Form O

Consolidated Local Service Plan

Local Mental Health Authorities and Local Behavioral Health Authorities

From

**Anderson-Cherokee Community Enrichment ServiceS**

**Fiscal Years 2020-2021**

Due Date: September 30, 2020

Submissions should be sent to:

[Performance.Contracts@hhsc.state.tx.us](mailto:Performance.Contracts@hhsc.state.tx.us) and [CrisisServices@hhsc.state.tx.us](mailto:CrisisServices@hhsc.state.tx.us)

**Contents**

[Introduction 3](#_Toc23232223)

[Section I: Local Services and Needs 4](#_Toc23232224)

[I.A Mental Health Services and Sites 4](#_Toc23232225)

[I.B Mental Health Grant Program for Justice Invovled Individuals 6](#_Toc23232226)

[l.C Community Mental Health Grant Progam 6](#_Toc23232228)

[I.D Community Participation in Planning Activities 7](#_Toc23232229)

[Section II: Psychiatric Emergency Plan 11](#_Toc23232230)

[II.A Development of the Plan 12](#_Toc23232231)

[II.B Utilization of Hotline, Role of Mobile Crisis Outreach Teams, and Crisis Response Process 13](#_Toc23232232)

[II.C Plan for local, short-term management of pre- and post-arrest patients who are incompetent to stand trial 20](#_Toc23232233)

[II.D Seamless Integration of emergent psychiatric, substance use, and physical healthcare treatment 23](#_Toc23232234)

[II.E Communication Plans 24](#_Toc23232235)

[II.F Gaps in the Local Crisis Response System 24](#_Toc23232236)

[Section III: Plans and Priorities for System Development 25](#_Toc23232237)

[III.A Jail Diversion 25](#_Toc23232238)

[III.B Other Behavioral Health Strategic Priorities 30](#_Toc23232240)

[III.C Local Priorities and Plans 36](#_Toc23232241)

[III.D System Development and Identification of New Priorities 37](#_Toc23232242)

[Appendix A: Levels of Crisis Care](#_Toc23232243) 39

Appendix B: Acronyms..………….…………………………………………………………………………………………………………………………………………..41

## Introduction

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

The CLSP asks for information related to community stakeholder involvement in local planning efforts. The Health and Human Services Commission (HHSC) recognizes that community engagement is an ongoing activity and input received throughout the biennium will be reflected in the local plan. LMHAs and LBHAs may use a variety of methods to solicit additional stakeholder input specific to the local plan as needed. In completing the template, please provide concise answers, using bullet points. Only use the acronyms noted in Appendix B and language that the community will understand as this document is posted to LMHAs and LBHAs’ websites. When necessary, add additional rows or replicate tables to provide space for a full response.

# 

# Section I: Local Services and Needs

## I.A Mental Health Services and Sites

* *In the table below, list sites operated by the LMHA or LBHA (or a subcontractor organization) providing mental health services regardless of funding. 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, adolescents, and children (if applicable):*
  + *Screening, assessment, and intake*
  + *Texas Resilience and Recovery (TRR) outpatient services: adults, adolescents, or children*
  + *Extended Observation or Crisis Stabilization Unit*
  + *Crisis Residential and/or Respite*
  + *Contracted inpatient beds*
  + *Services for co-occurring disorders*
  + *Substance abuse prevention, intervention, or treatment*
  + *Integrated healthcare: mental and physical health*
  + *Services for individuals with Intellectual Developmental Disorders(IDD)*
  + *Services for youth*
  + *Services for veterans*
  + *Other (please specify)*

| **Operator (LMHA/LBHA or Contractor Name)** | **Street Address, City, and Zip, Phone Number** | **County** | **Services & Target Populations Served** |
| --- | --- | --- | --- |
| ACCESS | 1011 College Avenue, Jacksonville, TX 75766 | Cherokee | * Screening, assessment, & intake; TRR outpatient services: adults, adolescents & children; substance abuse prevention, intervention, or treatment; MCOT; YES Waiver Services; Services for individuals with IDD; co-located mental and physical health services |
| ACCESS | 913 N. Jackson Street, Jacksonville, TX 75766 | Cherokee | * Skills training and family integration/support services for Youth enrolled in FAYS (Family and Youth Success Services) |
| ACCESS | 804 S. Main Street, Jacksonville, TX 75766 | Cherokee | * Veteran Services/Lone Star Military Group – current & former members of the US military & their families |
| ACCESS | 3320 S. Loop 256, Palestine, TX 75801 | Anderson | * Screening, assessment, & intake; TRR outpatient services: adults, adolescents & children; substance abuse prevention, intervention, or treatment; MCOT; YES Waiver Services; Services for individuals with IDD; co-located mental and physical health services |
| Palestine Regional Medical Center/Psychiatric Services | 4000 S. Loop 256 West Campus, Palestine, TX 75801 | Anderson | * In-patient psychiatric treatment for adults; * 20-bed competency restoration unit for adults |
| HMIH Cedar Crest Hospital | 3500 S IH-35, Belton, Tx 76513 | Bell | * In-patient psychiatric treatment for adults, children 5 to 12, and adolescents 13 to 17 |
| AVAIL Solutions | 4455 S. Padre Island Drive, Suite 44B, Corpus Christi, TX 78411 | Nueces | * 24/7 Accredited Crisis Screening Hotline |
| Cherokee County Peer Support Group | 410 Tilley Street  Jacksonville, TX 75766 | Cherokee | * Peer-run support groups, socialization, and skills training |

## I.B Mental Health Grant Program for Justice Involved Individuals

## The Mental Health Grant Program for Justice-Involved Individuals is a grant program authorized by Senate Bill (S.B.) 292, 85th Legislature, Regular Session, 2017, to reduce recidivism rates, arrests, and incarceration among individuals with mental illness, as well as reduce the wait time for individuals on forensic commitments. These grants support community programs by providing behavioral health care services to individuals with a mental illness encountering the criminal justice system and facilitate the local cross-agency coordination of behavioral health, physical health, and jail diversion services for individuals with mental illness involved in the criminal justice system.

