



Coastal Plains

Community MHMR Center

**CRISIS SERVICES PLAN
Fiscal Years
2008 and 2009**

Revision #2
Revised 3/4/08

Table of Contents

Revision #1 text is in burgundy font

Revision #2 text is in blue font and underlined

	Page #
I. Introduction.....	3
II. History.....	3-4
III. Planning Process for Redesign and Evaluation of Current Services	
III.a Planning.....	4-6
III.b Description of Current Services	
III.b.1 Crisis Hotline.....	6-7
III.b.2 Current Mobile Outreach.....	7
III.b.3 Current Crisis Response System Staffing.....	8
III.b.4 Current Crisis Services Budget.....	8
III.b.5 Current Crisis Response System Training.....	8-9
IV. New Crisis Funding Utilization Plan	
IV.a Crisis Hotline and Improvements.....	9-10
IV.b Implementation of Mobile Crisis Outreach Team (MCOT).....	10
<u>IV.c Mobile Crisis Outreach Team Staff and Contractors.....</u>	<u>11-12</u>
<u>IV.d MCOT Services.....</u>	<u>11-12</u>
IV.e Training for Re-Design Services.....	12
IV.f Other Crisis Services and Supports	12-13
V. Collaboration and Coordination with Other Agencies	
V.a Integration of MH and Substance Abuse Service Providers.....	13-14
V.b Mental Health Transformation Grant.....	14
V.c Contracts with Community Mental Health Service Providers.....	14
V.d Transportation Issues and Agreements.....	15
V.e Collaboration with Local, Regional and State Agencies.....	15-16
VI. Implementation Timeline.....	16
VII. Oversight.....	16-17
Attachment A: Current Crisis Flow Chart	
Attachment B: New Crisis Services Flow Chart	
<u>Attachments C & D: Crisis Funding Breakdown (475)</u>	
Attachment E: Crisis Services Meeting Outline	

Attachment F : Crisis Services Meeting Signature Sheets

I. Introduction

The goal of this document is to design a plan for crisis services based upon approximations of funding from the Texas Department of State Health Services (DSHS). This funding, which was appropriated by the 80th Legislature in the amount of \$82 million state-wide for the Fiscal Years 08-09 biennium, has not been distributed at the time this plan was written. The approximations in the plan are based upon identified funding for the Center for the next two years, with the understanding that some goals may be modified based upon the actual allocation distribution from DSHS. The funding, statewide for FY 2008 is \$27,317,890 and FY 2009 \$54,682,110. The allocation of the funds will be through a variety of methods, to include equity contribution (approximately 32%), proportional allocations (approximately 36%) and through a community investment incentive (approximately 30%) with approximately 1.5% going towards state expenditures for implementation expenses.

II. History

Two years ago, the Texas Department of State Health Services assessed the needs of the community as it relates to crisis services. The various stakeholders involved in the crisis redesign project included:

- medical professionals - both the public and private sector, including
 - emergency room staff,
 - state hospital staff,
 - private psychiatric hospitals, and
 - local mental health authority medical professionals;
- law enforcement – both police and sheriff departments statewide;
- judges;
- advocacy organizations;
- community mental health center staff; and
- DSHS staff.

A committee consisting of members from all of these stakeholder groups was assembled and charged with developing recommendations for a comprehensive array of specific services to meet the needs of Texans who are experiencing a mental health or substance abuse crisis.

The redesign committee conducted statewide community surveys to find out what the stakeholder concerns were regarding crisis services. The survey results were summarized with primary concerns emphasized from hospital/emergency room staff and law enforcement personnel. In addition, there were also site visits and hearings held in four (4) areas across the state (San Antonio, Austin, Big Spring, Harlingen). The major concerns were listed in the power point presentation given by DSHS on August 2, 2007 at the Implementation Overview Meeting and can be found on the DSHS website. From these needs the committee developed a list of core services which are essential to crisis services, statewide. Based on these results, the committee identified an array of core services that they believed were essential to meet the needs of individuals experiencing a psychiatric or substance abuse crisis.

The core services identified are:

Crisis Hotline and Mobile Outreach

The first priority for funds that were made available to each Local Mental Health Authority (LMHA) was to provide Crisis Hotline Services and Mobile Outreach. The hotlines must be continuously available telephone services staffed by trained crisis counselors 24 hours a day, 7 days a week. These hotlines are required to be accredited by the American Association of Suicidology (AAS). The trained counselors are to provide screening, intervention, information, and support to callers. The mobile crisis outreach services have been defined as rural and urban depending on the local. The primary purpose of the teams are to provide face-to-face assessment and crisis services 24 hours a day, 7 days a week. The goal is to provide emergency care, urgent care and crisis follow-up in a team approach. At a minimum, the teams must be able to make face-to-face assessments within one hour of a call.

