Bluebonnet Trails
Community Mental Health & Mental Retardation Center

Bluebonnet Trails Community MHMR Center

Crisis Services Plan

For Fiscal Year 2008

Presented to:

TEXAS
Department of State Health Services

December 28, 2007

Bluebonnet Trails
Community Mental Health & Mental Retardation Center

Bluebonnet Trails Community MHMR Center

Crisis Services Plan

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Crisis Services Plan

Introduction: Bluebonnet Trails Community MHMR Center.

Bluebonnet Trails Community Mental Health Mental Retardation Center (the Center) was formed in 1996 through an interlocal governmental agreement among the six counties of Bastrop, Burnet, Caldwell, Fayette, Lee and Williamson. After well-attended public hearings, and at the request of these counties, the Center was legally established as a community mental health mental retardation center in 1997 by the Texas Department of Mental Health and Mental Retardation. During September 2000, Gonzales and Guadalupe Counties joined the Center establishing the current eight-county service area in which the Center is designated by the State of Texas as the local mental health and mental retardation authority.

The Center is governed by a Board of Trustees appointed by the County Judges and Commissioners' Courts from each of the eight counties. The Trustees work in responsible and accountable cooperation with local and state government and citizens of their counties to ensure the needs of the communities are heard and considered in the strategic planning and development for the Center. The members of the Board of Trustees volunteer their time, experience and talents during regular monthly meetings as well as during Center events and discussions with our community leaders. The Center is fortunate to have the following dedicated individuals to govern our Center in providing high quality, efficient services to persons whose lives are seriously affected by mental disorders, substance abuse disorders and developmental disabilities:

Bob Heinrich, Chair -- Representing Fayette County
Hartley Sappington, Vice Chair – Representing Williamson County
Marilyn Price, Secretary – Representing Gonzales County
Barbara Bogart – Representing Bastrop County
Judge Martin McLean – Representing Burnet County
Judge H. T. Wright – Representing Caldwell County
Shirley Hester – Representing Guadalupe County
Mayor Robert Willrich – Representing Lee County

Today, the Center serves as the local mental health and mental retardation authority in eight counties with a population density of over 672,000 persons and a land mass of approximately 6,910 square miles.

County	Estimated Census: Year 2006	Square Mileage: Year 2000	Population Change: Years 2000 to 2006
Bastrop County	71,684	888.35	12.70%
Burnet County	42,896	996.04	25.70%
Caldwell County	36,720	545.73	14.10%
Fayette County	22,521	950.03	3.30%
Gonzales County	19,566	1,067.75	5.00%
Guadalupe County	108,410	711.14	21.80%
Lee County	16,573	628.50	5.90%
Williamson County	353,830	1,122.77	41.50%
Totals (Statistics of the US Census Bureau)	672,200	6,910.31	Average Growth Rate: 16.25%

Center services are provided to adults with serious mental illness and chemical dependency; to children and adolescents with serious mental illness or emotional disorders, chemical dependency, autism or pervasive developmental disorders; to persons with mental retardation; and to infants and toddlers with developmental delays.

The Department of State Health Services and the Department of Aging and Disability Services annually contract with the Center to function as the mental health and mental retardation authority for the counties of Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee and Williamson. The authority role holds the Center accountable for ensuring access to needed services for persons meeting the eligibility criteria established by the state. Along with defining the eligibility criteria of the persons authorized to receive services, the Departments define, through their contracts with the Center, the services that may be provided. In addition to providing mental health and mental retardation services, the Center focuses on ensuring access to substance abuse services. The Center operates as the Outreach, Screening, Assessment and Referral (OSAR) entity in the Texas Health and Human Services Commission Region 7. As the OSAR, the Center serves twenty-four counties in Central Texas, including six of the eight counties in which the Center provides mental health and mental retardation services. The Department of State Health Services oversees the OSAR program. The goal of the OSAR program is to support prevention services and provide access to effective treatment for persons with chemical dependency. The twenty-four counties served by the program encompass a population density of just under 2.3 million persons and a land mass of approximately 20,000 square miles. The following describes the counties served by the OSAR program.

