Department of State Health Services

Form O
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
Burke Center Mental Health Clinic	1522 West Frank Ave. Lufkin, Tx 75904	Angelina	• Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services: both adults and children • Services for co-occurring disorders • Substance abuse intervention • Integrated healthcare: mental and physical health • Mobile Crisis Outreach Team • Consumer Benefits
Burke Center Mental Health Clinic	1401 W. Austin Crockett, Tx 75835	Houston	• Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services: both adults and

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
			children • Services for co-occurring disorders • Substance abuse intervention • Integrated healthcare: mental and physical health • Mobile Crisis Outreach Team • Consumer Benefits
Burke Center Mental Health Clinic	1250 Marvin Hancock Dr. Jasper, Tx 75951	Jasper	• Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services: both adults and children • Services for co-occurring disorders • Substance abuse intervention • Integrated healthcare: mental and physical health • Mobile Crisis Outreach Team • Consumer Benefits
Burke Center Mental Health Clinic	4632 N.E. Stallings Dr. Nacogdoches, Tx 75965	Nacogdoches	• Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services: both adults and children • Services for co-occurring disorders • Substance abuse intervention • Integrated healthcare: mental and physical health • Mobile Crisis Outreach Team • Consumer Benefits
Burke Center Mental Health Clinic	1100 Ogletree Drive Livingston, Tx 77351	Polk	• Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services: both adults and

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
			children • Services for co-occurring disorders • Substance abuse intervention • Integrated healthcare: mental and physical health • Mobile Crisis Outreach Team • Consumer Benefits
Burke Center Mental Health Clinic	583 El Camino Crossing San Augustine, Tx 75972	San Augustine	• Screening, assessment, and intake • Texas Resilience and Recovery (TRR) outpatient services: both adults and children • Services for co-occurring disorders • Substance abuse intervention • Integrated healthcare: mental and physical health • Mobile Crisis Outreach Team • Consumer Benefits
Burke Center Mental Health Clinic	317 Prospect Dr. Trinity, Tx 75862	Trinity	• Texas Resilience and Recovery (TRR) outpatient services: both adults and children • Services for co-occurring disorders • Substance abuse intervention • Integrated healthcare: mental and physical health • Mobile Crisis Outreach Team • Consumer Benefits
Burke Center Mental Health Clinic	1100 West Bluff Woodville, Tx 75979	Tyler	• Texas Resilience and Recovery (TRR) outpatient services: both adults and children • Services for co-occurring disorders

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
			• Substance abuse intervention • Integrated healthcare: mental and physical health • Mobile Crisis Outreach Team • Consumer Benefits
Mental Health Emergency Center (MHEC)	105 Mayo Place Lufkin, Tx 75904	Angelina	• Extended Observation Unit • Crisis Residential Unit • Detox Services
Aspire Behavioral Health of Conroe	2006 S. Loop 336 W, Ste 500 Conroe, TX 77304	Montgomery	• Contracted inpatient beds
Cypress Creek Hospital	17750 Cali Dr. Houston, TX 77090	Harris	• Contracted inpatient beds
Hopebridge Hospital	5556 Gasmer Dr. Houston 77035	Harris	• Contracted inpatient beds
Palestine Regional Medical Center	2900 South Loop 256 Palestine, TX 75801	Anderson	• Contracted inpatient beds
Kingwood Pines Hospital	2001 Ladbrook Kingwood, Tx 77339	Montgomery	• Contracted inpatient beds

