Department of State Health Services

Form Y
Consolidated Local Service Plan (CLSP)

for Local Mental Health Authorities

October, 2015

Contents

Introduction

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

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

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

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

Section I: Local Services and Needs

I.A. Mental Health Services and Sites

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

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
Betty Hardwick Center Outpatient Services	2626 South Clack St Abilene, TX 79606	Taylor	• Adult MH FLOC • Child & Adolescent FLOC • Screening, Assessment and Intake for both • Crisis/MCOT for both • Psychiatric Services for both • Consumer Benefits Services for both
Wood Group	858 Formosa Abilene, TX 79602	Taylor	• Respite for Adults
Avail	Corpus Christi, TX	Nueces	• Hotline for all persons
Mental Health of America Abilene	PO Box 7282 Abilene, TX 79608	Taylor	• Consumer Operated Services for Adults and Children
Abilene Behavioral Health	4225 Woods Pl Abilene, TX 79602	Taylor	• Contracted Inpatient Services for both Adults and Children – PESC, Private Psych beds

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
Rivercrest Hospital	1636 Hunter's Glen Rd San Angelo, TX 76901	Tom Green	• Contracted Inpatient Services for both Adults and Children
Oceans Behavioral Hospital	6401 Directors Pkwy Abilene, TX 79606	Taylor	• Contracted Inpatient Services for both Adults and Children
Shannon Behavioral Health	2018 Pulliam St San Angelo, TX 76905	Tom Green	• Contracted Inpatient Services for both Adults and Children

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

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

1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity	Number Served/ Year
11	Expanded Psychiatric Services (additional capacity counted only)	1	n/a	2716
11	MCOT Expansion (increase in clients not hospitalized counted only)	1	n/a	989

1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity	Number Served/ Year

I.C Community Participation in Planning Activities

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

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

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

• Ongoing coordination of services for individuals in jail
• Funding and support for mental health peace officers
• Ongoing coordination of services for individuals with substance abuse disorders
• Need for increased access to mental health services including outpatient child and adolescent psychiatric care
• Transportation
• Improved collaboration on services for children in foster care
• Increased services for individuals with co-occurring IDD/MI with behavioral crisis

Section II: Psychiatric Emergency Plan

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

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

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

- Users of crisis services and their family members

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

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

II.A Development of the Plan

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

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

• Stakeholder input is solicited through quarterly Mental Health Task Force and as needed Jail Diversion Task Force meetings that include representatives from the LMHA, law enforcement, emergency room, medical hospitals, courts, DFPS, county officials, jails, county court officials and other social service agencies. Planning Network Advisory Committee that includes customers and family have input into crisis services as well. CEO/Board collect information from stakeholders ongoing.

II.B Crisis Response Process and Role of MCOT

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

o One full time MCOT QMHP and a full time MCOT LPHA Team Leader. Case managers provide crisis services to their assigned customers. ACT on call staff provide support and crisis services to their customers

b. After business hours

- Four full time MCOT QMHPs cover nights and weekends. There is a paid on call person as well on weekends for added coverage. ACT on call staff provide support and crisis services to their customers

c. Weekends/holidays

- Four full time MCOT QMHPs cover weekends and holidays. There is a paid on call person as well on weekends for added coverage. ACT on call staff provide support and crisis services to their customers
-

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

- The hotline triages calls to determine if risk to self or others is involved. Calls involving risk to self or others are triaged as emergent for immediate activation of MCOT staff. Urgent callers are treated the same with immediate activation of MCOT staff

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

- MCOT staff are activated for mobile assessment by the hotline. MCOT staff complete mental status and risk assessment on all mobile activations. MCOT staff have access to immediate center services, hospital resources and respite care. MCOT staff are responsible to complete recommended crisis follow up. Center admissions staff see crisis follow up customers that want intake for center services to determine eligibility.

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

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

- Emergency rooms: MCOT are deployed to all calls from ERs that the hotline triages as emergent and urgent
- Law enforcement: MCOT are deployed to all calls from law enforcement and jails

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

- Emergency rooms: Crisis assessment, care recommendations, referrals, hospitalizations and follow up are all offered to emergency room patients as needed
- Law enforcement: Crisis assessment, care recommendations, referrals, hospitalizations and follow up are all offered to law enforcement referrals as needed

5. What is the procedure if an individual cannot be stabilized at the site of the crisis and needs further assessment or crisis stabilization in a facility setting?
   a. Describe your community's process if a client needs further assessment and/or medical clearance:

- Psychiatric Emergency Services Center (PESC) beds, Private Psychiatric (PPB) beds and state hospital beds are available. PESC and PPB beds can be accessed without prior medical clearance if the crisis customer has no injuries or obvious medical issues. Medical clearance is completed later by those facilities within 24 hours. Local emergency rooms provide medical clearance if a crisis customer is injured, has some untreated medical issue or if a psychiatric hospital requires a clearance

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

- MCOT staff contact the PESC, PPB or state hospital providers and they can be referred voluntary or involuntary

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

- MCOT, case managers and ACT staff can access crisis respite services for their customers for crisis resolution or crisis avoidance. There is a simple referral form to access respite. LMHA staff also can use motels for temporary out of home respite.

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

- Contact the LMHA crisis hotline 800-758-3344 that a crisis assessment is needed for hospitalization

    b. After business hours

- Contact the LMHA crisis hotline 800-758-3344 that a crisis assessment is needed for hospitalization
-

    c. Weekends/holidays

- Contact the LMHA crisis hotline 800-758-3344 that a crisis assessment is needed for hospitalization
-

7. If an inpatient bed is not available:

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

- Emergency room patients waiting for psychiatric hospital beds remain in the emergency room until a psychiatric bed is found. Crisis respite can provide safety monitoring until a hospital bed is found.

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

- MCOT, case managers and ACT team staff provide continued follow up services

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

- MCOT, case managers and ACT team

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

- MCOT, case managers and ACT team or family

Crisis Stabilization

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

Name of Facility	Betty Hardwick Center Respite/Contracted with Wood Group
Location (city and county)	Abilene Texas (Taylor County)
Phone number	325-672-8911
Type of Facility (see Appendix B)	Type A Assisted Living Home operated as crisis respite
Key admission criteria (type of patient accepted)	Adult mental health
Circumstances under which medical clearance is required before admission	Only if customer is injured or has an active medical emergency
Service area limitations, if any	LMHA catchment area only
Other relevant admission information for first responders	NA
Accepts emergency detentions?	No

Inpatient Care

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

Name of Facility	Psychiatric Emergency Services Center (PESC)- Abilene Behavioral Health
Location (city and county)	Abilene Texas (Taylor County)
Phone number	325-698-6600
Key admission criteria	Adult and child mental health crisis
Service area limitations, if any	None
Other relevant admission information for first responders	NA

Name of Facility	Psychiatric Emergency Services Center (PESC)- Oceans Behavioral Health
Location (city and county)	Abilene Texas (Taylor County)
Phone number	325-691-0030
Key admission criteria	Adult mental health crisis on referral from LMHA staff
Service area limitations, if any	None
Other relevant admission information for first responders	NA

Name of Facility	Psychiatric Emergency Services Center (PESC)- Rivercrest Hospital
Location (city and county)	San Angelo Texas (Tom Green County)
Phone number	800-777-5722
Key admission criteria	Adult and child mental health crisis on referral from LMHA staff
Service area limitations, if any	None
Other relevant admission information for first responders	NA

Name of Facility	Psychiatric Emergency Services Center (PESC)- Shannon Behavioral Center

Location (city and county)	San Angelo Texas (Tom Green County)
Phone number	800-227-5908
Key admission criteria	Adult mental health crisis on referral from LMHA staff
Service area limitations, if any	None
Other relevant admission information for first responders	NA

Name of Facility	Psychiatric Emergency Services Center (PESC)- Red River Hospital
Location (city and county)	Wichita Falls Texas
Phone number	800-234-5809
Key admission criteria	Adult and child mental health crisis on referral from LMHA staff
Service area limitations, if any	None
Other relevant admission information for first responders	NA

Name of Facility	Private Psychiatric Bed (PPB)- Abilene Behavioral Health
Location (city and county)	Abilene Texas (Taylor County)
Phone number	325-698-6600
Key admission criteria	Adult and child mental health crisis
Service area limitations, if any	None
Other relevant admission information for first responders	NA

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

10. What local inpatient or outpatient alternatives to the state hospital does your service area currently have for competency restoration?
    a. Identify and briefly describe available alternatives.

