HILL COUNTRY MHDD CENTERS

Consolidated Local Service Plan (CLSP)

FY16 & FY17

Contents

Introduction

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

Local planning is a collaborative activity, and the CLSP asks for information related to community stakeholder involvement in planning. DSHS recognizes that community engagement is an ongoing activity, and input received throughout the biennium will be reflected in the local plan. LMHAs may use a variety of methods to solicit additional stakeholder input specific to the local plan as needed.

The Psychiatric Emergency Plan is a new component that stems from the work of the HB 3793 Advisory Panel. The panel was charged with assisting DSHS to develop a plan to ensure appropriate and timely provision of mental health services. The Advisory Panel also helped DSHS develop the required standards and methodologies for implementation of the plan, in which a key element requires LMHAs to submit to DSHS a biennial regional Psychiatric Emergency Plan developed in conjunction with local stakeholders. The first iteration of this Psychiatric Emergency Plan is embedded as Section II of the CLSP.

In completing the template, please provide concise answers, using bullet points. When necessary, add additional rows or replicate tables to provide space for a full response.

Section I: Local Services and Needs

I.A. Mental Health Services and Sites

- *In the table below, list sites operated by the LMHA (or a subcontractor organization) that provide mental health services regardless of funding (Note: please include 1115 waiver projects detailed in Section 1.B. below). Include clinics and other publicly listed service sites; do not include addresses of individual practitioners, peers, or individuals that provide respite services in their homes.*
- *Add additional rows as needed.*
- *List the specific mental health services and programs provided at each site, including whether the services are for adults, children, or both (if applicable):*
    - *Screening, assessment, and intake*
    - *Texas Resilience and Recovery (TRR) outpatient services: adults, children, or both*
    - *Extended Observation or Crisis Stabilization Unit*
    - *Crisis Residential and/or Respite*
    - *Contracted inpatient beds*
    - *Services for co-occurring disorders*
    - *Substance abuse prevention, intervention, or treatment*
    - *Integrated healthcare: mental and physical health*
    - *Other (please specify)*

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
LMHA	358 Landa Street, New Braunfels, Tx 78310	Comal	• Screening, assessment, and intake • TRR outpatient- adults and children • Services for co-occurring disorders
LMHA	1200 Bishop Street, San Marcos. Tx 78666	Hays	• Screening, assessment, and intake • TRR outpatient- adults and children • Services for co-occurring disorders • Integrated healthcare: mental and physical health
LMHA	221 Fawn Valley Drive #500, Boerne, Tx 78006	Kendall	• Screening, assessment, and intake • TRR outpatient- adults and children • Services for co-occurring disorders
LMHA	110 South 10th Street Junction, Tx 76849	Kimble	• Screening, assessment, and intake • TRR outpatient- adults and children

Operator (LMHA or Contractor Name)	Street Address, City, and Zip	County	Services & Populations
			• Services for co-occurring disorders
LMHA	183 Industrial Loop, Fredericksburg, Tx 78624	Gillespie	• Screening, assessment, and intake • TRR outpatient- adults and children • Services for co-occurring disorders
LMHA	906 E. 11th Street, Del Rio, Tx 78840	Val Verde	• Screening, assessment, and intake • TRR outpatient- adults and children • Services for co-occurring disorders
LMHA	1447 Hwy. 71 East, Suite C, Llano, Tx 78643	Llano	• Screening, assessment, and intake • TRR outpatient- adults and children • Services for co-occurring disorders
LMHA	728 18th Street, Hondo, Tx. 78861	Medina	• Screening, assessment, and intake • TRR outpatient- adults and children • Services for co-occurring disorders
LMHA	328 Crystal City Hwy Uvalde, Tx. 78801	Uvalde	• Screening, assessment, and intake • TRR outpatient- adults and children • Services for co-occurring disorders
LMHA	643 Sheppard Rees Kerrville, Tx 78028	Kerr	• Crisis Stabilization Unit (adults)
River City Advocacy	145 Landa Street, New Braunfels, Tx 78130	Comal	• Peer Support and Advocacy

