Mental Health & Developmental Disabilities Centers
HILL COUNTRY

Hill Country MHDD Needs Assessment

For Consolidated Local Service Plan

FY 2020

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For Consolidated Local Service Plan

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Introduction and Survey Purpose

Hill Country Mental Health and Developmental Disabilities Center (Center) conducted a community needs assessment survey from November 2019 to January 2020. The purpose of the survey assessment was to:

- Identify stakeholder perceptions of the Center's needs and services by using the Person-Centered Working/Not Working skill.
- Prioritize the top three identified community needs per county and stakeholder type.
- Review the assessment with our Citizen's Advisory Committee (CAC) and obtain their input and recommendations.

Due to the onset of COVID-19, the compilation of the data was delayed. These delays interfered with the original development timeframes. Modifications were made on several occasions. However, minimal input into the plan was obtained. The CAC was apprised of these changes and it was decided they would review by email once it was completed. These setbacks have created the need for further analysis.

The Center would like to thank all the individuals who participated in this assessment process. We appreciate your feedback.

Methodology/Procedures

Instrument: An open-ended survey format was utilized with basic check boxes for demographic information (see Needs Assessment Survey, below).

Field Procedure: The survey was distributed by email to Center contacts throughout our 19 counties with a link to Survey Monkey. Contacts included Individuals that we serve, family members, community resources/groups and staff were invited to participate. In addition, copies of the survey were provided to individuals and family members in person at Center facilities.

Needs Assessment Survey

Below is a copy of the Needs Assessment Survey that was distributed by email and handed out to people receiving services.

HCMHDDC NEEDS ASSESSMENT **11/16/2019**

At Hill Country Mental Health and Developmental Disability Centers, we support people to have positive control over the life they desire. We provide supports for adult and child behavioral health, intellectual & developmental disability, substance abuse, crisis care, and justice involved services. Our goal is to focus on each person and assist them to create the life they want to live.

We serve individuals throughout 19 counties of the greater Texas Hill Country region, which includes: Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde and Val Verde. With 22 locations, including 14 Mental Health Clinics and 8 Developmental Disability Centers, we serve a population of over 630,000 people within a 22,593 square mile area.

As both the Local Mental Health Authority (LMHA) and the Local Intellectual and Developmental Disability Authority (LIDDA), we have a unique and essential opportunity to define the needs of our counties to the state. We need your help to gather some basic needs assessment information that may impact the people and communities we serve at the state legislative level.

HCMHDDC NEEDS ASSESSMENT **11/16/2019**

1. **Which of the following categories best describes the group you represent? (Check all that apply)**

- ☐ Individual receiving services
- ☐ Family Member(s)
- ☐ Advocates for Children and Adults
- ☐ Community MH or IDD Service Providers
- ☐ Local Psychiatrist
- ☐ State Hospital Staff
- ☐ Emergency Health Care Providers (e.g., hospital emergency room personnel)
- ☐ Hospital (non-emergency)
- ☐ Fire Department
- ☐ Local public health care provider (e.g., federally qualified health centers, local health departments)
- ☐ Outreach, Screening, and Referral (OSAR) provider serving the area
- ☐ Law Enforcement
- ☐ Probation and Parole
- ☐ Criminal Justice
- ☐ Judicial Representative
- ☐ Education
- ☐ Local Public housing Authority, non-profit homeless service providers, non-profit and for-profit housing providers, or recovery homes
- ☐ Social Service Providers
- ☐ Business Leaders
- ☐ Government Representatives
- ☐ Concerned Citizens
- ☐ Primary Care Physician
- ☐ Support Staff (HCMHDD)
- ☐ Family Partner (HCMHDD)
- ☐ Nurse (HCMHDD)
- ☐ Service Coordinator (HCMHDD)
- ☐ Care Coordinator (HCMHDD)
- ☐ Director (HCMHDD)
- ☐ Licensed Staff (HCMHDD)
- ☐ Administration (HCMHDD)

HCMHDDC NEEDS ASSESSMENT **11/16/2019**

2. Which County do you live in?

- ☐ Bandera
- ☐ Blanco
- ☐ Comal
- ☐ Edwards
- ☐ Gillespie
- ☐ Hays
- ☐ Kendall
- ☐ Kerr
- ☐ Kimble
- ☐ Kinney
- ☐ Llano
- ☐ Mason
- ☐ Medina
- ☐ Menard
- ☐ Real
- ☐ Schleicher
- ☐ Sutton
- ☐ Uvalde
- ☐ Val Verde
- ☐ Other (Please specify)

_____

_____

3. Which County do you Work in?

- ☐ Bandera
- ☐ Blanco
- ☐ Comal
- ☐ Edwards
- ☐ Gillespie
- ☐ Hays
- ☐ Kendall
- ☐ Kerr
- ☐ Kimble
- ☐ Kinney
- ☐ Llano
- ☐ Mason
- ☐ Medina
- ☐ Menard
- ☐ Real
- ☐ Schleicher
- ☐ Sutton
- ☐ Uvalde
- ☐ Val Verde
- ☐ Other (Please specify)

_____

4. Which of the following service/support areas would you like to respond to (Please pick one and you can return to complete another)?

- ☐ Child Behavioral Health
- ☐ Adult Behavioral Health
- ☐ Substance Use Disorders
- ☐ Intellectual & Developmental Disabilities

HILL COUNTRY MHDD CENTERS 3

5. In the service/support area that you chose, what is WORKING well for you?

6. In the service/support area that you chose, what is NOT WORKING well for you?

7. What opportunities are you aware of that may positively impact the people we serve in the near future?

8. What concerns/ worries are you aware of that may have a negative impact on the people we serve in the near future?

9. Please identify the top three priorities that are most needed in your county, related to the service area you chose?

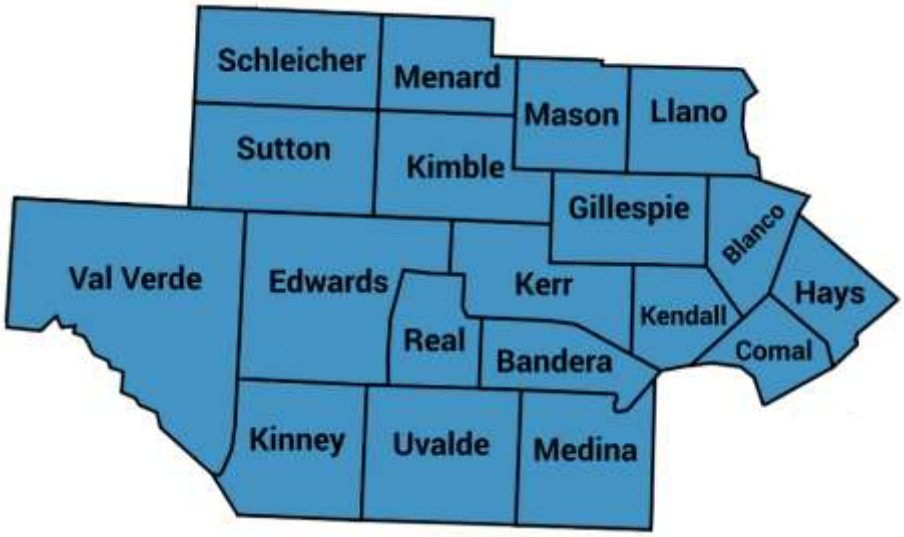
   1.

   2.

   3.

10. Other Comments

Hill Country MHDD Centers



Purpose

The Center's purpose is to help people have positive control over the life they desire and find satisfying and are recognized and valued for their contributions to their communities. Through our adult and child behavioral health, intellectual and developmental disabilities, substance abuse, crisis care, and justice involved services programs, we promote hope, independence, community integration and recovery.

Beginnings

The Center began operation in September of 1997. Prior to that date, components of six different State Facility Community Service divisions were merged to form a State Operated Community Service organization in September of 1996. As part of the initial foundation, staff met to develop the Mission, Values and Workplace Principles as a foundation for the newly formed organization, Hill Country Mental Health and Developmental Disabilities Centers (Hill Country MHDD Centers).

Today

Today, Hill Country MHDD Centers is one of 39 agencies that delivers mental health and developmental disability services in communities across Texas. Hill Country MHDD Centers serves the greater Texas Hill Country Region including 19-counties: Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde and Val Verde. With a mission of Promoting Independence, Community Integration and Recovery, Hill Country MHDD Centers has 22 locations including 14 Mental Health Clinics and 8 Developmental Disability Centers serving a population of over 665,274 within a 22,593 square mile area.

