Health and Human Services

Form O
Consolidated Local Service Plan (CLSP)

Denton County MHMR

March 2018

Contents

Introduction

The Consolidated Local Service Plan (CLSP) encompasses all of the service planning requirements for Local Mental Health Authorities (LMHA) and Local Behavioral Health Authorities (LBHA). 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/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/LBHA (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*
    - *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
Denton County MHMR	2519 Scripture, Denton Texas	Denton	Mental Health services for adults and children. Services include Intake, TRR outpatient services, and crisis screening and assessment. All services are provided for both adult and children. This location also houses our integrated mental health and physical health clinic.
Denton County MHMR	101 E. Corporate, Lewisville, Texas	Denton	Mental Health services for adults and children. Services include Intake, TRR outpatient services, and crisis screening and assessment. All services are provided for both adult and children.
Denton County	2509 Scripture, Denton	Denton	24 hour crisis assessment for Children and adults

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
MHMR	Texas		at the Psychiatric Triage Center. MCOT services for adults and children.
Denton County MHMR	Krum, Texas	Denton	Crisis Residential services for Adults in need of observation and intensive skills training for adults in psychiatric crisis.
Denton County MHMR	3835 Morse, Denton Texas	Denton	Provider services for individuals with IDD.
Denton County MHMR	3827 Morse, Denton Texas	Denton	Authority services and functions for individuals with IDD.

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	Population Served	Number Served/ Year
9	Psychiatric Triage- Designated 24 hour facility for crisis screening and assessment	5	Open for assessments 24 hours a day,	Serves all populations	1323 assessments /FY 2017

	1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity	Population Served	Number Served/ Year
			seven days a week		
9	Integrated clinic that includes primary care and preventive medical services and psychiatric services	5	Approximate capacity would be 250 unique clients	Serves adult population	240 unique clients served in FY2017
9	Crisis residential Unit	5	12 bed facility	Serves Adult population	323 unique clients/FY 2017

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
x	Consumers	x	Family members
x	Advocates (children and adult)	x	Concerned citizens/others
x	Local psychiatric hospital staff	☐	State hospital staff
x	Mental health service providers	☐	Substance abuse treatment providers
☐	Prevention services providers	☐	Outreach, Screening, and Referral (OSAR)
x	County officials	x	City officials
☐	FQHCs/other primary care providers	x	Local health departments
x	Hospital emergency room personnel	☐	Emergency responders
☐	Faith-based organizations	☐	Community health & human service providers
☐	Probation department representatives	x	Parole department representatives
x	Court representatives (judges, DAs, public defenders)	☐	Law enforcement
☐	Education representatives	x	Employers/business leaders
x	Planning and Network Advisory Committee	☐	Local consumer-led organizations
x	Peer Specialists	☐	IDD Providers
☐	Foster care/Child placing agencies	☐	Community Resource Coordination Groups
x	Veterans' organization	x	Other: United Way of Denton
			_____

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.

• Stake holder meetings
• Surveys
• County and city meetings
• PNAC meetings
• Behavioral Health Leadership advisory board meeting and work groups
• Grant collaborations with local agencies – Exploration of options and submissions

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.

• Homelessness and employment are areas that almost all stake holder groups are concerned about
• Veterans services and access to Veterans services and benefits
• Jail Diversion for individuals with Severe and persistent mental illness
• ER Diversion for individuals with severe and persistent mental illness
• Coordination of services across providers and agencies
•

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.

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/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

- We have met with key stakeholders including law enforcement, local hospitals, first responders, elected officials and community members to educate them on our current processes and to develop ways in which we can serve the needs of our county and clients more effectively and efficiently. We collaborate and serve on multiple sub-committees under the auspices of the Behavioral Health Executive committee for Denton County (a committee sponsored by the United Way). Information from these committees is distributed to stakeholders in the form of reports, presentations, and action plans to address needs related to a large array of needed services and seeks to make service delivery more efficient across multiple providers across the county. We have also taken surveys from current clients, input from our

PNAC and multiple other sources to help us identify the service needs that need to be addressed in our county. We have most recently worked with the county jail and the Sherriff's office to improve access to care and screening for the jail population specifically those who may be in crisis.

II.B Crisis Response Process and Role of MCOT

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

    - We currently have 7 two person teams. These teams consist of an LPHA or RN and a QMHP. We also have two QMHP positions dedicated to crisis follow-up that provide enhanced skills training and referrals.

    b. After business hours

    - We currently have 3 two person teams. These teams consist of an LPHA or RN and a QMHP.

    c. Weekends/holidays

    - We currently have 3 two person teams. These teams consist of an LPHA or RN and a QMHP.

