- **Support for Medical Teams:** Offering consultation and guidance to emergency room staff on managing behavioral health crises effectively.

b. Law Enforcement:
Law enforcement routinely contacts the LMHA or LBHA when encountering a person in crisis. MCOT's role includes:

- **Crisis Intervention:** Responding to law enforcement requests for assistance with individuals in mental health crises to provide immediate support and de-escalation.
- **Field Assessments:** Conducting on-site mental health assessments to determine the most appropriate course of action.
- **Alternatives to Incarceration:** Collaborating with law enforcement to divert individuals from the criminal justice system and connect them to outpatient behavioral health services, as there are no crisis facilities available.
- **Transport Coordination:** Assisting law enforcement in arranging safe transport to emergency rooms or other available care settings.
- **Training and Support:** Providing training and consultation to law enforcement officers on managing mental health crises and utilizing MCOT services effectively.

7. What is the process for MCOT to respond to screening requests at state hospitals, specifically for walk-ins?

Response:

Process for MCOT to Respond to Screening Requests at State Hospitals for Walk-Ins:

1. **Initial Notification:**
    - When a walk-in presents at a state hospital and requests a screening, the hospital staff contacts the LMHA or LBHA to notify MCOT of the need for an assessment.
2. **MCOT Dispatch:**
    - MCOT staff are dispatched promptly to the state hospital to respond to the screening request.
3. **Screening and Assessment:**
    - MCOT conducts a comprehensive screening to assess the individual's mental health status, risk level, and immediate needs.
    - This includes gathering relevant history, identifying presenting issues, and determining the appropriate level of care.
4. **Crisis Intervention:**

- If the individual is in acute crisis, MCOT provides de-escalation and stabilization services during the screening.

5. **Coordination of Care:**
   - Based on the screening outcome, MCOT coordinates appropriate next steps, which may include:
     - Referral to outpatient services.
     - Engagement in community-based resources.
     - Coordination with the hospital for any required medical or psychiatric evaluations.
6. **Documentation and Follow-Up:**
   - MCOT documents the screening process, including the individual's needs, interventions provided, and any referrals made.
   - Follow-up is arranged to ensure continuity of care and support for the individual after the initial screening.

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

a. During Business Hours:

1. **Contact MCOT:**
   - Emergency rooms and law enforcement should contact MCOT directly for an assessment when an inpatient level of care is needed.
   - MCOT staff will respond promptly to evaluate the individual and determine the appropriate course of action.
2. **Inpatient Referral Coordination:**
   - If an inpatient level of care is determined necessary, MCOT coordinates the referral to an appropriate inpatient facility.
   - MCOT works with the emergency room or law enforcement to ensure safe transport and admission.
3. **Consultation and Support:**
   - MCOT provides consultation to emergency room staff and law enforcement to address any immediate concerns and stabilize the situation until inpatient admission is secured.

b. After Business Hours:

1. **Contact the Crisis Hotline:**
   - Emergency rooms and law enforcement should contact the 24/7 Crisis Hotline, managed by AVAIL Solutions, to request MCOT assistance for after-hours assessments.
2. **MCOT Assessment and Coordination:**

- On-call MCOT staff, in consultation with the on-call LPHA or Crisis Supervisor, will evaluate the individual and determine the need for inpatient care.
- If inpatient care is necessary, MCOT arranges for placement and transport in coordination with the referring party.

3. **Ongoing Communication:**
   - The Crisis Hotline remains in communication with emergency rooms or law enforcement to provide updates on the process and ensure timely support.

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c. Weekends and Holidays:

1. **Daytime Hours:**
   - Emergency rooms and law enforcement can contact MCOT staff during normal daytime hours for assessments and inpatient referrals.
   - MCOT evaluates the individual, coordinates placement, and arranges transport as needed.
2. **Nighttime Hours:**
   - After regular hours, the process follows the **after-business hours protocol**, with AVAIL Solutions managing the initial contact and coordinating with MCOT.
3. **Collaboration:**
   - Throughout weekends and holidays, MCOT collaborates with emergency rooms and law enforcement to ensure seamless assessments, stabilization, and referrals.

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

   Response:

Procedure for a Person Who Cannot Be Stabilized On-Site and Requires Further Assessment or Crisis Stabilization in a Facility Setting:

1. **Immediate Assessment:**
   - MCOT conducts an initial assessment to determine the individual's mental health status and the need for a higher level of care.
   - If stabilization is not achievable on-site, MCOT evaluates the urgency and coordinates the next steps for facility-based care.
2. **Contacting Referral Resources:**
   - MCOT contacts the appropriate inpatient psychiatric facility, emergency department, or medical provider to arrange for further assessment or crisis stabilization.

- If no inpatient psychiatric beds are available, the individual may be referred to the nearest emergency room for evaluation and interim care.

3. **Transport Coordination:**
   - MCOT collaborates with law enforcement, emergency medical services (EMS), or family members to arrange safe transport to the identified facility.
   - MCOT ensures all necessary documentation and details are provided to the receiving facility to facilitate a smooth transition.
4. **Crisis Documentation:**
   - MCOT documents the crisis intervention, including:
     - The nature of the crisis.
     - Efforts made to stabilize the individual on-site.
     - Details of the referral, transport, and receiving facility.
5. **Communication with Receiving Facility:**
   - MCOT provides the receiving facility with critical information, including:
     - Assessment findings.
     - Risk factors and safety concerns.
     - Recommendations for immediate care.
6. **Follow-Up Services:**
   - Once the individual is admitted to a facility, MCOT coordinates follow-up care to ensure continuity of support upon discharge.
   - This includes arranging outpatient services, case management, or referrals to community resources as needed.

10. Describe the community's process if a person requires further evaluation, medical clearance, or both.

    Response:

Community Process for Individuals Requiring Further Evaluation, Medical Clearance, or Both:

1. **Initial Assessment by MCOT or First Responders:**
   - MCOT, law enforcement, or EMS conducts an initial assessment to determine whether the individual requires further evaluation or medical clearance prior to receiving behavioral health services.
   - If medical clearance is needed, the individual is referred to the nearest emergency department for evaluation.
2. **Referral to Emergency Department for Medical Clearance:**
   - The individual is transported to the closest emergency department (ED) by EMS, law enforcement, or a family member.

- In the ED, medical professionals perform a thorough evaluation to rule out any medical conditions that may be contributing to the crisis (e.g., infections, intoxication, or physical injuries).

3. **Coordination with Behavioral Health Providers:**
   - Once medically cleared, the ED staff notify MCOT or the designated behavioral health provider for follow-up evaluation and care coordination.
   - MCOT is often present to assess the individual for behavioral health needs and determine the appropriate level of care.
4. **Behavioral Health Evaluation:**
   - If further behavioral health evaluation is needed, MCOT or a licensed behavioral health professional conducts an assessment to identify the best course of action, such as outpatient services or inpatient psychiatric care.
5. **Transport to Appropriate Facility:**
   - If inpatient care is required, MCOT coordinates with the ED, the identified facility, and transport services (e.g., law enforcement or EMS) to ensure the individual is safely transported.
   - If outpatient care is appropriate, MCOT facilitates referrals and provides follow-up instructions.
6. **Documentation and Follow-Up:**
   - All assessments, referrals, and clearance processes are documented to ensure continuity of care.
   - MCOT schedules follow-up appointments or provides referrals to community resources for additional support.

11. Describe the process if a person needs admission to a psychiatric hospital.

Response:

Process for Admission to a Psychiatric Hospital:

1. **Initial Assessment:**
   - MCOT or the referring party (e.g., emergency room staff, law enforcement) conducts an initial crisis assessment to determine if the individual requires psychiatric hospitalization.
   - The assessment focuses on the individual's risk level, psychiatric symptoms, and need for immediate stabilization.
2. **Identification of Psychiatric Hospital:**
   - MCOT or the referring entity identifies an appropriate psychiatric hospital for admission based on the individual's needs, availability of beds, and location.

- If no psychiatric beds are available locally, efforts are made to locate a bed in the broader region.

3. **Medical Clearance:**
   - If required, the individual is transported to an emergency department for medical clearance prior to admission.
   - Emergency department staff perform the necessary evaluations (e.g., laboratory tests, physical exams) to ensure the individual is medically stable for psychiatric hospitalization.
4. **Coordination with the Receiving Facility:**
   - Once a psychiatric hospital is identified and medical clearance is completed (if required), MCOT or the referring party contacts the hospital to initiate the admission process.
   - The hospital is provided with all necessary documentation, including:
     - The individual's assessment.
     - Risk factors.
     - Relevant medical information.
5. **Transport to the Psychiatric Hospital:**
   - MCOT coordinates safe transport to the psychiatric hospital.
   - Law enforcement, EMS, or family members may provide transport, depending on the situation and safety considerations.
6. **Admission Process:**
   - Upon arrival at the psychiatric hospital, the individual undergoes an intake evaluation conducted by the hospital staff to confirm admission and develop an initial treatment plan.
7. **Documentation and Handoff:**
   - MCOT ensures that all details of the referral, transport, and handoff to the psychiatric hospital are thoroughly documented.
   - Any critical follow-up information is shared with the hospital to ensure continuity of care.
8. **Follow-Up Coordination:**
   - After admission, MCOT or the referring agency remains involved to coordinate discharge planning, outpatient follow-up, or ongoing support services as needed.

12. Describe the process if a person needs facility-based crisis stabilization (i.e., other than psychiatric hospitalization and may include crisis respite, crisis residential, extended observation, or crisis stabilization unit).

    Response:

Process for Facility-Based Crisis Stabilization:

Currently, there are **no facility-based crisis stabilization resources** (e.g., crisis respite, crisis residential, extended observation, or crisis stabilization units) available in the ACCESS service area. When such a level of care is deemed necessary, the following steps are taken:

1. Initial Assessment:

- **MCOT Assessment:** MCOT conducts a thorough crisis assessment to determine the need for a higher level of care.
- The assessment evaluates the individual's mental health symptoms, risk factors, and immediate stabilization needs.

2. Referral to Emergency Department:

- Due to the lack of local crisis stabilization facilities, individuals are referred to the nearest emergency department for evaluation and interim stabilization.
- MCOT coordinates with emergency department staff to ensure the individual's mental health needs are communicated effectively.

3. Transport Coordination:

- If transport is required, MCOT works with law enforcement, EMS, or family members to ensure the individual is safely transported to the emergency department.

