Health and Human Services

Gulf Bend Center - 110

Form O
Consolidated Local Service Plan (CLSP)

Local Mental Health Authorities and Local Behavioral Health Authorities

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Contents

Introduction 3
Section I: Local Services and Needs 4
I.A. Mental Health Services and Sites 4
I.B Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver Projects 6
I.C Community Participation in Planning Activities 8
Section II: Psychiatric Emergency Plan 11
II.A Development of the Plan 12
II.B Crisis Response Process and Role of MCOT 13
II.C Plan for local, short-term management of pre- and post-arrest patients who are incompetent to stand trial 19
II.D Seamless Integration of emergent psychiatric, substance use, and physical healthcare treatment 21
II.E Communication Plans 22
II.F Gaps in the Local Crisis Response System 22
Section III: Plans and Priorities for System Development 23
III.A Jail Diversion 23
III.B Other System-Wide Strategic Priorities 28
III.C Local Priorities and Plans 34
III.D System Development and Identification of New Priorities 35
Appendix A: Levels of Crisis Care 37

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
Gulf Bend Center-LMHA	6502 Nursery Drive, Ste 100 Victoria, 77904	Victoria	• Screening, assessment, and intake – Adult/Child • TRR outpatient services – Adult/Child • Crisis/MCOT – Adult/Child • Counseling – Adult/Child • DARS employment services - Adult • LIDDA services – eligibility screening/assessment, service coordination – Adult/Child • MH Deputy - Adult • Law Enforcement Navigation - Adult

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
Gulf Bend Center-LMHA	Place4 225 N. Virginia, Suite 6, Port Lavaca, 77979	Calhoun	• TRR outpatient services – Adult/Child • Counseling – Adult/Child
Gulf Bend Center – LMHA	The Wellness Center 1109 N. Nimitz Victoria, 77901	Victoria	• TRR outpatient services – Adult • Place 4 Services • IDD Services • Partnership with Mid-Coast Family Services
The Harris Center for Mental Health and IDD	9401 Southwest Freeway Houston, 77074	Harris	• Crisis Hotline
Detar Family Medicine Center	501 E. Colorado St. Victoria, TX. 77901	Victoria	• Counseling
Corpus Christi Medical Center – Bayview Behavioral	6629 Wooldridge Road Corpus Christi, 78414	Nueces	• Contracted Inpatient – Adult/Child (5 & up)-Rapid Crisis Stabilization
Nix Health Care System	414 Navarro Street San Antonio, 78205	Bexar	• Contracted Inpatient – Adult/Child (5 & up) – Rapid Crisis Stabilization
Cross Creek Psychiatric Hospital	8402 Cross Park Drive Austin, 78754	Travis	• Contracted Inpatient Services – Adult/Child (6 & up) – Substance Abuse and MH – Private Psychiatric Bed/Rapid Crisis Stabilization
SUN Behavioral Health Psychiatric Hospital	7601 Fannin Street Houston, 77054	Harris	• Contracted Inpatient Services – Adult/Child (6 & up) – Substance Abuse and MH – Private Psychiatric Bed/Rapid Crisis Stabilization
Camino Real Community Services	19971 FM 3175 N. Lytle, Texas 78052 2644 Encino Park Eagle Pass, Texas 78852	Lytle Maverick	• IDD Crisis Respite Services

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
4	Integrated Care (implement person-centered behavioral health and medical health, targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments or jails.)	3	650	Behavioral Health (MH & IDD) age 3 to adult.	Anticipating 650
4	Tele-Health Expansion of Services (Expand and enhance the psychiatric and behavioral health telemedicine services already provided by Gulf Bend in its service area in an effort to enhance and improve treatment for individuals with behavioral health conditions)	3	300 above baseline of 775.	Behavioral Health (MH & IDD) age 3 to adult.	Anticipating 300 above baseline of 775.
4	The Program Funding and Mechanics (PFM) Protocol began evolving with DY6	TBD	Not a metric	Defined System. We anticipate	Numeric volume is not applicable

	1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity	Population Served	Number Served/ Year
	(Oct 2016). Gulf Bend Center's above 1115 waiver projects will evolve into process and outcome-based measures. DY6 was approved as a 15-month extension to DY5 for the two above noted metrics. Community Centers are actively studying approved measures and gathering base-line data for calendar year 2017 (July-Dec). Our Center is planning to align ourselves with the CCBHC and SAMSA measures. As of March 16, 2018, CMS has approved the PFM as of 12/22/2017. Gulf Bend Center has submitted our Plan Update to our RHP-04 and we've identified 5 measures we will be tracking and reporting on for DY 7&8.		under new PFM.	these quality measures will expand to all areas of our system. However, each measure has a defined denominator and achievement numerator.	under the proposed PFM. Numerator (achievement) over denominator population improvement percentage will be the goal. Quality of Process and Outcome is the measured goal of selected measures.