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

- MCOT is deployed when a person is deemed in crisis via an initial screening from the crisis line staff or the psychiatric triage center staff. MCOT is also deployed when requested by Law enforcement, hospital, community member or other mental health provider requests assessment of someone who is potentially in crisis.

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

- Our MCOT conducts a face to face risk of harm assessment when they are deployed. The level of care is determined by MCOT during this initial visit. Clients who receive MCOT services during their crisis also receive a follow up visit either face to face or by phone if face to face is not possible within 24 hours. MCOT staff determine at this follow up visit the most appropriate ongoing care for the individual. This could include, but is not limited to: Transitional services through the LMHA, referral for a full level of care with the LMHA, referral to private provider if funded and applicable. MCOT also uses the 24hr follow up as a way to determine if the individual has experienced and deterioration that might indicate the need for re-assessment.

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

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

    - Emergency rooms: The emergency rooms in Denton county routinely contact the LMHA when and individual is deemed to be in a mental health crisis. MCOT is deployed when the request for crisis services is made following medical stabilization. MCOT facilitates the needed level of care following the assessment in the ER.
    - Law enforcement: Law enforcement does routinely contact the LMHA when an individual is determined to be experiencing a mental health crisis. MCOT routinely responds to the location where the officer and parson ore, or responds to where the officer is taking the individual (ER, Psychiatric triage center, DCMHMR outpatient clinics).

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

- Emergency rooms: In the ER, our MCOT performs a risk of harm assessment. We then determine the least restrictive environment for the person to receive services. For clients who are recommended for inpatient care we coordinate and facilitate the transfer of person to an inpatient level of care. For individuals who are recommended outpatient treatment we coordinate and facilitate that care and follow up. The specific providers are determined based on client choice and the funding that is available to them.
- Law enforcement: When encountering law enforcement officers involved with clients who are presenting in crisis, MCOT performs a risk of harm assessment. MCOT determines the least restrictive environment for the person to receive services. Clients recommended for inpatient care are then transferred to a facility and this is facilitated by MCOT. For individuals who are recommended for outpatient treatment we coordinate and facilitate that care and follow up. The specific providers are determined based on client choice and the funding that is available to them. Our MCOT also tries to offer law enforcement alternatives and ideas on how to help clients who may not fit into proscribed modes of treatment or risk. Our Psychiatric triage center is utilized often by law enforcement as non-violent individuals who are in crisis can be brought by law enforcement and dropped off for assessment thus freeing the officer to return to patrol.

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:

- If an individual needs medical clearance they will be sent to an ER for clearance. Once they have been medically cleared MCOT will respond to the ER to complete a risk of harm assessment. Individuals that need inpatient psychiatric care (regardless of the setting they are assessed in) MCOT will coordinate and facilitate that transfer or admission.

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

- If MCOT determines that inpatient hospitalization is the least restrictive environment for an individual to receive care then MCOT will coordinate and facilitate admission into a psychiatric hospital. This process looks different based on many variables, but can generally be broken down to three general scenarios. If a client is agreeable to hospitalization and has funding to pay for the hospitalization then MCOT will coordinate and

facilitate admission to the psychiatric hospital of their choice based on bed availability and the hospital accepting their insurance coverage. If the individual is agreeable to hospitalization and has no funding, then MCOT will request that the person receive local funds or diversion funds through the LMHA to pay for short term hospitalization at of the local hospitals that we contract with for stabilization. If the individual is unwilling to go to the hospital or it is determined that individual needs involuntary commitment then the sheriff's department is contacted and a mental health deputy responds. The client is typically taken to a local psychiatric facility for one night and brought before a probate judge the following day. The judge makes the determination as to whether the individual will be committed to a facility. (Private or state hospital).

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

- We operate a Crisis Residential program as one our DSRIP projects. We use this program as a level care more restrictive than outpatient but less restrictive than inpatient care. The facility allows for intake 24hrs a day. MCOT can refer an individual to this program following assessment.

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

- MCOT responds to all locations in our county. If the area is considered non-secure then we have law enforcement accompany us to secure the location.

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

- Contact MCOT vail the hotline. MCOT will then respond to the scene of the crisis, make a determination of least restrictive environment for treatment, and coordinate and facilitate ongoing care.

b. After business hours

- Contact MCOT vail the hotline. MCOT will then respond to the scene of the crisis, make a determination of least restrictive environment for treatment, and coordinate and facilitate ongoing care.

c. Weekends/holidays

- Contact MCOT vail the hotline. MCOT will then respond to the scene of the crisis, make a determination of least restrictive environment for treatment, and coordinate and facilitate ongoing care.

