MHMR Authority of Brazos Valley

Consolidated Local Service Plan

2018

Health and Human Services

Form O
Consolidated Local Service Plan (CLSP)

Local Mental Health Authorities and Local Behavioral Health Authorities

September, 2017

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Introduction

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

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

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

Section I: Local Services and Needs

I.A Mental Health Services and Sites

- *In the table below, list sites operated by the LMHA or LBHA (or a subcontractor organization) providing mental health services regardless of funding (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*
  - *Services for individuals with IDD*
  - *Services for at-risk youth*
  - *Services for veterans*
  - *Other (please specify)*

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
LMHA	804 S. Texas Ave, Bryan, TX 77802	Brazos	• Screening, assessment, and intake (both adult and children • TRR for adult and children • YES Waiver for children
LMHA	103 HWY 21 East, Caldwell, TX 77836	Burleson	• Screening, assessment, and intake (both adult and children • TRR for adult and children • YES Waiver for children
LMHA	702 La Salle, Navasota, TX 77868	Grimes	• Screening, assessment, and intake (both adult and children • TRR for adult and children

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
			• YES Waiver for children
LMHA	203 W. Main, Madisonville, TX 75833	Madison	• Screening, assessment, and intake (both adult and children • TRR for adult and children
LMHA	1212 West Brown St, Hearne, TX 77859	Robertson	• Screening, assessment, and intake (both adult and children • TRR for adult and children • YES waiver for children
LMHA	609 E. Blue Bell Rd., Brenham, TX 77833	Washington	• Screening, assessment, and intake (both adult and children • TRR for adult and children • YES Waiver for children
Rock Prairie Behavioral Health	3550 Normand Drive	All	• Inpatient psychiatric PESC and PPB contract beds for adults and children
Houston Behavioral Hospital	2801 Gessner Road Houston, TX 77080	All	• Inpatient psychiatric PESC contract beds for adults
Cross Creek Behavior Health Hospital	8402 Cross Park Dr. Austin, TX 78754	All	• Inpatient psychiatric PESC contract beds for adults and children
Tri-County Services	706 FM 2854 Conroe, TX. 77301	All	• Inpatient psychiatric CSU contract beds for adults
Dansby House	703 Dean St., Bryan, TX 77803	All	• Crisis Respite for adults
Patrick Baca	2710 Finfeather, Bryan, TX 77801	All	• Peer support for military veterans

I.B Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver Projects

- *Identify the Regional Health Partnership (RHP) Region(s) associated with each project.*
- *List the titles of all projects you proposed for implementation under the 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	Population Served	Number Served/ Year
17	Crisis Triage (crisis assessments diverted from ER)	4	8	Adults/child	899/2017
17	Rural ACT Expansion	4	16	Adults	45

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, Assessment, 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
☒	Peer Specialists	☒	IDD Providers
☐	Foster care/Child placing agencies	☒	Community Resource Coordination Groups
☒	Veterans' organization	☐	Other: _____

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

• Participation in other regional planning activities; including the Brazos Valley Council of Govt; and Health Dept;
• Coordinated meetings with county and law enforcement representatives
• Participation in Quarterly CRCG Meetings
• Input from quarterly CNAC meetings
• Quarterly meetings with Juvenile justice and hospital representatives
• Quarterly CIT meetings

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

• Not enough mental health providers/psychiatrist
• Need for a Crisis Respite/Stabilization unit
• Need for a detox facility
•
•
•

Section II: Psychiatric Emergency Plan

The Psychiatric Emergency Plan is intended to ensure stakeholders with a direct role in psychiatric emergencies have a shared understanding of the roles, responsibilities, and procedures enabling them to coordinate 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.

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

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

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

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

II.A Development of the Plan

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

- Ensuring all key stakeholders were involved or represented
- Ensuring the entire service area was represented

- Soliciting input

• Coordinated meetings with county law enforcement and hospital representatives to discuss and obtain input in crisis process.

II.B Crisis Response Process and Role of MCOT

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

○ 2 FTE MCOT staff from 8a-5p

   b. After business hours

○ 2 FTE MCOT staff from 4p-11p. On-call staff from 11p-8a

   c. Weekends/holidays

○ Use of primary and secondary on-call staff

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

• Calls are routed through the crisis hotline who assess and determine need for deployment.