4. Collaboration with Regional Resources (If Applicable):

- If crisis stabilization options are available in nearby regions, MCOT works to locate an appropriate facility and coordinates referrals.
- Transportation to such facilities may depend on available resources, safety considerations, and family support.

5. Alternative Support Options:

- In situations where no facility-based care is accessible, MCOT explores alternative support strategies, including:
    - Enhanced outpatient care through frequent check-ins and skills training.
    - Crisis planning to manage symptoms in the home environment.
    - Connection to peer support services or local community resources.

6. Documentation and Follow-Up:

- MCOT documents the referral process, the individual's needs, and the interventions provided.
- Follow-up is arranged to ensure the individual receives continued care through outpatient services or other community-based programs.

13. Describe the process for crisis assessments requiring MCOT to go into a home or alternate location such as a parking lot, office building, school, under a bridge or other community-based location.

    Response:

Process for Crisis Assessments in Community-Based Locations:
When MCOT is required to conduct a crisis assessment in a home or alternate location, such as a parking lot, office building, school, or under a bridge, the following process is followed to ensure safety and effective intervention:

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1. Initial Screening and Dispatch:

- **Request Intake:** MCOT receives a request for a crisis assessment through the crisis hotline, law enforcement, or other referral sources.
- **Risk Assessment:** A preliminary assessment is conducted over the phone to evaluate the situation's urgency, potential safety risks, and the need for on-site intervention.

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2. Preparation and Safety Planning:

- **Team Deployment:** MCOT staff are dispatched in pairs whenever possible to enhance safety.
- **Coordination with Law Enforcement (If Needed):** If the situation is deemed potentially unsafe, law enforcement is contacted to provide standby assistance.
- **Location Information:** The team gathers as much information as possible about the location and individual prior to arriving on-site, including history, behavior patterns, and any potential threats.

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3. On-Site Crisis Assessment:

- **Engagement:** Upon arrival, MCOT engages with the individual to establish rapport and reduce tension.
- **Comprehensive Assessment:** The team conducts a thorough crisis assessment, evaluating mental health status, risk factors, and immediate needs.
- **De-Escalation:** If the individual is in acute distress, MCOT utilizes de-escalation techniques to stabilize the situation.

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4. Intervention and Support:

- **Crisis Resolution:** MCOT provides immediate interventions, such as emotional support, skills training, or linkage to resources, to stabilize the individual.
- **Referrals:** If further care is required, MCOT coordinates referrals to outpatient services, inpatient care, or other appropriate programs.

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5. Documentation and Follow-Up:

- **Real-Time Documentation:** All actions and observations during the crisis assessment are documented in detail to ensure accuracy and compliance with protocols.
- **Follow-Up Plan:** A follow-up plan is developed, including additional MCOT visits, phone check-ins, or referrals to ensure ongoing support.

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6. Safety Protocols:

- **Team Safety:** MCOT staff prioritize their own safety by assessing environmental risks and using situational awareness at all times.
- **Withdrawal if Unsafe:** If the situation escalates to an unsafe level, MCOT withdraws and contacts law enforcement or other emergency services for assistance.

14. If an inpatient bed at a psychiatric hospital is not available, where does the person wait for a bed?

    Response:

If an inpatient bed at a psychiatric hospital is not immediately available, this is a rarity due to ACCESS's procedure to secure a **single case agreement** in such situations. When these issues do occur, the following process is followed:

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1. Emergency Department Placement:

- The individual typically remains in the **emergency department (ED)** while awaiting placement.
- ACCESS works closely with the ED to ensure the individual receives necessary monitoring and support during this time.

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2. Timely Bed Placement:

- ACCESS strives to ensure that individuals do not remain in the ED for longer than **24 hours post-medical clearance**.
- If a psychiatric bed is not available, ACCESS secures a **single case agreement** to facilitate placement in an alternative inpatient facility.

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3. MCOT and ED Collaboration:

- **Ongoing Communication:** MCOT maintains communication with the ED staff to monitor the individual's status and provide updates on placement efforts.
- **Crisis Monitoring:** MCOT continues to provide crisis support, as needed, during the waiting period.

4. Documentation and Advocacy:

- MCOT documents all efforts to secure inpatient placement and advocates for expedited admission to ensure minimal wait time in the ED.

15. Who is responsible for providing ongoing crisis intervention services until the crisis is resolved or the person is placed in a clinically appropriate environment at the LMHA or LBHA?

Response:

MCOT is responsible for providing ongoing crisis intervention services until the crisis is resolved or the individual is placed in a clinically appropriate environment. This includes:

1. **Crisis Stabilization:**
    - MCOT engages with the individual to provide de-escalation, emotional support, and short-term stabilization.
2. **Continuous Monitoring:**
    - MCOT conducts regular follow-ups via phone or in-person visits to assess the individual's status and ensure their safety.
3. **Care Coordination:**
    - MCOT coordinates with emergency departments, law enforcement, and other community resources to facilitate placement in the most appropriate environment.
4. **Supportive Interventions:**
    - Skills training, referrals to additional resources, and crisis planning are provided as needed to ensure continuity of care.

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

Response:

In cases not involving emergency detention for adults, **the individual or their support system (e.g., family members, caregivers, or community resources)** is typically responsible for transportation.
If transportation assistance is needed:

1. **MCOT Coordination:**

- MCOT can help coordinate transportation by connecting the individual to available community resources, such as public transit, non-emergency medical transport, or local service providers.

2. **Family or Caregiver Support:**
   - Family members or caregivers may provide transportation if they are available and willing to assist.
3. **Alternative Options:**
   - In some cases, ACCESS may facilitate transportation through contracted services or other arrangements, depending on the situation and available resources.

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

Response:

In cases not involving emergency detention for children, **the child's parent, legal guardian, or caregiver** is typically responsible for transportation.
If additional transportation support is needed:

1. **Parental or Guardian Responsibility:**
   - The child's parent or legal guardian is expected to provide transportation to necessary appointments or facilities.
2. **MCOT Assistance:**
   - MCOT may assist in coordinating transportation by working with the family or connecting them to community resources, such as non-emergency medical transport or local support services.
3. **Alternative Options:**
   - If parents or guardians are unable to provide transportation and no other options are available, ACCESS may explore additional solutions based on available resources and the child's needs.

Crisis Stabilization

Use the table below to identify the alternatives the local service area has for facility-based crisis stabilization services (excluding inpatient services). Answer each element of the table below. Indicate "N/A" if the LMHA or LBHA does not have any facility-based crisis stabilization services. Replicate the table below for each alternative.

Table 5: Facility-based Crisis Stabilization Services

Name of facility	N/A
Location (city and county)	N/A

Name of facility	N/A
Phone number	N/A
Type of facility (see Appendix A)	N/A
Key admission criteria	N/A
Circumstances under which medical clearance is required before admission	N/A
Service area limitations, if any	N/A
Other relevant admission information for first responders	N/A
Does the facility accept emergency detentions?	N/A
Number of beds	N/A
HHSC funding allocation	N/A

Inpatient Care

Use the table below to identify the alternatives to the state hospital the local service area has for psychiatric inpatient care for uninsured or underinsured people. Answer each element of the table below. Indicate "N/A" if an element does not apply to the alternative provided. Replicate the table below for each alternative.

Table 6: Psychiatric Inpatient Care for Uninsured or Underinsured

Element	Response
Name of facility	Cedar Crest Hospital & Residential Treatment Center
Location (city and county)	Belton, Bell County
Phone number	(254) 939-2100

Element	Response
Key admission criteria	- Individuals experiencing a psychiatric emergency requiring inpatient stabilization. - May be uninsured or underinsured. - Meet medical necessity criteria for inpatient care.
Service area limitations if any	No specific service area limitations; open to all referrals from ACCESS's designated area.
Other relevant admission information for first responders	First responders should call ahead to provide crisis incident details, mental health risk factors, and recent behaviors.
Number of beds	134 beds available
Is the facility currently under contract with the LMHA or LBHA to purchase beds?	Yes
If under contract, is the facility contracted for contracted psychiatric beds (funded under the Community-Based Crisis Programs contract or Mental Health Grant for Justice-Involved Individuals), private psychiatric beds, or community mental health hospital beds (include all that apply)?	Contracted psychiatric beds funded under Community-Based Crisis Programs.
If under contract, are beds purchased as a guaranteed set or on an as-needed basis?	As needed
If under contract, what is the bed day rate paid to the contracted facility?	$650 per bed per day
If not under contract, does the LMHA or LBHA use facility for single-case agreements for as needed beds?	N/A

Element	Response
Element	**Response**
Name of facility	Palestine Regional Medical Center
Location (city and county)	Palestine, Anderson County
Phone number	(903) 731-1000
Key admission criteria	- Individuals experiencing a psychiatric emergency requiring inpatient stabilization. - May be uninsured or underinsured. - Meet medical necessity criteria for inpatient care.
Service area limitations if any	Primarily serves residents of Anderson County and surrounding areas.
Other relevant admission information for first responders	First responders should provide incident details, including mental health risk factors and recent behaviors. Hospital must be contacted prior to arrival for bed availability.
Number of beds	6 beds available for psychiatric care
Is the facility currently under contract with the LMHA or LBHA to purchase beds?	Yes
If under contract, is the facility contracted for contracted psychiatric beds (funded under the Community-Based Crisis Programs contract or Mental Health Grant for Justice-Involved Individuals), private psychiatric beds, or community mental health hospital beds (include all that apply)?	Contracted psychiatric beds funded under Community-Based Crisis Programs.
If under contract, are beds purchased as a guaranteed set or on an as-needed basis?	As needed
If under contract, what is the bed day rate paid to the contracted facility?	$500 per bed per day
If not under contract, does the LMHA or LBHA use facility for single-case agreements for as needed beds?	N/A

Element	Response
If not under contract, what is the bed day rate paid to the facility for single-case agreements?	N/A

Element	Response
Name of facility	UT Health North Campus Hospital
Location (city and county)	Tyler, Smith County
Phone number	(903) 877-7000
Key admission criteria	- Individuals experiencing a psychiatric emergency requiring inpatient stabilization. - May be uninsured or underinsured. - Meet medical necessity criteria for psychiatric hospitalization.
Service area limitations if any	Primarily serves residents within Smith County and surrounding areas.
Other relevant admission information for first responders	First responders should contact the hospital in advance to confirm bed availability and provide relevant crisis details.
Number of beds	Unknown number of beds designated for psychiatric care
Is the facility currently under contract with the LMHA or LBHA to purchase beds?	Yes

Element	Response
If under contract, is the facility contracted for contracted psychiatric beds (funded under the Community-Based Crisis Programs contract or Mental Health Grant for Justice-Involved Individuals), private psychiatric beds, or community mental health hospital beds (include all that apply)?	Contracted psychiatric beds funded under Community-Based Crisis Programs.
If under contract, are beds purchased as a guaranteed set or on an as-needed basis?	As needed
If under contract, what is the bed day rate paid to the contracted facility?	$625 per bed per day
If not under contract, does the LMHA or LBHA use facility for single-case agreements for as needed beds?	N/A
If not under contract, what is the bed day rate paid to the facility for single-case agreements?	N/A
Element	**Response**
Name of facility	Clear Lake Hospital
Location (city and county)	Webster, Harris County
Phone number	(281) 853-5000
Key admission criteria	- Individuals experiencing a psychiatric emergency requiring inpatient stabilization. - May be uninsured or underinsured. - Meet medical necessity criteria for inpatient psychiatric care.
Service area limitations if any	Open to referrals from the broader region; no strict service area limitations.