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
1	Expansion. Expand the capacity of the Burke Center to serve more children and adults with mental illness.	5	*	138/DY4
2	Expansion. Expand the capacity of the Burke Center to serve more children and adults with mental illness.	5	*	1562/ DY4
2	Telemedicine. Improve access to psychiatric care by enhancing and expanding the current telemedicine infrastructure.	5	*	1588/ DY4
2	Peer Support Services. Train and employ Peer Specialists to provide "whole health" support to mental health consumers in order to prevent or manage comorbid chronic health conditions.	5	*	170/ DY4
2	Integrated Care. Integrate primary care with behavioral health care services the Center provides in order to improve access to needed health services and improve overall health and wellbeing.	5	*	954/ DY4
2	Enhanced Behavioral Management. Promote mental health recovery and prevent individuals from experiencing repeated hospitalizations or incarcerations.	5	*	642/ DY4
2	Mental Health Education, Outreach, and Engagement. To develop and implement a public education and outreach plan using a variety of social media platforms to improve engagement in behavioral healthcare services and promote mental health.	4	*	25,893/ DY4
2	Medical Detox and Treatment Services. To create a medically supervised residential detoxification unit in the Burke Center's Mental Health Emergency Center.	4	*	50/ DY3
*	Our projects do not limit the number of individuals that can be served.			

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.

• Transportation of consumers, particularly those seeing voluntary hospitalization or crisis residential services
• Lack of psychiatric hospital beds
• Respite services for families of children and adolescents with mental health disorders
•
•
•

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

- The Rural East Texas Health Network (RETHN) was formed in 2006 through a federal grant in response to the tremendous need within our rural communities for a strategic plan/infrastructure to handle mental health crisis situations in an efficient and effective manner.
- The RETHN is a collaborative effort of twelve counties within our region. Local advisory boards were formed for the counties of Angelina, Nacogdoches, Houston, Jasper, Newton, Polk, San Augustine, San Jacinto, Shelby, Sabine, Tyler, and Trinity. These local boards include police chiefs/officers, sheriffs/deputies, hospital administrators, emergency room/trauma directors, judges, magistrates, mental health workers, physicians, city managers, NAMI representatives, as well as other interested community members. A representative from each of these local boards serves on the RETHN Regional Board of Directors. Each local advisory board and the Board of Directors meets quarterly.

II.B Crisis Response Process and Role of MCOT

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

- 7 program staff are available for assessment and intervention services. Additionally, psychiatric services are available on demand via telemedicine through contractual arrangement.

b. After business hours

- 12 program staff are available for dispatch for assessment and intervention services.

c. Weekends/holidays

- 12 program staff are available for dispatch for assessment and intervention services.

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

- MCOT staff are deployed whenever an individual, family member, or community member indicates an individual is in a mental health crisis.

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 provide assessment, linking with other resources, follow up monitoring and facilitating placement into the next needed level of care, whether hospitalization or outpatient services.

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 routinely contact emergency services and MCOT is routinely deployed to such location.

- Law enforcement routinely contacts emergency services and MCOT is routinely deployed to such location.

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

- Emergency rooms: Mental health and lethality assessment, assistance with placement.
- Law enforcement: Mental health and lethality assessment, assistance with transportation, consultation to law enforcement on EPOWs.

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:

- Medical clearance, when necessary, is obtained through our integrated care clinic or a local emergency room. Further assessment of mental health status, when necessary, is obtained through the use of our contracted on-demand psychiatric services or the Mental Health Emergency Center (MHEC).

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

- In many cases, stabilization can be achieved through services at the MHEC. If not, hospitalization for those without payor source or those requiring involuntary commitment is coordinated though Burke Emergency services. Individuals who are voluntarily seeking placement and who have a payor source may obtain these services through the MHEC, Burke Emergency Services, or transfer from a local general hospital. In the case of the latter, Burke Emergency Services offers assistance is needed, and facilitates transportation if needed.

   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.):

- Law enforcement, emergency rooms, Burke staff and other providers contact the MHEC. A brief phone screening is done to assess for appropriateness to the facility and the client is either accepted for on site evaluation or a higher level of care facilitated.

6. What steps should emergency rooms and law enforcement take when an inpatient level of care is needed?
    a. During business hours
        - Contact the MHEC to initiate services.

    b. After business hours

        - Contact the MHEC to initiate services.

    c. Weekends/holidays

        - Contact the MHEC to initiate services.