*In the table below, describe the LMHA or LBHA S.B. 292 projects; indicate N/A if the LMHA or LBHA does not receive funding. Add additional rows if needed.*

| Fiscal Year | Project Title (include brief description) | County(s) | Population Served | Number Served per Year |
| --- | --- | --- | --- | --- |
|  | N/A |  |  |  |

## l. C Community Mental Health Grant Program - Projects related to Jail Diversion, Justice Involved Individuals, and Mental Health Deputies

The Community Mental Health Grant Program is a grant program authorized by House Bill (H.B.) 13, 85th Legislature, Regular Session, 2017. H.B. 13 directs HHSC to establish a state-funded grant program to support communities providing and coordinating mental health treatment and services with transition or supportive services for persons experiencing mental illness. The Community Mental Health Grant Program is designed to support comprehensive, data-driven mental health systems that promote both wellness and recovery by funding community-partnership efforts that

provide mental health treatment, prevention, early intervention, and/or recovery services, and assist with persons with transitioning between or remaining in mental health treatment, services, and supports.

*In the table below, describe the LMHA or LBHA H.B. 13 projects related to jail diversion, justice involved individuals and mental health deputies; indicate N/A if the LMHA or LBHA does not receive funding. Add additional rows if needed.*

| Fiscal Year | Project Title (include brief description) | County | Population Served | Number Served per Year |
| --- | --- | --- | --- | --- |
|  | N/A |  |  |  |

## I.D Community Participation in Planning Activities

*Identify community stakeholders who participated in comprehensive local service planning activities.*

|  | **Stakeholder Type** |  | **Stakeholder Type** |
| --- | --- | --- | --- |
|  | Consumers |  | Family members |
|  | Advocates (children and adult) |  | Concerned citizens/others |
|  | Local psychiatric hospital staff  *\*List the psychiatric hospitals that participated:*   * Palestine Regional Medical/Psychiatric Center * UT Health- Northeast Campus |  | State hospital staff  *\*List the hospital and the staff that participated:*   * *Rusk State Hospital/Matthew Gallagher* * *Rusk State Hospital/Michelle Foster* * *Rusk State Hospital/Jim LaRue* |
|  | Mental health service providers |  | Substance abuse treatment providers |
|  | Prevention services providers |  | Outreach, Screening, Assessment, and Referral Centers |
|  | County officials  *\*List the county and the official name and title of participants:*   * Captain Thomas Choate- Anderson County Jail * Deputy Alan Langston- Cherokee County MH Deputy * Deputy Seabron Peterson-Anderson County MH Deputy * Captain Fred Butler, Cherokee County Jail   Elmer Beckworth - Cherokee County DA  Cherokee County -Judge Chris Davis  Anderson County - Judge Robert Johnston |  | City officials  *\*List the city and the official name and title of participants:*   * Joe Tinsley- Detective Palestine PD * Judge Janice Stone, Cherokee County Municipal Judge * Joe Williams, Jacksonville Chief Of Police * Steven Hughes, Rusk Chief Of Police * Jeremy Williams, Alto Chief Of Police * Dana Young, Rusk, City Attorney * Dick Stone, Jacksonville Mayor * Randy Gorham, Jacksonville Mayor |
|  | Federally Qualified Health Center and other primary care providers |  | Local health departments  LMHAs/LBHAs  *\*List the LMHAs/LBHAs and the staff that participated:*  **ACCESS (LMHA):**   * Terry Camp, Forensic Unit * Ryan Bruton, TCOOMMI CMI * Kelli Perry, YES CC * Rick Matthews, MCOT Supervisor * Shavonne Minor, IDD Manager * Lynsie Fisher, MH Manager * Destiny Routt, Family Partner * Clynell Anderson, MCOT * Alicia Boggs, MCOT * Glenda Grundy, MCOT * Dennis Steelman, Crisis Services/MCOT Manager * Ted Debbs, CEO * Karen Pate, COO * Donna Daigle-Thomas, CPO * Courtney Sammons, CFO |
|  | Hospital emergency room personnel |  | Emergency responders |
|  | Faith-based organizations |  | Community health & human service providers |
|  | Probation department representatives |  | Parole department representatives |
|  | Court representatives (Judges, District Attorneys, public defenders)  *\*List the county and the official name and title of participants:*   * Judge Chris Davis- County Judge Cherokee County * Judge Robert Johnston- County Judge Anderson County * Allyson Mitchell, Anderson County DA * Dana Young, Rusk City Attorney * Elmer Beckworth, Cherokee County DA |  | Law enforcement  *\*List the county/city and the official name and title of participants:*  James Campbell, Cherokee CountySheriff  Greg Taylor, Anderson County Sheriff  Joe Tinsley- Detective, Palestine PD  Judge Janice Stone, Municipal Judge  Joe Williams, Jacksonville COP  Steven Hughes, Rusk COP  Jeremy Williams, Alto COP |
|  | Education representatives |  | Employers/business leaders |
|  | Planning and Network Advisory Committee |  | Local consumer peer-led organizations |
|  | Peer Specialists |  | IDD Providers |
|  | Foster care/Child placing agencies |  | Community Resource Coordination Groups |
|  | Veterans’ organizations |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

