TEXOMA COMMUNITY CENTER

Local Service Area Plan, Attachment A

Crisis Services and Diversion Action Plan

(Updated & submitted with Local Service Area Plan on 7/27/10)

This plan was developed and initially submitted to the Department of State Health Services (DSHS) in November 2009. In an effort to consolidate plans, DSHS requested that the plan be updated and resubmitted with the Local Service Area Plan (LSAP.) Per instructions from DSHS, new information added since the November 2009 submission has been highlighted in yellow. Other slight modifications such as wording changes to enhance clarity were not highlighted in yellow, if they did not actually provide any new or additional information.

Introduction

This document is intended to be a compendium of activities and outcomes for Texoma Community Center (TCC or "the Center") and its stakeholders as a comprehensive jail diversion plan has been pursued and crisis services implemented. It is not intended to serve as a detailed review of the many stakeholder meetings that have taken place at various community levels, nor does it address all of the diverse issues the Center has faced as it has attempted to create a comprehensive understanding and joint ownership in jail diversion as a concept.

This document provides an overview of activities that constitute on-going planning and communicate some of the substantial progress that has been made. Stakeholders have provided collaborative attention to a greatly expanded and effective crisis response system as well as the broader concept of "diversion." Although not easily quantifiable, this has resulted in greater stabilization of local communities, reduced burden on law enforcement, and diverted many individuals from more restrictive environments such as jails and hospitals.

Future formal planning related to crisis services and diversion initiatives will be done in the context of what both the Center and state agree should be a consolidated plan document for the Center. The Center has come to clearly understand that jail diversion, crisis service planning, and provider network development cannot be adequately discussed as mutually exclusive planning initiatives, and that they are all interlinked by strategies that serve common purposes. The common purposes served are:

- providing early intervention that saves lives and enhances the personal dignity of the individuals being served
- utilizing cost-effective local resources to help people reside in the least restrictive environment possible

- striving to keep family units as healthy and as supportive as possible of their members with serious mental illness
- attempting to reduce system stress and cost for local units of government.

Historical Review

MHMR Services actually began its efforts to create a multi-county jail diversion program several years before one was required by the state. Three consecutive meetings with Judges and Sheriffs from the Center's three counties were held at least two years before the legislative mandate for community centers was created. Videos presentations of successful jail diversion and Mental Health Deputy programs of other states were presented and the Center's local officials were engaged in discussions regarding a prospect for sharing resources in ways that would help divert individuals with mental illness from their jails and judicial system. Although the participants found the concept to be laudable, and commended the Center's staff for their initiative and broad thinking, they ultimately determined that a coordinated program was not practical for them due to resource costs and jurisdictional restrictions.

In FY 2004 and 2005, following enactment of relevant legislation, the Center began a concerted effort to bring together representatives of consumers, local agency service providers, law enforcement, emergency medical responders, judicial systems, and other local units of government into what was called a service area Jail Diversion Committee. Three consecutive group meetings were held in an effort to describe the intended purposes of a jail diversion plan and develop a collectively designed document that would clarify goals and collegial commitments to activities that would help appropriately defer individuals with mental illness from unnecessary incarceration.

These initial planning efforts did not result in an outcome that was satisfactory to most parties. The early meetings were marked by considerable disagreement, with some parties calling for immediate implementation of what was considered by many to be implausible and costly activities such as mental health courts and appointment of Mental Health Deputies. Representatives that were at least indirectly responsible for finances for their units of government quickly registered a waning interest in a jail diversion plan because they either believed it would not be financially feasible, or they foresaw insurmountable resistance from their elected officials to establish jail diversion as a budgetary priority. When a concept for developing a shared cost for a centralized mental health court and deployment of Mental Health Officers was proposed, the representatives again stated what they believed to be statutorily enforced geographical restrictions to coordinating resources across county lines. Further, it became apparent that some officials were not willing to share resources for a consolidated diversion initiative. This is reportedly because their experience in other areas where cooperation and coordination of resources had been attempted led them to believe that the largest county had received the greater benefit at the expense of the smaller counties.

