Department of State Health Services

# Form O
# Consolidated Local Service Plan (CLSP)

**Gulf Coast Center**
**March 2018**

# Contents

## Introduction

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

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

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

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

# SectionI: Local Services and Needs

## I.A. Mental Health Services and Sites

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

| Operator (LMHA or Contractor Name) | Street Address, City, and Zip | County | Services & Populations |
|---|---|---|---|
| Gulf Coast Center | 123 Rosenberg, 4th floor, Galveston, 77550 | Galveston | • MH adult outpatient clinic; TRR adult outpatient services; adult outpatient telemedicine intake; screening and assessment; TCOOMMI case management<br>• Adult substance abuse outpatient treatment; Outreach, Screening, Assessment and Referral (OSAR); Recovery Peer Support; Co-occurring Psychiatric and Substance Use Disorder (COPSD) services; 1115 COPSD psychiatry services; HIV case management & outreach<br>• Integrated Healthcare Mental & Physical Health<br>• PATH and permanent supported housing |
| Gulf Coast Center | 7510 FM 1765, Texas | Galveston | • MH adult outpatient clinic; TRR adult outpatient |

| Operator (LMHA or Contractor Name) | Street Address, City, and Zip | County | Services & Populations |
|---|---|---|---|
| | City, 77591 | | services; adult outpatient telemedicine intake; screening and assessment; TCOOMMI continuity of care intake; TCOOMMI case management; MCOT<br>• OSAR; Recovery Peer Support |
| Gulf Coast Center | 3201 FM 2004, Texas City, 77591 | Galveston | • MH child outpatient clinic; TRR childrens services; child outpatient intake; screening and assessment; YES waiver; 1115 childrens crisis (SLECT) services<br>• AIR (Adolescents in Recovery); Youth Prevention Services; Juvenile Justice Services<br>• YPS (Youth Prevention Services)<br>• Juvenile Justice Teams for non TRR Services |
| The Wood Group | 4352 FM 1764, Texas City, 77591 | Galveston | • Contracted 10 bed crisis respite services for adults |
| Gulf Coast Center | 101 Brennen, Alvin, 77511 | Brazoria | • MH adult outpatient clinic; TRR adult outpatient services; adult outpatient telemedicine intake; screening and assessment; TCOOMMI continuity of care intake; TCOOMMI case management<br>• Integrated Healthcare Mental & Physical Health |
| Gulf Coast Center | 101 Tigner, Angleton, 77515 | Brazoria | • MH adult outpatient clinic; TRR adult outpatient services; adult outpatient telemedicine intake; screening and assessment; TCOOMMI case management; MCOT<br>• Adult Substance abuse outpatient treatment, OSAR; COPSD; 1115 COPSD Psychiatry Service; Recovery Peer Support;<br>• Integrated Healthcare Mental & Physical Health |
| Gulf Coast Center | 2352 E. Mulberry, | Brazoria | • MH Child outpatient clinic; TRR childrens |

| Operator (LMHA or Contractor Name) | Street Address, City, and Zip | County | Services & Populations |
|---|---|---|---|
| | Angleton, 77515 | | services; child outpatient intake, screening and assessment; YES waiver; 1115 children and adolescent crisis (SLECT) services |
| St. Joseph Medical Center | 1401 St. Joseph Parkway, Houston, 7002 | Harris | • 20-Bed Community Mental Health Hospital (CMHH) Regional Hospital Inpatient Unit |

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

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

| 1115 Waiver Projects | | | | |
|---|---|---|---|---|
| RHP Region(s) | Project Title (include brief description if needed) | Years of Operation | Capacity | Number Served/ Year |
| 2 | SLECT CHILDRENS CRISIS SERVICES - (Continuing as a Project) | 4.5 | 6 | 220 |
| 2 | SAFE HARBOR - (Spread Across System - DY6) | 4 | 80 - Past TBD - System wide | 278 |
| 2 | TRANSITIONS - (Spread Across System - DY6) | 4.5 | 20 - Past TBD - System wide | 195 |
| 2 | SMOKING CESSATION - (Spread Across System - DY6) | 4 | 22 - Past TBD - System wide | 476 |
| 2 | PEER SUPPORT - (Spread Across System - DY6) | 4.5 | 24 - Past TBD - System wide | 260 |

| 1115 Waiver Projects | | | | |
|---|---|---|---|---|
| RHP Region(s) | Project Title (include brief description if needed) | Years of Operation | Capacity | Number Served/ Year |
| 2 | CRISIS RESPITE (Closed Program - DY5) | 4.5 | 8 - Past<br>0 - Forward | 161 |
| 2 | WELLNESS & RECOVERY (Closed Program - Select Services Transitioned into System - DY6) | 6 | 15 - Past<br>TBD - System wide | 5 |
| 2 | AMBULATORY DETOX (Program Closed - Select Services Transitioned into System - DY 6) | 6 | 25 - TBD System wide | 177 |
| 2 | TELEMED ACCESS - (Spread Across System - DY6) | 6.5 | 13 - Past<br>TBD System wide | 459 |
| 2 | IDD RESPITE - (Closed Program - Select Service Available within System - DY6) | 6 | 3 - Past<br>TBD System wide | 19 |
| 2 | INTEGRATED HEALTH CARE (IHC) - (Continuing as a Project) | 6.5 | 20 | 464 |
| 2 | CAT/CET (Closed Program- DY5) | 4.5 | 15- Past<br>0 - Forward | 166 |