|  |
| --- |
| To ensure broad-based community and stakeholder input into the local planning process, ACCESS:   * Conducted public forums in each County to elicit input from community stakeholders. * Participated in interagency committees meeting in Anderson and Cherokee Counties * Conducted quarterly Jail/Crisis Diversion Meetings in both Counties with broad-based participation from local acute-care hospitals and their ED staff, East Texas Crisis Center, Rusk State Hospital, local psychiatric hospitals, County Judges, Sheriffs and their Deputies from each County, Police Chiefs and their Officers representing municipalities in each County, local District Attorneys, Probation and Parole Staff, Mental Health Deputies, and ACCESS staff * Participated in the local East Texas Human Needs Network identifying and addressing service gaps in the local areas * Participated in RHP 1’s 1115 regional needs assessment and forums * Participated and chaired CRCGs in each County with participation from APS, CPS, Juvenile Probation, local ISDs, ACCESS staff, Foster Care staff, faith-based and other non-profits providing local services and supports * Participated in planning activities through East Texas Behavior Network (ETBHN) RPNAC and local IDD PAC to identify gaps in services and develop possible solutions * Participated in the East Texas Council of Governments (ETCOG) to develop funding opportunities and distribute grant funds to organizations addressing areas of need in local communities * Participated in All Access Texas and distributed All Access needs assessment surveys to community stakeholders |

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

|  |
| --- |
| * Lack of Public Transportation |
| * Lack of affordable housing & Section 8 vouchers |
| * Lack of transitional & longer-term residential options for those with mental illnesses |
| * Lack of behavioral health providers (beyond those of the LMHA) |
| * Lack of employment opportunities |
| * Lack of regional in-patient psych beds for adults, children & adolescents |
| * Lack of substance abuse in-patient treatment and detox facilities |
| * Lack of crisis respite services |

# Section II: Psychiatric Emergency Plan

The Psychiatric Emergency Plan is intended to ensure stakeholders with a direct role in psychiatric emergencies have a shared understanding of the roles, responsibilities, and procedures enabling them to coordinate efforts and effectively use available resources. The Psychiatric Emergency Plan entails a collaborative review of existing crisis response activities and development of a coordinated plan for how the community will respond to psychiatric emergencies in a way that is responsive to the needs and priorities of consumers and their families. The planning effort also provides an opportunity to identify and prioritize critical gaps in the community’s emergency response system.

The following stakeholder groups are essential participants in developing the Psychiatric Emergency Plan:

* Law enforcement (police/sheriff and jails)
* Hospitals/emergency departments
* Judiciary, including mental health and probate courts
* Prosecutors and public defenders
* Other crisis service providers (to include neighboring LMHAs and LBHAs)
* Users of crisis services and their family members
* Sub-contractors

Most LMHAs and LBHAs are actively engaged with these stakeholders on an ongoing basis, and the plan will reflect and build upon these continuing conversations.

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

## II.A Development of the Plan

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

Ensuring all key stakeholders were involved or represented, to include contractors where applicable;

* Quarterly Crisis/Jail Diversion meetings are held in each County with invited participation from Judges, District Attorneys, Sheriff’s Departments, Police Departments, and representatives from the local Crisis Center, representatives from Rusk State Hospital (in Cherokee County), hospital administrators from local acute care hospitals and from contracted local private psychiatric hospitals, as well as representation from all departments of ACCESS.

Ensuring the entire service area was represented; and

* + These meetings are held in each County with participation from individuals and organizations representative of crisis services in each.

Soliciting input.

* + Emails inviting participation are sent to all individuals, organizations, and agencies involved in the crisis response systems in each County to ensure broad-based input into development of the PEP.

## II.B Utilization of the Crisis Hotline, Role of Mobile Crisis Outreach Teams (MCOT), and the Crisis Response Process

1. How is the Crisis Hotline staffed?

During business hours

* + Through contract with Avail, an AAS certified 24/7 hotline

After business hours

* + Through contract with Avail, an AAS certified 24/7 hotline

Weekends/holidays

* + Through contract with Avail, an AAS certified 24/7 hotline

2. Does the LMHA/LBHA have a sub-contractor to provide the Crisis Hotline services? If, yes, please list the contractor:

* + Avail Solutions, Inc.

3. How is the MCOT staffed?

During business hours

* + ACCESS employs the MCOT team to be ready for activation year round, including twenty four hour coverage during weekends and Holidays. Team members work staggered schedules to ensure availability of continuous coverage and rapid crisis response.

After business hours

* + ACCESS employs the MCOT team to be ready for activation year round, including twenty four hour coverage during weekends and Holidays. Team members work staggered schedules to ensure availability of continuous coverage and rapid crisis response.

Weekends/holidays

* + ACCESS employs the MCOT team to be ready for activation year round, including twenty four hour coverage during weekends and Holidays. Team members work staggered schedules to ensure availability of continuous coverage and rapid crisis response.

4. Does the LMHA/LBHA have a sub-contractor to provide MCOT services? If yes, please list the contractor:

* + No

5. Provide information on the type of follow up MCOT provides (phone calls, face to face visits, case management, skills training, etc.).

