Department of State Health Services

Form O

Consolidated Local Service Plan (CLSP)

for Local Mental Health Authorities

March 2018

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## 

## Introduction

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

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

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

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

# Section I: Local Services and Needs

## I.A. Mental Health Services and Sites

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

| **Operator (LMHA or Contractor Name)** | **Street Address, City, and Zip** | **County** | **Services & Populations** |
| --- | --- | --- | --- |
| Pecan Valley Centers | 906 Lingleville Hwy.  Stephenville, 76401 | Erath | * Full levels of care: adults, children * Telehealth: screening/assessment/intake: adults, children * Crisis services provided to adults and children regardless of current client status. |
| Pecan Valley Centers | 532 W Green St.  Stephenville, 76401 | Erath | * Crisis respite unit |
| Pecan Valley Centers | 104 Pirate Dr.  Granbury, 76048 | Hood | * Full levels of care: adults, children * Crisis services: adults, children |
| Pecan Valley Centers | 108 Pirate Dr.  Granbury, 76048 | Hood | * Full levels of care: adults, children * Telehealth: screening/assessment/intake: adults, children * Crisis services provided to adults and children regardless of current client status. |
| Pecan Valley Centers | 1601 N Anglin St.  Cleburne, 76031 | Johnson | * Screening/assessment/intake: adults, children * Crisis services, MCOT: adults, children |
| Pecan Valley Centers | 214 SW 26th Ave., Ste. A  Mineral Wells, 76068 | Palo Pinto | * Routine/intensive case management: adults * Crisis services, MCOT: adults, children |
| Pecan Valley Centers | 1715 Santa Fe Dr.  Weatherford, 76086 | Parker | * Full levels of care: adults, children * Telehealth: screening/assessment/intake: adults, children * Crisis services: adults, children |
| Pecan Valley Centers | 1429 Clear Lake Rd., Ste.200  Weatherford, 76087 | Parker | * Screening/assessment/intake: adults, children * Crisis services, MCOT: adults, children |
| Pecan Valley Centers | 301 Bo Gibbs  Glen Rose, 76043 | Somervell | * Routine/intensive case management: adults |

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

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

| **1115 Waiver Projects** | | | | |
| --- | --- | --- | --- | --- |
| **RHP Region(s)** | **Project Title (include brief description if needed)** | **Years of Operation** | **Capacity** | **Number Served/ Year** |
| 10 | Integrated Care | 3 | 150 | 418 |
| 10 | Expand Specialty Care Capacity | 3 | 28 | 1956 |
| 10 | Extended Hours & Transport (Weatherford, Granbury) | 2 | 32 | 333 |
| 10 | Crisis Respite | 3 | 12 | 213 |
| 11 | Expand Specialty Care Capacity \*consolidated under Region 10 in FY17/DY6 | \* | \* | \* |
|  |  |  |  |  |
|  | **Note: Project activities will be integrated into services consistent with guidelines established for current DSRIP demonstration year.** |  |  |  |
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## I.C Community Participation in Planning Activities

*Identify community stakeholders who participated in your comprehensive local service planning activities over the past year.*

|  | **Stakeholder Type** |  | **Stakeholder Type** |
| --- | --- | --- | --- |
|  | Consumers |  | Family members |
|  | Advocates (children and adult) |  | Concerned citizens/others |
|  | Local psychiatric hospital staff |  | State hospital staff |
|  | Mental health service providers |  | Substance abuse treatment providers |
|  | Prevention services providers |  | Outreach, Screening, and Referral (OSAR) |
|  | County officials |  | City officials |
|  | FQHCs/other primary care providers |  | Local health departments |
|  | Hospital emergency room personnel |  | Emergency responders |
|  | Faith-based organizations |  | Community health & human service providers |
|  | Probation department representatives |  | Parole department representatives |
|  | Court representatives (judges, DAs, public defenders) |  | Law enforcement |
|  | Education representatives |  | Employers/business leaders |
|  | Planning and Network Advisory Committee |  | Local consumer-led organizations |
|  | Veterans’ organization |  |  |

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

|  |
| --- |
| * More counseling services in their counties |
| * More clinics convenient to client’s locations |
| * Additional mental health and substance abuse services in Palo Pinto County |
| * Additional clinic appointment times |
|  |
|  |