## 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 |

| | Stakeholder Type | | Stakeholder Type |
|---|---|---|---|
| ☒ | Mental health service providers | ☒ | Substance abuse treatment providers |
| ☒ | Prevention services providers | ☒ | Outreach, Screening, and Referral (OSAR) |
| ☒ | County officials | ☐ | City officials |
| ☒ | FQHCs/other primary care providers | ☐ | Local health departments |
| ☒ | Hospital emergency room personnel | ☐ | Emergency responders |
| ☐ | Faith-based organizations | ☒ | Community health & human service providers |
| ☒ | Probation department representatives | ☒ | Parole department representatives |
| ☒ | Court representatives (judges, DAs, public defenders) | ☒ | Law enforcement |
| ☒ | Education representatives | ☐ | Employers/business leaders |
| ☒ | Planning and Network Advisory Committee | ☐ | Local consumer-led organizations |
| ☒ | Veterans' organization | | |

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

| |
|---|
| • Substance Use Disorder Inpatient Treatment |
| • Local Psychiatric Hospital Beds |
| • Psychiatric Hospital Beds for IDD Crisis |
| • Treatment Alternatives for Justice Involved Mentally Ill |

## Section II: Psychiatric Emergency Plan

The Psychiatric Emergency Plan is intended to ensure that stakeholders with a direct role in psychiatric emergencies have a shared understanding of the roles, responsibilities, and procedures that will enable them to coordinate their efforts and effectively use available resources. The Psychiatric Emergency Plan entails a collaborative review of existing crisis response activities and development of a coordinated plan for how the community will respond to psychiatric emergencies in a way that is responsive to the needs and priorities of consumers and their families. The planning effort also provides an opportunity to identify and prioritize critical gaps in the community's emergency response system. Planning should consider all available resources, including projects funded through the 2015 Crisis and Inpatient Needs and Capacity Assessments.

The HB 3793 Advisory Panel identified the following stakeholder groups as essential participants in developing the Psychiatric Emergency Plan:

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

Most LMHAs are actively engaged with these stakeholders on an ongoing basis, and the plan will reflect and build upon these continuing conversations, including those related to the 2015 Crisis Needs and Capacity Assessment.

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

## II.A Development of the Plan

Describe the process you used to collaborate with stakeholders to develop the Psychiatric Emergency Plan, including:

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

- Soliciting input

- Routine meetings/presentations with stakeholders including law enforcement, district attorney offices, courts, county jails, local hospitals, NAMI, public schools and local colleges, health districts, and emergency management.

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

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

        - MCOT staff provides coverage 56 hours during the work week 8:00am-7:30pm (Mon, Tues, Wed, Thurs & Fri)

    b. After business hours

        - After business hours, MCOT staff is on-call daily during the work week to provide community response to crisis situations until reopening of the Center the following morning

    c. Weekends/holidays
        - MCOT staff or a designated QMHP is on-call

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

    - Our contracted crisis hotline service completes a risk assessment. The crisis hotline staff then contact our Center and staff respond to the crisis

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

- When an individual calls the hotline it is triaged and labeled. This information is communicated to our Center via a designated phone number and response is coordinated with MCOT staff and Crisis Services Director. Once the crisis is resolved, follow-up services will begin within 24 hours which are initiated by a phone call and then followed by a face-to-face contact.

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

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

   - Emergency rooms: The local emergency rooms call our crisis hotline when an individual presents in crisis. Once the individual has been medically cleared the local emergency room will call and request a screener and staff are dispatched to that location to complete the crisis assessment and coordinate care with physicians and nursing staff.
   - Law enforcement: MCOT works closely with the Mental Health Division of the Sheriff's Departments both in Brazoria and Galveston Counties. Typically, the Crisis Services Director is contacted and then MCOT staff is dispatched accordingly. There are times when local police departments contact the LMHA and they are connected to the Crisis Services Program where the situation is staffed and MCOT staff is deployed.

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

   - Emergency rooms: Complete crisis screening/assessment and attempt to facilitate an inpatient bed at our local community mental health hospital (CMHH) when available. If outpatient services are recommended, MCOT staff will arrange for a telemedicine appointment as soon as possible for the individual to have a full diagnostic evaluation completed.

- Law enforcement: Complete crisis screening/assessment and attempt to facilitate an inpatient bed at our local community hospital when available. If outpatient services are recommended, MCOT staff will arrange for a telemedicine appointment as soon as possible for the individual to have a full diagnostic evaluation completed.

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:

- MCOT staff will work with hospital staff (if at a local ER) to secure an inpatient bed. If MCOT is working with law enforcement, MCOT will search to secure an inpatient bed and law enforcement will transport.

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

- MCOT staff will work to secure a bed, fax over the crisis assessment as well as other pertinent information such as the presenting problem, labs or any other relevant information.

