



**Comprehensive Review of Community-
Based Crisis and Treatment Facilities
for Persons with Mental Health and
Substance Use Disorders
in Fiscal Year 2016**

**As Required By
2016-17 General Appropriations Act, House Bill 1,
84th Legislature, Regular Session, 2015 (Article II,
Department of State Health Services, Rider 80)**

**Health and Human Services Commission
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1. Executive Summary

The 2016-17 General Appropriations Act, House Bill (H.B.) 1, 84th Legislature, Regular Session, 2015 (Article II, Department of State Health Services [DSHS], Rider 80) requires DSHS to conduct a comprehensive review of contract funding requirements and standards governing community-based crisis and treatment facilities for persons with mental health and substance abuse disorders.

As part of the review, DSHS behavioral health program staff and regulatory staff, in collaboration with the Health and Human Services Commission (HHSC) and stakeholders, are to identify best practices for and unnecessary barriers to the effective delivery of mental health and substance abuse services by community-based crisis and treatment facilities.

Rider 80 also requires submission of a report, including a summary of activities related to the review, and recommendations for any changes to statutes or regulatory requirements needed to ensure the safe, effective, and efficient treatment of persons with mental health disorders, substance abuse disorders, or co-occurring mental health and substance abuse disorders in community settings.

Senate Bill (S.B.) 200, 84th Legislature, Regular Session, 2015, required the transfer of the legacy DSHS Mental Health and Substance Abuse (MHSA) division to HHSC on September 1, 2016. As a result, HHSC is now responsible for community-based crisis and treatment facilities. For purposes of this report, the legacy DSHS MHSA Division will be referred to the HHSC Behavioral Health Services Section.

There are four types of community-based crisis facilities in the State of Texas: crisis stabilization units, extended observation units, crisis residential units, and crisis respite units. Community-based crisis services provided in these facilities offer an alternative to costly inpatient care by treating individuals in the least restrictive environment, reducing use of local emergency rooms, diverting individuals from the criminal justice system, and minimizing law enforcement time spent transporting and assisting individuals in crisis. Most of these mental health crisis facilities are unlicensed and managed through contractual requirements.

Additionally, residential treatment facilities provide five types of residential services for substance use disorders (SUD) for adults and youth (13-17 years old): intensive residential treatment, supportive residential treatment, residential withdrawal management,¹ specialized residential services for women and youth, and Human Immunodeficiency Virus (HIV) residential services. SUD residential treatment facilities are required to be licensed and are primarily governed by statute, administrative rules, and contract requirements. There are no specific licenses for facilities providing co-occurring HIV and SUD treatment.

¹ The term “detoxification” has been changed to “withdrawal management.” American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. 5th ed. DSM-5.* Washington, DC: American Psychiatric Publishing. 2013.

The HHSC Behavioral Health Services Section and DSHS Division for Regulatory Services (DRS), in collaboration with stakeholders, identified several barriers to the effective delivery of mental health and SUD services including:

- Costly requirements for licensed crisis stabilization units
- Unlicensed crisis mental health facilities
- Challenges with providing integrated mental health and substance use disorder treatment within the same facility
- Inadequate number of mental health and SUD resources for children and youth
- Inadequate number of mental health regulations addressing the needs of children and youth in mental health facilities

The HHSC Behavioral Health Services Section plans will address the non-statutory recommendations by amending 25 Texas Administrative Code (TAC), Chapter 411, Subchapter M, Standards of Care and Treatment in Crisis Stabilization Units. DSHS DRS is addressing non-statutory recommendations through clarifying internal policies regarding the co-location of mental health and substance use treatment facilities, as well as authorizing exemptions for certain crisis stabilization unit facility standards considered cost prohibitive to operations. The HHSC Behavioral Health Services Section and DSHS DRS anticipate these rule and policy changes will positively affect crisis stabilization units and extended observation units.

In addition, options were identified to address statutory barriers. One option adds language to Texas Health and Safety Code, Chapter 577, exempting crisis stabilization units and crisis residential facilities from licensure. A second option allows the development of new license types for a fuller crisis facility continuum. This second option also allows certain providers to be exempted from licensure.

2. Introduction

Rider 80 requires DSHS DRS and the HHSC Behavioral Health Services Section to conduct a comprehensive review of contract funding requirements and standards governing community-based crisis and treatment facilities for persons with mental health and SUD.² As part of the review, the agency staff was required to collaborate with stakeholders to identify barriers and best practices for the effective delivery of mental health and SUD services by community-based crisis facilities.

S.B. 200 required the transfer of the legacy DSHS MHSA division, which administered this program, to HHSC on September 1, 2016. As a result, HHSC is now responsible for community-based crisis and treatment facilities. For purposes of this report, the legacy DSHS MHSA Division will be referred to the HHSC Behavioral Health Services Section.

² The term “substance abuse disorder” has been changed to “substance use disorder.” American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. 5th ed. DSM-5.* Washington, DC: American Psychiatric Publishing. 2013.

This report discusses the barriers facing mental health and substance use service delivery via community-based crisis services and facilities and provides options for overcoming these barriers.

3. Background

3.1 Overview of Community-Based Crisis Services and Facilities

Community-based crisis services provide alternatives to costly inpatient care by treating individuals in the least restrictive environment, reducing use of local emergency rooms, diverting individuals from the criminal justice system, and minimizing law enforcement time spent transporting and assisting individuals in crisis.³ Crisis services assist individuals get through a crisis situation without requiring a higher level of care.

Up to December 2016, each of the 37 Local Mental Health Authorities (LMHAs) and ValueOptions, a behavioral health organization for NorthSTAR, received HHSC Behavioral Health Services Section funding to provide crisis hotline and mobile crisis outreach team services. NorthSTAR was a publicly-funded, integrated care model with a managed care approach to the delivery of mental health and SUD services to the eligible residents of Dallas, Ellis, Collin, Hunt, Navarro, Rockwall, and Kaufman counties.

The HHSC Behavioral Health Services Section contracted with ValueOptions to manage the provider network, verify member eligibility, manage clinical authorizations, and pay claims for the delivery of mental health and SUD services.

Each crisis hotline operates 24-hours per day, 7-days per week (24/7). The hotlines function as the initial point of notification for LMHAs and NorthSTAR when an individual was experiencing a crisis. When the crisis hotline is called, a screening is conducted to determine the immediate level of need and to mobilize emergency services, if necessary. Mobile Crisis Outreach Teams (MCOTs) provide 24/7, prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up, and relapse prevention services. MCOTs respond to crisis calls in the community and collaborate closely with community partners, such as law enforcement and local emergency departments, to ensure behavioral health care needs are appropriately addressed.

As of January 1, 2017, the NorthSTAR model ceased operations and transitioned to the North Texas Behavioral Health Authority and to the local mental health authority serving Collin County, an entity known as LifePath Systems.

³ In accordance with Texas Health and Safety Code §571.004, the least restrictive appropriate setting is one that is available, provides the greatest probability of improvement, and is no more restrictive to an individual's physical or social rights than is necessary to provide the most effective treatment and to protect adequately against any danger the individual poses to himself or others. Community-based crisis services are recovery focused and aim to serve individuals in the least restrictive environment in the community as compared to a hospital in order to avoid more intensive services, which can be costly.

3.1.1 HHSC Behavioral Health Services Section-Funded Community-Based Crisis Facilities

Of the 37 LMHAs and ValueOptions, 22 entities operate community-based crisis facilities (see Appendix A) funded by HHSC Behavioral Health Services Section and/or through the Texas 1115 Medicaid Waiver.⁴

Crisis facilities may be staffed with mental health and medical professionals, as well as peer providers who offer assessment and psychiatric stabilization services to individuals with behavioral health issues. There are four types of HHSC-funded community-based crisis facilities, ranging from the most intensive mental health treatment (crisis stabilization units) to least intensive (crisis respite units).

Crisis Stabilization Units (CSU) are the only licensed facilities on the crisis continuum⁵ and may accept individuals 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 individuals with a high to moderate risk of harm to self or others.

Extended Observation Units (EOU) provide up to 48-hours of emergency services to individuals in mental health crisis who may pose a high to moderate risk of harm to self or others. EOUs may accept individuals on emergency detention.

Crisis Residential Units provide community-based residential crisis treatment to individuals 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 facilities are not authorized to accept individuals on involuntary status.

Crisis Respite Units provide community-based residential crisis treatment for individuals 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 individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons they care for to avoid mental health crisis. Crisis respite facilities are not authorized to accept individuals on involuntary status.

Health and Safety Code, Chapter 577, authorizes services provided in private mental hospitals and other mental health facilities to include CSUs. Health and Safety Code, §577.001(b) specifies: “A community center or other entity designated by the department to provide mental

⁴ The 82nd Texas Legislature directed HHSC to expand Medicaid managed care to achieve savings and to preserve hospital access to funding consistent with upper payment limit (UPL) funding. The best approach was determined to be through an 1115 Medicaid Waiver. The 1115 Texas Healthcare Transformation Waiver is a five-year Medicaid demonstration waiver that created the Delivery System Reform Incentive Payment (DSRIP) funding pool that is designed to support coordinated care and quality improvements through 20 Regional Healthcare Partnerships (RHP). Delivery System Reform Incentive Payment (DSRIP) is an incentive program developed to transform delivery systems through infrastructure development and testing innovative care models.

⁵ Title 25, Texas Administrative Code, Part 1, Chapter 134 and Chapter 411, Subchapter M.

health services may not operate a mental health facility that provides court-ordered mental health services without a license issued by the department under this chapter.” CSUs are the only licensed facility type on the crisis continuum. The other facilities on the crisis continuum are not licensed. Thus, the unlicensed facilities may not serve individuals on a court order for treatment, including temporary or extended court orders for mental health treatment and court orders for outpatient competency restoration treatment. Though CSUs are licensed facilities, they may not accept individuals on temporary or extended orders for mental health treatment as specified in 25 TAC, Chapter 411, Subchapter M, Standards of Care and Treatment in Crisis Stabilization Units.

3.1.2 1115 Medicaid Waiver-Funded Community-Based Crisis Facilities

With the federal approval of the Texas 1115 Waiver Medicaid request, LMHAs and private providers were able to obtain funding to establish behavioral health projects in their communities to address service gaps in mental health, substance use, and physical health. Many of these providers established CSUs, EOUs, crisis residential units, crisis respite units, and other mental health facilities.⁶ Since these facilities or projects were established utilizing a funding source outside of the HHSC Behavioral Health Services Section funding structure, the waiver funded entities' facility and clinical standards for operation are not subject to contract standards or monitoring required by HHSC Behavioral Health Services Section. Consequently, HHSC Behavioral Health Services Section has limited information about the number of community-based crisis facilities established with the waiver funds, or the organizations operating these facilities.

3.2 Overview of Substance Use Disorder Treatment Services and Facilities

Contracted SUD treatment services for youth and adults funded by the HHSC Behavioral Health Services Section aim to engage the individual and their family in recovery starting with outreach, the provision of treatment, and ongoing care. Pregnant women who use drugs intravenously and intravenous drug users are prioritized for receiving treatment services according to federal guidelines from the Substance Abuse and Mental Health Service Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant authorized by section 1921 of Title XIX, Part B, Subpart II and III, Public Health Service Act.

SUD treatment is evidence-based, holistic in design, and emphasizes coordination of care across the continuum. Treatment services include residential and ambulatory detoxification for adults, intensive and supportive residential services, and outpatient programs with varying intensities to meet individual needs and preferences. Services include family, group, and individual counseling, as well as educational presentations and other support services.

There are five types of SUD residential services for youth (13-17 years old) and adults.

⁶ Lopez MA & Stevens-Manser S. Texas 1115 Medicaid Demonstration Waiver: A Review of Behavioral Health Projects. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin. <http://sites.utexas.edu/mental-health-institute/files/2012/10/1115-Waiver-BH-Projects-Report-Final.pdf> Published: September 2014. Accessed: May 27 2016.

Intensive residential programs provide multidisciplinary clinical support to facilitate recovery from addiction in a structured treatment environment and have the following characteristics:

- Operational – 24/7
- Service hours – 30-hours per client per week
- Adult staff to client ratio when awake – 1:16
- Adult staff to client ratio when asleep⁷ – 1:32
- Number of programs⁸ – 18

Supportive residential treatment provides supportive residential treatment programs and longer-term (additional 30-60 days post intensive residential treatment, up to 90-days total) treatment for individuals who require less intense treatment and a structured environment to maintain sobriety. Services are delivered with the following characteristics:

- Operational – 24/7
- Service hours – 6-hours per client per week
- Adult staff to client ratio when awake – 1:20
- Adult staff to client ratio when asleep⁹ – 1:50
- Number of programs¹⁰ – 97

Residential withdrawal management provides nursing care, under the consultation of a medical director, to monitor an individual's intoxicated states and withdrawal from alcohol and other drugs and alleviate symptoms.¹¹ Services are delivered with the following characteristics:

- Operational – 24/7
- Service hours – licensing requirements do not include service hours due to nature of this service
- Adult staff to client ratio when awake – 2:12
- Adult staff to client ratio when asleep – 2:12 (with one more staff on duty for each additional one to 16 clients¹²)
- Number of programs¹³ – 43

Specialized residential services for women, women with children, and youth only provide intensive and supportive treatment environments for women, women with children, and youth in separate programs. The residential treatment for women and women with children includes gender-specific, trauma-informed counseling. The treatment services for youth are designed to engage the individual and the family in recovery efforts both in the home and at school. Services are delivered with the following characteristics:

- Youth staff-to-client ratio when awake – 1:8
- Youth staff to client ratio when asleep¹⁴ – 1:16

⁷ [25 TAC, Chapter 448, Subchapter I, §448.93\(d\)\(e\)](#)

⁸ Department of State Health Services, Regulatory and Licensing Division. Accessed April 2016.

⁹ [25 TAC, Chapter 448, Subchapter I, §448.93\(g\)\(h\)](#)

¹⁰ Department of State Health Services, Regulatory and Licensing Division. Accessed April 2016.

¹¹ [25 TAC, Chapter 448, Subchapter I, §448.902](#)

¹² [25 TAC, Chapter 448, Subchapter I, §448.902\(k\)\(1\)\(2\)](#)

¹³ Department of State Health Services, Regulatory and Licensing Division. Accessed April 2016.

¹⁴ [25 TAC, Chapter 448, Subchapter I, §448.905\(5\)](#)

The *HIV Residential* program is the only HHSC Behavioral Health Services Section-funded SUD residential treatment program providing specialized services for individuals who are HIV positive or who have been diagnosed with Acquired Immunodeficiency Disease.¹⁵

The Substance Abuse Prevention and Treatment Block Grant, funded by SAMHSA, pays for 87 percent of HHSC Behavioral Health Services Section expenditures for SUD services. A funding formula based on population, poverty, and need determines the amount of funding allocated for each of the 11 HHSC Behavioral Health Services Section regions in Texas, including the NorthSTAR service area. These regional provider contracts are competitively procured every four years.

The state also has a Medicaid benefit for SUD outpatient services (assessment, ambulatory detoxification, counseling, and medication assisted therapy) and SUD residential services (treatment, detoxification, and specialized services for women).

Each region has a continuum of services provided in accordance with the block grant guidelines, direction from the Texas Legislature, and the 2015-19 Health and Human Services System Strategic Plan. In fiscal year 2015, 15,712 individuals were served through SUD residential treatment facilities funded by the HHSC Behavioral Health Services Section.^{16,17}

4. Review of Contract Funding Requirements and Governing Standards

4.1 Community-Based Crisis Facilities

Services provided in community-based crisis facilities are less intensive than services provided in inpatient hospital facilities. Treatment in these facilities is designed to increase options for support closer to a patient's home and to avoid unnecessary cost by providing more flexibility regarding staffing and length of stay than inpatient hospitals. Currently, community-based crisis facility standards are based on national best practices published by the American Psychiatric Association (APA) Task Force on Psychiatric Emergency Services. The HHSC Behavioral Health Services Section has incorporated several interventions from the APA Task Force relating to the provision of crisis services into a document entitled *Information Item V – Crisis Services Standards* (Appendix B), which serves as an attachment to the performance contracts in place with all LMHAs. The *Information Item V- Crisis Services Standards* addresses licensed CSU, EOU, crisis residential, and crisis respite unit operations.

Of the four types of community-based crisis facilities discussed in this report, a CSU is the only community-based crisis facility type licensed. There are five CSUs in the state located in the following cities: Beaumont, Conroe, Houston, Kerrville, and Kilgore. Health and Safety Code, Chapter 577, Private Mental Hospitals and Other Mental Health Facilities, authorizes the HHSC

¹⁵ Department of State Health Services, Regulatory and Licensing Division. Accessed April 2016.

¹⁶ Department of State Health Services, Mental Health and Substance Abuse Division, Office of Decision Support, May 12, 2016.

¹⁷ DSHS is unable to collect the number of individuals served in non-DSHS funded SUD residential treatment facilities.

Behavioral Health Services Section to license CSUs. Health and Safety Code, §577.010 states the standards for community-based crisis stabilization and crisis residential services must be less restrictive than the standards for mental hospitals. However, in many ways, the current standards for licensure for CSUs are not less restrictive than hospital standards.

EOUs, crisis residential units, and crisis respite units are not licensed. Crisis residential units and crisis respite units may be operated under an exemption in Health and Safety Code, Chapter 247, Assisted Living Facilities, §247.004. This provision exempts assisted living facilities funded, in whole or in part, by HHSC Behavioral Health Services Section from licensure requirements regulated by the Department of Aging and Disability Services (DADS). However, EOUs, crisis residential units, and crisis respite units may provide services beyond those in assisted living facilities and may include those services associated with facilities in Health and Safety Code, Chapter 577.