# Section II: Psychiatric Emergency Plan

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

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

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

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

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

## II.A Development of the Plan

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

* Ensuring all key stakeholders were involved or represented
* Ensuring the entire service area was represented
* Soliciting input
* Stakeholders are informed about emergency planning. Stakeholders include law enforcement, emergency department staff, jail administrators, and court representatives. Meetings occur quarterly and as needed throughout the service area. Topics discussed include needs assessment, training, education and updates on policy and collaborative solutions to difficult situations. This group also routinely submits collaborative applications for additional resources.

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

1. How is your MCOT service staffed?
   1. During business hours
   * Pecan Valley Centers has three MCOT teams to cover our service area. A four person team dedicated to Erath, and Hood Counties. A four person team dedicated to Parker and Palo Pinto Counties and a three person team dedicated to Johnson and Somervell Counties.
2. After business hours

* After business hours, Pecan Valley Centers has one QMHP-CS on call in Erath and Hood Counties, one QMHP-CS on call for Parker and Palo Pinto counties and one QMHP-CS on call for Somervell and Johnson Counties. Additionally, there is an administrative supervisor on call 24/7.
  1. Weekends/holidays

1. Pecan Valley Centers has one QMHP-CS on call in Erath and Hood Counties, one QMHP-CS on call for Parker and Palo Pinto counties and one QMHP-CS on call for Somervell and Johnson Counties. Additionally, there is an administrative supervisor on call 24/7.
2. What criteria are used to determine when the MCOT is deployed?

* Crisis hotline completes risk and/or lethality screening and deploys MCOT when indicated.

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

* MCOT completes the crisis assessment and determines resolution. MCOT completes face to face follow up within 24 hours and daily thereafter until crisis is resolved. When crisis is resolved, individuals are referred to appropriate level of care which includes transitional services, traditional LMHA services or private provider services.

1. Describe MCOT support of emergency rooms and law enforcement:
   1. Do emergency room staff and law enforcement routinely contact the LMHA when an individual in crisis is identified? If so, is MCOT routinely deployed when emergency rooms or law enforcement contact the LMHA?
   * Emergency rooms: All emergency departments in our service area contact the crisis hotline when an individual in crisis is identified. Crisis response is face to face within 1 hour.
   * 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.
   1. What activities does the MCOT perform to support emergency room staff and law enforcement during crises?
   * Emergency rooms: MCOT responds face to face at Emergency departments when requested. All face to face responses initiate a crisis risk assessment to determine immediate threat of harm or danger. Once the assessment is complete, crisis staff determine appropriate resolution (safety plan, crisis respite services, hospitalization). If hospitalization is warranted, crisis staff locate and facilitate a transfer to a psychiatric facility.
   * Law enforcement: MCOT responds on scene with law enforcement when requested. All face to face responses initiate a crisis risk assessment to determine immediate threat of harm or danger. Once the assessment is complete, crisis staff determine appropriate resolution (safety plan, crisis respite services, hospitalization). If hospitalization is warranted, crisis staff locate and facilitate a transfer to a psychiatric facility.
2. 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?
   1. Describe your community’s process if a client needs further assessment 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.
   1. Describe the process if a client needs admission to a 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).
   1. Describe the process if a client needs facility-based crisis stabilization (i.e., other than hospitalization–may include crisis respite, crisis residential, extended observation, etc.):
   * MCOT responds to location of individual, completes crisis assessment, contacts crisis respite facility, and facilitates transfer by sending assessment to facility and arranging transportation.
3. What steps should emergency rooms and law enforcement take when an inpatient level of care is needed?
   1. During business hours
   2. Emergency rooms and law enforcement 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.
   3. After business hours
   * Emergency rooms and law enforcement contact crisis hotline and deploys crisis on call worker. Crisis on call worker responds face to face within 1 hour to complete assessment and facilitate resolution.
   1. Weekends/holidays
   * Emergency rooms and law enforcement contact crisis hotline and deploys crisis on call worker. Crisis on call worker responds face to face within 1 hour to complete assessment and facilitate resolution.
4. If an inpatient bed is not available:
   1. Where is an individual taken while waiting 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.
   1. Who is responsible for providing continued crisis intervention services?
   * MCOT provides face to face and telephone contacts daily or until crisis is resolved.
   1. Who is responsible for continued determination of the need for an inpatient level of care?
   * If the individual remains in an emergency department or med surge facility, MCOT reassess the need for inpatient services every 24 hours until bed is available or no longer needed.
   1. Who is responsible for transportation in cases not involving emergency detention?
   * Natural supports or ambulance services