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	☒	

	Stakeholder Type		Stakeholder Type
			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.

• Regional and local collaborative meetings with stakeholders, e.g. law enforcement agencies, hospitals, probation, judges and faith-based organizations.
• Community forums.
• Community conversations with schools.
• Provision of seminars to school staff and parents.
• PNAC 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.

• Lack of nearby psychiatric inpatient services.
• Transportation (to inpatient facilities).
• Judiciary system involvement – lack of a Mental Health Court; lack of timely processing of EDWs.
• Jail/criminal justice diversion of individuals with a mental illness.
• Improved/timely access to psychiatric services, e.g. initial psychiatric evaluation/diagnostic.
• Reduce recidivism.

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

- Collaborative meetings were held with Citizens Medical Center Staff to discuss decrease use of ED and reduction of time spent in ED.
- Gulf Bend Regional collaborative meetings with Sheriff's Departments, Police Departments, Probation, Hospitals, Judges, and faith-based representatives from all seven counties to discuss community mental health needs related to crisis services, jail diversion and psychiatric hospitalization.
- Meeting with Victoria County Sheriff's/Victoria Police Departments to plan for development and implementation of a MH Officer Program and Law Enforcement Navigator. Visited Gulf Coast Center in Galveston County to discuss Mental Health Deputy program implemented in that service area.
- Community forum sponsored by Victoria Advocate to discuss and identify mental health service needs in GBC's service area.
- Community Conversation to discuss challenges students face in a global society. Gulf Bend collaborated with Victoria Independent School District to sponsor the event.
- Parent Connect, a series of parent seminars covering a variety of topics, was provided by Gulf Bend Center and VISD.
- Solicitation of input and involvement of PNAC and ETBHN's Regional PNAC.

II.B Crisis Response Process and Role of MCOT

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

    - 8:00 a.m. to 5:00 p.m. - 6 QMHPs; 1 Crisis Team Lead; 1 Crisis Manager/LPHA.

    b. After business hours

    - 1 MCOT QMHP; 1 Crisis Team Lead (available by phone); 1 Crisis Manager/LPHA (available by phone)

    c. Weekends/holidays

    - 1 MCOT QMHP; 1 Crisis Team Lead (available by phone); 1 Crisis Manager/LPHA (available by phone)

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

- 1) Individual presents immediate danger to self or others; and/or
- 2) Individual's mental/physical health is at risk of serious deterioration

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 conducts crisis assessment to determine severity and immediate action to be taken - 1) Completes C-SSRS as part of the Crisis assessment; 2) Places on Pathway and develops a safety plan if the assessment scores indicate moderate to high risk; 3) Recommends inpatient services at private/contracted hospital or State Hospital when unable to safety plan.
- MCOT conducts follow-up (phone, face-to-face) with individual regarding individual's current well-being (24 hours f/u for regular crisis; inpatient discharge follow-up within 7 days.

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: Yes. MCOT activated after receiving anticipated/full medical clearance from ER staff. If ER staff gives an estimate of when individual may be medically cleared MCOT will be activated prior to receiving full medical clearance in an attempt to reduce wait time.
- Law enforcement: Yes. MCOT activated after phone triage conducted to determine severity/duration of SI/HI and psychosis. MCOT staff will provide law enforcement staff with a window of estimated time of arrival if face-to-face crisis evaluation is warranted.

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

- Emergency rooms: MCOT works closely in communication with ER staff throughout completion of Crisis assessments/evaluations; develop safety plans for individual and family; makes recommendations for higher level of care; assists with finding appropriate placement (e.g. private hospital beds, state hospital beds); facilitates transfers by EDW; finds transportation if needed.
- Law enforcement: MCOT provides direct communication and crisis assessment; develops safety plan; provide information/education on verbal and non-verbal signs of SI/HI.