As the early jail diversion meetings progressed, attendance began to rapidly fall; partly due to acrimony created by a few committee members, and in large part due to the fact that it was difficult for the multiple parties to dedicate time in their schedules to a concept they did not believe would gain collective traction and mutual satisfaction. Still, the meetings did lead to development of a written Jail Diversion Plan; although the plan was recognized to be questionable in terms of creating a coalesced program that would engage cooperative efforts for achieving a necessary outcome of reduced incarcerations. That plan was submitted to the state within the Performance Contract timeline.

Following development of the initial Jail Diversion Plan, the County Judge of the Center's largest county, Grayson, stepped forward with a proposal to take a leadership role as a high ranking local government official who would promote the advancement of jail diversion; something that had been strongly desired but not achieved through the initial plan development phase. His proposal was, however, conditional on the Center initially devoting its exclusive attention to jail diversion in Grayson County.

The Grayson County Judge had been motivated, in his offer to take a leadership role, largely by the fact that the county's jail had come under scrutiny for lack of compliance with standards of the Texas Commission on Jail Standards. It was clear that the County would either have to expand and improve its jail facilities or build a new one. While under scrutiny for lack of compliance, the County had received extensive consultation from The Pulitzer Group, a jail and prison management consulting firm. Although the County had received a compliance extension by the Texas Commission on Jail Standards, the Judge wisely recognized that the county needed to first follow the consultants' recommendations for lowering the jail's census by deferring low risk individuals. Doing so would show a "good faith" effort, insuring the Commission's compliance extension as the county determined its ultimate course of action.
As mentioned, as a part of the Judge's proposal for taking a leadership role in jail diversion planning, he was insistent that exclusive attention be given to his county. His genuine intent was to build a model plan that would collect data to demonstrate to the other counties in the Center's service area that jail diversion is, along with being a more humane alternative for offenders with mental impairments, a financially viable long-term partial solution to stemming the rapidly growing jail populations.

Due to need of a significant local government official to promote the benefits of jail diversion and eventually co-opt the other counties' involvement, the Center somewhat reluctantly agreed to the Judge's proposition. Meetings were held on almost a weekly basis for first three months following that agreement, and the pace of meetings seldom fell below one to two per month throughout the course of a year's time. The Jail Diversion Plan was modified during that period to reflect a shift in emphasis to working with Grayson County to establish a pilot that would serve as a guide for the other counties. Several positive outcomes were achieved; including the establishment of an inter-local agreement between local parties (e.g. the county, the county jail, probation, the Council on Governments, etc.), the Executive Director of the Texas Commission of Offenders with Medical and Mental Impairments was brought in to explore special funding for future initiatives, and a couple of grant applications were written and submitted to potential funding sources.

Procedures and forms were developed for a Mental Health Court and a couple of clients were selected, but this initiative was quickly dropped after the County Judge was unseated.

The Center did not entirely drop its work with the other two counties in the service area during the time spent focusing on jail diversion with Grayson County. Several meetings were held with officials in Cooke and Fannin counties. While staff explained that the Center was focusing a good deal of its jail diversion time on Grayson County in order that a model be developed, a willingness to work with the others continued to be expressed by center staff. Absent readily available resources to support development of jail diversion activities, and recognizing some resentment for Grayson County by the other two, little interest in forward movement was shown. It was during this time that Center staff began to understand a spirit of competitiveness that exists between its counties.

The Impact of Turnover on Jail Diversion Planning

Turnover in elected officials has created continuity challenges when giving consideration to the concept of a Jail Diversion Plan. After working intensively with the Grayson County Judge and other stakeholders, he was un-seated through the election process. Staff; and on one occasion the Board's Chair; met with the new Grayson County Judge on at least four occasions over the next year. On one other occasion, the Executive Director of the Center met with all three County Judges together in an effort to encourage forward movement with respect to jail diversion. On all occasions, the Grayson County Judge made it clear that he had little or no interest in a plan for diversion of persons with mental illness; stating that he was under no mandate to do so, and that it was his belief the Center's repeated attempts at developing collaborative momentum for a renewed and multi-county planning process was simply a matter of wanting someone else to write the plan document. Although he had been given numerous papers on models and available statistics from other states, he challenged the Center to prove that diversion would save his county money; something that would be impossible without complete access to the County's fixed and variable costs and a complement of full-time staff with sophisticated research capabilities. Absent the Judge's willing to "come to the table" for plan development and collaborative operational trials that could produce definitive data, the Center refocused its initiative to focus on law enforcement and hospital personnel. As indicated below, this new Center strategy emphasizes crisis response and this change in focus is making a positive difference in respect to jail diversion.