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**
6	**Mobile Crisis Outreach Teams (MCOT):** (one for Kerr and Gillespie counties and one for Val Verde County) to provide 24 hour a day, 7 day a week behavioral health crisis intervention and crisis follow up services within the community setting in order to reduce emergency department utilization, incarceration and hospitalizations.	2 years for implementation and 3 of operations	DY5 QPI goal 900	DY3=769 DY4=1,084
6,7,8	**Hill Country Virtual Psychiatric and Clinical Guidance:** Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally; in order to help physicians identify and treat behavioral health symptoms earlier in order to avoid exacerbation of symptoms into a behavioral health crisis.	3 years for implementation and 2 of operations	DY5 QPI goal RHP6=2500 RHP7=1000 RHP8=200	DY4=378
6,7,8,13	**Co-occurring Psychiatric and Substance Use Disorder Services (COPSD):** Purpose, to meet the needs of individuals with psychiatric and substance use issues within the community setting in order to reduce emergency department utilization, inpatient utilization, and incarceration.	2 years for implementation and 3 of operations	DY5 QPI goal RHP6=130 RHP7=60 RHP8=20 RHP13=20	All RHP's DY3=185 DY4=325
6,7,8,13	**Trauma Informed Care Services (TIC):** Purpose, to meet the needs of individuals who have experienced trauma that is impacting their behavioral health. The project will incorporate community education on the impact of trauma through Mental Health First Aid training and Trauma Informed Care training, and will provide trauma services through interventions such as Seeking Safety, Trust Based Relational Intervention and Cognitive Processing Therapy in order to help individuals deal with trauma they have	2 years for implementation and 3 of operations	DY5 QPI goal RHP6=270 RHP7=80 RHP8=17 RHP13=25	All RHP's DY3=281 DY4=411

1115 Waiver Projects				
RHP Region(s)	**Project Title (include brief description if needed)**	**Years of Operation**	**Capacity**	**Number Served/ Year**
	experienced.			
6,7,8,13	**Whole Health Peer Support:** Purpose, to meet the overall health needs of individuals who have behavioral health issues. The project will identify and train behavioral health peers on whole health risk assessments and working with peers to address overall health issues in order to treat symptoms prior to the need for utilization of emergency departments or inpatient hospitalization.	2 years for implementation and 3 of operations	DY5 QPI goal RHP6=200 RHP7=85 RHP8=40 RHP13=50	All RHP's DY3=74 DY4=382
6,7,8,13	**Veteran Mental Health Services:** Purpose, to meet the overall health needs of veterans dealing with behavioral health issues. The project will expand peer support services in an effort to identify veterans and their family members who need comprehensive community based wrap around behavioral health services, in order to treat symptoms prior to the need for utilization of emergency departments, inpatient hospitalization or incarceration.	2 years for implementation and 3 of operations	DY5 QPI goal RHP6=140 RHP7=120 RHP8=42 RHP13=20	All RHP's DY3=138 DY4=251
6,7	**Mental Health Courts:** Purpose, to meet the overall health needs of individuals dealing with behavioral health issues who frequently utilize the emergency departments or criminal justice system. The project will have dedicated case workers to provide wraparound services for the identified individuals and will have dedicated courts to monitor the patient's treatment compliance.	2 years for implementation and 3 of operations	DY5 QPI goal RHP6=80 RHP7=85	All RHP's DY3=64 DY4=136
6	**IDD Crisis Response Team:** Purpose, to meet the need of individuals dually diagnosed with mental illness and intellectual and developmental disabilities who are in a behavioral health crisis in order to provide behavioral assessment to determine cause and provide appropriate interventions, such as Cognitive Adaptation Therapy, for the individual to reduce the recurrence of the crisis in the future and avoid Emergency Department utilization or institutionalization.	3 year project	DY5 QPI goal RHP6=40	DY3=15 DY4=27

1115 Waiver Projects				
RHP Region(s)	**Project Title (include brief description if needed)**	**Years of Operation**	**Capacity**	**Number Served/ Year**
7	**Mobile Clinic**: Purpose, (through a Mobile Team which rotates between new clinic locations) to provide comprehensive behavioral health services (including Case Management, Counseling, Pharmacological Management, Medication Training and Support, Psychiatric Rehabilitation, Skills Training, Engagement Activities, Supported Employment and Supported Housing) to outlying areas of Hays and Blanco counties. Our goal is to reduce emergency department (ED) utilization, inpatient utilization, and incarceration by ensuring availability of services to outlying portions of the service area.	2 years for implementation and 3 of operations	DY5 QPI goal RHP7=237	DY3=220 DY4=381
7	**Integrated Primary Care:** The project will enable individuals being treated for Severe and Persistent Mental Illness to have a Health Home at the Hays County Mental Health Center where they can receive both their psychiatric and physical health care thus avoiding potentially preventable admissions to hospitals and reduce emergency department utilization.	2 years for implementation and 3 of operations	DY5 QPI goal RHP7=180	DY3=41 DY4=96
7 (Available to all 19 counties served by HCMHDD)	**IDD Crisis Center:** Developed for individuals dually diagnosed with mental illness and intellectual and developmental disabilities who are in a behavioral health crisis in order to provide temporary emergency respite for the individual and behavioral assessment to determine cause and provide appropriate interventions, such as Cognitive Adaptation Therapy, for the individual to reduce the recurrence of the crisis in the future, and establish community supports to maintain the individual in a community setting instead of in a hospital, emergency room, nursing home, or institutional care.	2 years for implementation and 3 of operations	DY5 QPI goal RHP7=60	DY3=15 DY4=17