Additional crisis services may also be provided through-out the state based upon allocation of funds, local contributions and local need for the services. These services will be developed in communities based upon community stakeholder recommendations and funding support (both through the crisis redesign allocation and through local match). These other crisis services include:

- Crisis Outpatient Services
- Children’s Crisis Outpatient Services
- Crisis Residential Treatment
- Crisis Stabilization Unit
- Emergency Crisis Psychiatric Services, w/Extended Observation

Other Crisis Funding Options:

- Crisis Intervention Team (CIT)/Mental Health Deputies Program
- Transportation offsets for local law enforcement

III. Planning Process for Redesign and Evaluation of Current Services

III.a Planning

The first step in the planning process was to solicit stakeholder input from persons in our Center’s service area. The Center was able to meet with many of the key stakeholders in the various communities we serve prior to the development of this plan. There were three main meetings in which crisis redesign was formally addressed during the first quarter. These meetings were with the community coalition groups (one that meets monthly and one that meets quarterly), the local National Alliance for the Mentally Ill (NAMI) group and the Center’s Planning and Network Advisory Committee (PNAC). The Board of Trustees, which consists of judges and commissioners from each county in our service area provided input regarding the needs of their individual communities, as related to crisis services and will continue to provide feedback and oversight of the implementation of crisis redesign and the planning process.

Our staff members developed an agenda (*see attachment E*) and contacted the local service providers to invite them to the meetings. This was acknowledged prior to completion of this plan. Due to time constraints, the majority of the invitations to the meetings were either face-to-

face or by telephone. Fliers regarding the crisis redesign planning meeting were posted at the two clinics closest to where the scheduled local NAMI group meeting was to be held (*see Attachment F*). The staff members who facilitated the meetings requested all people in attendance to sign-in, to assist in the tracking of attendees.

The following is a list of representatives from the community who attended the initial meetings held:

- Consumers and Family Members - 21
- Advocacy Members (NAMI) - 14
- Judges/JP's/Commissioners - 14
- Law Enforcement – police/sheriff/DA's/court staff - 6
- Mental Health Service Providers - 5
- Emergency/General Healthcare Providers (hospitals) – 3
- Local Public Healthcare Providers - 5
- Substance Abuse Providers (OSAR/New Vision/STARS, etc..) – 2
- Probation/Parole Department Representatives – 2
- Child and Adult Advocates – 16 (includes the NAMI members)
- Other Stakeholders - 1
- Nursing homes - 2
- Community Service Agencies – 1

In these meetings the Center informed the stakeholders of the required elements which the Center is to implement, specifically crisis hotline services 24 hours a day, 7 days a week and mobile crisis outreach services. They were also informed of the other services which can be provided in the community, based upon need and funding.

Community members participating in these meetings identified the following gaps, needs and issues related to crisis services in the Coastal Plains MHMR service area:

- Transportation
- Wait time at the hospitals
- Substance abuse services
- Education of law enforcement (police & sheriff departments) regarding MH crisis issues
- Education of emergency room workers regarding crisis services, processes and intervention for people with mental illness (it was expressed that some ER staff are not sensitive to or do not understand mental illnesses or know appropriate intervention)
 - 24 hour crisis line services or supports for consumers when not “suicidal” or “homicidal” e.g. consumer runs out of medication and realizes it after hours; panic attacks, etc...
 - Peer support groups
 - On-going jail diversion activities, such as educating the judges, district attorneys and police regarding options and decreasing incarceration, when the crime is directly related to the person's mental illness.
 - To continue to have MHMR be the provider of the crisis outreach services, not contract the service out to ensure continuity for the law enforcement and judicial intervention.

In order to ensure ongoing involvement and feedback from the stakeholders, the Center staff assigned to the various coalition groups will request to have crisis services placed on the agendas. Within these discussions, they will address topics such as rapid response; providing

services in the least restrictive environment; and jail diversion activities. This information will then be provided to Center management, for updates of the plan, when necessary. The Center will also seek ongoing feedback and involvement in the monitoring of the Crisis Redesign Plan from the Planning and Network Advisory Committee (PNAC). The NAMI group has asked for and will be provided updates on the progress of the implementation of the new crisis services.

The Center is currently involved with two main coalition groups. One of the groups is comprised of:

- Law enforcement;
- Probation and parole officers;
- CRCG (Community Resource Action Groups – CRCG) for both adults and children;
- Judges and justices of the peace;
- Mental health professionals;
- Hospital and emergency room personnel;
- Nursing home providers; and
- Community service agencies.