In addition to the loss of the Judge providing assertive leadership for formal development of a jail diversion system, other turnover in the three county area has affected continuity of diversion planning as a formal process. During the last three years the County Judge position for Fannin County has turned over twice, the Cooke County position has changed once, and three of four of the City Managers in the largest communities have changed at least once.

Political/Financial Influences on Jail Diversion

The Center has come to recognize that there are several significant realities that can impede what most would consider to be a construction direction of jail diversion. Among those are:

- The introduction of privatized jails to the area.
- Justification of numbers for expansion of jails or new facilities.
- District Attorney Offices' reluctance to delay or defer adjudication of offenders.
- Law enforcement and Corrections Officers' reluctance to recognize a need for special consideration for offenders with mental impairments.

Currently, Grayson County is in a heated debate over what to do with its non-compliant jail, a debate that has attracted a great deal of public attention with many differing opinions. One plan being given consideration is a privately financed jail with capacity beyond current demand. Since jail revenue used for financing the facility will come from local admissions and non-local transfers, it is anticipated that filling jail beds will be a priority of greater importance than deferring individuals. One other new jail in the service area is a private facility

that, by necessity, must also earn its revenues from occupancy. Prosecuting attorneys establish their records for being “hard on crime.”

Law enforcement officers tend to view offenders as criminals without a great deal of consideration for the cause of the crime.

The realities above do not mean that the individuals involved are unfeeling or insensitive to persons with mental impairments. However, there focus and priorities are different, and their acuity for alternative placement possibilities is not the same as that for staff who work with mentally ill people on a daily basis. In almost all cases where it has been agreed that a person with mental illness can be safely supported in the community, or the person needs an alternative treatment placement, the Center has received support and cooperation from officials.

Stakeholder Meetings, Continuing Education, and the Merging Concepts of Crisis Services and Jail Diversion

Despite challenges in development of a coalesced formal three-county jail diversion plan, the Center has continued to convene stakeholder meetings at various levels across the geographical area. As alluded, Center staff have come to recognize that when attention is given to system points that have the greatest need and desire for assistance, a positive impact can be made in the diversion of persons with mental illness. The Legislature’s allocation of funding for crisis services, and state’s parameters for crisis hotlines and Mobile Crisis Outreach Teams, has had a significant impact on the Center’s diversion of individuals from more costly and restrictive environments; including diversion from arrest at the site of a crisis, diversion from emergency rooms, diversion from the state hospitals, and diversion from judicial systems and the jails.

With the increased attentiveness to crisis situations resulting from of the state’s crisis services initiative for all community centers, the Center’s engagement with stakeholder’s has focused on intervention at the earliest point possible in mental health crisis situations, therefore leading to diversion at the lowest level possible for any given crisis situation; be it in the field where a crisis is first recognized, in an emergency room, or in pre- or post-adjudication. The concept of “Jail Diversion” has, for all practical purposes, morphed into use of the simple defining term of “Diversion” as staff interact with stakeholders.

The Center has found that larger-scale public input meetings have limited value. They have been beneficial in that dialogue has been meaningful for obtaining information and providing education. The Center has used commercial ads and a mailing list of close to 200 stakeholders in an effort to attract individuals to public forums. Despite these efforts to attract people’s attention to issues of importance to both Center and the state, only a small handful of individuals have shown up for any meeting. The Center has come to realize that small-scale, focused group meetings have been much more productive relative to creating meaningful change and fine-tuning its relationships across three counties that have vastly different personalities. They have found the small and focused group approach for stakeholder meetings to be extremely beneficial in advancing diversion at all levels. Although extremely exhausting for staff at times, it has resulted in: 1) Personal identification and relationship development between county representatives and Center staff who are to be contacted when a crisis arises. 2) A familiarity with and confidence in Center staff that reduces reluctance to contact the Center. 3) Creation of an understanding of the hierarchy of review that goes into each crisis contact, and an awareness that judgment calls made

by crisis workers do not take place without back-up consultation from licensed professionals. 4) Awareness and continuing review of Administrative Code that gives the Center its status as the Mental Health Authority and clarifies its role in seeking least restrictive placements alternatives for persons with mental illness. 5) The ability of all parties to quickly acknowledge system problems or personnel issues in order that adverse consequences may be more likely to be avoided in the future.