1115 Waiver Projects				
RHP Region(s)	**Project Title (include brief description if needed)**	**Years of Operation**	**Capacity**	**Number Served/ Year**
7 (Available to all 19 counties served by HCMHDD)	**Children's Mental Health Crisis Respite Center:** Provides temporary emergency respite for children/youth in order to reduce psychiatric hospital utilization, emergency department utilization, or incarceration. Located within Hays County to meet the needs of children in a behavioral health crisis in order to avoid psychiatric hospitalization. The crisis center is set up similar to a group home environment with more intensive staff to consumer ratios and with staff that have additional training in Children's mental health.	2 years for implementation and 3 of operations	DY5 QPI goal RHP7=100	DY3=30 DY4=8
7 (Available to all 19 counties served by HCMHDD)	**Children's Trauma Informed Care Services:** Purpose, is to meet the needs of children who have experienced trauma that is impacting their behavioral health. The project offers trauma counseling through evidence based practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy aimed specifically at children in order to help children deal with trauma they have experienced.	2 years for implementation and 3 of operations	DY5 QPI goal RHP7=120	DY3=41 DY4=93
7 (Available to all 19 counties served by HCMHDD)	**Family Partner Services:** The certified Family Partner will provide peer mentoring and support to the primary caregivers; introduce the family to the treatment process; model self-advocacy skills; provide information, referral and non- clinical skills training; assist in the identification of natural/non-traditional and community support systems; and document the provision of all family partner services, including both face-to-face and non- face-to-face activities.	2 years for implementation and 3 of operations	DY5 QPI goal RHP7=375	DY3=355 DY4=442

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.

• Reduce time between intake and initial psychiatrist appointment
• Need more substance use services (detox and residential)
•

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

- Information was gathered at various meetings and over the past year with stakeholders.
- Ongoing conversations with stakeholders at the local level
- Clinic directors have regular contact with local officials, hospitals, law enforcement, and other stakeholders.

II.B Crisis Response Process and Role of MCOT

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

    - 3QMHP and 1 LPHA

    b. After business hours

    - 1 Crisis QMHP and 1 LPHA Clinical available, on-call psychiatrist available

c. Weekends/holidays

- 1 Crisis QMHP and 1 LPHA Clinical available, on-call psychiatrist available

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

- Imminent risk of harm to self or others or decompensated to the point of needing stabilization for safety of self or others

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

- Crisis Intervention is to conduct screening for hospitalization, provide recommendation or not.
- Seeking least restrictive requires safety plan and follow-up.
- Person may authorize for services within transitional services. MCOT completes crisis intakes

4. Describe MCOT support of emergency rooms and law enforcement:

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

- Emergency rooms: If person is medically cleared, the ER will call crisis hotline. The hotline triages the call and determines activation of LMHA/MCOT.

- Law enforcement: Law Enforcement calls crisis hotline and the hotline will activate. We respond emergent to law enforcement. Work collaboratively with law enforcement to determine least restrictive, transportation, emergency detention, etc.

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

- Emergency rooms: MCOT provides screening for hospitalization to determine recommendation of inpatient care, outpatient care and follow-up, safety plan, respite, etc. Works with hospital social workers to create a plan for safety and stabilization. Sometimes refer to telepsych-consult if needed. MCOT will secure bed for inpatient care if recommended.

- Law enforcement: Screening for hospitalization to determine recommendation for inpatient, outpatient, follow-up, safety plan, respite, etc. MCOT works collaboratively to develop a plan of least restrictive environment for stabilization and safety.

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

- Determination of medical clearance is made by peace officers. If needing medical clearance, peace officer or EMS transports to nearest ER.

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

- MCOT completes screening, calls inpatient hospitals to secure bed, notifies appropriate person if necessary for need of OPC or ED to transport, and facilitates doctor-to-doctor if needed by the admitting facility.

