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
MHMR Services for the Concho Valley – Outpatient Clinic	202 N. Main St. San Angelo 76903	Tom Green	• Adult • Screening, assessment & intake • TX Resilience & Recovery outpatient services • Services for co-occurring disorders
MHMR Services - CV Family & Youth Guidance Center	424 S. Oakes San Angelo 76903	Tom Green	• Children/Adolescents • Screening, assessment & intake • TX Resilience & Recovery outpatient services
MHMR Services – CV Crisis Respite Center	244 N. Magdalen Bldg 240 San Angelo 76903	Tom Green	• Adult • Crisis Residential and/or Respite
W. TX Counseling & Guidance	242 N. Magdalen San Angelo 76903	Tom Green	• Adult CBT and CPT
MHMR Services – CV Rural ACT Team	244 N. Magdalen Bldg 240 San Angelo 76903	Tom Green	• Adult • Services for co-occurring disorders

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**
13	Expand & Enhance Behavioral Health Services	1-5	125	106
13	Integrate Primary and Behavioral Health Care	1-5	78	106
13	IDD Behavioral Health Crisis Response System	1-5	122	127

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.

• Co-occurring mental illness and substance abuse treatment
• Jail-based psychiatric and rehabilitation services
• Support groups for individuals with MI
• Jail-based psychiatric services
• Expansion of CSU beds
• Expansion of capacity at adult mental health Crisis Respite
• Tobacco cessation program
• Lack of availability of psychiatrists/LPCs
• Housing (such as group homes) for those with MI
• Expansion of capacity at IDD Crisis Respite
• Assisted Outpatient Treatment
• Substance abuse treatment of IDD/MH patients
• Need for more mental health awareness activities
• Need to increase recovery focused services
• Lack of state operated facilities for youth

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

- LMHA holds Jail diversion meetings monthly/quarterly with all stakeholders, i.e. SO, PD, Jail staff, Emergency room representatives, ADAC, school administrators, MCOT, and mental health deputies. All entities from service area are notified and encouraged to attend including county judges, officials, SO and FQHC.

II.B Crisis Response Process and Role of MCOT

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

   - Two full-time, deployable MCOT Coordinators and one Director of Crisis Services

   b. After business hours

   - One on-call worker per shift, four to eight on-call workers on rotation, M-F 5PM-8AM, Sat-Sun 8AM-8AM

   c. Weekends/holidays
   - One on-call worker per shift, 8AM-8AM

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

   - MHMRCV contracts with AVAIL Solutions, Inc. to provide a 24/7 hotline service for the purpose of crisis call screening and MCOT dispatch, in accordance with DSHS crisis services standards
   - MCOT is deployed at the discretion of the AVAIL hotline service.
   - Individuals must present as a danger to self or others by way of:
     - Suicidal Ideation
     - Homicidal Ideation
     - Psychotic Decompensation

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 is activated by the AVAIL hotline service for individuals who meet the criteria described above
- MCOT responds to a variety of community settings, to include local emergency rooms, county jail, schools, private psychiatric hospital intake departments, outpatient clinics, etc.
- MCOT provides a thorough assessment of the individual in crisis, in accordance with current DSHS standards
- MCOT provides referral to resources based on individual need, to include counseling, LMHA services, inpatient care, inpatient substance abuse care and related outpatient programs, and other community resources.
- MCOT provides follow-up with individuals in LOC-5/transitional services and assists in connecting them to the resources they need to thrive in the community

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: Yes, when activated via the AVAIL hotline service
- Law enforcement: Yes, when activated via the AVAIL hotline service

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

- Emergency rooms: Prompt screening, crisis intervention, and referral when necessary
- Law enforcement: Prompt screening, crisis intervention, and referral when necessary

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:

- If a pressing medical need is indicated, the individual is referred, either voluntarily or involuntarily, to a local ER prior to receiving psychiatric treatment

- Once medically cleared/stable, the individual is assessed by licensed mental health/ER staff, who then activate MCOT via the AVAIL hotline service for screening and referral

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

- MCOT determines individual's status as a voluntary or involuntary admission
- MCOT determines the least restrictive environment necessary for the individual's safety
- As needed and if applicable, MCOT assists in applying for an Emergency Detention Order for involuntary admissions
- MCOT makes the appropriate referral to a local, contracting private psychiatric facility or state hospital
- MCOT provides the LMHA screening to the receiving hospital's intake department
- MCOT assists in arranging transportation with the local Mental Health Deputies for involuntary admissions