Element	Response
Other relevant admission information for first responders	First responders should provide crisis details and verify bed availability by calling in advance. Clear Lake Hospital requires transfer documentation for high-risk cases.
Number of beds	92 beds designated for psychiatric care
Is the facility currently under contract with the LMHA or LBHA to purchase beds?	Yes
If under contract, is the facility contracted for contracted psychiatric beds (funded under the Community-Based Crisis Programs contract or Mental Health Grant for Justice-Involved Individuals), private psychiatric beds, or community mental health hospital beds (include all that apply)?	Contracted psychiatric beds funded under Community-Based Crisis Programs.
If under contract, are beds purchased as a guaranteed set or on an as-needed basis?	As needed
If under contract, what is the bed day rate paid to the contracted facility?	$725 per bed per day
If not under contract, does the LMHA or LBHA use facility for single-case agreements for as needed beds?	N/A
If not under contract, what is the bed day rate paid to the facility for single-case agreements?	N/A

II.C Plan for Local, Short-term Management for People Deemed Incompetent to Stand Trial Pre- and Post-arrest

1. Identify local inpatient or outpatient alternatives, if any, to the state hospital the local service area has for competency restoration? Indicate "N/A" if the LMHA or LBHA does not have any available alternatives.

   Response:

ACCESS utilizes a **Jail-Based Competency Restoration Program (JBCR)** as the primary local alternative to the state hospital for individuals deemed incompetent to stand trial. This program delivers competency restoration services within the secure environment of county jails in the ACCESS service area.

Jail-Based Competency Restoration Program (JBCR):

- **Location**: Operated within participating county jails across the ACCESS service area, including Smith and Anderson counties.
- **Description**: Provides a structured, multidisciplinary program designed to restore individuals' competency to stand trial while remaining in custody.
- **Key Features**:
    1. **Legal Competency Education**:
        - Daily sessions focused on legal rights, court processes, and understanding courtroom roles and responsibilities.
        - Individualized education plans tailored to participants' comprehension levels.
    2. **Mental Health Treatment**:
        - Psychiatric assessments and medication management.
        - Individual and group therapy to address mental health symptoms affecting competency.
    3. **Crisis Intervention**:

- Onsite mental health support for individuals experiencing acute symptoms or distress during the restoration process.

4. **Structured Activities**:

    - Cognitive and behavioral interventions aimed at improving attention, memory, and understanding of legal concepts.

    - Reinforcement of skills needed to participate in legal proceedings effectively.

5. **Court Coordination**:

    - Regular progress reports sent to the referring courts, including updates on competency status and any recommendations for further care or disposition.

Target Population:

- Individuals who are deemed incompetent to stand trial but do not require inpatient psychiatric hospitalization.

- Participants who can be safely managed within the jail environment.

Limitations:

- This program is not suitable for individuals with severe medical needs or those requiring intensive inpatient psychiatric care, who are referred to the state hospital or other inpatient facilities.

This jail-based approach offers an efficient and cost-effective solution for competency restoration, reducing reliance on state hospitals and addressing individuals' mental health needs within the local justice system.

2. What barriers or issues limit access or utilization to local inpatient or outpatient alternatives?

    Response:

Several barriers and issues limit access or utilization of local inpatient or outpatient alternatives for competency restoration within the ACCESS service area:

1. Limited Bed Availability:

- **Inpatient Facilities:** There is a shortage of available psychiatric beds in contracted facilities, particularly during high-demand periods. This can delay admission and extend wait times for individuals requiring urgent care.
- **Outpatient Alternatives:** Outpatient programs, including the Jail-Based Competency Restoration Program (JBCR), have capacity limitations that may restrict the number of participants served simultaneously.

2. Transportation Challenges:

- **For Inpatient Care:** Transportation to facilities like Cedar Crest Hospital or Palestine Regional Medical Center can be a logistical challenge for law enforcement and first responders, particularly for rural counties within the service area.
- **For Outpatient Services:** Lack of reliable transportation for outpatient services limits access for individuals who are not in custody but require community-based restoration programs.

3. Workforce Shortages:

- Limited availability of trained and licensed mental health professionals impacts the ability to provide timely services in both inpatient and outpatient settings. This includes clinicians, peer specialists, and legal educators required for competency restoration.

4. Resource Limitations in Jails:

- **Space Constraints:** Some local jails lack adequate facilities to host group sessions or accommodate the specific needs of the Jail-Based Competency Restoration Program.
- **Staffing Limitations:** Jail staff may not have sufficient training or capacity to support the mental health and educational needs of individuals undergoing restoration.

5. Funding Constraints:

- Funding limitations for competency restoration programs, particularly for uninsured or underinsured individuals, restrict the ability to expand capacity and access to care.

- The high cost of inpatient care and reliance on as-needed bed purchases strain available budgets.

6. Stigma and Misinformation:

- Lack of awareness or understanding of competency restoration services among families, referring courts, and some stakeholders may result in underutilization of available alternatives.

7. Complex Referral Processes:

- The process for referring individuals to inpatient or outpatient alternatives, including eligibility assessments and securing court approvals, can delay access to services.

8. Co-Occurring Disorders:

- Individuals with co-occurring mental health and substance use disorders often require more intensive treatment, which may not be fully addressed in local alternatives, limiting their effectiveness for certain populations.

Addressing these barriers requires coordinated efforts to expand capacity, streamline referral processes, increase funding, and enhance collaboration with local stakeholders

3. Does the LMHA or LBHA have a dedicated jail liaison position? If so, what is the role of the jail liaison and at what point is the jail liaison engaged? Identify the name(s) and title(s) of employees who operate as the jail liaison.

   Response:

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

   Response:

Yes, ACCESS utilizes its **Mobile Crisis Outreach Team (MCOT)** to serve in the capacity of a Jail Liaison. However, MCOT does not provide competency restoration services but instead focuses on addressing immediate mental health needs and ensuring care coordination for individuals in the jail setting.

Role of MCOT as Jail Liaison:

1. **Screening and Assessment:**
    - MCOT conducts mental health screenings for individuals referred by jail staff, law enforcement, or the courts.
    - Assesses individuals for immediate mental health needs, including risk of self-harm or crisis intervention requirements.
2. **Crisis Intervention:**
    - Provides rapid response to mental health crises within the jail, offering de-escalation and stabilization services.
    - Collaborates with jail staff to address acute mental health issues and develop immediate safety plans.
3. **Care Coordination:**
    - Facilitates referrals to appropriate mental health services, including inpatient or outpatient care, for individuals identified as needing treatment.
    - Ensures continuity of care for individuals transitioning from jail to community-based services.
4. **Support for Jail Staff:**
    - Provides consultation and training to jail staff on managing individuals with mental health conditions.
    - Assists in identifying mental health-related behaviors and appropriate interventions.
5. **Discharge and Reentry Planning:**
    - Coordinates with ACCESS outpatient teams to connect individuals to ongoing mental health services upon release from jail.

- Ensures individuals have access to medication, counseling, and community resources to support successful reintegration.

Engagement Point:

- MCOT is engaged when an individual in the jail is identified as having a mental health need or experiencing a crisis.

- They are typically activated through referrals from jail staff or law enforcement.

Limitations:

- While MCOT provides essential mental health services and coordination, they do not deliver competency restoration services. Individuals requiring competency restoration are referred to the Jail-Based Competency Restoration Program (JBCR) or other state hospital alternatives.

This structure ensures that ACCESS provides comprehensive mental health support to individuals in the criminal justice system while maintaining a clear delineation between crisis intervention and competency restoration services.

5. What plans, if any, are being developed over the next two years to maximize access and utilization of local alternatives for competency restoration?

   Response:

ACCESS is actively developing plans to maximize access and utilization of local alternatives for competency restoration over the next two years. These plans focus on expanding current services, improving coordination, and addressing barriers to care:

1. Expansion of Jail-Based Competency Restoration Program (JBCR):

- **Increased Capacity:** ACCESS is working with local jails to increase the capacity of the Jail-Based Competency Restoration Program by securing additional resources and staffing to serve more individuals.
- **Enhanced Training for Jail Staff:** Plans include providing additional training for jail staff on supporting individuals undergoing competency restoration, including understanding mental health needs and legal processes.

2. Strengthening Collaboration with Local Courts and Law Enforcement:

- **Streamlined Referral Processes:** ACCESS is collaborating with courts and law enforcement to simplify and expedite the referral process for individuals needing competency restoration.
- **Regular Stakeholder Meetings:** Initiating biannual meetings with stakeholders, including judges, attorneys, and law enforcement, to improve communication and address challenges in competency restoration.

3. Partnerships with Community Organizations:

- ACCESS is building partnerships with local organizations to provide supplemental services, such as housing support and case management, for individuals undergoing competency restoration.
- **Integrated Services:** Plans include integrating mental health services with legal education to address the holistic needs of participants.

4. Technology and Telehealth Integration:

- **Telehealth Competency Education:** Implementing telehealth solutions to expand access to competency education and mental health services for individuals in rural or underserved areas.
- **Virtual Court Liaison Support:** Providing virtual consultations and updates to courts to reduce delays in competency determinations.

5. Advocacy for Additional Funding:

- ACCESS is actively advocating for increased funding through grants and legislative support to expand local competency restoration programs.
- **Targeted Grants:** Pursuing funding opportunities through programs like the Mental Health Grant for Justice-Involved Individuals to enhance local alternatives.

6. Data Collection and Outcome Tracking:

- **Performance Metrics:** Implementing systems to track outcomes for individuals undergoing competency restoration, such as restoration rates and timeframes.
- **Continuous Improvement:** Using data to identify gaps and make informed decisions about program enhancements.

