Department of State Health Services

Form O

Consolidated Local Service Plan (CLSP)

for Local Mental Health Authorities

October, 2015

**Contents**

[Introduction 4](#_Toc431453353)

[Section I: Local Services and Needs 5](#_Toc431453354)

[I.A. Mental Health Services and Sites 5](#_Toc431453355)

[I. B Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver Projects 6](#_Toc431453356)

[I.C Community Participation in Planning Activities 8](#_Toc431453357)

[Section II: Psychiatric Emergency Plan 9](#_Toc431453358)

[II.A Development of the Plan 10](#_Toc431453359)

[II.B Crisis Response Process and Role of MCOT 10](#_Toc431453360)

[II.C Plan for local, short-term management of pre- and post-arrest patients who are incompetent to stand trial 15](#_Toc431453361)

[II.D Seamless Integration of emergent psychiatric, substance use, and physical healthcare treatment 17](#_Toc431453362)

[II.E Communication Plans 17](#_Toc431453363)

[II.F Gaps in the Local Crisis Response System 18](#_Toc431453364)

[Section III: Plans and Priorities for System Development 19](#_Toc431453365)

[III.A Jail Diversion 19](#_Toc431453366)

[III.B Other System-Wide Strategic Priorities 22](#_Toc431453367)

[III.C Local Priorities and Plans 24](#_Toc431453368)

[III.D Priorities for System Development 25](#_Toc431453369)

[Appendix A: Levels of Crisis Care 27](#_Toc431453370)

##

## 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 orContractor Name)** | **Street Address, City, and Zip** | **County** | **Services & Populations** |
| --- | --- | --- | --- |
| Center for Life Resources | 408 Mulberry, Brownwood TX 76801 | Brown | * TRR Outpatient Services: Adults and Children, Screening, Assessment and Intake, COPSD Services, Substance Abuse Intervention and Treatment, Crisis Respite
 |
| Center for Life Resources | 201-209 South Bridge, Brady TX 76825 | McCulloch | * TRR Outpatient Services: Adults and Children, Crisis Respite
 |
| Center for Life Resources | 1009 South Austin, Comanche TX 76442 | Comanche | * TRR Outpatient Services: Adults and Children, COPSD Services, Substance Abuse Intervention and Treatment, Crisis Respite.
 |
| Center for Life Resources | 111 North Cherokee, San Saba, TX 76877 | San Saba | * TRR Outpatient Services: Adult and Children, Crisis Respite
 |
| Center for Life Resources | 100 East Live Oak, Coleman TX 76834 | Coleman | * TRR Outpatient Services: Adults and Children, COPSD Services, Substance Abuse Intervention and Treatment, Crisis Respite
 |
| Center for Life Resources | 1207 Reynolds St Room# 54, Goldthwaite, TX 76844 | Mills | * TRR Outpatient Services: Adults and Children, Crisis Respite
 |
| Center for Life Resources | 301 Pogue Avenue, Eastland TX 76448 | Eastland | * TRR Outpatient Services: Adults and Children, COPSD Services, Crisis Respite, Substance Abuse Intervention and Treatment
 |

## 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** |
| 8 | 1.11 Implement technology-assisted services (telemonitoring, telementoring, or telemedicine) to support, coordinate or deliver behavioral health services. | 4 | 1 | 124 |
| 11 | 1.11 Implement technology-assisted services (telehealth, telemonitoring, telementoring or telemedicine) to support, coordinate or deliver behavioral health services. | 4 | 1 | 308 |
| 11C | 1.11.2 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers. | 4 | 1 | 118 |
| 13 | 1.11 Implement technology-assisted services (telehealth, telemonitoring, telementoring or telemedicine) to support, coordinate or deliver behavioral health services. | 4 | 1 | 337 |
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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** |
| --- | --- | --- | --- |
|[x]  Consumers |[x]  Family members |
|[x]  Advocates (children and adult) |[x]  Concerned citizens/others |
|[ ]  Local psychiatric hospital staff |[x]  State hospital staff |
|[x]  Mental health service providers |[x]  Substance abuse treatment providers |
|[ ]  Prevention services providers |[x]  Outreach, Screening, and Referral (OSAR) |
|[x]  County officials |[x]  City officials |
|[x]  FQHCs/other primary care providers |[ ]  Local health departments |
|[x]  Hospital emergency room personnel |[x]  Emergency responders |
|[x]  Faith-based organizations |[x]  Community health & human service providers |
|[x]  Probation department representatives |[x]  Parole department representatives |
|[x]  Court representatives (judges, DAs, public defenders) |[x]  Law enforcement  |
|[x]  Education representatives |[x]  Employers/business leaders |
|[x]  Planning and Network Advisory Committee |[x]  Local consumer-led organizations |
|[x]  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.*