In order to address this issue, standards of care in these facilities are established contractually through the application of *Information Item V – Crisis Services Standards*. Health and Safety Code, Section 577.001, Private Mental Hospitals and Other Mental Health Facilities, requires that court-ordered mental health services be provided in a licensed facility. Therefore, EOUs are not authorized to provide court-ordered mental health services, such as orders of protective custody. The unlicensed¹⁸ EOU is limited to providing mental health services up to 48-hours as authorized by Health and Safety Code, Chapter 573, Emergency Detention. Additionally, though Health and Safety Code, Section 577.010, authorizes the HHSC Behavioral Health Services Section to adopt standards for CSUs and crisis residential units, there are currently no standards of care in the TAC specific to crisis residential units.

4.2 Oversight of Community-Based Crisis Facilities

In 2008, the HHSC Behavioral Health Services Section's Quality Management and Compliance (QM) Unit began conducting on-site surveys of crisis respite units, crisis residential units, and EOUs. The purpose of the reviews is to ensure the safety and accessibility of the individuals being served. The QM Unit conducts reviews when new facilities are identified or when existing facilities are modified to another facility-type (for instance, if an EOU is transitioned to a crisis respite unit). The site visit includes a document review, such as medical records, and physical plant observations.

The HHSC Behavioral Health Services Section monitors facility compliance with contract requirements (facility and clinical service standards), which incorporate provisions of the Americans with Disabilities Act, International Fire Code, and Code of Federal Regulations. If the review yields results that confirm a finding or issue with facility or treatment standards, providers are required to submit a Corrective Action Plan (CAP). The CAPs are then reviewed by the QM Unit and program services staff, and either approved or disapproved by the QM Unit. For those facilities with repeat findings, the QM Unit refers the information to the Contracts Management Unit for a joint decision regarding penalties and sanctions pursuant to contract

¹⁸ Although also unlicensed, this does not apply to crisis respite and crisis residential facilities because they do not admit individuals on involuntary status.

provisions. If findings are repeatedly egregious, the HHSC Behavioral Health Services Section has the authority to provide technical assistance to promote correction of the issue.

If necessary, the HHSC Behavioral Health Services Section also has the authority to cease program funding for a crisis facility operated by an LMHA or LBHA since there is a contractual relationship. However, these expectations and oversight is not in place for entities other than LMHAs and LBHAs. A fuller continuum of licensed crisis facilities would allow other local entities to provide these valuable services while ensuring that appropriate safety measures and oversight are in place. DSHS DRS would have the authority under statute to regulate these facilities including ensuring that unsafe facilities cease operations.

4.3 Oversight of Substance Use Disorder Treatment Facilities

While mental health crisis facilities are largely managed by contract requirements, SUD treatment facilities are licensed by DSHS DRS and are governed by statute and administrative rules. DSHS is statutorily authorized to license facilities treating substance use disorders.¹⁹ In addition, the admissions practices, rights of persons receiving treatment, consent for voluntary and involuntary treatment, discharge practices, and other requirements for SUD treatment facilities, including physical plant requirements, are outlined in statute.^{20, 21} These statutes are operationalized in 25 TAC, Chapter 448, Standard of Care, which describes the facility requirements and standards of care. In order to ensure understanding of these rules, DSHS requires providers of SUD residential treatment facilities to attend a pre-licensure conference. In addition, HHSC Behavioral Health Services Section-funded SUD residential treatment facilities must comply with the federal Substance Abuse Prevention and Treatment Federal Block Grant requirements.²²

DSHS DRS conducts unannounced on-site inspections of SUD treatment facilities. Inspections of SUD residential and outpatient facilities and opioid treatment programs are conducted, on average, every two years. The inspection includes a review of medical records, policies, procedures, and the physical plant. DSHS DRS enforces the correction of non-compliance issues with providers. If the facility fails to correct issues of non-compliance, the case is referred to the DSHS DRS Enforcement Review Committee for action.

Additionally, DSHS DRS staff investigate complaints and incidents reported by community-based crisis facilities and substance use residential treatment facilities. Complaints and incidents include allegations of abuse, neglect, and exploitation, unethical or unprofessional behavior, and health and safety issues. Inspectors refer issues and complaints relating to the conduct or action(s) of licensed professionals, interns, and applicants for professional licensure to the appropriate licensing boards, according to DSHS policy.

¹⁹ [Health and Safety Code, Chapter 464](#)

²⁰ [Health and Safety Code, Chapter 164](#)

²¹ [Health and Safety Code, Chapter 462](#)

²² Substance Abuse and Mental Health Service Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant authorized by section 1921 of Title XIX, Part B, Subpart II and III of the Public Health Service (PHS) Act. <https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapXVII-partB.pdf> Accessed June 3, 2016.

5. Stakeholder Involvement

5.1 Community-Based Crisis Facilities

The HHSC Behavioral Health Services Section held four stakeholder meetings in 2015: one in June, two in August, and one in November. The purpose of the meetings was to revise the *Information Item V – Crisis Services Standards* for EOUs. Representatives from the LMHAs, the Texas Council of Community Centers, and Disability Rights Texas expressed interest in developing or amending laws, rules, and policies governing mental health crisis facilities, particularly those related to EOUs and the provision of services for individuals on emergency detention.

The HHSC Behavioral Health Services Section plans to incorporate several recommendations into the fiscal year 2017 *Information Item V – Crisis Services Standards*, including:

- Clarifying protocols regarding capacity to consent
- Clarifying discharge protocols for individuals on voluntary status
- Requiring facilities to develop staffing plans to address acuity and numbers of individuals served
- Amending facility requirements pertaining to telephone access

The HHSC Behavioral Health Services Section presented the recommendations to the Joint Commission on Access and Forensic Services on August 31, 2016, and at the statewide LMHA Behavioral Health Consortia on September 29, 2016. The HHSC Behavioral Health Services Section held additional stakeholder meetings to discuss the recommendations in this report on October 14 and October 28, 2016. For a comprehensive list of external stakeholders who helped develop the recommendations, please see Appendix C, External Stakeholders.

5.2 Barriers in Substance Use Disorder Treatment Facilities

HHSC and DSHS held four stakeholder meetings in 2014 and an additional stakeholder meeting on April 8, 2016, after the passage of S.B. 1560, 84th Legislature, Regular Session, 2015, to revise standards of care in 25 TAC, Chapter 448, relating to standard of care. Stakeholders who participated in these meetings included:

- Texas Department of Juvenile Justice
- Salvation Army
- Travis County Juvenile Probation
- Austin Travis County Integral Care
- Behavioral Health Alliance of Texas
- Texas Department of Criminal Justice
- Association of Addiction Professionals
- Association of Substance Abuse Professionals
- Alcohol and Drug Abuse Council for the Concho Valley
- Hays Caldwell Council on Alcohol and Drug Abuse
- Independent substance abuse facility owners and administrators
- General hospital representatives

- Advocacy organizations
- Other interested individuals

Three potential barriers to service integration were identified during the Chapter 448 stakeholder meetings and were subsequently addressed:

Barrier 1.1: Concerns regarding the ability of SUD treatment facilities to co-locate with other types of programs and services.

Option 1.1: DSHS DRS issued a guidance letter to SUD treatment providers in November 2014 allowing co-location of SUD treatment providers with other types of treatment programs if the program created an organizational structure that ensured adequate client, drug, and record protection and full legal compliance in those particular areas of concern. The co-location guidelines issued in the letter to providers were incorporated into the new proposed amendments to rules 25 TAC, Chapter 411, Subchapter M, relating to Standards of Care and Treatment in Crisis Stabilization Units.

Barrier 1.2: Denial of admission prohibited solely on an individual taking medication as prescribed. Two SUD treatment providers expressed concern that admitting an individual who is taking methadone (as a client of an outpatient narcotic treatment program) would be counterproductive or at odds with their program treatment model. The HHSC Behavioral Health Services Section and DSHS DRS disagreed.

Option 1.2: The new proposed amendments to rules 25 TAC, Chapter 411, Subchapter M, Standards of Care and Treatment in Crisis Stabilization Units indicate that a SUD treatment facility shall not deny an individual admission, or discharge an individual from treatment, solely based on the client having a disability, which includes an individual who is taking medication as prescribed, including methadone or other medications approved by the United States Food and Drug Administration, to treat opiate addiction.

Barrier 1.3: Confidentiality of client records resulting in limitation of integration of services. Providers expressed concern that current federal regulations prohibit the records of SUD clients to be shared among other health care providers and programs, thereby restricting the integration of services.

Option 1.3: On February 9, 2016, SAMHSA published proposed revisions to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations in Title 42, Code of Federal Regulation, Part 2, in an effort to facilitate information exchange within new health care models that seek integration of services. Adoption of these federal rules is anticipated in 2017. These rules will assist with development of guidance letters issued to providers by DSHS DRS, as well as the development of policy at HHSC about the exchange of information regarding comorbid treatment.

6. Additional Barriers and Major Findings

The HHSC Behavioral Health Services Section and DSHS DRS, in collaboration with stakeholders, identified several barriers to the effective delivery of mental health and SUD services by community-based crisis facilities. The HHSC Behavioral Health Services Section and DSHS DRS determined some changes could be addressed by amending existing TAC rules.

Recommendations include both non-statutory and legislative actions and entail two phases. Phase one involves modifying existing policies and rules in the TAC pertaining to CSUs. Such changes would impact CSUs and EOUs only. Phase two involves legislative action that would impact the continuum of community-based crisis facilities. The following are identified barriers and recommendations for change.

6.1 Barriers Specific to Crisis Stabilization Units

Barrier 2.1: Facility construction standards in 25 TAC, Chapter 134, Private Psychiatric Hospitals and Crisis Stabilization Units, are the same for hospitals and CSUs. As a result, this provision does not reflect the directive in Health and Safety Code, Section 577.010(c), Private Mental Hospitals and Other Mental Health Facilities, that HHSC Behavioral Health Services Section shall adopt less restrictive standards for CSUs and crisis residential units than those for private psychiatric hospitals.

Option 2.1: Amend 25 TAC, Chapter 134, relating to Private Psychiatric Hospitals and Crisis Stabilization Units, as well as, 25 TAC, Chapter 411, Subchapter M, relating to Standards of Care and Treatment in Crisis Stabilization Units. Revisions to these chapters in TAC would create lesser standards for operating a CSU.

Barrier 2.2: There are only five CSUs in Texas operated by the following LMHAs: Community HealthCore, Hill Country MHDD Centers, The Harris Center for Mental Health and IDD, Spindletop Center, and Tri-County Services. The reason for the limited number of CSUs may be partially due to construction costs to establish a new facility. Physical plant requirements in TAC, Chapter 134, Private Psychiatric Hospitals and Crisis Stabilization Units, stipulate that a CSU must have a commercial grade kitchen, which often represents a financial deterrent for the construction of a new licensed, freestanding CSU. Three of the currently licensed CSUs do not utilize their commercial grade kitchens because it is more cost effective for them to contract with a provider for prepared food delivery. In addition to the commercial grade kitchen, there may be additional requirements to have separate heating, ventilation, and air conditioning, as well as a separate generator from the host facility.

Recommendation 2.2: The HHSC Behavioral Health Services Section can develop internal policies allowing CSUs to meet the less restrictive licensing standards as hospital-based CSUs. DSHS DRS implemented an interim policy to address cost-prohibitive and outdated requirements until the current rules are modified through the formal rulemaking process. During the rule development process, DSHS DRS staff will give consideration to the various settings related to the operation of a CSU, such as whether the facility is hospital-based, or freestanding. There may be some differences in standards for facilities attached to hospitals versus

freestanding facilities. However, the focus will be on creating less restrictive standards of care and facility standards. As a result of the DSHS DRS interim policy change, more LMHAs will be able to have CSUs. DSHS DRS implemented a less restrictive policy for facility standards and was therefore able to license the Spindletop Center's new CSU operating within a licensed general or psychiatric hospital. The DSHS DRS allowed the Spindletop CSU to contract with the hospital for the delivery of meal services.

Barrier 2.3: Individuals in crisis have a high need for specialized mental health staff who can quickly assess and evaluate an individual, decide jointly on a plan of care, and initiate the plan. Staffing patterns are determined by the ratio and acuity of individuals, and although staffing patterns are generally lower in CSUs than hospitals, the CSU staffing costs will be relatively high as a consequence of the individuals' acuity in these facilities. Additionally, recruiting and maintaining qualified staff can be problematic due to existing workforce shortages of mental health professionals across the state, especially in rural areas.

Recommendation 2.3: The HHSC Behavioral Health Services Section can revise rules that broaden the types of mental health professionals who staff CSUs to include behavioral health professionals, such as licensed practitioners of the healing arts and licensed chemical dependency counselors. The physician, preferably a psychiatrist, shall maintain the role of director. However, some functions may be delegated to psychiatric advanced practice nurses and physician's assistants, as appropriate, and with appropriate supervision, which would help alleviate staffing concerns.

6.2 Unlicensed Crisis Facilities

Barrier 3.1: EOUs, crisis residential units, and crisis respite units are unlicensed and currently operating under HHSC Behavioral Health Services Section contract standards consistent with APA guidelines applicable to psychiatric emergency and crisis services. Health and Safety Code, Section 577.001, Private Mental Hospitals and Other Mental Health Facilities, requires court-ordered mental health services to be provided in a licensed facility; therefore, EOUs are not authorized to provide court-ordered mental health services, such as orders of protective custody. The unlicensed EOU is limited to providing mental health services up to 48-hours as authorized by Health and Safety Code, Chapter 573, Emergency Detention. Although also unlicensed, this provision does not apply to crisis respite and crisis residential facilities because they do not admit individuals on involuntary status. Additionally, Health and Safety Code, Section 577.010, requires HHSC to adopt standards for CSUs and crisis residential units. At this time, there are no standards of care in the TAC specific to crisis residential units, or a license for this facility type as issued under Health and Safety Code, Chapter 577.

The EOUs provide a level of care that should extend no longer than a 48-hour period. The purpose of the 48-hour period is to provide crisis-level services to individuals in the community in the least restrictive environment. Stakeholders have articulated concerns regarding the rights of individuals with acute symptoms being served in an unlicensed, locked facility, such as an EOU. The HHSC Behavioral Health Services Section QM reviews of existing EOU facilities resulted in a number of findings which could impact the health and safety of individuals in EOUs. Additionally, during stakeholder meetings, providers expressed some individuals are

being held longer than the 48-hours currently allowed by law because patients in need of additional care cannot be transferred when there are no available licensed inpatient beds in the community.

Option 3.1: Amend THSC, Chapter 577, Section 577.001(b) to do the following:

- Direct that a community center or other entity designated by the department to provide mental health services may not operate an inpatient mental health facility that provides court-ordered mental health services under section 574.034 or 574.035 without a license issued by the department under this chapter.
- Permit the department to issue one or more types of licenses for community-based crisis facilities or treatment facilities that provide crisis stabilization, extended observation, crisis residential, or crisis respite services.
- Require a provider to obtain a license issued under this chapter if operating a CSU, EOU, crisis residential unit, or crisis respite unit if providing crisis services to individuals with mental health disorders.
- Direct HHSC to adopt rules that establish requirements for licensure for CSUs, EOUs, crisis residential units, and crisis respite units.

Amend THSC, Chapter 577, Section 577.002 relating to Exemptions from Licensing Requirement to exempt community centers, LMHAs, LBHAs, and their subcontractors from being licensed under this chapter if they operate a CSU, EOU, crisis residential unit, or crisis respite unit.

Additionally, amend THSC, Chapter 577, by striking Section 577.009 relating to Limitation On Certain Contracts.

6.3 Challenges with Providing Integrated Care

Barrier 4.1: Many individuals served in crisis facilities have co-occurring mental health and substance abuse disorders. Rules regarding the delivery of mental health and SUD services create barriers for integrated treatment. For example, 25 TAC, Chapter 134.21(c)(4), allows for one license per facility. While this requirement does not prohibit the delivery of both mental health and SUD services, a mental health diagnosis must be the individual's primary diagnosis. The State Medicaid Plan requires SUD treatment facilities to be licensed in order to be reimbursed for SUD treatment services.²³ Consequently, unlicensed crisis residential facilities are ineligible for Medicaid reimbursement for SUD services provided to Medicaid eligible individuals.

The definitions and treatment criteria may also pose a barrier to accessing treatment for individuals whose primary diagnosis is SUD, but have an underlying mental illness. Health and Safety Code, Chapter 571, defines mental illness as “an illness, disease, or condition, other than epilepsy, dementia, substance abuse, or intellectual disability that, (a) substantially impairs a person's thought, perception of reality, emotional process, or judgment; or, (b) grossly impairs

²³ State Plan Attachments – Appendix 1 to 3.1-A Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Medically Needy. Item (13d) Substance Abuse and Dependency Treatment Services (SUD). <http://www.bhsc.state.tx.us/medicaid/about/state-plan/docs/basic-state-plan-attachments.pdf>.

behavior as demonstrated by recent disturbed behavior.”²⁴ This definition of mental illness excludes individuals with a sole diagnosis of SUD from receiving treatment at crisis treatment facilities if their only presenting issue is SUD without a primary psychiatric diagnosis.

Option 4.1: None.

