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Fiscal Year 2018

Consolidated Local Service Plan (CLSP)

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## 

## 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** |
| --- | --- | --- | --- |
| ACCESS | 1011 College Avenue, Jacksonville, TX 75766 | Cherokee | * Screening, assessment, & intake; TRR outpatient services: adults & children; substance abuse prevention, intervention, or treatment; MCOT; YES Waiver Services |
| ACCESS | 913 N. Jackson Street, Jacksonville, TX 75766 | Cherokee | * MH Counseling for Youth enrolled in STAR (Services to At-Risk Youth & families) |
| 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 & children; substance abuse prevention, intervention, or treatment; MCOT |
| Palestine Regional Medical Center/Psychiatric Services | 4000 S. Loop 256 West Campus, Palestine, TX 75801 | Anderson | * In-patient psychiatric treatment for adults; geropsych services; * 20-bed competency restoration unit for adults |
| UT/Behavioral Health Center | 4101 TX-248 Spur, Tyler, TX 75701 | Smith | * In-patient psychiatric treatment for adults, children 5 to 12, and adolescents 13 to 17 |
| Sundance Behavioral Hospital | 2696 W. Walnut St., Garland, TX 75042 | Dallas | * In-patient psychiatric treatment for adults, children, and adolescents |
| 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 Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver Projects

* *Identify the RHP Region(s) associated with each project.*
* *List the titles of all projects you proposed for implementation under the Regional Health Partnership (RHP) plan. If the title does not provide a clear description of the project, include a descriptive sentence.*
* *Enter the number of years the program has been operating, including the current year (i.e., second year of operation = 2)*
* *Enter the static capacity—the number of clients that can be served at a single point in time.*
* *Enter the number of clients served in the most recent full year of operation. If the program has not had a full year of operation, enter the planned number to be served per year.*
* *If capacity/number served is not a metric applicable to the project, note project-specific metric with the project title.*

| **1115 Waiver Projects** | | | | |
| --- | --- | --- | --- | --- |
| **RHP Region(s)** | **Project Title (include brief description if needed)** | **Years of Operation** | **Capacity** | **Number Served/ Year** |
| 1 | Project supports specialty care access to behavioral health providers in the underserved area by recruiting a full-time psychiatrist or other mental health provider for adult, outpatient services to increase clinic volume of visits and evidence of improved access for patients seeking services, especially for Medicaid and Uninsured patients seeking services. | 3 | 839 visits | 1572 (552 unduplicated clients) |
| 1 | Project established outpatient substance abuse treatment programs in Anderson and Cherokee Counties to meet the needs of a growing population, especially the poor and uninsured by hiring licensed chemical dependency counselor (LCDC) and obtaining site license for supportive outpatient services. | 3 | 125 | 122 clients (711 contacts) |
| 1 | ACCESS will train and employ Peer Specialists to provide peer support to other mental health consumers in Anderson County. Specialists will also engage their peers to prevent or manage chronic health conditions. | 3 | 50 clients/100 visits | 119 clients/529 visits |

## 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.*

|  |
| --- |
| * 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 sufficient regional in-patient psych beds for children & adolescents |
| * Lack of substance abuse in-patient treatment and detox facilities |

# 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

In formulating the development of the Psychiatric Emergency Plan (PEP), the agency believed that is was important to ensure all possible stakeholders were included. For this reason, the agency invested time in the community making valuable contacts through interagency outreach efforts, Jail/Crisis Diversion Meetings in each county served, and participation in the local Human Needs Network and RHP1’s 1115 regional needs assessments. Those outreach efforts also included conducting public forums in each county served to garner and assess the needs expressed by the communities that we serve. Through the agency’s efforts, ACCESS was able to build a meaningful and significant coalition of vested stakeholders to collaborate in the development of the PEP.

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

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

During normal hours of operation (8a.m-5p.m., Monday through Friday), ACCESS’s MCOT staff are available for activation in either Anderson or Cherokee County.

* 1. After business hours

After normal business hours, ACCESS employs one member of MCOT to cover Anderson and Cherokee Counties to ensure 24 hour coverage.

* 1. 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.