Advisory Council

The Board of Trustees and Citizens' Advisory Committee for Hill Country MHDD Centers represent population areas of the catchment region that are relatively equal. Some board members represent one county and others represent multiple counties depending on the

population of the counties. The Citizens' Advisory Committee has and continues to take an active role in obtaining community input into the strategic direction of the agency.

Diversity

Hill Country MHDD Centers serves a region of Texas that cannot be narrowly defined. There are pockets of the Greater Texas Hill Country Region with high rates of population growth particularly in those counties contiguous to Travis and Bexar counties, such as Hays, Comal and Kendall counties. Some of the region is sparsely populated with few, if any, alternative resources for behavioral health and intellectual and developmental disability services. A section of the region is on or close to the border of Mexico where we face the challenge of ensuring a provider network that is culturally diverse.

Challenges

Increased pressures on the financial well-being of the local authority, particularly around the expense of medications, has led to use of cost saving opportunities such as "'Patient Assistance Programs", improved access to third party pharmacy benefits and improved management of the local authority pharmacy benefit.

The overarching challenge facing Hill Country MHDD Centers is the need to be responsive and open to the needs of the hundreds of communities in the 19-county service region while ensuring an efficient and cost-effective operation with use of public funding. As the Local Mental Health Authority (LMHA) and Local Intellectual and Developmental Disability Authority (LIDDA) provider, Hill Country remains committed to evaluating the behavioral health and intellectual developmental disability needs of communities by collaborating with community partners and developing innovative programming using available local resources. The Hill Country MHDD Centers remains committed to:

- Ensuring people who need services can exercise individual choice by helping persons decide on their services, service provider and location of services.
- Ensuring the best use of public money to create a network of service providers.
- Making recommendations on the most appropriate services available to individuals who need services.
- Hill Country MHDD Centers will meet this challenge with the support of our diverse staff, the Citizens' Advisory Committee, our community providers, stakeholders, and Board of Trustees.

Shift in Care

Shifting toward a culture of evidenced-based care, corporate compliance has been the focus of Hill Country MHDD Centers' strategic efforts. As the LMHA and LIDDA provider, Hill Country MHDDC actively uses performance-based data for decision making to provide quality services that transform access to care in the local communities. By increasing access to behavioral health and substance use treatment, expanding capacities to address the opioid crisis and establishing viable stakeholder partnership with local hospitals, law

enforcement, jails, prisons and schools, Hill Country MHDD Centers' qualified personnel have been able to provide individualized and compassionate care to the individuals served.

Survey Responses

Summary of Survey Responses: Responses by Category or Group

This chart illustrates the total distribution of responses by stakeholder category. For example, 20% of the total responses were from stakeholders that are individuals that receive services from Hill Country. Four categories are used in this survey:

1. Individuals that receive services (20%).
2. Family Members (9.12%).
3. Community Responses that include all other categories (26.18%).
4. Staff (44.71%).

#	Group Represented	Number of Responses	Percentage of Responses
1.	Individuals Receiving Services	68	20%
2.	Family Member(s)	31	9.12%
3.	Advocates for Children and Adults	11	3.24%
4.	Community MH or IDD Service Providers (staff)	152	44.71%
5.	Local Psychiatrist	2	.59%
6.	State Hospital Staff	0	0%
7.	Emergency Health Care Providers (e.g., hospital emergency room personnel)	6	1.76
8.	Hospital (non-emergency)	0	0
9.	Fire Department	2	.59
10.	Local public health care provider (e.g., federally qualified health centers, local health departments)	4	1.18
11.	Outreach, Screening, Assessment, and Referral (OSAR) provider serving the area	2	.59
12.	Law Enforcement	18	5.29
13.	Probation and Parole	2	.59
14.	Criminal Justice	0	0
15.	Judicial Representative	5	1.47
16.	Education	14	4.12
17.	Social Service Providers	6	1.76
18.	Local Public housing Authority, non-profit homeless service providers, non-profit and for-profit housing providers, or recovery homes	1	.29
19.	Business Leaders	3	.88

Responses: 340

Individual and Family Responses: 99 or 29.12%

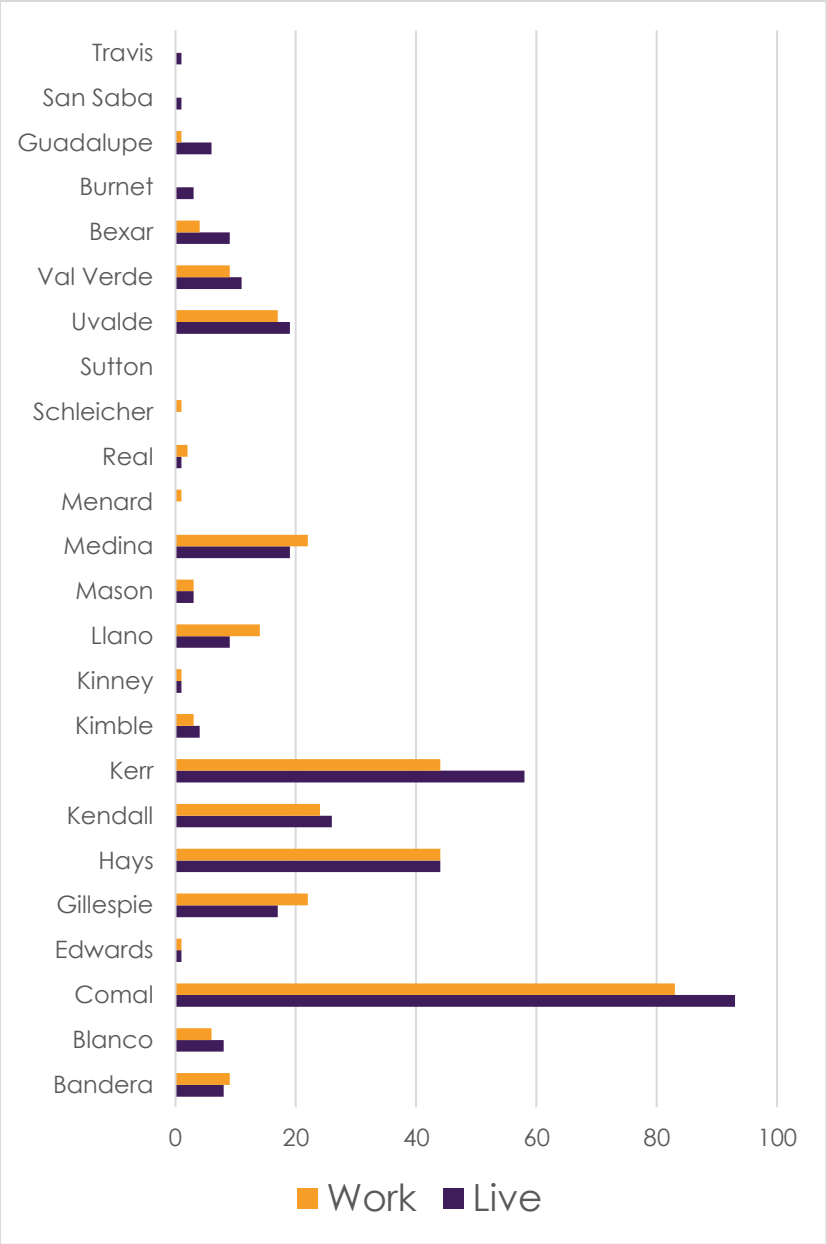
Community Responses: 89 or 26.18%

Staff Responses: 152 or 44.71%

20.	Government Representatives	5	1.47
21.	Concerned Citizens	5	1.47
22.	Primary Care Physician	3	.88
	TOTAL	**340**	**100%**

Counties Respondents Live and Work In

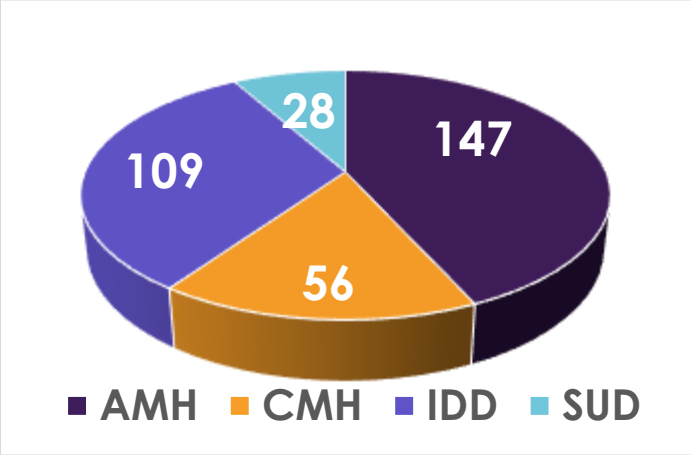
This chart illustrates the distribution of responses by where they live and work.