Barrier 4.2: There are existing statutory barriers to serving individuals with SUD in the same facility that provides treatment for mental illness. The Health and Safety Code gives statutory authority to provide involuntary treatment for individuals with SUDs or mental illness. However, these statutory provisions were initially developed 30 years ago. The standards to provide involuntary mental health treatment have kept pace with best practices in mental health treatment while the standards to provide involuntary SUD treatment have not.

Option 4.2: One option to address this barrier is to amend the sections of the Health and Safety Code describing the process for involuntary SUD treatment to align with current processes described for involuntary mental health treatment. The changes would provide parity between SUD treatment and mental health treatment. Additionally, if the civil involuntary SUD statutes resemble the much more prevalent civil involuntary mental health statutes, some individuals who enter involuntary SUD treatment through the criminal justice system may be diverted to the civil system, sparing criminal records, which, among other things, can be a barrier to employment.

6.4 Few Regulations for Mental Health Crisis Facilities Serving Children and

Barrier 5.1: There is one LMHA operating a crisis respite facility for youth funded by HHSC.²⁵ There are only a few existing standards in the TAC²⁶ addressing serving children and youth in crisis facilities, such as: 1) requiring children and youth to be separated from adults; 2) requiring children under the age of 13 to be separated from youth; and 3) requiring staff to have specialized training in developmental issues, as well as mental health and SUD issues, in order to serve and better treat this minority population.

In addition, there are approximately eighteen 1115 Medicaid Waiver projects reporting provision of crisis stabilization services to youth in facility settings.²⁷ As previously mentioned, these 1115 Medicaid Waiver facilities or projects were established utilizing a funding source outside of the HHSC Behavioral Health Services Section funding structure; therefore, the waiver funded entities' facility and clinical standards for operation are not subject to contract standards or monitoring required by the HHSC Behavioral Health Services Section.

²⁴ THSC, Section 571.003 (14)

²⁵ Tarrant County MHMR operates a separate DSHS-funded crisis respite facility for youth.

²⁶ Title 25, Texas Administrative Code, Chapter 412, Subchapter G

²⁷ Lopez MA & Stevens-Manser S. Texas 1115 Medicaid Demonstration Waiver: A Review of Behavioral Health Projects. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin. <http://sites.utexas.edu/mental-health-institute/files/2012/10/1115-Waiver-BH-Projects-Report-Final.pdf> Published: September 2014. Accessed: May 27 2016.

Option 5.1: Amend THSC, Chapter 577, Section 577.001(b) to do the following:

- Direct that a community center or other entity designated by the department to provide mental health services may not operate an inpatient mental health facility that provides court-ordered mental health services under section 574.034 or 574.035 without a license issued by the department under this chapter.
- Permit the department to issue one or more types of licenses for community-based crisis facilities or treatment facilities that provide crisis stabilization, extended observation, crisis residential, or crisis respite services.
- Require a provider to obtain a license issued under this chapter if operating a CSU, EOU, crisis residential unit, or crisis respite unit if providing crisis services to individuals with mental health disorders.
- Direct HHSC to adopt rules that establish requirements for licensure for CSUs, EOUs, crisis residential units, and crisis respite units.²⁸

Amend THSC, Chapter 577, Section 577.002 relating to Exemptions from Licensing Requirement to exempt community centers, LMHAs, LBHAs, and their subcontractors from being licensed under this chapter if they operate a CSU, EOU, crisis residential unit, or crisis respite unit.

Additionally, amend THSC, Chapter 577, by striking Section 577.009 relating to Limitation On Certain Contracts.

7. Recommendations

Several barriers impacting the effective delivery of mental health and SUD services by community-based crisis and treatment facilities became evident as a result of the coordinated, comprehensive review. The HHSC Behavioral Health Services Section and DSHS DRS, in collaboration with stakeholders, identified several changes which could improve the services provided in community-based crisis and SUD treatment facilities. The recommendations include both statutory and non-statutory changes which could address these barriers.

²⁸ The creation of rules governing the standards of care received in crisis facilities could address specific issues related to serving youth in crisis facilities.

Recommended Statutory Changes: Options for Addressing Barriers to Treatment

Option 1:

Amend THSC, Chapter 577, relating to Private Mental Hospitals and Other Mental Health Facilities to include striking Section 577.001(b). This change would allow a community center, LMHA, LBHA, or their subcontractors to operate a CSU and serve individuals on a court order for mental health treatment. This option would also require modification to 25 TAC, Chapter 411, Subchapter M, Section 411.608, relating to Admission Criteria, as the rule prohibits individuals on a temporary or extended court order for mental health treatment under THSC, Chapter 574.034 or 574.035 from being served in a CSU.

Additionally, amend THSC, Chapter 577, Section 577.002 relating to Exemptions from Licensing Requirement to exempt community centers, LMHAs, LBHAs, and their subcontractors from being licensed under this chapter if they operate a CSU or crisis residential unit.

Option 2:

Amend THSC, Chapter 577, Section 577.001(b) to do the following:

- Direct that a community center or other entity designated by the department to provide mental health services may not operate an inpatient mental health facility that provides court-ordered mental health services under Section 574.034 or 574.035 without a license issued by the department under this chapter.
- Permit the department to issue one or more types of licenses for community-based crisis facilities or treatment facilities that provide crisis stabilization, extended observation, crisis residential, or crisis respite services.
- Require a provider to obtain a license issued under this chapter if operating a CSU, EOU, crisis residential unit, or crisis respite unit if providing crisis services to individuals with mental health disorders.
- Direct HHSC to adopt rules establishing requirements for licensure for CSUs, EOUs, crisis residential units, and crisis respite units.

Additionally, amend THSC, Chapter 577, Section 577.002 relating to Exemptions from Licensing Requirement to exempt community centers, LMHAs, LBHAs, and their subcontractors from being licensed under this chapter if they operate a CSU, EOU, crisis residential unit, or crisis respite unit.

Finally, amend THSC, Chapter 577, by striking Section 577.009 relating to Limitation on Certain Contracts.

Recommended Non-statutory Changes: Addressing Barriers to Treatment

- Amend 25 TAC, Chapter 411, Subchapter M, Standards of Care and Treatment in Crisis Stabilization Units.
- Continue to refine internal policies allowing for hospital-based CSUs to meet less restrictive licensing standards such as, an exemption from having a commercial grade kitchen.

List of Acronyms

Acronym	Full Name
APA	American Psychiatric Association
CAP	Corrective Action Plan
CSU	Crisis Stabilization Unit
DADS	Department of Aging and Disability Services
DRS	Division for Regulatory Services
DSHS	Department of State Health Services
EOU	Extended Observation Unit
H.B.	House Bill
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
LBHA	Local Behavioral Health Authority
LIDDA	Local Intellectual and Developmental Disability Authority
LMHA	Local Mental Health Authority
MCOT	Mobile Crisis Outreach Team
MHSA	Mental Health and Substance Abuse
QM	Quality Management and Compliance Unit
SAMHSA	Substance Abuse and Mental Health Service Administration
S.B.	Senate Bill
SUD	Substance Use Disorder
TAC	Texas Administration Code

Appendix A: Fiscal Year 2016 HHSC-Funded Community-Based Crisis Facilities

Local Authorities	Community-Based Crisis Alternative
Andrews Center	Crisis respite
Betty Hardwick Center	Crisis respite
Austin Travis County Integral Care	Crisis respite
Bluebonnet Trails Community MHMR Center	Extended observation unit, crisis respite
Burke Center	Extended observation unit, crisis residential
Camino Real Community Services	Crisis residential
Center for Health Care Services	Extended observation unit
Center for Life Resources	Crisis respite
Central Plains Center	Crisis respite
Community HealthCore	Crisis stabilization unit, extended observation unit, crisis residential
Emergence Health Network	Crisis residential
Gulf Bend MHMR Center	Extended observation unit
Heart of Texas Region MHMR Center	Extended observation unit, crisis respite, crisis residential
Helen Farabee Centers	Crisis respite
Hill Country MHDD Centers	Crisis stabilization unit
MHMR of Tarrant County	Crisis respite, youth crisis respite, crisis residential
MHMR Services for the Concho Valley	Crisis respite
Nueces County MHMR Community Center	Crisis respite
Spindletop Center	Crisis stabilization unit, extended observation unit, crisis respite, crisis residential
The Harris Center for Mental Health and IDD	Crisis peer respite
Tri-County Services	Crisis stabilization unit
West Texas Centers	Crisis respite

Appendix B: Information Item V Crisis Service Standards

I. Hotline

A. Definition

A hotline is continuously available telephone service staffed by trained and competent crisis staff that provides information, screening and intervention, support, and referrals to callers 24 hours per day, seven days per week. Any entity providing hotline services for any portion of the day must be accredited by the American Association of Suicidology (AAS).

B. Goals

- Immediate telephone response to a real or potential crisis situation.
- Immediate activation and coordination of the mental health crisis response system.

C. Description

The hotline is an integrated component of the overall crisis program; it operates continuously and is accessible toll-free throughout the local service area. The hotline serves as the first point of contact for mental health crises in the community, providing confidential telephonic triage to determine the immediate level of need and to mobilize emergency services for the caller if necessary. Trained and competent paraprofessionals may answer the hotline and provide information and non-crisis referrals; however, a trained and competent Qualified Mental Health Professional (QMHP-CS) is required to provide screening and assessment of the nature and seriousness of the call. The initial assessment leads to immediate and appropriate referrals for assistance or treatment. The hotline facilitates referrals to 911, a Mobile Crisis Outreach Team, or other crisis services and conducts follow-up contacts to ensure that callers successfully accessed the referred services. If an emergency is not evident after further screening or assessment, the hotline includes referral to other appropriate resources within or outside the Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA). The hotline works in close collaboration with local law enforcement, 211, and 911 systems.

D. Standards

The hotline must be accredited by AAS and integrated with the LMHA's local crisis response system including the Mobile Crisis Outreach Team and other crisis services in the LMHA's crisis service array. The hotline must also meet minimum scoring requirements outlined by the Department of State Health Services (DSHS) below. If the LMHA contracts with an outside entity to provide all or part of the hotline service, the contractor must also be accredited by AAS, meet minimum scoring requirements outlined below and remain contractually responsible for compliance with the applicable standards.

For all components, under each area, excluding Lethality Assessment and Rescue Services in the 9th and 10th edition, a minimum component score of 2 is required and an area minimum score is required as shown below. The contractor should use the edition of the AAS Organization Accreditation Standards Manual that is applicable to the year of accreditation.

Listed below are the minimum scores acceptable to meet DSHS standards in each area described in the [8th, 9th, and 10th Edition of the AAS Organization Accreditation Standards Manual](#).

AREA	8 th Ed MINIMUM SCORE	9 th Ed MINIMUM SCORE	10 th Ed MINIMUM SCORE
1. Administration and Organizational Structure	12	11	14
2. Training Program (8 th ed)/ Screening, Training, and Monitoring Crisis Workers	24	16	16
3. General Service Delivery	21	16	16
4. Services in Life-Threatening Situations	16	8	8
5. Ethical Standards and Practice	19	13	13
6. Community Integration	13	9	9
7. Program Evaluation	18	10	10

II. Mobile Crisis Outreach Team

A. Definition

Mobile Crisis Outreach Teams (MCOTs) provide a combination of crisis services including emergency care, urgent care, and crisis follow-up and relapse prevention to the child, youth, or adult in the community.

- **Emergency Care Services** – Mental health community services or other necessary interventions directed to address the immediate needs of an individual in crisis in order to assure the safety of the individual and others who may be placed at risk by the individual's behaviors, including, but not limited to, psychiatric evaluations, administration of medications, hospitalization, stabilization or resolution of the crisis. (25 TAC, Subchapter G, §412.303, (20), general provisions) ○ Requirements per 25 TAC, Subchapter G, §412.314, (1)(B), emergency care services: If during a screening it is determined that an individual is experiencing a crisis that may require emergency care services, the QMHP-CS must:
 - (i) take immediate action to address the emergency situation to ensure the safety of all parties involved;
 - (ii) activate the immediate screening and assessment processes as described in §412.321 of this title (relating to Crisis Services); and
 - (iii) provide or obtain mental health community services or other necessary interventions to stabilize the crisis.
- **Urgent Care Services** - Mental health community services or other necessary interventions provided to persons in crisis who do not need emergency care services, but

who are potentially at risk of serious deterioration. (25 TAC, Subchapter G, §412.303, (61), general provisions) ○ Requirements per 25 TAC, Subchapter G, §412.314, (1) (C), urgent care services: If the screening indicates that an individual needs urgent care services, a QMHP-CS shall, within eight hours of the initial incoming hotline call or notification of a potential crisis situation:

- (i) perform a face-to-face assessment; and
- (ii) provide or obtain mental health community services or other necessary interventions to stabilize the crisis.

B. Goals

- Prompt assessment and evaluation in the community
- Stabilization in the least restrictive environment
- Crisis resolution
- Linkage to appropriate services
- Reduction of inpatient and law enforcement interventions

C. Description

MCOTs are clinically staffed mobile treatment teams that provide prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up, and relapse prevention services for individuals in the community. These services shall reach individuals at their place of residence, school and/or other community-based safe locations, 24 hours per day, 365 days per year. Although MCOTs may transport an individual for the purpose of obtaining crisis services, if the MCOT determines that they cannot transport the individual safely, they may arrange for or coordinate transportation with law enforcement. MCOTs shall have arrangements for back-up and linkages with other services and referral services.

Children and their families shall receive crisis services unless it is contraindicated to include the family. Children's crisis services are flexible, multi-faceted, and immediately accessible services provided to children and youths at high risk for hospitalization or out-of-home placement and their families. These services shall reach individuals at their place of residence, school and/or other community-based safe locations. Services shall be designed to be family-focused, intensive, and time-limited.

D. Standards

1. Availability

- a. Emergency care services shall be available 24 hours per day, seven days per week.
 - 1) Urban LMHAs:
 - a) One MCOT shall be on call 24 hours a day, seven days a week; and
 - b) In addition, a minimum of one MCOT shall be on duty during peak crisis hours, 84 hours per week to immediately respond to crisis calls.
 - 2) Rural LMHAs:
 - a) Mobile outreach capability shall be maintained throughout the local service area 24 hours a day seven days a week; and
 - b) One MCOT shall be on duty during peak crisis hours, 56 hours per week to immediately respond to crisis calls.

- b. Contractor shall respond to emergent crises within one hour and to urgent crises within eight hours.
- c. Initial crisis follow-up and relapse prevention services shall be provided within 24 hours of the initial call or contact.

2. Staffing Standards

- a. A MCOT at a minimum shall be comprised of the following:
 - 1) Urban MCOT: A QMHP-CS a physician (preferably a psychiatrist), advance practice nurse (APN), registered nurse (RN), physician assistant (PA), or licensed practitioner of the healing arts (LPHA) , or 1 LPHA may be deployed with trained and competent paraprofessional;
 - 2) Rural MCOT: A QMHP-CS, a physician (preferably a psychiatrist), advance practice nurse (APN), physician assistant (PA), registered nurse (RN), Qualified Mental Health Professional (QMHP-CS) or licensed practitioner of the healing arts (LPHA). If they are not deployed as part of the MCOT, they must be available to provide face-to-face assessment as needed or clinically indicated, or 1 LPHA may be deployed with a trained and competent paraprofessional
- b. A psychiatrist shall serve as the medical director for all crisis services and must approve all policies, procedures, and protocols used in crisis services.
- c. All MCOT staff shall receive crisis training that includes but is not limited to:
 - 1) Signs, symptoms, and crisis response related to substance use and abuse;
 - 2) Signs, symptoms, and crisis response to trauma, abuse, and neglect; and
 - 3) Assessment and intervention for children and youths.
- d. All MCOT staff providing screenings, assessments, and/or interventions must be either a physician (preferably a psychiatrist), an APN, an RN, a PA, a LPHA, or a QMHP-CS.
- e. Contractor shall develop and implement written policies and procedures to define the duties and responsibilities for all staff involved in the assessment or treatment of a crisis. The policies and procedures shall address staff training, experience, and be in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- f. Contractor shall develop and implement written policies and procedures to ensure that services reach individuals at their place of residence, school and/or other community-based safe locations. When the level of risk to staff or the individual in crisis is determined to be significant, Contractor shall implement a protocol to ensure that someone in law enforcement meets the MCOT members and the individual at the location of the crisis.
- g. If crisis exists in an institution such as a jail or hospital, at least one trained MCOT member shall respond to emergent or urgent crises.
- h. Contractor shall deploy one MCOT member to the location of the individual for subsequent contacts or crisis follow-up and relapse prevention services in accordance with approved policies, procedures, and protocols.

- i. In compliance with Texas Health & Safety Code §573.021(c), Contractor shall arrange for a physician (preferably a psychiatrist) to examine an individual as soon as possible, but no later than 12 hours after the time the individual is apprehended by a peace officer, or transported for emergency detention by the individual's guardian.

