Health and Human Services

Form O
Consolidated Local Service Plan (CLSP)

Local Mental Health Authorities and Local Behavioral Health Authorities

September, 2017

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Introduction

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

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

In completing the template, please provide concise answers, using bullet points. 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 LBHA (or a subcontractor organization) providing 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*
  - *Services for individuals with IDD*
  - *Services for at-risk youth*
  - *Services for veterans*
  - *Other (please specify)*

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
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 • 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

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
Mental Health of America Abilene	PO Box 7282 Abilene, TX 79602	Taylor	• ~~Contracted Inpatient Services for both Adults and Children- PESC, Private Psych beds~~Consumer Operated Services
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 Regional Health Partnership (RHP) Region(s) associated with each project.*
- *List the titles of all projects you proposed for implementation under the 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	Population Served	Number Served/ Year
11	Expanded Psychiatric Services (additional capacity counted only)	~~2~~5	n/a	Adults and Children with Mental Illness and	~~2716~~848

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	1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity	Population Served	Number Served/ Year
				dually diagnosed IDD persons	
11	MCOT Expansion (increase in client not hospitalized counted only)	25	n/a	Any person in crisis	989900

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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, Assessment, 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

	Stakeholder Type		Stakeholder Type
☒	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
☒	Peer Specialists	☒	IDD Providers
☒	Foster care/Child placing agencies	☒	Community Resource Coordination Groups
☒	Veterans' organization	☐	Other: ___________________________

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

- Ongoing Mental Health Task Force Groups
- Lead survey and planning for Behavioral Health Chapter in local Community Justice Plan
- Planning and Network Advisory Committee Meetings
- Participation a host of other local groups – 211 Advisory Group, West Texas Homeless Network, Basic Needs Network, Military Veteran Partnership Group, Champions for Children, Recovery Oriented Systems Of Care
- Client survey tools, complaint data
- Meetings with Contracted Providers – COS, Hospitals, Hotline, and Respite

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

• ~~Ongoing coordination of services for individuals in jail~~Improved Crisis Collaborations – mental health peace officers, medical partnerships
• More coordinated Jail Diversion efforts~~Funding and support for mental health peace officers~~
• Expanded service capacity (both inpatient and outpatient) for in~~Ongoing coordination of services for in~~dividuals 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

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Section II: Psychiatric Emergency Plan

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

The following stakeholder groups are 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 and LBHAs are actively engaged with these stakeholders on an ongoing basis, and the plan will reflect and build upon these continuing conversations.

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

II.A Development of the Plan

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

- Ensuring all key stakeholders were involved or represented
- 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 on an ongoing basis.~~.~~

II.B Crisis Response Process and Role of MCOT

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

      - One full time MCOT QMHP and a full time MCOT QMHP~~LPHA~~ Team Leader. MCOT~~Case managers~~ provides crisis services to ~~their assigned~~ all enrolled and non-enrolled customers. Case Managers provide backup crisis services to enrolled consumers if needed. ACT on call staff provide support and crisis services to their customers.

   b. After business hours

      - 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.

   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 unless there is already an emergent call in which case calls are handled in the order of severity and the order received.

3. What is the role of MCOT during and after a crisis when crisis care is initiated through the LMHA or LBHA (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 or LBHA.

- 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 or LBHA when an individual in crisis is identified? If so, is MCOT routinely deployed when emergency rooms or law enforcement contact the LMHA or LBHA?

      - ~~Emergency rooms:~~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
      - ~~Law enforcement:~~

   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
- ~~Emergency rooms:~~
- ~~Law enforcement:~~

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 as a voluntary or involuntary admission

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

- MCOT, 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.

d. Describe your process for crisis assessments requiring MCOT to go into a home or alternate location such as a parking lot, office building, school, or under a bridge:

MCOT is to be on the scene in the community with local law enforcement; law enforcement stabilizes the location ensuring there are no weapons and the MCOT staff are not at any risk which performing their assessments.

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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~~A Continuity of Care Liaison works with the Utilization Review staff at our contract hospitals and determines continued need for treatment based on clinical information provided by the hospital.

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/Contracted with Wood Group
Location (city and county)	Abilene Texas (Taylor County)
Phone number	325-672-8911
Type of Facility (see Appendix A)	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)- 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 Anglo Texas (Tom Green County)
Phone number	800-777-5722
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)- Shannon Behavioral Center
Location (city and county)	San Anglo 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 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 (PPB)- Oceans 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

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Name of Facility	
Location (city and county)	
Phone number	
Key admission criteria	
Service area limitations, if any	
Other relevant admission information for first responders	

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

10. What local inpatient or outpatient alternatives to the state hospital does your service area currently have for competency restoration?

    a. Identify and briefly describe available alternatives.

o There are not outpatient alternatives available locally at this time.

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

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

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

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

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

o 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.

o 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? Who have you collaborated with in these efforts?