Respondents per Service/Support Area

This chart illustrates the number of respondents per our service/support areas. The following categories are used in the survey:

- Adult Behavioral Health of Adult Mental Health = AMH
- Children's Mental Health = CMH
- Intellectual Developmental Disabilities = IDD
- Substance Use Disorders = SUD



Priority Groupings

The following 16 groupings were created to represent the myriad of priorities identified in this Needs Assessment. Each of these groupings listed below are used consistently throughout the Needs Assessment. These grouping are defined by the specific repeated priorities provided in the survey responses.

- **Basic Needs** – limited community resources and more resources for food, shelters, and affordable housing is needed.
- **Communication/Collaboration/Awareness/Education** – Communication and Collaboration between local stakeholders (e.g., Hill Country, Law Enforcement, Courts, School Districts, Faith Based, etc.) is needed. Communication to stakeholders is needed. Support from other stakeholders in the community is needed.
- **Day Habilitation /Daily Activities** – Need day activities for individuals we serve.
- **Efficiencies** – Need to lessen the length of time to get services (i.e., Intakes, Psychiatric Evaluation, IDD Waitlist, and other services. Need to modify Hours of operation to meet the needs of people receiving services. Need to address Doctor and staff cancellations, performance measures for staff, office practices, staff attitudes, and staff turnover.
- **Funding** – Grant, State and Federal funding
- **Healthcare**
- **Homeless Services**
- **IDD Services** – Service Coordination, Intake Process, need more HCS Services,
- **Increase Staff** – Psychiatrists, Licensed Staff, Care Coordinators, Service Coordinators, and Support Staff are needed to decrease caseloads.

- **Job/Volunteer Opportunities**
- **MH Services** – Need to become a Certified Community Behavioral Health Clinics (CCBHC). Increase Community-based Services, Crisis Services, MCOT, Medication Management, Counseling, Therapeutic Groups, Case Management, Psychosocial Rehabilitative Services, Supported Housing, Supported Employment, Telepsych, Peer Support, Family Support, and inpatient beds.
- **New Facilities or Updates** – New Building or renovations needed
- **SUD Services** – Additional providers and services for prevention, outpatient treatment, and detox/ inpatient services. Need to focus on recovery and utilize peers in service delivery.
- **Training** – Need to continue and expand Mental Health First Aid, Person Centered Thinking, clinical or rehabilitation skills, Trauma Informed Care, Mental Health Education for Parents, and reduce stigma.
- **Transportation** – Local public transportation and crisis transportation. Need to reduce distances to travel in rural counties to get services or increase transportation.
- **Wages/Benefits** – Cost of Living and increases identified for staff

Top 3 Priorities identified for Adult Mental Health

The table is a compilation of responses to an open-ended question on priorities. The responses were compiled into a priority grouping and they are listed based on the grouping's percentage.

Rank	Priorities	%
1	MH Services	22%
2	Increase Staff	14%
3	Communication/Collaboration/Awareness/Education	9%
3	Basic Needs	9%

Top 3 Priorities identified for Children's Mental Health

The table is a compilation of responses to an open-ended question on priorities. The responses were compiled into a priority grouping and they are listed based on the grouping's percentage.

Rank	Priorities	%
1	MH Services	20%
2	Increase Staff	14%
3	Communication/Collaboration/Awareness/Education	13%

Top 3 Priorities identified for Intellectual and Developmental Disabilities

The table is a compilation of responses to an open-ended question on priorities. The responses were compiled into a priority grouping and they are listed based on the grouping's percentage.

Rank	Priorities	%
1	Increase Staff	17%
2	Communication/Collaboration/Awareness/Education	17%
3	Day Habilitation/ Daily Activities	12%

Top 3 Priorities identified for Substance Use Disorders

The table is a compilation of responses to an open-ended question on priorities. The responses were compiled into a priority grouping and they are listed based on the grouping's percentage.

Rank	Priorities	%
1	Substance Use Services	38%
2	MH Services	26%
3	Communication/Collaboration/Awareness/Education	8%
3	Basic Needs	8%

Priority Groupings Responses

The table represents the response number and percentage from all stakeholders for all priority groupings. Later in this report, priorities will be identified from each county.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	84	15.64%
2.	Increase in Staff	76	14.15%
3.	Communication/Collaboration/Awareness/Education	67	12.48%
4.	SUD Services	44	8.19%
5.	Transportation	43	8.01%
6.	Efficiencies	40	7.45%
7.	Basic Needs	33	6.15%
8.	Day Habilitation / Activities	27	5.03%
9.	Wages/Benefits	23	4.28%
10.	Funding	22	4.10%
11.	Jobs/Vol	20	3.72%
12.	Training	17	3.17%
13.	New Facilities	16	2.98%
14.	Healthcare	11	2.05%
15.	IDD Services	10	1.86%
16.	Homeless Services	4	.74
	Total Respondents	537	100%

Priorities for Individuals we serve

The table represents the response number and percentage from individuals we serve for all priority groupings.

#	Priorities	Number of Responses	Percentage of Responses
1.	Increase in Staff	14	17.5%
2.	MH Services	12	15%
3.	Communication/Collaboration/Awareness/Education	10	12.5%
4.	Transportation	9	11.25%
5.	Day Habilitation / Activities	8	10%
6.	Basic Needs	7	8.75%
7.	SUD Services	4	5%
8.	Jobs/Vol	4	5%
9.	Wages/Benefits	3	3.75%
10.	Efficiencies	2	2.5%
11.	Funding	2	2.5%
12.	New Facilities	2	2.5%
13.	Healthcare	1	1.25%
14.	IDD Services	1	1.25%
15.	Training	1	1.25%
	Total Respondents	80	100%

Priorities for Family Members

The table represents the response number and percentage from family members for all priority groupings.

#	Priorities	Number of Responses	Percentage of Responses
1.	Communication/Collaboration/Awareness/Education	11	20.37%
2.	Increase in Staff	6	11.11%
3.	Day Habilitation / Activities	6	11.11%
4.	Jobs/Vol	5	9.25%
5.	MH Services	4	7.41%
6.	Efficiencies	4	7.41%
7.	Basic Needs	3	5.56%
8.	Healthcare	3	5.56%
9.	SUD Services	3	5.56%
10.	Training	3	5.56%
11.	New Facilities	2	3.7%
12.	Funding	1	1.85%
13.	Transportation	1	1.85%
14.	Homeless Services	1	1.85%
15.	IDD Services	1	1.85%
	Total Respondents	54	100%

Priorities for the Community Responding

The table represents the response number and percentage from all community respondents for all priority groupings. The community responding represent the following subgroups: Advocates for Children and Adults, Local Psychiatrist, State Hospital Staff, Emergency Health Care

Providers (e.g., hospital emergency room personnel), Hospital (non-emergency), Fire Department, Local public health care provider (e.g., federally qualified health centers, local health departments), Outreach, Screening, Assessment, and Referral (OSAR), Law Enforcement, Probation and Parole, Criminal Justice, Judicial Representative, Education, Social Service Providers, Local Public housing Authority, non-profit homeless service providers, non-profit and for-profit housing providers, or recovery homes, Business Leaders, Government Representatives, Concerned Citizens, and Primary Care Physician.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	46	32.62%
2.	SUD Services	23	16.31%
3.	Communication/Collaboration/Awareness/Education	16	11.35%
4.	Transportation	11	7.80%
5.	Efficiencies	9	6.38%
6.	Increase in Staff	8	5.67%
7.	Basic Needs	6	4.26%
8.	Funding	5	3.55%
9.	Healthcare	4	2.84%
10.	Jobs/Vol	4	2.84%
11.	New Facilities	3	2.13%
12.	Day Habilitation / Activities	2	1.42%
13.	IDD Services	2	1.42%
14.	Homeless Services	1	.71%
15.	Wages/Benefits	1	.1%
	Total Respondents	**141**	**100%**