The other coalition group is primarily comprised of local service organizations, both state funded and independent non-profit service providers, including:

- Food stamp representatives;
- Teachers;
- Churches;
- Food banks;
- Counseling centers; and
- Mental health professionals.

The Planning and Network Advisory Committee is currently comprised of

- Consumers of both mental health and mental retardation services,
- Family members from all service areas,
- School teachers and/or counselors,
- University Instructors/Professors.

III.b Description of Current Services

III.b.1 Crisis Hotline:

Coastal Plains Community MHMR Center presently provides crisis hotline services, after hours, through a contract with Avail Solutions, Inc. (Avail). Avail has obtained their accreditation through the American Association of Suicidality (AAS). Coastal Plains MHMR Center assisted them in the process, to ensure that the crisis line that we contract with is accredited. This was done through donation of staff time to proctor the testing and review procedures. The staff member has already applied for proctor status and received approval from the Director of Accreditation and Certification of AAS to provide this oversight. Avail will then ensure that the staff employed are AAS trained and that their agency continues to maintain accreditation as

required in the contract. The Center handles the crisis calls that come into the individual mental health clinics during regular business hours (8 a.m. – 5 p.m.).

The current crisis call response system is as follows:

Monday – Friday 8 am – 5 pm:

- A QMHP-CS (Qualified Mental Health Professionals – Community Services) or LPHA (Licensed Practitioner of the Healing Arts) who is trained to respond to crisis situations in each clinic (rotate daily/weekly) will take the crisis call.
- The staff person will provide crisis assessment via telephone or on-site, as needed or requested (e.g. if someone is at the jail or hospital, a face-to-face assessment will be done; if a person is calling for themselves, then initially a telephone assessment will be done and determination will be made regarding making a home visit, having the person come in to the clinic or go to the hospital, sending the police out for a welfare check or picking the person up on a warrant, etc...)
- If the call is from a person who receives services and their QMHP-CS or other team member is available, then this person will provide intervention typically providing face-to-face skills training to help the person cope with their stressor(s), de-escalate and avoid hospitalization.
- When the person is not enrolled in services or if the person's QMHP-CS or other team member is not available, then the on-call person will address the crisis situation as per the "Crisis Flow Chart" Attachment A - see flow chart for details on how various crisis situations are addressed.

After hours, Monday – Friday and Weekends

- Avail Solutions, Inc. receives all crisis calls through a toll-free number made available in the telephone books, handouts provided to consumers/family members and on Center answering machines.
- Avail staff screens the calls to determine if a CPMHMR staff or contractor who is assigned on-call status needs to be activated.
- When the CPMHMR staff or contract person receives a call from Avail, they make arrangements to assess the person in crisis face-to-face (typically at the hospital, police department or sheriff's department – a safe place for both the consumer and staff member)
- The staff member then follows the "Crisis Flow Chart" *Attachment A* to make a determination on handling each individual situation. This includes attempting to provide services in the least restrictive way, by providing skills training to de-escalate the crisis situation and assist the person in gaining coping skills needed or hospitalization.

III.b.2 Current Mobile Outreach

The Center has a mobile on-call system in the evenings and on weekends in which there are QMHP-CS's and supervisors which rotate on a weekly basis. The QMHP's are contacted by Avail after they receive a call via the crisis hotline number. Avail will assess the caller's situation and make a determination to contact the on-call worker. The QMHP-CS on-call will be dispatched to the location of the individual and perform a crisis assessment and/or crisis skills training, based upon need. Each face-to-face contact includes a suicide assessment and consultation with the supervisor, for clinical guidance, disposition and/or approval for bed-day authorization. The on-call staff are not required to be awake nor are there formal teams. Staff

members on-call are required to be available, by cell phone and be able to make a face-to-face contact within one hour of receiving a call for a crisis assessment.

III.b.3 Current Crisis Response System Staffing

The Center hires Qualified Mental Health Professionals – Community Services (QMHP-CS) to provide Service Coordination, Case Management and Rehabilitation Skills Training services. The same staff are required to rotate night and weekend “on-call” services, to be available after-hours to respond to crisis calls. In some of the service areas, the Center has also contracted with QMHP-CS qualified individuals to be in the “on-call” rotation. There is a system in place where the QMHP-CS/Case Manager on-call is to contact a supervisor for guidance and approval of certain actions, such as hospitalizations. The supervisors also rotate on-call status and are either QMHP-CS qualified or LPHA’s (Licensed Practitioners of the Healing Arts).

Avail Solutions, Inc. only hires QMHP-CS qualified or above staff to provide crisis hotline services. Various centers across the state have credentialing criteria written into their contracts with Avail and ensure each staff is credentialed. As these Centers have extremely high standards for credentialing and at least one of them is JCAHO accredited, the Center does not go through a complete credentialing process with Avail.