County * Indicates County in Which the Center provided MHMR Services in Addition to Substance Abuse Services	Estimated Census: Year 2006	Square Mileage: Year 2000	Population Change: Years 2000 - 2006
* Bastrop County	71,684	888.35	12.70%
Bell County	257,897	1059.72	8.40%
Blanco County	9,250	711.24	9.90%
Brazos County	159,006	585.78	4.30%
Burleson County	16,932	665.54	2.80%
* Burnet County	42,896	996.04	25.70%
* Caldwell County	36,720	545.73	14.10%
Coryell County	72,667	1051.76	-3.10%
* Fayette County	22,521	950.03	3.30%
Grimes County	25,552	793.6	8.50%

Hamilton County	**8,186**	**835.71**	**-0.50%**
Hays County	**130,325**	**677.87**	**33.60%**
Lampasas County	**20,758**	**712.04**	**16.90%**
*** Lee County**	**16,573**	**628.5**	**5.90%**
Leon County	**16,538**	**1072.04**	**7.80%**
Llano County	**18,269**	**934.76**	**7.10%**
Madison County	**13,310**	**469.65**	**2.90%**
Milam County	**25,286**	**1016.71**	**4.30%**
Mills County	**5,184**	**748.11**	**0.60%**
Robertson County	**16,214**	**854.56**	**1.40%**
San Saba County	**5,993**	**1134.47**	**-3.10%**
Travis County	**921,006**	**989.3**	**13.40%**
Washington County	**31,912**	**609.22**	**5.10%**
*** Williamson County**	**353,830**	**1122.77**	**41.50%**
Totals (Statistics of the US Census Bureau)	**2,298,509**	**20,053.50**	**Average Growth Rate: 9.31%**

The Center also contracts with the Department of Assistive and Rehabilitative Services to provide early childhood intervention services (ECI) to children and the families of those children, ages 0 – 3 years, who have developmental problems. ECI services are provided in Bastrop, Burnet, Caldwell, Fayette, Lee and Williamson Counties.

The Opportunity.

During May 2007, the Texas Legislature appropriated $82 million for the biennium, to enhance crisis services systems in Texas. This period of time covers the Center's fiscal years 2008 through 2009. Guided by the Legislature and in response to Rider 69, these funds will allow the State of Texas to make significant progress toward improving the response to mental health and substance abuse crises. The appropriation is intended to specifically support a redesigned crisis service system in Texas allowing local Community MHMR Centers to work with the stakeholders in their communities to determine the best use of the funds.

This Crisis Service Plan acknowledges the collaborative effort to determine the best use of the funds to address the crisis services needs identified by our stakeholders in the counties served by the Center.

Fiscal Year 2008 Overview. From the Fiscal Year 2008 appropriation, Bluebonnet Trails Community MHMR Center will receive $352,932 for the initiation and enhancement of crisis services designated, and defined by standards, by the Department of State Health Services. This initial funding supports nine months of services. The priority for the Center will be to ensure a minimum level of the critical crisis services providing rapid and mobile response to crisis situations. During Fiscal Year 2008, the first phase of implementation will focus on enhancement of the Center's Crisis Hotline Service and continued development of the Mobile Crisis Outreach Services. These services will provide each of our counties with 24-hour crisis response capabilities, including identification, screening and stabilization of patients who can be safely treated in the community. During the year, should our budgeting process identify any unspent funds from the allocation, the unspent funds will be prioritized to address crisis respite services and further development of the Mobile Crisis Outreach Services during Fiscal Year 2008. Secondarily, any remaining unspent funds will be used to address the equipment costs for the Mobile Crisis Outreach Services not currently included in the limited budget.

Crisis Hotline Services. By January 1, 2008, the Center will be contracting for services allowing for a single crisis hotline number, available 24-hours per day. The single hotline will now serve our eight counties in which we provide mental health services, and our twenty-four counties in which we are the OSAR. In addition to providing a single point of access for crisis services, the hotline will foster a more integrated approach to serving the dually diagnosed. The Center will be in compliance with the Department of State Health Services standards for Crisis Hotline Services by January 1, 2008.