Priorities for Advocates for Children and Adults

The table represents the response number and percentage from Advocates for Children and Adults - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	4	22.22%
2.	SUD Services	3	16.67%
3.	Transportation	3	16.67%
4.	Communication/Collaboration/Awareness/Education	2	11.11%
5.	Efficiencies	2	11.11%
6.	Increase in Staff	1	5.56%
7.	Basic Needs	1	5.56%
8.	Jobs/Vol	1	5.56%
9.	Homeless Services	1	5.56%
	Total Respondents	18	100%

Priorities for Business Leaders

The table represents the response number and percentage from Business Leaders - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	Transportation	2	22.22%
2.	Communication/Collaboration/Awareness/Education	1	11.11%
3.	Day Habilitation / Activities	1	11.11%
4.	Jobs/Vol	1	11.11%
5.	MH Services	1	11.11%
6.	Efficiencies	1	11.11%
7.	Healthcare	1	11.11%
8.	SUD Services	1	11.11%
	Total Respondents	9	100%

Priorities for Concerned Citizens

The table represents the response number and percentage from Concerned Citizens - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	2	25%
2.	SUD Services	2	25%
3.	Basic Needs	1	12.25%
4.	Communication/Collaboration/Awareness/Education	1	12.25%
5.	Efficiencies	1	12.25%
6.	Transportation	1	12.25%
	Total Respondents	8	100%

Priorities for Education

The table represents the response number and percentage from Education - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	7	33.33%
2.	Communication/Collaboration/Awareness/Education	4	19.05%
3.	Funding	2	10%
4.	Increase in Staff	2	10%
5.	SUD Services	2	10%
6.	Day Habilitation / Activities	1	4.8%
7.	Efficiencies	1	4.8%
8.	Healthcare	1	4.8%
9.	Transportation	1	4.8%
	Total Respondents	21	100%

Priorities for Emergency Health Care Providers (e.g., hospital, emergency room personnel)

The table represents the response number and percentage from Emergency Health Care Providers (e.g., hospital, emergency room personnel) - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	4	50%
2.	SUD Services	2	25%
3.	Basic Needs	1	12.5%
4.	Funding	1	12.5%
	Total Respondents	8	100%

Priorities for Fire Departments Responding

The table represents the response number and percentage from Fire Departments - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	2	50%
2.	SUD Services	1	25%
3.	Transportation	1	25%
	Total Respondents	4	100%

Priorities for Governmental Representatives Responding

The table represents the response number and percentage from Governmental Representatives - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	3	50%
2.	Communication/Collaboration/Awareness/Education	2	33.33%
3.	Efficiencies	1	16.67%
	Total Respondents	6	100%

Priorities for Judicial Representatives Responding

The table represents the response number and percentage from Judicial Representatives - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	3	30%
2.	SUD Services	2	20%
3.	Communication/Collaboration/Awareness/Education	1	10%
4.	Increase in Staff	1	10%
5.	Jobs/Vol	1	10%
6.	Healthcare	1	10%
7.	New Facilities	1	10%
	Total Respondents	10	100%

Priorities for Law Enforcement

The table represents the response number and percentage from Law Enforcement - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	12	52.17%
2.	SUD Services	3	13.04%
3.	Efficiencies	2	8.7%
4.	Increase in Staff	2	8.7%
5.	New Facilities	2	8.7%
6.	Communication/Collaboration/Awareness/Education	1	4.35%
7.	Transportation	1	4.35%
	Total Respondents	23	100%

Priorities for Local Psychiatrists Responding

The table represents the response number and percentage from Local Psychiatrists - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	Communication/Collaboration/Awareness/Education	1	16.67%
2.	Increase in Staff	1	16.67%
3.	Jobs/Vol	1	16.67%
4.	Basic Needs	1	16.67%
5.	Funding	1	16.67%
6.	Wages/Benefits	1	16.67%
	Total Respondents	6	100%

Priorities for Local public health care provider (e.g., federally qualified health centers, local health departments)

The table represents the response number and percentage from Local public health care provider (e.g., federally qualified health centers, local health departments) - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	3	42.86%
2.	SUD Services	2	28.57%
3.	Efficiencies	1	14.29%
4.	IDD Services	1	14.29%
	Total Respondents	7	100%

Priorities for Local Public Housing Authority, non-profit homeless service providers, non-profit and for-profit housing providers, or recovery homes

The table represents the response number and percentage from Local Public Housing Authority, non-profit homeless service providers, non-profit and for-profit housing providers, or recovery homes - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	Communication/Collaboration/Awareness/Education	1	50%
2.	Basic Needs	1	50%
	Total Respondents	2	100%

Priorities for Outreach Screening Assessment and Referral (OSAR)

The table represents the response number and percentage from OSAR - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	Basic Needs	1	33.33%
2.	Transportation	1	33.33%
3.	IDD Services	1	33.33%
	Total Respondents	3	100%

Priorities for Primary Care Physicians

The table represents the response number and percentage from Primary Care Physicians - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	1	33.33%
2.	Healthcare	1	33.33%
3.	SUD Services	1	33.33%
	Total Respondents	3	100%

Priorities for Probation and Parole

The table represents the response number and percentage from Probation and Parole - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	MH Services	2	66.67%
2.	SUD Services	1	33.33%
	Total Respondents	3	100%

Priorities for Social Services

The table represents the response number and percentage from Social Services - a subgroup of the Community respondents.

#	Priorities	Number of Responses	Percentage of Responses
1.	SUD Services	3	30%
2.	MH Services	2	20%
3.	Communication/Collaboration/Awareness/Education	2	20%
4.	Increase in Staff	1	10%
5.	Funding	1	10%
6.	Transportation	1	10%
	Total Respondents	10	100%

Priorities for Staff Responding

The table represents the response number and percentage from Hill Country MHDD Staff.

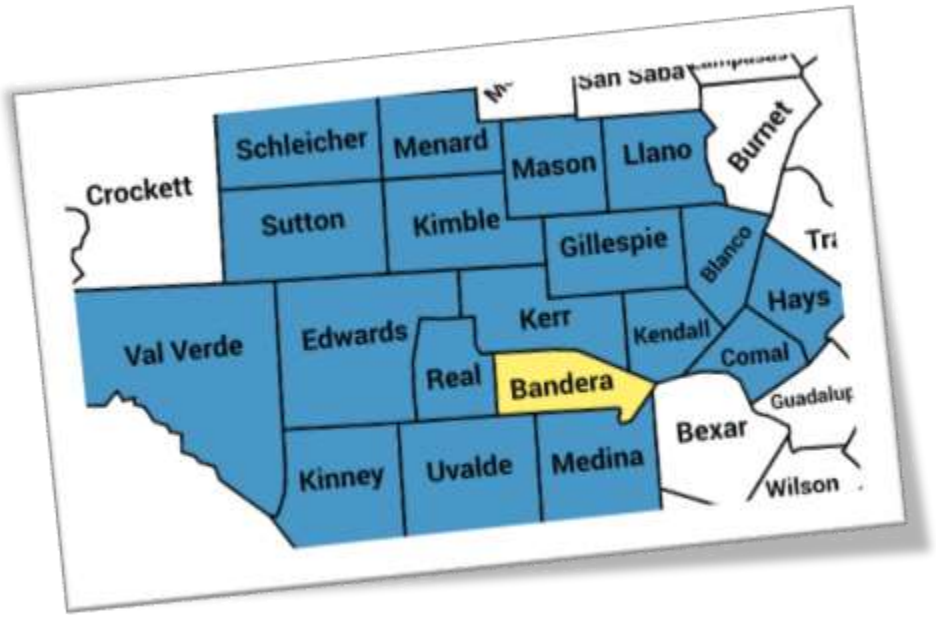
#	Priorities	Number of Responses	Percentage of Responses
1.	Increase in Staff	28	23.93%
2.	Communication/Collaboration/Awareness/Education	12	10.26%
3.	Efficiencies	12	10.26%
4.	Wages/Benefits	10	8.55%
5.	Transportation	8	6.84%
6.	Basic Needs	7	5.98%
7.	SUD Services	7	5.98%
8.	Day Habilitation / Activities	6	5.13%
9.	Funding	6	5.13%
10.	MH Services	6	5.13%
11.	New Facilities	6	5.13%
12.	IDD Services	3	2.56%
13.	Training	3	2.56%
14.	Jobs/Vol	1	.85%
15.	Homeless Services	1	.85%
16.	Healthcare	1	.85%
	Total Respondents	**117**	**100%**

Profile for each Hill Country MHDD County

A profile on each Hill Country county is created to provide a summary of the following information collected:

- Demographic information. Data collected is from Data USA (https://datausa.io).
- Priorities per each stakeholder group that responded within their county.
- Working and Not Working for the county.
- Positive opportunities and negative concerns that may impact people in the county.