    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.):

- MCOT staff will call our local Crisis Respite Unit to inquire about bed availability, then complete the Crisis Respite Referral Form and arrange for transportation to facility. Follow-up services will begin as soon as possible.

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

- The emergency rooms should contact the hotline and request a "screener". Then the "screener" will go out and follow the normal process of completing the assessment and sending the appropriate paperwork to the inpatient facility. Law Enforcement should communicate all concerns to staff when the initial call is made.

MCOT staff will complete their assessment and then work to secure an inpatient bed and fax over all pertinent information to the receiving hospital. Law Enforcement will be responsible for transporting the individual once that person has been accepted into a facility.

b. After business hours

- The emergency rooms should contact the hotline and request a "screener". Then the "screener" will go out and follow the normal process of completing the assessment and sending the appropriate paperwork to the inpatient facility. Law Enforcement should communicate all concerns to staff when the initial call is made. MCOT staff will complete their assessment and then work to secure an inpatient bed and fax over all pertinent information to the receiving hospital. Law Enforcement will be responsible for transporting the individual once that person has been accepted into a facility.

c. Weekends/holidays

- The emergency rooms should contact the hotline and request a "screener". Then the "screener" will go out and follow the normal process of completing the assessment and sending the appropriate paperwork to the inpatient facility. Law Enforcement should communicate all concerns to staff when the initial call is made. MCOT staff will complete their assessment and then work to secure an inpatient bed and fax over all pertinent information to the receiving hospital. Law Enforcement will be responsible for transporting the individual once that person has been accepted into a facility.

7. If an inpatient bed is not available:

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

- When the Center's CMHH is at capacity, in some instances, individuals may remain in the local emergency department during which time LMHA & emergency department staff work to facilitate an inpatient admission

to a hospital in the greater Houston area. If the individual awaiting a bed is in the community, the LMHA staff work with local law enforcement to secure inpatient bed in the greater Houston area and subsequent transport of individual via mental health deputy to the identified hospital.

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

- MCOT staff provides crisis intervention services as long as necessary. If the individual is in a local emergency department, MCOT staff will communicate any safety concerns and often times a "sitter" is assigned to that person while they are waiting for a bed, or security is contacted if the individual poses a threat to themselves or others.

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

- If the individual is in a local emergency room, the medical doctor is responsible for continued determination of what level of care is needed at that time. If the individual is in the community and a bed cannot be located, law enforcement (and MCOT if present) will work together to determine what the next option may be if a bed is not available or if the individual appears to have improving symptoms.

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

- If in the community, law enforcement provides transportation. If the individual is in a local emergency department then an ambulance will provide transportation. If someone is at a clinic setting there is a possibility that EMS will be dispatched and an ambulance will transport the individual to a local emergency department.

### *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 | Harbor House Crisis Respite- Adults |
| Location (city and county) | 5825 E.F. Lowry Expressway, Texas City, Galveston County |
| Phone number | 409-935-4629 |
| Type of Facility (see Appendix B) | Voluntary Crisis Respite program, providing stabilization of individuals experiencing or recently experienced mental health crisis; step-down program following inpatient psychiatric admission |
| Key admission criteria (type of patient accepted) | Voluntary program. Geared for individuals experiencing behavioral health crises and in need of continued crisis stabilization. Must have ability to understand admission process and adhere to house rules. |
| Circumstances under which medical clearance is required before admission | On-site medical support not readily available, thus individuals with co-occurring medical condition who lack self-care ability shall be referred to medical provider as appropriate. |
| Service area limitations, if any | Primarily available to Galveston and Brazoria County residents |
| Other relevant admission information for first responders | Voluntary program for ages 18 and older. Exclusionary criteria includes individuals under the influence of drugs/alcohol, current risk of harm to self/others, convicted of sexual or violent offense or in need of Skilled nursing services |
| Accepts emergency detentions? | No |

### *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 | St. Joseph Behavioral Health Hospital- Community Mental Health Hospital (CMHH) |
| Location (city and county) | 1401 St. Joseph Parkway, Houston Texas, Harris County |
| Phone number | 713-757-7512 (Intake Line) |
| Key admission criteria | 18 yrs or older with imminent risk of harm to self/others; lesser levels of care have failed to resolve significant behavioral health symptoms |

| | |
|---|---|
| Name of Facility | St. Joseph Behavioral Health Hospital- Community Mental Health Hospital (CMHH) |
| Service area limitations, if any | Primarily intended for Galveston/Brazoria County residents, though admissions excepted from other neighboring LMHA's and/or State Hospitals as a part of inpatient capacity management program |
| Other relevant admission information for first responders | Exclusionary criteria includes individuals with primary diagnosis of IDD |

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

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

- Physician provider psychiatric services are available within both local county jails. Individuals in need of in-patient psychiatric services are transported to local hospitals pending availability. Out-patient needs are met within the psychiatric jail-based services.

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

- Tri-County operates a competency restoration program; however, it is not a locked unit. Not providing a locked unit presents a barrier to access as an alternative.

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

- Yes, Jail Liaisons are assigned to engage individuals identified to have a mental health need post booking.

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

- N/A

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.

- Additional local alternatives are not available at this time.