Mobile Crisis Outreach Services. By the end of Fiscal Year 2008, the Williamson County Mobile Crisis Outreach Team (MCOT) will be in compliance with the Department of State Health Services standards for Mobile Crisis Outreach Services. The goal during Fiscal Year 2008 for our remaining counties of Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe and Lee Counties is to develop hub services. The locations of the hub services are identified based on historical need, anticipated community need, and demonstrated growth of the areas. During Fiscal Years 2008 and 2009, the Center will develop MCOTs in the hub locations of Bastrop, Burnet and Guadalupe Counties. The MCOT hubs will also serve their neighboring counties:

Bastrop County MCOT Hub:	Bastrop, Fayette and Lee Counties
Burnet County MCOT Hub:	Burnet County with backup for Williamson County
Guadalupe County MCOT Hub:	Caldwell, Gonzales and Guadalupe Counties

For the counties of Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe and Lee, the goal for the Center is to achieve compliance with the Department of State Health Services standards for Mobile Crisis Outreach Services by the end of Fiscal Year 2009.

Competitive Funding Opportunity. In addition, Bluebonnet Trails Community MHMR Center will partner with Williamson County to apply for the Competitive Allocation in order to further enhance our local crisis services delivery system. It is intended that the proposal will support crisis respite or extended observations services benefiting the community by reducing unnecessary incarcerations and inpatient psychiatric interventions; and by relieving the client, family members and law enforcement agencies from unnecessary transportation time and costs. The initial funding will support the development and initial infrastructure for the crisis respite or extended observations services.

Fiscal Year 2009 Overview. During Fiscal Year 2009, the Center anticipates to receive additional funding supporting the full twelve-month period. After assessing the progress and effectiveness of the initial crisis services implemented during 2008, funds will be budgeted to further support achievement of the standards of crisis services defined by the Department of State Health Services. The majority of the resources will be spent on further developing and expanding the Mobile Crisis Outreach Teams within our catchment area. As during Fiscal Year 2008, any unspent funds will be prioritized to address crisis respite services and further development of the Mobile Crisis Outreach Services. The Center establishes as a goal to achieve the Crisis Respite Services standards by the end of the first quarter of Fiscal Year 2010. As noted above, the Center anticipates achieving compliance with the Department of State Health Services standards for Mobile Crisis Outreach Services by the end of Fiscal Year 2009.

Should the Center and Williamson County be successful in the Fiscal Year 2008 application for the Competitive Funding Allocation, funding will be concentrated development of crisis respite or extended observations services for staffing and provision of services to meet the needs of persons in the service area. The Center will establish as a goal to achieve the standards governing the services funded by the Department of State Health Services under this competitive grant by the end of the second quarter of Fiscal Year 2010.

Intended Use of the Crisis Services Plan.

This plan is intended to become an integral part of the Center's Local Plan and will serve as a guiding tool for future planning and discussions with our communities as we continue to enhance crisis services in the counties we serve. The plan will be under continuous, planned and purposeful review and revision to identify and address the ongoing and changing needs of our service area.

Process for Gathering Ideas and Information from Our Stakeholders.

The Center has been fortunate to engage a body of interested and invested stakeholders in developing the initial Crisis Services Plan. Community meetings were held in each of the counties served by the Center and included participants with diverse interests and backgrounds. Each person contributed insight into the needs and gaps in services in our counties. [See Attachment A: Stakeholder Participation, page 1.]

During this initial round of discussions, participants represented: clients, family members, the office of a State Senator, county judges, county commissioners, county district attorneys, county attorneys, county management staff, jail administrators, directors of emergency services, representatives from the sheriffs' offices, adult and juvenile probation, county and city health district, city economic development corporation executives, independent school district representatives, law enforcement agents, local Federally Qualified Health Centers (FQHCs), staff making application for an FQHC, current and potential mental health providers, current chemical dependency treatment providers, community MHMR centers served by the OSAR program, state hospital representatives, the Center Board of Trustees and Center staff. [See Attachment A: Stakeholder Participation, page 4.] Meetings were conducted during the month of October 2007 when the Center received confirmation of the standards for services and funding allocations. The Center acknowledges that, due to the limited timeframe for the meetings, input has not yet been received from key stakeholders.

As the Crisis Services Plan is implemented during the next two years, the Center has established a timeline allowing opportunities to receive input from our stakeholders. [See Attachment B: Crisis Services Redesign Timeline.] Future meetings will be scheduled and conducted during the year to ensure the Center has accurately identified the expressed needs and receives feedback regarding our progress toward achieving our goals. By engaging our stakeholders throughout the implementation of the service design, we will best be able to gauge satisfaction of the delivery of the newly implemented crisis services as well as determine areas needing improvement or better integration with the existing services system.