* + MCOT provides follow up through face to face visits, screening & referrals, case management, skills training, counseling services, and phone calls

6. Do emergency room staff and law enforcement routinely contact the LMHA/LBHA when an individual in crisis is identified? If so, please describe MCOT’s role for:

Emergency Rooms:

* MCOT Crisis schedule is provided to local law enforcement departments and hospital emergency departments each month with phone numbers and direct contact information. MCOT works diligently with emergency departments in our community: to streamline the process for medical clearance in an attempt to serve the needs of the client in crisis; to reduce the overall time spent in an emergency room awaiting medical clearance which can often unnecessarily occupy a needed bed in the emergency room; and, to better serve local law enforcement agencies that may be responsible for accompanying the individual in crisis to the emergency room and staying there for the duration of the medical clearance procedure.

Law Enforcement:

As a standard operating procedure, MCOT makes their schedule known to the Emergency Departments and Law Enforcement agencies of Anderson and Cherokee County in an effort to hasten the activation of MCOT and is routinely deployed when contacted by either group. MCOT attempts to provide a seamless integration of services to both local Law Enforcement agencies and local Emergency Departments. MCOT offers these services through their availability to respond to activations throughout the communities we serve when notified by local Law Enforcement agencies or by local Emergency Departments. These services are provided wherever and whenever needed and MCOT has developed meaningful relationships with various members of law enforcement and local emergency departments in an attempt to better serve those agencies in the facilitation of crisis services.

7. What is the process for MCOT to respond to screening requests at state hospitals, specifically for walk-ins?

* As above, MCOT also provides the local state hospital with its monthly Crisis schedule and direct contact information and phone numbers. When requested, MCOT go directly to the state hospital to provide screenings and assessments for walk-ins.

8. What steps should emergency rooms and law enforcement take when an inpatient level of care is needed?

During business hours:

* MCOT is available for activation year round. Referring agencies may contact the MCOT worker directly or contact the AVAIL crisis hotline.

After business hours:

* MCOT is available for activation year round. Referring agencies may contact the MCOT worker directly or contact the AVAIL crisis hotline.

Weekends/holidays:

* MCOT is available for activation year round. Referring agencies may contact the MCOT worker directly or contact the AVAIL crisis hotline.

9. 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?

* When further assessment or medical clearance is necessary, MCOT will refer that individual to the appropriate emergency department. Once stabilized, MCOT facilitates referral of the individual to the needed LOC, transporting via MH Deputies, local PD, or by ambulance, and paying for in-patient psychiatric treatment when no other funds are available.

10. Describe the community’s process if an individual requires further evaluation and/or medical clearance.

* Community calls to MCOT to confer on what LOC is needed and MCOT works on facilitating that LOC. MCOT works diligently with law enforcement and emergency departments in our community: to streamline the process for medical clearance in an attempt to serve the needs of the client in crisis; to reduce the overall time spent in an emergency room awaiting medical clearance which can often unnecessarily occupy a needed bed in the emergency room; and, to better serve local law enforcement agencies that may be responsible for accompanying the individual in crisis to the emergency room and staying there for the duration of the medical clearance procedure.

11. Describe the process if an individual needs admission to a psychiatric hospital.

* If psychiatric hospitalization is required, MCOT will assist in the facilitation of placement of the individual being screened. We locate an available bed, ensure transportation, and guarantee payment if no other resources are available. MCOT contracts with two private facilities to serve the adult, adolescent, and child indigent populations of Anderson and Cherokee Counties and coordinates with local law enforcement if transportation is needed.

12. Describe the process if an individual needs facility-based crisis stabilization (i.e., other than psychiatric hospitalization and may include crisis respite, crisis residential, extended observation, or crisis stabilization unit).

* There are no local options currently available for non-hospital facility-based crisis stabilization. MCOT can refer and arrange transport for individuals to such facilities in neighboring LMHA’s and has a contract with Andrews Center for the use of IDD crisis respite beds on an as needed basis. If those options are not available, MCOT remains with the individual in local Emergency Departments until the crisis resolves or further assessment indicates a need for the individual to be hospitalized.

13. Describe the process for crisis assessments requiring MCOT to go into a home or alternate location such as a parking lot, office building, school, under a bridge or other community-based location.

* MCOT go with local law enforcement or MH Deputy to sites to assess and secure safety of the site and then provide the necessary screenings and assessments.

14. If an inpatient bed at a psychiatric hospital is not available:

Where does the individual wait for a bed?

* When hospitalization is recommended, placement is normally procured that day. If there is ever any delay in placement, the individual will remain in the local emergency department until placement occurs. This is a rare event as placement is normally procured within twenty-four hours of activation.

15. Who is responsible for providing ongoing crisis intervention services until the crisis is resolved or the individual is placed in a clinically appropriate environment at the LMHA/LBHA?

* MCOT is responsible for providing ongoing crisis intervention services and will continue to monitor and assess the stability of the person to determine if further interventions are necessary. MCOT will offer community resources and linkage to resources needed by the individual. If a higher level of care is needed to ensure the person’s stability, MCOT will recommend placement in a LOC5 package.

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

* Family members can provide transportation but the Mental Health Deputy for the respective county will offer transportation if no other alternative are available. (ACCESS provides funding for a Mental Health Deputy in each County.)