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

Activation for MCOT can occur in the following ways: (1) activation from the AVAIL Crisis Hotline;(2) activation from Local Emergency Departments; (3) activation from Local Law Enforcement; and (4) activation from Local Independent School Districts.

1. What is the role of MCOT during and after a crisis when crisis care is initiated through the LMHA (for example, when an individual calls the hotline)? Address whether MCOT provides follow-up with individuals who experience a crisis and are then referred to transitional or services through the LMHA.

The role of MCOT is to complete competent and accurate assessments on individuals in crisis upon activation. MCOT will provide a recommendation and will facilitate placement if requested by the referring agency or if deemed necessary. After the recommendation of action has been implemented, MCOT will continue to monitor and assess the stability of the person formerly screened 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 persons stability, MCOT will recommend placement in a LOC5 package.

1. Describe MCOT support of emergency rooms and law enforcement:
   1. Do emergency room staff and law enforcement routinely contact the LMHA when an individual in crisis is identified? If so, is MCOT routinely deployed when emergency rooms or law enforcement contact the LMHA?

MCOT has worked diligently to forge a strong and meaningful relationship with the Emergency Departments and Law Enforcement agencies in both Anderson and Cherokee Counties. MCOT has reached a meaningful relationship with these agencies through working in collaboration to reach successful resolutions in which both agencies are mutually involved. 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.

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

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.

1. What is the procedure if an individual cannot be stabilized at the site of the crisis and needs further assessment or crisis stabilization in a facility setting?
   1. Describe your community’s process if a client needs further assessment and/or medical clearance:

When further assessment or medical clearance is necessary, MCOT will refer that individual to the appropriate emergency department. 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.

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

If hospitalization is required, MCOT will assist in the facilitation of placement of the individual being screened. MCOT contracts with three private facilities to serve both the adult and adolescent indigent populations of Anderson and Cherokee Counties and coordinates with local law enforcement if transportation is needed.

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

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 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.

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

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

* 1. After business hours

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

* 1. Weekends/holidays

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

1. If an inpatient bed is not available:
   1. Where is an individual taken while waiting 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.

* 1. Who is responsible for providing continued crisis intervention services?

MCOT is responsible for providing continued and ongoing crisis interventions.

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

This agency will defer to the recommendation of the attending doctor as to determining the length of stay for an individual placed in a psychiatric level of care.

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

The Mental Health Deputy for the respective county will offer transportation. (ACCESS provides funding for a Mental Health Deputy in each County.)

#### Crisis Stabilization

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

| Name of Facility | None in our 2 Counties |
| --- | --- |
| Location (city and county) |  |
| Phone number |  |
| Type of Facility (see Appendix B) |  |
| Key admission criteria (type of patient 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? |  |

#### Inpatient Care

1. What alternatives to the state hospital does your service area have for psychiatric inpatient care for medically indigent? Replicate the table below for each alternative.

| Name of Facility | 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. |

|  |  |
| --- | --- |
| Name of Facility | UT/Behavioral Health Center (formerly ETMC/BHC) |
| Location (city and county) | Tyler/ Smith |
| Phone number | 903-266-2200 |
| 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. |

|  |  |
| --- | --- |
| Name of Facility | Sundance Hospital |
| Location (city and county) | Garland/Dallas |
| Phone number | 469-440-5566 |
| 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. |

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

1. What local inpatient or outpatient alternatives to the state hospital does your service area currently have for competency restoration?
   1. Identify and briefly describe available alternatives.
   * 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.
   1. What barriers or issues limit access or utilization to local inpatient or outpatient alternatives? If not applicable, enter N/A.
   * N/A
   1. Does the LMHA have a dedicated jail liaison position? If so, what is the role of the jail liaison? At what point is the jail liaison engaged?
   * No – 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 does not have a dedicated jail liaison, identify the title(s) of employees who operate as a liaison between the LMHA and the jail.

* + MCOT staff perform this function.
  1. What plans do you have over the next two years to maximize access and utilization of local alternatives for competency restoration? If not applicable, enter N/A.
  + N/A – Again, local population numbers are too small to support such ongoing programs.

1. Does your community have a need for new alternatives for competency restoration? If so, what kind of program would be suitable (i.e., Outpatient Competency Restoration Program, inpatient competency restoration, jail-based competency restoration, etc.)?