Although small focused group meetings can be called at any time, over the past three years the following small meetings have taken place on a regular basis.

- *Meetings with emergency room staff of the two largest hospitals in the area, including a representative from the local in-patient psychiatric hospital -*

  These meetings were initially schedule on a monthly basis. The group initially resolved numerous communication issues. The Center also brought in an attorney to help create an understanding of the role of the Center as an Authority responsible for screening psychiatric hospital admissions and seeking least restrictive alternatives for individuals. After the role of the Center was clarified, the hospital staff have evidenced a high regard for the Center's role and defer to its professional judgment on almost all cases. The group now meets on at least a quarterly basis.

- *Meetings with Fannin County Officials –*

  Starting over three years ago, the early meetings took place on a monthly basis. Although they have been moved to routine quarterly meetings, they have been and continue to be conducted on an additional ad hoc/called basis. The meetings have been well attended by two of the three Justices of the Peace, the County Judge, other assisting court staff, Adult Probation staff, local attorneys, VA Hospital representatives, and NAMI. Although the Sheriff's Department was represented in the earlier meetings that representation has since diminished. Fannin County has been the representative example of dedicated collaborative work toward hospital and jail diversion. The District Judge, who had been involved in early work with the County's diversion group, has been unable to participate at that level. However, she has assertively established a Mental Health Court in which Center staff have played a key role.

- *Meetings with key law enforcement and jail personnel in Grayson and Cooke Counties –*

  Because the judicial leadership in two of the Center's counties has not evidenced any real interest in diversion, staff have focused on communications with lead law enforcement officers of the two largest cities in the county, along with representatives from the County Jail. Formal interaction at this level, which has taken place at least two times per year over the past three years, appears to be proving beneficial in that officers are relying more on the MCOT for intervention.

Communications in Cooke County; which have been formalized in at least two meetings per year; have relied on meetings with the Chief of Police, the Sheriff, and occasional participation by local magistrates. In Cooke County, law enforcement and transport responsibilities rest primarily with the Gainesville Police Department. There were a number of misunderstandings in roles and responsibilities of parties in that county, along with lack of clarity regarding the authority of the Center to provide screenings and seek the least restrictive placements available. Communications and support provided by the Center has resulting in an increased confidence in the Center's crisis response system by law enforcement, and an increased reliance on it by officers.

- *Ad hoc meetings and training –*

  As a part of diversion strategies, the Center has promoted its willingness to provide education and solicit input throughout the service area. For example, the Assistant Mental Health Program Director has, at the request of emergency room physicians, recently spent an extensive amount of time with emergency room nursing staff reviewing statutes and clarifying with them the reasons for alternate placement determinations that are contradictory to their desired immediate placement of individuals in hospitals or jails. The Mental Health Program Director has recently been involved in training with Grayson County Juvenile Probation regarding requirements for processing hospital commitments. Staff of the Center have also been presenters at a local consumer conference, sponsored jointly by the Center and the local chapter of the National Alliance for the Mentally Ill (NAMI), for the past five years. Staff have also met one-on-one with new judges, or those who have an expressed interest in learning more about the role of the Center in managing mental illness related cases, to provide information about laws and the ways in which the Center desires to be of assistance to them and their criminal justice associates.

Outcomes of Diversion Initiatives

The Center's active involvement in building an effective crisis response system, and communicating the intent of those efforts to result in diversion of persons with mental illness from more costly, less humane, and more restrictive environments has proven to date to be successful in many ways. Dramatic improvements resulting from diversion activities can be attributed primarily to five factors: 1) The opening of a ten bed crisis respite facility that has resulted in a large number of persons diverted from jail and costly hospital stays to short term in-house stabilization. 2) A dedicated MCOT for rapid response to crises. 3) Perhaps most importantly, the active awareness of the mental health disposition of each consumer as they have been placed into crisis respite services and effectively moved to alternative arrangements after a short stay. 4) The ability of Mental Health leadership and case management staff to secure lesser restrictive and stable living options for consumers. 5) The overall commitment of Center staff to work daily toward improving consumer treatment and diversion systems. Some of the positive results of evolving diversion planning activities have been:

- Establishment of many important relationships that have resulted in improved communications and an increased reliance on the knowledge base of the Center for purposes of education and judgment calls when making crisis management related decisions.