3. Screening and Assessment

- a. For emergent calls, a face-to-face (or telehealth based on policies and procedures approved by the medical director) crisis response shall be provided within one hour. After crisis intervention services are provided, and if the individual is still in need of emergency care services then the individual shall be assessed by a physician (preferably a psychiatrist) within 12 hours.
- b. Immediately upon arrival a face-to-face screening shall be completed by a QMHP-CS if a telephone screening has not been previously completed.
- c. A written process for performing the screening shall be followed. The process shall address the criteria for requesting an immediate crisis assessment, medical screening/assessment, and psychiatric evaluation.
 - d. A crisis assessment shall be performed using the crisis elements of the Adult Texas Recommended Assessment Guidelines (Adult-TRAG) or the Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG) or other DSHS-approved screening tool.
- e. A crisis assessment shall include an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full crisis assessment, need for emergency intervention, and an evaluation of the need for an immediate medical screening/assessment by an physician (preferably a psychiatrist), psychiatric APN, PA, or RN.
- f. The full crisis assessment process shall include:
 - 1) Consumer interviews by a physician (preferably a psychiatrist), psychiatric APN, RN, PA, LPHA, or QMHP-CS with training in behavioral health crisis care.
 - 2) Review of records of past treatment (when available).
 - 3) History from collateral sources. The team is proactive in gathering input and/or corroboration of events from family members whenever possible. Every effort should be made to engage family support around the individual in crisis while maintaining confidentiality.
 - 4) Contact with the current health providers whenever possible.
 - 5) If available, a history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and adherence, and an up-to-date record of all medications currently prescribed, and the name of the prescribing professional.
 - 6) A detailed assessment of substance use and abuse, including the quantity and frequency of all substances used.
 - 7) Identification of social, environmental, and cultural factors that may be contributing to the emergency.

- 8) An assessment of the individual's ability and willingness to cooperate with treatment.
- 9) A general medical history that addresses conditions that may affect the individual's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of trauma).
- 10) In emergent care, an assessment that addresses any medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition.
- 11) In emergent care, an appropriate physical health assessment. In urgent care, a written procedure, approved by the medical director, is implemented to assess the need for referral for a physical health assessment including laboratory screening.
- 12) Every individual is assessed for possible trauma, abuse, and neglect, and identified cases of potential abuse or neglect are appropriately reported.

4. Intervention, Coordination and Continuity of Care

- a. A written protocol shall be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies seen by the MCOT and is approved by the medical director. The protocol shall be reviewed and updated as needed. Revisions shall be submitted in accordance with Information Item S.
- b. If screening or assessment indicates the need for transportation to a more restrictive environment to ensure safety or further treatment, a protocol and procedure shall be in place and used for providing immediate crisis intervention and transporting the individual to an appropriate facility. The individual shall be monitored continuously until transferred.
- c. An individual crisis treatment plan that provides the most effective and least restrictive available treatment shall be developed and implemented for each individual. The plan shall be based on the provisional psychiatric diagnosis and incorporates, to the extent possible, individual and family preferences. The crisis treatment plan shall address intervention, outcomes, plans for follow-up and aftercare, and referrals.
- d. Children's crisis services must be provided by a QMHP-CS with additional experience, training, and competency in children and family crisis and treatment issues and working with children and families in crisis.
- e. Children's counseling must be provided by LPHAs with additional experience, training, and competency in child/youth treatment issues and working with children and families in crisis.
- f. Individuals and families shall receive appropriate educational information that is relevant to their diagnoses. This includes information about the most effective treatment for the individual's behavioral health disorder.
- g. Written policies and procedures, approved by the medical director, shall define appropriate reassessment intervals in emergent, urgent, and routine care.

- h. Whenever it appears necessary, the crisis treatment plan shall be adjusted to incorporate the individual's response to previous treatment.
- i. Coordination of crisis services shall be provided for every individual. Coordination of crisis services consists of identifying and linking the individual with all available services necessary to stabilize the behavioral health crisis and ensure transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up and relapse prevention services to determine the individual's status and need for further service. This includes contacting and coordinating with the individual's existing service providers in a timely manner and in conformance with applicable confidentiality requirements.
- j. Upon resolution of the crisis, eligible individuals shall be transitioned to a non-crisis LOC as medically necessary, or receive crisis follow-up and relapse prevention either by the MCOT or from another community service provider throughout a 90-day period (LOC 5) until he/she is stabilized and/or transitioned to appropriate behavioral health services.
- k. Services shall link children and families with intensive evidence-based treatments aimed at reducing further risk of out of home placement as soon as possible.

III. Walk-In Crisis Services

A. Definition

Walk-in crisis services are office-based crisis services providing immediate screening and assessment and brief, intensive interventions focused on resolving a crisis and preventing admission to a more intensive level of care.

B. Goals

- Prompt screening and assessment
- Stabilization in the least restrictive environment
- Crisis resolution
- Linkage to appropriate services

C. Description

Walk-in crisis services are immediately accessible services for adults, children, and youths that serve two purposes: ready access to psychiatric assessment and treatment for new individuals with urgent needs, and access to same-day psychiatric assessment and treatment for existing individuals within the system with urgent needs. For persons whose crisis screening and/or assessment indicate that they are an extreme risk of harm to themselves or others in their immediate environment, rapid transfer to a higher level of care is facilitated. If extreme risk of harm is ruled out, brief crisis intervention services are provided on-site. Walk-in crisis services are designed to be intensive and time-limited, and are provided until the crisis is resolved or the person is referred to another level of care. After the initial crisis assessment and intervention, continuing services may be provided in the office or in vivo for up to 90 days until the individual is stabilized and/or transitioned to appropriate behavioral health services. Walk-in crisis services are offered in the local service area based on availability of LMHA funding.

D. Standards

1. Availability

- a. Contractor shall provide immediate access to qualified staff to provide crisis screening, assessment and intervention services during hours of operation.
- b. Children's walk-in crisis service hours shall be flexible to meet family needs.

2. Physical plant

- a. The location of the walk-in crisis services shall be clearly marked from the street, and Contractor shall include the location in LMHA service literature, community media and telephone directories.
- b. Contractor's offices must meet all Americans with Disabilities Act Accessibility Guidelines/Texas Accessibility Standards (ADAAG/TAS).
- c. Contractor's offices shall have at least one designated area where persons in extreme crisis can be safely maintained until transported to another level of care (e.g., hospital or crisis stabilization unit).
- d. Contractor's office spaces shall afford privacy for protection of confidentiality.

3. Staffing

- a. A psychiatrist shall serve as the medical director for all crisis services and approve all written procedures and protocols.
- b. Duties and responsibilities for all staff involved in assessment or treatment shall be defined in writing, appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- c. All crisis service staff members shall receive crisis training that includes but is not limited to:
 - 1) Signs, symptoms, and crisis response related to substance use and abuse;
 - 2) Signs, symptoms, and crisis response to trauma, abuse and neglect;
and
 - 3) Assessment and intervention for children and youths.
- d. All crisis services staff members must be trained physicians (preferably psychiatrists), psychiatric APNs, PAs, RNs, LPHAs, QMHP-CSs or trained and competent paraprofessionals.
 - e. All staff providing crisis screening, assessment, and intervention must be physicians (preferably psychiatrists), psychiatric APNs, PAs, RNs, LPHAs, or QMHP-CSs
- f. As clinically indicated, a physician (preferably a psychiatrist), or a psychiatric APN or PA shall be available for telephone consultation or face-to-face assessment/telemedicine assessment.
- g. When the level of risk to staff or the individual exceeds the capability of on-site staff, a written protocol shall be implemented to access emergency LMHA resources.

- h. When emergency medical services are not available on site, trained staff who are prepared to provide first-responder health care (Basic Life Support, First Aid, et cetera) shall be on site at all times during business hours.

4. Screening and Assessment

- a. Individuals shall receive a face-to-face crisis triage or screening by a QMHP-CS within 15 minutes of presentation.
- b. After the person presents on the physical premises for a crisis screening, the individual shall wait in a location with rapid access to staff. If acuity worsens, trained and competent paraprofessionals may be utilized to provide observation.
- c. Crisis screening shall be performed using the crisis elements of the Adult-TRAG, CATRAG or other DSHS-approved screening tool.
- d. Crisis screening shall be documented, and the screening shall evaluate risk of harm to self or others, contributive medical issues and the need for immediate full crisis assessment, emergency intervention, and evaluates the need for immediate medical screening assessment by a physician (preferably a psychiatrist), psychiatric APN, PA or RN.
- e. A written procedure for performing the crisis screening shall be developed and implemented. The procedure shall address the criteria for requesting an immediate crisis assessment, medical screening/assessment, and psychiatric evaluation.
- f. An assessment shall be completed by an LPHA or RN within one hour of referral from the screening process.
- g. A written process and procedure shall be developed and implemented that ensures that those who require a more immediate assessment can begin the full crisis assessment by an LPHA ,or RN within 15 minutes of initial presentation to walk-in crisis services.
- h. A physician (preferably a psychiatrist), or a psychiatric APN or PA shall be available to examine and complete a psychiatric assessment for an individual in emergent crisis between three and eight hours from presentation to the services.
- i. The full crisis assessment process shall include:
 - 1) Clinical interviews conducted by a physician (preferably a psychiatrist), psychiatric APN, PA, RN LPHA or a QMHP-CS with training in behavioral health crisis care.
 - 2) Review of available records of past treatment (as available and in keeping with laws governing confidentiality).
 - 3) History from collateral sources, including input and/or corroboration of events from family members whenever possible. Every effort should be made to engage family support around the individual in crisis while maintaining confidentiality.
 - 4) Contact with current health providers whenever possible.
 - 5) If available, a history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and adherence, and an up-to-date record of all medications currently prescribed, and the name of the prescribing professional.

- 6) A detailed assessment of substance use and abuse that includes the quantity and frequency of all substances used.
- 7) Identification of social, environmental, and cultural factors that may be contributing to the emergency.
- 8) An assessment of the individual's ability and willingness to cooperate with treatment.
- 9) A general medical history that addresses conditions that may affect the individual's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of trauma).
- 10) In emergent care, an assessment addresses medical conditions that may cause similar psychiatric symptoms or complicate the individual's condition. Contractor shall provide access to phlebotomy services, with same day lab results. Services shall include, but are not limited to, the following laboratory tests or evaluations:
 - a) A complete blood count with differential;
 - b) A comprehensive metabolic panel;
 - c) A thyroid screening panel;
 - d) A toxicology evaluation
 - e) A pregnancy test;
 - f) A screening test for tertiary syphilis;
 - g) Psychiatric medication levels; and
 - h) Other tests or evaluations, as appropriate, based on the patterns of illness in the individuals served.
- 11) Every individual shall be evaluated for possible trauma, abuse, or neglect, and identified cases of potential abuse or neglect are appropriately reported.

5. Intervention, Coordination and Continuity of Care

- a. A written protocol shall be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in the walk-in crisis services and is approved by the medical director. The protocol shall be reviewed and updated as needed.
- b. If screening or assessment indicates the need for transportation to a more restrictive environment to ensure safety or further treatment, a protocol and procedure shall be used for providing immediate crisis intervention and safely transporting the individual to an appropriate facility. The individual shall be monitored continuously until transferred.
- c. An individual crisis treatment plan shall be developed and implemented for each individual that provides the most effective and least restrictive available treatment. The plan shall be based on the provisional psychiatric diagnosis and incorporates, to the extent possible, individual and family preferences. The crisis plan shall address intervention, outcomes, plans for follow-up and aftercare, and referrals.
- d. Whenever necessary, the crisis treatment plan shall be adjusted to incorporate the individual's response to previous treatment.

- e. Individuals and families shall receive appropriate educational information that is relevant to their condition, including information about the most effective treatment for the individual's behavioral health disorder.
- f. The medical director shall define appropriate reassessment intervals for emergent, urgent, and routine care.
- g. Walk-in crisis services for children and youths must be provided by a QMHP-CS with additional experience, training, and competency in children and family crisis and treatment issues.
- h. Children's counseling must be provided by LPHAs with additional experience, training, and competency in child/youth treatment issues and working with children and families in crisis.
- i. Services provided shall link families with intensive evidence-based treatments aimed at reducing further the risk of out of home placement.
- j. Coordination of crisis services shall be provided for every individual. Coordination of crisis services consists of linking the individual with all available services necessary to stabilize the behavioral health crisis and ensure transition to routine care, providing necessary assistance in accessing those services, conducting follow-up and relapse prevention services to determine the individual's status and need for further service. This includes contacting and coordinating with the individual's existing service providers in a timely manner and in conformance with applicable confidentiality requirements.
- k. Upon resolution of the crisis, eligible individuals shall be transitioned to a non-crisis LOC if determined to be medically necessary, or receive crisis follow-up and relapse prevention either by the MCOT or from another community service provider throughout a 90-day period (LOC 5) until he/she is stabilized and/or transitioned to appropriate behavioral health services.

IV. Extended Observation Unit

A. Definition

Extended observation units are designed to provide emergency stabilization to individuals in behavioral health crisis in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised environment with immediate access to urgent or emergent medical evaluation and treatment. Individuals are provided appropriate and coordinated transfer to a higher level of care when needed.

B. Goals

- Prompt and comprehensive assessment of a behavioral health crisis
- Rapid stabilization in a secure, protected, and safe environment
- Crisis resolution
- Linkage to appropriate aftercare services
- Reduction of inpatient and law enforcement interventions

C. Description

An extended observation unit provides access to emergency care at all times and has the ability to safely and appropriately manage individuals with the most severe psychiatric symptoms. It is designed to provide a safe and secure environment for short-term stabilization of behavioral health symptoms that may or may not require a continued stay in an acute care facility. Extended observation and treatment can take place for up to 23 hours or up to 48 hours, depending on the physical setting of the facility. Individuals who cannot be stabilized within that timeframe would be linked to the appropriate level of care (inpatient hospital unit or CSU). The availability of an extended observation unit is dependent on LMHA funding.

D. Standards

1. Availability

- a. If provided, this service shall be available 24 hours a day, seven days a week throughout the participating service areas.
- b. Admission to extended observation shall be determined by the LMHA and based on medical necessity as determined by a Licensed Practitioner of the Healing Arts (LPHA).

2. Physical Plant

- a. The extended observation unit shall be in a secure location, which could be a locked unit, if the facility accepts persons on Emergency Detention.
- b. The physical plant shall have policies and procedures for monitoring environmental safety.
- c. The physical plant shall have a designated area where persons in extreme crisis can be observed and safely maintained until the crisis is resolved or the individual is transported to another level of care.
 - 1) If the facility provides 23 hour observation, with chairs/beds in a shared room or bedrooms, monitoring of the area shall be maintained at all times.
 - 2) If the facility provides up to 48 hour observation, the facility shall provide individual beds for consumers. When beds are in a shared room, monitoring shall be maintained at all times. If individuals are provided with individual bedrooms, monitoring of the bedroom areas may be maintained on a regular basis, with direct observations of individuals conducted no more than 15 minutes apart, unless one-to-one continuous observation is required as determined by the treating physician or treatment team.
- d. When obtaining any information protected under HIPAA rules, standards and implementation guides, the facility shall afford privacy for protection of confidentiality.
- e. If services are provided for children and youths, the physical plant shall have separate child, youth and adult observation areas.
- f. The physical plant shall provide a clean and safe environment.
- g. All medications shall be securely stored.

3. General Facility Environment

- a. Waste water and sewage shall be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
- b. The water supply shall be of safe, sanitary quality, suitable for use and adequate in quantity and pressure, and must be obtained from a water supply system
 - c. Waste, trash and garbage shall be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations shall not be permitted. The facility must comply with 25 TAC Subsection 1.131-1.137 (concerning Definition, Treatment, and Disposal of Special Waste from Health Care Related Facilities).
- d. Operable windows shall be insect screened.
- e. An ongoing pest control program shall be provided by facility staff or by contract with a licensed pest control company. Contractor shall use the least toxic and least flammable effective chemicals.
- f. In kitchens and laundries, facility staff shall implement procedures to avoid cross-contamination between clean and soiled utensils and linens.
- g. The facility shall be kept free of accumulations of dirt, rubbish, dust and hazards.
- h. Floors shall be maintained in good condition and cleaned regularly.
- i. Walls and ceilings shall be structurally maintained, repaired and repainted or cleaned as needed.
- j. Storage areas and cellars shall be kept in an organized manner.
- k. Storage shall not be permitted in the attic spaces.
- l. The building shall be kept in good repair, and electrical, heating and cooling systems shall be maintained in a safe manner.
- m. Contractor shall provide at least one telephone in the facility available to both staff and consumers for use in case of an emergency.
- n. Cooling and heating shall be provided for occupant comfort. Conditioning systems shall be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in consumer-use areas.
- o. An extended observation unit shall provide space at least 80 usable square feet per individual in single-occupancy rooms; or 60 usable square feet per individual in multiple occupancy rooms.
- p. Furnishings provided by the facility shall be maintained in good repair.
- q. At least one water closet and lavatory per every six persons, and one tub or shower for every ten occupants shall be provided in each extended observation unit.
- r. Privacy partitions and or curtains shall be provided at water closets and bathing units in rooms for multi-consumer use.
- s. Tubs and showers shall have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
- t. Hot water for lavatories and bathing units shall be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
- u. Towels, soap and toilet tissue shall be available at all times for individual use.

- v. The facility shall provide sufficient and appropriate separate storage spaces or areas for the following:
 - 1) Administration and clinical records;
 - 2) Office supplies;
 - 3) Medications and medical supplies (these areas must be locked);
 - 4) Poisons and other hazardous materials (these must be kept in a locked area and must be kept separate from all food and medications);
 - 5) Food preparation (if the facility prepares food); and
 - 6) Equipment supplied by the facility for consumer needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen equipment, etc.
- w. A supply of hot and cold water shall be provided. Hot water for sanitizing must reach 180 degrees F. or manufacturers suggested temperature for chemical sanitizers.
- x. Food storage areas shall provide storage for, and facilities must maintain, a four-day minimum supply of non-perishable foods at all times.
- y. Food subject to spoilage shall be dated.
- z. If laundry is processed off the site, the following shall be provided on the premises: soiled linen holding room, a clean linen receiving, holding, inspecting, sorting or folding and storage room.
 - 1) Consumer-use laundry, if provided, shall utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area shall be one-hour fire separated or provided with sprinkler protection.
 - 2) Smoking regulations shall be established and if smoking is permitted, outdoor smoking areas may be designated for consumers. Ashtrays of noncombustible material and safe design shall be provided in smoking areas.
 - 3) Only break-away or collapsible clothes bars in wardrobes, lockers, towel bars, and closets and shower curtain rods shall be permitted.
 - 4) Bedrooms, private spaces, unsupervised social spaces and unsupervised common areas shall not contain any cords, ropes or other materials that could effectively be used by an individual for purposes of inflicting self-harm.