7. If an inpatient bed is not available:

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

- The individual would remain at the facility they were currently in or be taken to a local psychiatric facility until an involuntary bed becomes available.

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

- MCOT would continue to monitor the client during this period. The administrator of crisis services would be working to find any alternative for placement.

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

- MCOT would re-assess as necessary.

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

- MCOT assessors facilitate and coordinate transportation for non-emergency detention individuals. This may be done by providing a ride, finding an alternative transport (friend or family), or contacting EMS. In an ER setting the ER would be responsible for the MOT.

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	Denton County MHMR- Crisis Residential
Location (city and county)	Krum, Texas – Denton County
Phone number	940 381 5000 – (Denton County MHMR main number)
Type of Facility (see Appendix A)	Crisis Residential Unit
Key admission criteria (type of patient accepted)	Clients experiencing mental health crisis who would benefit from observation and intensive skills training. The facility is not a locked facility.
Circumstances under which medical clearance is required before admission	Any untreated medical condition that needs attention or any recent overdose.
Service area limitations, if any	Client must be in Denton County at the onset of their crisis.
Other relevant admission information for first responders	Referrals are made through MCOT.
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	University Behavioral Health

Location (city and county)	Denton, TX. Denton County
Phone number	904 320 8100
Key admission criteria	Determination of need for inpatient level of care
Service area limitations, if any	None
Other relevant admission information for first responders	Private facility
Name of Facility	Mayhill Hospital
Location (city and county)	Denton, TX. Denton County
Phone number	940 239 3000
Key admission criteria	Determination of need for inpatient level of care
Service area limitations, if any	none
Other relevant admission information for first responders	Private facility
Name of Facility	Millwood Hospital
Location (city and county)	Arlington, TX. County of Tarrant
Phone number	817 261 3121
Key admission criteria	Determination of need for inpatient level of care
Service area limitations, if any	None
Other relevant admission information for first responders	Private facility
Name of Facility	Red River Hospital
Location (city and county)	Wichita Falls, Texas.
Phone number	
Key admission criteria	Determination of need for inpatient level of care
Service area limitations, if any	None
Other relevant admission information for first responders	Private facility.

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

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

○ We do not provide competency restoration directly. If we had a case at our county jail for competency restoration they would be evaluated by Tarrant County MHMR.

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

○ N/A

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

○ We do not have a dedicated jail liaison at this time. Our TCOOMMI staff is contacted when the jail has clients whom may need ongoing services. We do have a CTI staff that works closely with jail staff in identifying clients that may need outpatient services and we are currently working with the county jail on a program that would have MH case management provided for inmates currently in jail.

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

- Our TCOOMMI continuity of Care case manager is the typical liaison between jail staff and our LMHA.

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.

- We are working on an opportunity with our county jail to have case management, referral services, and level of care assessment with shared staff in the jail.

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.)?

- Tarrant County currently assesses for competency restoration in Denton County.

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

- N/A

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

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

- We currently have an integrated clinic that has both psychiatric and physical health care services.
- We have a strong referral networks with local physical health care service providers.
- We currently integrate substance abuse treatment into our TRR services including skills training and referral, if needed, to inpatient substance abuse or detox clinics in Tarrant and Dallas Counties.

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

- We are currently exploring and preparing to seek CCBHC certification.
- We are exploring the feasibility of increasing capacity in our integrated clinic
- Emphasis on integrating substance abuse treatment into our current service delivery, with a focus on evidence-based outpatient treatment. We have added a second LCDC position over the past year to increase capacity in this area.
- Continue to increase our ability to coordinate detox treatment for our clients in service areas that have this ability.

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.

- We share our programs and processes on our website.
- We use pamphlets to share our programs and processes with the public.
- We have a dedicated community liaison who hosts meetings, attends meetings and educates stakeholders in any change in process that occurs.
- We have staff that serve on many community committees and coalitions that include members of our stakeholder groups. We share any changes in process or programs with these groups.
- When we have changes that are immediate and change how or when other entities might contact us we call those entities directly and discuss the changes with them.

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

- We provide extensive training for those involved in our MCOT as well as for the center administrative staff who may be involved in these processes. If there are changes, new training is provided and information is passed on via team meetings, emails or memos.
- We have face to face meetings with our contracted crisis line where there is a need based on policy changes that we make or changes in our workflow.
- Our MCOT meets as a team weekly to ensure that the plan is being properly implemented.