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.

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

- Additional staff with qualifications and expertise in forensic treatment. Barrier to meeting this need includes funding and recruiting staff meeting qualifications.

## 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?

- As a result of several 1115 Waiver projects our Center has been able to provide essential crisis response, substance use, and physical healthcare services in addition to existing services provided in our outpatient MH clinics. Center MCOT and OSAR staff provide integrated crisis response for individuals in crisis with co-occurring psychiatric and substance use disorders

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

- The Center is working on integrating mental health and substance use disorder intake and treatment services in our clinic facilities. The Center is working to integrate COPSD services to include outpatient counseling, case management and psychiatry services for our COPSD individuals. The Center was awarded a TTOR grant to add an LCDC to the MCOT team for integrated screening, assessment and clinical interventions for COPSD individuals in crisis.

## II.E Communication Plans

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

- Presentations by Crisis Staff/ Center website/Brochures/Crisis Cards/Regular Scheduled Meetings

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

- MCOT staff have trainings throughout the year. Other LMHA staff have information regarding the psychiatric emergency plan during their New Employee Trainings as well as additional trainings throughout the year by the Crisis Director as well as other Supervisory Staff.

### 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 |
|---|---|
| Brazoria | • Brazoria County lacks an adequate number of community providers to meet the need for physical healthcare, mental health, and counseling services.<br>• Brazoria County has rural areas do not have bus routes or public transportation, which impacts access to the services in the community. |

# Section III: Plans and Priorities for System Development

### III.A Jail Diversion

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

| Intercept 1: Law Enforcement and Emergency Services | |
|---|---|
| **Components** | **Current Activities** |
| ☒ Co-mobilization with Crisis Intervention Team (CIT)<br>☒ Co-mobilization with Mental Health Deputies<br>☐ Co-location with CIT and/or MH Deputies<br>☐ Training dispatch and first responders<br>☒ Training law enforcement staff<br>☒ Training of court personnel<br>☐ Training of probation personnel | • MCOT responds to law enforcement (often Mental Health Deputy) calls for assistance – response provided is per DSHS contract requirements.<br>• Center leadership participate in Article 16.22 trainings with representatives from law enforcement, district attorney office, courts and |

| Intercept 1: Law Enforcement and Emergency Services | |
|---|---|
| **Components** | **Current Activities** |
| ☒ Documenting police contacts with persons with mental illness<br>☐ Police-friendly drop-off point<br>☒ Service linkage and follow-up for individuals who are not hospitalized<br>☐ Other: Click here to enter text. | jails<br>• Individuals identified as meeting criteria are referred to local District Attorney's office supporting an expedited status and access to services.<br>• Individuals placed on probation and eligible for TCOOMMI are placed on a specialized mental health caseload. |
| **Plans for the upcoming two years:**<br>• Add to training for law enforcement and participate in development of our LMHA as a Suicide Safe Center. | |

| Intercept 2: Post-Arrest: Initial Detention and Initial Hearings | |
|---|---|
| **Components** | **Current Activities** |
| ☒ Staff at court to review cases for post-booking diversion<br>☒ Routine screening for mental illness and diversion eligibility<br>☒ Staff assigned to help defendants comply with conditions of diversion<br>☒ Staff at court who can authorize alternative services to incarceration<br>☒ Link to comprehensive services<br>☐ Other: Click here to enter text. | • LMHA liaisons at Galveston County jail participate in court for review of cases for diversion to treatment; LMHA liaisons at Brazoria County provide recommendations to the court for diversion and are available to the courts to offer available treatment alternatives.<br>• Both locations; begins at point of booking.<br>• TCOOMMI Caseload<br>• LMHA liaison staff attending Galveston County court can offer available services; Brazoria county liaison staff are available to the courts to |

| Intercept 2: Post-Arrest: Initial Detention and Initial Hearings | |
|---|---|
| **Components** | **Current Activities** |
| | offer available treatment alternatives.<br>• Refer to resources available – MH and SUD |
| **Plans for the upcoming two years:**<br>• For Galveston County, the Center continues to work with the county legal systems and jails on the Article 16.22 and 17.032 processes and other new jail legislation.<br>• The Gulf Coast Center participates in a Galveston County criminal justice-mental health collaborative. The Galveston County collaborative are the apparent awardees of a SB 292 grant to enhance and expand ACT services to a caseload of mentally ill high utilizers of the Galveston Count jail. The Center will continue to work with a Galveston county collaborative to identify opportunities for joint projects, assessment of local needs and resources, information sharing, cross-training and future grant funding applications to address local needs.<br>• For Brazoria County, the county has agreed to fund the Center for additional jail liaison staff to address the Article 16.22 and 17.032 jail legislation. | |

| Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments | |
|---|---|
| **Components** | **Current Activities** |
| ☐ Routine screening for mental illness and diversion eligibility<br>☐ Mental Health Court<br>☒ Veterans' Court<br>☒ Drug Court<br>☐ Outpatient Competency Restoration<br>☐ Services for persons Not Guilty by Reason of Insanity<br>☐ Services for persons with other Forensic Assisted Outpatient Commitments | • MVPN Veteran Volunteer coordinator works with Veteran's Courts for Galveston County & Brazoria County<br>• GCC jail liaisons in Galveston and Brazoria counties coordinate with Veterans courts for veterans to have community resources<br>• Brazoria jail liaisons assist with determining |

| Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments | |
|---|---|
| **Components** | **Current Activities** |
| ☐ Providing services in jail for persons Incompetent to Stand Trial<br>☐ Compelled medication in jail for persons Incompetent to Stand Trial<br>☐ Providing services in jail (for persons without outpatient commitment)<br>☐ Staff assigned to serve as liaison between specialty courts and services providers<br>☐ Link to comprehensive services<br>☐ Other: Article 16.22 and 17.032 Processes | inmates needing jail psychiatry services.<br>• GCC jail liaisons assist jails with inpatient referrals.<br>• Once an individual is found incompetent to stand trial, a court order is sought to require medication (if medically necessary) until individual is admitted to a SMHF for competency restoration.<br>• Gulf Coast Center has staff assigned to work in the Brazoria County Drug Court and the PACE DWI Court to work to connect offenders who are in diversion programs into GCC COPSD program<br>• Link to Substance Use Disorder treatment as needed.<br>• Center jail liaison staff is available to trial courts considering PR bond for mentally ill individuals to offer available services. |
| **Plans for the upcoming two years:**<br>• Continue what is currently in place; seeking additional funding as possible to address gaps in services. | |

| Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization | |
|---|---|
| **Components** | **Current Activities** |

| Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization | |
|---|---|
| **Components** | **Current Activities** |
| ☒ Providing transitional services in jails<br>☒ Staff designated to assess needs, develop plan for services, and coordinate transition to ensure continuity of care at release<br>☐ Structured process to coordinate discharge/transition plans and procedures<br>☐ Specialized case management teams to coordinate post-release services<br>☐ Other: | • Gulf Coast Center has staff assigned to both jails to assist individuals as they transition back into the community. |
| **Plans for the upcoming two years:**<br>• The Galveston County criminal justice-mental health collaborative are the apparent awardees of a SB 292 grant to enhance and expand ACT services to a caseload of mentally ill high utilizers of the Galveston Count jail. The Center will continue to work with a Galveston county collaborative to identify opportunities for joint projects, assessment of local needs and resources, information sharing, cross-training and future grant funding applications to address local needs. | |

| Intercept 5: Community corrections and community support programs | |
|---|---|
| **Components** | **Current Activities** |
| ☐ Routine screening for mental illness and substance use disorders<br>☐ Training for probation or parole staff<br>☒ TCOOMMI program<br>☐ Forensic ACT<br>☐ Staff assigned to facilitate access to comprehensive services; specialized caseloads | • TCOOMMI continuity of care intake services in both counties for probationers and parolees returning from state correctional facilities.<br>• TCOOMMI intensive case management in both counties for probationers and parolees to have intensive mental health/substance use disorder services to comply with conditions of |

| Intercept 5: Community corrections and community support programs | |
|---|---|
| **Components** | **Current Activities** |
| ☒ Staff assigned to serve as liaison with community corrections<br>☒ Working with community corrections to ensure a range of options to reinforce positive behavior and effectively address noncompliance<br>☐ Other: | supervision and for increased coordination with county supervision offices.<br>• Gulf Coast Center case managers assist non-TCOOMMI probation and parole individuals as they work to manage their mental illness/substance use while remaining in compliance with conditions of probation or parole. |
| **Plans for the upcoming two years:**<br>• Expand services to help meet the growing need for forensic services in Brazoria and Galveston Counties. | |

## III.B Other System-Wide Strategic Priorities

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

| Area of Focus | Current Status | Plans |
|---|---|---|
| Improving continuity of care between inpatient care and community services | • Gulf Coast has contracted Community Mental Health Hospital consisting of 20-bed psychiatric unit<br>• Long-standing relationship with UTMB physicians familiar with LMHA service delivery system, responsible for inpatient treatment/care | • Increased part-time COC worker to full-time capacity<br>• Continue to utilize telepsychiatry services (MD's/mid-level providers) available via telemedicine within 7 days post discharge with subsequent referral/transition to appropriate MH adult outpatient clinic for pharmacological management & other |

| Area of Focus | Current Status | Plans |
|---|---|---|
| | • UTMB contracted inpatient physicians regularly attend Gulf Coast Center quarterly physician meetings<br>• Gulf Coast continuity of care liaison(s) embedded on inpatient psychiatric unit & actively participate in patient discharge/aftercare planning, linking patients to appropriate outpatient services, crisis respite or other services external to LMHA as appropriate<br>• Regular communication/problem solving with leadership at contracted hospital<br>• Goal is to see patient in outpatient setting within 7 days post inpatient discharge | TRR service provision<br>• Plan for MCOT/ Level of Care 5 Staff to engage inpatient customers with history of non-adherence with aftercare pre-discharge<br>• Urban ACT team expected to increase participation in inpatient admission/ discharge process for individuals authorized to higher level of care<br>• ACT team participation in coordinating care w/identified caseload prior to inpatient discharge, including commitment hearings where applicable<br>• Explore potential funding resources to support nursing support to include teach-back method to ensure medication immediately upon integration back to community following inpatient discharge<br>• Implementing the new GCC electronic health record system and trained Center contracted aftercare providers in the use of the EHR for improved continuity of care information. |
| Reducing hospital readmissions | • Created Readmissions email distribution group as a forum for program-wide communication in | • Continue to strengthen awareness of outpatient alternatives to hospitalization |