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.):

- MHMR Services for the Concho Valley operates an MH Crisis Respite service for adults
- MCOT, for individuals requiring this service, can contact MH Crisis Respite staff to check bed availability and refer
- MCOT staff, or a QMHP on-shift at the MH Crisis Respite facility, completes a Crisis ANSA to authorize bed days

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

- Emergency Room, Individual with insurance:
  - Barring the need for further medical intervention, contact River Crest Hospital and Shannon Behavioral Health to determine bed availability and refer as needed
  - Should the individual be declined at both facilities, contact MCOT via the AVAIL hotline service to assist with placement as needed
- Emergency Room, Individual without insurance or any individual requiring state hospital referral:

- Barring the need for further medical intervention, contact MCOT via the AVAIL hotline service for screening and referral

- Law Enforcement: Initiate Peace Officer's Detention Order for individual's immediate safety and transport to nearest emergency room or psychiatric hospital intake department for assessment and MCOT activation as needed.

b. After business hours

- Follow the protocol noted above

c. Weekends/holidays

- Follow the protocol noted above

7. If an inpatient bed is not available:

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

- If the individual is presenting in:
  - An Emergency Room: Individual will be admitted to the medical hospital associated with that emergency room, in accordance with the medical hospital's admissions protocols
  - Jail: Individual will remain in the custody of jail staff for observation as allowed by the individual's charges/detention order. Should the individual require immediate release from custody or medical clearance, they will be referred to the nearest emergency room for further evaluation
  - Private Psychiatric Facility Intake: Individual will be referred to the nearest, comparable facility for treatment due to limited bed availability

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

- MCOT will remain responsible for providing continued crisis intervention services for those individuals referred via the AVAIL hotline service

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

- MCOT will remain responsible for determining the need for an inpatient level of care throughout the crisis episode for those individuals referred via the AVAIL hotline service

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

- Depending on the location of the individual in crisis, the service organization or hospital in charge of the individual's care will be responsible for arranging transportation via a non-emergency ambulance, taxi service, or agreeable family member/friend.
- Individuals in crisis at an MHMR facility will be transported as necessary by case management staff, MH Crisis Respite staff, or an agreeable family member/friend.

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	MH Crisis Respite
Location (city and county)	San Angelo, TX/Tom Green County
Phone number	(325)481-4382
Type of Facility (see Appendix B)	Crisis Respite
Key admission criteria (type of patient accepted)	Individual with present or history of MI, no active suicidal/homicidal thoughts, need for medication monitoring or "respite" from current stressors.
Circumstances under which medical	Presence of active heart condition causing current symptoms, severe

Name of Facility	MH Crisis Respite
clearance is required before admission	pain, flu symptoms, suicidal/homicidal ideation, or detox risk.
Service area limitations, if any	Limited to MHMR-CV service area
Other relevant admission information for first responders	N/A
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	River Crest Hospital
Location (city and county)	San Angelo, TX/Tom Green County
Phone number	(325)949-5722
Key admission criteria	Suicidal/Homicidal ideation, psychotic decompensation, substance abuse
Service area limitations, if any	N/A
Other relevant admission information for first responders	N/A
Name of Facility	Shannon Behavioral Health
Location (city and county)	San Angelo, TX/Tom Green County
Phone number	(325)659-7300
Key admission criteria	Suicidal/Homicidal ideation, psychotic decompensation
Service area limitations, if any	N/A
Other relevant admission information for first responders	Must be assessed via Shannon Medical Center Emergency Room
Name of Facility	Abilene Behavioral Health/ACADIA
Location (city and county)	Abilene, TX/Taylor County

Name of Facility	River Crest Hospital
Phone number	(325)698-6600
Key admission criteria	Suicidal/Homicidal ideation, psychotic decompensation, substance abuse
Service area limitations, if any	N/A
Other relevant admission information for first responders	N/A
Name of Facility	Oceans Behavioral Health
Location (city and county)	Abilene, TX/Taylor County
Phone number	(325)691-0030
Key admission criteria	Suicidal/Homicidal ideation, psychotic decompensation
Service area limitations, if any	N/A

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.