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:

- Voluntary clients: Individual's family transports individual to local ER.
- Involuntary clients: Law enforcement is called to assist with transporting individual to local ER or inpatient facility for psychiatric hospitalization.

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

- MCOT will make recommendation for hospitalization based on crisis assessment.
- Uninsured individuals: If no State Hospital beds available MCOT will utilize contracted bed days through PPB or PESC. Involuntary individuals will be transported to the inpatient facility by EDW.
- Insured individuals: ER staff will initiate hospital to hospital transfer.

   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.):

- There are no resources in Center's service area for crisis respite, residential or extended observation 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:

- Crisis Hotline will contact MCOT. MCOT will be accompanied to the home or alternate location with MHO (Mental Health Officer) to complete a crisis assessment. MHO's do not accompany MCOT to schools for crisis assessments.

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

- Contact GBC Crisis Hotline who will contact MCOT staff. MCOT staff will call appropriate ED staff/Law enforcement and speak directly with caller to determine individual's current level of crisis and need for further assistance and safety of MCOT worker.

   b. After business hours

- Contact GBC Crisis Hotline who will contact the on call MCOT staff. MCOT staff will call appropriate ER staff/Law enforcement and speak directly with caller to determine individual's current level of crisis and need for further assistance and safety of MCOT worker.

   c. Weekends/holidays

- Contact GBC Crisis Hotline who will contact the on call MCOT staff. MCOT staff will call appropriate ER staff/Law enforcement and speak directly with caller to determine individual's current level of crisis and need for further assistance and safety of MCOT worker.

7. If an inpatient bed is not available:

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

   - If at ER, individual will remain there.
   - If in the community, development of a safety plan is an option for voluntary Individual (pending placement). If needed, law enforcement can provide assistance for MCOT safety.

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

   - Gulf Bend Center MCOT

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

   - Gulf Bend Center MCOT, Crisis Team Lead, or Crisis Manager.

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

   - Family, friends, or EMS.

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	None.
Location (city and county)	
Phone number	
Type of Facility (see Appendix A)	
Key admission criteria (type of patient accepted)	
Circumstances under which medical clearance is required before admission	
Service area limitations, if any	
Other relevant admission information for first responders	
Accepts emergency detentions?	

Inpatient Care

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	Bayview Hospital - PESC
Location (city and county)	Corpus Christi, Texas - Nueces County
Phone number	361-986-8200
Key admission criteria	12 years of age and older.
Service area limitations, if any	12 years of age and older.
Other relevant admission information for first responders	*Transportation provided by Law Enforcement or family/friends.

Name of Facility	Nix Health Care System - PESC
Location (city and county)	San Antonio, Texas - Bexar County
Phone number	210-579-3800
Key admission criteria	5 years of age and older.
Service area limitations, if any	N/A
Other relevant admission information for first responders	*Transportation provided by Law Enforcement or family/friends.

Name of Facility	Cross Creek Psychiatric Hospital – PPB/PESC
Location (city and county)	Austin, Texas – Travis County
Phone number	512-215-3900
Key admission criteria	6 years of age and older
Service area limitations, if any	N/A
Other relevant admission information for first responders	*Transportation provided by Law Enforcement or family/friends.

Name of Facility	SUN Behavioral Health Psychiatric Hospital – PPB
Location (city and county)	Houston, Texas – Harris County
Phone number	713-796-2273
Key admission criteria	6 years of age and older
Service area limitations, if any	N/A
Other relevant admission information for first responders	*Transportation provided by Law Enforcement or family/friends.

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.

- None available.

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

- Limited resources – no local psychiatric inpatient beds available; limited outpatient alternatives; no transportation funding.

    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?

- No

    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.

- Gulf Bend Center's MCOT Crisis QMHPs, Crisis Team Lead, Crisis Manager, Director of Behavioral Health Services.

    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.

- None.

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. Jail-based competency restoration (local) - Victoria County.

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

- More funding/dollars, psychiatrists/physicians, counselors.
- Collaboration and participation by all law enforcement agencies and judiciary system.

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?