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

- We no longer have crisis respite for MH Adults. For patients coming from Bluebonnet we will refer to their extended observation units in Seguin or Burnet counties.

6. What steps should emergency rooms and law enforcement take when an inpatient level of care is needed?
    a. During business hours
        - Call Avail to request screening for hospitalization by LMHA or call private inpatient hospitals they have MOUs with for patients with insurance. No OPC are signed after hours so if law enforcement refuses Ed, the hospital must secure patient until the OPC can be obtained Monday morning.

    b. After business hours

        - Call Avail to request screening for hospitalization by LMHA or call private inpatient hospitals they have MOUs with for patients with insurance. No OPC are signed after hours so if law enforcement refuses Ed, the hospital must secure patient until the OPC can be obtained Monday morning.

    c. Weekends/holidays

        - Call Avail to request screening for hospitalization by LMHA or call private inpatient hospitals they have MOUs with for patients with insurance. No OPC are signed after hours so if law enforcement refuses Ed, the hospital must secure patient until the OPC can be obtained Monday morning.

7. If an inpatient bed is not available:

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

- ER

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

- MCOT, ER, MHOs (we have 4 right now)

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

d.

- LMHA reassess within every 48 hours while patient waits for inpatient bed

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

- Either law enforcement will transport under Emergency Detention Warrant (ED) or the hospital or facility will request OPC via DA's office. The LMHA must secure the bed then the judge will sign the Order of Protective custody to transport to the designated hospital. You cannot stack EDs and if we know one will expire we will go ahead and recommend the OPC process to cover the patient until the accepting hospital can schedule the probable cause hearing.

Crisis Stabilization

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

Name of Facility	Youth Crisis Respite Center
Location (city and county)	San Marcos, Hays County
Phone number	(512) 667-9868
Type of Facility (see Appendix B)	Crisis Respite

Name of Facility	Youth Crisis Respite Center
Key admission criteria (type of patient accepted)	Youth between 13-17 years of age.
Circumstances under which medical clearance is required before admission	Cannot require specialized medical care.
Service area limitations, if any	None
Other relevant admission information for first responders	Youth must enter voluntarily. Youth must be at low risk of harm to self and/or others. Youth must be able to participate in daily activities with minimal supervision or instruction. Youth must be able to self-administer medication. Youth must be able to take care of own Activities of Daily Living.
Accepts emergency detentions?	

Inpatient Care

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

Name of Facility	Linda Werlein Crisis Stabilization Unit
Location (city and county)	Kerrville, Kerr County
Phone number	(830) 257-5111
Key admission criteria	Danger to self, danger to others
Service area limitations, if any	None
Other relevant admission information for first responders	Patient must be medically stable Adults only, 18 years of age and older

Name of Facility	Laurel Ridge Treatment Center
Location (city and county)	San Antonio, Bexar County
Phone number	(210) 491-9400
Key admission criteria	Danger to self, danger to others Adults only, 18 years of age and older
Service area limitations, if any	None
Other relevant admission information for first responders	Purpose is to provide temporary psychiatric hospitalization for adult crisis patients when no State-funded beds are available. Must be approved by Hill Country personnel.

Name of Facility	Nix Health Hospital
Location (city and county)	San Antonio, Bexar County
Phone number	(210) 271-1800
Key admission criteria	Danger to self, danger to others Child, adolescent and adults
Service area limitations, if any	None
Other relevant admission information for first responders	Purpose is to provide temporary psychiatric hospitalization for individuals when no State-funded beds are available. Must be approved by Hill Country personnel.

Name of Facility	Clarity Child Guidance Center
Location (city and county)	San Antonio, Bexar County
Phone number	(210) 616-0300
Key admission criteria	Danger to self, danger to others Child, adolescent
Service area limitations, if any	None
Other relevant admission information	Purpose is to provide temporary psychiatric hospitalization for individuals when

Name of Facility	Clarity Child Guidance Center
for first responders	no State-funded beds are available. Must be approved by Hill Country personnel.

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

10. What local inpatient or outpatient alternatives to the state hospital does your service area currently have for competency restoration?
    a. Identify and briefly describe available alternatives.

- Uvalde, Medina, Hays, and Comal Counties have a Mental Health Court. Outpatient clinic psych evaluations and medications for MH clients who are involved in the justice system.