#### Crisis Stabilization

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

|  |  |
| --- | --- |
| Name of Facility | None in our 2 Counties |
| Location (city and county) |  |
| Phone number |  |
| Type of Facility (see Appendix A) |  |
| Key admission criteria (type of individual accepted) |  |
| Circumstances under which medical clearance is required before admission |  |
| Service area limitations, if any |  |
| Other relevant admission information for first responders |  |
| Accepts emergency detentions? |  |
| Number of Beds |  |

#### Inpatient Care

What alternatives to the state hospital does the local service area have for psychiatric inpatient care for uninsured or underinsured individuals? Replicate the table below for each alternative.

|  |  |
| --- | --- |
| Name of Facility | Palestine Regional Medical Center- Psychiatric Hospital |
| Location (city and county) | Palestine/ Anderson |
| Phone number | 903-731-5000 |
| Key admission criteria | Admissions are at the discretion of the admitting facility. |
| Service area limitations, if any | Unknown |
| Other relevant admission information for first responders | Admissions are at the discretion of the admitting facility. |
| Number of Beds | 8 |
| Is the facility currently under contract with the LMHA/LBHA to purchase beds? | Yes |
| If under contract, is the facility contracted for rapid crisis stabilization beds (funded under the Psychiatric Emergency Service Center contract or Mental Health Grant for Justice-Involved Individuals), private psychiatric beds, or community mental health hospital beds (include all that apply)? | Community mental health hospital beds |
| If under contract, are beds purchased as a guaranteed set or on an as needed basis? | On an “as needed” basis |
| If under contract, what is the bed day rate paid to the contracted facility? | $385 a bed day, with additional per visit physician fee of $40 |
| If not under contract, does the LMHA/LBHA use facility for single-case agreements for as needed beds? | N/A |
| If not under contract, what is the bed day rate paid to the facility for single-case agreements? | N/A |

## 

|  |  |
| --- | --- |
| Name of Facility | HMIH Cedar Crest Hospital |
| Location (city and county) | Belton/Bell |
| Phone number | 254-939-4021 |
| Key admission criteria | Admissions are at the discretion of the admitting facility. |
| Service area limitations, if any | Unknown |
| Other relevant admission information for first responders | Admissions are at the discretion of the admitting facility. |
| Number of Beds | 68 |
| Is the facility currently under contract with the LMHA/LBHA to purchase beds? | Yes |
| If under contract, is the facility contracted for rapid crisis stabilization beds (funded under the Psychiatric Emergency Service Center contract or Mental Health Grant for Justice-Involved Individuals), private psychiatric beds, or community mental health hospital beds (include all that apply)? | Community mental health hospital beds |
| If under contract, are beds purchased as a guaranteed set or on an as needed basis? | On an “as needed” basis |
| If under contract, what is the bed day rate paid to the contracted facility? | $600/day (all inclusive) |
| If not under contract, does the LMHA/LBHA use facility for single-case agreements for as needed beds? | N/A |
| If not under contract, what is the bed day rate paid to the facility for single-case agreements? | N/A |

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

What local inpatient or outpatient alternatives to the state hospital does the local service area currently have for competency restoration? If not applicable, enter N/A.

Identify and briefly describe available alternatives.

* None. The population of the 2 Counties served by ACCESS and need for such services is too small to make running such a program economically feasible or realistic. The Andrews Center (contiguous to the ACCESS service area) has an Outpatient Competency Restoration Program to which ACCESS refers, when needed.

What barriers or issues limit access or utilization to local inpatient or outpatient alternatives?

* + N/A

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

* + No – Again, due to the small population of the 2 Counties and limited need for such services, members of the MCOT function as liaisons and go daily to the local jails to provide services, as needed.

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

* + MCOT staff perform this function.

What plans, if any, are being developed over the next two years to maximize access and utilization of local alternatives for competency restoration?

* + N/A – Again, local population numbers are too small to support such ongoing programs.

Does the 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 average less than one (1) individual a month deemed incompetent in our service area so continuing to refer to the Andrews Center meets current local needs.

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 and the development of Certified Community Behavioral Health Clinics (CCBHCs)

## 

1. What steps have been taken to integrate emergency psychiatric, substance use, and physical healthcare services? Who did the LMHA/LBHA collaborate with in these efforts?

* As one of its 1115 projects, ACCESS implemented outpatient substance abuse services through the addition of licensed chemical dependency staff and obtained licensure from HHSC for its substance abuse services. There is an in-house referral process between substance abuse and mental health services when needs are identified during treatment and co-occurring needs are also addressed. ACCESS has provided space for a FQHC in each of its outpatient clinics to provide co-located physical healthcare services for its indigent and MCAID/MCARE population. Mental health consumers with chronic physical conditions such as diabetes are referred to the FQHC for follow-up and, conversely, individuals presenting with possible mental health needs at the FQHC clinic are referred to ACCESS for follow-up. Additionally, individuals presenting in psychiatric emergencies with medical and substance abuse issues are assessed when stable for referral to needed mental health or substance abuse services. Efforts to integrate emergency psychiatric services are addressed through quarterly crisis diversion and other meetings with local ED staff and through contracts with private psychiatric hospitals.

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

* ACCESS will further integrate and expand these services as it seeks certification as a CCBHC, expecting to increase MAT and outpatient substance abuse services, as well as further integrating its services with the physical services provided by the FQHC. In addition to expanding integration of substance abuse, mental health, and physical health services beyond co-location and referrals, the LMHA has entered into a contractual relationship with the FQHC to pursue additional opportunities for integrating services between the two entities. Another partnership has been developed with the Pharmacy program at the University of Texas at Tyler. Pharmacy students, under the supervision of the Director of that program, will review ACCESS client medications to identify possible drug interactions and work to coordinate continuity in medication practices between ACCESS prescribers and local PCPs. The new initiatives are expanding availability of local treatment options, particularly for the large indigent population in the area.

## II.E Communication Plans

1. What steps have been taken to ensure key information from the Psychiatric Emergency Plan is shared with emergency responders and other community stakeholders?

Information will be available on the ACCESS website, as well as on ACCESS brochures that are widely distributed throughout the service area at community events, annual public forums, and regularly scheduled meetings of CRCGs and Crisis/Jail Diversion Meetings in each County. Brochures and information are also provided to emergency responders and placed in local service provider offices and emergency departments.