#### Crisis Stabilization

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

| Name of Facility | Green Street Crisis Respite Unit |
| --- | --- |
| Location (city and county) | 535 Green Street Stephenville, Texas 76401 |
| Phone number | 254-552-2050 |
| Type of Facility (see Appendix B) | Facility based crisis respite |
| Key admission criteria (type of patient 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. |
| Service area limitations, if any | Individuals experiencing crisis in or residents of Pecan Valley catchment area. |
| Other relevant admission information for first responders | City ordinance prohibits the admission of registered sex offenders to respite. |
| Accepts emergency detentions? | No, voluntary admissions only. |

#### Inpatient Care

1. What alternatives to the state hospital does your service area have for psychiatric inpatient care for medically indigent? Replicate the table below for each alternative.

| Name of Facility | 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 |  |

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

1. What local inpatient or outpatient alternatives to the state hospital does your service area currently have for competency restoration?
   1. Identify and briefly describe available alternatives.
   * We currently have no local alternatives for competency restoration
   1. What barriers or issues limit access or utilization to local inpatient or outpatient alternatives? If not applicable, enter N/A.
   * N/A
   1. Does the LMHA have a dedicated jail liaison position? If so, what is the role of the jail liaison? At what point is the jail liaison engaged?
   * No

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

* + MCOT staff operate as a liaison between the LMHA and the jail.
  1. What plans do you have over the next two years to maximize access and utilization of local alternatives for competency restoration? If not applicable, enter N/A.
  + N/A

1. Does your community have a need for new alternatives for competency restoration? If so, what kind of program would be suitable (i.e., Outpatient Competency Restoration Program, inpatient competency restoration, jail-based competency restoration, etc.)?

* 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.

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

* Staffing, funding, facility and support.

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

1. What steps have been taken to integrate emergency psychiatric, substance use, and physical healthcare services?

* An open access model has been adopted for mental health services including the completion of the Columbia Suicide Severity Rating Scale and referrals for treatment of substance use on all individuals who present for services.
* The Weatherford Clinic has been licensed as substance use treatment facility to integrate the provision of substance abuse services with clinical services.
* A grant has been secured to provide detoxification and inpatient treatment to clients without insurance or a means to pay for a private treatment facility.

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

* Pecan Valley Centers will work with local indigent care clinics to identify sustainable ways to integrate mental health services in a primary care setting.
* Expand outpatient substance use treatment throughout other Pecan Valley Centers locations.

## II.E Communication Plans

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

* Pecan Valley Centers will continue to communicate with stakeholders through community partner meetings, collaborations, and will provide information via website, brochures, and community presentations.

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

* All employees have access to “Relias” online training and receive email alerts on upcoming training routinely.

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

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

| **Counties** | **Service System Gaps** |
| --- | --- |
| Erath, Somervell, Parker and Palo Pinto Counties | * Dedicated MH deputies are needed in these counties. |

# Section III: Plans and Priorities for System Development

## III.A Jail Diversion

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

| **Intercept 1: Law Enforcement and Emergency Services** | |
| --- | --- |
| **Components** | **Current Activities** |
| Co-mobilization with Crisis Intervention Team (CIT)  Co-mobilization with Mental Health Deputies  Co-location with CIT and/or MH Deputies  Training dispatch and first responders  Training law enforcement staff  Training of court personnel  Training of probation personnel  Documenting police contacts with persons with mental illness  Police-friendly drop-off point  Service linkage and follow-up for individuals who are not hospitalized  Other: Click here to enter text. | * Crisis staff currently respond on scene with law enforcement. * Pecan Valley Centers provides TCOLE class 4001 Mental Health Peace Officer training quarterly and free of charge to law enforcement. * Pecan Valley Centers provides free training and orientation to services to probation, law enforcement, and jail personnel. * 24 hour face to face follow up with all individuals who are not hospitalized. |
| **Plans for the upcoming two years:**   * Continued planning, training and applications for additional resources. | |