- 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 (Abilene Community Health Clinic)

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~~BH leadership team will be responsible for getting the psychiatric emergency plan to stakeholders

16. How will you ensure LMHA or LBHA 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	• Limited ~~No emergency detox for single diagnosis substance abuse customers~~outpatient, detox and inpatient substance abuse treatment. No permanent supportive housing availability.
Callahan	• Limited outpatient, detox and inpatient substance abuse treatment. No permanent supportive housing availability. ~~No emergency detox for single diagnosis substance abuse customers~~

Stephens	• Limited outpatient, detox and inpatient substance abuse treatment. No permanent supportive housing availability. No emergency detox for single diagnosis substance abuse customers
Jones	• Limited outpatient, detox and inpatient substance abuse treatment. No permanent supportive housing availability. No emergency detox for single diagnosis substance abuse customers
Shackelford	• Limited outpatient, detox and inpatient substance abuse treatment. No permanent supportive housing availability. No emergency detox for single diagnosis substance abuse customers

Section III: Plans and Priorities for System Development

III.A Jail Diversion

The Texas Statewide Behavioral Health Services Plan highlights the need for effective jail diversion activities:

- *Gap 5: Continuity of care for individuals exiting county and local jails*
- *Goal 1.1.1, Address the service needs of high risk individuals and families by promoting community collaborative approaches, e.g., Jail Diversion Program*
- *Goal 1.1.2: Increase diversion of people with behavioral health needs from the criminal and juvenile justice systems*

In the table below, 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 describing the strategies checked in the first column. For those areas not required in the HHSC Performance Contract, enter NA if the LMHA or LBHA 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	• Law enforcement access crisis staff to divert mentally ill persons from jail • Jails access crisis staff to pre-book divert mentally ill persons • PESC, PPB and state hospital 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

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☐ Other:	
Plans for the upcoming two years: • Implement mental health peace officer or crisis response teams. deputy program	

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:	• Jail-CARE match reports viewed 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 ☐ 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:	• Courts refer for outpatient and inpatient mental health stabilization • Veterans court docket • Aftercare for NGRI referrals • Forensic aftercare psychiatry • Enrollment for outpatient services if jail discharges a mentally ill person
Plans for the upcoming two years: • Have applied for NCA funding to expand services in jail prior to release to ensure linkage with community providers and to prevent rearrest.	

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Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
☒☐ Providing transitional services in jails ☐ Staff designated to assess needs, develop plan for services, and coordinate transition to ensure continuity of care at release ☐ Structured process to coordinate discharge/transition plans and procedures ☐ Specialized case management teams to coordinate post-release services ☐ Other:	• Jail Clinic services provided now for person who are incarcerated. NA
Plans for the upcoming two years: • Have applied for NCA funding to expand services in jail prior to release to ensure linkage with community providers and to prevent rearrest.	

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	• TCOOMMI continuity of care to provide intake and continuity of care for state jail releases • TCOOMMI 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.

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☒ Working with community corrections to ensure a range of options to reinforce positive behavior and effectively address noncompliance ☐ Other:	
Plans for the upcoming two years: •	

III.B Other Behavioral Health Strategic Priorities

The Texas Statewide Behavioral Health Strategic Plan identifies other significant gaps in the state's behavioral health services system, including the following:

- *Gap 1: Access to appropriate behavioral health services for special populations (e.g., individuals with co-occurring psychiatric and substance use services, individuals who are frequent users of emergency room and inpatient services)*
- *Gap 2: Behavioral health needs of public school students*
- *Gap 4: Veteran and military service member supports*
- *Gap 6: Access to timely treatment services*
- *Gap 7: Implementation of evidence-based practices*
- *Gap 8: Use of peer services*
- *Gap 10: Consumer transportation and access*
- *Gap 11: Prevention and early intervention services*
- *Gap 12: Access to housing*
- *Gap 14: Services for special populations (e.g., youth transitioning into adult service systems)*

Related goals identified in the plan include:

- *Goal 1.1: Increase statewide service coordination for special populations*
- *Goal 2.1: Expand the use of best, promising, and evidence-based behavioral health practices*
- *Goal 2.3: Ensure prompt access to coordinated, quality behavioral healthcare*
- *Goal 2.5: Address current behavioral health service gaps*

- *Goal 3.2: Address behavioral health prevention and early intervention services gaps*
- *Goal 4.2: Reduce utilization of high cost alternatives*

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

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Improving access to timely outpatient services	• Gap 6 • Goal 2,5	• Under the 1115 DSRIP program, we opened Elm Creek Clinic to serve non priority pop clients with Psychiatry	• Have applied for NCA funds to help support this moving forward in partnership with Hendrick Medical Center and local FQHC
Behavioral health needs of public school students~~Improving continuity of care between inpatient care and community services and reducing hospital readmissions~~	• Gap 2~~1~~ • Goal 2.1~~Goals 1,2,4~~	• The Center continues to provide Mental health first aid courses to public school staff in an effort to enhance prevention	• We have an adequate number of trainers, but continue to partner with districts and the Regional ESC for ongoing training
Veteran and military service member supports ~~Transitioning long-term state hospital patients who no longer need an inpatient level of care to~~	• Gap 4 •	• The Center operates an MVPN program locally and coordinates with other veteran service agencies	