4. Accessibility (ADA Compliance)

- a. Extended Observation units must comply with ADAAG / TAS, and all applicable sections of the Texas Administrative Code.
- b. At least 10 percent of patient bedrooms and toilets, and all public use and common use areas shall be designed and constructed to be accessible.

5. Postings

- a. The facility shall ensure that there is a list in or near or within the medication room stating the names of all staff that can have access to the medication room.
- b. Emergency telephone numbers, including at least fire, police, ambulance, EMS, and poison control center, shall be posted conspicuously at or near the telephone.

- c. If smoking areas are permitted, the facility shall ensure that they are clearly marked as designated smoking areas.
- d. The facility shall post a notice that prohibits firearms and other weapons, alcohol, illegal drugs, illegal activities, and violence on the program site.
- e. The facility shall post an emergency evacuation floor plan.
- f. The following shall be prominently displayed in areas frequented by the consumers:
 - 1) Contact information for the Rights Protection Officer;
 - 2) Contact information with instructions on how to make an abuse/neglect report, toll-free number for reporting abuse and neglect; and
 - 3) A notice stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
- g. Postings shall be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area.
- h. If the facility prepares food, the facility shall post the current food service permit from the local health department.

6. Safety

- a. The facility shall comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code (IFC). Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.
- b. All facilities shall be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code as defined by the local fire authority.
- c. Facilities shall maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the code.
- d. The facility shall conduct fire drills and, when applicable, calculate evacuation scores in accordance with the fire code under which the facility is inspected.
- e. Facilities shall provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual or quarterly or other periodic inspections must be signed and dated.
- f. Initial and ongoing inspections for compliance with the applicable code must be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State Fire Marshal. The facility is responsible for arranging these inspections and for ensuring that these inspections are carried out in a timely manner. The initial and ongoing fire safety reports shall be signed by the certified inspector performing inspection. These reports must be kept on file and be readily available for review by the state.
- g. If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, facility staff shall take immediate corrective action to bring the facility into compliance with the

applicable code. The facility shall have on file a date for a return inspection by the Certified Fire Inspector to review the corrective actions. After that date, the facility shall have on file documentation by the Certified Fire Inspector that all deficiencies have been corrected and that the facility is in full compliance with all applicable codes. During the period of corrective action, the facility shall take any steps necessary to ensure the health and safety of individuals residing in the facility during the time the repairs or corrections are being completed.

- h. If the facility has been in operation for less than one year, the documentation of compliance with the applicable fire code may be completed and signed by an architect licensed to practice in the State of Texas. Such certification shall be based on the architect's inspection of the facility completed after (or immediately prior to) the commencement of operation as an extended observation unit. If the facility has been remodeled or renovated, the inspection by the architect shall be conducted after the remodeling or renovation was completed.
- i. The following initial and annual inspections are required and shall be kept on file:
 - 1) Local Fire safety as outlined in 6f., above;
 - 2) Alarm system by the fire marshal or an inspector authorized to install and inspect alarm systems;
 - 3) Annual kitchen inspection by the local health authority or the Texas Department of State Health Services;
 - 4) Gas pipe pressure test one every three years by the local gas company or a licensed plumber;
 - 5) Monthly inspection and annual maintenance of fire extinguishers by personnel licensed or certified to perform the inspection; and
 - 6) (If applicable) inspection of liquefied petroleum gas systems by an inspector certified by the Texas Railroad Commission.
- j. All fires causing damage to the extended observation unit or to equipment shall be reported to the DSHS Contract Manager with 72 hours. Any fire causing injury or death shall be reported to the DSHS Contract Manager immediately. Notification shall be by telephone if during normal business hours and by e-mail during other times with a follow-up telephone call to the Contract Manager on the first business day following the event.
- k. All facilities shall post emergency evacuation floor plans.
- l. The administration shall have in effect and available to all supervisory personnel written copies of a plan for the protection of all persons in the event of fire and for their remaining in place, for their evacuation to areas of refuge, and from the building when necessary. The plan shall include special staff actions including fire protection procedures needed to ensure the safety of any consumer and shall be amended or revised when needed. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. A copy of the plan shall be readily available at all times within the facility. This written plan shall require documentation that reflects the current evacuation capabilities of the consumers.

- m. Open flame heating devices shall be prohibited. All fuel burning heating devices shall be vented. Working fireplaces are acceptable if of safe design and construction and if screened or otherwise enclosed.
- n. All vehicles used to transport consumers shall be maintained in safe driving condition.
- o. Every vehicle used for consumer transportation shall have a fully stocked first aid kit and an A:B:C type fire extinguisher that is easily accessible.
- p. Any vehicle used to transport a consumer shall have appropriate insurance coverage.
- q. The facility shall ensure that consumer areas, bathrooms and other private or unsupervised areas are free of materials that could be utilized by a consumer to cause harm to self or others. Such items include but are not limited to, ropes, cords (including window blind cords), sharp objects, and substances that could be harmful if ingested.
- r. The facility shall not admit individuals whose needs cannot be effectively addressed in the facility. Individuals requiring a greater or lesser level of care must be referred to a more appropriate level of care.

7. Infection Control

- a. Each facility shall establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
- b. The facility shall comply with departmental rules regarding special waste in 25 TAC §§1.131-1.137.
- c. The facility shall have written policies for the control of communicable disease in employees and consumers, which includes tuberculosis screening and provision of a safe and sanitary environment for consumers and employees. The name of any consumer of a facility with a reportable disease as specified in 25 TAC §§97.1-97.13 (Control of Communicable Diseases) shall be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate infection control procedures must be implemented as directed by the local health authority.
- d. If employees contract a communicable disease that is transmissible to consumers through food handling or direct consumer care, the employee shall be excluded from providing these services as long as a period of communicability is present.
- e. The facility shall maintain evidence of compliance with local and/or state health codes or ordinances regarding employee and consumer health status.
- f. The facility shall screen all employees for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (CDC) Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings. All persons who provide services under an outside resource contract shall, upon request of the facility, provide evidence of compliance with this requirement.

- g. All consumers shall be screened upon admission and after exposure to tuberculosis and provided follow-up as needed. DSHS will provide TB screening questionnaire for admission screening upon request.
- h. Personnel who handle, store, process and transport linens shall do so in a manner that prevents the spread of infection.
- i. Universal precautions shall be used in the care of all consumers.
- j. First Aid Kits shall be sufficient for the number of consumers served at the site.
- k. Gloves shall be immediately accessible to all staff.
- l. One-way, CPR masks shall be immediately available to all staff.
- m. Spill Kits shall be immediately accessible to all staff.
- n. Running water or dry-wash disinfectant shall be available to staff where sinks are not easily available.
- o. Sharps containers shall be puncture resistant, leak proof and labeled.
- p. Sharps containers shall not be overfilled.
- q. Needles in the sharps containers shall not be capped or bent.
- r. Staff shall be able to accurately describe the policy for handling a full sharps container.
- s. Particulate masks (surgical masks) shall be available to staff and individuals at high risk for exposure to TB.
- t. Staff shall be able to describe the actions to take if exposed to blood or body fluids.
- u. Staff shall be able to describe how to clean a blood or body-fluid spill.
- v. Staff shall be able to direct surveyor to all protective equipment.
- w. Poison Control phone numbers shall be posted throughout the Center.
- x. Information regarding Emergency Medical Treatment for Poisoning shall be available to staff.
- y. All medical materials shall be properly stored on shelves or in cabinets that shall be correctly labeled.
- z. Disinfectants and externals shall be separated from internals and injectables.
- aa. Medications that require special climatic conditions (e.g. refrigeration, darkness, tightly sealed, etc.) shall be stored properly.
 - bb. There shall be a thermometer in the refrigerator.
 - cc. Recorded refrigerator temperatures shall be maintained between 36 and 40 degrees Fahrenheit.

8. Medication Management

- a. All facilities that provide or store consumer medication during the length of stay shall implement written procedures for medication storage, administration, documentation, inventory, and disposal.
- b. The facility shall maintain a record indicating that staff regularly checks the temperature in the refrigerator.
- c. Refrigerators used to store medications shall be kept neat, clean and free of non-pharmacy / non-medical items. (Lab specimens shall be stored separately.)
- d. The facility shall ensure that there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.

- e. Individuals shall not be allowed to retain their own medications while in the facility.
- f. Medications that are kept on-site shall be kept locked at all times.
- g. Controlled substances shall be approved by a physician employed by or contracting with the facility or Community MHMR Center that operates the facility.
- h. Controlled substances shall be stored under double locks.
- i. Staff shall be able to provide a copy of the most recent stock inspection.
- j. The facility management shall ensure that only licensed medical staff members have access to medications that are administered to individuals.
- k. The facility management shall maintain a current list in the medication room of all practitioners who are allowed to prescribe medications that are administered from the medication room.
- l. The facility management shall maintain a current list in the medication room of all staff allowed to administer medications to consumers.
- m. The facility management shall ensure that staff does not ever transfer medications from one container to another. Consumers may independently transfer their own medications from a bottle to a daily medication reminder.
- n. Medication labels shall not be handwritten or changed.
- o. There shall be a medication guide, (e.g. Physician's Desk Reference (PDR) or similar publication) that is available to staff.
- p. The PDR shall be current (i.e., an edition published within the previous 2 years).
- q. The facility shall maintain an Emergency Medication Kit.
- r. The medications in the emergency medication kit shall be monitored with a perpetual inventory and make use of breakaway seals.
- s. The medication kit shall contain medications and other equipment as specified by the facility medical director. This generally includes but is not limited to short acting neuroleptics, anti-Parkinsonian medications, and anti-anxiety medications
- t. There shall be evidence in the clinical records that consumers are educated about their medications whenever medications are prescribed or changed.

9. Food Preparation and Food Service

- a. If the facility prepares meals in a centralized kitchen on site, it shall pass an annual kitchen health inspection as required by law. The facility shall immediately address any deficiencies found during any health inspection. The facility shall post the current food service permit from local health department.
- b. If providing nutrition services, the kitchen or dietary area shall meet the general food service needs of the consumers. It shall include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal. Exception: Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary manner.
- c. All facilities shall provide a means for washing and sanitizing dishes and cooking utensils must be provided. The kitchen shall contain a multi-compartment pot sink large enough to immerse pots and pans cookware and dishes used in the facility,

and a mechanical dishwasher for washing and sanitizing dishes. Separation of soiled and clean dish areas shall be maintained, including air flow.

- d. At least three meals or their equivalent shall be served daily, at regular times, with no more than a 16-hour span between a substantial evening meal and breakfast the following morning.
- e. In all facilities when therapeutic diets are ordered, they shall be provided by the facility.
- f. In facilities that prepare food for the consumers, the menus shall be prepared to provide a balanced and nutritious diet, such as recommended by the National Food and Nutrition Board, and shall accommodate consumer kosher dietary needs or other related dietary practice.
- g. In all facilities, food and beverages shall be available to accommodate consumers who enter the facility.
- h. In all facilities, supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period shall be maintained on premises. Food subject to spoilage shall be dated.
- i. When meals are provided by a food service, a written contract shall require the food service to: comply with the rules referenced in this Information Item V, and pass an annual kitchen health inspection as required by law. The facility shall ensure the meals are transported to the facility in temperature controlled containers to ensure the food remains at the temperature at which it was prepared. The facility shall ensure that at least one facility staff, at minimum, maintains a current food handler's permit.

10. Staffing

- a. A psychiatrist shall serve as the medical director for all crisis services and shall approve all procedures and protocols used in crisis services.
- b. Duties and responsibilities for all staff involved in assessment or treatment shall be defined in writing, appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- c. All staff involved in assessment or treatment shall receive crisis training that includes but is not limited to:
 - 1) Signs, symptoms, and crisis response related to substance use and abuse;
 - 2) Signs, symptoms, and crisis response to trauma, abuse and neglect; and
 - 3) Assessment and intervention for children and youths.
 - 4) The unit shall have sufficient physicians (preferably psychiatrists) psychiatric APNs, PAs, RNs, LPHAs, QMHP-CSs, and trained and competent paraprofessionals to allow for:
 - a) Individual reassessment at least every 15 minutes by trained and competent paraprofessionals, two hours by nursing, and 24 hours by physician (preferably a psychiatrist) or a psychiatric APN or PA;
 - b) Active therapeutic intervention consistent with the individual's clinical state; and

- c) Consumer and staff safety including one-to-one observation as needed. 5) Staffing shall include:
 - a) A physician, (preferably a psychiatrist), or a psychiatric APN or PA on call 24 hours/day to evaluate individuals face-to-face or via telemedicine as needed;
 - b) At least one LPHA on site seven days/week from 8:00 a.m. to 8:00 p.m.;
 - c) At least one RN on site 24 hours/day, seven days/week;
 - d) A QMHP-CS on each shift between the hours of 8 a.m. to 7 p.m., to be assigned to identified individuals; and
 - e) Trained and competent paraprofessionals on site 24 hours/day, seven days/week.

11. Screening and Assessment

- a. Triage:
 - 1) Individuals shall be triaged by a physician (preferably a psychiatrist), psychiatric APN, PA, or RN, within 15 minutes of presentation, with procedures to prioritize imminently dangerous individuals. The psychiatrist triage may be performed via telemedicine.
 - 2) Until the individual receives that triage he or she shall wait in a safe and secure location with constant staff observation and monitoring.
 - 3) The triage shall include an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full crisis assessment, need for emergency intervention, and need for a medical screening/assessment, including vital signs and a medical history, whenever possible.
 - 4) A written description of the process for performing this triage shall be followed. The description shall address screening for emergency medical conditions and the process for accessing emergency medical intervention. When emergency medical services are not available on site, trained staff who are prepared to provide first-responder health care (Basic Life Support, First Aid, et cetera) shall be on site at all times.
 - 5) Written criteria shall be developed and implemented to determine which individuals presenting for care are referred to another health care facility or provider. These criteria ensure that those referred to a lower level of care are at low or no risk of harm to themselves or others, have no more than mild functional impairment, and do not have significant medical, psychiatric, or substance abuse comorbidity. Referral decisions consider the individual's ability to understand and accept the need for treatment (if such need exists) and to comply with the referral.
- b. Assessment Process:
 - 1) Individuals who are not referred for care elsewhere after triage shall receive a full crisis assessment (psychosocial, psychiatric and as ordered medical).
 - 2) The assessment by an LPHA shall be initiated within one hour of the individual's presentation to the extended observation services.

- 3) All individuals who receive an assessment shall see a physician (preferably a psychiatrist) within eight hours of presentation to the extended observation unit.
 - 4) A written procedure shall be implemented that allows for individuals who require a psychosocial or psychiatric assessment more immediately to be seen and assessed within 15 minutes of that determination.
- c. Psychosocial and Psychiatric Assessment:
- 1) The psychosocial and psychiatric assessment shall include:
 - a) Consumer interview(s) by physicians (preferably psychiatrists) either in person or electronically;
 - b) Review of records of past treatment (when available);
 - c) History from collateral sources. Staff is proactive in gathering input and/or corroboration of events from family members whenever possible. Every effort should be made to engage family support while maintaining confidentiality.
 - d) Contact with the current health providers whenever possible;
 - e) A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and adherence, and an up-to-date record of all medications currently prescribed, and the name of the prescribing professional;
 - f) A detailed assessment of substance use and abuse, including the quantity and frequency of all substances used;
 - g) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 - h) An assessment of the individual's ability and willingness to cooperate with treatment; and
 - i) A general medical history that addresses conditions that may affect the individual's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of trauma).
 - 2) Every individual shall be screened for possible trauma, abuse or neglect, and identified cases of potential abuse or neglect are appropriately reported. When a consumer is screened, whether or not they have had a history of trauma, abuse or neglect it shall be documented.
 - 3) Every individual less than 18 years of age shall be assessed (including a developmental assessment) by an LPHA with appropriate training in the assessment and treatment of children and youths in a crisis setting.
- d. Physical Health Assessment
- 1) Individuals shall receive a physical health assessment within four hours of presentation.
 - 2) A written process and procedure shall be developed and implemented that ensures that those who require a physical health assessment more immediately can be seen and assessed within five minutes of initial presentation.

- 3) The initial evaluation for physical health shall be performed as ordered by a physician (preferably a psychiatrist), or a psychiatric APN or PA and generally includes, but is not necessarily limited to:
 - a) Vital signs;
 - b) A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
 - c) A screening neurological examination that is adequate to rule out significant acute pathology;
 - d) A medical history and review of symptoms;
 - e) A pregnancy test (for females of child bearing age);
 - f) A toxicology evaluation;
 - g) Blood levels of psychiatric medications that have established therapeutic or toxic ranges; and
 - h) Other tests and examinations including rapid toxicology testing as appropriate and indicated.
- e. Access to phlebotomy and laboratory studies shall be provided.
 - 1) Immediate access to urgent and emergent non-psychiatric medical assessment and treatment shall be provided.
 - 2) Screening for intoxication and, when indicated, screening for symptoms and complications of substance withdrawal shall be provided.

