Form O

Consolidated Local Service Plan

 Local Mental Health Authorities and Local Behavioral Health Authorities

**Fiscal Years 2020-2021**

Due Date: September 30, 2020

Submissions should be sent to:

Performance.Contracts@hhsc.state.tx.us and CrisisServices@hhsc.state.tx.us

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## Introduction

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

The CLSP asks for information related to community stakeholder involvement in local planning efforts. The Health and Human Services Commission (HHSC) recognizes that community engagement is an ongoing activity and input received throughout the biennium will be reflected in the local plan. LMHAs and LBHAs may use a variety of methods to solicit additional stakeholder input specific to the local plan as needed. In completing the template, please provide concise answers, using bullet points. Only use the acronyms noted in Appendix B and language that the community will understand as this document is posted to LMHAs and LBHAs’ websites. When necessary, add additional rows or replicate tables to provide space for a full response.

#

# Section I: Local Services and Needs

##  I.A Mental Health Services and Sites

* *In the table below, list sites operated by the LMHA or LBHA (or a subcontractor organization) providing mental health services regardless of funding. 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, adolescents, and children (if applicable):*
	+ *Screening, assessment, and intake*
	+ *Texas Resilience and Recovery (TRR) outpatient services: adults, adolescents, or children*
	+ *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 Intellectual Developmental Disorders(IDD)*
	+ *Services for youth*
	+ *Services for veterans*
	+ *Other (please specify)*

| **Operator (LMHA/LBHA orContractor Name)** | **Street Address, City, and Zip, Phone Number** | **County** | **Services & Target Populations Served** |
| --- | --- | --- | --- |
| Pecan Valley Centers (Cleburne Clinic) | 1601 N. Anglin Cleburne, TX 76031 | Johnson  | * Screening/Assessment/ Intake: adults, adolescents, and children.
* Texas Resilience and Recovery (TRR) outpatient services: adults, adolescents, and children.
* Integrated healthcare: mental and physical health.
* Services for individuals with Intellectual Developmental Disorders (IDD)
* Services for youth
* Services for Veterans
* Crisis Services/MCOT: adults, adolescents, and children.
* Substance Abuse Prevention, Intervention or Treatment.
* Services for Co-occurring disorders.
 |
| Pecan Valley Centers (Granbury Clinic)  | 104 Pirate Drive Granbury, TX 76048 | Hood | * Texas Resilience and Recovery (TRR) outpatient services: adults, adolescents, and children.
* Integrated healthcare: mental and physical health.
* Services for individuals with Intellectual Developmental Disorders (IDD)
* Services for youth
* Services for Veterans
* Substance Abuse Prevention, Intervention, or Treatment.
* Services for Co-occurring disorders.
* Crisis Services/MCOT: adults, adolescent, and children.
 |
| Pecan Valley Centers(Mineral Wells Clinic)  | 100 Travis Dr Mineral Wells, TX 76067 | Palo Pinto  | * Texas Resilience and Recovery (TRR) outpatient services: adults, adolescents, and children.
* Integrated healthcare: mental and physical health.
* Services for individuals with Intellectual Developmental Disorders (IDD)
* Services for youth
* Services for Veterans
* Crisis Services/MCOT: adults, adolescents, and children.
* Substance Abuse Prevention, Intervention, or Treatment.
* Services for Co-occurring disorders.

• Screening/Assessment/ Intake: adults, adolescents, and children. |
| Pecan Valley Centers(Stephenville Clinic)  | 906 Lingleville Hwy. Stephenville, TX 76401 | Erath  | * Texas Resilience and Recovery (TRR) outpatient services: adults, adolescents, and children.
* Integrated healthcare: mental and physical health.
* Services for individuals with Intellectual Developmental Disorders (IDD)
* Services for youth
* Services for Veterans
* Crisis Services/MCOT: adults, adolescents, and children.
* Substance abuse prevention, intervention, or treatment.
* Services for Co-occurring disorders.