| Area of Focus | Current Status | Plans |
|---|---|---|
| | effort to improve coordination of care<br>• Established *frequent admission* focus group to identified factors leading to repeated inpatient admissions & identified potential solutions for addressing these factors<br>• Increased use of Crisis Respite facilities for short-term stay as a step-down following inpatient discharge or as an alternative to hospitalization<br>• ACT team services for customers court ordered to Assisted Outpatient Treatment | • Continue telepsychiatry routine access services following inpatient discharge.<br>• Meetings & ongoing collaboration with local emergency departments to identify least restrictive treatment options with plans to expand collaborative efforts to both counties<br>• Increase use of Crisis Respite service where clinically appropriate<br>• Plan for MCOT/ Level of Care 5 Staff to engage inpatient customers with history of repeat admissions pre-discharge to improve continuity of care |
| Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community | • Utilizing the Long Term Stay Report to identify long-term SMHF individuals with potential for integration to the community with expansive supports<br>• Implemented designated HCBS-AMH Inquiry Line. Appointed an ACT team staff to be responsible for HCBS Inquiry Line. Developed HCSB-AMH pre-engagement desk procedures for staff assigned to the Inquiry Line. Hosted and | • Continue to review Long Term Stay reports for identification of individuals eligible for discharge from SMHF. Continue to participate on recurring webinars, TA calls<br>• Continue to consider intensive ACT services/supports & HCBS for long-term care individuals integrated back to the community<br>• Continue collaborative efforts with SMHFs; participate in discharge planning for all individuals |

| Area of Focus | Current Status | Plans |
|---|---|---|
| | participated in a meet & greet meeting with HHSC HCBS-AMH leads and identified Provider and Recovery Managers for HCBS-AMH<br>• In collaboration with SMHFs, participated in discharge planning for individuals identified as NGRI | transitioning from long-term inpatient back to the community |
| Reducing other state hospital utilization | • Effective utilization of local community mental health hospital beds, reducing the need for the use of state hospital beds<br>• Submitted NCA for increased funding to expand CMHH contract to 22 beds, though Center was not awarded funding to support expansion of inpatient beds | • Maximize use of local inpatient beds to further reduce need for state hospital beds<br>• As a part of DSHS capacity management, utilize local inpatient psychiatric beds to accommodate the needs of surrounding LMHA's and/or state hospitals |
| Tailoring service interventions to the specific identified needs of the individual | • Continue Trauma Informed Care training to improve the clinical competencies of Center clinical staff.<br>• Mental Health First Aid training required for current staff and new hires<br>• New hire crisis workers and case managers are now trained in Applied Suicide Intervention Skills Training | • Continue providing Trauma Informed Care Training for all Center clinical staff. |

| Area of Focus | Current Status | Plans |
|---|---|---|
| | • Counseling on Access to Lethal Means training now required for all current and new hire crisis workers and case managers | |
| Ensuring fidelity with evidence-based practices | • ANSA Super User completed/ maintaining required training in accordance with Praed Foundation<br>• ANSA Super User completed quality assurance training with certified ANSA users<br>• Ongoing online IMR training for new/existing employees with modification to training material in accordance with DSHS directives. Continued use of IMR worksheets/curriculum by case workers. Participating on recurring IMR webinars, TA calls<br>• Continued clinical supervision and QA activities to ensure Urban ACT services provided according to fidelity tool.<br>• ACT Team Lead implemented *shift manager* concept as per guidance received through DSHS training.<br>• Continued collaboration with GCC SUD program for consultation purposes until which time the ACT | • Continue required quality assurance activity provided by ANSA Super User<br>• Four MH adult leadership staff have attended the Person Centered Recovery Planning workshop training.<br>• Continue regular online IMR training for new/existing staff. Continue participation on DSHS IMR recurring TA calls<br>• Plan to hire full-time RN for the Urban ACT program.<br>• Continue to recruit for ACT team applicants that could serve as the SUD specialist for the team.<br>• Ongoing discussions with Texas Workforce Commission & continuing to establish rapport with employers in the community.<br>• Plans for an additional practitioner or to contract for CBT therapy. |