* 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.

1. 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

1. What steps have been taken to integrate emergency psychiatric, substance use, and physical healthcare services?

* A LCDC was hired through one of the 1115 projects and clinic sites are now licensed to provide substance abuse supportive 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 entered into an arrangement to provide space in its Jacksonville location to True North, a teaching clinic providing low-cost adult primary, pediatric, geriatric, and women’s health services through a University of Texas at Tyler academic practice partnership for family practice nurse practitioner students. Mental health consumers with chronic physical conditions such as diabetes are referred to True North for follow-up and, conversely, individuals presenting with possible mental health needs at that clinic are referred to ACCESS for follow-up. This program is in its infancy but is expected to expand over time. 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.

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

* In addition to expanding the above referenced co-location and expanding integration of substance abuse, mental health, and physical health services, the LMHA has entered into a contractual relationship with the FQHC -Special Health Resources for Texas (SHRT), which is providing administrative and financial support to the True North Clinic. Further opportunities for integrating services between the two entities are being explored. Another new partnership is being developed with the new 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. 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.

* 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 you ensure LMHA 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

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

| **Counties** | **Service System Gaps** |
| --- | --- |
| Anderson, Cherokee | * No short or long-term residential treatment available |
| Anderson, Cherokee | * No substance abuse detox available or residential SA treatment |
| Anderson, Cherokee | * No local respite or facility-based crisis observation programs available |

# Section III: Plans and Priorities for System Development

## III.A Jail Diversion

*Indicate which of the following strategies you use to divert individuals from the criminal justice system. List current activities and any plans for the next two years. Include specific activities that describe the strategies checked in the first column. For those areas not required in the DSHS Performance Contract, enter NA if the LMHA has no current or planned activities.*

| **Intercept 1: Law Enforcement and Emergency Services** | |
| --- | --- |
| **Components** | **Current Activities** |
| Co-mobilization with Crisis Intervention Team (CIT)  Co-mobilization with Mental Health Deputies  Co-location with CIT and/or MH Deputies  Training dispatch and first responders  Training law enforcement staff  Training of court personnel  Training of probation personnel  Documenting police contacts with persons with mental illness  Police-friendly drop-off point  Service linkage and follow-up for individuals who are not hospitalized  Other: Click here to enter text. | * ACCESS funds a MH Deputy in each County who are physically located at the ACCESS MH Clinics and accompany MCOT staff and other emergency personnel in attempts to provide intervention services before incarceration is needed. MCOT and other ACCESS staff provide crisis training to Juvenile Probation Departments, dispatch/first responders, and have paid to send Palestine and Jacksonville Police personnel to receive crisis training. MHFA training has also been provided and one of the original trainers was an Officer with the Palestine Police Department. Staff document police contacts with individuals served when that information is available to them, either from information obtained from AVAIL (crisis hotline provider), MCOT staff, MH Deputies, or through personal knowledge. Police are able to drop individuals off at the Clinics during business hours and at local Emergency Departments where MCOT staff will meet them. MCOT also screens individuals at local Police Departments, in client homes and will go to alternate sites in the community, whenever feasible, to prevent unnecessary hospitalizations and ED admissions. The MCOT provides service linkage and follow-up for individuals who are not hospitalized until they are no longer in crisis, making referrals to services as needed. |
| **Plans for the upcoming two years:**  ACCESS will continue to explore opportunities to educate stakeholders in the communities we serve on known jail diversion strategies. This process will include; strengthening the relationships of all available stakeholders; educating all first responders on available resources for diversion when applicable; continuing to educate and formulate diversions strategies with community partners and law enforcement agencies through quarterly meetings. Additionally, MCOT staff are starting “ride alongs” with the Palestine Police Department and will pursue initiation of that same activity with Jacksonville Police Department. | |

| **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. | * MCOT staff do screenings at jails to initiate services. Psychiatric services are provided via telemedicine in Cherokee County and face to face at the MH Clinic in Anderson County. If requested by the Courts, staff attend court hearings to assist with suggestions for alternative services to incarceration and to provide links to comprehensive services, although this occurs more with Juvenile Courts. As noted previously, numbers are too small in the Counties to make ongoing assignment of staff to the Courts a viable option. |
| **Plans for the upcoming two years:**   * Will continue with current practices unless need for these services increase or designated funding for such services becomes available. | |