- A recognition on the part of many authority figures in local governments that diversion is a cost-effective and worthwhile pursuit, as evidenced by increased utilization of the Center as a constant resource in dealing with local mental health issues. The Center's crisis response system and diversion initiative has recognized a monthly increase in the number of calls received and provided a face-to face response from an average of 40 per month three years ago to the an average of approximately 76 per month with some months having exceeded 100. Based on the upward trends over recent years, that number is expected to increase.
- The Center's 98% plus face-to-face response time by a crisis worker in less than one hour has resulted in virtually no complaints about arrival delays.
- Reported pleasure of physicians for decreased numbers of persons with mental illness being brought to the emergency rooms. It is impossible to determine how many individuals might have gone beyond the emergency rooms to jails or psychiatric hospitals, but the fact that the number of "pre-emergency room interventions" (i.e. in the field interventions) has move from non-existent three years ago to a conservative average of 22 per month is a positive indicator that early intervention is reducing cost and system stress. The Center has estimated that every diversion from the emergency room has resulted in a combined savings to the community of at least $3,000. That being the case, a minimum savings of approximately $90,000 per month is being achieved across the region as a result of diversion activities.
- The Center was approximately 30% over its allocated bed days at state hospitals three years ago. At the end of last fiscal year it had only used 67% of its allocated bed days.
- Local hospitalization costs was $347,000 three years ago. Last year its cost was $32,000.

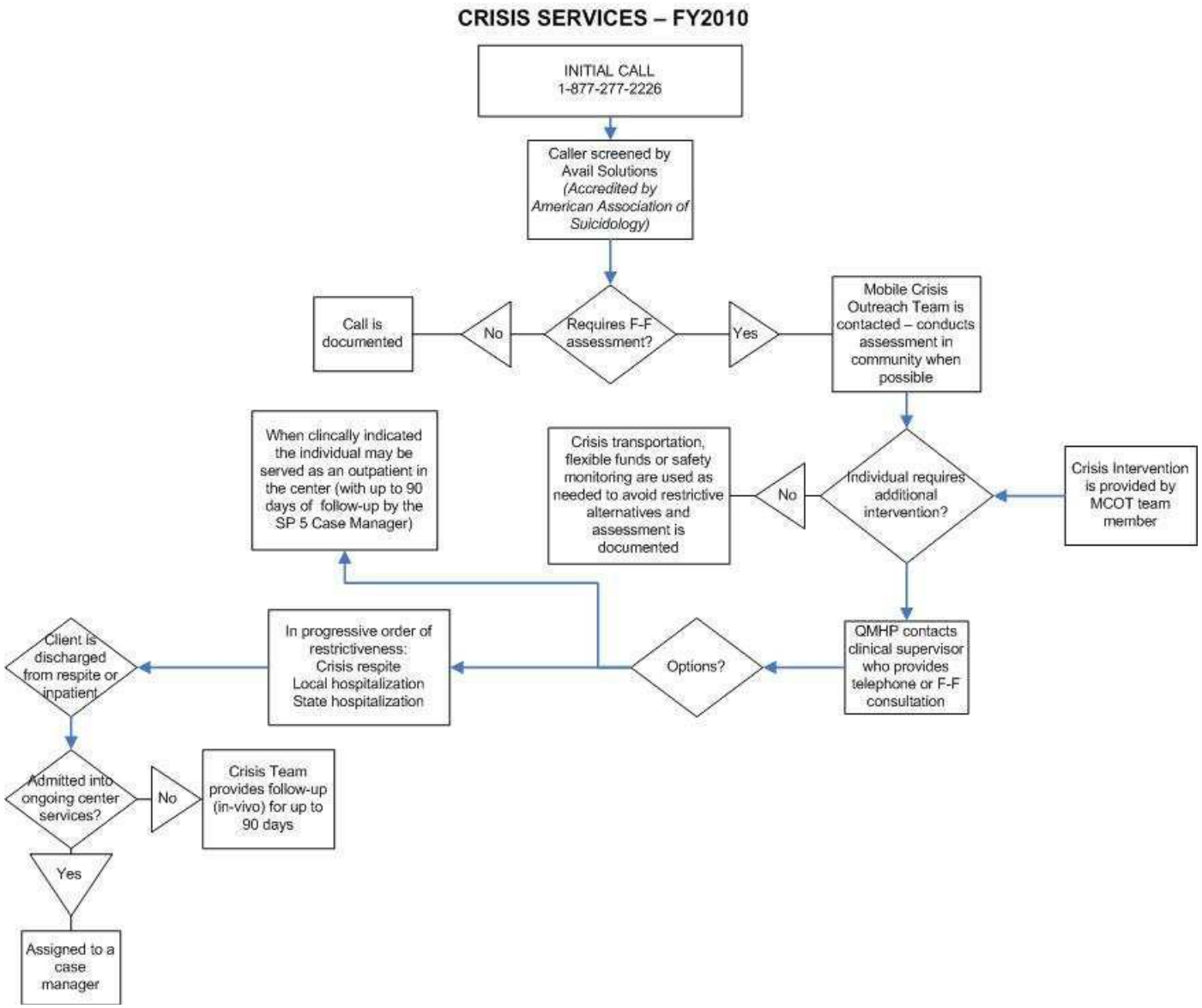
Structure of Crisis Intervention Services (the information from this point forward has all been added since the 2009 submission)