III.b.4 Current Crisis Services Budget

The following is a summary of the current services and their costs. For a comparison of the current crisis services and costs and proposed services and projected costs refer to *Attachment C* of this plan titled “Crisis Services Comparison”.

- Crisis Hotline Services – Contract w/Avail Solutions, Inc. \$34,800/year for evening/weekend hotline services
- On-call costs for current staff rotating crisis on-call services: \$7200/year for rotation pay (\$50/week per staff on-call).
- On-call costs for contract staff (2 contracts) taking a rotation for staff relief: \$26,000/year
- Psychiatric Services – 24 hours/day, 7 days a week – value-added service with no extra cost based upon current contract with psychiatrist on contract.

III.b.5 Current Crisis Response System Training

Prior to providing services to individuals in mental health all staff are required to receive basic training from qualified professionals at the agency. They are also provided specialized training within the first three months of their employment with the Center and annual refresher training on certain courses. Staff are placed on rotation after they are trained and competent in handling crisis. They are observed by supervisors in the clinics, prior to being placed on-call. The following is a condensed list of new employee training which is required of Center staff:

- Abuse/Rights/Confidentiality/HIPAA, PMAB, Infection Control, Cultural Competency, and Communication Strategies/Relay Texas (w/in 2 days of employment)
- Behavior Intervention, Case Management/Rehab, Crisis Training, and TRAG/RDM (w/in 30 days of employment)
- Homicide/Suicide, Pharmacology, TIMA and CMAP (w/in 60 days of employment) and

- Co-occurring Substance Abuse training (w/in 45 days of employment)

Avail Solutions, Inc. has specific training in regards to crisis services, crisis intervention, communication strategies, HIPAA, Confidentiality, Rights, Abuse, Cultural Competency, Relay Texas, and Suicide/homicide intervention. As previously noted, Avail has recently become accredited through the American Association of Suicidality.

IV. New Crisis Funding Utilization Plan

IV.a Crisis Hotline and Improvements

Crisis Hotline Requirements:

- AAS Accreditation;
- 2 or more staff on duty at the phone center 24/7;
- Staff answering calls are trained meeting AAS requirements;
- Staffing sufficient to handle volume;
- Bilingual capable; and
- Capacity for rapid surge, to handle sudden influx of calls.

Rural mental health clinics have limited number of Qualified Mental Health Professionals – Community Services (QMHP-CS's) handling large, mixed package caseloads. As such, it is not always possible to ensure that these requirements can be met within the clinics themselves. Center staff are frequently deployed in the field engaging consumers in treatment. Avail Solutions, Inc., currently contracts with at least one community center to provide the day crisis calls. That community center was contacted and the mental health director reported that this arrangement has worked successfully.

The Center has decided it would be the most cost effective and best value for consumers if the contract with Avail is modified. Avail will now provide crisis hotline screening and assessment services 24 hours a day, 7 days a week. A transition period will be necessary to revise the crisis call system so that crisis calls are transferred to Avail during regular business hours. There will be a need to educate staff, consumers and community service providers on the new process. The Center staff will visit the various community service providers to discuss the changes in the crisis service system. A handout will be developed to ensure that the transition goes as smooth as possible. They will also be provided a copy of the flow chart, to assist them in understanding the system that has been established. This flow chart (**Attachment B**) describes the crisis response system from the first call or contact with the contractor/MHA through resolution and follow-up.

Avail Solutions, Inc has obtained and will maintain accreditation with the American Association of Suicidality. The Center's contribution to this is the time it will take for Avail staff to take the test, as the Center is donating center staff time to proctor the test to ensure test protocol is followed. The Center does contract with Avail for the crisis hotline services, current costs are \$2900.00/month not to exceed \$34,800.00/year. This is for crisis hotline calls to be answered after 5:00 pm through 8:00 am on weekdays, 24 hours a day on holidays and weekends. The change in crisis hotline services will increase these costs, as Avail will be providing the hotline services 24 hours a day/7 days a week. The increase of costs for hotline services is an additional

\$1000/month for Avail to answer the calls during the workday. This would be an increase of \$12,000/year, resulting in the total cost for crisis hotline services to be \$46,800/year. There may also be additional costs, through staff time for education of the community service providers regarding these changes, to ensure continuity of services. The costs should be minimal.

IV.b Implementation of Mobile Crisis Outreach Team (MCOT)

Rural community centers mobile outreach services are required to have one MCOT team on duty during peak crisis hours with awake coverage eight (8) hours per day, seven (7) days a week. There must also be another team or teams on-call during non-peak hours. These teams must be sufficient in numbers and availability to assure face-to-face assessment within one (1) hour of receiving a call. The initial calls must be addressed with two (2) people per team who are Qualified Mental Health Professionals – Community Services (QMHP-CS's) or one QHMP-CS with one trained law enforcement official at the scene or a location deemed safe for the crisis assessment. There must also be a physician on-call 24/7 to conduct face-to-face assessments as needed.