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

- There are limited inpatient psychiatric hospitals offering these services. These programs are difficult to sustain due to low volume of individuals needing these services.

    c. Does the LMHA have a dedicated jail liaison position? If so, what is the role of the jail liaison? At what point is the jail liaison engaged?

- Hays, Comal, Medina, and Uvalde Counties have a MH Court Case Manager. Works with justice involved individuals with MH diagnosis. Engagement at all intercept locations (pre-booking, Magistration, jail, courts, probation)

    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 workers. Mental Health Court Case Managers- Hays, Medina Uvalde & Comal Counties

d. What plans do you have over the next two years to maximize access and utilization of local alternatives for competency restoration? If not applicable, enter N/A.

- Establishment of Specialty Court- MH Court in Hays and Comal Counties.

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

- Yes, Outpatient Competency Restoration Program, inpatient competency restoration, jail-based competency restoration and jail diversion.
- MH Court would be helpful to assist with persons who continue to get in trouble with the law but also appear to suffer from mental illness. It is possible that competency restoration could be utilized in conjunction with a program like this.

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

- Funding for court liaisons, community support for such program(s), funding for LMHA staff to coordinate with LE and courts while providing mental health services.

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

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

- Recovery coaches and MCOT workers refer consumers to services needed as appropriate. Case management/care coordination is provided to refer to local agencies/programs for assistance.

- Private Dual Diagnosis hospitals are utilized when possible at the time of psychiatric hospitalizations (for insured individuals).
- Integrated health Home in San Marcos for individuals with severe and persistent Mental illness. COPSD staff are also officed at this location and the OSAR will screen and assess individuals as needed.

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

- Plan to continue to expand on these current projects.

II.E Communication Plans

15. How will key information from the Psychiatric Emergency Plan be shared with emergency responders and other community stakeholders? Consider use of pamphlets/brochures, pocket guides, website page, mobile app, etc.

- Website posting, email, and magnetic cards for the Crisis Hotline number.

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

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- The Crisis Hotline is accredited with AAS and staff receive ongoing training to remain competent. MCOT and clinic staff receive annual training and additional training as needed to remain competent to implement the plan.

II.F Gaps in the Local Crisis Response System

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

Counties	Service System Gaps
Real, Edwards, Schleicher, Sutton, Menard, Kinney, and Mason	• Need for Mental Health Deputies in these rural counties • Distance to respond to crisis from Mental Health Clinic
	•

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	• Mobile Crisis Outreach Team (MCOT) Hays & Comal- jail screenings & referral to Jail Psych for inmates who report +MH HX upon intake into jail. • Mental Health Court (MHC)- Case Managers (CM) provide skills training to inmates in the following county jails: Hays, Comal, Uvalde & Medina • MHC-CMs work with Adult Probation, DA,

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☒ Service linkage and follow-up for individuals who are not hospitalized ☒ Other: Mental health Court Initiative in Hays & Comal Counties. Established MHC Docket in Uvalde, Medina	Defense Attorneys and judges to provide MH services to justice involved individuals- Comal, Hays, Uvalde & Medina. • Lobbying to establish MHC docket/specialty courts in Comal & Hays
Plans for the upcoming two years: • Establish Mental Health Court docket and specialty courts in Comal and Hays Counties	

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.	• MHC-CM regularly attend District & CCL Courts to assist the court in referrals for individuals with MH Diagnosis/issues in an attempt to engage the individuals into comprehensive MH services to include MH Court Initiative program providing wraparound services as needed
Plans for the upcoming two years: • Continue current initiatives	

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

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☒ Routine screening for mental illness and diversion eligibility ☒ Mental Health Court ☒ Veterans' Court ☐ Drug Court ☐ Outpatient Competency Restoration ☐ Services for persons Not Guilty by Reason of Insanity ☒ Services for persons with other Forensic Assisted Outpatient Commitments ☒ Providing services in jail for persons Incompetent to Stand Trial ☐ Compelled medication in jail for persons Incompetent to Stand Trial ☒ Providing services in jail (for persons without outpatient commitment) ☒ Staff assigned to serve as liaison between specialty courts and services providers ☒ Link to comprehensive services ☐ Other:	• Assist with local DAs, Courts & Probation to formulate Conditions of Probation which include MH components i.e. intake, psych assessment, medication management, case management, skill training, supportive housing & employment. • For individuals found incompetent- work with courts to facilitate outpatient MH services in an attempt to stabilize on medication while providing wrap around MH services. Assist with MH outpatient commitments from State Hospitals. • MHC-CMs provide skills training to inmates with MH diagnosis who are in the MHC Initiative Program • Participation in Veteran's court in Hays and Comal Counties.
Plans for the upcoming two years: • Veteran's court in Hays and Comal Counties. Plan to extend Veteran court to other counties. Currently determining which counties to prioritize.	