Bandera County

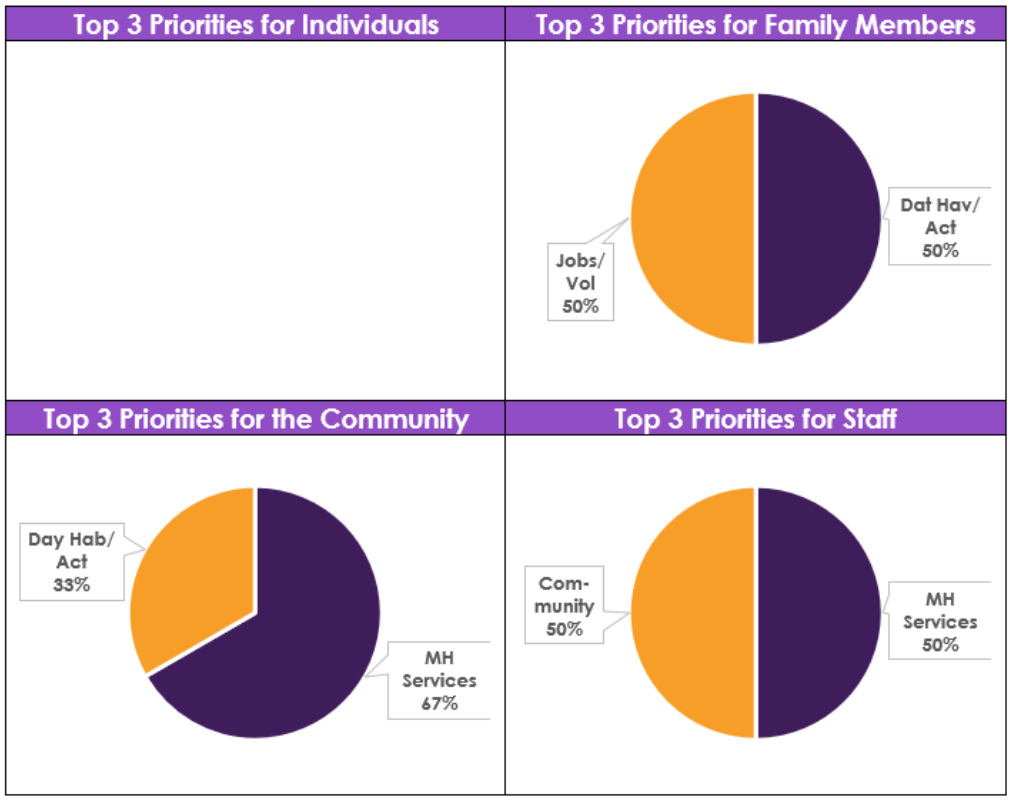


- In 2017, Bandera County, TX had a population of 21.3k people with a median age of 52 and a median household income of $56,413.
- Between 2016 and 2017 the population of Bandera County, TX grew from 21,015 to 21,316, a 1.43% increase and its median household income grew from $55,434 to $56,413, a 1.77% increase.
- The 5 largest ethnic groups in Bandera County, TX are White (Non-Hispanic) (78.8%), White (Hispanic) (13.5%), Two or More Races (Hispanic) (2.98%), Two or More Races (Non-Hispanic) (1.73%), and Black or African American (Non-Hispanic) (0.999%). 97.6% are U.S. citizens.
- The median property value in Bandera County, TX is $165,900, and the homeownership rate is 84.6%. Most people in Bandera County, TX commute by Driving Alone, and the average commute time is 34.2 minutes. The average car ownership in Bandera County, TX is 2 cars per household.

Priorities identified in Bandera County

Rank	Priorities	%
1	MH Services	20%
2	Increase Staff	20%
3	Communication/Collaboration/Awareness/Education	10%
3	Day Habilitation/ Daily Activities	10%
3	Job/Volunteer Opportunities	10%
3	New Facilities or Updates	10%
3	Wages/Benefits	10%
3	Training	10%

Top 3 Priorities identified in Bandera County per Category of Respondents



Working and Not Working in Bandera County

Adult Behavioral Health or Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Law Enforcement	• Crisis response has improved • The Telepsych system has been very useful to use at the Jail. The crisis hotline has been helpful when we need an assessment or assistance with finding placement for inmates	• Faxing our screenings to local MHDD is pointless we have never had a response • A local clinic would be helpful for indigent patients that have no support after they are released from our custody. We need more community based services to assist us in diverting people from jail. We need more beds available for inmates that require hospitalization.

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Community MH or IDD Service Providers (staff)	• The training that I received in this new position was awesome and great support from supervisor.	• Meeting hours when there is so much travel involved and travel time not counting.

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• Co-workers/supervisor	• High caseload numbers, low pay and need for more service coordinators
Family Member(s)	• Got signed up for HCS	• - Service coordination - service in Bandera County is absent (have to go to Kerrville) - The special opportunity center in Kerrville is not good at all
Community MH or IDD Service Providers (staff)	• Relationship between the individuals we serve and their families. • client and co-worker relationships..good communication • The support received from upper level management and their ability to understand that the job we do is a very BIG job.	• Lack of enough support staff to accomplish all we hope! • pay rate • The difficulty with getting staff buy in and implement the strategies needed to work towards positive change. The lack of staff to provide the services that are needed to help support the individuals we serve. The pay is not working well either for the direct service professionals that we depend on the most to provide the direct service.

Positive opportunities and negative concerns that may impact the people in Bandera County

Adult Behavioral Health or Adult Mental Health

Group Represented	Positive Opportunities	e Concerns
Law Enforcement		• Time involved in getting on the case load.

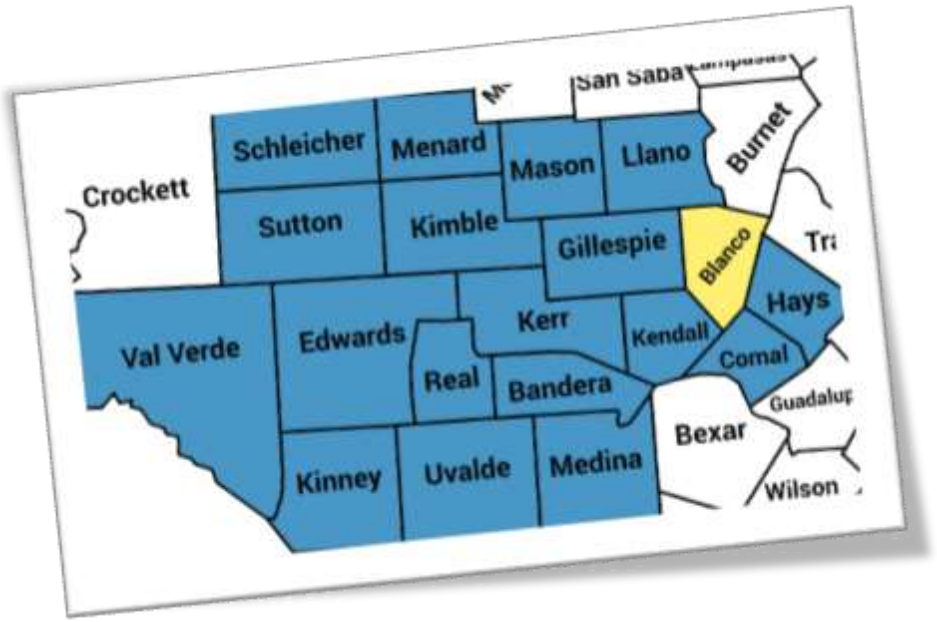
Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• Not sure	• Lack of providers for professional services.