The following is a break-out of what the Center's MCOT will consist of, in relation to employees, both employed by the center and contractors. Currently, if a person receives a face-to-face crisis assessment in the evenings or on the weekends, one of three things happens: 1) they are referred to outpatient services to meet with case manager the next working day; 2) they are hospitalized and the Center staff will make a face-to-face contact with them within seven (7) days after discharge; 3) they are not hospitalized, but referred to either the Center or other community services. Presently, the Center staff follows up with people who are hospitalized for their post-discharge contact, within seven (7) days. However, other non-center referrals do not receive follow-up services. However, with the MCOT, the team will attempt to follow-up with each non-client they make contact with. Follow-up contacts will be facilitated either face-to-face or by telephone. The projected increase of contacts could be up to fifty people a month, based upon non-consumers seen for crisis screenings and assessments, but not admitted into services over the past fiscal year.

IV.c Mobile Crisis Outreach Team – Staff and Contractors;

The Center has developed an outline of what the “Mobile Crisis Outreach Team” will be in order to meet the standards defined in the contract. The Center's MCOT will consist of the following:

Coastal Plains MHMR Community Center Employees:

Employed Staff

- **3 QMHP-CS – FTE's, 4 pm – 12 midnight Monday – Friday (covering 6 of 9 counties – every county except Brooks, Duval and Live Oak)**
- **3 Half (1/2) time QMHP-CS Saturday 10 am – 8 pm & Sunday 12 noon – 10 pm (covering 6 of 9 counties – every county except Brooks, Duval and Live Oak)**
- **5 LPHA's – rotating weeks – on-call supervision and clinical intervention.**

Contracted Staff:

- **Contract Provider w/QMHP-CS's to cover Brooks, Duval and Live Oak Counties – all peak and non-peak hours outside of regular business hours.**
- **Contract Provider w/QMHP-CS's to cover all counties during non-peak hours, outside of regular business hours and MCOT team coverage hours.**

- **LPHAs – at least 2 contracts – to be “on-call” within rotation coverage to provide continuous supervision and clinic intervention.**

For a complete financial breakdown for both fiscal years 2008 and 2009, to include the new crisis redesign funding, general revenue match and the incorporation of funds from the change in crisis serves, refer to the attachment titled: Crisis Funding Breakdown.

Procedures for the MCOT will be developed, consistent with contract requirements and mental health standards. The team’s purpose will be to attempt to prevent a crisis from escalating while providing services in the least restrictive environment. The MCOT will consist of full time and contract staff. There will be a minimum of fifty six (56) hours a week where the MCOT be awake and on-duty during peak crisis hours. The Center has determined that the peak crisis hours during the week **from 4:00 p.m. to 12:00 midnight during the weekdays; 10 am – 8 pm on Saturdays; and 12 noon to 10:00 pm on Sundays.** There will be at least two MCOT staff who are Qualified Mental Health Professional (QMHP-CS) level or above during these times to provide mobile crisis outreach. Staffing will also include a Licensed Practitioner of the Healing Arts (LPHA) level staff available for both telephone consults and, when clinically appropriate, to conduct face-to-face assessment and crisis counseling. The Center has psychiatrists on contract who are available 24 hours a day, 7 days a week for face-to-face and telephone consult. The MCOT will continue to be able to access these services.

Utilizing both contract and Center staff increases cost effectiveness while providing for continuity of care. Deployment of paid Center employees during peak hours provides continuity for consumers and existing crisis service providers, such as hospital, sheriff departments and local police departments. In addition to ensuring consistency of approach, paid staff satisfy the stakeholder request verbalized during the crisis re-design planning meetings. Thus the creation of employed MCOT teams would be viewed by the community as an enhancement of our current system of crisis response. Also, the utilization of contractors during non-peak hours will decrease costs, as the Center will not be providing medical coverage, retirement and other benefits for the contractors.

IV.d MCOT Services

The Center will continue to provide face-to-face crisis services to people who reside in the nine (9) county service area. With this said, the Mobile Crisis Outreach Team will be providing the new services to 6 of the 9 counties served. These six counties have 85% of the total population served and account for 80% of our annual crisis responses. Also, in order to meet the one (1) hour response time, with a centrally located MCOT, it is not possible to meet the required team member structure and remain within the funding allotted by the State. The Center posted requests for proposal (RFP) and received a contracted bid to provide crisis services for all counties and times not covered by MCOT services and regularly scheduled business hours. Upon approval from the Planning and Network Advisory Committee (PNAC) and the Board of Trustees, the crisis response services for Brooks, Duval and Live Oak Counties will be contracted to an agency which can guarantee meeting the one (1) hour time-frame during peak, non-office hours.