7. If an inpatient bed is not available:

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

        - Options include the MHEC, home with a safety plan and MCOT monitoring, or remain where they were when crisis services were initiated.

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

        - MHEC and MCOT

    c. Who is responsible for continued determination of the need for an inpatient level of care?
    d.
        - MHEC and MCOT; local hospital staff may pursue unilaterally if they choose

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

- Clients, and their family and friends. Burke Center assists with exploring options when requested.

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	Mental Health Emergency Center
Location (city and county)	Lufkin; Angelina County
Phone number	936/674-3500
Type of Facility (see Appendix B)	EOU and Crisis Residential
Key admission criteria (type of patient accepted)	Adults in mental health crisis or in need of detox
Circumstances under which medical clearance is required before admission	Medical clearance is not required. It is requested when the individual is currently exhibiting any symptoms or behaviors that might indicate an acute or chronic medical problem that cannot be safely treated and managed at the facility.
Service area limitations, if any	All counties in our 12 county service area are included
Other relevant admission information for first responders	The MHEC requires phone contact for a preliminary screening prior to face to face evaluation.
Accepts emergency detentions?	Individuals who otherwise meet admission criteria may be admitted involuntarily for a Preliminary Examination under a Mental Health Warrant or a Peace Officer's Emergency Detention form.

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	None in our service area. Contacts are done with facilities outside of our service area (see page 8)
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/post-arrest patients 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.

- No local alternatives for competency restoration are available.

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

- N/A

    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

    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.

- Clinical Coordinators; Continuity of care workers

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.

- N/A

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.)?

- No; we have a very low frequency of request for this service.

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

- N/A

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?

- Through our DSRIP projects, funding has been obtained to coordinate substance abuse services with the Alcohol and Drug Abuse Counsel, placing substance abuse staff at outpatient mental health clinics and the MHEC. Additionally, funding was obtained to implement a detox program at the MHEC. An integrated care clinic was opened in the Mental Health Clinic in Angelina County through partnership with the Angelina County and Cities Health District.

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

- Offer integrated care in two other mental health clinics.

- Continue existing partnerships and 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.

- The protocol for access to these services is communicated verbally at regional stakeholder meetings, as well as by a laminated guide. Protocols, forms, training materials and resources for law enforcement and other first responders and medical providers are available on the Burke website. We have a Crisis Coordinator who was hired to exchange information with stakeholders and to judge satisfaction.

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?

- All relevant staff receives training on the process at hire and when changes to processes are enacted.

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
All	• Transportation
All	• Access to psychiatric hospital beds
All	• Safety monitoring when an individual is involuntary, and cannot be transferred

Counties	Service System Gaps
	from the ER as they are not medically stable, or a bed is being sought

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: MH Deputy	• The MH Deputy is embedded in our crisis system, and is available to assess individuals and intervene prior to arrest if requested by law enforcement to do so.
Plans for the upcoming two years:	

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
• Continue CIT • Advocate for funds to expand hire additional MH deputies	

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.	• None
Plans for the upcoming two years: • Use newly hired Continuity of Care workers to cross-check lists, and then communicate with courts and facilitate treatment.	

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	• One county has a MH court, and Burke has dedicated staff to this function

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☐ 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:	
Plans for the upcoming two years: • Advocate for the development of additional MH courts in our service area	

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	• • Through our contract with Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), Burke provides continuity of care services for offenders that are transitioning to re-entry from the criminal justice system. Burke provides assessment of needs, development of

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
☒ Specialized case management teams to coordinate post-release services ☐ Other:	plans for services, psychiatric assessment, medication management, and case management from the time of re-entry through the point in which the offender is transitioned to an LMHA caseworker within our outpatient mental health clinics. • Continuity of care workers assure aftercare appointments to discharges of forensic evaluations, with referral to services as appropriate
Plans for the upcoming two years: • Continue processes	