Identification of the Gaps in Services.

The limited funding for the crisis services redesign supporting the communities served by the Center makes the collaborative effort at the local level a critical strategic component for this crisis plan. Through this crisis planning initiative with our stakeholders, we have identified gaps in successful treatment options for adults, adolescents and children.

As noted above, the eight counties the Center serves as the local mental health authority represent a combined growth rate of 16.25%, a rate well above the state average growth rate of 12.7%. Our stakeholders are well aware of the key healthcare issues and needs resulting from the aggressive growth. The stakeholders communicate the need and desire to proactively and progressively address the identified needs. When meeting with our clients, family members, local officials, law enforcement agents,

community members, healthcare partners and staff, the following issues were routinely identified as the immediate concerns or needs to be addressed during the initial phase of the crisis redesign in our counties:

1. Provide an immediate response to a crisis.
2. Ensure access to effective resources within our communities.
3. Assure effective integration with existing partners and service delivery systems.

Provide an immediate response to a crisis. The most essential element identified through local input was the immediate availability of crisis services to individuals experiencing a mental health emergency. Typically, crisis services provided within our communities initiate the introduction to ongoing mental health and substance abuse services provided through the continuum of care available throughout our service areas. The failure to provide timely and adequate crisis services can lead to unnecessary incarceration or hospitalization of the individual, the disruption and separation of families, and the costly involvement of other community services including law enforcement and the courts. The immediate availability of professionals triaging the persons in crisis via the hotline services as well as with enhanced mobile crisis outreach will greatly contribute to crisis prevention and reducing utilization of more intensive, more restrictive emergency services.

Ensure access to effective resources within our communities. The second need identified through local input focuses on the availability of local resources enabling stabilization of those persons in crisis in their home communities. The costly alternative is to transport or seek services outside the person's home community. Adding to the cost is the tendency to transport persons to the state hospital or into acute care when the level of care identified through the assessment indicates the person may best be served in a less intensive care option. At this time, the less intensive care options do not exist in our communities. Partnerships with local healthcare providers are critical to the success of this goal. The opportunity to provide local stabilization services will alleviate transporting clients to more acute settings away from the home communities. Our ability to provide crisis stabilization in the community is expected to reduce the trauma of the experience for the individual resulting in better and quicker achievement of outcomes; decrease dependence on intensive and restrictive levels of care; enhance the coordination of the services provided to the individual through the local partners; as well as reduce the burden on law enforcement and families for intervention and transportation to acute care settings. As the populations, school systems and roadways/transit systems within our communities grow, the Center focuses on access to prevention and treatment services to meet the increased needs of the areas we serve. Efforts will be made to provide ongoing community education regarding the development of crisis services. In addition, ongoing training opportunities will be pursued to ensure an informed and educated professional staff.

Assure effective integration with existing partners and service delivery systems. Although this issue is incorporated in both issues above, the end result is anticipated to allow the community partners to identify and plan for the needs for healthcare in a realistic, creative, knowledgeable, cost-effective and integrated manner in our communities—without duplicating efforts and systems. In addition to being costly, the duplication of systems causes confusion for the persons we serve, our providers and our communities. The needed integration of physical health, mental health, substance abuse, disaster services and services for returning veterans were noted as key issues during the stakeholder discussions. Better integration of services and service providers will afford our communities a stronger healthcare system able to meet the true needs of our community as well as a combined financial base to support development of less intensive, less costly levels of care.

Furthermore, integrated services must be developed to address the challenges facing families involved

with the veteran, judicial and protective services systems due to mental health disorders and chemical dependency. Mental health and chemical dependency treatment alone will not ensure family reunification and self sufficiency. In particular, service systems addressing domestic violence, primary health care, housing, and employment are central partners in achieving successful outcomes. Collectively, community-based organizations and support systems assist with the prevention of abuse, chemical dependency and related mental health problems. Realizing that inclusion of these partners will be critical to the success of the redesign of crisis services, the Center will invite these partners as key stakeholders.

A Comparison of the Existing and Redesigned Crisis Services Systems.

Before considering the plan to redesign the crisis services system, the Center and stakeholders reviewed the existing system for crisis service response. [See Attachment C: Current Flow of Crisis Services.] Input from key stakeholders allowed the Center to develop a proposal for improving the flow of crisis services and eliminating duplication and fostering integration of existing crisis services. [See Attachment D: Proposed Flow of Crisis Services.] The Center will continually assess the effectiveness of the proposed flow with stakeholders and modify the plan as difficulties and opportunities are identified.