This arrangement will allow all people in crisis to have trained staff available to provide these services during peak hours and non-peak hours (evenings, weekends and holidays) within one (1) hour of contact from the crisis hotline service, requesting a face-to-face assessment for emergent crisis. The MCOT team will be located in Portland, Texas at the Central Administration building. The team will consist of a minimum of two (2) , with a maximum of three (3) QMHP-CS staff on duty during peak hours. This will allow deployment to make the face-to-face contact time for emergent crisis within one (1) hour to the seven counties the MCOT will cover. By limiting the area to be served, the MCOT will be able to meet emergent crisis response within one hour, there will be no barrier in meeting the requirement for urgent crisis services response time to be within eight hours.

During regular work days, defined as Monday through Friday between the hours of 8:00 am and 5:00 pm with the exception of holidays, trained Qualified Mental Health Professionals (QMHP's) from the Center's clinics in each service area will provide this face-to-face service for both emergent and urgent crisis assessments and services. At each clinic, typically there is at least one Licensed Practitioner of the Healing Arts (to include Licensed Practicing Counselors and/or Psychiatrists) available to provide additional assessment, intervention and, as necessary medical/psychiatric evaluation and care. Each clinic site has video-teleconferencing equipment with connectivity with the other clinics and the local jails, to provide assessments by LPHA's, when face-to-face assessment cannot be done.

IV e. Training for Re-design Crisis Services

The Center staff currently receives extensive training regarding crisis services and supports. This information is summarized in section III.B.4 of this plan. With crisis re-design, the Center will increase the training, once the state authority provides this additional training to key staff. We will designate a minimum of two (2) staff members to attend training provide by DSHS through the American Association of Suicidology. Avail Solutions, Inc. personnel has received AAS training and will continue to be accredited. With this level of accreditation, there is extensive training in crisis services. The Center will also be revising the current curriculum for crisis services to include the Question, Persuade, Refer (QPR) which was provided to a key staff person in the Center. The QPR training was offered by DSHS in FY 2007 through a state-wide training project and was a "train-the-trainer" program, which certifies Center personnel to provide this education to other staff. There will additional training provided regarding referrals and linking to community resources, especially substance abuse services and supports.

IV.f Other Crisis Services and Supports

The Center's current allocations for crisis services redesign are limited. The Center has outlined probable costs for the redesigned services to be provided through Crisis Hotline and the Mobile Crisis Outreach Team. Actual costs will not be identified until implementation of this plan. Based upon the planned budget, the Center will most likely be augmenting the allocation from the state, to ensure Mobile Crisis Outreach Teams are available to meet the one-hour response time in all service areas.

There are other crisis services which are defined in the FY 2008 Performance Contract Information Item V, which could be provided with additional funding. As funding is limited at this time, the following is a summary describes services Coastal Plains MHMR currently provides as they relate to the contract. Noted in each bullet is the capacity of services currently provided and the limitations to meeting the contract requirements without additional funding.

- **Crisis Outpatient Services and Children’s Crisis Outpatient Services** – any person, adult or child, can present to Coastal Plains MHMR clinic and be evaluated (screened) for services and supports. These services are limited in nature and do not meet the definition or all of the standards as listed in the DSHS performance contract amendment, information item V. The Center’s mental health clinics are all rural in nature and staffing is based upon services provided and need. In order to meet all of the requirements for “Crisis Outpatient Services” and “Children’s Crisis Outpatient Services” as defined in the DSHS contract, there would be a need to hire additional staff to ensure that the person receives “triage” assessment within fifteen minutes of presentation and then additional assessment by LPHA or RN within 1 hour of referral to the screening process. Also, some clinics the clinics would have to be modified to ensure that there is “a designated area where persons in extreme crisis can be safely maintained until transported to another level of care”. Currently, any crisis, child or adult, our Center provides assessment services and support, to include referrals as appropriate. However, the contract defined “Children’s Crisis Outpatient Services” are not financially feasible, based upon staffing requirements, and current service locations would not accommodate all of the specifications required.
- **Extended Observation Unit and Crisis Residential Services** – The Center contracts with multiple psychiatric facilities/hospitals in the service area for crisis stabilization. However, we do not have a “Psychiatric Emergency Service Center” nor will our Center be submitting a proposal for one, as this is cost prohibitive and would not be a good use of public funds, due to the rural nature of our services. The “Crisis Residential Services” for either adults or children would require a physical location, with 24 hour a day staffing, to include a large array of services and supports by specialist, such as Registered Nurses, Licensed Practitioners of the Healing Arts (LPHA) and medical staff, with medical equipment. Funding and support for this type of service is not a priority to community members nor is it feasible, based upon current allocation of funds.
- **Crisis Respite Services and Crisis Stabilization** - Respite services are provided to individuals in need, however are limited due to rural service location. Due to the large, rural service area, provision of “Crisis Respite” services as defined in the contract amendment is cost prohibitive. The contract amendment on crisis redesign has changed “crisis respite” to more of a definition of a “crisis stabilization unit”. Both the respite and crisis stabilization unit contract requirements indicate that these will have 24 hour a day staff, with multiple levels of services and supports. As the current and additional funding allocation to the Center does not allow for such intensive services. Respite services currently provided are usually providing an alternative living environment for the person, to give both the person and the caregiver a break.