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
Denton	• The largest gap in the system in Denton County is a lack of detox beds that be easily accessed for indigent clients.
Denton	• Short term shelter and intermediate housing for homeless individuals
Denton	• County wide access to primary care for the indigent population.

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 that describe the strategies checked in the first column. For those areas not required in the HHSC Performance Contract, enter NA if the LMHA/LBHA has no current or planned activities.

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☐ Co-mobilization with Crisis Intervention Team (CIT) x Co-mobilization with Mental Health Deputies ☐ Co-location with CIT and/or MH Deputies ☐ Training dispatch and first responders x Training law enforcement staff ☐ Training of court personnel ☐ Training of probation personnel x Documenting police contacts with persons with mental illness x Police-friendly drop-off point x Service linkage and follow-up for individuals who are not hospitalized ☐ Other: Click here to enter text.	• We are constantly working with our mental health deputies and our MH probate court to streamline processes and procedures striving for efficiencies related to staff time and individual wait time for service or assessment. • Our community liaison provides training and program updates to several of our local law enforcement groups. • Our Psychiatric triage has become a police-friendly drop off point. This is a DSRIP project that is currently dependent on funding through the 1115 waiver. We are currently working with community partners to work on alternative funding mechanisms. • We currently complete 24hr follow ups with all clients who are assessed by MCOT and not hospitalized. We link these clients to needed services either within the LMHA levels of care or with private providers.
Plans for the upcoming two years:	

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
• We are meeting and working with our MH probate court and city law enforcement to increase efficiency for clients who need psychiatric assistance. • Offer more training to law enforcement and alternative for them when dealing with clients who have mental health issues. •	

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 x Link to comprehensive services ☐ Other: Click here to enter text.	• We work closely with the Denton county substance abuse court and Mental Health court to provide services when clients do not have a private provider.
Plans for the upcoming two years: • We would like increase our interaction with these two courts. • We are hoping that our CTI position will be able to work more closely with these individuals during their detention and initial hearing phase.	

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☐ Routine screening for mental illness and diversion eligibility	•

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
x Mental Health Court x 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) x Staff assigned to serve as liaison between specialty courts and services providers x Link to comprehensive services ☐ Other:	We are currently working with Mental health court to provide services for clients who do not have private provider options. Our MVPN coordinator is a member of our veterans court treatment team and is able to help facilitate services for clients in veterans court that need psychosocial or psychiatric services.
Plans for the upcoming two years: • Increase the linkage between our specialty courts and the LMHA so that timely and appropriate services can be provided.	

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
x Providing transitional services in jails ☐ Staff designated to assess needs, develop plan for services, and	• We often receive referrals from the Jail for clients that need outpatient services or who have been identified as being in crisis. We provide crisis

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
coordinate transition to ensure continuity of care at release x Structured process to coordinate discharge/transition plans and procedures ☐ Specialized case management teams to coordinate post-release services ☐ Other:	services and ongoing services to these clients as needed.
Plans for the upcoming two years: • We are hoping to develop a partnership with the Sheriff's department to have case management services provided in the jail that would include assessing needs, developing plans for services and smooth transitions to care outside of the jail setting. The discussions with the department are ongoing.	

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
☐ Routine screening for mental illness and substance use disorders x Training for probation or parole staff x TCOOMMI program ☐ Forensic ACT ☐ Staff assigned to facilitate access to comprehensive services; specialized caseloads ☐ Staff assigned to serve as liaison with community corrections x Working with community corrections to ensure a range of options to reinforce positive behavior and effectively address noncompliance ☐ Other:	• Our current TCOOMMI program includes a continuity of care case manager who is responsible for lining clients coming out of jail with the appropriate mental health services that they need. We also have an intensive case manager that works with clients who indeed intensive case management and are at a high or moderate risk for re-offending. • These two positions work closely with parole officers and courage them to make referrals for clients even if they do not meet the requirements of the TCOOMMI program. We are then able to bring them into a level of care that is appropriate for the individual.

Plans for the upcoming two years:

- Over the next two years we hope to increase our coordination with our probation department. We continue to consider the possibility of a probation caseload assigned to a specific case manager.
- We hope to provide more training on mental health and substance abuse issues to both our parole and probation departments over the next two years.

III.B Other Behavioral Health Strategic Priorities

The Texas Statewide Behavioral Health Strategic Plan (BHSP) 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 members 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 and current activities), and then summarize objectives and activities planned for the next two years.