- There are not outpatient alternatives at this time

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

- Judges won't consider out-patient forensic alternative unless the forensic patient is in a facility or supervised housing

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

- No dedicated jail liaison. MCOT and case management staff are engaged by the jails for diversion

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

- Law enforcement and jails contact the hotline to get MCOT staff or case managers to offer diversion alternatives

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

- The Center would consider any opportunities to apply for new outpatient competency funding

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

- We had 27 forensic patients in the state hospital system in FY 2015. We would need either a community, inpatient or jail-based alternative to reduce our use of state hospital forensic capacity

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

- We need funding for staff, training, curriculum and testing materials to provide the services. We need a facility or supervised housing setting for supervision of the forensic patients

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

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

- PESC, PPB and state hospitals provide integrated psychiatric, substance use and physical health care services. LMHA staff offer COPSD services and referrals to substance abuse programming and health care resources. Center will consider development of outpatient substance abuse services. The Center has explored co-locating mental health and physical health care services with Abilene-Taylor County Health Department and the Larry Combest Center

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

- Center will consider development of outpatient substance abuse services and study possibility of co-locating services

II.E Communication Plans

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

- Center public information officer will be responsible for getting the psychiatric emergency plan to stakeholders

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

- Center and hotline staff have the above plan and information

II.F Gaps in the Local Crisis Response System

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

Counties	Service System Gaps
Taylor	• No emergency detox for single diagnosis substance abuse customers
Callahan	• No emergency detox for single diagnosis substance abuse customers
Stephens	• No emergency detox for single diagnosis substance abuse customers
Jones	• No emergency detox for single diagnosis substance abuse customers
Shackelford	• No emergency detox for single diagnosis substance abuse customers

Section III: Plans and Priorities for System Development

III.A Jail Diversion

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

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☐ Co-mobilization with Crisis Intervention Team (CIT) ☒ Co-mobilization with Mental Health Deputies ☒ Co-location with CIT and/or MH Deputies ☐ Training dispatch and first responders ☒ Training law enforcement staff ☒ Training of court personnel ☒ Training of probation personnel ☒ Documenting police contacts with persons with mental illness ☒ Police-friendly drop-off point ☒ Service linkage and follow-up for individuals who are not hospitalized ☐ Other: Click here to enter text.	• Law enforcement access crisis staff to divert mentally ill persons from jail • Jails access crisis staff to pre-book book divert mentally ill persons • PESC, PPB and state hosp resources are available for jail diversion • Jail Diversion Task Force for planning • Provided CIT law enforcement training • MCOT service site is a police drop off site • Hiring mental health deputies to be co-located
Plans for the upcoming two years: • Implement mental health deputy program	

Intercept 2: Post-Arrest: Initial Detention and Initial Hearings	
Components	**Current Activities**

Intercept 2: Post-Arrest: Initial Detention and Initial Hearings	
Components	**Current Activities**
☒ Staff at court to review cases for post-booking diversion ☒ Routine screening for mental illness and diversion eligibility ☐ Staff assigned to help defendants comply with conditions of diversion ☐ Staff at court who can authorize alternative services to incarceration ☒ Link to comprehensive services ☐ Other: Click here to enter text.	• Jail-CARE match provided to jails to identify mentally ill persons in county jails • Jails forward CARE match information to court administrators • Court Supervised Bond Process for reduced rate bond and can require mental health services • Meetings with judges and jail administration to discuss barriers to diversion • Jails access crisis staff to post-book divert mentally ill persons • Psychiatry provided to jail inmates pre-release • Provide forensic aftercare
Plans for the upcoming two years: • Continued collaboration meetings with judges and jail administration to reduce barriers to jail release	

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☒ Routine screening for mental illness and diversion eligibility ☐ Mental Health Court ☒ Veterans' Court	• Courts refer for outpatient and inpatient mental health stabilization • Veterans court docket

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☐ Drug Court ☐ Outpatient Competency Restoration ☒ Services for persons Not Guilty by Reason of Insanity ☐ Services for persons with other Forensic Assisted Outpatient Commitments ☒ Providing services in jail for persons Incompetent to Stand Trial ☐ Compelled medication in jail for persons Incompetent to Stand Trial ☒ Providing services in jail (for persons without outpatient commitment) ☐ Staff assigned to serve as liaison between specialty courts and services providers ☒ Link to comprehensive services ☐ Other:	• Aftercare for NGRI referrals • Forensic aftercare in the jails post state hospital discharge • Forensic aftercare psychiatry • Enrollment for outpatient services if jail discharges a mentally ill person
Plans for the upcoming two years: •	

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
☐ Providing transitional services in jails ☐ Staff designated to assess needs, develop plan for services, and coordinate transition to ensure continuity of care at release ☐ Structured process to coordinate discharge/transition plans	• NA

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
and procedures ☐ Specialized case management teams to coordinate post-release services ☐ Other:	
Plans for the upcoming two years: •	