These initiatives reflect ACCESS's commitment to providing effective, accessible, and locally driven solutions for competency restoration while reducing reliance on state hospital resources.

6. Does the community have a need for new alternatives for competency restoration? If so, what kind of program would be suitable (e.g., Outpatient Competency Restoration, Inpatient Competency Restoration, Jail-based Competency Restoration, FACT Team, Post Jail Programs)?

   Response:

Yes, the community has a need for new alternatives for competency restoration to address the growing demand and gaps in the current system. The following programs would be suitable for implementation to enhance competency restoration services in the ACCESS service area:

1. Outpatient Competency Restoration Program (OCRP):

- **Rationale:** An outpatient program would allow individuals who can safely remain in the community to receive competency restoration services while reducing reliance on inpatient facilities or jail-based programs.
- **Components:**
  - Legal education sessions tailored to competency restoration.
  - Psychiatric treatment, therapy, and case management services.

    - Coordination with courts to monitor progress and provide status updates.
- **Target Population:** Individuals with stable housing and low-risk behaviors who do not require inpatient or jail-based services.

2. Forensic Assertive Community Treatment (FACT) Team:

- **Rationale:** A FACT Team would provide intensive, community-based services for individuals with severe mental illness who are justice-involved, helping to stabilize mental health conditions and restore competency.
- **Components:**
    - Multidisciplinary team including clinicians, case managers, and peer specialists.
    - Intensive outreach, medication management, and legal education.
    - Support for reentry into the community post-jail or post-hospitalization.
- **Target Population:** High-need individuals who require wraparound support to address mental health, legal, and social needs.

3. Expansion of Jail-Based Competency Restoration Program (JBCR):

- **Rationale:** The existing JBCR program has capacity limitations and may not meet the growing demand. Expansion would allow more individuals to access services within the secure environment of local jails.
- **Components:**
    - Increased staffing to serve more participants simultaneously.
    - Enhanced training for jail staff on mental health needs and competency restoration processes.
- **Target Population:** Individuals deemed incompetent to stand trial who can safely remain in a jail setting.

4. Post-Jail Programs:

- **Rationale:** Programs focused on reentry support and ongoing competency restoration would help prevent recidivism and ensure continuity of care for individuals released from jail.
- **Components:**
    - Linkage to outpatient mental health services and legal education.
    - Housing support and assistance with employment or vocational training.
    - Case management to address ongoing mental health and social needs.
- **Target Population:** Individuals transitioning from jail-based competency restoration or short-term incarceration.

Overall Need:

These alternatives would address current gaps in competency restoration services, particularly for individuals who do not require inpatient care but still need structured support. Implementing a combination of these programs would reduce reliance on state hospitals, improve access to local services, and better meet the needs of individuals within the ACCESS service area.

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

Response:

The implementation of new or expanded competency restoration alternatives requires a combination of resources, stakeholder collaboration, and resolution of existing barriers. Below are the key needs and considerations:

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1. Resources Needed:

- **Funding:**
    - Secure funding from state and federal grants (e.g., Mental Health Grant for Justice-Involved Individuals).
    - Allocate local resources to cover program development, staffing, and operational costs.
- **Staffing:**
    - Recruit and train additional qualified mental health professionals (QMHPs), licensed mental health professionals (LMHPs), and peer support specialists.
    - Hire specialized staff for competency restoration, such as legal educators or forensic case managers.
- **Facilities:**
    - Designate spaces within outpatient clinics or jails for competency restoration services.
    - Renovate or equip spaces for group sessions, legal education, and therapy.
- **Technology:**
    - Implement telehealth infrastructure to provide remote competency restoration services, particularly for rural or underserved areas.
    - Develop or enhance data tracking systems for monitoring participant progress and outcomes.
- **Training and Education:**

- Provide training for staff and stakeholders (e.g., jail staff, court personnel) on competency restoration processes and evidence-based practices.
- Develop curriculum and materials for legal education and competency restoration sessions.

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2. Barriers to Resolve:

- **Funding Constraints:**
  - Lack of consistent or sufficient funding can hinder program expansion. Advocacy for state and federal support is critical.
- **Workforce Shortages:**
  - Difficulty recruiting and retaining qualified professionals may delay program implementation. Competitive salaries and professional development opportunities can help address this issue.
- **Coordination Challenges:**
  - Coordination among stakeholders, including courts, law enforcement, and mental health providers, can be complex. Clear protocols and regular communication are essential.
- **Stigma and Misunderstanding:**
  - Misinformation about competency restoration programs may lead to reluctance from some stakeholders. Community education and outreach are needed to address these concerns.
- **Space and Facility Limitations:**
  - Limited availability of appropriate spaces for competency restoration services, particularly in jails and rural areas, can be a barrier.
- **Transportation Issues:**
  - Individuals in rural areas or without access to reliable transportation may struggle to access outpatient services. Transportation support programs should be developed.

3. Stakeholder Collaboration:

- Work with courts and law enforcement to streamline referral processes and ensure timely participation in competency restoration programs.
- Partner with community organizations to provide supplemental services, such as housing and vocational support.
- Engage with policymakers to advocate for regulatory changes and increased funding.

4. Timeline for Implementation:

- **Short-Term (0-12 months):**
    - Conduct needs assessments and secure initial funding.
    - Recruit staff and provide training.
    - Identify and prepare facilities or program spaces.
- **Long-Term (12-24 months):**
    - Launch pilot programs and evaluate effectiveness.
    - Expand services based on pilot outcomes and community feedback.

By addressing these needs and barriers, ACCESS can successfully implement expanded competency restoration alternatives to better meet the needs of the community.

II.D Seamless Integration of Emergent Psychiatric, Substance Use, and Physical Health Care Treatment and the Development of Texas Certified Community Behavioral Health Clinics

1. What steps have been taken to integrate emergency psychiatric, substance use, and physical healthcare services? Who did the LMHA or LBHA collaborate with in these efforts?

   Response:

ACCESS has taken several proactive steps to integrate emergency psychiatric, substance use, and physical healthcare services, aligning with the goals of becoming a Texas Certified Community Behavioral Health Clinic (CCBHC). These efforts focus on providing a seamless, person-centered approach to care, with collaboration from key stakeholders across the service area.

Steps Taken:

1. **Development of Integrated Care Teams:**
   - ACCESS established multidisciplinary care teams consisting of psychiatric providers, substance use counselors, medical professionals, and care coordinators to ensure holistic care delivery.
   - Teams collaborate to address the co-occurring needs of individuals in crisis.
2. **Co-Location of Services:**
   - ACCESS has worked to co-locate emergency psychiatric, substance use, and primary healthcare services within outpatient clinics in Jacksonville and Palestine to reduce barriers to access.
   - Clinics provide mental health evaluations, substance use screenings, and basic physical health assessments in a single setting.
3. **Crisis Response Enhancements:**
   - ACCESS partnered with AVAIL Solutions to ensure crisis hotline staff can assess for psychiatric and substance use needs and refer individuals to appropriate care pathways.
   - Mobile Crisis Outreach Teams (MCOT) now conduct initial physical health screenings during psychiatric or substance use crisis responses and refer individuals to medical care as needed.
4. **Substance Use Disorder Integration:**
   - ACCESS expanded access to Medication-Assisted Treatment (MAT) for individuals with opioid or alcohol use disorders.
   - Substance use counselors are embedded in crisis response teams to address co-occurring disorders during emergency interventions.
5. **Collaboration with Local Hospitals:**

- ACCESS partnered with Palestine Regional Medical Center, UT Health North Campus, and Cedar Crest Hospital to ensure individuals presenting with psychiatric or substance use emergencies can receive coordinated care, including referrals to primary healthcare providers.
- Joint protocols were developed to facilitate warm handoffs between hospital emergency departments and ACCESS services.

6. **Use of Telehealth:**
   - Telehealth services were implemented to connect individuals in rural areas to integrated psychiatric, substance use, and physical health assessments.
7. **Training for Staff:**
   - ACCESS staff across all service lines received training in trauma-informed care, co-occurring disorders, and the integration of behavioral and physical health services.
8. **Community Education and Outreach:**
   - Conducted educational campaigns to inform stakeholders about integrated care services and how to access them.

Collaboration Efforts:
ACCESS collaborated with the following organizations and stakeholders to advance integration efforts:

- **Hospitals and Emergency Departments:**
  - Palestine Regional Medical Center, UT Health North Campus, and Cedar Crest Hospital.
- **Substance Use Disorder Providers:**
  - Local treatment providers offering MAT and inpatient detoxification services.
- **Primary Healthcare Providers:**
  - Partnerships with Federally Qualified Health Centers (FQHCs) to provide physical health services for individuals accessing psychiatric or substance use care.
- **Crisis Service Partners:**
  - AVAIL Solutions and MCOT for emergency psychiatric and substance use crisis intervention.
- **Local Government and Law Enforcement:**
  - Collaboration with law enforcement to address psychiatric and substance use crises in the community.
- **Community Organizations:**
  - Advocacy groups and peer support organizations to promote whole-person care.

These steps represent ACCESS's ongoing commitment to delivering integrated, comprehensive services that address the mental health, substance use, and physical health needs of the community.

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

   Response:

Over the next two years, ACCESS plans to enhance coordination and integration of emergency psychiatric, substance use, and physical healthcare services through strategic initiatives focused on infrastructure development, stakeholder collaboration, and service expansion.

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1. Expansion of Co-Located Services:

- **Integrated Clinics:** ACCESS will expand co-located services at its outpatient clinics in Jacksonville and Palestine, ensuring individuals have access to psychiatric, substance use, and physical health services in one location.
- **Substance Use Services:** Increase access to Medication-Assisted Treatment (MAT) by integrating more substance use specialists within existing clinics.

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2. Enhanced Crisis Response Coordination:

- **Medical Screening in Crisis Situations:** MCOT will be equipped with tools and training to conduct basic physical health assessments during psychiatric and substance use crises.
- **Emergency Room Partnerships:** Strengthen existing relationships with local emergency departments to streamline referrals and facilitate warm handoffs to ACCESS services.
- **Integrated Crisis Plans:** Develop joint crisis response plans that address co-occurring psychiatric and substance use disorders with input from physical health providers.

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3. Data Sharing and Technology Integration:

- **Electronic Health Record (EHR) Enhancements:** Implement upgrades to ACCESS's EHR system to enable seamless data sharing across psychiatric, substance use, and physical health services.
- **Health Information Exchange (HIE):** Join regional HIEs to improve communication and coordination with hospitals, primary care providers, and specialty care facilities.