Area of Focus	Related Gaps and Goals from the BSHP	Current Status	Plans
Improving access to timely outpatient services	• Gap 6 • Goal 2	• We currently have no waitlist for outpatient services	• We hope to be able to continue to have no waitlist in the future, however we are nearing capacity.
Improving continuity of care between inpatient care and community services and reducing hospital readmissions	• Gap 1 • Goals 1,2,4	• We currently use direct drop offs to our center from both the state hospital and our local psychiatric hospitals. This allows us to bring those clients directly into services upon their discharge from the hospital. • We have also been able to us our diversion bed day funding to keep clients hospitalized in our local community.	• Increased shelter and intermediate housing options is an area that we would like to work on with community partners. We believe that this would help with re-admission rates.
Transitioning long-term state hospital patients	• Gap 14	• Our hospital liaison meets with clients face to face	• We are working as part of our communities' homeless

Area of Focus	Related Gaps and Goals from the BSHP	Current Status	Plans
who no longer need an inpatient level of care to the community and reducing other state hospital utilization	• Goals 1,4	while they are at the hospital. The liaison also meets with the social workers at the hospital that are assigned to the individuals. The liaison works to overcome barriers that may be psychosocial issues that are keeping the client from being able to be discharged.	coalition to increase the availability of temporary and intermediate housing. • The guardianship program in our community as increased the capacity for guardianship in our community and we hope this may help to provide a guardian for those people in the hospital who could function in the community if they had this resource.
Implementing and ensuring fidelity with evidence-based practices	• Gap 7 • Goal 2	• Ongoing training on evidence based practices. • Technical assistance from HHSC. • Monitoring fidelity through chart reviews and observations	• We are beginning the process of becoming a CCBHC. • We plan to begin a center wide focus on trauma informed care.
Transition to a recovery-oriented system of care, including use of peer support services	• Gap 8 • Goals 2,3	• We have two peer specialist who provide high quality service. • We work with via hope consistently.	• We plan to begin a center wide focus on trauma informed care.

Area of Focus	Related Gaps and Goals from the BSHP	Current Status	Plans
		• We have individuals in service who serve on our PNAC.	
Addressing the needs of consumers with co-occurring substance use disorders	• Gaps 1,14 • Goals 1,2	• We have two LCDC counselors on staff. • We train all clinical staff in COSPD.	• We are planning to add substance abuse groups. • We are planning to provide more access to our LCDC staff for individuals in service.
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• Gap 1 • Goals 1,2	• We currently have an integrated clinic that serves clients who need both behavioral and psychiatric needs. This program is funded through the DSRIP program.	• We are looking at alternative funding sources for this program. • We are seeking more access for our clients to health care through increase in capacity of the integrated clinic.
Consumer transportation and access to treatment in remote areas	• Gap 10 • Goal 2	• We provide rides to our clients who cannot access our public transportation	• We would like to work with our local public transportation authority to increase the availability and affordability to these services.
Addressing the needs of	• Gap 14	• We currently provide a full	• Examine options to offset

Area of Focus	Related Gaps and Goals from the BSHP	Current Status	Plans
consumers with Intellectual Disabilities	• Goals 2,4	array of IDD services. • We have added crisis respite services for IDD population. • We have educated our local and state elected officials on the significant waitlist for HCS and Texas home living services.	funding and reimbursement cuts. • Increase the availability of psychiatric care, especially inpatient for IDD clients that need to be hospitalized. • Continue to educate stakeholders about the increasing need and decreasing funding related to providing quality IDD services.
Addressing the needs of veterans	• Gap 4 • Goals 2,3	• MVPN coordination of services. • Have collaborated with our local United Way to expand a Veteran navigation program.	• Increase the availability of Veterans psychiatric service in Denton County through partnerships with private providers and VA providers.

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
Veteran services	• See above	• See above
1115 Waiver projects	• Two years of current funding	• Explore alternative funding strategies for these projects. • Seek community support for these projects.
Detox and Substance abuse services	• We provide outpatient services for substance abuse disorders. • Community jail diversion focus has defined this need as way to help with jail diversion.	• Working with our community to collaborate on Detox beds for indigent individuals in need of this services.
	•	•
	•	•

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 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/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	Acute and intermediate shelters or housing	Resources would be used to provide shelter for those experiencing acute homelessness. Resources would also be used to fund programs for those experiencing chronic homelessness.	• 500,000.00
2	Availability of Detox beds	Increase the availability of Detox beds in Denton County. There are currently no detox beds in Denton County specifically for indigent individuals	• 575,000.00 – Would provide three available beds a day for a 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.