|  |
| --- |
| * Counseling Services for Youth.
 |
| * The need for detoxification beds/funding for substance abuse treatment for indigent population
 |
| * The need for mental health deputies/funding for a mental health deputy program.
 |
| * Access to local psychiatric care, both inpatient and outpatient, in our local service area.
 |
|  |
|  |

# 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
* Center for Life Resources MCOT staff and our CEO visit with local judges, law enforcement, jail staff, hospital staff, and courthouse staff from all seven counties on a regular basis to create rapport, and also as needed for any issues that may arise. Additionally, our counties are well represented at our PNAC meetings, where comments and opinions are solicited from our stakeholders. Center for Life Resources staff also attend our area CRCG’s as well as the Heart of Texas Network meeting on a regular basis. Finally, Center for Life Resources also provides free training to our local stakeholders in the areas of suicide awareness, jail diversion strategies, and crisis response. These events are always well attended.

## II.B Crisis Response Process and Role of MCOT

1. How is your MCOT service staffed?
	1. During business hours
	* One Licensed Professional Counselor oversees our MCOT, with two bachelor’s level Qualified Mental Health Professionals (QMHP) and one Master’s QMHP. Additionally, there are one to two QMHP’s in each of our other six counties that are available to cover an eminent crisis until a member of our MCOT can be deployed to that county.
	1. After business hours
	* Two QMHP’s are on call to respond to crises.
	1. Weekends/holidays
	* Two QMHP’s are on call to respond to crises.
2. What criteria are used to determine when the MCOT is deployed?
* Our crisis line is staffed by AVAIL, and they determine when to deploy a worker to a crisis, with respect to Info Item V. Center for Life Resources will always deploy a crisis worker if law enforcement calls the crisis line.
1. 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 bridges the gap between crisis and transitional services. If the ANSA/CANS indicates a score of zero, follow-up services are provided until the client is provided an intake and is assigned a case worker to assist them. If the ANSA/CANS score indicates a nine, the client is provided follow-up and referred to local resources.
1. Describe MCOT support of emergency rooms and law enforcement:
	1. 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 is always deployed when the client is medically stable.
	* Law enforcement: MCOT is always deployed when law enforcement calls.
	1. What activities does the MCOT perform to support emergency room staff and law enforcement during crises?
	* Emergency rooms: Screening, referral or hospitalization or other outpatient treatment, coordinating transport.
	* Law enforcement: Screening, referral or hospitalization or other outpatient treatment, coordinating transport, assist with jail diversion if applicable.
2. 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?
	1. Describe your community’s process if a client needs further assessment and/or medical clearance:
	* MCOT facilitates transport by utilizing emergency medical services, family or law enforcement, to the nearest emergency room, where MCOT waits for the client to be medically cleared before further assessment.
	1. Describe the process if a client needs admission to a hospital:
	* MCOT evaluates the client, and if they are at risk of eminent harm, MCOT contacts a psychiatric hospital admissions representative, secures an emergency detention order, and coordinates transport through law enforcement, family, or emergency medical services.
	1. 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 and client, along with family or other supportive individuals, develop a Safety Plan, with MCOT coordinating transport and admission to our Crisis Respite Facility.
3. What steps should emergency rooms and law enforcement take when an inpatient level of care is needed?
	1. During business hours
	* Call our Crisis Line at 1-800-458-7788.
	1. After business hours
	* Call our Crisis Line at 1-800-458-7788.
	1. Weekends/holidays
	* Call our Crisis Line at 1-800-458-7788.
4. If an inpatient bed is not available:
	1. Where is an individual taken while waiting for a bed?
	* Our Crisis Respite Facility or a local medical hospital.
	1. Who is responsible for providing continued crisis intervention services?
	* MCOT, Respite staff, and the Assigned Case Manager if the person is already in Center for Life Resources regular services.
	1. Who is responsible for continued determination of the need for an inpatient level of care?
	* MCOT, Respite staff, and the Assigned Case Manager if the person is already in Center for Life Resources regular services.
	1. Who is responsible for transportation in cases not involving emergency detention?
	* Family, if possible, emergency medical services, or other non-emergency medical services.