Intellectual Developmental Disabilities

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• Local church offering programs that help address ways to achieve a healthy lifestyle. This is free to the public. • n/a • The CCBHC Models that we are being mandated to provide the individuals we work with. This will help to provide a quality of life to the individuals we work with.	• Lack of affordable housing and enough supports available to help individuals accomplish the desire to live independently in a rural community. • not enough educational support/advocacy for those ind. still in school • I see how difficult it is to provide the services we need to provide now in a structured more controlled setting (Day Habs) and have concerns with how difficult services outside of Day Habs and more community involvement will be to provide. With such significant staffing issues moving services to less structured more naturalistic settings takes a lot more effort and support from staff for some individuals. That support is difficult to provide now.
Family Member	• - State laws about having day habs move to more of a employment center and less of a baby sitter	• - Serving rural areas - Can meaningful jobs be found for people

Blanco County



- In 2017, Blanco County, TX had a population of 11.1k people with a median age of 49.5 and a median household income of $58,500.

- Between 2016 and 2017 the population of Blanco County, TX grew from 10,918 to 11,089, a 1.57% increase and its median household income grew from $56,573 to $58,500, a 3.41% increase.

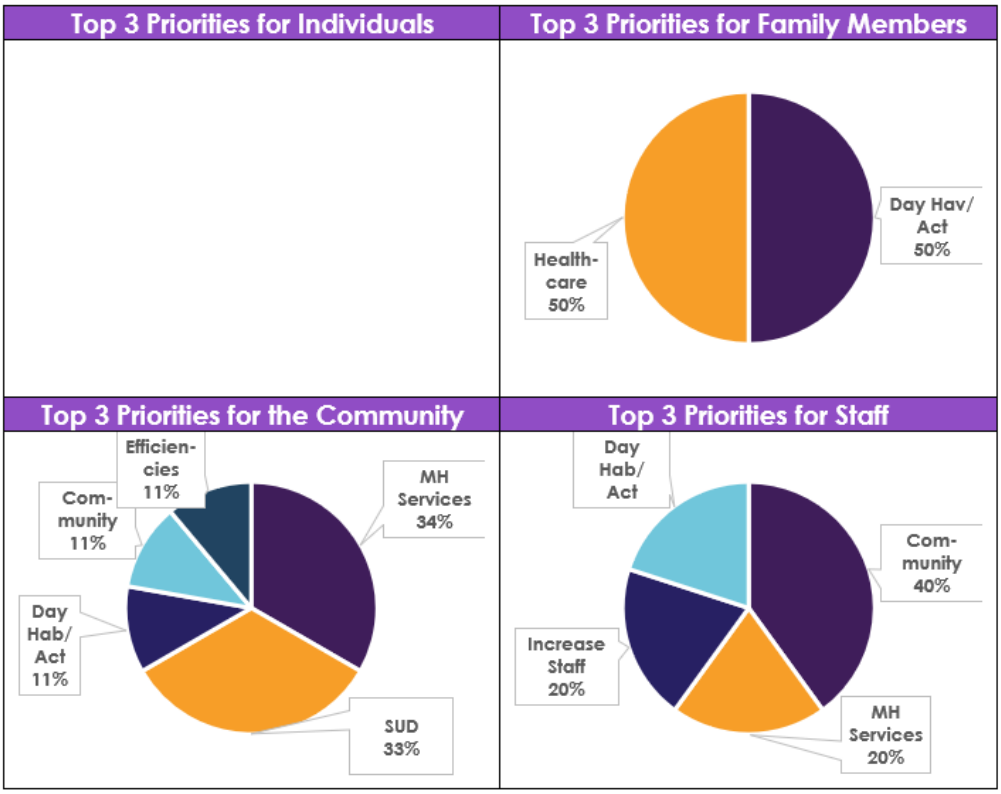
- The 5 largest ethnic groups in Blanco County, TX are White (Non-Hispanic) (77.6%), White (Hispanic) (14.4%), Two or More Races (Non-Hispanic) (2.74%), Some Other Race (Hispanic) (2.49%), and American Indian & Alaska Native (Hispanic) (0.92%). 95.3% are U.S. citizens.

- The median property value in Blanco County, TX is $230,800, and the homeownership rate is 76.6%. Most people in Blanco County, TX commute by Driving Alone, and the average commute time is 25.3 minutes. The average car ownership in Blanco County, TX is 2 cars per household.

Priorities identified in Blanco County

Rank	Priorities	%
1	MH Services	25%
2	Substance Use Services	19%
2	Communication/Collaboration/Awareness/Education	19%
2	Day Habilitation/ Daily Activities	19%
3	Efficiencies	6%
3	Healthcare	6%
3	Increase Staff	6%

Top 3 Priorities identified in Blanco County per Category of Respondents



Working and Not Working in Blanco County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Community MH or IDD Service Providers (staff)	• None in Johnson City except New Hope has a counselor that comes to the Methodist church on Friday to see patients.	• We need more counselors.
Law Enforcement	• None	• response slow and no fallow up outreach for patients that cant go to clinic

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Education	• Blanco Child Advocacy Board & Good Samaritan Center	• N/A
Social Service Providers	• I work with kids through the YES Waiver and those services are going very well.	• I feel like there is not enough access to different services in rural areas due to lack of providers.
Business Leaders	• education for youth about mental health issues, including substance abuse prevention	• Blanco County is a rural area. We are finding that some parents are condoning substance abuse. Annual surveys show evidence-based confirmation.

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Family Member(s)	• Very little! Once services are approved (a horrible process) it becomes a constant battle to keep services, work with administrators (agencies, contractors, etc.)	• Application process, waiting list, knowledge of administrators regarding process and medical needs
Community MH or IDD Service Providers (staff)	• Having a teamwork centered group of coworkers.	• Not being able to determine activities that are age appropriate for certain consumers.

Substance Use Disorders

Group Represented	What is Working?	What is Not Working?
Education	• Preventative education for youth and adults	• Lack of local mental health and substance use disorder providers in Blanco

Positive opportunities and negative concerns that may impact the people in Blanco County

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• Opening of the Community Resource Center	• Increase in Mental health issues
Law Enforcement	• none that I know of. Maybe the addition of a clinic in Johnson City	• lack of outreach to help prevent entering the jail system

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Business Leader	• working more closely with faith-based groups for more referrals to your MH programs	• MH stigma
Education	• Pajama Drive for Angel Tree & Spring Break Backpacks Activity Packets for Children 4-5th grade & Babies Closet for Expectant Mothers & Toddelers	• N/A
Social Service Providers	• There are many services provided by MHDD that can impact people but it is helping people in the community learn how to access them.	• There are not services close by and individuals have to drive to get them.

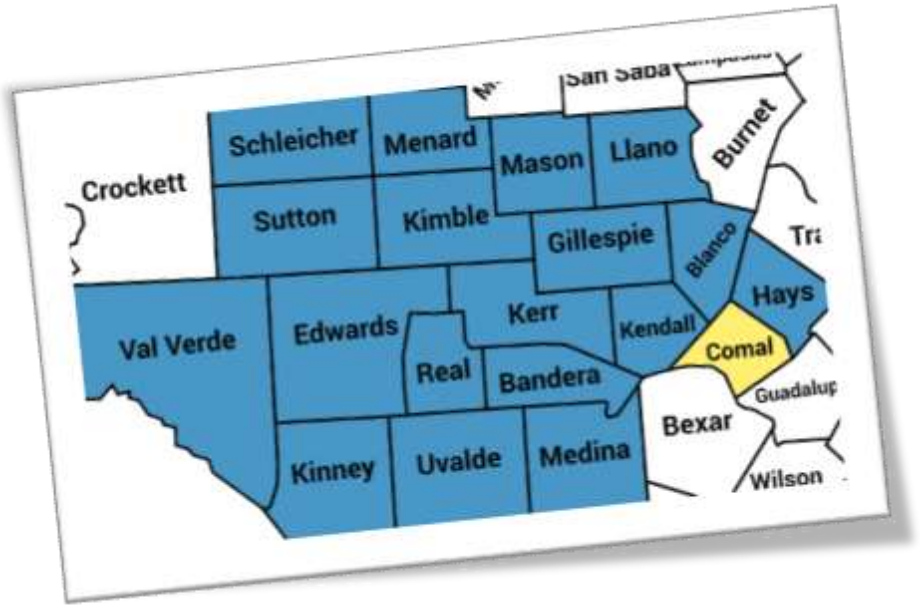
Intellectual Developmental Disabilities

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• The attitude of my supervisors and coworkers, that we genuinely care about the well being of our consumers, we all try to brainstorm activities to better their daily living and health.	• My concern is the sedentary lifestyle of some of our consumers.
Family Member	• NO direct services in Blanco County!!!!!	• NO direct services in Blanco County

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Education	• N/a	• Lack of mental health services