Crisis services at TCC have been greatly enhanced since the allocation of additional funds by the Texas Legislature. The staff of the Center have also spent a considerable amount of time "marketing" the toll free hotline number, educating stakeholders about the role of the Center as the authority and the types of crisis services available. The Center contracts with Avail Solutions to provide **crisis hotline** services. The toll-free number is the same for all three counties and is answered 24 hours per day, seven days per week. The number is provided on all client appointment cards, posted in the local telephone directories and on the Center's website. When the number was new, Center staff were interviewed several times by local media sources and the number was included in the media reports. The main telephone at each clinic is also forwarded to the crisis hotline after hours as a back up safety measure. Avail Solutions is accredited by the *American Association on Suicidology*. The staff at Avail Solutions screens the caller, provides referral information or supportive listening as appropriate and notifies the **Mobile Crisis Intervention Team (MCOT)** a.k.a. "the crisis team" as clinically indicated for individuals who need face to face assessments/services. The local law enforcement personnel have also been provided with education and encouragement to request an assessment in the community whenever possible to reduce the burden on hospitals and/or jails. The only request that has been made is that the law enforcement personnel arrive "on scene" first and assess for safety. The agencies have increased their requests for "on scene" assessments whenever possible as evidenced by the fact that assessments were provided in the community less than ten times per month in 2007 to a new average of around 35 each month.

The crisis team arrives at all calls deemed emergent within one hour. The calls determined to be urgent are responded to within eight

hours and the routine calls are scheduled for an appointment within 24 hours. The crisis team conducts a thorough face to face assessment, to determine the relative lethality of the situation (i.e. is the person suicidal, homicidal or extremely psychotic?) The status of each situation is discussed with a clinical supervisor before a final disposition is determined. If necessary, the Center's psychiatrists are also on call. Sometimes the situation can be handled by providing Crisis Intervention Rehabilitative Services, including positive thinking or coping strategies, anger management, etc. Sometimes the individual needs to be monitored for ongoing safety but does not need the restrictiveness of an inpatient setting. Those individuals will be served in the Crisis Respite Unit provided by the Center through a contract with The Wood Group. Typical respite stays are for a duration of seven days or less. If the individual is suicidal or homicidal and needs hospitalization (voluntary or involuntary), the local psychiatric hospital is the first option. The Center provides this service through a contractual arrangement with the Behavioral Health Center (a division of Texoma Medical Center.) As a last resort for individuals who cannot be maintained safely in this community, arrangements are made for an involuntary commitment to one of two state hospitals. Individuals in Fannin County are sent to Terrell State Hospital and individuals in Cooke or Grayson Counties are sent to North Texas State Hospital. The increasing demands for forensic patients at the state facilities across the state sometimes make it difficult to secure a bed. The other challenge the Center faces when attempting state hospitalization is differing opinions among medical and crisis personnel. Sometimes the local ER doctor will agree that state hospitalization is needed and a doctor to doctor referral is made, but by the time the person actually arrives at the state hospital, a different doctor with a different opinion is on duty and the individual is returned back to the local county. Center management staff have tried to reduce this occurrence as much as possible by working with the physicians and administrators at the state hospital level. For individuals who are not suicidal, homicidal or extremely psychotic, crisis transportation and crisis flexible funds are available as a resource to the team when attempting to resolve the crisis.