| Area of Focus | Current Status | Plans |
|---|---|---|
| | team's integrated services approach is attained & SUD specialist is a member of the team.<br>• Supported Employment identified service providers utilize the Individual Placement & Support model. Staff trained upon hire with ongoing SE training thereafter.<br>• Regular participation on recurring Supported Employment, Supported Housing and ACT webinars/TA calls and ongoing support by SE team lead | |
| Transition to a recovery-oriented system of care, including development of peer support services and other consumer involvement in Center activities and operations (e.g., planning, evaluation) | • Gulf Coast employs 3 full-time Recovery Peer Specialists<br>• Peer Support groups for adults available at each of the 4 MH adult outpatient clinics & Crisis Respite facilities<br>• In partnership with Hogg Foundation & East Texas Behavioral Health Network, continued training for Peer Support staff to include WHAM, Focus for life, Respect Institute, Intentional Peer Support & Peer Support Network face-to-face meetings | • Continue group services as scheduled, possibly increasing COPSD groups as the need/availability arises<br>• Expand individual peer support service teaching WHAM & WRAP<br>• Explore possibility of partnering with Recovery peer coaches to create collaboration between Recovery services & MH Adult services<br>• Contingent upon available funding, explore possibility of another full-time Certified Peer Support worker<br>• Review potential for supporting the ACT Fidelity by addressing need for |

| Area of Focus | Current Status | Plans |
|---|---|---|
| | • Wellness Recovery Action Planning (WRAP) trainings ended | Peer Provider |
| Addressing the needs of consumers with co-occurring substance use disorders | • Restructured COPSD program, refining referral/admission process through treatment and subsequent discharge<br>• Redesigned COPSD referral process to include online referral functionality with development of email distribution group; trained/educated program staff furthering integration of mental health & recovery services<br>• Initiated contract with addition psychiatrist ½ day twice weekly to assess & evaluate individuals for SUD treatment; physician embedded in MH adult outpatient clinic<br>• Recovery program now co-located with MH adult clinics<br>• Received grant funding to support COPSD physician service for Galveston Island residents<br>• Developed linking process for individuals transitioning out of COPSD service to the MH adult clinic or referral to community | • Continue use of online COPSD referral system with plans to enhance process to promote integration of recovery & mental health services<br>• Continue on-site drug screening for adult population<br>• Substance Use Recovery staff to continue attendance at quarterly MH adult physicians' meetings<br>• Continued integration of mental health services and recovery outpatient services at our adult outpatient treatment sites.<br>• Identified COPSD addiction psychiatrist to participate in quarterly provider meetings<br>• Expanding COPSD program to Brazoria County via telemedicine service |

| Area of Focus | Current Status | Plans |
|---|---|---|
| | resource<br>• Continued use referral system, linking MH adults to Gulf Coast Recovery services<br>• On-site drug screening upon admission & yearly thereafter for adults<br>• Substance Use Recovery staff attending quarterly MH adult physicians' meetings<br>• Short-term bed day utilization at MH adult Crisis Respite program while awaiting admittance to intensive outpatient treatment<br>• Completion of required on-line COPSD training by QMHP adult workers and ongoing participation in recurring DSHS COPSD TA webinar series<br>• COPSD program provides counseling services, case management and psychiatry/ offers wraparound services appropriate to persons with co-occurring diagnosis of chemical dependency & mental illness | |
| Integrating behavioral health | • Through contractual agreement | • Plans to continue co-location of |

| Area of Focus | Current Status | Plans |
|---|---|---|
| and primary care services and meeting physical healthcare needs of consumers. | with FQHC, physical health services available at 3 mental health adult outpatient clinics across 2-county catchment area.<br>• Embedded mid-level practitioner on-site 3 days/week, providing physical healthcare services to identified behavioral health adults without assigned medical home<br>• Physical health visits to include emphasis on controlling blood pressure, diabetes and other chronic health conditions<br>• Women's health to include well-woman exams available at 3 of the Integrated Healthcare sites<br>• EKG testing available<br>• Revised integrated healthcare electronic referral process<br>• RN Care Manager available to coordinate physical healthcare and referral to outside specialty care as clinically appropriate<br>• FQHC responsible for claims submission following IHC service delivery<br>• Conducting monthly meeting with | behavioral health/physical health clinics at GCC mental health outpatient adult clinics<br>• Increase IHC caseload across all 3 IHC sites so as to ensure physical health needs are met. Continue to educate GCC staff to this wellness resource<br>• Sustainability plans include increased billing by FQHC so as to support all expenses associated with IHC service delivery (part time mid-level practitioner, medical assistant, lab costs, medication costs, etc.)<br>• Exploring the use of FQHC mobile unit at the largest MH adult outpatient clinic for the provision of physical health care and dental needs<br>• In partnership with FQHC and Center's MIS team, looking into possibility of shared medical record<br>• Continue to conduct monthly meeting with FQHC partner |

| Area of Focus | Current Status | Plans |
|---|---|---|
| | FQHC partner | |

## 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 |
|---|---|---|
| • Substance use disorder (SUD) inpatient treatment | Due to the growing need for inpatient SUD treatment the Center applied for, but was not awarded, DSHS funding for Detox bed. | The Center would like to have a dedicated Detox bed to offer inpatient services to assist individuals with co-occurring substance use disorders and/or co-morbid chronic medical conditions. |
| • Treatment alternatives for justice involved mentally ill | The Galveston County Justice System Assessment completed by the Council of State Governments Justice Center in June 2017 notes the need for more inpatient and/or outpatient alternatives for the justice involved mentally ill in Galveston County.<br>Brazoria county is also lacking in jail diversion alternatives | The Center will continue to work Galveston county officials and the Galveston County Criminal Justice-Mental Health collaborative to identify opportunities for future grant funding to address local needs.<br>The Center will continue to look for new funding opportunities for jail diversion resources. |