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:	• MHC-CMs work closely with Jail Infirmaries, Defense Attorneys & Individuals upon notice an individual will be released in an attempt to ensure an individual will follow up with MH services concentrating on wrap around services. MHC-CMs will see individuals on a regular structured basis to ensure individual has the opportunity to continue and expand on services provided in the jail. Referrals based on the individual's needs.
Plans for the upcoming two years: • Refine current strategies	

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	• TCOOMMI- Hays, Comal • MHC-CMs work closely with Adult Probation in providing a collaborative approach in meeting an individual's needs. MHC-CM staff provide education on the referral process for the MHC Initiative Program.

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
noncompliance ☐ Other:	
Plans for the upcoming two years: • Refine current strategies	

III.B Other System-Wide Strategic Priorities

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

Area of Focus	Current Status	Plans
Improving continuity of care between inpatient care and community services	• Hospital liaison has regular contact with hospitals and the local clinics to ensure continuity of service • Services are coordinated with CSU staff and the local clinic prior to individuals being discharged from the CSU	• Continue coordination efforts with the hospital liaison • Continue continuity of service with individuals at the CSU, and other inpatient facilities, and the community services.
Reducing hospital readmissions	• Person Centered Recovery Planning, wrap- around services, YES waiver, COPSD, and trauma informed care.	• Meet with county officials to discuss need and collaborate resources • Offer MH first aid to responders through DSHS contract and 1115 waiver.
Transitioning long-term state hospital patients who no longer need an inpatient level	• Visit patients frequently and work with social worker and Team at state hospital to begin discharge	• Continue current strategies and ensure 7 day follow up upon discharge.

Area of Focus	Current Status	Plans
of care to the community	planning as soon as possible	
Reducing other state hospital utilization	• Monitor medication compliance, offer wrap around, PSRP, trauma informed care, COPSD, and other needed supports.	• Continue current strategies and provide continuity of care.
Tailoring service interventions to the specific identified needs of the individual	• This is accomplished through person centered recovery planning • Trauma Informed Care Learning Collaborative • Integrate trauma informed approaches into PCRP.	• Provide training on Person Centered Recovery Planning to all of the 1115 waiver programs in order to ensure interventions are specific to identified needs of the individual.
Ensuring fidelity with evidence-based practices	• Fidelity is monitored and audited on a regular basis.	• Continue to ensure fidelity with current processes.
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)	• Peer support services are integrated into all levels of service delivery • Center continues to evaluate peer involvement in other activities and operations.	• Continue to transition all programs, including the 1115 waiver projects, to a recovery system of care.
Addressing the needs of consumers with co-occurring substance use disorders	• Currently employ COPSD specialist at mental health clinics funded through the 1115 project.	• Continue to explore sustainability and apply for funding as available.
Integrating behavioral health and primary care services and	• This is being accomplished with the primary care integration 1115	• Continue to work on project sustainability

Area of Focus	Current Status	Plans
meeting physical healthcare needs of consumers.	Waiver project.	

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
Maximize access to service	• Need more LPHA coverage for intakes • Utilizing video to expand access to LPHA for intake	• Evaluate salary for LPHAs in order to attract and retain providers • Recruit nurse practitioners to augment psych services
Sustainability of the 1115 Waiver projects	• Currently seeking all funding and billing opportunities • Meeting with Waiver managers to plan for sustainability	• Continue to seek other federal and state grants as well as local resources in order to sustain programs.
Increase Staff Retention- for consistency in consumer care	• Adjusted salaries to be more competitive • Created incentive plan for staff	• Enhance training for staff and provide ongoing mentoring

III.D Priorities for System Development

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

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

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

Priority	Need	How resources would be used (brief)	Estimated Cost
1	Funding to sustain the Youth Crisis respite facility	• Fund staff positions and operating cost of the Youth Crisis Respite facility	• Staffing and operation cost of facility ($646,909)
2	Seven (7) Mental Health Deputies	• MH Deputies would serve rural and frontier counties	• $371,000

Priority	Need	How resources would be used (brief)	Estimated Cost
3	More PRN private psychiatric beds	• PRN psychiatric beds would be utilized as needed when no other options are available.	• $600-$800 per day per bed

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.