• Screening/Assessment/ Intake: adults, adolescents, and children. |
| Pecan Valley Centers(Weatherford Clinic)  | 1715 Santa Fe Dr. Weatherford, TX 76086 | Parker  | * Texas Resilience and Recovery (TRR) outpatient services: adults, adolescents, and children.
* Integrated healthcare: mental and physical health.
* Services for individuals with Intellectual Developmental Disorders (IDD)
* Services for youth
* Services for Veterans
* Crisis Services/MCOT: adults, adolescents, and children.
* Substance abuse prevention, intervention, or treatment.
* Services for Co-occurring disorders.
 |
| Pecan Valley Centers(Granbury Intake)  | 108 Pirate Dr. Granbury, TX 76048 | Hood  | * Screening/Assessment/Intake: adults, adolescents, and children.
* Texas Resilience and Recovery (TRR) outpatient services: adults, adolescents, and children.
* Crisis Services/MCOT: adults, adolescents, and children.
 |
| Pecan Valley Centers(Green Street Crisis Respite Unit)  | 532 Green Street Stephenville, TX 76401 | Erath | * Crisis Stabilization Unit
* Texas Resilience and Recovery (TRR) outpatient services: adults.
* Screening/Assessment/Intake: adults, adolescents, and children.
* Services for Individuals with Intellectual Developmental Disorders (IDD)
 |
|  |  |  |  |

## I.B Mental Health Grant Program for Justice Involved Individuals

## The Mental Health Grant Program for Justice-Involved Individuals is a grant program authorized by Senate Bill (S.B.) 292, 85th Legislature, Regular Session, 2017, to reduce recidivism rates, arrests, and incarceration among individuals with mental illness, as well as reduce the wait time for individuals on forensic commitments. These grants support community programs by providing behavioral health care services to individuals with a mental illness encountering the criminal justice system and facilitate the local cross-agency coordination of behavioral health, physical health, and jail diversion services for individuals with mental illness involved in the criminal justice system.

*In the table below, describe the LMHA or LBHA S.B. 292 projects; indicate N/A if the LMHA or LBHA does not receive funding. Add additional rows if needed.*

| Fiscal Year | Project Title (include brief description) | County(s) | Population Served | Number Served per Year |
| --- | --- | --- | --- | --- |
|  | N/A  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

## l. C Community Mental Health Grant Program - Projects related to Jail Diversion, Justice Involved Individuals, and Mental Health Deputies

The Community Mental Health Grant Program is a grant program authorized by House Bill (H.B.) 13, 85th Legislature, Regular Session, 2017. H.B. 13 directs HHSC to establish a state-funded grant program to support communities providing and coordinating mental health treatment and services with transition or supportive services for persons experiencing mental illness. The Community Mental Health Grant Program is designed to support comprehensive, data-driven mental health systems that promote both wellness and recovery by funding community-partnership efforts that

provide mental health treatment, prevention, early intervention, and/or recovery services, and assist with persons with transitioning between or remaining in mental health treatment, services, and supports.

*In the table below, describe the LMHA or LBHA H.B. 13 projects related to jail diversion, justice involved individuals and mental health deputies; indicate N/A if the LMHA or LBHA does not receive funding. Add additional rows if needed.*

| Fiscal Year | Project Title (include brief description) | County  | Population Served | Number Served per Year |
| --- | --- | --- | --- | --- |
| FY21 | HB 13 In-patient Substance Abuse Treatment | Johnson, Parker, Hood, Palo Pinto, Erath, Somervell | SUD | 17 |
|  |  |  |  |  |
|  |  |  |  |  |

## I.D Community Participation in Planning Activities

*Identify community stakeholders who participated in comprehensive local service planning activities.*