| **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: | * MCOT provide screening for mental illness and diversion eligibility, as well as services in jail for persons Incompetent to Stand Trial and for persons without an outpatient commitment. Services have also been provided for persons NGRI who have been placed in the local community in the past and the LMHA will continue to do so when such services are needed, as well as ensuring linkage to comprehensive services. ACCESS will continue to use Outpatient Competency Restoration services provided by the Andrews Center due to the very limited, current need for such services in its local service area. |
| **Plans for the upcoming two years:**   * Will continue with current practices unless need for these services increase or designated funding for such services becomes available. | |

| **Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization** | |
| --- | --- |
| **Components** | **Current Activities** |
| Providing transitional services in jails  Staff designated to assess needs, develop plan for services, and coordinate transition to ensure continuity of care at release  Structured process to coordinate discharge/transition plans and procedures  Specialized case management teams to coordinate post-release services  Other: | * MCOT staff provide transitional services in jails, as well as assess needs, develop plans for services, and coordinate transitions between involved agencies and systems to ensure continuity of care at release. ACCESS staff adhere to existing structured processes and procedures governing discharge/transition plans with the various forensic entities to facilitate as seamless a transition as possible. |
| **Plans for the upcoming two years:**   * Will continue with current practices unless need for these services increase where funding for a specialized case management team should be considered as a possible option. | |
| **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 options to reinforce positive behavior and effectively address noncompliance  Other: | * ACCESS staff provide routine screening for mental illness and substance use disorders for community corrections and support programs upon request. ACCESS staff routinely meet with probation and parole staff and have provided specific training on crisis and other services, particularly to Juvenile Probation staff. There is a TCOOMMI program and specific staff assigned to that program to ensure it runs smoothly. Although there are no specialized caseloads, all MH staff are expected to facilitate access to comprehensive services and serve as liaisons to community corrections for individuals on their caseloads involved with probation or parole services. |
| **Plans for the upcoming two years:**   * Will continue to provide current services and focus on providing additional Mental Health First Aid to community corrections staff and community support programs to assist them in early identification of potential mental health issues and possible need for referral to ACCESS services. | |