- Referrals are made to Billy T. Cattan for substance abuse services. Billy T. Cattan contracts with designated OSAR for the Region.
- MOU with Billy T. Cattan for outpatient substance abuse services.
- Referrals are made to community providers, Detar Residency clinic, and area FQHC.

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

- Use current resources available and continue to apply for grants to help growth and financial assistance needed to better serve the community.
- Collaboration with community stakeholders to partner.

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.

- Brochures that describe Crisis services
- Center's website page that describes Crisis services and the steps to take to access crisis services.
- Ongoing meetings with emergency responders/law enforcement in all seven counties within service area.
- Offering to provide speakers at various meetings of community stakeholders throughout the service area, e.g. Lions Club, Rotary, Chamber of Commerce, health fairs, hospitals, etc.)

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?

- Provision of ongoing trainings (one on one, online tutorials)
- Team Meetings to review plan and discuss implementation of plan
- Development/availability of protocols/manuals that describe processes 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
All seven counties	• Budget limitations/issues within Center and for law enforcement
All seven counties	• Proximity of inpatient psychiatric services
All seven counties	• Transportation of individuals to inpatient facilities
All seven counties	• Additional psychiatrists (shortage/rural 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	• Mental Health First Aid is being provided to local law enforcement personnel. • Mental Health Officers will respond to crisis calls through local dispatch to conduct wellness checks and assess situation to determine if MCOT needs to be contacted. • MCOT staff provide mobile crisis services in the community with law enforcement at the scene, as determined by assessment.

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☒ Service linkage and follow-up for individuals who are not hospitalized ☐ Other: Click here to enter text.	• 8-hour response to calls from jails to conduct assessment to determine if appropriate for services. • MCOT staff provide follow-up services for individuals who have not been hospitalized. If individual is active, assigned case manager will follow-up.
Plans for the upcoming two years: • Improve communication and build relationships with EDs and law enforcement via ongoing face-to-face meetings in the community. • Expand MH Officer Program to include all seven counties. This expansion would include a team of two staff, Mental Health Officer and a Mental Health Case Manager that could be deployed to address crisis situations in the community. • Develop MH court. • Implement ZEST initiative with all law enforcement agencies in catchment area.	

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	• Provide screenings at all county jails within service area via televideo. • Provide televideo diagnostic assessment at local jails. • Availability of evaluation by forensic psychiatrist through televideo provided by Gulf

Intercept 2: Post-Arrest: Initial Detention and Initial Hearings	
Components	**Current Activities**
☒ Link to comprehensive services ☐ Other: Click here to enter text.	Bend Center. • Referrals made for comprehensive services as identified through completion of screening and evaluations.
Plans for the upcoming two years: • Look for funding opportunities to enhance our crisis response and jail diversion services. • Continuation of 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 DUI court. • Routine screenings completed to determine mental illness eligibility. • Availability of evaluation by forensic psychiatrist through televideo provided by Gulf Bend Center. • Provide psychiatric medical services via televideo for individuals enrolled in GBC services. • Provide Crisis services to inmates.

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☒ Staff assigned to serve as liaison between specialty courts and services providers ☐ Link to comprehensive services ☐ Other:	
Plans for the upcoming two years: • Plans to develop MH court and Veteran's court.	

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:	• TCOOMMI program.
Plans for the upcoming two years: • Modify the Law Enforcement Navigator position to assist individuals released from jail with transitioning to community and linking to local resources. • Develop structured process to coordinate discharge/transition plans and procedures. • Utilize Mental Health Officers to conduct follow ups on individuals to ensure continuity of services.	

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:	• Center operates TCOOMMI program that includes four QMHPs. • QMHPs provide case management and rehab services to individuals involved in community corrections and support programs.
Plans for the upcoming two years: • Look into expansion of probation TCOOMMI caseload into all seven counties. • Continue with TCOOMMI grant.	