|  | **Stakeholder Type** |  | **Stakeholder Type** |
| --- | --- | --- | --- |
|[x]  Consumers |[x]  Family members |
|[x]  Advocates (children and adult) |[ ]  Concerned citizens/others |
|[x]  Local psychiatric hospital staff*\*List the psychiatric hospitals that participated:** Red River
 |[ ]  State hospital staff*\*List the hospital and the staff that participated:* |
|[x]  Mental health service providers |[x]  Substance abuse treatment providers |
|[ ]  Prevention services providers |[ ]  Outreach, Screening, Assessment, and Referral Centers |
|[x]  County officials*\*List the county and the official name and title of participants:** Parker County Sheriff Larry Fowler
* Hood County Sheriff Roger Deeds
* Johnson County Sheriff Adam King
* Erath County Sheriff
* Somervell County Sheriff Alan West
* Palo Pinto County Sheriff Brett McGuire
 |[x]  City officials*\*List the city and the official name and title of participants:* |
|[ ]  Federally Qualified Health Center and other primary care providers | [ ] [ ]  | Local health departmentsLMHAs/LBHAs*\*List the LMHAs/LBHAs and the staff that participated:*  |
|[x]  Hospital emergency room personnel |[x]  Emergency responders |
|[x]  Faith-based organizations |[x]  Community health & human service providers |
|[x]  Probation department representatives |[x]  Parole department representatives |
|[x]  Court representatives (Judges, District Attorneys, public defenders)*\*List the county and the official name and title of participants:* |[x]  Law enforcement *\*List the county/city and the official name and title of participants:* |
|[x]  Education representatives |[x]  Employers/business leaders |
|[x]  Planning and Network Advisory Committee |[x]  Local consumer peer-led organizations |
|[x]  Peer Specialists |[x]  IDD Providers |
|[x]  Foster care/Child placing agencies |[x]  Community Resource Coordination Groups |
|[x]  Veterans’ organizations |[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

|  |
| --- |
| * Satisfaction Surveys
 |
| * Planning and Network Advisory Committee (PNAC)
 |
| * Trainings across our 6 counties
 |
| * Community Outreach
 |
|  |
|  |

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

|  |
| --- |
| * More counseling services across our 6 counties
 |
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# Section II: Psychiatric Emergency Plan

The Psychiatric Emergency Plan is intended to ensure stakeholders with a direct role in psychiatric emergencies have a shared understanding of the roles, responsibilities, and procedures enabling them to coordinate 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 (to include neighboring LMHAs and LBHAs)
* Users of crisis services and their family members
* Sub-contractors

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

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

##

## II.A Development of the Plan

Describe the process implemented 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, to include contractors where applicable,

* + Ensuring the entire service area was represented, and

* + Soliciting input.

## II.B Utilization of the Crisis Hotline, Role of Mobile Crisis Outreach Teams (MCOT), and the Crisis Response Process

1. How is the Crisis Hotline staffed?
	* During business hours

* + After business hours

* + Weekends/holidays

2. Does the LMHA/LBHA have a sub-contractor to provide the Crisis Hotline services? If, yes, please list the contractor:

* + Yes, Avail Solutions

3. How is the MCOT staffed?

During business hours

* + Pecan Valley Centers has three MCOT teams to cover our service area. Each team is responsible for a two-county region as follows: Erath/Hood, Johnson/Somervell, and Parker/Palo Pinto Counties.

After business hours

* + After business hours, Pecan Valley Centers has one QMHP-CS on call for each of the two county regions. (Erath/Hood, Johnson/Somervell and Parker/Palo Pinto Counties). There is also an LPHA on call 24/7 for clinical consult if needed.

Weekends/holidays

• After business hours, Pecan Valley Centers has one QMHP-CS on call for each of the two county regions. (Erath/Hood, Johnson/Somervell and Parker/Palo Pinto Counties). There is also an LPHA on call 24/7 for clinical consult if needed.

4. Does the LMHA/LBHA have a sub-contractor to provide MCOT services? If yes, please list the contractor:

* + N/A

5. Provide information on the type of follow up MCOT provides (phone calls, face to face visits, case management, skills training, etc.).

* + MCOT does a face to face follow up within 24 hours. If we are unable to locate or they have left the service area we do the follow up via telephone or call for a welfare check. At the follow-up we determine if there is further action needed for this crisis incident or to initiate intake into services. (\*\*Due to COVID-19 most services are provided via telephone but face to face is offered if necessary)

 6. Do emergency room staff and law enforcement routinely contact the LMHA/LBHA when an individual in crisis is identified? If so, please describe MCOT’s role for:

 Emergency Rooms:

* + Emergency rooms in our service area contact our crisis line to request an assessment. If they meet criteria MCOT QMHP-CS is deployed and is face to face within 1 hour. MCOT QMHP-CS then complete Crisis Risk Assessment and makes a recommendation of Hospitalization, Crisis Respite Services, or safety plan. If hospitalization or Respite is required MCOT QMHP-CS facilitate (secure a bed, obtain magistrates order, and ensure transport). If a safety plan is recommended the safety plan is also completed by the MCOT QMHP-CS, individual in crisis and any family or collateral involved in the safety plan. A hospital consultation form is provided to the ED.