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

During annual scheduled training, all current staff receive training on the crisis response systems, including any updates/revisions. New staff receive crisis training during their orientation training. Front office staff, including individuals answering incoming phone calls, also receive additional training on responding to phone or walk-in crises. Information is also shared with the contracted crisis hotline provider to ensure they remain current with the LMHA’s crisis practices. The information is also available on the organization’s local intranet for quick references.

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

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

|  |  |  |
| --- | --- | --- |
| **County** | **Service System Gaps** | **Recommendations to Address the Gaps** |
| Anderson, Cherokee | * No short or long-term residential treatment available | * Participate in All Access Texas to identify gaps for HHSC to procure funding to address the need for regional residential treatment options |
| Anderson, Cherokee | * No substance abuse detox available or residential SA treatment | * Coordinate with ETCADA to look for SA services and also seek CCBHC certification to expand outpatient SA services, while acknowledging difficulty in providing scope of services needed due to lack of funding. |
| Anderson, Cherokee | * No local respite or facility-based crisis observation programs available | * Participate in All Access Texas to identify gaps for HHSC to procure funding to address the need for regional respite or facility-based crisis observation programs * Locate and contract with any regional providers of respite services |

# Section III: Plans and Priorities for System Development

## III.A Jail Diversion

## The Sequential Intercept Model (SIM) informs community-based responses to the involvement of individuals with mental and substance use disorders in the criminal justice system. The model is most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change.

A link to the SIM can be accessed here:

<https://www.prainc.com/wp-content/uploads/2017/08/SIM-Brochure-Redesign0824.pdf>

In the tables below, indicate the strategies used in each intercept to divert individuals from the criminal justice system and indicate the counties in the service area where the strategies are applicable. List current activities and any plans for the next two years.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Intercept 0: Community Services**  Current Programs and Initiatives: | County(s) | | Plans for upcoming two years: | |
| * Crisis Hotline (AVAIL) | * Anderson/ Cherokee | | * Promote the crisis line in the community and encourage its utilization as a means of intercepting individual’s prior to incarceration when appropriate. This will be evidenced by distributing the number at community meetings; inter-agency meetings; community events; and jail diversion meetings. | |
| * MCOT | * Anderson/ Cherokee | | * The ongoing plan is to develop meaningful relationships with community partners and stakeholders in an attempt to educate members of the community about the availability of acute psychiatric care and assessment as delivered by MCOT. This will be implemented through the distribution of the daily crisis schedule to known community partners and stakeholders. We will capitalize on available opportunities to widen the current distribution lists to unidentified community partners and underserved populations. | |
| * ED’s | * Anderson/ Cherokee | | * (SEE ABOVE) | |
| * Municipal Police Departments | * Anderson/ Cherokee | | * (SEE ABOVE) | |
| * Local ISD’s | * Anderson/ Cherokee | | * (SEE ABOVE) | |
| * Local FQHC’s | * Anderson/ Cherokee | | * (SEE ABOVE) | |
| **Intercept 1: Law Enforcement**  Current Programs and Initiatives: | | County(s) | | Plans for upcoming two years: |
| * Jail Diversion meetings | | * Anderson/ Cherokee | | * The current plan for the next two years is to increase collaborative efforts between ACCESS and Municipal Police Departments. This is accomplished through a program that embeds MCOT with Municipal Police Departments on a normal patrol. Through this collaboration, MCOT will be able to respond, assess, and advocate in a more deliberate and effective manner. |

|  |  |  |
| --- | --- | --- |
| **Intercept 3: Jails/Courts**  Current Programs and Initiatives: | County(s) | Plans for upcoming two years: |
| * Jail Diversion Meetings | * Anderson/ Cherokee | * The plan for the next two years is to establish and foster meaningful relationships with county jails and the court. In this capacity, the center will serve as an advocate and offer alternative placements options  in lieu of incarceration that adequately address the needs of the population we serve and serve the overall best interest of the communities we serve. |

|  |  |  |
| --- | --- | --- |
| **Intercept 4: Reentry**  Current Programs and Initiatives: | County(s) | Plans for upcoming two years: |
| • Dedicated Jail based services | * Anderson/ Cherokee | • Historically, this agency has dedicated resources to servicing those in our jails as an overall inclusive service and delivery approach. Over the next two years, the agency will further our efforts to address needs of those coming out of County, State, and Federal Detention centers to facilitate a warm hand-off from one system of care to another. This hand-off will look to address the basic human needs of the individual including connecting the individual to community based services that aid in housing and employment. The agency will look to develop collaborative partnerships with community partners to address the significant and critical gaps in our catchment area to the best of our means and ability. |

|  |  |  |
| --- | --- | --- |
| **Intercept 5: Community Corrections**  Current Programs and Initiatives: | County(s) | Plans for upcoming two years: |
| • MCOT and TCOOMMI ICM | * Anderson/ Cherokee | • The agency will continue to support those with special challenges in part due to their legal status. MCOT and the TCOOMMI ICM will have dedicated and specialized caseloads that will have a stated goal to address negative behaviors that threaten their legal status. |

## III.B Other Behavioral Health Strategic Priorities

## 

*The* [*Texas Statewide Behavioral Health Strategic Plan*](https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf) *identifies other significant gaps and goals in the state’s behavioral health services system. The gaps identified in the plan are:*