Comal County



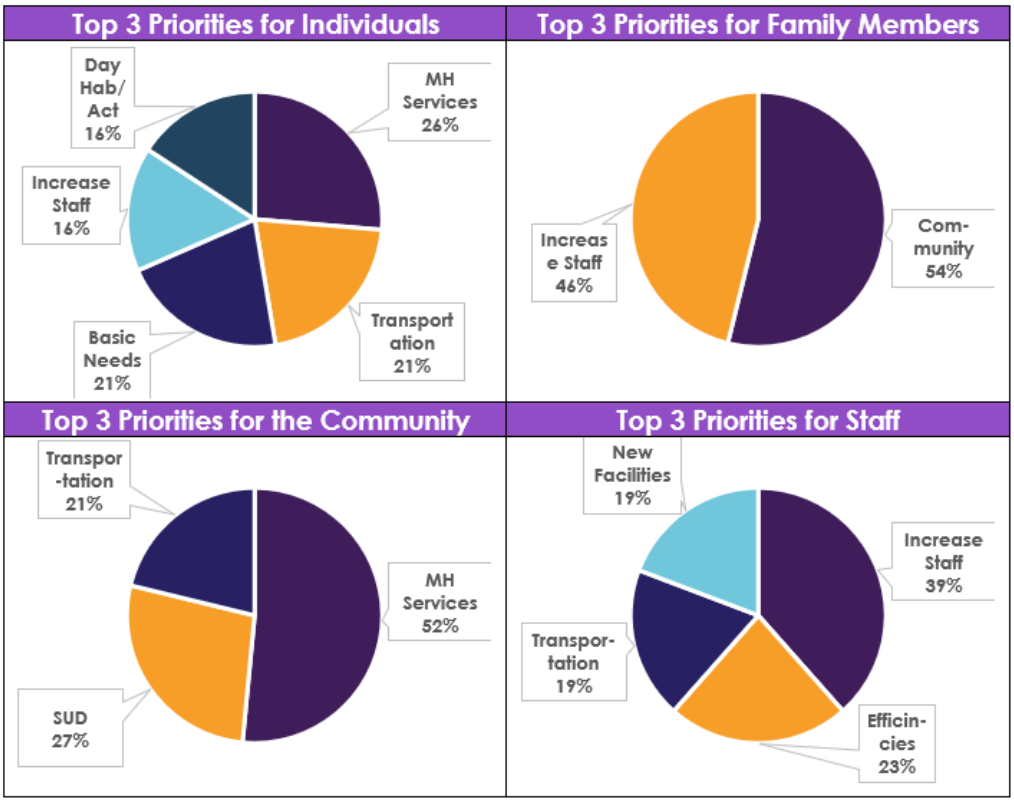
- In 2017, Comal County, TX had a population of 129k people with a median age of 42.2 and a median household income of $73,655.
- Between 2016 and 2017 the population of Comal County, TX grew from 124,234 to 129,100, a 3.92% increase and its median household income grew from $69,666 to $73,655, a 5.73% increase.
- The 5 largest ethnic groups in Comal County, TX are White (Non-Hispanic) (68.7%), White (Hispanic) (21.9%), Some Other Race (Hispanic) (3.91%), Black or African American (Non-Hispanic) (1.97%), and Two or More Races (Non-Hispanic) (1.3%). 96% are U.S. citizens.
- The median property value in Comal County, TX is $244,100, and the homeownership rate is 75.3%. Most people in Comal County, TX commute by Driving Alone, and the average commute time is 28.3 minutes. The average car ownership in Comal County, TX is 2 cars per household.

Priorities identified in Comal County

Rank	Priorities	%
1	MH Services	16%
2	Increase Staff	14%
3	Communication/Collaboration/Awareness/Education	10%
3	Transportation	10%
4	Efficiencies	9%
5	Substance Use Services	8%
6	Basic Needs	7%
7	New Facilities or Updates	6%
7	Day Habilitation/ Daily Activities	6%

8	Funding	4%
9	Wages/Benefits	3%
10	Healthcare	2%
10	Job/Volunteer Opportunities	2%
11	IDD Services	1%
11	Training	1%
11	Homeless Services	1%

Top 3 Priorities identified in Comal County per Category of Respondents



Working and Not Working in Comal County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• None • Varied and daily therapy groups available. Receptive staff. Awesome case workers. • nothing • yes • Peer to peer, art groups, my Dr., my peer specialist • Nothing. Sometimes the casworkers services are helpful. • The painting groups are enjoyable. Marcia and Larry • Individual counseling, peer support • Just being able to start to open up • Peer Group, Group Meeting • There are services available • Coolaboration among stakeholders • Easy communication	• None • Lack of weekend assistance • nothing • all is great • Its all working • Unhappy with the psychiatrist. I don;t think nothings happening. I feel like I am just pushing paper. I dont feel like MHMR is connected to the community. • finding a peer support as laid back as the ones in group • everything is working well • the lack of self support • too soon to tell • Too long of a wait - not enough providers available • Lack of structure/on-the-job training Lack of knowledge of resources
Family Member(s)	• Individual and group support services. • Heightened awareness • The increase of awareness that is starting to bring education and resources in the area is encouraging.	• Referrals from outside entities • Mental Health Care providers • The stigma around mental health, especially in a "small town" type of community with limited resources and education is very challenging to overcome.
Advocates for Children and Adults	• Support from admin staff, directors, and peers • N/A	• Lack of teamwork, at times
Community MH or IDD Service Providers (staff)	• The support I get from my director Jenni. • To see the people we serve come into our clinic and seeing them improve as time goes on. • Staff being on time for work and prepared for the day. • Helping the individuals we serve. • training, supportive administration, opportunities for growth. • Staff are committed to doing a great job. The move to more person centered thinking. • Person centered staff culture • Control of my schedule, and supportive coworkers.	• The pay does not keep up with the cost of living or pay for equivalent positions. • Some of the people we serve can fall through the cracks and not get the help they really need. • Low pay and OSC saying that they are working on it with no progress • Not enough time to get daily work done. Not enough help for the individuals we serve. • school debt, pay • Intakes and Psychiatrist appointments. People needing MH services should not have to wait so long.

	• Teamwork at my clinic	• Intake is not person centered • pay. I don't feel valued. • Strict quarterly hours requirements that aren't adjusted for vacation, sick time, trainings, holidays, etc. It is a good recipe for burnout! Keeping up with PCRPs is also very difficult.
Local Psychiatrist	• Nursing support at Kimble is excellent. Medical director is readily available. Equipment for telepsych clinic usually works well.	• All providers work in isolation, but doctors are almost totally isolated and have little contact with other staff due to our heavy work loads. administration have been dismissive of doctors' complaints. My work environment is uncomfortable; in summer the A/C keeps my room at 55 degrees and I have to run a heater, in winter it is too warm. I'm expected to do too many other tasks in addition to seeing pts: disability paperwork, jury excuse letters, supervising other staff. This prevents me from being able to get all my documentation and training done as there is NO extra time allotted for these tasks. No time for a break; all the doctors eat at their desks while getting work done. No comp time for working on days off or working late. Very little credit for the work that we do. All of us feel unsupported by the administration. All staff are asked to meet goals in which they have no part developing. There is no consensus building in this organization. Staff feels that their hard work is unrecognized and not appreciated by administration; therefore, we have an extremely high turnover in staff.
Emergency Health Care Providers (e.g., hospital emergency room personnel)	• MCOT team is responsive and works together with us to meet pateints needs.	• There is not a lot of help for homeless/uninsured.
Fire Department	• Increased access to services in western Comal County • We don't really have a program, we transport to the ER or Law Enforcement completes an ED for the individual.	• Need additional providers to increase service offerings

Local public health care provider (e.g., federally qualified health centers, local health departments)	• Access to the mental health clinic • Providing patients with a medical professional, medications, and specialty referrals.	• Transportation, there needs to be more transportation • We have quite a few no shows • Comal is the only county that has access to services
Law Enforcement	• We have a great MCOT Team working together as well as other support personnel. • Our MHPO is working well with MCOT and they keep lines of communication open which helps the program stay successful. • Multidisciplinary working relationships. Working together to assist those we serve. • As a Mental Health Peace Officer, having the MCOT Team readily available to assist is a great asset to Law Enforcement and the Community.	• Sometimes the Canyon Lake and Spring Branch Clinics do not have the properly trained personnel to handle and conduct a crisis assessment. I will usually end up driving into New Braunfels and meeting up with someone from the MCOT team to conduct the assessment. • Nothing at this time.
Education	• Professional networking	• Access to services for uninsured
Business Leaders	• Locating services.	• Poorly trained staff who lack interpersonal relationship skills.
Concerned Citizens	• No idea but there seems to be a need when there appears to be many unstable mentally ill people that have problems with little outreach actively shown to be available.	
Primary Care Physician	• N/A	