Law Enforcement:

* + Law enforcement routinely contact and request crisis services. MCOT response time is face to face within one hour. MCOT staff respond on scene in the community with law enforcement when requested. MCOT QMHP-CS then complete Crisis Risk Assessment and makes a recommendation of Hospitalization, Crisis Respite Services, or safety plan. If hospitalization or Respite is required MCOT QMHP-CS facilitate (secure a bed, obtain magistrates order, and ensure transport). If a safety plan is recommended the safety plan is also completed by the MCOT QMHP-CS, individual in crisis and any family or collateral involved in the safety plan.

7. What is the process for MCOT to respond to screening requests at state hospitals, specifically for walk-ins?

* + There are no state hospitals in our service area.

8. What steps should emergency rooms and law enforcement take when an inpatient level of care is needed?

During business hours:

* + Emergency rooms contact crisis hotline or MCOT line directly to request assessment for hospitalization. MCOT responds face to face within one hour and completes assessment and facilitates resolution.

 After business hours:

* + Emergency rooms contact crisis hotline and deploys crisis on call worker. Crisis on call worker responds face to face within one hour to complete assessment and facilitate resolution.

 Weekends/holidays:

* + Emergency rooms contact crisis hotline and deploys crisis on call worker. Crisis on call worker responds face to face within one hour to complete assessment and facilitate resolution.

9. 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?

* + MCOT completes crisis assessment, determines appropriate resolution. If hospitalization is required, MCOT contacts inpatient psychiatric facilities and secures a bed. MCOT then assists with the memorandum of transfer (if in an emergency room), arranges transportation and completes required paperwork (EDO if patient is involuntary).

10. Describe the community’s process if an individual requires further evaluation and/or medical clearance.

* + MCOT only refers to Emergency room departments if medically necessary. If referred for medical clearance, MCOT then responds to the Emergency department when individual is medically cleared to facilitate crisis resolution.

11. Describe the process if an individual needs admission to a psychiatric hospital.

* + MCOT completes crisis assessment, determines appropriate resolution. If hospitalization is required, MCOT contacts inpatient psychiatric facilities and secures a bed. MCOT then assists with the memorandum of transfer (if in an emergency room), arranges transportation and completes required paperwork (EDO if patient is involuntary).

12. Describe the process if an individual needs facility-based crisis stabilization (i.e., other than psychiatric hospitalization and may include crisis respite, crisis residential, extended observation, or crisis stabilization unit).

* + MCOT responds to location of individual, completes crisis assessment, contacts crisis respite facility, and facilitates transfer by sending assessment to facility and arranging transportation.

13. Describe the process for crisis assessments requiring MCOT to go into a home or alternate location such as a parking lot, office building, school, under a bridge or other community-based location.

* + MCOT completes crisis assessment, determines appropriate resolution. If hospitalization is required, MCOT contacts inpatient psychiatric facilities and secures a bed, arranges transportation and completes required paperwork (EDO if patient is involuntary).

14. If an inpatient bed at a psychiatric hospital is not available:

Where does the individual wait for a bed?

* + Individuals assessed in emergency rooms continue to wait in emergency departments if bed is not available. Individuals assessed in the community are assessed for crisis respite or taken to inpatient facilities by law enforcement.

15. Who is responsible for providing ongoing crisis intervention services until the crisis is resolved or the individual is placed in a clinically appropriate environment at the LMHA/LBHA?

* + MCOT provides face to face and telephone contacts daily or until crisis is resolved.