- MHMR-CV has no alternatives available at this time.

    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?

- MHMRCV does not have a dedicated jail liaison position

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.

- The Assistant Respite Supervisor dedicates part of their time to performing Continuity of Care Query match screening at the local jail
- Both MCOT Coordinators dedicate part of their time to performing firewatch clearance and release screenings at the jail
- All three of the above employees serve as liaisons between the LMHA and the jail

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.)?

- Yes; the MHMRCV service area has a need for competency restoration alternatives
- Jail-based/Outpatient Competency Restoration programs would be suitable

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

- Lack of local judges that can be appointed is a barrier based on the capacity of the dockets for other cases.

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?

- The local Alcohol and Drug abuse council has current plans to build and support a medical d-tox facility. The local emergency room of the 501-C3 has implemented telepsychaiatry in near future. Local center through the 1115 grant has developed primary health care within center outpatient services.

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

- Continue working on transformational grants in order to fill gaps in services to include supporting through communication on the medical d-tox facility.

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.

- Our center coordinates on quarterly basis with stakeholders via a Jail diversion partnership meeting. As needed the meetings have been on monthly basis in order to coordinate service needs.

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?

- LMHA sends staff to applicable trainings when available. LMHA is one of smaller centers and communicates daily with stakeholders via telephone, internet, websites. MCOT sends staff to state hospital forensic conferences as scheduled.

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	• Limited bed availability at state hospitals for severe crisis symptoms/episodes of mental illness
All	• Psychiatrists, telemedicine physicians,

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	• MHMR Concho Valley continues to provide training to criminal justice partners as needed, which includes "Identification of Mental Illness" and Mental Health First Aid Training. Training provided upon request and as needed throughout the year.

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☐ Police-friendly drop-off point ☐ Service linkage and follow-up for individuals who are not hospitalized ☐ Other: Click here to enter text.	

Plans for the upcoming two years:

- Continue training of law enforcement staff and probation personnel as needed
- Begin training of court personnel as needed via newly created Jail Diversion Coordinator/Continuity of Care position

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.	• Continuity of Care Query screenings as needed at Tom Green Co. Jail • Firewatch/Safety screenings as needed at the Tom Green Co. Jail • Safety screenings prior to release for individuals with symptoms of MI and history of suicidal ideation or attempts

Plans for the upcoming two years:

- Implement the above strategies via the newly created Jail Diversion Coordinator/Continuity of Care position

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**

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:	• There is minimal forward activity to report at this time. The ideas of Mental Health and Veteran's courts have not yet gained momentum. However, the LMHA continues to strive to meet the identified needs for forensic evaluations and commitments. In addition, the drug and DWI courts are utilized more often at the local CSCD office. LMHS staff are assisting and collaborating with these courts to better serve the offender and their families. • Provision of psychiatric medications for incarcerated individuals with MI via TCOOMMI or Tom Green Co. Indigent Health
Plans for the upcoming two years: • Continued discussion with local judicial representatives regarding AOT programs	

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	• Newly Allocated TCOOMMI Program Position for Jail Diversion and Continuity of Care, will

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
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:	assist with pre and Post-booking activities with the local Tom Green County Jail and Judicial courts. • TCOOMMI Jail Diversion program will assist with diverting, post booking individuals identified with mental illness to appropriate treatment/support services, as well as liaison with the local courts/judges on the behalf of the offender and will assist in coordinating transition into services as well as post release. •
Plans for the upcoming two years: • Continue the above strategies with newly created Jail Diversion Coordinator/Continuity of Care position	

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
■ Routine screening for mental illness and substance use disorders ■ Training for probation or parole staff ■ TCOOMMI program ☐ Forensic ACT ■ Staff assigned to facilitate access to comprehensive services; specialized caseloads ■ Staff assigned to serve as liaison with community corrections ■ Working with community corrections to ensure a range of	• MHMR Concho Valley TCOOMMI Programs assist in providing training to criminal justice partners, such as parole and probation staff. • TCOOMMI program staff routinely screen all individuals eligible for services whom may have a mental health/illness issue. • TCOOMMI staff/Program Director serve as liaison with criminal justice partners and