Focus is placed on ensuring integration of the existing crisis and non-crisis service systems in our counties promoting a seamless system without costly duplication of existing services. This initial Crisis Services Plan concentrates on the development and implementation of the required Crisis Hotline and Mobile Crisis Outreach Services. [See Attachment E: Comparison of Existing and Redesigned Crisis Services.]

The Center coordinates with local crisis response and healthcare systems to find alternatives to costly and restrictive crisis services, to divert individuals from incarceration, to plan for available and appropriate treatment options, and to implement an effective, accessible crisis response system. The Center will coordinate and collaborate with our partners regarding existing crisis systems ensuring consideration of the goals noted in the section above, "Identification of the Gaps in Services":

- Improve and develop coordination among the existing local crisis response systems. The Center has identified and will be working with key partners including law enforcement, mental health deputies, crisis intervention teams, 9-1-1 emergency response systems, and local emergency rooms to implement coordinated access for deployment of an immediate crisis response. The enhancement to the Center's Crisis Hotline Service will be critical in achieving this goal. Collaboration with and commitment between the key partners will drive the coordination of integrated access to local crisis services.

- Maximize the available crisis funding through partnerships with local healthcare stakeholders and providers. The criminal justice system will benefit from increased access to local crisis services by reducing the burden of travel time to transport persons in crisis as well as increase options to divert persons demonstrating disorders from incarceration to an effective treatment alternative. Funding for implementation of local service options including crisis respite services will provide relief to the existing mental health deputy system. In addition, the Center is fortunate to partner with the existing Williamson County Mobile Outreach Team operating through the county Sheriff's Department to maximize crisis funds by enhancing the current service rather than developing a duplicative system. The Center will also be working through existing partnerships such as Healthy

Students, Safe Schools and Family Partner programs to enhance family support and education of crisis services in our service areas.

- Reinforce and expand opportunities for assessment and referrals for substance abuse services. Discussions with our local substance abuse providers identified that diverting persons with chemical dependency, as well as mental illness, from the criminal justice system is a key issue. Discussions with our community partners identified the need for increased options for local treatment to be necessary for achieving positive long-term outcomes. The local independent school districts have identified the need for prevention and intervention services for grades 1-5. These services will be vital for successful outcomes. The Center OSAR will be instrumental in addressing substance abuse related issues by working with our local providers of preventive and treatment services. Implementation of a single access point for initiating triage for persons with chemical dependency through the Crisis Hotline as well as ongoing education for the Mobile Crisis Outreach Teams will improve the timely assessment and effective coordination of and referral to necessary substance abuse services.

- Address community concerns with implementation of the crisis systems. The initial concern expressed by the stakeholders regards the impact the new crisis services system will have on the existing local services system. In particular, the Center and stakeholders will be assessing and monitoring the impact of providing increased access to crisis services to the existing capacity of healthcare, law enforcement, judicial and chemical dependency services. As the Crisis Hotline and Mobile Crisis Outreach Team services are implemented, the partners will be assessing the impact on the existing capacity for ongoing services determining strategies to balance the systems. These strategies may include consideration of waiting lists for services and reassessment of admission and discharge criteria for existing service systems.

  Then too, additional treatment options, and funding opportunities to develop these treatment options, will be considered. Stakeholders have identified a need for treatment options allowing for a less restrictive service setting than hospitalization. Included among these considered options are crisis respite and extended observations services. The Center will be able to consider crisis respite services with any Crisis Services Redesign funds remaining from the implementation of the required services: Crisis Hotline and Mobile Crisis Outreach Team services. As noted above, the Center will be partnering with Williamson County to make application for expanding availability of crisis respite or extended observations services through the Competitive Funding allocation.

Monitoring Performance: Measuring Success.

In collaboration with the Legislative Budget Board (LBB), the Department of State Health Services (DSHS) develops statewide performance measures to be reported and reviewed on a quarterly basis. The following measures have been proposed by DSHS to the LBB in the first quarter of fiscal year 2008.

The following table is provided courtesy of the Texas Department of State Health Services as a part of the Crisis Services Redesign Implementation Overview, dated October 2, 2007.