3. What is the role of MCOT during and after a crisis when crisis care is initiated through the LMHA or LBHA (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 or LBHA.

- MCOT responds to emergent calls within 1 hour and to all urgent calls within 8 hours. MCOT is accompanied by a CIT Deputy all emergent and urgent calls. If a CIT Deputy is not available, two MCOT staff may report to a call. After MCOT crisis intervention services, if the individual is still in need of emergency care services, then the individual is assessed by a physician (MHMR, ER, Psychiatric hospital) within 12 hours.
- CIT Specialist performs a crisis assessment immediately, using TRAG assessment.
- If client presents an immediate danger to self/others, individual shall be detained by CIT officer and hospitalization coordinated. Individual shall have access to a medical screening assessment when there is a medical problem indicated, such as intoxication, open wound, delirium, difficulty breathing, etc. In this situation, QMHP shall call EMS to respond to the individual. Individuals served in Service Package 0 shall be contacted daily by MCOT, either in person or by phone.
- Individuals served in Service Package 5 shall be contacted by MCOT at a minimum once weekly (face to face contact). Initial crisis follow-up and relapse prevention services performed by MCOT shall be provided within 24 hours of crisis. One MCOT member may be deployed for subsequent crisis contacts or crisis follow-up and relapse prevention services.

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

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

      - Emergency rooms: emergency room staff call the crisis hotline number and MCOT are dispatched to ER
      - Law enforcement: Law Enforcement either bring individual directly to the LMHA office, or call crisis hotline and MCOT dispatched to crisis location.

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

      - Emergency rooms: MCOT perform crisis assessment; crisis counseling; and crisis resolution services.
      - Law enforcement: MCOT perform crisis assessment; crisis counseling; and crisis resolution services.

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:

    - Individual shall have access to a medical screening assessment when there is a medical problem indicated, such as intoxication, open wound, delirium, difficulty breathing, etc. In this situation, QMHP shall call EMS to respond to the individual.

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

    - If client presents an immediate danger to self/others, law enforcement is call and detained by CIT officer and hospitalization coordinated

    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.):

    - LMHA maintain contracts with Tri-County Services and TEXANA MHMR for extended observation and Crisis Residential Services.

    d. Describe your process for crisis assessments requiring MCOT to go into a home or alternate location such as a parking lot, office building, school, or under a bridge:

    - MCOT is accompanied by a CIT Deputy all emergent and urgent calls. If a CIT Deputy is not available, two MCOT staff may report to a call.

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

- Call Crisis hotline

b. After business hours

- Call crisis hotline

c. Weekends/holidays

- Call crisis hotline

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?

- LMHA MCOT staff

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

- LMHA MCOT staff

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

○ LMHA staff

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	Tri-County Crisis Stabilization Unit
Location (city and county)	Conroe, Montgomery County
Phone number	(936) 583-1102
Type of Facility (see Appendix A)	CSU
Key admission criteria (type of patient accepted)	Deterioration in psychiatric condition that could result in severe exacerbation if not addressed. Primary depressive symptoms without suicidal/homicidal plan.
Circumstances under which medical clearance is required before admission	Suspicion of drug/alcohol intoxication or overdose; unstable medical condition, or medical emergency.
Service area limitations, if any	N/A
Other relevant admission information for first responders	Required to be assessed by MHMRABV prior to admission
Accepts emergency detentions?	Yes

Name of Facility	Texana Crisis Center
Location (city and county)	Rosenberg, Fort Bend County
Phone number	(281) 2386708
Type of Facility (see Appendix A)	CSU
Key admission criteria (type of patient accepted)	Deterioration in psychiatric condition that could result in severe exacerbation if not addressed. Primary depressive symptoms without suicidal/homicidal plan.
Circumstances under which medical clearance	Suspicion of drug/alcohol intoxication or overdose; unstable medical

is required before admission	condition, or medical emergency.
Service area limitations, if any	N/A
Other relevant admission information for first responders	Required to be assessed by MHMRABV prior to admission
Accepts emergency detentions?	Yes

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	Rock Prairie Behavioral Health
Location (city and county)	College Station, Brazos County
Phone number	(979) 703-8848
Key admission criteria	Individuals experiencing acute psychiatric symptoms requiring inpatient treatment as least restrictive treatment option to ensure safety of individual or others
Service area limitations, if any	N/A
Other relevant admission information for first responders	If patient is uninsured, an assessment by MHMRABV required prior to admission using state indigent funds.