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4. Workforce Development:

- **Cross-Training Programs:** Expand cross-training for clinicians, crisis responders, and care coordinators in co-occurring disorders, trauma-informed care, and physical health basics.
- **Recruitment Efforts:** Increase hiring of dual-licensed professionals (e.g., psychiatric nurse practitioners with primary care training) to provide integrated care.

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5. Community-Based Outreach and Education:

- **Public Awareness Campaigns:** Educate the community about the availability and benefits of integrated services.
- **Stakeholder Engagement:** Host regular stakeholder meetings with hospitals, law enforcement, and community partners to enhance collaboration and share progress.

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6. Telehealth and Mobile Services Expansion:

- **Telehealth for Rural Areas:** Expand telehealth offerings to ensure individuals in remote areas have access to psychiatric, substance use, and physical healthcare services.
- **Mobile Integrated Health Teams:** Develop mobile teams that include mental health clinicians, substance use counselors, and medical professionals to provide integrated care in the field.

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7. Certified Community Behavioral Health Clinic (CCBHC) Certification:

- **CCBHC Implementation:** Pursue full CCBHC certification to formalize ACCESS's commitment to integrated care.
- **Standards Compliance:** Align programs and services with CCBHC requirements, focusing on evidence-based practices and outcomes measurement.

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8. Funding and Resource Development:

- **Grant Applications:** Apply for state and federal funding to expand integrated service capacity, including grants under the Certified Community Behavioral Health Clinic (CCBHC) program.
- **Infrastructure Investments:** Invest in facility improvements and staffing to support service integration.

By pursuing these initiatives, ACCESS aims to provide a fully integrated system of care that improves health outcomes, reduces service fragmentation, and ensures timely access to comprehensive services for the community.

II.E Communication Plans

1. What steps have been taken to ensure key information from the Psychiatric Emergency Plan is shared with emergency responders and other community stakeholders?

   Response:

ACCESS has implemented several strategies to ensure that key information from the Psychiatric Emergency Plan is effectively shared with emergency responders and community stakeholders. These steps promote collaboration, clarity, and preparedness in managing psychiatric emergencies:

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1. Regular Stakeholder Meetings:

- **Emergency Responders:** ACCESS conducts quarterly meetings with law enforcement, EMS, and fire departments to review the Psychiatric Emergency Plan, discuss updates, and address operational concerns.

- **Community Stakeholders:** Meetings with hospitals, local government officials, and community organizations ensure that all relevant stakeholders are informed about the plan.

2. Training and Workshops:

- ACCESS provides **Crisis Intervention Training (CIT)** to law enforcement and first responders, which includes detailed information about the Psychiatric Emergency Plan, crisis de-escalation techniques, and referral processes.
- Specialized workshops are held for hospital staff, school counselors, and community partners to educate them on emergency procedures and available services.

3. Distribution of Written Materials:

- **Emergency Protocols Handbook:** ACCESS developed a comprehensive handbook summarizing the Psychiatric Emergency Plan, which is distributed to emergency responders, hospitals, and community organizations.
- **Quick Reference Guides:** Wallet-sized cards and posters with key contact numbers, crisis hotline information, and referral pathways are provided to first responders for quick access during emergencies.

4. Crisis Hotline Coordination:

- ACCESS collaborates with AVAIL Solutions (Crisis Hotline contractor) to ensure hotline staff are well-informed about the Psychiatric Emergency Plan and can communicate key details to emergency responders during crisis calls.
- First responders are encouraged to contact the hotline for immediate guidance and support.

5. Digital Communication Channels:

- **Website Information:** The Psychiatric Emergency Plan and related resources are available on ACCESS's website for easy reference by stakeholders.
- **Email Updates:** Regular email updates are sent to stakeholders to share changes to the plan, new resources, or upcoming training opportunities.

6. Simulation Drills and Scenario Planning:

- ACCESS organizes joint simulation drills with emergency responders to practice implementing the Psychiatric Emergency Plan in real-time scenarios.
- Debriefing sessions following these drills help refine communication strategies and identify areas for improvement.

7. Designated Points of Contact:

- ACCESS assigns dedicated staff members, including MCOT representatives, to serve as liaisons with emergency responders and community partners, ensuring consistent communication and collaboration.

8. Feedback Mechanisms:

- ACCESS collects feedback from emergency responders and stakeholders through surveys and focus groups to evaluate the effectiveness of communication efforts and identify areas for improvement.

These steps ensure that all relevant parties have access to the information they need to respond effectively to psychiatric emergencies and maintain a coordinated approach to care.

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

   Response:

ACCESS has established a comprehensive approach to ensure that all staff, including MCOT, hotline staff (via AVAIL Solutions), and staff receiving incoming calls, are well-equipped with the knowledge and training to implement the Psychiatric Emergency Plan effectively. This approach includes the following steps:

1. Initial Training and Onboarding:

- **Standardized Training Curriculum:**
  - New staff undergo training during onboarding that covers all components of the Psychiatric Emergency Plan, including protocols, referral processes, and emergency procedures.
- **Role-Specific Training:**
  - MCOT staff receive specialized training in crisis intervention, de-escalation techniques, and field response protocols.
  - Hotline staff (via AVAIL Solutions) are trained in assessing crises, coordinating with MCOT, and facilitating referrals to services.
  - Administrative staff receiving incoming calls are trained in call triage, routing emergencies to the appropriate personnel, and providing critical crisis resources.

2. Ongoing Professional Development:

- **Quarterly Refresher Trainings:**
  - All relevant staff participate in quarterly trainings to stay updated on changes to the Psychiatric Emergency Plan and review best practices.
- **Scenario-Based Drills:**

- Staff participate in role-playing exercises and drills to simulate real-life scenarios, ensuring they can respond effectively in emergencies.
- **Cross-Training Opportunities:**
  - MCOT, hotline staff, and call center personnel attend joint training sessions to understand each other's roles and ensure seamless coordination.

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3. Access to Resources:

- **Emergency Plan Handbook:**
  - Each staff member is provided with a comprehensive handbook detailing the Psychiatric Emergency Plan, including workflows, contact lists, and escalation procedures.
- **Quick Reference Materials:**
  - Staff have access to cheat sheets, flowcharts, and decision trees for quick guidance during high-pressure situations.

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4. Technology Integration:

- **Electronic Access to Protocols:**
  - The Psychiatric Emergency Plan is embedded in ACCESS's electronic systems, ensuring staff can access the latest information in real time.
- **Crisis Call Management Systems:**
  - Hotline and call center staff use systems that integrate crisis assessment tools and referral options directly linked to the plan.

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5. Supervision and Support:

- **Regular Supervision:**
  - Supervisors conduct regular check-ins with MCOT and hotline staff to address questions, provide guidance, and review implementation effectiveness.
- **24/7 On-Call Support:**
  - A senior clinician is available at all times to assist staff with complex cases or to clarify emergency protocols.

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6. Feedback and Continuous Improvement:

- **Staff Feedback Mechanism:**
    - Staff are encouraged to provide feedback on the plan's implementation and suggest improvements based on their experiences.
- **Performance Reviews:**
    - Regular reviews are conducted to assess staff adherence to the plan and identify additional training needs.

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7. Collaboration with AVAIL Solutions:

- ACCESS works closely with AVAIL Solutions to ensure hotline staff receive updates on the plan and participate in ACCESS-led training sessions.
- Shared debriefings after critical incidents are used to refine practices and protocols collaboratively.

By ensuring consistent training, access to resources, and robust support systems, ACCESS guarantees that all staff are prepared to implement the Psychiatric Emergency Plan effectively and provide high-quality, coordinated care during crises.

II.F Gaps in the Local Crisis Response System

Use the table below to identify the critical gaps in the local crisis emergency response system? Consider needs in all parts of the local service area, including those specific to certain counties. Add additional rows if needed.

Table 7: Crisis Emergency Response Service System Gaps

County	Service System Gaps	Recommendations to Address the Gaps	Timeline to Address Gaps (if applicable)
Anderson, Cherokee	Limited availability of psychiatric beds for crisis stabilization.	Increase contracted bed capacity with local inpatient facilities and develop partnerships with nearby hospitals for overflow needs.	N/A
Anderson, Cherokee	Insufficient Mobile Crisis Outreach Team (MCOT) coverage during evenings and weekends.	Hire additional MCOT staff to provide 24/7 crisis response services for both counties.	N/A
Anderson, Cherokee	Transportation barriers for individuals in rural areas needing access to crisis services.	Establish a transportation assistance program in partnership with local transit providers or develop a dedicated crisis transport team.	N/A

Section III: Plans and Priorities for System Development

III.A Jail Diversion

The Sequential Intercept Model (SIM) informs community-based responses to people with mental health and substance disorders involved in the criminal justice system. The model is most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change.

A link to the SIM can be accessed here:

https://www.prainc.com/wp-content/uploads/2017/08/SIM-Brochure-Redesign0824.pdf

In the tables below, indicate the strategies used in each intercept to divert people from the criminal justice system and indicate the counties in the service area where the strategies are applicable. List current activities and any plans for the next two years. Enter N/A if not applicable.

Table 8: Intercept 0 Community Services

Current Programs and Initiatives	County(s)	Plans for Upcoming Two Years
Crisis Hotline (AVAIL Solutions): 24/7 hotline providing immediate support for mental health and substance use crises.	Anderson, Cherokee	Expand public awareness campaigns to increase utilization, particularly in rural areas. Integrate telehealth for seamless referrals during crisis calls.
Mobile Crisis Outreach Team (MCOT): Provides on-site crisis intervention and stabilization services for individuals in the community.	Anderson, Cherokee	Increase MCOT staffing to achieve 24/7 coverage. Enhance training for MCOT staff to address co-occurring disorders.
Crisis Intervention Training (CIT) for Law Enforcement: Educates officers on de-escalation techniques and mental health awareness.	Anderson, Cherokee	Expand CIT participation among law enforcement officers and offer refresher courses to reinforce skills.

Table 9: Intercept 1 Law Enforcement

Current Programs and Initiatives	County(s)	Plans for Upcoming Two Years
Crisis Intervention Training (CIT): Educates law enforcement on recognizing and responding to mental health and substance use crises.	Anderson, Cherokee	Expand CIT participation to include all law enforcement agencies in both counties. Develop refresher courses and specialized modules for crisis response.
MCOT Collaboration with Law Enforcement: MCOT provides on-site support for de-escalation and mental health crisis response upon law enforcement request.	Anderson, Cherokee	Strengthen collaboration by hosting joint training exercises and regular coordination meetings between MCOT and law enforcement agencies.
Law Enforcement Referral Protocols: Established processes for law enforcement to divert individuals to crisis services instead of arresting them.	Anderson, Cherokee	Update and streamline referral protocols. Incorporate telehealth consultations to support officers in determining diversion options in real time.