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

* + Natural supports or ambulance services

#### Crisis Stabilization

What alternatives does the local service area have for facility-based crisis stabilization services (excluding inpatient services)? Replicate the table below for each alternative.

|  |  |
| --- | --- |
| Name of Facility | Green Street Crisis Respite Unit  |
| Location (city and county) | 532 Green Street Stephenville, TX 76401 |
| Phone number | 817-552-2050 |
| Type of Facility (see Appendix A)  | Crisis Respite Unit  |
| Key admission criteria (type of individual accepted) | Adults assessed and identified in mental health crisis  |
| Circumstances under which medical clearance is required before admission | When evidence is observed which suggests a medical concern. Examples include overdose, assault, confused or disoriented, evidence of injuries (ex. head injury) unable to move any parts of body, severe chest pains, abdominal pains, and shortness of breath, Substance use related issues. |
| Service area limitations, if any | Individuals experiencing crisis in or residents of Pecan Valley Centers Region.  |
| Other relevant admission information for first responders  | City Ordinance prohibits the admission of registered sex offenders to Green Street Crisis Respite Unit.  |
| Accepts emergency detentions? | No, Voluntary Admissions Only.  |
| Number of Beds | 12 |

#### Inpatient Care

What alternatives to the state hospital does the local service area have for psychiatric inpatient care for uninsured or underinsured individuals? Replicate the table below for each alternative.

|  |  |
| --- | --- |
| Name of Facility | No such alternatives exist within our service area.  |
| Location (city and county) |  |
| Phone number |  |
| Key admission criteria  |  |
| Service area limitations, if any |  |
| Other relevant admission information for first responders |  |
| Number of Beds |  |
| Is the facility currently under contract with the LMHA/LBHA to purchase beds? |  |
| If under contract, is the facility contracted for rapid crisis stabilization beds (funded under the Psychiatric Emergency Service Center contract or Mental Health Grant for Justice-Involved Individuals), private psychiatric beds, or community mental health hospital beds (include all that apply)? |  |
| If under contract, are beds purchased as a guaranteed set or on an as needed basis? |  |
| If under contract, what is the bed day rate paid to the contracted facility? |  |
| If not under contract, does the LMHA/LBHA use facility for single-case agreements for as needed beds? |  |
| If not under contract, what is the bed day rate paid to the facility for single-case agreements? |  |

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

What local inpatient or outpatient alternatives to the state hospital does the local service area currently have for competency restoration? If not applicable, enter N/A.

Identify and briefly describe available alternatives.

* + We currently have no local alternatives for competency restoration

What barriers or issues limit access or utilization to local inpatient or outpatient alternatives?

* + N/A

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

* + We have a law enforcement liaison that is contacted for continuity of care reasons.

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

* + MCOT staff also operate as liaison between the LMHA and the jail

What plans, if any, are being developed over the next two years to maximize access and utilization of local alternatives for competency restoration?

* + We are working on getting a grant through HHSC for an Outpatient Competency Restoration Program.

Does the 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.)?

* Due to current priority given to forensic admissions, civil bed capacity is limited for community needs. Local alternatives for competency restoration (jail-based and outpatient) will provide the much-needed bed availability for the community.

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

* + Funding to begin the program and staffing for the new positions.

## II.D Seamless Integration of emergent psychiatric, substance use, and physical healthcare treatment and the development of Certified Community Behavioral Health Clinics (CCBHCs)

##

1. What steps have been taken to integrate emergency psychiatric, substance use, and physical healthcare services? Who did the LMHA/LBHA collaborate with in these efforts?
	* Red River Hospital is utilized for outpatient services, and Green Street Crisis Respite Unit is used for voluntary admission. We are also currently working on getting MOU’s with local agencies.

1. What are the plans for the next two years to further coordinate and integrate these services?
	* Care Coordinators are currently being hired to further coordinate mental healthcare and physical healthcare within the clinics.

## II.E Communication Plans

1. What steps have been taken to ensure key information from the Psychiatric Emergency Plan is shared with emergency responders and other community stakeholders?
	* Law Liaison provides ongoing education and training regarding services provided by Pecan Valley Centers.
2. How will the LMHA or LBHA ensure staff (including MCOT, hotline, and staff receiving incoming telephone calls) have the information and training to implement the plan?
	* All MCOT staff are credentialed as QMHP-CS’ upon hire and all QMHP-CS’ receive crisis training on a yearly basis.