12. Treatment

- a. A written protocol shall be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies in the service and is approved by the medical director. The protocol shall be reviewed and updated as needed.
- b. Immediate care to stabilize a behavioral health emergency (e.g., to prevent harm to the individual or to others) shall be available at all times.
- c. A nursing care plan shall be developed for every individual.
- d. An individualized treatment plan shall be developed for each person that provides the most effective and least restrictive treatment for the individual's behavioral health disorder. The plan shall be based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, individual preferences. The crisis plan addresses intervention, outcomes, plans for follow-up and aftercare, and referrals.
- e. Treatment planning shall place emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization.
- f. Response to treatment shall be assessed at least every two hours by RNs trained in the assessment of acute behavioral health patients or by a psychiatrist, or by a psychiatric APN or PA.
- g. Whenever necessary, the treatment plan shall be adjusted to incorporate the individual's response to previous treatment.
- h. Individuals and families shall receive appropriate educational information that is relevant to their diagnoses or situation. This includes information about the most effective treatment for the individual's behavioral health disorder.

- i. An LPHA shall be responsible for providing the individual with active treatment including psycho-education, crisis counseling, substance abuse counseling, and developing a plan for returning to the community that addresses potential obstacles to a successful return.

13. Coordination and Continuity of Care

- a. A discharge plan shall be developed for every individual.
- b. If inpatient treatment is not indicated, the discharge plan shall include appropriate education relevant to the individual's condition, information about the most effective treatment for the individual's behavioral health disorder, information about follow-up care, and appropriate linkages to post discharge providers.
- c. If a physical health issue requires hospitalization, the individual shall be transferred to appropriate community hospital to address the physical health issue.
- d. A written procedure shall be implemented for ensuring continuity of care and successful linkage with the referral provider.
- e. Continuity of care shall be provided for every individual. Continuity of care consists of identifying and linking the individual with all available services including substance abuse services, necessary to stabilize the crisis and ensure transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service. This includes contacting and coordinating with the individual's existing services providers in a timely manner and in conformance with applicable confidentiality requirements.

V. Crisis Residential Services

A. Definition

Crisis residential services provide short-term, community-based residential, crisis treatment to persons who may pose some risk of harm to self or others and who may have fairly severe functional impairment. Crisis residential facilities provide a safe environment with staff on site at all times. However these facilities are designed to allow individuals who are receiving services in these facilities to come and go at will. Individuals served in these facilities must have at least a minimal level of engagement to be served in this environment. Utilization of these services is managed by the Local Mental Health Authority (LMHA) based on medical necessity. The recommended length of stay ranges from 1-14 days. Crisis residential facilities are distinct from Crisis Stabilization Units (CSUs) in that crisis residential facilities provide a less restrictive and less intensive level of care than CSUs and crisis residential facilities do not accept individuals who are court committed for treatment.

B. Goals

- Conduct or ensure that a comprehensive assessment has been conducted.
- Stabilize the immediate crisis
- Restore sufficient functioning to allow the individual to transfer to a less intensive level of care
- Provide the individual with critical coping skills to prevent or minimize relapse

- Mobilize individual/family/community resources and support systems
- Link the individual with continuing care and appropriate support services
- Prevent unnecessary hospitalization and assist the individual in maintaining residence in the community

C. Description

Crisis residential treatment involves 24-hour residential services that are short-term. Crisis residential treatment is offered to individuals who are demonstrating psychiatric crises that cannot be stabilized in a less intensive setting. This level of care provides a safe environment to individuals with trained and competent staff on site at all times. However, there is only moderate/limited monitoring and reassessment of individuals to ensure safety. Crisis residential services may attempt to re-create a normalized environment (e.g., apartments, group and foster homes, and the individual's own home). This normalized environment provides a venue for biological, psychological, and social interventions targeted at the current crisis while fostering community reintegration. A physician, (preferably a psychiatrist), or a psychiatric APN or PA and RN must be on site or readily accessible to provide face-to-face services either in person or via telemedicine (as appropriate).

Psychosocial programming shall be provided as medically necessary and should focus on a range of topics that includes but is not limited to: problem-solving, communication skills, anger management, community re-integration skills, as well as co-occurring psychiatric and substance use diagnosis issues. Individual counseling shall also be provided as necessary. Individuals should have enough medication on arrival to ensure psychiatric and medical stabilization for at least 3 days and a process must exist to obtain medical and psychiatric medications as needed by the individual. The availability of crisis residential services is dependent on LMHA funding for these types of services. The recommended maximum length of stay is 14 days and the average anticipated length of stay is between 3 and 7 days.

D. Standards

1. Availability

- a. If provided, this service shall be available 24 hours a day, seven days a week to individuals in crisis in the local service area.
- b. Admission to crisis residential shall be determined by the LMHA and based on medical necessity as determined by a Licensed Practitioner of the Healing Arts (LPHA).
- c. When appropriate, the LPHA may use telemedicine to make the determination of need for admission.

2. Physical Plant

- a. If the LMHA holds an Assisted Living Type A license, the facility will be accepted as "deemed status" by DSHS, and any Quality Management and Compliance reviews will entail only programmatic elements.
- b. Crisis residential service units shall provide a clean and safe environment.

- c. Crisis residential services shall create as normalized an environment as possible.
- d. Crisis residential services units shall not be designed to prevent elopement and shall not use locks, mechanical restraints or other mechanical mechanisms to prevent elopement from the facility.
- e. All medications shall be securely stored.

3. General Facility Environment

- a. Waste water and sewage shall be discharged into an approved sewage system or an onsite sewage facility approved by the Texas Commission on Environmental Quality or its authorized agent.
- b. The water supply shall be of safe, sanitary quality, suitable for use and adequate in quantity and pressure, and must be obtained from a water supply system.
- c. Waste, trash and garbage shall be disposed of from the premises at regular intervals in accordance with state and local practices. Excessive accumulations shall not be permitted. The facility shall comply with 25 TAC Subsection 1.131-1.137 (concerning Definition, Treatment, and Disposal of Special Waste from Health Care Related Facilities).
- d. Operable windows shall be insect screened.
- e. An ongoing pest control program shall be provided by facility staff or by contract with a licensed pest control company. The least toxic and least flammable effective chemicals shall be used.
- f. In kitchens and laundries, facility staff shall use procedures to avoid cross-contamination between clean and soiled utensils and linens.
- g. The facility shall be kept free of accumulations of dirt, rubbish, dust and hazards.
- h. Floors shall be maintained in good condition and cleaned regularly.
- i. Walls and ceilings shall be structurally maintained, repaired and repainted or cleaned as needed.
- j. Storage areas and cellars shall be kept in an organized manner.
- k. Storage shall not be permitted in the attic spaces.
- l. The building shall be kept in good repair, and electrical, heating and cooling systems shall be maintained in a safe manner.
- m. There shall be at least one telephone in the facility available to both staff and consumers for use in case of an emergency.
- n. Cooling and heating shall be provided for occupant comfort. Conditioning systems shall be capable of maintaining the comfort range of 68 degrees Fahrenheit to 82 degrees Fahrenheit in consumer-use areas.
- o. A bedroom shall have no more than four beds.
- p. The facility shall provide for each consumer a bed with mattress, bedding, chair, dresser (or other drawer space), and enclosed closet or other comparable space for clothing and personal belongings.
- q. Furnishings provided by the facility shall be maintained in good repair.
- r. At least one water closet, lavatory, and bathing unit shall be provided on each sleeping floor accessible to consumers of that floor.

- s. One water closet and one lavatory for each six occupants or fraction thereof shall be provided. One tub or shower for each ten occupants or fraction thereof shall be provided.
- t. Privacy partitions and or curtains shall be provided at water closets and bathing units in rooms for multi-consumer use.
- u. Tubs and showers shall have non-slip bottoms or floor surfaces, either built-in or applied to the surface.
- v. Consumer-use hot water for lavatories and bathing units shall be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit.
- w. Towels, soap and toilet tissue shall be available at all times for individual consumer use.
- x. The facility shall provide sufficient and appropriate separate storage spaces or areas for the following:
 - 1) Administration and clinical records;
 - 2) Office supplies;
 - 3) Medications and medical supplies (these areas shall be locked);
 - 4) Poisons and other hazardous materials (these shall be kept in a locked area and must be kept separate from all food and medications;
 - 5) Food preparation (if the facility prepares food); and
 - 6) Equipment supplied by the facility for consumer needs such as wheelchairs, walkers, beds, mattresses, cleaning supplies, food storage, clean linens and towels, lawn and maintenance equipment, soiled linen storage or holding rooms, and kitchen equipment etc.
- y. A supply of hot and cold water shall be provided. Hot water for sanitizing shall reach 180 degrees F. or manufacturers suggested temperature for chemical sanitizers.
- z. Food storage areas shall provide storage for, and facilities must maintain, a four-day minimum supply of non-perishable foods at all times.
- aa. Food subject to spoilage shall be dated.
- bb. A large facility (i.e., a facility with more than 16 beds) which co-mingles and processes laundry on-site in a central location shall comply with the following:
 - 1) The laundry shall be separated and provided with sprinkler protection if located in the main building. (Separation shall consist of a one-hour fire rated partition carried to the underside of the floor or roof deck above.)
 - 2) Access doors to the laundry area shall be from the exterior of the facility or if from within the building by, way of non-consumer use areas.
 - 3) Soiled linen receiving, holding and sorting rooms shall have a floor drain and forced exhaust to the exterior shall operate at all times that soiled linen being held in this area.
- cc. If laundry is processed off the site, the following shall be provided on the premises: soiled linen holding room, clean linen receiving, holding, inspecting, sorting or folding and storage room.
- dd. Consumer-use laundry, if provided, shall utilize residential type washers and dryers. If more than three washers and three dryers are located in one space, the area shall be one-hour fire separated or provided with sprinkler protection.

- ee. Smoking regulations shall be established and if smoking is permitted, outdoor smoking areas may be designated for consumers. Ashtrays of noncombustible material and safe design shall be provided in smoking areas. Social-divisional spaces such as living rooms, day rooms, lounges, or sunrooms shall be provided and have appropriate furniture.
- ff. Dining areas shall be provided and have appropriate furnishings.
- gg. Only break-away or collapsible clothes bars in wardrobes, lockers, towel bars, and closets and shower curtain rods shall be permitted.
- hh. Bedrooms, private spaces, unsupervised social spaces and unsupervised common areas shall not contain any cords, ropes or other materials that could effectively be used by an individual for purposes of inflicting self-harm.

4. Accessibility (ADA Compliance)

Crisis residential facilities shall comply with ADAAG / TAS, and all applicable sections of the Texas Administrative Code.

5. Postings

- a. The facility shall ensure that there is a list in or near or within the medication room stating the names of all staff that can have access to the medication room.
- b. Emergency telephone numbers, including at least fire, police, ambulance, EMS, and poison control center, shall be posted conspicuously at or near the telephone.
- c. If smoking areas are permitted, the facility shall ensure that they are clearly marked as designated smoking areas.
- d. The facility shall post a notice that prohibits firearms and other weapons, alcohol, illegal drugs, illegal activities, and violence on the program site.
- e. The facility shall post an emergency evacuation floor plan.
- f. The following shall be prominently displayed in areas frequented by the consumers:
 - 1) Contact information for the Rights Protection Officer;
 - 2) Contact information with instructions on how to make an abuse/neglect report, toll-free number for reporting abuse and neglect; and
 - 3) A notice stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
- g. Postings shall be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area.
- h. If the facility prepares food, the facility shall post the current food service permit from the local health department.

6. Safety

- a. The facility shall comply with the most recent edition of the National Fire Protection Association's Life Safety Code (NFPA 101) as adopted by the State Fire Marshal, or with the International Fire Code (IFC). Determination of the specific code to be applied is determined by the local fire authorities having jurisdiction.

- b. All facilities shall be classified as to type of occupancy and incorporate all life safety protections set forth in the applicable code.
- c. Facilities shall maintain continuous compliance with the life safety requirements set forth in the applicable chapters of the code.
- d. The facility shall conduct fire drills and, when applicable, calculate evacuation scores in accordance with the fire code under which the facility is inspected.
- e. Facilities shall provide a safe environment, participate in required inspections, and keep a current file of reports and other documentation to demonstrate compliance with applicable laws and regulations. Files and records that record annual or quarterly or other periodic inspections shall be signed and dated.
- f. Initial and ongoing inspections for compliance with the applicable code shall be conducted by a fire safety inspector certified by the Texas Commission on Fire Protection or by the State fire marshal. The facility is responsible for arranging these inspections and for ensuring that these inspections are carried out in a timely manner. The initial and ongoing fire safety reports shall be signed by the certified inspector performing inspection. These reports shall be kept on file and be readily available for review by the state.
- g. If the Certified Fire Inspector finds that the facility does not comply with one or more requirements set forth in the applicable fire code, facility staff shall take immediate corrective action to bring the facility into compliance with the applicable code. The facility shall have on file a date for a return inspection by the Certified Fire Inspector to review the corrective actions. After that date, the facility must have on file documentation by the Certified Fire Inspector that all shall have been corrected and that the facility is in full compliance with all applicable codes. During the period of corrective action, the facility shall take any steps necessary to ensure the health and safety of individuals residing in the facility during the time the repairs or corrections are being completed.
- h. If the facility has been in operation for less than one year, the documentation of compliance with the applicable fire code may be completed and signed by an architect licensed to practice in the State of Texas. Such certification shall be based on the architect's inspection of the facility completed after (or immediately prior to) the commencement of operation as a crisis residential or crisis respite facility. If the facility has been remodeled or renovated the inspection by the architect shall have been conducted after the remodeling or renovation was completed.
- i. The following initial and annual inspections are required and shall be kept on file:
 - 1) Local Fire safety as outlined in 6.f., above;
 - 2) Alarm system by the fire marshal or an inspector authorized to install and inspect alarm systems;
 - 3) Annual kitchen inspection by the local health authority or the Department of State Health Services;
 - 4) Gas pipe pressure test once every three years by the local gas company or a licensed plumber;

- 5) Inspection and maintenance of fire extinguishers by personnel licensed or certified to perform the inspection; and
- 6) (If applicable) inspection of liquefied petroleum gas systems by an inspector certified by the Texas Railroad Commission.
- j. All fires causing damage to the crisis residential service unit or to equipment shall be reported to the DSHS Contract Manager with 72 hours. Any fire causing injury or death shall be reported to the DSHS Contract Manager immediately. Notification shall be by telephone if during normal business hours and by e-mail during other times with a follow-up telephone call to the Contract Manager on the first business day following the event.
- k. All facilities shall post emergency evacuation floor plans.
- l. The administration shall have in effect and available to all supervisory personnel written copies of a plan for the protection of all persons in the event of fire and for their remaining in place, for their evacuation to areas of refuge, and from the building when necessary. The plan shall include special staff actions including fire protection procedures needed to ensure the safety of any resident and must be amended or revised when needed. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. A copy of the plan shall be readily available at all times within the facility. This written plan shall require documentation that reflects the current evacuation capabilities of the consumers.
- m. Open flame heating devices shall be prohibited. All fuel burning heating devices shall be vented. Working fireplaces are acceptable if of safe design and construction and if screened or otherwise enclosed.
- n. All vehicles used to transport consumers shall be maintained in safe driving condition.
- o. Every vehicle used for consumer transportation shall have a fully stocked first aid kit and an A:B:C type fire extinguisher that are easily accessible.
- p. Any vehicle used to transport a consumer shall have appropriate insurance coverage.
- q. The facility shall ensure that consumer bedrooms, bath rooms and other private or unsupervised areas are free of materials that could be utilized by a consumer to cause harm to self or others. Such items include but are not limited to, ropes, cords (including window blind cords), sharp objects, and substances that could be harmful if ingested.
- r. The facility shall not admit individuals whose needs cannot be effectively addressed in the facility. Individuals requiring a greater or lesser level of care shall be referred to a more appropriate level of care.

7. Infection Control

- a. Each facility shall establish and maintain an infection control policy and procedure designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
- b. The facility shall comply with departmental rules regarding special waste in 25 TAC §§1.131-1.137.

- c. The facility shall have written policies for the control of communicable disease in employees and consumers, which includes tuberculosis screening and provision of a safe and sanitary environment for consumers and employees. The name of any consumer of a facility with a reportable disease as specified in 25 TAC §§97.1-97.13 (Control of Communicable Diseases) shall be reported immediately to the city health officer, county health officer, or health unit director having jurisdiction and appropriate infection control procedures must be implemented as directed by the local health authority.
- d. If employees contract a communicable disease that is transmissible to consumers through food handling or direct consumer care, the employee shall be excluded from providing these services as long as a period of communicability is present.
- e. The facility shall maintain evidence of compliance with local and/or state health codes or ordinances regarding employee and consumer health status.
- f. The facility shall screen all employees for TB within two weeks of employment and annually, according to Centers for Disease Control and Prevention's (CDC) Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings. All persons who provide services under an outside resource contract shall, upon request of the facility, provide evidence of compliance with this requirement.
- g. All consumers shall be screened upon admission and after exposure to tuberculosis and provided follow-up as needed. DSHS will provide TB screening questionnaire for admission screening upon request.
- h. Personnel who handle, store, process and transport linens shall do so in a manner that prevents the spread of infection.
- i. Universal precautions shall be used in the care of all consumers.
- j. First Aid Kits shall be sufficient for the number of consumers served at the site.
- k. Gloves shall be immediately accessible to all staff.
- l. One-way, CPR masks shall be immediately available to all staff.
- m. Spill Kits shall be immediately accessible to all staff.
- n. Running water or dry-wash disinfectant shall be available to staff where sinks are not easily available.
- o. Sharps containers shall be puncture resistant, leak proof and labeled.
- p. Sharps containers shall not be overfilled.
- q. Needles in the sharps containers shall not be capped or bent.
- r. Staff shall be able to accurately describe the policy for handling a full sharps container.
- s. Particulate masks (surgical masks) shall be available to staff and individuals at high risk for exposure to TB.
- t. Staff shall be able to describe the actions to take if exposed to blood or body fluids.
- u. Staff shall be able to describe how to clean a blood or body-fluid spill.
- v. Staff shall be able to direct surveyor to all protective equipment.
- w. Poison Control phone numbers shall be posted throughout the Center.
- x. Information regarding Emergency Medical Treatment for Poisoning shall be available to staff.