Table 10: Intercept 2 Post Arrest

Current Programs and Initiatives	County(s)	Plans for Upcoming Two Years
Jail-Based Mental Health Screenings: Screening individuals at booking to identify mental health and substance use needs.	Anderson, Cherokee	Enhance screening protocols through expanded training for jail staff and implement electronic tools for tracking and follow-up.
Jail-Based Competency Restoration Program (JBCR): Provides competency restoration services for individuals deemed incompetent to stand trial.	Anderson, Cherokee	Expand the JBCR program by increasing staff capacity and providing additional training for mental health liaisons and jail staff.
Pre-Trial Diversion Programs: Diverts individuals with mental health or substance use issues to community-based treatment instead of proceeding through the criminal justice system.	Anderson, Cherokee	Increase participation in diversion programs by improving collaboration with courts and expanding follow-up care resources.
Coordination Between Courts and Jail Mental Health Staff: Regular communication ensures timely mental health evaluations and care for individuals post-arrest.	Anderson, Cherokee	Streamline coordination through electronic referral systems and periodic joint reviews of cases involving mental health needs.
MCOT Crisis Intervention Support in Jails: MCOT provides crisis response and de-escalation support for individuals in custody.	Anderson, Cherokee	Extend MCOT availability for jails to include after-hours support and develop tailored crisis intervention plans for high-risk individuals.

Current Programs and Initiatives	County(s)	Plans for Upcoming Two Years
Substance Use Assessment and Referral: Referrals for individuals with substance use needs to detox or outpatient treatment upon release.	Anderson, Cherokee	Standardize substance use assessments at booking and increase partnerships with detox facilities and outpatient providers.
Intercept 2: Post Arrest; Initial Detention and Initial Hearings Current Programs and Initiatives:	County(s)	Plans for Upcoming Two Years:

Table 11: Intercept 3 Jails and Courts

Intercept 3: Jails and Courts Current Programs and Initiatives:	County(s)	Plans for Upcoming Two Years:
Table 11: Intercept 3 Jails and Courts		
Current Programs and Initiatives	County(s)	Plans for Upcoming Two Years
Jail-Based Competency Restoration Program (JBCR): Provides competency restoration services for individuals deemed incompetent to stand trial within local jails.	Anderson, Cherokee	Increase JBCR staffing to serve more participants. Provide enhanced training for jail staff to support program implementation and monitoring.

Table 12: Intercept 4 Reentry

Intercept 4: Reentry Current Programs and Initiatives:	County(s)	Plans for Upcoming Two Years:
Reentry Case Management Services: ACCESS provides case management to individuals transitioning from jail to community services.	Anderson, Cherokee	Expand case management services to include dedicated staff for reentry planning with a focus on housing and vocational support.
Behavioral Health Treatment Linkage: Coordination between jails and ACCESS ensures individuals are connected to mental health and substance use treatment upon release.	Anderson, Cherokee	Develop a formalized referral system with tracking to ensure timely follow-up for treatment appointments post-release.
Peer Support Services: Peer specialists support individuals during reentry by providing guidance, advocacy, and connections to community resources.	Anderson, Cherokee	Expand peer support programs to include in-reach services before release and specialized groups for veterans and individuals with co-occurring disorders.

Table 13: Intercept 5 Community Corrections

Intercept 5: Community Corrections Current Programs and Initiatives:	County(s)	Plans for Upcoming Two Years:
Probation and Parole Coordination: ACCESS collaborates with probation and parole officers to ensure individuals with mental health or substance use needs receive appropriate services.	Anderson, Cherokee	Develop formal communication protocols with probation and parole offices to streamline referrals and enhance tracking of compliance with treatment plans.
Behavioral Health Treatment Services: ACCESS provides outpatient mental health and substance use services to individuals referred by probation and parole.	Anderson, Cherokee	Increase service availability by expanding telehealth options and adding evening hours to accommodate individuals' schedules.
Peer Support for Justice-Involved Individuals: Peer specialists assist individuals under community supervision in accessing resources and maintaining recovery.	Anderson, Cherokee	Expand peer support programs to include targeted groups for individuals with co-occurring disorders and those transitioning from incarceration.

III.B Other Behavioral Health Strategic Priorities

The Statewide Behavioral Health Coordinating Council (SBHCC) was established to ensure a strategic statewide approach to behavioral health services. In 2015, the Texas Legislature established the SBHCC to coordinate behavioral health services across state agencies. The SBHCC is comprised of representatives of state agencies or institutions of higher education that receive state general revenue for behavioral health services. Core duties of the SBHCC include developing, monitoring, and implementing a five-year statewide behavioral health strategic plan; developing annual coordinated statewide behavioral health expenditure proposals; and annually publishing an updated inventory of behavioral health programs and services that are funded by the state.

The Texas Statewide Behavioral Health Plan identifies other significant gaps and goals in the state's behavioral health services system. The gaps identified in the plan are:

- Gap 1: Access to appropriate behavioral health services
- Gap 2: Behavioral health needs of public-school students
- Gap 3: Coordination across state agencies
- Gap 4: Supports for Service Members, veterans, and their families

- Gap 5: Continuity of care for people of all ages involved in the Justice System
- Gap 6: Access to timely treatment services
- Gap 7: Implementation of evidence-based practices
- Gap 8: Use of peer services
- Gap 9: Behavioral health services for people with intellectual and developmental disabilities
- Gap 10: Social determinants of health and other barriers to care
- Gap 11: Prevention and early intervention services
- Gap 12: Access to supported housing and employment
- Gap 13: Behavioral health workforce shortage
- Gap 14: Shared and usable data

The goals identified in the plan are:

- Goal 1: Intervene early to reduce the impact of trauma and improve social determinants of health outcomes.
- Goal 2: Collaborate across agencies and systems to improve behavioral health policies and services.
- Goal 3: Develop and support the behavioral health workforce.
- Goal 4: Manage and utilize data to measure performance and inform decisions.

Use the table below to briefly describe the status of each area of focus as identified in the plan (key accomplishments, challenges, and current activities), and then summarize objectives and activities planned for the next two years.