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	• Through our contract with Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), Burke provides comprehensive services to offenders who are supervised through the Angelina County Community Supervision and Corrections Department (CSCD). Burke provides LPHA diagnostic evaluations for offenders who have been referred from CSCD to screen for mental

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
☐ Working with community corrections to ensure a range of options to reinforce positive behavior and effectively address noncompliance ☐ Other:	health and substance use disorders. Offenders who meet diagnostic criteria for LMHA services are placed on the specialized TCOOMMI Intensive Case Management caseload. Staff from Burke's TCOOMMI program (Intensive Case Management caseworker and program director) serve as a liaison with Angelina County CSCD.
Plans for the upcoming two years: • Continue processes	

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	• Four new continuity of care staff have been funded by DSHS grant	• Improve continuity of care to and from crisis and forensic treatment settings
Reducing hospital readmissions	• Four new continuity of care staff have been funded by DSHS grant • Expansion of MCOT services through DSRIP funding	• Improve continuity of care to and from crisis and forensic treatment settings • Advocate for continued funding of these processes
Transitioning long-term state hospital patients who no	• The emergency services director works with hospital staff in	• Explore viability of developing HCBS-AMH opportunities in our service area

Area of Focus	Current Status	Plans
longer need an inpatient level of care to the community	identifying those long term clients eligible for discharge and identifies viable community settings for transfer	
Reducing other state hospital utilization	• This is a primary purpose of our MHEC • The emergency services director identifies viable private hospitals willing to accept our clients, and negotiates rates for general revenue clients	• Continue processes
Tailoring service interventions to the specific identified needs of the individual	• Implementation of Person centered Recovery Planning • Implementation of Integrated Care Clinic • Involvement in the National Council's Depression Care Collaborative • Involvement in DSHS Trauma Informed Care Collaborative	• Continue processes
Ensuring fidelity with evidence-based practices	• Regular fidelity reviews of evidence based practices using relative "toolkits" to assess adherence	• Continue processes
Transition to a recovery-oriented system of care, including development of peer	• Implementation of Person Centered Recovery Planning	• Continue processes

Area of Focus	Current Status	Plans
support services and other consumer involvement in Center activities and operations (e.g., planning, evaluation)	• Certified Peer Specialist are part of the teams at all outpatient MH clinics	
Addressing the needs of consumers with co-occurring substance use disorders	• With DSRIP funding, 2 licensed substance abuse counselors were placed in our outpatient mental health clinics, and a residential detox program was implemented	• Advocate for continued funding
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• With DSRIP funding, an Integrated Care Clinic was placed in our largest outpatient mental health clinic	• Advocate for continued funding

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
Availability of psychiatric	• We contract with all willing and	• Continue to advocate for funding.

Local Priority	Current Status	Plans
hospital beds	able providers within reasonable driving distance of our service area. A grant proposal to DSHS for funding to reserve beds exclusively for Burke use was submitted but was not awarded.	
Transportation of consumers, particularly those seeing voluntary hospitalization or crisis residential services	• A grant proposal to DSHS for funding to reserve beds exclusively for Burke use was submitted but was not awarded.	• Continue to advocate for funding.
	•	•
	•	•
	•	•

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	How resources would be used (brief)	Estimated Cost
1	Psychiatric hospitalization availability	• Reserve 5 contract beds to assure access	• $1,646,150
1	Crisis transportation	• Contract transportation to reduce burden on law enforcement	• $350,000
1	MH Deputy	• Hire two more deputies to expand area covered	• $150,000
2	MCOT after hour assessors	• Additional after hour assessors to remote areas	• $200,000
2	Outpatient psychiatric care	• Provide 2000 hours of tele-psychiatry to improve timely access to psychiatric care, thus reducing potential for crisis	• $500,000

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.