| **Intercept 2: Post-Arrest: Initial Detention and Initial Hearings** | |
| --- | --- |
| **Components** | **Current Activities** |
| Staff at court to review cases for post-booking diversion  Routine screening for mental illness and diversion eligibility  Staff assigned to help defendants comply with conditions of diversion  Staff at court who can authorize alternative services to incarceration  Link to comprehensive services  Other: Click here to enter text. | * Pre-trial diversion programs available in parts of our service area. * MH screenings at booking on all individuals arrested. * Notification when individual screens positive for mental illness. |
| **Plans for the upcoming two years:**   * Continued planning, training and applications for additional resources. | |

| **Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments** | |
| --- | --- |
| **Components** | **Current Activities** |
| Routine screening for mental illness and diversion eligibility  Mental Health Court  Veterans’ Court  Drug Court  Outpatient Competency Restoration  Services for persons Not Guilty by Reason of Insanity  Services for persons with other Forensic Assisted Outpatient Commitments  Providing services in jail for persons Incompetent to Stand Trial  Compelled medication in jail for persons Incompetent to Stand Trial  Providing services in jail (for persons without outpatient commitment)  Staff assigned to serve as liaison between specialty courts and services providers  Link to comprehensive services  Other: Providing services for persons with outpatient commitment. | * Assessment to determine immediate threat or risk of harm. * Providing services to individuals released from jail or hospital on outpatient commitment. |
| **Plans for the upcoming two years:**   * Continued identification of needs and applications for resources. | |

| **Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization** | |
| --- | --- |
| **Components** | **Current Activities** |
| Providing transitional services in jails  Staff designated to assess needs, develop plan for services, and coordinate transition to ensure continuity of care at release  Structured process to coordinate discharge/transition plans and procedures  Specialized case management teams to coordinate post-release services  Other: Notification on positive CCQ Matches |  |
| **Plans for the upcoming two years:**   * Continued identification of needs and obtain resources. | |

| **Intercept 5: Community corrections and community support programs** | |
| --- | --- |
| **Components** | **Current Activities** |
| Routine screening for mental illness and substance use disorders  Training for probation or parole staff  TCOOMMI program  Forensic ACT  Staff assigned to facilitate access to comprehensive services; specialized caseloads  Staff assigned to serve as liaison with community corrections  Working with community corrections to ensure a range of options to reinforce positive behavior and effectively address noncompliance  Other: | * Ongoing training for probation and parole staff in region * TCOOMMI referrals are on a specialized caseload for parole-specific intensive case management * TCOOMMI program has a dedicated intake process in addition providing services * TCOOMMI program director and TCOOMMI case managers work with parole and probation on a regular basis to ensure clients’ needs are met |
| **Plans for the upcoming two years:**   * Continue to build relationships with criminal justice partners & provide services for probationers and parolees * Expand TCOOMMI program by adding two more TCOOMMI case managers to include an intensive case manager in Johnson County and a probation caseload. | |