Table 14: Current Status of Texas Statewide Behavioral Health Plan

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Expand Trauma-Informed Care, linguistic, and cultural awareness training and build this knowledge into services	• Gaps 1, 10 • Goal 1	Trauma-informed care (TIC) training is provided to ACCESS staff, including MCOT and outpatient clinicians. - Limited linguistic and cultural awareness training specific to diverse populations in Anderson and Cherokee counties. - Initial feedback mechanisms implemented to assess the effectiveness of cultural competence in service delivery. -	Expand TIC training to include law enforcement, first responders, and school staff. - Develop partnerships with local community organizations to deliver cultural awareness workshops tailored to the demographics of Anderson and Cherokee counties. - Provide bilingual training materials and interpretation services to address linguistic gaps. - Introduce regular staff assessments and feedback loops to ensure ongoing cultural competency development.
Coordinate across local, state, and federal agencies to increase and maximize use of funding for access to housing, employment, transportation, and other needs that impact health outcomes	• Gaps 2, 3, 4, 5, 10, 12 • Goal 1	- ACCESS collaborates with local housing agencies and the Texas Workforce Commission to provide housing and job training for individuals with behavioral health needs. - Limited partnerships with transportation providers create barriers to accessing services, especially in rural areas. - Existing coordination efforts address veterans' housing and employment needs but require expanded integration across systems.	- Establish formal agreements with regional transportation providers to create affordable, accessible options for rural and underserved areas. - Increase engagement with state housing programs to secure more supported housing options for justice-involved individuals and those in crisis. - Develop a centralized resource hub to integrate funding sources and improve collaboration between local, state, and federal agencies. - Pursue additional grant opportunities for behavioral health services related to housing, employment, and transportation.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Explore financial, statutory, and administrative barriers to funding new or expanding behavioral health support services	• Gaps 1, 10 • Goal 1	- ACCESS has identified funding constraints as a primary barrier to expanding outpatient services and telehealth capabilities. - Initial discussions held with local and state legislators to address these barriers. - Administrative processes for grant applications are under review to identify inefficiencies.	- Conduct a comprehensive review of financial, statutory, and administrative barriers, including collaboration with state and local policymakers. - Advocate for expanded funding through legislative initiatives and regional partnerships. - Simplify grant application processes by streamlining internal administrative workflows and increasing staff training on grant-writing best practices. - Pursue federal and state funding opportunities to address unmet behavioral health needs, particularly in rural areas.
Implement services that are person- and family-centered across systems of care	• Gap 10 • Goal 1	- ACCESS incorporates person-centered care planning in outpatient services, including individual goal setting and tailored care coordination. - Limited integration of family-centered support, such as caregiver training or family therapy. - Initial training for staff on person-centered approaches completed.	- Expand person- and family-centered care training for all ACCESS staff, including peer specialists and crisis teams. - Develop family support programs, including caregiver resources, family counseling, and educational workshops. - Implement feedback mechanisms (e.g., surveys, focus groups) to assess and refine person- and family-centered care practices. - Collaborate with schools and community organizations to provide family-centered behavioral health education and outreach.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Enhance prevention and early intervention services across the lifespan	• Gaps 2, 11 • Goal 1	- ACCESS provides youth-focused mental health screenings and early intervention services in partnership with local schools. - Limited availability of prevention and early intervention services for adults and older adults. - Community awareness campaigns on early intervention services are ongoing but require expansion.	- Develop new prevention programs targeting adults and older adults, focusing on early detection of mental health and substance use disorders. - Expand collaboration with schools to implement trauma-informed practices and mental health education for students and staff. - Partner with local healthcare providers to integrate behavioral health screenings into primary care visits for all age groups. - Increase outreach campaigns to promote prevention services and reduce stigma across the lifespan.
Identify best practices in communication and information sharing to maximize collaboration across agencies	• Gap 3 • Goal 2	- Current communication between ACCESS, law enforcement, healthcare providers, and community organizations is primarily through scheduled meetings and email updates. - Limited use of shared electronic data systems for real-time information exchange. - Initial participation in regional behavioral health planning discussions.	- Implement a shared data platform to enable secure and efficient real-time information sharing across agencies. - Host regular multi-agency meetings to review and refine communication practices and identify barriers. - Develop standardized communication protocols to improve coordination between ACCESS, law enforcement, and healthcare providers. - Create a centralized resource directory to streamline information sharing and referral processes for community stakeholders.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Collaborate to jointly develop behavioral health policies and implement behavioral health services to achieve a coordinated, strategic approach to enhancing systems	• Gaps 1, 3, 7 • Goal 2	- ACCESS participates in regional behavioral health planning meetings and has established partnerships with local stakeholders. - Limited involvement in state-level policy development and advocacy. - Initial efforts to align ACCESS policies with evidence-based practices are underway.	- Increase ACCESS participation in state-level behavioral health planning and policy-making efforts. - Host joint planning sessions with law enforcement, healthcare providers, and community organizations to align goals and improve service delivery. - Develop policies that formalize the use of evidence-based practices across all programs and ensure regular evaluation for effectiveness. - Advocate for legislative support to address behavioral health gaps specific to rural and underserved areas in Anderson and Cherokee counties.
Identify and strategize opportunities to support and implement recommendations from SBHCC member advisory committees and SBHCC member strategic plans	• Gap 3 • Goal 2	- ACCESS has participated in initial discussions with SBHCC member advisory committees and reviewed strategic plan recommendations. - Limited integration of SBHCC strategies into local behavioral health planning efforts. - Current activities include tracking updates to the SBHCC strategic plan for alignment.	- Conduct a gap analysis to identify areas where ACCESS's programs align with SBHCC strategic plan recommendations and prioritize areas for implementation. - Increase ACCESS participation in SBHCC advisory committees to stay informed on updates and influence policy recommendations. - Develop localized action plans to implement key SBHCC recommendations in collaboration with community partners. - Establish a formal process for monitoring and reporting on progress toward SBHCC-aligned goals.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Increase awareness of provider networks, services and programs to better refer people to the appropriate level of care	• Gaps 1, 11, 14 • Goal 2	- ACCESS currently disseminates information about services through brochures, community events, and its website. - Referral pathways exist but are underutilized due to limited awareness among stakeholders and the community. - Collaboration with law enforcement and healthcare providers for referrals is inconsistent.	- Develop a comprehensive digital resource directory accessible to all stakeholders to streamline referrals to appropriate services. - Launch targeted community outreach campaigns to increase public awareness of available programs and how to access them. - Conduct regular training for partner agencies (e.g., law enforcement, schools, and healthcare providers) on ACCESS's referral processes and available services. - Implement a tracking system to monitor referral patterns and identify gaps in service awareness or utilization.
Identify gaps in continuity of care procedures to reduce delays in care and waitlists for services	• Gaps 1, 5, 6 • Goal 2	- ACCESS has implemented basic care coordination for individuals transitioning from crisis services to outpatient care. - Waitlists for outpatient mental health services persist due to staff shortages and high demand. - Limited use of shared data systems to track care continuity and identify bottlenecks.	- Conduct a comprehensive review of care transitions to identify delays and gaps in continuity of care procedures. - Expand staff capacity by hiring additional clinicians and support staff to reduce wait times. - Implement a shared care coordination system to improve communication and tracking of client progress across services. - Develop partnerships with additional community providers to create overflow capacity for high-demand services.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Develop step-down and step-up levels of care to address the range of participant needs	• Gaps 1, 5, 6 • Goal 2	- ACCESS currently provides basic outpatient services but has limited options for intermediate levels of care, such as intensive outpatient programs (IOP) or partial hospitalization programs (PHP). - Crisis services are not fully integrated with step-down care plans, leading to gaps in service transitions. - Case management services are available but not consistently utilized to support step-up or step-down needs.	- Develop an intensive outpatient program (IOP) and explore the feasibility of a partial hospitalization program (PHP) to fill the gap between crisis and outpatient care. - Create step-down protocols to ensure individuals transitioning from crisis stabilization or inpatient care receive coordinated follow-up services. - Train staff on identifying step-up care needs to provide earlier interventions for participants at risk of escalating crises. - Establish partnerships with community providers to expand options for step-down housing and recovery-focused programs.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Create a data subcommittee in the SBHCC to understand trends in service enrollment, waitlists, gaps in levels of care and other data important to assessing the effectiveness of policies and provider performance	• Gaps 3, 14 • Goal 3	- ACCESS participates in SBHCC meetings but does not currently have a designated subcommittee focused on data trends. - Data collection on service enrollment, waitlists, and care gaps is done at the local level but lacks statewide standardization. - Limited use of data analytics to assess the impact of policies or identify performance trends.	- Collaborate with SBHCC members to establish a formal data subcommittee tasked with analyzing enrollment trends, waitlists, and service gaps. - Develop standardized metrics and reporting systems to ensure consistency across providers. - Advocate for the integration of local and state-level data to inform strategic planning and performance evaluation. - Provide ACCESS representation in the subcommittee to share insights and prioritize rural and underserved populations in data analysis efforts.
Explore opportunities to provide emotional supports to workers who serve people receiving services	• Gap 13 • Goal 3	- ACCESS has implemented some support measures, such as team debriefings after critical incidents and access to an employee assistance program (EAP). - Limited structured emotional support programs for staff, especially for those in crisis response roles. - High turnover in some positions suggests additional emotional support measures may be needed.	- Develop peer support groups for workers to share experiences and strategies for coping with job-related stress. - Introduce regular wellness check-ins with supervisors to proactively identify and address emotional needs of staff. - Provide ongoing training on resilience-building and self-care strategies tailored for behavioral health professionals. - Explore partnerships with external organizations to deliver trauma-informed emotional support services for workers.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Use data to identify gaps, barriers and opportunities for recruiting, retention, and succession planning of the behavioral health workforce	• Gaps 13, 14 • Goal 3	- ACCESS collects workforce data on hiring trends, turnover rates, and vacancies but lacks a formalized process for analyzing and acting on the data. - Current efforts focus on addressing immediate staffing needs, with limited long-term succession planning in place. - High turnover in certain positions highlights the need for targeted retention strategies.	- Implement a data analytics system to track workforce trends, including recruitment success rates, retention challenges, and succession planning needs. - Develop a strategic workforce plan based on data insights, with a focus on retaining staff in high-turnover roles. - Conduct surveys and focus groups to identify workforce barriers, such as salary competitiveness and job satisfaction, and use the results to inform policy changes. - Partner with local colleges and universities to create pipelines for recruiting new behavioral health professionals and improving succession planning.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Implement a call to service campaign to increase the behavioral health workforce	• Gap 13 • Goal 3	- ACCESS currently participates in local job fairs and collaborates with community colleges for recruitment. - Limited public-facing campaigns to promote careers in behavioral health, especially in underserved areas. - Existing recruitment efforts rely heavily on traditional job postings.	- Launch a regional "Call to Service" campaign to highlight the importance of careers in behavioral health and attract diverse talent. - Use social media, community events, and partnerships with schools to promote behavioral health careers, focusing on underserved populations. - Collaborate with local high schools, colleges, and universities to create behavioral health career exploration programs and internships. - Highlight success stories of current staff to inspire new applicants and promote the mission of ACCESS.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Develop and implement policies that support a diversified workforce	• Gaps 3, 13 • Goal 3	- ACCESS has taken steps to increase diversity by promoting equal opportunity hiring practices and providing cultural competence training for staff. - Limited policies specifically aimed at actively recruiting underrepresented groups in behavioral health. - Current workforce demographics do not fully reflect the diversity of the service population.	- Develop targeted recruitment strategies to attract candidates from underrepresented groups, including bilingual and bicultural professionals. - Implement mentorship programs to support career advancement for employees from diverse backgrounds. - Establish partnerships with Historically Black Colleges and Universities (HBCUs) and Hispanic-Serving Institutions (HSIs) to build a pipeline of diverse behavioral health professionals. - Regularly review workforce demographics and update hiring policies to align with diversity, equity, and inclusion (DEI) goals.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Assess ways to ease state contracting processes to expand the behavioral health workforce and services	• Gaps 3, 13 • Goal 3	- ACCESS engages with state agencies but faces challenges with lengthy contracting processes that delay service expansion. - Current contracting policies require significant administrative effort, limiting the focus on direct workforce development and service delivery. - Minimal collaboration with state-level stakeholders to address systemic barriers in contracting.	- Work with state agencies to identify inefficiencies and propose streamlined contracting processes, such as electronic submissions and reduced documentation redundancies. - Advocate for the inclusion of expedited contracting provisions for behavioral health providers in rural and underserved areas. - Collaborate with other providers and professional associations to develop unified recommendations for simplifying state behavioral health contracts. - Conduct regular feedback sessions with ACCESS staff to identify specific barriers encountered during state contracting and implement internal solutions to improve efficiency.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Create a data subcommittee in the SBHCC to understand trends in service enrollment, waitlists, gaps in levels of care and other data important to assessing the effectiveness of policies and provider performance	• Gaps 3, 14 • Goal 4	- ACCESS currently tracks service enrollment and waitlists but lacks integration with statewide data trends. - Minimal involvement in analyzing system-wide data on gaps in levels of care or the effectiveness of existing policies. - SBHCC has not yet formalized a dedicated data subcommittee focused on these areas.	- Advocate for the establishment of a formal SBHCC data subcommittee to analyze statewide trends in enrollment, waitlists, and service gaps. - Partner with other providers to share best practices for data collection and analysis, emphasizing consistent metrics across agencies. - Enhance ACCESS's internal data systems to align with statewide priorities and facilitate reporting to the subcommittee. - Use subcommittee findings to inform policy changes, improve service planning, and optimize resource allocation across the behavioral health system.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Explore the use of a shared data portal as a mechanism for cross-agency data collection and analysis	• Gaps 3, 14 • Goal 4	- ACCESS currently relies on individual data systems for tracking service delivery, with limited cross-agency data sharing. - There is no centralized portal to integrate data from law enforcement, healthcare, and community organizations. - Initial discussions have taken place regarding the need for a regional or statewide data-sharing solution.	- Collaborate with state agencies and SBHCC to evaluate existing data-sharing platforms and identify suitable models for a shared data portal. - Pilot a regional data-sharing initiative with local stakeholders, including law enforcement and healthcare providers. - Ensure the portal is designed with user-friendly features, robust privacy protections, and the ability to analyze trends across agencies. - Use data from the portal to improve service coordination, reduce duplication of efforts, and identify gaps in care and policy effectiveness.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Explore opportunities to increase identification of service members, veterans, and their families who access state-funded services to understand their needs and connect them with appropriate resources	• Gaps 3, 4, 14 • Goal 4	- ACCESS has implemented intake processes to identify veterans and their families, but reporting and tracking are not fully integrated. - Limited collaboration with veteran-specific organizations, leading to gaps in linking individuals to specialized services. - Data on veteran service utilization is collected locally but not consistently shared across agencies.	- Partner with state and local agencies to develop standardized protocols for identifying service members, veterans, and their families during intake processes. - Collaborate with veteran-focused organizations to improve referral pathways and ensure comprehensive support services. - Develop a shared data system to track the needs, service usage, and outcomes for this population, ensuring privacy and compliance with data protection laws. - Launch targeted outreach campaigns to increase awareness of available resources among veterans and their families.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Collect data to understand the effectiveness of evidence-based practices and the quality of these services	• Gaps 7, 14 • Goal 4	- ACCESS utilizes some evidence-based practices (EBPs) in outpatient and crisis services but lacks a formal evaluation framework. - Current data collection focuses on service usage and outcomes but does not consistently assess the quality or fidelity of EBPs. - Staff receive periodic training on EBPs, but the impact of these practices is not fully tracked.	- Develop a formalized data collection framework to assess the effectiveness, quality, and fidelity of evidence-based practices across all programs. - Implement regular performance evaluations and client satisfaction surveys to gather qualitative and quantitative data on service quality. - Partner with academic institutions or research organizations to analyze EBP outcomes and identify areas for improvement. - Use collected data to refine training programs and ensure ongoing fidelity to evidence-based models.