#### Crisis Stabilization

1. 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 | Center for Life Resources Crisis Respite Facility |
| --- | --- |
| Location (city and county) | Brownwood, Brown County |
| Phone number | 325-646-6952 |
| Type of Facility (see Appendix B)  | Crisis Respite |
| Key admission criteria (type of patient accepted) | Clients that are at a low risk of harm to self or others. Crisis Respite does not accept clients that are intoxicated, have a history of severe violence, registered sex offenders or those that are actively suicidal or homicidal. |
| Circumstances under which medical clearance is required before admission | Known medical issues, acute substance abuse, or other presentation deemed necessary by clinical staff providing the assessment. |
| Service area limitations, if any | Limited to residents of CFLR Catchment Area. |
| Other relevant admission information for first responders  | Client must be screened and admitted by Center for Life Resources MCOT.  |
| Accepts emergency detentions? | No |

#### Inpatient Care

1. 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 | Rivercrest Hospital |
| --- | --- |
| Location (city and county) | San Angelo, Concho County |
| Phone number | 800-777-5722 |
| Key admission criteria  | Eminent danger to self or others, or in danger of further decompensation. |
| Service area limitations, if any | CFLR will only pay for inpatient treatment for residents of our seven county catchment area.  |
| Other relevant admission information for first responders | Center for Life Resources MCOT must screen and approve any client needing inpatient hospitalization as payment is made through CFLR contract dollars. |

| Name of Facility | Abilene Behavioral Health  |
| --- | --- |
| Location (city and county) | Abilene, Taylor County |
| Phone number | 844-273-0478 |
| Key admission criteria  | Eminent danger to self or others, or in danger of further decompensation. |
| Service area limitations, if any | CFLR will only pay for inpatient treatment for residents of our seven county catchment area. |
| Other relevant admission information for first responders | Center for Life Resources MCOT must screen and approve any client needing inpatient hospitalization as payment is made through CFLR contract dollars. |

| Name of Facility | Oceans Behavioral Hospital of Abilene |
| --- | --- |
| Location (city and county) | Abilene, Taylor County |
| Phone number | 325-691-0030 |
| Key admission criteria  | Eminent danger to self or others, or in danger of further decompensation |
| Service area limitations, if any | CFLR will only pay for inpatient treatment for residents of our seven county catchment area. |
| Other relevant admission information for first responders | Center for Life Resources MCOT must screen and approve any client needs inpatient hospitalization as payment is made through CFLR contract dollars. |

## **II.C Plan for local, short-term management of pre/post-arrest patients** **incompetent to stand trial**

1. What local inpatient or outpatient alternatives to the state hospital does your service area currently have for competency restoration?
	1. Identify and briefly describe available alternatives.
	* None.
	1. What barriers or issues limit access or utilization to local inpatient or outpatient alternatives? If not applicable, enter N/A.
	* We have no local inpatient or outpatient options for mental health treatment in our catchment area.
	1. 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.

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.

* + Director of Crisis Services and Suicide Prevention.
	1. 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.
	+ N/A. We have no local options in any of our counties.
1. 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.)?
* Yes, we need an OCR Program and funding.
1. What is needed for implementation? Include resources and barriers that must be resolved.
* Funding and providers.

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

1. What steps have been taken to integrate emergency psychiatric, substance use, and physical healthcare services?
* We have applied for grants to integrate physical and behavioral healthcare and for funding through HHSC and DSHS for additional beds, but were denied for both.
1. What are your plans for the next two years to further coordinate and integrate these services?
* Continue to look for and apply for funding resources and grants.