## III.B Other System-Wide Strategic Priorities

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

| **Area of Focus** | **Current Status** | **Plans** |
| --- | --- | --- |
| Improving continuity of care between inpatient care and community services | * Currently, have very good working relationships with inpatient facilities due in large part to expansion of crisis service supports and availability of 24/7 MCOT and MH Deputies in each County. | * Continue current practices and work towards better integration of physical and mental health services through co-location of primary care teaching clinic which will reduce the burden of uncompensated care provided by the hospitals and improve access to services for the truly needy. |
| Reducing hospital readmissions | * Current hospital readmission rate is minimal as staff work with individuals released from hospitals on a daily basis to prevent recidivism. | * Continue current practices of enhanced follow-up to reduce readmissions. |
| Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community | * ACCESS staff work with the facilities to find placement whenever possible. However, there is a severe shortage of affordable housing and no transitional or longer-term residential supported housing available in the local service area -which would be beneficial to this population. | * Continue current practices and work with local Housing Authorities and community organizations to locate affordable housing options and additional support services to assist individuals in successfully transitioning out of long-term care. |
| Reducing other state hospital utilization | * There are virtually no non-forensic state hospital beds available and have not been for some time. Therefore, ACCESS provides outpatient support and pays for short-term in-patient psychiatric treatment. | * Continue current practices. However, DSHS has awarded a contract to ACCESS to subcontract with Palestine Regional Medical Center’s Psychiatric facility to provide a 20 bed competency restoration unit that is hoped will eventually open more civil beds as forensic individuals regain competency and return to court. This unit opened 3/1/2016. |
| Tailoring service interventions to the specific identified needs of the individual | * Services are tailored to the specific identified needs of the individual through the TRR discovery process with the individual and development of a Recovery Plan meaningful to that individual. Plans change and evolve as needs or desires for services change for the individual. | * The current Recovery Plan has been revised to further address needs for individualization after receiving consumer input into the development of the new tool. Training of staff on the new tool is currently being implemented. |
| Ensuring fidelity with evidence-based practices | * Fidelity is monitored through routine and targeted documentation reviews, as well as through staff peer review and training activities. Staff receive training before providing evidence-based practices and are required to maintain current training status. | * Will continue current activities and have also included a formal review using fidelity tools to assess level of fidelity to evidence-based practices. |
| Transition to a recovery-oriented system of care, including development of peer support services and other consumer involvement in Center activities and operations (e.g., planning, evaluation) | * Peers are actively involved in providing services in both Counties, with the addition of Peer staff funded through a 1115 project that allowed ACCESS to expand peer services into Anderson County. They provide training to current and new staff members on peer support services and recovery and are involved in planning and evaluation activities. ACCESS also has a subcontract with the Cherokee County Peer Support Group which group also provides group activities, skills training, socialization, and emotional support to peers. | * Will continue current practices but also plan to expand offerings of Peer Run Groups. Will also provide opportunities for Peers to obtain additional training and interaction/support with Peers from other LMHAs. |
| Addressing the needs of consumers with co-occurring substance use disorders | * Through another 1115 project, ACCESS was able to hire a LCDC and subsequently obtained licensure to provide substance abuse services at its clinics. These services are increasingly more integrated with mental health services as referrals between the services grow. These are the only substance abuse services available in either County and local hospitals, agencies, and service providers are anxious to see the service capacity grow. | * Plan to continue current services and also will be approaching local probation and parole providers regarding referrals from those sources if additional capacity can be developed. As 1115 funding winds down, sustainability is a possible concern and funding from those other sources will help offset revenue shortfalls. |
| Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers. | * ACCESS medical providers ensure physical concerns are addressed through referrals to primary care physicians and follow-up to ensure services are obtained. In addition, ACCESS has provided space in its Jacksonville location to the True North Clinic for co-location of behavioral health and primary care health services. ACCESS is able to refer individuals with chronic health conditions such as diabetes to the Clinic for follow-up and True North refers individuals to ACCESS for MH and SA screenings and follow-up. | ACCESS will continue to pursue opportunities for improved integration between physical healthcare and behavioral healthcare for its consumers. In addition to the co-location of services with the True North Clinic at its Jacksonville MH Clinic location, ACCESS is exploring opportunities for integration of other services through a new contractual relationship with a local FQHC. The implementation of a medication review program in conjunction with the Pharmacy School at the University of Texas at Tyler will provide further opportunities for improving health outcomes of the clients served by ACCESS. These new initiatives provide many more opportunities for enhanced integration of physical healthcare and behavioral healthcare services, resulting in improved health outcomes, and probable reductions in the amount of local emergency services currently provided. |

## 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** |
| --- | --- | --- |
| 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 Priorities for System Development

Development of the local plans should include a process to identify local priorities and needs, and the resources that would be required for implementation. The priorities should reflect the input of key stakeholders involved in development of the Psychiatric Emergency Plan as well as the broader community. This will build on the ongoing communication and collaboration LMHAs have with local stakeholders, including work done in response to the 2015 Crisis Needs and Capacity Assessment. The primary purpose is to support local planning, collaboration, and resource development. The information will also provide a clear picture of needs across the state and support planning at the state level. Please provide as much detail as practical for long-term planning.

In the table below, identify your service area’s priorities for use of any new funding for crisis and other services. Consider regional needs and potential use of robust transportation and alternatives to hospital care. Examples of alternatives to hospital care include residential facilities for non-restorable individuals, outpatient commitments, and other individuals needing long-term care, including geriatric patients with mental health needs. Also consider services needed to improve community tenure and avoid hospitalization.

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

| **Priority** | **Need** | **How resources would be used (brief)** | **Estimated Cost** |
| --- | --- | --- | --- |
| *1* | ***Example:*** *Detox Beds* | * *Establish a 6-bed detox unit at ABC Hospital.* |  |
| *2* | ***Example:*** *Nursing home care* | * *Fund positions for a part-time psychiatrist and part-time mental health professionals to support staff at ABC Nursing Home in caring for residents with mental illness.* * *Install telemedicine equipment in ABC Nursing Facility to support long-distance psychiatric consultation.* |  |
| 1 | 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 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 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.