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
☒ Routine screening for mental illness and substance use disorders ☒ Training for probation or parole staff ☒ TCOOMMI program ☐ Forensic ACT ☒ Staff assigned to facilitate access to comprehensive services; specialized caseloads ☒ Staff assigned to serve as liaison with community corrections ☒ Working with community corrections to ensure a range of options to reinforce positive behavior and effectively address noncompliance ☐ Other:	• TCOOMMI continuity of care to provide intake and continuity of care for state jail releases • TCOOMM staff have regular meetings with probation and parole to identify offenders needing services • TCOOMMI staff provide technical assistance and training to parole and probation units • TCOOMMI staff facilitate enrollment to center services
Plans for the upcoming two years: •	

III.B Other System-Wide Strategic Priorities

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

Area of Focus	Current Status	Plans
Improving continuity of care between inpatient care and community services	• New hospital continuity of care staff hired to do pre-discharge enrollments and follow up services	• Hospital continuity of care worker will continue pre-discharge enrollments and discharge follow up services
Reducing hospital readmissions	• Hospital Continuity of Care worker facilitating aftercare. • Adding an MCOT Relapse Prevention Worker to enhance crisis follow up	• Implement crisis relapse prevention follow up services and Zero Suicide recommended Pathway to Care for persons at risk
Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community	• Hospital Continuity of Care worker facilitating aftercare following up to confirm enrollment for all state hospital aftercare referrals •	• Hospital Continuity of Care worker facilitating aftercare following up to confirm enrollment for all state hospital aftercare referrals •
Reducing other state hospital utilization	• PESC and PPB as alternatives	• PESC and PPB as alternatives
Tailoring service interventions to the specific identified needs of the individual	• Individualized recovery plans for hospital aftercare. • Intensive services package for aftercare customers with repeat admissions	• Individualized recovery plans for hospital aftercare. • Intensive services package for aftercare customers with repeat admissions
Ensuring fidelity with evidence-based practices	• QA chart audits	• QA chart audits

Area of Focus	Current Status	Plans
Transition to a recovery-oriented system of care, including development of peer support services and other consumer involvement in Center activities and operations (e.g., planning, evaluation)	• Contracting with Advocates of Abilene for Consumer Operated Services • Employ peer specialist for adult population • Employ Family Partner for child population • Participation in Recovery Reads	• Consideration of peer program expansion and training
Addressing the needs of consumers with co-occurring substance use disorders	• Ongoing participation in the local Taylor Alliance for Prevention for juveniles • MOU with ARCADA • COPSD Training for all staff and inclusion in treatment plans • Coordinate housing with halfway houses • Participation in Recovery Oriented System of Care (ROSC)	• Ongoing participation in the local Taylor Alliance for Prevention for juveniles • MOU with ARCADA • COPSD Training for all staff and inclusion in treatment plans • Coordinate housing with halfway houses • Participation in Recovery Oriented System of Care (ROSC)
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• Co-locate our psychiatric clinic in rural community in the hospital • Coordinate with local FQHC regarding mutual patients	• Co-locate our psychiatric clinic in rural community in the hospital • Coordinate with local FQHC regarding mutual patients •

III.C Local Priorities and Plans

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

Local Priority	Current Status	Plans
Housing demand exceeds available community resources.	• Supported Housing financial assistance • Supported Housing skills training • Case management assistance with housing referrals • Improve ACT customers housing	• Local coalition working on housing first initiative
Emergency Shelter	• Crisis Respite • Purchase halfway houses • Purchase shelter	• Local coalition working on shelter initiative
Improved Support for Jail Diversion and Coordination	• Discuss with local officials ability to increase resources to support these efforts	• Consider dedicated staff position
	•	•
	•	•

III.D Priorities for System Development

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

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

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

Priority	Need	Brief description of how resources would be used	Estimated Cost
1	***Housing First Initiative for homeless mentally ill***	• *Emergency shelter* • *Safe and affordable housing*	• *$300,000 for shelter* • *Additional dedicated staff position*
2	***Emergency Detox***	• *Purchase inpatient substance detox services*	• *$350,000* • *Additional staff with substance abuse*

			expertise
3	Dedicated Jail Diversion/Coordination position	• Colocate at jail • Work with Law Enforcement pre booking • Evaluate inmates post booking at discharge and coordinate referrals	• $65,000 for staff position
		•	•
		•	•
		•	•

Appendix A: Levels of Crisis Care

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

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

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

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

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

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

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

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

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

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

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

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