* *Gap 1: Access to appropriate behavioral health services for special populations (e.g., individuals with co-occurring psychiatric and substance use services, individuals who are frequent users of emergency room and inpatient services)*
* *Gap 2: Behavioral health needs of public school students*
* *Gap 3: Coordination across state agencies*
* *Gap 4: Veteran and military service member supports*
* *Gap 5: Continuity of care for individuals exiting county and local jails*
* *Gap 6: Access to timely treatment services*
* *Gap 7: Implementation of evidence-based practices*
* *Gap 8: Use of peer services*
* *Gap 9: Behavioral health services for individuals with intellectual disabilities*
* *Gap 10: Consumer transportation and access*
* *Gap 11: Prevention and early intervention services*
* *Gap 12: Access to housing*
* *Gap 13: Behavioral health workforce shortage*
* *Gap 14: Services for special populations (e.g., youth transitioning into adult service systems)*
* *Gap 15: Shared and usable data*

*The goals identified in the plan are:*

* *Goal 1: Program and Service Coordination - Promote and support behavioral health program and service coordination to ensure continuity of services and access points across state agencies.*
* *Goal 2: Program and Service Delivery - Ensure optimal program and service delivery to maximize resources in order to effectively meet the diverse needs of people and communities.*
* *Goal 3: Prevention and Early Intervention Services - Maximize behavioral health prevention and early intervention services across state agencies.*
* *Goal 4: Financial Alignment - Ensure that the financial alignment of behavioral health funding best meets the needs across Texas.*
* *Goal 5: Statewide Data Collaboration – Compare statewide data across state agencies on results and effectiveness.*

*In the table below briefly describe the current status of each area of focus as identified in the plan (key accomplishments, challenges and current activities), and then summarize objectives and activities planned for the next two years.*

| **Area of Focus** | **Related Gaps and Goals from Strategic Plan** | **Current Status** | **Plans** |
| --- | --- | --- | --- |
| Improving access to timely outpatient services | * Gap 6 * Goal 2 | * Currently have sufficient access to timely outpatient services through expansion of available prescriber time and expansion of open access intake slots in each County with no waiting lists for services. | * Continue current staffing patterns. If delays in access begin to occur, will re-evaluate and alter staffing to meet increased need. |
| Improving continuity of care between inpatient care and community services and reducing hospital readmissions | * Gap 1 * Goals 1,2,4 | * Actively manage transitions between inpatient care and community services by monitoring aftercare appointment compliance to ensure early engagement with needed services to reduce hospital readmissions * Continuity of care concerns are elevated and resolved whenever possible at Quarterly Crisis/Jail Diversion meetings and potential additional community resources identified | * Continue current practices * Continue current practices and efforts to increase community alternatives to inpatient hospitalizations |
| Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community and reducing other state hospital utilization | * Gap 14 * Goals 1,4 | * Meet with clinical and administrative staff at least annually to review all patients hospitalized for more than 365 days to see whether the individual(s) has a safer alternative to inpatient care | * Attempt to find community alternatives willing to accept individuals from long-term state hospital care |
| Implementing and ensuring fidelity with evidence-based practices | * Gap 7 * Goal 2 | * Review implementation and fidelity of EBPs through ongoing documentation reviews, staff peer reviews, and training activities. Staff receive training before providing evidence-based practices and are required to maintain current training status. | * Continue current practices and implement higher-level review and feedback loop through utilization of sanctioned EBP fidelity tools |
| Transition to a recovery-oriented system of care, including use of peer support services | * Gap 8 * Goals 2,3 | * Meet with the clinical staff quarterly to address and identify barriers to care. * Adopt language that reflects a culture of recovery. * Assure service provisions are person-centered and reflect client choice * Inclusion of Peer Support in clinical staffing. * Peers provide training to current and new staff members on peer support services and recovery and are involved in planning and evaluation activities. * ACCESS has a subcontract with the Cherokee County Peer Support Group (CCPSG) hich group also provides group activities, skills training, socialization, and emotional support to peers. | * Continue current practices * Continue current practices * Ongoing pursuit through careful monitoring of clinical practices * Continue current practices * Continue current practices * Expand CCPSG Peer Run Groups to Anderson County. |
| Addressing the needs of consumers with co-occurring substance use disorders | * Gaps 1,14 * Goals 1,2 | * Provide outpatient substance use disorder treatment * Referral provided for inpatient care and detox when appropriate * Provide complex service array to address the specific needs of co-occurring disorders | * Continue current practices * Continue current practices * Continue current practices |
| Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers. | * Gap 1 * Goals 1,2 | * ACCESS medical providers ensure physical concerns are addressed through referrals to primary care physicians and follow-up to ensure services are obtained. * Provide space for a FQHC in each of its outpatient clinics to provide co-located physical healthcare services for its indigent and MCAID/MCARE population. Mental health consumers with chronic physical conditions such as diabetes are referred to the FQHC for follow-up and, conversely, individuals presenting with possible mental health needs at the FQHC clinic are referred to ACCESS for follow-up. * Efforts to integrate emergency psychiatric services are addressed through quarterly crisis/jail diversion and other meetings with local ED staff and through contracts with private psychiatric hospitals. | * Continue current practice * Continue current practices and obtain certification as a CCBHC, expanding and enhancing integration of behavioral health and primary healthcare for individuals served * Continue current practices |
| Consumer transportation and access to treatment in remote areas | * Gap 10 * Goal 2 | * Consumers in remote areas currently rely on themselves or family. When those options are unavailable, they rely on Medicaid Transportation and the Go Bus to access treatment. | * Continue current practice * Locate office space in remote areas of each County where staff will be able to provide treatment services one or more days each month to reduce need for travel from remote areas to access services |
| Addressing the behavioral health needs of consumers with Intellectual Disabilities | * Gap 14 * Goals 2,4 | * Consumers with Intellectual Disabilities currently receive behavioral health services through referrals from the LIDDA and, conversely, from the LMHA to the LIDDA to ensure they receive services in the most appropriate and least restrictive setting available | * Continue current practices * Seeking providers to deliver needed ABA services in the local region |
| Addressing the behavioral health needs of veterans | * Gap 4 * Goals 2,3 | * Veterans’ behavioral health needs are addressed through the existing service array provided by ACCESS, with referrals to the VA system for individuals needing higher levels of care not currently provided by the LMHA, e.g. CSU, substance use detox, long-term inpatient psychiatric hospitalization | * Continue existing services array, with potential for expansion of other services such as ambulatory detox after certification as CCBHC |