Legislative Budget Board Performance Measure	Type	Reporting Frequency	Definition

1	Average Monthly Number of Persons Served in Residential Crisis Services	Output	Quarterly	The unduplicated average monthly number of persons who receive a residential crisis service (i.e., respite, crisis residential, crisis stabilization unit, or extended observation) from Community Mental Health Centers including NorthSTAR *(public behavioral health managed care initiative serving Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall Counties)* paid from GR *(State General Revenue)* or CRD *(Crisis Services Redesign Funding)* awarded to DSHS.
2	Average Monthly Number of Persons Served in Outpatient Crisis Services	Output	Quarterly	The unduplicated average monthly number of persons who receive an outpatient crisis service (i.e., mobile crisis outreach team, walk-in crisis, or crisis follow-up) from Community Mental Health Centers including NorthSTAR paid from GR or CRD awarded to DSHS.
3	Percent of Persons with Medicaid Receiving Crisis Services that is followed by an ER *(Emergency Room)* Visit within 30 days	Outcome	Annual	The percent of persons with Medicaid receiving crisis services at Community Mental Health Centers including NorthSTAR that is followed by an ER visit within 30 days.
4	Percent of Persons Receiving Crisis Services that is followed by a Psychiatric Hospitalization within 30 Days	Outcome	Annual	The percent of persons receiving crisis services at Community Mental Health Centers including NorthSTAR that is followed by a State or Community psychiatric hospitalization within 30 days.
5	Percent of Persons Receiving Crisis Services that is followed by a Jail Booking within 7 Days	Outcome	Annual	The percent of persons receiving crisis services at Community Mental Health Centers including NorthSTAR that is followed by a jail booking within 7 days.

Over the biennium, the Center, through its quality management processes, will review the progress toward achieving stated goals and performance measures. The processes will include, but will not be limited to, the following mechanisms for oversight:

- The Center will monitor and evaluate service performance and outcome data to identify needs for additional training or collaboration with key stakeholders and community partners to immediately address roadblocks in the service delivery system. Initially, reviews will be conducted with our providers on a monthly basis to ensure we are able to quickly identify risk areas and modify the service system. Timely assessment will allow for implementation of best practices and achievement of goals.
- The Center will conduct desk reviews of service records and on-site reviews evaluating adherence to clinical design by providers implementing new crisis services. Initially, a monthly review will be conducted assessing the delivery of crisis redesign services including monitoring crisis hotline logs and service records as well as the quality and timeliness of assessments and services provided through the mobile crisis outreach teams.
- The Center will seek stakeholder feedback and satisfaction including surveys of clients, family members, local officials, law enforcement and key healthcare community partners. The opportunities

for collaboration during the scheduled meetings will allow for an integrated effort for assessment and timely action. [See Attachment B: Crisis Services Redesign Timeline.]

- The Center will assess with the providers budget and expenditure reports related to the costs of delivering the crisis response system. On a monthly basis, the Center will assess the financial status reports to ensure accurate accounting for all crisis redesign funds and calculation of the costs to deliver crisis services within the funding allocation.
- The Center will participate in the independent evaluation, as required by DSHS, assessing the community health crisis services anticipated to be conducted during fiscal year 2009.

It is noted that the Center anticipates performance assessment and measurement practices will be revised over the biennium to ensure the Center focuses on key areas of risk identified by the Center, stakeholders and DSHS through the implementation phase of the crisis redesign system.

Next Steps.

A timeline made a part of this Crisis Service Plan describing key steps in achieving our implementation goals. [See Attachment B: Crisis Services Redesign Timeline.] Along with the Crisis Services Plan, this timeline will continually be updated to be an effective performance measurement tool and to serve as a useful communication tool to our stakeholders.

The next steps in the planning process will be to include the above noted participants as well as the Provider Network Advisory Committee. In addition, the Center will make ongoing efforts to engage and involve interested community stakeholders. As we continually refine our plan, a broader spectrum of local emergency service providers and law enforcement staff will be included in the development of the services and the scope of the plan. Of note, the specific performance measures and expectations will be added to the plan in the near future. These measures will be assessed to ensure the Center demonstrates accountability for achieving the service and budgetary targets required of the State of Texas upon allocation of the Crisis Services Redesign funds.