## II.F Gaps in the Local Crisis Response System

What are the critical gaps in the local crisis emergency response system? Consider needs in all parts of the local service area, including those specific to certain counties.

|  |  |  |
| --- | --- | --- |
| **County** | **Service System Gaps** | **Recommendations to Address the Gaps** |
| Erath, Somervell, Parker and Palo Pinto Counties | * Dedicated MH deputies are needed in these counties.
 | * Speak with the departments in each county and share the success of these positions with our other counties.
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# Section III: Plans and Priorities for System Development

## III.A Jail Diversion

## The Sequential Intercept Model (SIM) informs community-based responses to the involvement of individuals with mental and substance use disorders in the criminal justice system. The model is most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change.

A link to the SIM can be accessed here:

<https://www.prainc.com/wp-content/uploads/2017/08/SIM-Brochure-Redesign0824.pdf>

In the tables below, indicate the strategies used in each intercept to divert individuals from the criminal justice system and indicate the counties in the service area where the strategies are applicable. List current activities and any plans for the next two years.

|  |  |  |
| --- | --- | --- |
| **Intercept 0: Community Services**Current Programs and Initiatives: | County(s) | Plans for upcoming two years: |
| * 24/7 Crisis Hotline
 | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | * Maintain this 24/7 crisis hotline
 |
| * 24/7 MCOT
 | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | * Maintain a 24/7 MCOT
 |
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| --- | --- | --- |
| **Intercept 1: Law Enforcement**Current Programs and Initiatives: | County(s) | Plans for upcoming two years: |
| * Crisis staff currently respond on scene with law enforcement
 | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | * Continued planning, training and applications for additional resources.
 |
| * Pecan Valley Centers provides TCOLE class 4001 Mental Health Peace Officer Training Quarterly and free of charge to law enforcement
 | * Parker, Hood, Erath and Johnson
 | * Continued planning, training and applications for additional resources.
 |
| * Pecan Valley Centers provides free training and orientation to services to probation, law enforcement, and jail personnel.
 | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | * Continued planning, training and applications for additional resources.
 |
| * 24 hour face to face follow up with all individuals who are not hospitalized.
 | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | * Continued planning, training and applications for additional resources.
 |
| * Law Enforcement Liaison have regular meetings, assist and educate in all areas of law enforcement on mental health/suicide awareness
 | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | * Continued planning, training and applications for additional resources.
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| --- | --- | --- |
| **Intercept 3: Jails/Courts**Current Programs and Initiatives: | County(s) | Plans for upcoming two years: |
| * MH screenings at booking on all individuals arrested
 | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | * Continued planning, training and applications for additional resources.
 |
| * Notification when individual screens positive for mental health
 | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | * Continued planning, training and applications for additional resources.
 |
| * Assessment to determine immediate threat or risk of harm.
 | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | * Continued planning, training and applications for additional resources.
 |
| * Interlocal agreement for LMHA to provide services while individual is incarcerated (Initial psychiatric, Evaluation, Doctor to Doctor, Initial Diagnostic Evaluation, MH Individual Counseling)
 | * Hood, Palo Pinto and Somervell
 | * Continued planning, training and applications for additional resources.
 |
| * Providing services to individuals released from jail or hospital on outpatient commitment
 | * Johnson
 | * Continued planning, training and applications for additional resources.
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| --- | --- | --- |
| **Intercept 4: Reentry**Current Programs and Initiatives: | County(s) | Plans for upcoming two years: |
| • Notification on positive CCQ Matches | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | • Continue to review these matches |
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| **Intercept 5: Community Corrections**Current Programs and Initiatives: | County(s) | Plans for upcoming two years: |
| • Ongoing training for probation and parole staff in the region | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | • |
| • TCOOMMI referrals are on a specialized caseload for parole-specific intensive case management  | * Parker, Palo Pinto, Erath and Hood
 | • Continue to build relationships with criminal justice partners & provide services for parolees |
| • TCOOMMI Program has dedicated intake process in addition providing services for continuity of care | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | • Continue to build relationships with criminal justice partners & provide services for probationers and parolees |
| • TCOOMMI Program director and TCOOMMI case managers work with parole and probation on a regular basis to ensure clients’ needs are met | * Palo Pinto, Parker, Hood, Erath, Somervell and Johnson
 | • Continue to build relationships with criminal justice partners & provide services for probationers and parolees |
| • TJJD serves juveniles on probation that also have mental health needs | * Parker and Hood
 | • Continue to build relationships with criminal justice partners & provide services for juvenile probationers  |
| • |  | • |
| • |  | • |