## III.D Priorities for System Development

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

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

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

| Priority | Need | How resources would be used (brief) | Estimated Cost |
|---|---|---|---|
| 1 | Substance Use Disorder In-Patient Treatment | • Funding would be used to pay for a dedicated Detox bed for individuals requiring an inpatient level of care for treatment of co-occurring substance use disorders. | • The Center did not receive funding for this project. The total estimated cost per bed day would be $883.30 |
| 2 | Treatment | • New funding would be used to create a treatment | • The Center would need new funding for |

| Priority | Need | How resources would be used (brief) | Estimated Cost |
|---|---|---|---|
| | alternatives for justice involved mentally ill | alternative for law enforcement to divert mentally ill offenders to treatment in lieu of jail | strategic planning to determine the best jail diversion treatment alternatives and funding to create the treatment alternatives |

# Appendix A:Levels of Crisis Care

**Admission criteria** – Admission into services is determined by the individual's rating on the Uniform Assessment and clinical determination made by the appropriate staff. The Uniform Assessment is an assessment tool comprised of several modules used in the behavioral health system to support care planning and level of care decision making. High scores on the Uniform Assessment module items of Risk Behavior (Suicide Risk and Danger to Others), Life Domain Functioning and Behavior Health Needs (Cognition) trigger a score that indicates the need for crisis services.

**Crisis Hotline** – The Crisis Hotline is a 24/7 telephone service that provides information, support, referrals, screening and intervention. The hotline serves as the first point of contact for mental health crisis in the community, providing confidential telephone triage to determine the immediate level of need and to mobilize emergency services if necessary. The hotline facilitates referrals to 911, the Mobile Crisis Outcome Team (MCOT), or other crisis services.

**Crisis Residential** – Up to 14 days of short-term, community-based residential, crisis treatment for individuals who may pose some risk of harm to self or others, who may have fairly severe functional impairment, and who are demonstrating psychiatric crisis that cannot be stabilized in a less intensive setting. Mental health professionals are on-site 24/7 and individuals must have at least a minimal level of engagement to be served in this environment. Crisis residential facilities do not accept individuals who are court ordered for treatment.

**Crisis Respite** – Short-term, community-based residential crisis treatment for individuals who have low risk of harm to self or others and may have some functional impairment. Services may occur over a brief period of time, such as 2 hours, and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons for whom they care to avoid mental health crisis. Crisis respite services are both facility-based and in-home, and may occur in houses, apartments, or other community living situations. Facility based crisis respite services have mental health professionals on-site 24/7.

**Crisis Services** – Crisis services are brief interventions provided in the community that ameliorate the crisis situation and prevent utilization of more intensive services such as hospitalization. The desired outcome is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse. (TRR-UM Guidelines)

**Crisis Stabilization Units (CSU)–**Crisis Stabilization Units are licensed facilities that provide 24/7 short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected, clinically staffed, psychiatrically supervised, treatment environment that complies with a Crisis Stabilization Unit licensed under Chapter 577 of the Texas Health and

Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code. CSUs may accept individuals that present with a high risk of harm to self or others.

**Extended Observation Units (EOU)** – Emergency services of up to 48 hours provided to individuals in psychiatric crisis, in a secure and protected, clinically staffed, psychiatrically supervised environment with immediate access to urgent or emergent medical and psychiatric evaluation and treatment. These individuals may pose a moderate to high risk of harm to self or others. EOUs may also accept individuals on voluntary status or involuntary status, such as those on Emergency Detention. Individuals on involuntary status may receive preliminary examination and observation services only. EOUs may be co-located within a licensed hospital or CSU, or be within close proximity to a licensed hospital.

**Mobile Crisis Outreach Team** (MCOT) – Mobile Crisis Outreach Teams are clinically staffed mobile treatment teams that provide 24/7, prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up, and relapse prevention services for individuals in the community.

**Psychiatric Emergency Service Center (PESC) and Associated Projects** – There are multiple psychiatric emergency services programs or projects that serve as step down options from inpatient hospitalization. Psychiatric Emergency Service Center (PESC) projects include rapid crisis stabilization beds within a licensed hospital, extended observation units, crisis stabilization units, psychiatric emergency service centers, crisis residential, and crisis respite. The array of projects available in a service area is based on the local needs and characteristics of the community and is dependent upon LMHA funding.

**Psychiatric Emergency Service Centers (PESC)** – Psychiatric Emergency Service Centers provide immediate access to assessment, triage and a continuum of stabilizing treatment for individuals with behavioral health crisis. PESCs are staffed by medical personnel and mental health professionals that provide care 24/7. PESCs may be co-located within a licensed hospital or CSU, or be within close proximity to a licensed hospital. PESCs must be available to individuals who walk in, and must contain a combination of projects.

**Rapid Crisis Stabilization Beds** – Hospital services staffed with medical and nursing professionals who provide 24/7 professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute behavioral health crisis. Staff provides intensive interventions designed to relieve acute symptomatology and restore the individual's ability to function in a less restrictive setting.