III.C Local Priorities and Plans

Based on identification of unmet needs, stakeholder input and internal assessment, identify the 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 plans for the next two years, including a relevant timeline. If local priorities are addressed in the table above, list the local priority and enter "see above" in the remaining two cells.

Table 15: Local Priorities

Local Priority	Current Status	Plans
Develop step-down and step-up levels of care to address gaps in service transitions	- Limited availability of intermediate levels of care, such as intensive outpatient programs (IOP) and partial hospitalization programs (PHP). - Clients transitioning from crisis or inpatient care often face delays in accessing outpatient services.	- Launch an IOP within 12 months to address the immediate gap in transitional care. - Explore feasibility for a PHP within 18-24 months. - Develop clear protocols for transitioning clients between levels of care to ensure continuity and avoid service delays.
Increase access to housing and transportation for behavioral health clients	- ACCESS collaborates with local housing agencies but faces challenges with availability, particularly for justice-involved individuals. - Transportation services are insufficient in rural areas, creating barriers to accessing care.	- Partner with regional transit providers to create affordable and reliable transportation options within the next 12 months. - Secure additional funding or grants to expand access to supported housing programs for individuals with behavioral health needs.
Expand workforce capacity to address behavioral health workforce shortages	- ACCESS faces high turnover in certain roles and struggles to recruit for rural areas. - Limited initiatives to build a pipeline of qualified candidates.	- Implement a "Call to Service" campaign to attract diverse candidates to behavioral health careers. - Partner with local colleges and universities to develop internship and training programs within the next 18 months. - Provide additional professional development opportunities to retain current staff.

Local Priority	Current Status	Plans
Improve data collection and analysis to monitor service quality and gaps in care	- Current data systems track service usage but are insufficient for evaluating quality or identifying trends. - Limited integration with statewide data-sharing initiatives.	- Implement an upgraded data system within the next 12 months to track outcomes, waitlists, and gaps in services. - Collaborate with state and local stakeholders to pilot a shared data portal for cross-agency collaboration. - Use data insights to inform decision-making and improve service quality.

IV.D System Development and Identification of New Priorities

Developing the local plans should include a process to identify local priorities and needs and the resources 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 builds on the ongoing communication and collaboration LMHAs and LBHAs have with local stakeholders. The primary purpose is to support local planning, collaboration, and resource development. The information provides a clear picture of needs across the state and support planning at the state level.

Use the table below to identify the local service area's priorities for use of any new funding should it become available in the future. Do not include planned services and projects that have an identified source of funding. Consider regional needs and potential use of robust transportation and alternatives to hospital care. Examples of alternatives to hospital care include residential facilities for people not restorable, outpatient commitments, and other people needing long-term care, including people who are geriatric mental health needs. Also consider services needed to improve community tenure and avoid hospitalization.

Provide as much detail as practical for long-term planning and:

- Assign a priority level of 1, 2, or 3 to each item, with 1 being the highest priority.

- Identify the general need.
- Describe how the resources would be used—what items or components would be funded, including estimated quantity when applicable.
- Estimate the funding needed, listing the key components and costs (for recurring or ongoing costs, such as staffing, state the annual cost).

Table 16: Priorities for New Funding

Priority	Need	Brief description of how resources would be used	Estimated cost	Collaboration with community stakeholders
1	***Detox Beds***	• *- Establish a 6-bed detox unit within a local hospital or standalone facility to address the growing need for substance use treatment.* *- Fund staff positions, including nurses, counselors, and medical oversight for detox services.*	$1,200,000 annually	*Collaborate with local hospitals, substance use treatment providers, and law enforcement to identify location and operational needs.*
2	***Intensive Outpatient Program (IOP)***	• *- Launch an IOP to bridge the gap between inpatient and outpatient care, targeting individuals transitioning out of crisis care.* *- Fund staff positions (therapists, case managers, administrative support) and operational costs.*	*$800,000 annually*	*Partner with local behavioral health providers and community organizations to identify referral pathways and service coordination.*

Priority	Need	Brief description of how resources would be used	Estimated cost	Collaboration with community stakeholders
3	Transportation Services	- Develop a transportation program to ensure rural residents have reliable access to behavioral health services. - Fund vehicles, drivers, and operational costs for a dedicated transport team.	$500,000 annually	Engage with local transit authorities, law enforcement, and healthcare providers to create a regional transportation network.
4	Supported Housing for Behavioral Health Clients	- Establish a 10-unit supported housing program for individuals transitioning from inpatient care or those at risk of hospitalization. - Fund rental subsidies, case management, and life skills programming.	$1,000,000 annually	Partner with housing authorities, local shelters, and advocacy groups to identify eligible participants and provide support services.
5	Expansion of Crisis Stabilization Services	- Expand crisis stabilization services by increasing bed capacity and hiring additional crisis intervention staff. - Equip the facility with telehealth capabilities for psychiatric consultations.	$1,500,000 annually	Collaborate with law enforcement, EMS, and local hospitals to ensure coordinated crisis response and utilization of stabilization services.

Appendix A: Definitions

Admission criteria – Admission into services is determined by the person's level of care as determined by the TRR Assessment found here for adults or here for children and adolescents. The TRR assessment tool is comprised of several modules used in the behavioral health system to support care planning and level of care decision making. High scores on the TRR Assessment module, such as items of Risk Behavior (Suicide Risk and Danger to Others) or Life Domain Functioning and Behavior Health Needs (Cognition), trigger a score that indicates the need for crisis services.

Community Based Crisis Program (CBCP) - Provide immediate access to assessment, triage, and a continuum of stabilizing treatment for people with behavioral health crisis. CBCP projects include contracted psychiatric beds within a licensed hospital, EOUs, CSUs, s, crisis residential units and crisis respite units and are staffed by medical personnel, mental health professionals, or both that provide care 24/7. CBCPs may be co-located within a licensed hospital or CSU or be within proximity to a licensed hospital. 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 or LBHA funding.

Community Mental Health Hospitals (CMHH), Contracted Psychiatric Beds (CPB) and Private Psychiatric Beds (PPBs) – 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 person's ability to function in a less restrictive setting.

Crisis hotline – 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, MCOT or other crisis services.

Crisis residential units (CRU) – Provide community-based residential crisis treatment to people with a moderate to mild risk of harm to self or others, who may have fairly severe functional impairment, and whose symptoms cannot be stabilized in a less intensive setting. Crisis residential units are not authorized to accept people on involuntary status.

Crisis respite units – Provide community-based residential crisis treatment for people who have low risk of harm to self or others, and who may have some functional impairment. Services may occur over a brief period of time, such as two hours, and generally serve people with housing challenges or assist caretakers who need short-term housing or supervision for the person they care for to avoid mental health crisis. Crisis respite units are not authorized to accept people on involuntary status.

Crisis services – Immediate and short-term interventions provided in the community that are designed to address mental health and behavioral health crisis and reduce the need for more intensive or restrictive interventions.

Crisis stabilization unit (CSU) – The only licensed facilities on the crisis continuum and may accept people on emergency detention or orders of protective custody. CSUs offer the most intensive mental health services on the crisis facility continuum by providing short-term crisis treatment to reduce acute symptoms of mental illness in people with a high to moderate risk of harm to self or others.

Diversion centers - Provide a physical location to divert people at-risk of arrest, or who would otherwise be arrested without the presence of a jail diversion center and connects them to community-based services and supports.

Extended observation unit (EOU) – Provide up to 48-hours of emergency services to people experiencing a mental health crisis who may pose a high to moderate risk of harm to self or others. EOUs may accept people on emergency detention.

Jail-based competency restoration (JBCR) - Competency restoration conducted in a county jail setting provided in a designated space separate from the space used for the general population of the county jail with the specific objective of attaining restoration to competency pursuant to Texas Code of Criminal Procedure Chapter 46B.

Mental health deputy (MHD) - Law enforcement officers with additional specialized training in crisis intervention provided by the Texas Commission on Law Enforcement.

Mobile crisis outreach team (MCOT) – A 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 people in the community.

Outpatient competency restoration (OCR) - A community-based program with the specific objective of attaining restoration to competency pursuant to Texas Code of Criminal Procedure Chapter 46B.

Appendix B: Acronyms

CBCP	Community Based Crisis Programs
CLSP	Consolidated Local Service Plan
CMHH	Community Mental Health Hospital
CPB	Contracted Psychiatric Beds
CRU	Crisis Residential Unit
CSU	Crisis Stabilization Unit
EOU	Extended Observation Units
HHSC	Health and Human Services Commission
IDD	Intellectual or Developmental Disability
JBCR	Jail Based Competency Restoration
LMHA	Local Mental Health Authority
LBHA	Local Behavioral Health Authority
MCOT	Mobile Crisis Outreach Team
MHD	Mental Health Deputy
OCR	Outpatient Competency Restoration
PESC	Psychiatric Emergency Service Center
PPB	Private Psychiatric Beds
SBHCC	Statewide Behavioral Health Coordinating Council
SIM	Sequential Intercept Model