## III.B Other Behavioral Health Strategic Priorities

##

*The* [*Texas Statewide Behavioral Health Strategic Plan*](https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf) *identifies other significant gaps and goals in the state’s behavioral health services system. The gaps identified in the plan are:*

* *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 3: Coordination across state agencies*
* *Gap 4: Veteran and military service member supports*
* *Gap 5: Continuity of care for individuals exiting county and local jails*
* *Gap 6: Access to timely treatment services*
* *Gap 7: Implementation of evidence-based practices*
* *Gap 8: Use of peer services*
* *Gap 9: Behavioral health services for individuals with intellectual disabilities*
* *Gap 10: Consumer transportation and access*
* *Gap 11: Prevention and early intervention services*
* *Gap 12: Access to housing*
* *Gap 13: Behavioral health workforce shortage*
* *Gap 14: Services for special populations (e.g., youth transitioning into adult service systems)*
* *Gap 15: Shared and usable data*

*The goals identified in the plan are:*

* *Goal 1: Program and Service Coordination - Promote and support behavioral health program and service coordination to ensure continuity of services and access points across state agencies.*
* *Goal 2: Program and Service Delivery - Ensure optimal program and service delivery to maximize resources in order to effectively meet the diverse needs of people and communities.*
* *Goal 3: Prevention and Early Intervention Services - Maximize behavioral health prevention and early intervention services across state agencies.*
* *Goal 4: Financial Alignment - Ensure that the financial alignment of behavioral health funding best meets the needs across Texas.*
* *Goal 5: Statewide Data Collaboration – Compare statewide data across state agencies on results and effectiveness.*

 *In the table below briefly describe the current status of each area of focus as identified in the plan (key accomplishments, challenges and current activities), and then summarize objectives and activities planned for the next two years.*

| **Area of Focus** | **Related Gaps and Goals from Strategic Plan** | **Current Status** | **Plans** |
| --- | --- | --- | --- |
| Improving access to timely outpatient services | * Gap 6
* Goal 2
 | * All intakes are now open 5 days a week, utilizing an open access model.
 | * Continue using open access model.
 |
| Improving continuity of care between inpatient care and community services and reducing hospital readmissions | * Gap 1
* Goals 1,2,4
 | * We have a dedicated Continuity of Care Coordinator for Mental Health and for Intellectual Developmental Disabilities programs. COC helps coordinates transitions from inpatient back to community.
 | * Expand list of contracted hospitals closer to our designated region.
 |
| Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community and reducing other state hospital utilization | * Gap 14
* Goals 1,4
 | * Continuity of Care Coordinator and Intake/ Crisis Staff Coordinate care in order to bring clients into most appropriate program.
 | * Newly Developed programs are Assisted Outpatient Therapy (AOT) and First Episode Psychosis (FEP). ACT and SUD Programs will be continued as needed.
 |
| Implementing and ensuring fidelity with evidence-based practices | * Gap 7
* Goal 2
 | * Fidelity is monitored by Monthly Supervision, QM Chart Audits, and UM Authorizations.
 | * Program Supervisors to begin monitoring for fidelity within the programs.
 |
| Transition to a recovery-oriented system of care, including use of peer support services  | * Gap 8
* Goals 2,3
 | * We currently employee 3 peer providers.
 | * With CCBHC expansion grant we plan to employee an additional 3 peer providers.
 |
| Addressing the needs of consumers with co-occurring substance use disorders | * Gaps 1,14
* Goals 1,2
 | * QMHP-CS’ are currently certified yearly in COPSD and use this to provide skills training to clients.
 | * Continue with expansion of current SUD Program.
 |
| Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers. | * Gap 1
* Goals 1,2
 | * Recent accreditation of CCBHC and in the process of hiring Care Coordinators to continue to “Close the Loop.”
 | * HQI Risk Stratification Tool will be administered to all clients in order to assess Care Coordination needs.
 |
| Consumer transportation and access to treatment in remote areas | * Gap 10
* Goal 2
 | * All 6 of our counties have a high need for consumer transportation to access mental and physical healthcare.
 | * Care Coordinators will begin assisting with transportation needs of our clients if the need is associated with physical or mental healthcare.
 |
| Addressing the behavioral health needs of consumers with Intellectual Disabilities  | * Gap 14
* Goals 2,4
 | * We have an IDD Crisis Intervention Specialist that is responsible for responding to any crisis calls within our 6 counties for those that have an IDD diagnosis.
 | * We have plans to hire a second person to help with behavior supports as well as IDD crisis intervention.
 |
| Addressing the behavioral health needs of veterans  | * Gap 4
* Goals 2,3
 | * We have a Veterans Service Coordinator, he is responsible for networking within our 6 counties, training veteran peer supports, as well as training staff and community on military culture.
 | * We plan to write a grant for a veteran court program.
 |