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
options to reinforce positive behavior and effectively address noncompliance ■ Other:	include partners in IDT meetings as well as quarterly meetings. The Local TCOOMMI Program works closely and collaboratively with Juvenile/Adult Probation, Local parole office, CRTC/SATF facilities via the local CSCD Probation offices. •
Plans for the upcoming two years: • Add Jail Diversion Coordinator/Continuity of Care position to consolidate several of the above strategies	

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	• Continuity of care worker travels to state hospital weekly for staffing. BSSH refers to worker for aftercare. Local psychiatric hospitals refer upon discharge and coordinate with LMHA referrals/appointments for aftercare.	• Continue with current plan as needed. When local emergency room acquires telepsychiatry integrate resources and referrals.
Reducing hospital readmissions	LMHA works with key mental health deputies and coordinates	• Strengthen the LMHA RACT team, OPC staff.

Area of Focus	Current Status	Plans
	screenings with MCOT to reduce rapid readmissions.	
Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community	• LMHA currently works with housing, primary care, emergency rooms and local nursing homes to ensure seamless coordination from discharge.	• Lack of adequate housing is barrier to placement. Work with housing authority, low income housing department and other local stakeholders.
Reducing other state hospital utilization	• LMHA coordinates with local ADAC with co-occurring disorders to include primary care providers if patient has medical needs.	• Continuing working with courts, SO, PD on least restrictive placements.
Tailoring service interventions to the specific identified needs of the individual	• LMHA develops individualized treatment plans according to standards. Tailored services include referrals to CBT outside therapists, primary care and FQHC settings.	• Continue working with stakeholders to include ADAC, counseling centers and primary care settings.
Ensuring fidelity with evidence-based practices	• LMHA works with CBT therapy groups and coordinates with primary care settings.	• Continuing education and trainings for CBT standards with LMHA therapists.
Transition to a recovery-oriented system of care, including development of peer support services and other	• LMHA has one part-time peer specialist working with RACT team.	• Peer specialist will continue to be an active team member with our RACT services and provide skill training services when services are deemed

Area of Focus	Current Status	Plans
consumer involvement in Center activities and operations (e.g., planning, evaluation)		medically necessary while being under the supervision of an LPC.
Addressing the needs of consumers with co-occurring substance use disorders	• LMHA coordinates with local ADAC with co-occurring disorders to include primary care providers if patient has medical needs.	• Continue to develop and coordinate with ADAC when d-tox facility is completed in near future.
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• Transformational grants have been established to help with primary care.	• Continue to make coordinated referrals as needed with FQHC.

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
1. Expansion of peer provider supports	• LMHA has one part-time peer support specialist working with RACT team.	• Hiring one to two more part- time specialists.

Local Priority	Current Status	Plans
2. Recovery based support programs	• Supported Housing, Supported Employment, COPSD	• To ensure staff are trained in SAMHSA Supported Employment, SAMHSA Permanent Supported Housing, and DSHS approved COPSD training prior to the provision of these supports.
3. Expand capacity of respite services	• Received grant to expand/update/furnish current facility to accommodate more patients.	• Currently receiving RFP on expansion of respite facility.

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	Co-occurring mental illness and substance abuse treatment	• Fund positions for a full time LCDC/Case Manager and part time Advanced Nurse Practitioner to support staff at the Alcohol & Drug Abuse Council of the Concho Valley. • Install telemedicine equipment at the Alcohol & Drug Abuse Council of the Concho Valley to support psychiatric consultation.	• $200,000 annually
2	Jail-based psychiatric & rehabilitation services	• Establish an education & rehabilitation program with the Tom Green County Jail. • Fund positions of full time mental health professional, full time Licensed Chemical Dependency Counselor, and part time Advanced Nurse Practitioner to provide education, rehabilitation, psychiatric supports, and residential outpatient competency restoration to individuals with mental illness residing in the Tom Green County Jail.	• $500,000 annually
3	Mobile Psychiatric Clinic	• Improve access to psychiatric services in small communities in surrounding counties. Address the needs of the low income and indigent. • Provide for a vehicle, poly-com / communication equipment. • Fund position for a full time LVN/QMHP.	• $250,000 annually

Priority	Need	How resources would be used (brief)	Estimated Cost
		• Fund position for a part time Advanced Nurse Practitioner.	
4	Expand Crisis Stabilization Unit	• Establish 6 additional CSU beds for Shannon Behavioral Health & Rivercrest Hospitals.	• $220,000 annually

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.