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Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
~~the community and reducing other state hospital utilization~~ • ~~Gap 14~~ • ~~Goals 1,4~~			
Implementing and ensuring fidelity with evidence-based practices	• Gap 7 • Goal 2	• The Center has participated in the National Council's Trauma Informed Care Learning Collaborative this year and has made solid strides in training staff • The Center has implemented Zero Suicide initiative and trained staff	• Continued focus on the various domains • Continued development and training efforts.
Transition to a recovery-oriented system of care, including use of peer support services	• Gap 8 • Goals 2,3	• The Center contracts with a local Consumer Operated Services group and employs peers in MH services	• The Center has submitted an NCA that includes the hiring and work of peers with justice involved individuals

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Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Addressing the needs of consumers with co-occurring substance use disorders	• Gaps 1,14 • Goals 1,2	•	•
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• Gap 1 • Goals 1,2	• The Center collaborates informally with area FQHCs for clients who lack regular primary care providers.	• The Center continues to explore more formal collaborations and improved care coordination with acute care providers.
Consumer transportation and access to treatment in remote areas	• Gap 10 • Goal 2	•	•
Addressing the behavioral health needs of consumers with Intellectual Disabilities	• Gap 14 • Goals 2,4	• The Center incorporates the IDD population into our Elm Creek Psychiatry clinic, including private HCS/ICF residents	• The Center hopes to retain and expand that service to be available.
Addressing the behavioral health needs of veterans	• Gap 4 • Goals 2,3	•	•

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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
Create Crisis Response Team Efforts~~Housing demand exceeds available community resources~~	~~Supported Housing financial assistance~~ ~~Supported Housing skills training~~ ~~Case Management assistance with housing referrals~~ • ~~Improved ACT customers housing~~Community partners have met with Meadows Foundation for initial discussions.	• ~~Local coalition working on housing first initiative~~Develop a plan to submit for funding under the SB292 NCA in fall 2018.
Increase Substance Abuse service availability~~Emergency Shelter~~	~~Crisis Respite~~ ~~Purchase halfway houses~~ • ~~Purchase shelter~~Limited detox, outpatient and medication assisted therapy exists in our community.	• ~~Local coalition working on shelter initiative~~Collaborate with partner agencies to expand services.
Improve Support for Jail Diversion and Coordination	• Pre-arrest diversion could be improved. ~~Discuss with local officials ability to increase resources to support these efforts~~	• Consider dedicated staff position, training, coordinate local resources with law enforcement and judicial partners.

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Local Priority	Current Status	Plans
	•	•
Housing demand exceeds available community resources, specifically for Permanent Supported Housing options	• Supported Housing program offers housing for BHC clients • Local housing coalition working to expand emergency shelter, transitional housing and adding permanent supported housing options	• Local coalition working on housing first initiative and coordinated entry to be effective early 2018. • Continue to explore funding opportunities to expand and improve all forms of housing availability.

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III.D System Development and Identification of New Priorities

Development of the local plans should include a process to identify local priorities and needs, and the resources required for implementation. The priorities should reflect the input of key stakeholders involved in development of the Psychiatric Emergency Plan as well as the broader community. This will build on the ongoing communication and collaboration LMHAs and LBHAs have with local stakeholders. The primary purpose is to support local planning, collaboration, and resource development. The information 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 should it become available in the future. Do not include planned services and projects that have an identified source of funding. Consider regional needs and potential use of robust transportation and alternatives to hospital care. Examples of alternatives to hospital care include residential facilities for 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	***Example:*** *Detox Beds*	• *Establish a 6-bed detox unit at ABC Hospital.*	•
2	***Example:*** *Nursing home care*	• *Fund positions for a part-time psychiatrist and part-time mental health professionals to support staff at ABC Nursing Home in caring for residents with mental illness.* • *Install telemedicine equipment in ABC Nursing Facility to support long-distance psychiatric consultation.*	•
1	Housing First Initiative for homeless mentally ill	• Emergency Shelter and Permanent Supportive Housing • Safe and affordable housing	• $300,000 for shelter • Additional dedicated staff position
2	Emergency Detox	• Purchase inpatient substance detox services	• $350,000
3	Dedicated Jail Diversion/Coordination position	• Co-locate at jail • Work with Law Enforcement pre-booking • Evaluate inmates post booking at discharge and coordinate referrals	• $65,000 for staff position
4	Crisis Response Team Implementation	• Coordinate with paramedics and police to respond to crisis •	• Uncertain – some collaboration can occur but likely some financial resources needed.

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. 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/LBHA 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.