## III.C Local Priorities and Plans

* *Based on identification of unmet needs, stakeholder input, and internal assessment, identify the 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 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** |
| --- | --- | --- |
| Integration of physical and behavioral healthcare | * See above | * See above |
| Increase access to substance abuse services & substance abuse providers | * Have increased the number of LCDC’s available to provide supportive outpatient SA services in each County, with additional staff pursuing licensure. Received certification from HHSC as a training site for individuals to pursue LCDC licensure status. | * Pursue additional funding streams to ensure sustainability of program and work towards finding additional resources to possibly expand the program’s capacity |

## III.D System Development and Identification of New Priorities

Development of the local plans should include a process to identify local priorities and needs and the resources required for implementation. The priorities should reflect the input of key stakeholders involved in development of the Psychiatric Emergency Plan as well as the broader community. This builds on the ongoing communication and collaboration LMHAs and LBHAs have with local stakeholders. The primary purpose is to support local planning, collaboration, and resource development. The information provides a clear picture of needs across the state and support planning at the state level.

In the table below, identify the local service area’s priorities for use of any *new* funding should it become available in the future. Do not include planned services and projects that have an identified source of funding. Consider regional needs and potential use of robust transportation and alternatives to hospital care. Examples of alternatives to hospital care include residential facilities for non-restorable individuals, outpatient commitments, and other individuals needing long-term care, including geriatric patients with mental health needs. Also consider services needed to improve community tenure and avoid hospitalization.

Provide as much detail as practical for long-term planning and:

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Priority** | **Need** | **Brief description of how resources would be used** | **Estimated Cost** |
| 1 | Respite/Transitional Housing Support Program | * Locate suitable housing for 4 individuals that would meet ADA and other concerns and assist in increasing community tenure for individuals at risk for readmission or incarceration | * Housing/utilities/food: $6,000/month * On-site staff/benefits (QMHP to provide transition training and other supports, activities): $55,000/yr * Computers/phones/connectivity:$12,000/1st year * Furnishings: $6,000 * Items for residents (unknown): $6,000/yr * Staff training/mileage costs: $2,500 * Indirect costs @10%: $14,000 |
| 2 | Additional funding for added full-time LCDC | * Expand capacity for substance abuse services in the LSA | * Staff/benefits/training: $65,000/yr * Office Space/equipment/supplies: $6,000/yr * Indirect costs@10%: $7,000 |

# Appendix A: Levels of Crisis Care

**Admission criteria** – Admission into services is determined by the individual’s level of care as determined by the TRR Assessment found [here](https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf) for adults or [here](https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-child.pdf) for children and adolescents. The TRR assessment tool is comprised of several modules used in the behavioral health system to support care planning and level of care decision making. High scores on the TRR Assessment module, such as items of Risk Behavior (Suicide Risk and Danger to Others) or 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, MCOT, or other crisis services.

**Crisis Residential** **Units**– provide community-based residential crisis treatment to individuals with a moderate to mild risk of harm to self or others, who may have fairly severe functional impairment, and whose symptoms cannot be stabilized in a less intensive setting. Crisis residential facilities are not authorized to accept individuals on involuntary status.

**Crisis Respite Units** –provide community-based residential crisis treatment for individuals who have low risk of harm to self or others, and who may have some functional impairment. Services may occur over a brief period of time, such as two hours, and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons they care for to avoid mental health crisis. Crisis respite facilities are not authorized to accept individuals on involuntary status.

**Crisis Services** – Crisis services are brief interventions provided in the community that ameliorate the crisis 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.

**Crisis Stabilization Units (CSU) –** are the only licensed facilities on the crisis continuum and may accept individuals on emergency detention or orders of protective custody. CSUs offer the most intensive mental health services on the crisis facility continuum by providing short-term crisis treatment to reduce acute symptoms of mental illness in individuals with a high to moderate risk of harm to self or others.

**Extended Observation Units (EOU)** – provide up to 48-hours of emergency services to individuals in mental health crisis who may pose a high to moderate risk of harm to self or others. EOUs may accept individuals on emergency detention.

**Mobile Crisis Outreach Team (MCOT)** – MCOTs 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)** – PESCs provide immediate access to assessment, triage and a continuum of stabilizing treatment for individuals with behavioral health crisis. 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 and 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 proximity to a licensed hospital. The array of projects available in a service area is based on the local needs and characteristics of the community and is dependent upon LMHA/LBHA funding.

**Rapid Crisis Stabilization and Private Psychiatric 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.

# Appendix B: Acronyms

**CSU** Crisis Stabilization Unit

**EOU** Extended Observation Units

**HHSC** Health and Human Services Commission

**LMHA** Local Mental Health Authority

**LBHA** Local Behavioral Health Authority

**MCOT** Mobile Crisis Outreach Team

**PESC** Psychiatric Emergency Service Center