All crisis services at TCC are funded with a combination of the Center's original general revenue allocation and the additional general revenue funding that has been received starting with fiscal year 2008. For example, the Center initiated the contract with The Wood Group for crisis respite services during fiscal year 2007 due to the Center's need for alternatives to local and state hospitalizations. With the crisis funding that was added in 2008, the Center created the MCOT that is on duty and awake at least 56 hours each week which provides for increased availability and a more rapid response time. With the additional funding that was provided at the beginning of fiscal year 2010, the Center added a full-time case manager to the crisis team who provides the follow-up services for up to 90 days for individuals who do not meet eligibility requirements, but need linkage, support and referrals. The county and local community do not provide any contribution to crisis services in the Texoma area beyond each sponsoring government's "inkind contribution, which becomes part of the Center's overall funding base. The contributions are fairly small compared to the Center's overall budget and none of the funds are targeted toward crisis services. The following flowchart provides a pictorial representation of the Center's crisis intervention services.


CRISIS SERVICES – FY2010
INITIAL CALL
1-877-277-2226
Caller screened by Avail Solutions (Accredited by American Association of Suicidology)
Requires F-F assessment?
No
Call is documented
Yes
Mobile Crisis Outreach Team is contacted – conducts assessment in community when possible
Individual requires additional intervention?
No
Crisis transportation, flexible funds or safety monitoring are used as needed to avoid restrictive alternatives and assessment is documented
Crisis Intervention is provided by MCOT team member
When clincally indicated the individual may be served as an outpatient in the center (with up to 90 days of follow-up by the SP 5 Case Manager)
QMHP contacts clinical supervisor who provides telephone or F-F consultation
Options?
In progressive order of restrictiveness:
Crisis respite
Local hospitalization
State hospitalization
Client is discharged from respite or inpatient
Admitted into ongoing center services?
No
Crisis Team provides follow-up (in-vivo) for up to 90 days
Yes
Assigned to a case manager

One of the challenges facing the Texoma community is a lack of substance abuse resources. Approximately 75% or more of the crisis assessments completed involve an individual either currently under the influence of a substance or with a history of addiction to substances. Since many of these individuals do not meet the state's target population criteria and limited resources are available, the crisis team must rely on creativity to connect the individuals to appropriate inpatient or outpatient substance abuse treatment options. One strategy that has been utilized is to place the person (if medically stable) in the Center's Crisis Respite Unit for a few days while the crisis team makes arrangements for substance abuse treatment. The crisis team works closely with the Outreach Screening and Referral (OSAR) office based in Tarrant County. The staff from that office will come to the respite unit to assess the individual, if necessary. There are some inpatient facilities in Fort Worth that the OSAR staff can refer to, but there is often a waiting list for these placements. The Center does collaborate with Four Rivers in Grayson County. Four Rivers is a local, not-for-profit facility that provides shelter (and some limited substance abuse services) to individuals that may not have other options.

The crisis team has also received special training to work with children and adolescents who experience a mental health crisis. The team works with the children and families to utilize the least restrictive environment. The Center has a contract with Juvenile Alternatives in Grayson County for children's respite, if needed. If hospitalization is necessary, there are several options available to the parents of because there are more hospitals in the area who accept children. The Center collaborates with the local Crisis Center for victims of domestic trauma. For victims of other trauma, the crisis team is utilized as well as some of the licensed clinicians on staff who have experience providing those types of services. The Center received praise from the community for its work with the victims of a bus crash that occurred in the area in August 2008. For veterans who experience a mental health crisis, the team works closely with the VA hospital in Bonham (Fannin County) as well as the one in Dallas. Representatives from the Bonham VA Hospital collaborate with Center staff on activities such as the Mental Health Court and other diversion initiatives.

The Center faces some local challenges that occur due to reporting to seven different sponsoring governments and three different counties. Each of these entities work well with the Center, but not always as collaboratively with each other. Despite these challenges, the Center has established a system of crisis services and jail diversion that meets the needs of each county.