It is anticipated that with application for the services available through the Competitive Funding portion of the statewide Crisis Services Redesign funding, additional key stakeholders will be identified and engaged in the planning and development process.

Identification of Champions. During the implementation of the crisis redesign, the Center is fortunate to work with key community collaborators or champions in each of the counties served by the Center. These persons will assist the Center in the implementation process and will offer support as they have authority to make decisions regarding resources, collaboration, and coordination of services:

Bastrop County:	County Judge and Sheriff Department representative
Burnet County:	County Judge and County Health Advisory Committee members
Caldwell County:	County Judge
Fayette County:	County Judge
Gonzales County:	County Judge and County Health Advisory Committee members
Guadalupe County:	County Judge and County Health Advisory Committee members
Williamson County:	County Judge and Mental Health Committee members
OSAR Counties:	Substance Abuse Services Directors for the LMHAs in the service area

Conclusion. This Crisis Services Plan and associated Attachments will be regarded as the roadmap for the design and implementation of the services in our counties. The Center will be accountable seeking and documenting the input received from our stakeholders resulting in enhancement of the initial plan. Finally, the Center will be responsible for timely updates and communication of the plan for crisis services redesign to our clients, family members, stakeholders, staff and the Board of Trustees.

Addendum to Crisis Services Plan Dated October 31, 2007

Prepared following Technical Assistance Discussion with Pat Garrett, DSHS December 4, 2007

DSHS Requested Point of Clarification: Identify current gaps and current needs for adolescents and children.

Center Response: Within the Crisis Services Plan submitted to DSHS on October 31, 2007, the Center outlined stakeholder feedback concerning identified needs in the section entitled **Identification of the Gaps in Services.** As a result of meetings with our stakeholders, the "gaps in successful treatment options for adults, adolescents and children" are specified within the Crisis Services Plan. This section, recorded on page 6 of the Crisis Services Plan, categorizes the gaps in existing needs for services in broad terms to ensure accurate and concise reporting of the needs identified by our stakeholders for all populations, including adolescents and children.

The following are the identified gaps in services noted within the Crisis Services Plan dated October 31, 2007, specific to the adolescent and child population:

- **Provide immediate response to a crisis.** [Page 7 of the Crisis Services Plan.]
  In this section, the stakeholders identified the need for "immediate availability of crisis services to individuals experiencing a mental health emergency". Specifically affecting the adolescent and child population is the "unnecessary incarceration or hospitalization of the individual, the disruption and separation of families, and the costly involvement of other community services including law enforcement and the courts". The course of action is noted as "immediate availability of professionals triaging the persons in crisis via the hotline services as well as with enhanced mobile crisis outreach" indicating this action will likely result in "reducing utilization of more intensive, more restrictive emergency services".

- **Ensure access to effective resources within our communities.** [Page 7 of the Crisis Services Plan.] In this section, the stakeholders focused on "the availability of local resources enabling stabilization of those persons in crisis in their home communities". Of noted concern is "the tendency to transport persons to the state hospital or into acute care when the level of care identified through the assessment indicates the person may best be served in a less intensive care option". Noting that "less intensive care options do not exist in our communities", stakeholders expressed the need for "local stabilization services" to "alleviate transporting clients to more acute settings away from home settings". With a nod to the growth in our service area as well as a desire for a proactive educational

approach, the plan states, "As the populations, school systems, roadways/transit systems in our communities grow, the Center focuses on access to prevention and treatment services to meet the increased needs of the areas we serve."

- **Assure effective integration with existing partners and service delivery systems.** [Pages 7-8 of the Crisis Services Plan.] In this section, the plan describes the need for ongoing communication with our "community partners" to ensure we plan for and develop an effective system of care "without duplicating efforts and systems"—noting that in addition "to being costly, the duplication of systems causes confusion for the persons we serve, our providers and our communities". Focusing on improved integration of our existing community healthcare systems, the Crisis Services funding will secure "a combined financial base to support development of less intensive, less costly levels of care". Stakeholders noted the need to collaborate with our community partners to ensure integrated services will "address the challenges facing families involved with the veteran, judicial and protective services systems due to mental health disorders and chemical dependency".

Bluebonnet Trails Community MHMR Center respectfully submits this clarifying addendum to the Crisis Services Plan identifying the statements and locations of the information within the Crisis Services Plan submitted on October 31, 2007.