- y. All medical materials shall be properly stored on shelves or in cabinets that shall be correctly labeled.
- z. Disinfectants and externals shall be separated from internals and injectables.
- aa. Medications that require special climatic conditions (e.g. refrigeration, darkness, tightly sealed, etc.) shall be stored properly.
- bb. There shall be a thermometer in the refrigerator.
- cc. Recorded refrigerator temperatures shall be maintained between 36 and 40 degrees Fahrenheit.
- dd. Animals housed at the facility or visiting the facility shall be properly vaccinated and supervised.

8. Medication Management

- a. All facilities that provide or store consumer medication during the length of stay shall implement written procedures for medication storage, administration, documentation, inventory, and disposal.
- b. The facility shall maintain a record indicating that staff regularly checks the temperature in the refrigerator.
- c. Refrigerators used to store medications shall be kept neat, clean and free of non-pharmacy / non-medical items. (Lab specimens shall be stored separately.)
- d. The facility shall ensure that there are no expired, recalled, deteriorated, broken, contaminated or mislabeled drugs present.
- e. Individuals shall not be allowed to retain their own medications while in the facility.
- f. Medications that are kept on-site shall be kept locked at all times.
- g. Controlled substances shall be approved by a physician employed by or contracting with the facility or Community MHMR Center that operates the facility.
- h. Controlled substances shall be stored under double locks.
- i. Staff shall be able to provide a copy of the most recent stock inspection.
- j. The facility management shall ensure that only licensed medical staff members have access to medications administered to individuals.
- k. The facility management shall maintain a current list in the medications room of all practitioners who are allowed to prescribe medications that are administered from the medications room.
- l. The facility management shall maintain a current list in the medication room of all staff allowed to administer medications to consumers.
- m. The facility management shall ensure that staff does not ever transfer medications from one container to another. Consumers may independently transfer their own medications from a bottle to a daily medication reminder.
- n. Medication labels shall not be handwritten or changed.
- o. There shall be a medication guide, (e.g. Physician's Desk Reference (PDR) or similar publication) that is available to staff.
- p. The PDR shall be current (i.e., an edition published within the previous 2 years).
- q. The facility shall maintain an Emergency Medication Kit.

- r. The medications in the emergency medication kit shall be monitored with a perpetual inventory and make use of breakaway seals.
- s. The medication kit shall contain medications and other equipment as specified by the facility medical director. This generally includes but is not limited to short acting neuroleptics, anti-Parkinsonian medications, and anti-anxiety medications
- t. There shall be evidence in the clinical records that consumers are educated about their medications whenever medications are prescribed or changed.

9. Food Preparation and Food Service

- a. If the facility prepares meals in a centralized kitchen on site, it shall pass an annual kitchen health inspection as required by law. The facility shall immediately address any deficiencies found during any health inspection. The facility shall post the current food service permit from local health department.
- b. If providing nutrition services, the kitchen or dietary area shall meet the general food service needs of the consumers. It shall include provisions for the storage, refrigeration, preparation, and serving of food, for dish and utensil cleaning, and for refuse storage and removal. Exception: Food may be prepared off-site or in a separate building provided that the food is served at the proper temperature and transported in a sanitary manner.
- c. All facilities shall provide a means for washing and sanitizing dishes and cooking utensils must be provided. The kitchen shall contain a multi-compartment pot sink large enough to immerse pots and pans cookware and dishes used in the facility, and a mechanical dishwasher for washing and sanitizing dishes. Separation of soiled and clean dish areas shall be maintained, including air flow.
- d. In facilities that prepare meals for consumers, at least three meals or their equivalent shall be served daily, at regular times, with no more than a 16-hour span between a substantial evening meal and breakfast the following morning.
- e. In all facilities, when therapeutic diets as are ordered they shall be provided by the facility.
- f. In facilities that prepare food for the consumers, the menus shall be prepared to provide a balanced and nutritious diet, such as recommended by the National Food and Nutrition Board, and will accommodate consumer kosher dietary needs or other related dietary practice.
- g. In facilities where consumers prepare their own food:
 - 1) The facility shall ensure that a variety of foods are available for each meal to allow consumer's to have a choice of foods for to prepare for each meal;
 - 2) The facility shall ensure that the foods available are nutritious and well balanced such as recommended by the National Food and Nutrition Board and shall accommodate consumer kosher dietary needs or other related dietary practice;
 - 3) Food for at least 3 meals shall be provided daily for consumers to prepare;
 - 4) If consumers require special dietary items, the facility shall ensure that such items are provided to the consumer; and
 - 5) Regular food preparation and mealtimes shall be established by the facility.

- h. In all facilities, food and beverage shall be available to accommodate consumers who enter the facility after established meal times.
- i. In all facilities, supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period shall be maintained on premises. Food subject to spoilage shall be dated.
- j. When meals are provided by a food service, a written contract shall require the food service to: comply with the rules referenced in this Information Item V, and pass an annual kitchen health inspection as required by law. The facility shall ensure the meals are transported to the facility in temperature controlled containers to ensure the food remains at the temperature at which it was prepared. The facility shall ensure that at least one facility staff, at minimum, maintains a current food handler's permit.

10. Staffing

- a. A psychiatrist shall serve as the medical director for all crisis services and must approve all written procedures and protocols. Duties and responsibilities for all staff involved in the assessment or treatment of individuals shall be defined in writing by the medical director and be appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- b. The competence of all staff shall be continuously evaluated, monitored during the actual delivery of services and continually enhanced to address the unique needs of consumers in different settings and situations.
- c. An on-call roster of clinical (QMHP-CS and above) and nursing (RN and LVN) staff shall be maintained and a process must be in place for assessing and anticipating staffing needs to ensure clinical or nursing staff members are on-site at all times.
- d. Trained and competent professional staff (i.e. QMHPs) shall provide staff coverage during the first and second shifts.
- e. Trained and competent paraprofessional staff (i.e. non-licensed staff with less than a bachelor's degree in a human services field) may be used on the third (i.e., overnight) shift.
- f. Staff on duty shall remain awake and alert at all times.
- g. An LPHA shall be immediately available during the day and shall be responsible for ensuring the individual is provided active treatment defined in a crisis plan.
- h. There shall be a sufficient number of trained staff available to ensure that when individuals show signs of agitation there is immediate verbal intervention.
- i. No fewer than two staff members, trained in verbal and physical management of assaultive/aggressive behavior, shall be on site at all times to ensure a safe environment.
- j. When indicated by acuity and/or increased census, the number of staff trained in the verbal and physical management of assaultive/aggressive behavior shall be increased to a level that is sufficient to ensure the safety of all consumers and staff in the facility.

- k. When one-on-one supervision of one or more individuals is indicated, the facility shall ensure that there is sufficient staff on site to provide such supervision.
- l. At least one LPHA shall be available to conduct patient interviews and initiate a full assessment within eight hours of presentation to the unit or sooner when indicated.
- m. Active psychosocial programming shall be provided for at least 4 hours per day.
- n. Post admission, a physician (preferably a psychiatrist) or a psychiatric APN or PA shall see every individual at least once per week, or more frequently as clinically indicated, and be on call 24 hours a day to evaluate individuals as needed and to provide supervision and consultation.
- o. An RN shall be on call for emergencies, supervision and consultation 24 hours a day.
- p. A physician (preferably a psychiatrist), a psychiatric APN, a PA or an RN shall be on site or readily accessible to provide services either in person (or via telemedicine when appropriate).
- q. If a physician is not already on site, the physician (preferably a psychiatrist) or a psychiatric APN or PA shall be available to provide face-to-face services or via telemedicine when appropriate within one hour.
- r. If a RN is not on site, the RN shall be available to provide face-to-face services as soon as practically possible
- s. Facility staff shall take whatever measures are necessary to ensure the safety and well-being during the time the physician or RN is in route to provide needed services.
- t. Staff shall not provide or facilitate consumer access to tobacco products.

11. Assessment

- a. Full Assessment
 - 1) Prior to admission to the crisis residential unit, individuals shall receive a full psychiatric assessment by a physician (preferably a psychiatrist) or a psychiatric APN or PA within 24 hours of the individual's presentation to the service if not referred directly from an active inpatient unit or psychiatric emergency service.
 - 2) A written process shall be implemented that ensures that those who require a full psychiatric assessment more quickly can be seen and assessed within 8 hours of initial presentation.
 - 3) Individuals not currently in services, or for whom the health status is unknown, shall receive a comprehensive nursing assessment by an RN within 1 hour of presentation.
- b. Assessment Process
 - 1) The assessment process includes patient interviews by LPHAs or PAs;
 - 2) When indicated and as appropriate, telemedicine may be used to conduct assessments.
 - 3) The assessment process shall include a review of available records of past treatment;
 - 4) The assessment process shall gather and incorporate:
 - a) Proactive history from family and collateral sources and in keeping with laws on confidentiality;

- b) The assessment shall include contact with the current behavioral health providers whenever possible and in keeping with laws on confidentiality;
 - c) A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
 - d) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 - e) An assessment of the individual's ability and willingness to cooperate with treatment;
 - f) A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and compliance, and an up-to-date record of all medications currently prescribed, and the name of the prescribing practitioner;
 - g) A general medical history that addresses conditions that may affect the patient's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma);
 - h) A detailed assessment of substance use or abuse conducted by an individual trained in assessing substance related disorders;
 - I) An assessment for trauma, abuse or neglect by trained clinical staff, preferably an LPHA, with training in this assessment; and
 - j) A physical health assessment as outlined below.
- 5) Physical Health Assessment
- a) Individuals shall receive a physical health assessment by a physician (preferably a psychiatrist) or a psychiatric APN or PA, or an RN, within two hours of entering a crisis residential unit unless:
 - i. Such an assessment was already conducted within the last week; and
 - ii. There are no recent changes or other indications that another assessment may be warranted.
 - b) This evaluation shall include assessment of medical and psychiatric stability, capability to self-administer medication, vital signs, pain, and dangerousness to self or others.
 - c) The initial evaluation for physical health shall be performed as ordered, by a physician (preferably a psychiatrist) or a psychiatric APN or PA and generally includes, but is not necessarily limited to:
 - i. Vital signs;
 - iii. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
 - iv. A screening neurological examination that is adequate to rule out significant acute pathology;
 - v. A medical history and review of symptoms;
 - vi. A pregnancy test (for females of child bearing age);
 - vii. vi. A toxicology evaluation;
 - vii. Blood levels of psychiatric medications that have established therapeutic or toxic ranges; and

- viii. Other tests and examinations including rapid toxicology testing as appropriate and indicated.
- d) Access to phlebotomy and laboratory studies shall be provided.
- e) Immediate access to urgent and emergent non-psychiatric medical assessment and treatment shall be provided.
- f) Screening for intoxication and, when indicated, screening for symptoms and complications of substance withdrawal shall be provided.

12. Interventions

- a. Upon admission but no later than 24 hours, every individual shall receive an orientation that explains facility rules and expectations, explains patients' rights and the grievance policy, and describes the schedule of activities.
- b. A written protocol shall be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in the service and is approved by the clinical director. The written protocol shall be reviewed and updated as needed.
- c. An individual crisis treatment plan shall be developed for each individual that provides the most effective and least restrictive treatment for the individual's behavioral health disorder.
This information shall be shared with the individual and the individual's family, as appropriate. The plan shall be based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, individual preferences.
- d. An array of treatment interventions may exist in the crisis residential setting in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. A minimum of four hours per day of such programming shall be available and shall be provided. Services should be goal-oriented and focus on reality orientation, symptom reduction and management, appropriate social behavior, improving peer interactions, improving stress tolerance, and the development of coping skills; and may consist of the following component services: psychiatric nursing services, pharmacological instruction, symptom management training, and functional skills training. The programming requirements may be fulfilled through the provision of individual crisis intervention services or by providing group services. Group services may be delivered by LOC assignment or through the provision of Day Programs for Acute Needs as specified in 25 TAC §419 L. Individuals who have significant substance abuse co-morbidity must receive counseling designed to motivate the patient to continue with substance abuse treatment following discharge from the program.
- e. Individuals shall not be denied access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.
- f. The program shall provide a stable therapeutic environment that includes consistently assigned personnel and consistently scheduled activities.

- g. Individuals should practice self-administration of medication under supervision. When needed, same-day access to medications shall be available and staff members shall provide medication education.

13. Coordination and Continuity of Care

- a. Coordination of emergency services shall be provided for every individual. Coordination of emergency services includes but is not limited to identifying and linking the individual with all available services necessary to stabilize the crisis, ensuring transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service.
- b. A written policy shall be in place that defines the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the individual's assessment in the service.
- c. A written procedure shall be developed and implemented to ensure continuity of care and successful linkage with the referral facility or provider.
- d. A discharge plan shall be developed for every individual, and shall include:
 - 1) Appropriate education relevant to the individual's condition;
 - 2) Information about the most effective treatment for the individual's behavioral health disorder;
 - 3) Identification of potential obstacles to a successful return to the community and means to address these obstacles; and
 - 4) Information about follow-up care, and appropriate linkages to post discharge providers.

VI. Crisis Respite Services

A. Definition

In contrast with crisis residential services, crisis respite services provide short-term, community-based residential, crisis treatment to persons who have low risk of harm to self or others and may have some functional impairment who require direct supervision and care but do not require hospitalization. These services can occur in houses, apartments, or other community living situations and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons for whom they care to avoid a mental health crisis. Utilization of these services is managed by the LMHA based on medical necessity. Crisis respite services may occur over a relatively brief period of time, such as a 2-hour service to allow a caretaker to complete necessary tasks or on a full day basis.

B. Goals

- Avoid an impending crisis due to housing challenges or other identified stressors in the family.
- Provide short-term assistance to caregivers of the consumer to minimize the need for a more restrictive service setting.

- Provide the consumer with appropriate supervision and assistance in a non-stressful environment
- Prevent unnecessary hospitalization and assist the individual in maintaining residence in the community

C. Description

Crisis respite treatment involves hourly or 24-hour care that is usually short-term and offered to individuals who are at risk of psychiatric crises due to a housing challenge and/or severe stressors in the family, but are at low risk of harm to self or others. Individuals must be able to cooperate with staff support, but functioning is only mildly impaired. If substance use is suspected that causes more than mild impairment this would not be an appropriate placement. There shall be defined processes in place to address substance use issues. Mild medical comorbidity (as specified and approved by the facility medical director) is allowed while individual is taking his/her medications. Crisis respite units shall create a normalized environment (e.g., • apartments, group and foster homes, and the individual's own home). This normalized environment provides a venue for biological, psychological, and social interventions targeted at the current crisis while fostering community reintegration. During facility-based respite, individual and group skills training are provided and are based on the needs of the individual and the goals of their individual crisis plans. Limited supervision shall be provided by trained and competent paraprofessionals. Individuals shall be able to perform their own activities of daily living. With staff supervision, individuals shall be able to self-administer medication. Individuals should have enough medications upon arrival to ensure psychiatric and medical stabilization for the expected length of stay. There are procedures in place to obtain medications for individuals when needed. The primary objective of crisis respite services is stabilization and resolution of a crisis situation for the individual and/or the individual's caregiver(s). Crisis respite is both facility-based and in-home, and may be available for children, youths, and adults. The availability of facility-based respite units is dependent on LMHA funding for this type of respite.

D. Standards

1. Availability

- a. When offered, this service shall be available 24 hours a day, seven days a week and respite services shall be made available to individuals throughout the local service area.
- b. Admission to crisis respite shall be determined by the LMHA and shall be based on a medical necessity determination by an LPHA

2. Physical Plant

- a. For facility-based crisis respite, if the LMHA holds an Assisted Living Type A license, the facility will be accepted as "deemed status" by DSHS, and any Quality Management and Compliance reviews will entail only programmatic elements.
- b. Shall provide a clean and safe environment.
Shall create a normalized environment.

- c. Crisis respite services units are not designed to prevent elopement and shall not use locks, mechanical restraints or other mechanical mechanisms to prevent elopement from the facility.
- d. All medications shall be securely stored.
- e. Contracted residential treatment centers or foster care homes that serve children and are used for crisis respite are subject to licensing regulations of the Department of Family and Protective Services (DFPS).

3. General Facility Environment

- a. A Crisis Respite Facility shall have 100% of its beds in bedrooms of four beds or less.
- b. When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall meet the Standards as described in Information Item V. Section D. Crisis Residential Services Item 3, General Facility Environment.

4. Accessibility (ADA Compliance)

Crisis respite facilities shall comply with ADAAG / TAS, and all applicable sections of the Texas Administrative Code.