- **Training of Mental Health Peace Officers/Mental Health Deputies and transportation:** in accordance with Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE) the Center currently provides a qualified staff member to provide training to local law enforcement. This support service has been offered to the police and sheriff's departments in our service area for several years now and will continue to be offered. The communities we serve have many certified mental health peace officers, due to the training our Center offers. The Center will continue to offer opportunities for law enforcement officials in our service area to participate in this training and become certified. Through the Crisis Re-Design funds, we will assist the officers in attending training by paying for overtime costs, as budgeted in this plan (See Attachment C – FY 08). Currently the sheriffs department in the service areas, with the exception of one county, provide the transportation when an order of protective custody or court commitment is issued. Based upon current funding, there will not be enough additional funds to provide alternatives for this type of transportation. However, our Center does anticipate that transportation may decrease due to increased face-to-face intervention and supports from the MCOT.

V. Collaboration and Coordination with Other Agencies

V.a Integration of Mental Health and Substance Abuse Service Providers

Coastal Plains Community MHMR Center provides services to rural areas. As the service areas are rural, there is limited substance abuse service providers located in the area. The closest metropolitan area is in Corpus Christi, TX. Coastal Plains MHMR provides services to people residing in the nine (9) counties surrounding Corpus Christi, which is MHMR Services of Nueces County's service area. In the nine (9) counties our agency serves, there is one treatment program located in the Center's service area. As there are several detoxification and drug treatment programs in Nueces County, the Center has a referral process to link people to these programs. Our agency also works together with probation and parole, to facilitate treatment for offenders who are still using illicit drugs and are in our services, as there are more treatment services available through the Texas Department of Criminal Justice, in regards to substance abuse. The Center also works together with OSAR (Outreach, Screening, Assessment and Referral) staff assigned to the service area by DSHS. Several of the Center's mental health clinics provide office space to the OSAR staff to facilitate linkage to substance abuse services.

V.b Mental Health Transformation Grant

Along with the Crisis Redesign Funding, there are other funds being utilized by the Center to assist in the transformation of the mental health system in Texas. Coastal Plains Community MHMR Center is involved in the Mental Health Transformation Grant, which is a collaborative effort with other community service organizations in order to link people with both the mental health and public health care system, to prevent people from falling through the cracks of the system. The use of this grant, along with the crisis redesign funding, will enhance services in the community with the goal of providing services to people in the least restrictive service setting.

V.c Contracts with Community Mental Health Service Providers

Currently, Coastal Plains Community MHMR Center has contracts with the following hospitals for emergency psychiatric services: Northbay and Padre Behavioral. We are also in the process of developing a contract with Coastal Plains (no affiliation with MHMR) Hospital for individuals who are 55 years or older. With these contracts, the goal is to provide short-term crisis stabilization in the community where the person lives. The hospitals and their employees understand the treatment focus is to provide services in the community, which is least restrictive environment. This provides opportunity for consumers and family members to remain in contact and even visit with each other, with limited travel. Northbay hospital is co-located with physical health hospital and emergency room, which allows for medical clearance and medical services, if necessary. All contract hospitals have psychiatrists available by telephone or for face-to-face assessment to meet the 12 hour compliance standards defined in House Bill 518 (Texas Health & Safety Code §573.021 a and b, and § 574.021d).

V.d Transportation Issues and Agreements

Bee County has a contract with local ambulance companies to provide transportation upon execution of mental health detention warrants. The county has this agreement to provide safe and medically supervised environment for transportation to hospitals, when someone is in a mental health crisis. This also allows for the sheriff's department to concentrate on law enforcement issues. In the other eight (8) counties the Center serves, the sheriff's department is the main provider of transportation for mental health emergencies. Through the community coalition groups, Center staff work closely with law enforcement to coordinate response between city police department and county sheriff's department in mental health emergencies.