Name of Facility	Cross Creek Hospital
Location (city and county)	Austin, Travis County
Phone number	(512) 549-8021
Key admission criteria	Individuals experiencing acute psychiatric symptoms requiring inpatient treatment as least restrictive treatment option to ensure safety of individual or others
Service area limitations, if any	N/A

Other relevant admission information for first responders	If patient is uninsured, an assessment by MHMRABV required prior to admission using state indigent funds.

Name of Facility	Houston Behavioral Healthcare Hospital
Location (city and county)	Houston, Harris County
Phone number	(832) 834-7710
Key admission criteria	Individuals experiencing acute psychiatric symptoms requiring inpatient treatment as least restrictive treatment option to ensure safety of individual or others
Service area limitations, if any	N/A
Other relevant admission information for first responders	If patient is uninsured, an assessment by MHMRABV required prior to admission using state indigent funds.

II.C Plan for local, short-term management of pre- and post-arrest patients who are 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.

○ We provide psychiatry services while in the jail waiting competency evaluation.

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

- No funding and no inpatient facility willing to do inpatient competency restoration

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

- We have a dedicated liaison staff co-located at our largest county jail (Brazos) and a dedicated staff who liaison between 2 other counties (Washington and Burleson)

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

- We have case workers who perform role of liaison with the other county jails (Grimes, Madison, Robertson, and Leon) as part of their job functions.

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

- N/A

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

- N/A

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

- N/A

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

13. What steps have been taken to integrate emergency psychiatric, substance use, and physical healthcare services? Who have you collaborated with in these efforts?

- Submitted a HB 13 grant for integration with Texas A&M Health Science Family Medical Practice and local indigent primary medical provider (Health for All)
- MOU with local Council on Alcohol and Substance Abuse

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

- Looking a future enhanced collaboration with Texas A&M Health Science Center for co-location of Family Medical doctor into LMHA clinic. Until such time, will pursue co-locating LMHA at these location to liaison between LMHA and primary health care provider

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.

- Information will be shared through joint meetings, brochures, and website page

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

- Information is communicated via internal emails and the availability of, and training on policy & procedures

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
Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington	• Crisis services for the IDD population, particularly crisis respite/stabilization other than the state hospital.
Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington	• Detox facility
Brazos, Burleson, Grimes, Leon, Madison, Robertson, Washington	• Crisis respite/stabilization unit in the service area as opposed to having to transport out of the area

Section III: Plans and Priorities for System Development

III.A Jail Diversion

The Texas Statewide Behavioral Health Services Plan highlights the need for effective jail diversion activities:

- *Gap 5: Continuity of care for individuals exiting county and local jails*
- *Goal 1.1.1, Address the service needs of high risk individuals and families by promoting community collaborative approaches, e.g., Jail Diversion Program*
- *Goal 1.1.2: Increase diversion of people with behavioral health needs from the criminal and juvenile justice systems*

In the table below, 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 describing the strategies checked in the first column. For those areas not required in the HHSC Performance Contract, enter NA if the LMHA or LBHA 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	• MCOT dispatched to law enforcement location, or law enforcement bring individual to office for crisis if needed. • Mental health deputies trained to do Peace Officer Warrant. • Court and probation personnel trained on Peace officer Magistrate Warrant Process and LMHA role • Quarterly CIT meetings to discuss crisis concerns • Follow-up are conducted within 24 hours and individual linked to appropriate services

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☐ Other: Click here to enter text.	
Plans for the upcoming two years: • Recently implemented Suicide Safe Care initiative which requires intensive follow-up with individuals who score in the moderate to high on suicide rating scale.	

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.	• Staff at court in Brazos, Washington and Burleson County for routine screening and to post booking diversion. • Routine screening in all counties for for mental illness and link to comprehensive services.
Plans for the upcoming two years: • Pursuing options for staff to be assigned to jail in every county for screening, diversion, and follow-up activities to comply with conditions of release/diversion.	