5. Postings

- a. There shall be a list in or immediately outside of the medication room stating the names of all staff that have access to the medication room.
- b. Emergency telephone numbers, including at least fire, police, ambulance, EMS, and poison control center, shall be posted conspicuously at or near the telephone.
- c. If smoking areas are permitted, they shall be clearly marked as designated smoking areas.
- d. The facility shall prohibit firearms and other weapons, alcohol, illegal drugs, illegal activities, and violence on the program site.
- e. The following shall be prominently displayed in areas frequented by the consumers: contact information for the Rights Protection Officer, contact information with instructions on how to make an abuse/neglect report, toll-free number for reporting abuse and neglect, a notice stating the name, address, telephone number, TDD/TTY telephone number, FAX, and e-mail address of the person responsible for ADA compliance.
- f. If the facility prepares food, the facility shall post the current food service permit from the local health department.
- g. Postings shall be displayed in English and in a second language(s) appropriate to the population(s) served in the local service area.

6. Safety

When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall meet the Standards as described in Information Item V. Section D. Crisis Residential Services Item 6, Safety.

7. Infection Control

When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall meet the Standards as described in Information Item V. Section D. Crisis Residential Services Item 7, Infection Control.

8. Medication Management

When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall follow the Standards as described in Information Item V. Section D. Crisis Residential Services Item 8, Medication Management, except for D.8.q. An Emergency Medication Kit should be maintained if the facility contains the staff qualified to handle such medications.

9. Food Preparation and Food Service

When crisis respite services are provided at a residential or crisis triage facility of the LMHA, the facility shall meet the Standards as described in Information Item V. Section D. Crisis Residential Services Item 9, Food Preparation and Food Service.

10. Staffing for Facility-based Crisis Respite

- a. A psychiatrist shall serve as the medical director for all crisis services and shall approve all written procedures and protocols. Duties and responsibilities for all staff involved in the assessment or treatment of individuals shall be defined in writing by the medical director and be appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- b. The competence of all crisis respite staff members shall be continuously evaluated, monitored and expanded.
- c. There shall be a process for assessing and anticipating staffing needs.
- d. Staff members on duty shall remain awake and alert at all times.
- e. There shall be a defined process for on-site staff to obtain supervision, consultation, and evaluation when needed for medical emergencies 24 hours a day from a physician (preferably a psychiatrist), a psychiatric APN, a PA or an RN. For clinical emergencies an RN or LPHA shall be accessible.
- f. Trained and competent paraprofessionals shall be on site 24 hours a day, with numbers, qualifications, and training sufficient to ensure patient and staff safety and the provision of needed services.
- g. Staff members shall be trained in CPR, management of seizures, choking, and first aid as well as crisis respite protocols and procedures, and supervision of self-administration of medications.
- h. Staff members providing in-home crisis respite services to children or youths shall be trained paraprofessionals competent to provide crisis services to children and youths.
- i. Staff shall not provide or facilitate consumer access to tobacco products.

11. Assessment

- a. Prior to admission to crisis respite services individuals shall receive a full crisis assessment by a physician (preferably a psychiatrist) or a psychiatric APN or PA, LPHA, RN or QMHP-CS.
- b. Immediate access to urgent and emergent non-psychiatric medical assessment and treatment shall be provided.

12. Interventions for Facility-based Crisis Respite

- a. Upon admission, every individual shall receive an orientation that explains rules and expectations, explains patients' rights and the grievance policy, and describes the schedule of any activities.
- b. Immediate care to stabilize a behavioral health emergency (e.g., to prevent harm to the individual or to others) shall be accessible at all times.
- c. A written protocol shall be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies seen in the service and is approved by the medical director. The protocol shall be reviewed and updated as needed.
- d. An individual crisis treatment plan shall be followed for each individual that provides the most effective and least restrictive treatment for the individual's behavioral health disorder. This information shall be shared with the individual and the individual's family, as appropriate. The plan shall be developed by qualified crisis staff and shall be based on the provisional psychiatric diagnosis and must incorporate, to the maximum extent possible, individual preferences.
- e. An array of treatment interventions shall be provided in the crisis respite setting in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. Services should be goal-oriented and based on the individual's needs and individual crisis plan. Services should focus on reality orientation, symptom reduction and management, appropriate social behavior, improving peer interactions, improving stress tolerance, and the development of coping skills; and may consist of the following component services: psychiatric nursing services, pharmacological instruction, symptom management training, and functional skills training. The programming requirements may be fulfilled through the provision of individual crisis intervention services or by providing group services. Group services may be delivered by LOC assignment or through the provision of Day Programs for Acute Needs as specified in 25 TAC Chapter 419, Subchapter L. Individuals who have significant substance abuse co-morbidity shall receive counseling designed to motivate the patient to continue with substance abuse treatment following discharge from the program.
- f. Each consumer's response to treatment shall be reassessed daily by staff. This response shall be reflected in an updated crisis treatment plan.
- g. Individuals shall not be denied access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.
- h. Facility-based crisis respite units shall maintain a stable therapeutic environment that includes assigned personnel and scheduled activities.

13. Coordination and Continuity of Care

- a. Coordination of emergency services shall be provided for every individual. Coordination of emergency services includes but is not limited to identifying and linking the individual with all available services necessary to stabilize the crisis, ensuring transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service.
- b. A written policy shall be developed and implemented that defines the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the individual's assessment in the service.
- c. A written procedure shall be developed and implemented to ensure continuity of care and successful linkage with the referral facility or provider.
- d. A discharge plan shall be developed for every individual, and shall include:
 - 1) Appropriate education relevant to the individual's condition;
 - 2) Information about the most effective treatment for the individual's behavioral health disorder;
 - 3) Identification of potential obstacles to a successful return to the living situation of the individual's choice and means to address these obstacles; and
 - 4) Information about follow-up care, and appropriate linkages to post discharge providers.

VII. Psychiatric Emergency Service Centers

A. Definitions

Psychiatric Emergency Service Centers (PESCs) provide immediate access to assessment and a continuum of stabilizing treatment for individuals presenting with behavioral health crises. These units are co-located with licensed hospitals or Crisis Stabilization Units (CSUs) and have the ability to manage the most severely ill individuals at all times, including immediate access to emergency medical care. PESCs must be available to individuals who walk in, and must contain a combination of service types including Extended Observation and Inpatient Hospital Services or a CSU.

1. Extended Observation Unit

Emergency and crisis stabilization services that provide emergency stabilization in a secure and protected, clinically staffed (including medical and nursing professionals) psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment.

2. Inpatient Hospital Services

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

3. Crisis Stabilization Unit (CSU)

Short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised, treatment environment that complies with a crisis stabilization unit licensed under Chapter 577 of the Texas Health and Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code.

B. Goals

- Prompt and comprehensive assessment
- Stabilization in a secure environment
- Crisis resolution
- Reduction of inappropriate inpatient admissions
- Referral to clinically appropriate levels of care

C. Description

The PESC is co-located with a licensed hospital or CSU with immediate access to emergency medical services, and is staffed by medical personnel and mental health professionals. Medication and crisis intervention services are provided to stabilize individuals with the goal of transitioning them to clinically appropriate levels of care.

The PESC includes extended observation services, which may be appropriate for individuals who cannot be promptly stabilized and discharged to a lower level of care. The service offers observation beds in a secure and protected, clinically staffed, psychiatrically supervised treatment environment. These programs are designed to provide a safe and secure environment for short-term stabilization of symptoms that may or may not require a continued stay in an acute care facility. Duration of extended observation services shall not exceed 48 hours, by which time stabilization and/or a determination of the appropriate level of care shall be made. Continuity of care is provided to ensure transfer to continuing treatment and linkage with necessary support services.

The PESC also includes inpatient hospital or crisis stabilization beds for individuals who cannot be stabilized within 48 hours. These individuals receive more extensive treatment for up to 14 days, with an average length of stay of 3-5 days. The availability of PESC is dependent on LMHA funding.

D. Standards

1. Availability

If provided, this service shall be available 24 hours a day, seven days a week throughout the participating service areas.

2. Physical Plant

- a. Services shall be co-located with a DSHS licensed hospital or CSU.
- b. The LMHA shall have a written agreement with the hospital or CSU with which the PESC is co-located.

- c. Facilities shall be accessible and meet all ADAAG/TAS and applicable sections of the Texas Administrative Code.
- d. Facilities shall have provisions for ensuring safety.
- e. Offices shall have at least one designated area where persons in extreme crisis can be safely maintained and monitored until transported to another level of care (e.g., hospital or crisis stabilization unit).
- f. Facility spaces shall afford privacy for protection of confidentiality.
- g. If services are provided for children and youths, the facility shall have separate child, youth, and adult treatment and observation areas.

3. Staffing

- a. A psychiatrist shall serve as the medical director for all crisis services and approves all procedures and protocols used in crisis services.
- b. Duties and responsibilities for all staff involved in assessment or treatment shall be defined in writing, appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- c. All staff involved in assessment or treatment shall receive crisis training that includes but is not limited to:
 - 1) Signs, symptoms, and crisis response related to substance use and abuse;
 - 2) Signs, symptoms, and crisis response to trauma, abuse, and neglect; and
 - 3) Assessment and intervention for children and youths.
- d. The unit shall have sufficient trained physicians (preferably psychiatrists), or psychiatric APNs, PAs, RNs, LVNs, LPHAs, QMHP-CSs, and trained and competent paraprofessionals to allow for:
 - 1) Individual reassessment at least every 15 minutes for trained and competent paraprofessionals, two hours for nursing, four hours for QMHP-CSs, and 12 for physicians (preferably psychiatrists) or a psychiatric APN or PA;
 - 2) Active therapeutic intervention consistent with the individual's clinical state; and
 - 3) Patient and staff safety including one to one observation as needed.
 Staffing shall include:
 - i A physician (preferably a psychiatrist), or a psychiatric APN or PA on call 24 hours/day to evaluate individuals face-to-face or via telemedicine as needed;
 - ii At least one LPHA on site 24 hours/day, seven days/week;
 - iii At least one RN on site 24 hours/day, seven days/week;
 - iv A QMHP-CS on each shift is assigned to identified individuals; and
 - v Trained and competent paraprofessionals on site 24 hours/day, seven days/week.

4. Assessment

a. Triage:

- 1) Individuals shall be triaged by a physician (preferably a psychiatrist), a psychiatric APN, PA, or RN within 15 minutes of presentation, with procedures to prioritize imminently dangerous individuals. The psychiatrist triage may be performed via telemedicine.
- 2) Until the individual receives that triage he or she shall wait in a safe and secure location with constant staff observation and monitoring.
- 3) The triage shall include an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full assessment, need for emergency intervention, and a medical screening assessment, including vital signs and a medical history, whenever possible.
- 4) A written description of the process for performing this triage shall be followed. The description addresses screening for emergency medical conditions and the process for accessing emergency medical intervention. When emergency medical services are not available on site, trained staff who are prepared to provide first-responder health care (Basic Life Support, First Aid, et cetera) shall be on site at all times.
- 5) Written criteria shall be developed and implemented to determine which individuals presenting for care are to be referred to another health care facility or provider. These criteria ensure that those referred to a lower level of care are at low risk of harm to themselves or others, have no more than mild functional impairment, and do not have significant medical, psychiatric, or substance abuse comorbidity. Referral decisions shall consider the individual's ability to understand and accept the need for treatment (if such need exists) and to comply with the referral.

b. Assessment Process:

- 1) Individuals who are not referred for care elsewhere after triage shall receive a full assessment.
- 2) The assessment shall be initiated within one hour of the individual's presentation.
- 3) Individuals who receive an assessment shall see a psychiatrist within eight hours of presentation to the PESC.
- 4) A written procedure shall be developed and implemented that allows individuals who require a psychosocial assessment more immediately to be seen and assessed within 15 minutes of that determination.

c. Psychosocial and Psychiatric Assessment:

- 1) The psychosocial and psychiatric assessment shall include:
 - a) Patient interview(s) by a physician (preferably a psychiatrist) or a psychiatric APN or PA, either face to face or electronically or by a physician with electronic access to emergency psychiatrist;
 - b) Review of records of past treatment (when available);
 - c) History from collateral sources (as available and in keeping with laws governing confidentiality);
 - d) Contact with the current health providers whenever possible;

- e) A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and adherence, and an up-to-date record of all medications currently prescribed, and the name of the prescribing professional;
 - f) A detailed assessment of substance use and abuse that includes the quantity and frequency of all substances used;
 - g) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 - h) An assessment of the individual's ability and willingness to cooperate with treatment; and
 - i) A general medical history that addresses conditions that may affect the individual's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of trauma).
- 2) Every individual shall be screened by trained staff for possible trauma, abuse or neglect, and identified cases of potential abuse or neglect are appropriately reported.
 - 3) Every individual less than 18 years of age shall be assessed (including a developmental assessment) by an LPHA with appropriate training in the assessment and treatment of children and youths in a crisis setting.
- d. Physical Health Assessment
- 1) The individual shall receive a physical health assessment within four hours of presentation.
 - 2) A written process and procedure shall be developed and implemented that ensures that those who require a physical health assessment more immediately can be seen and assessed within five minutes of initial presentation.
 - 3) An initial evaluation for physical health generally includes:
 - a) Vital signs;
 - b) A cognitive examination that screens for significant cognitive or neuron-psychiatric impairment;
 - c) A screening neurological examination that is adequate to rule out significant acute pathology;
 - d) A medical history and review of systems; and
 - e) Other tests and examinations as appropriate and indicated.
 - 4) Immediate access to urgent and emergent non-psychiatric medical assessment and treatment shall be provided.
 - 5) Due to the high medical and substance abuse comorbidity in this population, on-site capability shall be provided for such routine assessments as pulse oximetry, glucometry (or stat blood glucose testing), urgent urine toxicology (results available within four hours), and a targeted physical examination.
 - 6) Immediate access to on-site to phlebotomy and same-day laboratory tests and evaluations shall be provided, including but not limited to the following:
 - a) A complete blood count with differential;
 - b) A comprehensive metabolic panel;
 - c) A thyroid screening panel;

- d) A toxicology evaluation;
- e) A pregnancy test (women);
- f) A screening test for tertiary syphilis; and
- g) Psychiatric medication levels.

5. Treatment

- a. A written protocol shall be developed and implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies in the service and is approved by the medical director. The protocol shall be reviewed and updated as needed.
- b. Immediate care to stabilize a behavioral health emergency (e.g., to prevent harm to the patient or to others) shall be available at all times.
- c. A nursing care plan shall be developed for every individual.
- d. An individualized treatment plan shall be developed for each patient that provides the most effective and least restrictive treatment for the individual's behavioral health disorder. The plan shall be based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, individual preferences. The crisis plan shall address intervention, outcomes, plans for follow-up and aftercare, and referrals.
- e. Treatment planning shall place emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization.
- f. Response to treatment shall be assessed at least every two hours by RNs trained in the assessment of acute behavioral health patients or by a physician (preferably a psychiatrist), or by a psychiatric APN or PA.
- g. Whenever necessary, the treatment plan shall be adjusted to incorporate the individual's response to previous treatment.
- h. Individuals and families shall receive appropriate educational information that is relevant to their condition. This includes information about the most effective treatment for the individual's behavioral health disorder.
- i. An LPHA shall be responsible for providing the individual with active treatment including psychoeducation, crisis counseling, substance abuse counseling, and developing a plan for returning to the community that addresses potential obstacles to a successful return.

6. Inpatient and Crisis Stabilization Services

- a. Individuals who cannot be stabilized within 48 hours shall be admitted to inpatient or crisis stabilization services. If a bed is not available, a consumer may also be transferred to an appropriate State mental health hospital or community based psychiatric hospital.
- b. Each consumer admitted shall receive a psychosocial assessment by an LPHA.
- c. Consumers shall be involved in active treatment that includes psychiatric assessment and treatment, psychotherapy, psycho-education, crisis counseling, family intervention, substance abuse treatment, and relapse-prevention.

- d. CSUs shall comply with Chapter 577 of the Texas Health and Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code.
- e. Inpatient units shall comply with TAC Chapter 411 Subchapter J Standards of Care and Treatment in Psychiatric Hospitals.

7. Coordination and Continuity of Care

- a. A discharge plan shall be developed for every individual.
- b. If inpatient treatment is not indicated, the discharge plan shall include appropriate education relevant to the individual's condition, information about the most effective treatment for the individual's behavioral health disorder, information about follow-up care, and appropriate linkages to post discharge providers.
- c. If a physical health issue requires hospitalization, the individual shall be transferred to appropriate community hospital to address the physical health issue.
- d. A written procedure shall be developed and implemented for ensuring continuity of care and successful linkage with the referral facility or provider.
- e. Continuity of care shall be provided for every individual. Continuity of care consists of identifying and linking the individual with all available services necessary to stabilize the crisis and ensure transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service. This includes contacting and coordinating with the individual's existing services providers in a timely manner and in conformance with applicable confidentiality requirements.

Appendix C: External Stakeholders

- Texas Council of Community Centers
- Disability Rights of Texas
- Texas Hospital Association
- Hogg Foundation for Mental Health
- National Alliance on Mental Illness Texas
- The Association of Substance Abuse Programs
- Texas Society of Psychiatric Physicians
- Texas Department of Criminal Justice
- Local Mental Health Authorities
- Prosumers
- Texas Correctional Office on Offenders with Medical or Mental Impairments
- Texas Department of Criminal Justice
- Texas Association of Counties
- County Judges and Commissioners Association of Texas
- Sheriffs' Association of Texas
- Texas Municipal League
- Texas Conference of Urban Counties
- Texas Hospital Association
- Texas Catalyst for Empowerment
- Texas Juvenile Justice Department
- Texas District and County Attorneys Association
- North Texas State Hospital
- Department of Aging and Disability Services