## II.E Communication Plans

1. 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 for Life Resources website, brochures, PNAC meeting, CRCG’s and CIA (Community Inner Agency Meetings held monthly).
1. How will you ensure LMHA staff (including MCOT, hotline, and staff receiving incoming telephone calls) have the information and training to implement the plan?
* Monthly training and oversight by supervisors and monthly clinical supervision.

## II.F Gaps in the Local Crisis Response System

1. 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** |
| --- | --- |
| All seven of our counties – Brown, Mills, Comanche, Eastland, Coleman, San Saba, and McCulloch counties. | * Local inpatient alternatives.
 |
| All seven of our counties – Brown, Mills, Comanche, Eastland, Coleman, San Saba, and McCulloch counties. | * Facility based crisis stabilization.
 |
| All seven of our counties – Brown, Mills, Comanche, Eastland, Coleman, San Saba, and McCulloch counties. | * Mental Health Deputy Program.
 |

# 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[x]  Documenting police contacts with persons with mental illness[ ]  Police-friendly drop-off point[x]  Service linkage and follow-up for individuals who are not hospitalized[x]  Other: Click here to enter text. | * Periodic meetings with local law enforcement to discuss ways of reducing the number of mentally ill who are incarcerated.
 |
| **Plans for the upcoming two years:** * Apply for all opportunities to create and expand a Mental Health 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 [x]  Staff at court who can authorize alternative services to incarceration[ ]  Link to comprehensive services[ ]  Other: Click here to enter text. | * We assist our district court in finding alternate placement and provide guidance with respect to the court provided psychiatric evaluation, to reduce undue incarceration of the mentally ill.
 |
| **Plans for the upcoming two years:** * Continue gathering community input on local resources to address local mental health needs.
 |

| **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:  | * n/a
 |
| **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 and procedures[ ]  Specialized case management teams to coordinate post-release services[ ]  Other:  | * n/a
 |
| **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[x]  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:  | * We currently have a TCOOMMI Contract and program.
 |
| **Plans for the upcoming two years:** * Continue contracting for TCOOMMI services.
 |

## 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 | * Good
 | * Continue current level or better.
 |
| Reducing hospital readmissions | * Good
 | * We have made significant improvement in this area over the last FY. Continue current level or better.
 |
| Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community | * n/a
 | * n/a
 |
| Reducing other state hospital utilization | * Good
 | * Continue to divert clients to our crisis Respite Facility when clinically appropriate and using our contract hospitals when clinically appropriate for short term (1-3 days) inpatient stay.
 |
| Tailoring service interventions to the specific identified needs of the individual | * Good
 | * Continue current level or better.
 |
| Ensuring fidelity with evidence-based practices | * Good
 | * Continue current level or better.
 |
| 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) | * Excellent
 | * Continue to grow our Peer Support provider pool.
 |
| Addressing the needs of consumers with co-occurring substance use disorders | * Good
 | * Continue current level or better.
 |
| Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers. | * Poor
 | * Continue to look for funding sources.
 |

## 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** |
| --- | --- | --- |
| Mental Health Deputy Program | * Gathering stakeholder input.
 | * Seek funding sources.
 |
| Local inpatient psychiatric beds | * Gathering stakeholder input.
 | * Seek funding sources.
 |
| Respite expansion | * Our Respite Facility is very old and needs to be larger to accommodate more clients.
 | * Seek funding sources.
 |
| Increased Peer Lead services | * We have added one Peer Support Specialist in the last six months.
 | * Continue to recruit Peer Support Specialists.
 |
| Increased psychiatric provider time | * We have added two part time child psychiatrists in the last FY.
 | * Seek funding sources.
 |

## 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.

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

| **Priority**  | **Need** | **How resources would be used (brief)** | **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 | Mental Health Deputy Program | * Develop and implement a Mental Health Deputy Program in each of our seven counties to assist in jail diversion.
 | * $175,000.00
 |
| 2 | Local inpatient psychiatric beds | * Establish inpatient beds at each of our local medical hospitals in our seven county catchment area.
 | * $200,000.00
 |
| 3 | Increased Psychiatrist time | * Recruit and employ additional psychiatrists.
 | * $200,000.00
 |
| 4 | Respite funding | * Purchase a new respite facility that is larger, which will allow us to utilize the additional beds for hospital diversion.
 | * $475,000.00
 |

# 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.