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	• Staff at court in Brazos, Washington and Burleson County for routine screening and to post booking diversion. • Provide psychiatry services to individual in jail

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☐ 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:	while waiting on competency evaluation, or who are incompetent to stand trial.
Plans for the upcoming two years: • Pursuing options for staff to be assigned to jail in every county for screening, diversion, and follow-up activities to comply with conditions of release/diversion. • Pursing Mental Health Court in Brazos County	

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	• Staff assist with assessing needs and developing plans to transition client into services post release in Brazos, Washington, and Burleson

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
☒ Structured process to coordinate discharge/transition plans and procedures ☐ Specialized case management teams to coordinate post-release services ☐ Other:	County.
Plans for the upcoming two years: • Pursuing options for staff to be assigned to jail in every county for screening, diversion, and follow-up activities to comply with conditions of release/diversion.	

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:	• TCOOMI program provides routine screening and services to individuals involved on probation and parole • Provide periodic training to probation and parole staff
Plans for the upcoming two years: • Develop collaboration with other 6 rural counties to establish a probation/parole liaison staff where feasible to work	

with probation/parole staff in serving mutual individuals.

- Working in collaboration with Brazos County judge to develop a mental health court.

III.B Other Behavioral Health Strategic Priorities

The Texas Statewide Behavioral Health Strategic Plan identifies other significant gaps in the state's behavioral health services system, including the following:

- *Gap 1: Access to appropriate behavioral health services for special populations (e.g., individuals with co-occurring psychiatric and substance use services, individuals who are frequent users of emergency room and inpatient services)*
- *Gap 2: Behavioral health needs of public school students*
- *Gap 4: Veteran and military service member supports*
- *Gap 6: Access to timely treatment services*
- *Gap 7: Implementation of evidence-based practices*
- *Gap 8: Use of peer services*
- *Gap 10: Consumer transportation and access*
- *Gap 11: Prevention and early intervention services*
- *Gap 12: Access to housing*
- *Gap 14: Services for special populations (e.g., youth transitioning into adult service systems)*

Related goals identified in the plan include:

- *Goal 1.1: Increase statewide service coordination for special populations*
- *Goal 2.1: Expand the use of best, promising, and evidence-based behavioral health practices*
- *Goal 2.3: Ensure prompt access to coordinated, quality behavioral healthcare*
- *Goal 2.5: Address current behavioral health service gaps*
- *Goal 3.2: Address behavioral health prevention and early intervention services gaps*
- *Goal 4.2: Reduce utilization of high cost alternatives*

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

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Improving access to timely outpatient services	• Gap 6 • Goal 2	• We provide open access model for pre-admission assessments for timely admissions to appropriate services, and prioritize psychiatric follow-up for individuals released from a hospital. Challenges include recruitment of additional psychiatric time to prevent long waits for medication management and/or waiting list	• We are aggressively pursuing more doctor time. Also have contractual agreement with Texas A&M Health Science center for psychiatry services. They are also considering adding staff with whom we might be able to contract.
Improving continuity of care between inpatient care and community services and reducing hospital readmissions	• Gap 1 • Goals 1,2,4	• Currently have a continuity of care staff providing continuity services for all clients admitted and released from hospitals. Average re-admission within 180 days is averaging around 3.5%, which is a reduction from about 6%	• Will enhance communication with local psychiatric hospital and staff to develop plans and interventions to reduce re-admissions.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		over the past 2 years. However are seeing an upward trend which appears to be primarily related to walk-in admission at our local psychiatric hospital.	
Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community and reducing other state hospital utilization	• Gap 14 • Goals 1,4	• Currently have a continuity of care staff providing continuity services for all clients admitted and released from hospitals. We currently have only one individual on the long-stay hospital list that we are attempting to transition into the HCBS program. We also have worked aggressively with the jails to prevent forensic commitments by providing medication treatment while in the jail. Our current challenge are preventing RTC admission of our Child & Adolescent	• Continue to evaluate YES program for fidelity • Consult with centers who appear to be operating at high fidelity