It is anticipated that with the development of the two Mobile Crisis Outreach Teams it is expected to decrease the frequency of hospitalization and the associated transportation requirements will be diminished. This is predicted that there will be two teams on duty, during peak crisis times both weekdays and weekends. Their assigned tasks will be to work towards crisis stabilization, de-escalation of the crisis, decrease of hospitalization and increase in follow-up post crisis, for non-consumers. Though it is anticipated that hospitalizations and the concomitant transportation will decrease, it is expected that the total number of activations of the mobile crisis outreach teams will increase. Once law enforcement becomes familiar and accustomed to accessing the MCOT for the resolution of after hours emergency behavioral events it is presumed that the service contacts will escalate out of convenience.

V.e Collaboration with Local, Regional and State Agencies

The planning process produced unexpected benefits to the Center. While gathering stakeholder input, we found that we were educating the community and providers regarding the potential benefit represented by the increased crisis service funding. Stakeholders left the planning meetings with an expectation and increased awareness of potential partnering. This process provided each participant with the potential opportunity to explore methods by which they could derive maximum benefit from our enhanced services. For example, discussions have ensued regarding the increase of education to law enforcement. Consequently, Center staff has recently provided training and certified seven (7) mental health peace officers in Jim Wells County. This positions the Center MCOT for a law enforcement interface during crisis contacts. Additionally, Center staff have provided this training in other counties in our service area, resulting in a

number of certified mental health peace officers, trained to interact in a therapeutic, facilitative manner with community members in mental health crisis situations.

The Center has laid the foundation for the roll-out of the crisis re-design plan, subsequent to DSHS approval. It is expected that future meetings with community members will be enhanced by the additional time period and the inevitable processing of information provided in our original planning meetings. The priorities outlined by the state authority involve the creation of core services, specifically an accredited crisis hotline and a mobile crisis outreach team. The focus of rollout meetings will be to take the core services and local nuance according to each of the communities needs. For example, the certification of peace officers in Jim Wells County may result in the crisis contact being made with both the peace officer and the MCOT staff. The peace officer would have the training and skills to assist with the crisis, provide protection and remove weapons; through the crisis de-escalation process, the presence of law enforcement will fade out of this crisis as the MCOT works with the consumer to develop the coping skills to address what is happening in their life. It was also noted in the crisis redesign planning meetings that there was a need for more certified mental health peace officers. To address this need, the Center designated funds during the first year to assist with overtime costs, to increase the number of officers who can attend the training we are providing. This type of cooperation cannot occur, without collaborative meetings and coordination of services.

VI. Implementation Timeline

The Center's intent is to begin implementation of this plan upon approval by the Department of State Health Services (DSHS). With that said, Center employees have begun development and revision of policies and procedures, as they relate to crisis services. The following is a projected timeline for accomplishing the goals indicated in this plan:

October 2007

1. Begin development and revision of procedures for crisis services
2. Continue to obtain community stakeholder feedback regarding the gaps and needs in current crisis services and supports
3. Begin development of job descriptions and requests for proposals
4. Review plan with Board of Trustees
5. Submit plan to DSHS by October 31, 2007

November 2007

1. Present plan to the Planning and Network Advisory Committee (Nov. 10)
2. Continue development and revision of procedures.

December 2007

1. Revise plan based upon DSHS feedback (if needed)
2. Post employment positions and RFP's (for LPHA's and QMHP's for non-peak hours)
3. Begin contracting for daytime hotline services coverage to be 24/7/365

January 2008

1. Interview staff for peak hour services.
2. Provide feedback to stakeholders
3. Review and evaluate RFP responses for non-peak hours

February 2008

1. Present RFPs to PNAC and Board of Trustees

2. Begin training of staff and contractors – both formal and on-the-job
March 2008
 - * Start Mobile Crisis Outreach Team

VII. Oversight

Coastal Plains Community MHMR Center will monitor required outcomes developed by DSHS through Utilization Management Team. This will afford opportunities for primary providers of services and the authority team oversight to review implementation; provide a forum to identify any outliers in service provision and will allow for key leadership staff to be involved in the supervision of the new services and supports. This meeting includes both provider services supervisors and leadership for the organization to review ongoing progress and identify barriers to services in a timely manner. The utilization management committee formally meets once a month. The Quality Management Team will also develop goals, objectives, strategies and outcome measures based upon this plan and Planning and Network Advisory Committee (PNAC) input. These goals and objectives will be incorporated into the quality improvement plan, which is monitored on a quarterly basis. The PNAC will be able to provide feedback and oversight at their meetings. Specific reports regarding the implementation of this plan will be provided to the PNAC on benchmarks and input regarding implementation will be sought. Part of the quality improvement plan will include the development of a review tool and survey to provide oversight to services and a have a method to obtain input from the consumers served.