## 

## III.B Other System-Wide Strategic Priorities

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

| **Area of Focus** | **Current Status** | **Plans** |
| --- | --- | --- |
| Improving continuity of care between inpatient care and community services | * MCOT to assess for hospitalization and refer to least restrictive environment when appropriate. | * Continue Crisis intervention, crisis follow up, and admissions to crisis respite. |
| Reducing hospital readmissions | * Currently monitor and receive updates on individuals while inpatient. Defer to Hospital staff to determine appropriate length of stay. | * Continue to monitor and engage individuals discharged from hospital to prevent re-hospitalization. |
| Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community | * Pecan Valley Centers Continuity of Care collaborates with state hospital staff and  community providers to facilitate discharge planning that will promote community tenure | * Continuity of Care will continue to network with state hospital staff via onsite, telephonic, and electronic communications to assist hospital social workers in community placement. * Enroll and engage individuals discharged from inpatient to outpatient ACT, Peer Support, Support Employment, and Supported housing services to better serve clients at highest risk of readmission. |
| Reducing other state hospital utilization | * Services are tailored to the individual needs based on the adult needs and strengths assessment followed by clinically appropriate recovery planning. | * Additional tools and strategies will be applied as they become available and determined to be appropriate. |
| Tailoring service interventions to the specific identified needs of the individual | * All employees receive training in Person Centered Recovery Planning. Recovery Plans should be tailored to the needs of the clients and the interventions listed. | * Additional tools and strategies will be applied as they become available and determined to be appropriate. |
| Ensuring fidelity with evidence-based practices | * Pecan Valley Centers ensures staff are trained and supervised on appropriate evidence-based practices such as ACT, Illness Management and Recover, and other services. * Services are provided throughout our service area. * Staff are focused on implementation of trauma informed care. | * Additional tools and strategies will be applied as they become available and determined to be appropriate. |
| Transition to a recovery-oriented system of care, including development of peer support services and other consumer involvement in Center activities and operations (e.g., planning, evaluation) | * PVC has expanded peer services to include a peer provider or family partner in all counties. * PVC has incorporated consumer representation in Trauma Informed Care work. * Implementation of a customer satisfaction tool allows consumer feedback and input into service improvements. | * Additional tools and strategies will be applied as they become available and determined to be appropriate. |
| Addressing the needs of consumers with co-occurring substance use disorders | * PVC has obtained funding for 28 day in-patient co-occurring substance use treatment. * All potential clients get a single item assessment for alcohol abuse at initial intake. * If positive at intake, case managers can request additional assessment and referral to treatment. | * Seek additional resources and funding to expand the system of care for consumers with co-occurring substance use & psychiatric disorders. * Expand our use of in-house substance abuse treatments. * Build collaborations with outside providers as needed to provide services not available at PVC. |
| Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers. | * Case managers assist clients in searching for and identifying appropriate primary care providers or connect with indigent care or community clinics if appropriate. | * Pecan Valley Centers will work with local indigent care clinics to identify sustainable ways to integrate mental health services in a primary care setting. |

## III.C Local Priorities and Plans

* *Based on identification of unmet needs, stakeholder input, and your internal assessment, identify your top local priorities for the next two years. These might include changes in the array of services, allocation of resources, implementation of new strategies or initiatives, service enhancements, quality improvements, etc.*
* *List at least one but no more than five priorities.*
* *For each priority, briefly describe current activities and achievements and summarize your plans for the next two years. If local priorities are addressed in the table above, list the local priority and enter “see above” in the remaining two cells.*

| **Local Priority** | **Current Status** | **Plans** |
| --- | --- | --- |
| Substance use treatment | * PVC has obtained funding for 28 day in-patient co-occurring substance use treatment. * Recently licensed one clinic as a treatment facility * Identify and refer clients not eligible for current programing to local resources for treatment of substance use disorders. | * Seek additional resources and funding to expand the system of care for consumers with co-occurring substance use & psychiatric disorders. |

## III.D Priorities for System Development

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

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

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

| **Priority** | **Need** | **How resources would be used (brief)** | **Estimated Cost** |
| --- | --- | --- | --- |
| *1* | ***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.* |  |
| 1 | Substance Use Disorders program | * Hire additional staff, including LCDC-licensed staff to provide treatment and support for individuals identified with co-occurring disorders. | * $193,000 annually year needed for initial and ongoing salaries and materials. |
| 1 | Youth Services Capacity | * Resources would be used to expand PVC’s regional capacity to serve eligible youth and their families. * Additional staff would include medical staff (MD/ANP and LVN), case managers for TRR services as well as wrap facilitators and family partners for YES waiver services. | * $400,000 annually |

Appendix A: Levels of Crisis Care

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

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

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

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

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

**Crisis Stabilization Units (CSU) –** Crisis Stabilization Units are licensed facilities that provide 24/7 short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected, clinically staffed, psychiatrically supervised, treatment environment that complies with a Crisis Stabilization Unit licensed under Chapter 577 of the Texas Health and Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code. CSUs may accept individuals that present with a high risk of harm to self or others.

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

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

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

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

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