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		population	
Implementing and ensuring fidelity with evidence-based practices	• Gap 7 • Goal 2	• We currently conduct program & agency-level program reviews & audit to ensure fidelity to evidence-based practices with follow-up corrective action plans. We recently added a dedicated supported employment specialist to enhance fidelity to the program.	• Will continue to conduct fidelity reviews and operationalize plans of corrections as needed.
Transition to a recovery-oriented system of care, including use of peer support services	• Gap 8 • Goals 2,3	• We have an active peer support program and continue to participate in state-level peer support planning and activities. • Assisted Director of Behavioral Health Services serve on the state level Via Hope advisory Council • Operate a peer support center • Implemented recovery focus service delivery	• Will continue to look for opportunities to use peers in service delivery system and in advisory capacity.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Addressing the needs of consumers with co-occurring substance use disorders	• Gaps 1,14 • Goals 1,2	• All clinicians are trained on COPSD services • We have a local OSAR staff in the unit at least 1 day per week • We have an MOU with the local Substance Abuse Council (BVCASA) for referrals and co-location in 2 of our 7 county offices. • We have an LCDC staff providing services within our ACT Team.	• Look for grant opportunities to expand integrated care with local substance abuse provider and/or hire additional internal LCDC staff.
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• Gap 1 • Goals 1,2	• We are currently referring to primary care providers and FQHC through informal agreements. • We currently have a 1115 Waiver project for controlling high blood pressure. • Challenge include not having a full integrated system to ensure consistency of treatment	• Completed an HB13 grant with Texas A&M Health Science Center for a collaborative integration project.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		and follow-up	
Consumer transportation and access to treatment in remote areas	• Gap 10 • Goal 2	• We provide transportation as needed • Provide training on accessing public transportation • Coordinate with transportation providers as available.	• Collaborating with Brazos Valley Council of Governments to increase local bus routes and hours in the remote areas.
Addressing the behavioral health needs of consumers with Intellectual Disabilities	• Gap 14 • Goals 2,4	• We are Coordinating with IDD providers to address needs • We are cross-training IDD and MH staff on mental health and IDD service needs and interventions • A challenge appears to be a need for additional training for prescribers specific to the IDD population	• Investigate training opportunities for psychiatrist specific to the treatment of the IDD population
Addressing the behavioral health needs	• Gap 4 • Goals 2,3	• We have a Veteran Services grant to assist	• Continue collaboration with VA and other veteran

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
of veterans		veterans in accessing services. • We have entered into single case agreements with the VA for psychiatry services	programs through Veteran Services grant

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
• Not enough mental health providers/psychiatrist	• We currently have a total of 2.4 FTE Adult psychiatrists and a .40 child psychiatrist. There are currently only 2 other adult psychiatrist in the community to who we can refer private paying individuals and 1 child psychiatrist. This has resulted in a wait of up to 3 months for a first appointment for routine services, and an average of 30 adults being on	• Continue to recruit psychiatrist to the area. • Continue to collaborate with TAMU Health Science center for contract psychiatry.

Local Priority	Current Status	Plans
	the waiting list for services.	
• Need for a detox facility/sobering center	• No current detox/sobering center in service area	• Working with committee through the Brazos Valley Council of Governments to study the feasibility of establishing a detox/sobering center
	•	•
	•	•
	•	•

III.D System Development and Identification of New Priorities

Development of the local plans should include a process to identify local priorities and needs, and the resources required for implementation. The priorities should reflect the input of key stakeholders involved in development of the Psychiatric Emergency Plan as well as the broader community. This will build on the ongoing communication and collaboration LMHAs and LBHAs have with local stakeholders. The primary purpose is to support local planning, collaboration, and resource development. The information 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 should it become available in the future. Do not include planned services and projects that have an identified source of funding. Consider regional needs and potential use of robust transportation and alternatives to hospital care. Examples of alternatives to hospital care include residential facilities for non-restorable individuals, outpatient commitments, and other individuals needing long-term care, including geriatric patients with mental health needs. Also consider services needed to improve community tenure and avoid hospitalization.

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	Brief description of how resources would be used	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	Crisis Residential Unit	• Funds construction/renovation of facility • Fund staffing of facility	• $1.5 million • $1.7 million
		•	•
		•	•
		•	•

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. 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/LBHA 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.