## III.C Local Priorities and Plans

* *Based on identification of unmet needs, stakeholder input, and internal assessment, identify the 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 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** |
| --- | --- | --- |
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## III.D System Development and Identification of New Priorities

Development of the local plans should include a process to identify local priorities and needs and the resources required for implementation. The priorities should reflect the input of key stakeholders involved in development of the Psychiatric Emergency Plan as well as the broader community. This builds on the ongoing communication and collaboration LMHAs and LBHAs have with local stakeholders. The primary purpose is to support local planning, collaboration, and resource development. The information provides a clear picture of needs across the state and support planning at the state level.

In the table below, identify the local 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.

Provide as much detail as practical for long-term planning and:

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Priority**  | **Need** | **Brief description of how resources would be used** | **Estimated Cost**  |
| *1* | ***Example:*** *Detox Beds* | * *Establish a 6-bed detox unit at ABC Hospital.*
 |  |
| *2* | ***Example:*** *Nursing home care* | * *Fund positions for a part-time psychiatrist and part-time mental health professionals to support staff at ABC Nursing Home in caring for residents with mental illness.*
* *Install telemedicine equipment in ABC Nursing Facility to support long-distance psychiatric consultation.*
 | *
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# Appendix A: Levels of Crisis Care

**Admission criteria** – Admission into services is determined by the individual’s level of care as determined by the TRR Assessment found [here](https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf) for adults or [here](https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-child.pdf) for children and adolescents. The TRR assessment tool is comprised of several modules used in the behavioral health system to support care planning and level of care decision making. High scores on the TRR Assessment module, such as items of Risk Behavior (Suicide Risk and Danger to Others) or 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, MCOT, or other crisis services.

**Crisis Residential** **Units**– provide community-based residential crisis treatment to individuals with a moderate to mild risk of harm to self or others, who may have fairly severe functional impairment, and whose symptoms cannot be stabilized in a less intensive setting. Crisis residential facilities are not authorized to accept individuals on involuntary status.

**Crisis Respite Units** –provide community-based residential crisis treatment for individuals who have low risk of harm to self or others, and who may have some functional impairment. Services may occur over a brief period of time, such as two hours, and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons they care for to avoid mental health crisis. Crisis respite facilities are not authorized to accept individuals on involuntary status.

**Crisis Services** – Crisis services are brief interventions provided in the community that ameliorate the crisis 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.

**Crisis Stabilization Units (CSU) –** are the only licensed facilities on the crisis continuum and may accept individuals on emergency detention or orders of protective custody. CSUs offer the most intensive mental health services on the crisis facility continuum by providing short-term crisis treatment to reduce acute symptoms of mental illness in individuals with a high to moderate risk of harm to self or others.

**Extended Observation Units (EOU)** – provide up to 48-hours of emergency services to individuals in mental health crisis who may pose a high to moderate risk of harm to self or others. EOUs may accept individuals on emergency detention.

**Mobile Crisis Outreach Team (MCOT)** – MCOTs 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)** – PESCs provide immediate access to assessment, triage and a continuum of stabilizing treatment for individuals with behavioral health crisis. 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 and 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 proximity to a licensed hospital. 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.

 **Rapid Crisis Stabilization and Private Psychiatric 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.

# Appendix B: Acronyms

**CSU** Crisis Stabilization Unit

**EOU** Extended Observation Units

**HHSC** Health and Human Services Commission

**LMHA** Local Mental Health Authority

**LBHA** Local Behavioral Health Authority

**MCOT** Mobile Crisis Outreach Team

**PESC** Psychiatric Emergency Service Center