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	• Using Just in Time scheduling process. • Hiring/contracting with more psychiatrists. • Additional LPHA added for diagnostic evaluations. • Contract with ETBHN for timely authorizations.	• Continue to support current status.
Improving continuity of care between inpatient care and community services and reducing hospital readmissions	• Gap 1 • Goals 1,2,4	• Assigned Continuity of Care Worker who works with State hospital staff to ensure transition between inpatient care and community. Meeting with SASH Medical Director to improve COC process. • Contracts with hospitals identify what the hospital's responsibility is with continuity of care back to Gulf Bend Center. • GBC staff conduct seven-day follow-up with	• Continue to improve GBC post-discharge follow-up procedures

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		clients upon discharge from State Hospital and contract hospitals.	
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	• No current status	• Look into options for services for transitioning long-term state hospital patients back into the community.
Implementing and ensuring fidelity with evidence-based practices	• Gap 7 • Goal 2	• Ensuring provider staff are trained in the DSHS approved evidence-based practices prior to provision of the services (e.g. Assertive Community Treatment, IMR).	• Continue ongoing training of staff in evidence-based practices. • Regular oversight of compliance through internal monitoring.
Transition to a recovery-oriented system of care, including use of peer support services	• Gap 8 • Goals 2,3	• Participation in Peer certification training • Employ a full-time peer support specialist(s)	• Employ Family Partner. • Enhance peer support specialist program. • Continue with training in

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		• Using volunteer peer support specialist • Recruiting for a Family Partner for children services • Client/client family members appointed to PNAC • All direct care staff have received training in the Person-Centered Recovery Planning.	PCRP.
Addressing the needs of consumers with co-occurring substance use disorders	• Gaps 1,14 • Goals 1,2	• COPSD Training provided for all provider staff. • Inclusion of COPSD in recovery plans • Provision of psychosocial rehabilitation services to COPSD individuals. • Referrals to community providers (e.g. Billy T. Cattan).	• Continue communications with Billy T. Cattan for substance abuse services • Establish protocols for referring GBC clients to local resources for easier/smoother transitions. • Collaborate with Billy T. Cattan to integrate LCDC presence within GBC services.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• Gap 1 • Goals 1,2	• Refer individuals to community primary healthcare providers. • Coordinate with local FQHC regarding identification of mutual consumers. • Employ LPC to provide consultation to local community clinic. • Utilize medical school residents to provide primary healthcare to current GBC consumers.	• Continue to develop coordination and partnership with FQHC. • Utilization of medical school residents within the Gulf Bend Psychiatric Outpatient Clinic.
Consumer transportation and access to treatment in remote areas	• Gap 10 • Goal 2	• Provide televideo psychiatric and crisis services for individuals in remote/rural areas.	• Continue to develop and coordinate access.
Addressing the behavioral health needs of consumers with Intellectual Disabilities	• Gap 14 • Goals 2,4	• PASSRR program in place to provide behavioral services for nursing home residents. • Employed a Crisis	• Continue to develop and coordinate access.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		Intervention Specialist to provide crisis services for IDD individuals. • Contract with Camino Real for provision of Crisis Respite Services. • Provision of psychiatric medical services for IDD individuals.	
Addressing the behavioral health needs of veterans	• Gap 4 • Goals 2,3	• Contract for Veterans Program in place through HHSC. Employing a Veteran's Peer Support through the contract.	• Continue current status.

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
Psychiatric inpatient services and transportation (to and from inpatient facilities)	• Shortage of psychiatric inpatient facilities/beds for the local service area and statewide. • Transportation provided to hospital by law enforcement or family. Return to community by bus.	• Improved continuity with the state and private hospitals. • Implement local program for GBC staff to coordinate with Psychiatric Inpatient facilities to potentially pick up discharged inpatient consumers.
Improve Judiciary system involvement.	• Lack of a Mental Health Court; lack of timely processing of EDWs	• Work with community stake-holders for options.
Increasing knowledge and skill related to suicide prevention, intervention and postvention.	• Trained the trainers in ASIST (Applied Suicide Intervention Skills Training), Safe TALK, ASK and CALM • Trained direct care and support staff in Suicide Prevention. • Provided training to school counselors. • Provided training to law enforcement.	• Continue provision of staff training. • Continue to educate and inform community.

Local Priority	Current Status	Plans
Mental Health Officer	• Two MHOs in place for Victoria County. • Two part time MHOs in place for Jackson County.	• Submitted a proposal to HHSC to expand the MHO Officer Program

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	*Detox Beds*	• *Contract with inpatient substance abuse treatment facility*	• *Contract @ $650.00 per day*
2	*MH Crisis Respite*	• *Fund additional QMHP, LPHA, and RN positions to provide crisis respite services in our region.*	• *$500,000 per fiscal year*

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.