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• I like the toys in Dr's. office • Committment my grandaughter is doing in relationship to the support she is recieiving here.	• medicine • Appointments cancelled due to other reasons by staff.
Family Member(s)	• The clinic I work in runs well, it is team oriented and our voices are heard • The clinic in Comal has staff that care about my loved one.	• My program requires minimum hours that is equal to Care Coordinator hours. I feel at times I am not giving parents a choice to see me or utilize my services, I feel I need to tell them

	• that my son's care coordinator can go to the school and work with him. • Doctor listens to medication concerns and allows me (parent) to make decisions. • The Children's psychiatrist works well with my granddaughter. She talks to her at her level and makes her feel like she is important and has a voice about her treatment.	we will meet in order to try and reach my hours. • Doctor often calls in sick and our appointment gets rescheduled. We have to miss work several times. This is unacceptable anywhere else but we have n where else to go. • not enough staff to do the work and the wait it takes to get into the doctor • I work from 8-5 and have to have a family member take my child to appointments or use what little sick time I have on appointments. • Staff turn over
Advocates for Children and Adults	• MCOT, Case management • Having the doctor available for my child. • I don't work directly with clients, but we have excellent counselors who utilize TF-CBT with our children and they report that this type of therapy is very effective.	• I am not aware of anything that is not working well with TF-CBT. The only thing I've heard is that TF-CBT will not work unless a child believes they have been through a trauma; and in these situations, our counselors refer the children to other therapists. • Getting in to see psychiatrist. Many times appointments are canceled just before they are supposed to happen and there is another long wait before the patient can be seen by the psychiatrist. Too long. • I do not training for parents about children's mental health. I would like to see more trauma informed care for families in services.
Community MH or IDD Service Providers (staff)	• Support from director and clinical staff • supportive director, culture of team work to provide the best services to families • Team approach • There is a variety of services offered to support youth and their family.	• Hours needed per quarter. You can't take a week vacation without knowing you will miss it • access to doctor's services sooner • more training over skills curriculum, • Limited Resources, One child counselor and one child psychiatrist for the most rapidly growing county in Texas. • turnover of staff resulting in lack of support to families (i.e. not having therapist in house, family partner, or having limited staff to cover large case load)
Local public health care provider (e.g., federally qualified health centers, local	• Comal at this time is the only county that i work in who has good access to services	

health departments)		
Probation and Parole	• MCOTS is awesome! Also we are working with TCOMNI and this works great, and Jenny is the best ! • Referral to the TCOOMMI Continuity of Care for juveniles. It expedites the intake process.	• I really don't have any complaints • If the juvenile is not referred through TCOOMMI, the intake process is too long to get them into services.
Education	• Enthusiasm for Mental Health Education in schools and communities. • There is a more recently opened local office/provider who services quite a few of our students (elementary school). Prior to this office opening in Startzville, we had quite a few impoverished students who did not get mental health services due to care givers not being able to travel long distances to seek care. • Honesty- encouraging students to talk and I LISTEN • not much • many great SpEd support staff to assist in managing behaviors seen in the schools • Consultation and communication with local MHDD staff and MCOT staff in New Braunfels and Canyon Lake	• Not enough parent education on mental health. • enabling kids to "get out of class" for little reasons that can wait. that doesn't help with perserverence • The programs and the limited amount of displinary actions that can hold students with behavioral issues accountable is very discouraging. These students remain in public schools and continue to harm other students, faculty, and themselves at times. It seems like current laws and school policies make it very difficult to get these students the help they need in a quick and efficient manner • limitations for nursing staff as far as behavioral interventions/education • Not enough psychiatric nor licensed clinical staff to meet needs.
Social Service Providers	• MCOT response has been amazing. we also love the collaboration with the MHDD center director and team. • We are able to provide mental health services for children, youth, and families; however, there are not enough providers in the area. • STAR program provides free counseling for youth through Connections	• There is more need than capacity • There are not enough providers for the need. • Stigma against mental health topics- reluctance for some people to talk to a counselor
Government Representatives	• I think some areas work well, but I think absentee parenting/passive parenting is one of the drivers in this crisis.	• I think less medicating of kids and more educating of parents to take an **active** role in parenting, vs. putting screens in their faces would do wonders for our children.

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• Guidance and support from service center. Improvement in communication with parents and clients. (monthly schedules and special notifications). • Individuals receiving services • I like what you are doing for me and I hope yall can help me a little bit more and keep in shape. • Fitness programs and acitivities • Service coordinators • Great teaM SUPPORT AND client relationships	• Working very well considering the budget restraints Texas places on them. • If one of the workers is are out someone else is picked that day to perform the services. • Do something a little different. See me more, please do • Space sometimes for certain programs and attendance numbers. • All the political loop holes to get any services • Our building
Family Member(s)	• She loves going to the Center! Staff and social workers very helpful and know how to help her. They keep her active and part of the activities that inrich all the consumers lives from what I see and hear from her. She loves pottery, sewing, Rec, fieldtrips thay are doing and painting. She loves how happy and fun the staff are for sure. • The attitude of the staff • Having a great support system with my son's day hab • There is a safe place to take my son to socialize with others outside the home. • Having my son in a good day hab,and also getting speech therapy.	• Lack of daily transportation or compensation for a driver to get paid for time and fuel to take her, I miss work to do or pay somebody witch I cant afford to do. • Respite, lack of timely response from service coordinators and upper division coordinators at Hill Country administrative office • I would like more communication from the center, because I do not drop off (or) pickup _____ He is in a host home. Having the schedule, calendar mailed to me early in the month - & perhaps once a week up-date on his behavios and what activities they are doing. • Not having consistent services available to support his needs since individuals with DD need consistency to learn beyond the educational careers. • currently everything is working well.
Advocates for Children and Adults	• none • transportation • communication working on their goals • working as a team • Our growth of individuals in our program. Volunteer opportunities are good. We are moving forward as a company and a team. • Supportive Team • Team Collaboration • Hours, flexibility and staff	

	• We are growing so much. The community is becoming knowledgeable of us. We are growing together as a great team. • Separation of Provider and authorization - Service Coordination and Providers working together to support the individuals with IDD. Allowing the individuals choice for services and providers • I like interacting with the clients every month. • A responsive and encouraging supervisor, flexibility to come early or stay late as needed, and a team environment.	
Business Leaders	• Single entity providing resources and opportunities throughout the area.	• Too many entities trying to secure services from the same resources. Resources are getting frustrated. Prefer working with one entity.
Community MH or IDD Service Provider	• transportation • communication working on their goals • working as a team • Our growth of individuals in our program. Volunteer opportunities are good. We are moving forward as a company and a team. • Supportive Team • Support from director and clinical staff • Team Collaboration • Hours, flexibility and staff • We are growing so much. The community is becoming knowledgeable of us. We are growing together as a great team. • Separation of Provider and authorization - Service Coordination and Providers working together to support the individuals with IDD. Allowing the individuals choice for services and providers • I like interacting with the clients every month. • A responsive and encouraging supervisor, flexibility to come early or stay late as needed, and a team environment. •	• I have worked with Hill Country for 2 years and still haven't obtained full time. I currently provide for myself and pick up shifts to make ends meet. I would like the opportunity to be full-time and work 40 hours a week. I would also like to see a pay raise every 6 months. • all is well • No complaints • Lack of having center in good repair. Pay could be better. • Employment for the individuals we serve. • Office space is too small. • Overworked, due to support staff shortage, Under Paid, due to no raises for amount of work assigned/flex time. • Availability of support, use of company vehicles • We suffer in the area of employment for our individuals. The community and the government entities are running slow. • Changes to Day Habitation - attempts to make everyone into the community and not taking into consideration those that need more supports such as wheelchairs, feeding tube, medically fragile - We should have the option to attend a facility that cares for us and allows us to do activities

		and not push aside us by "no congregate locations" and get out. We should have activities in the community required but not take away options that we have now. • There was missing documentation and missed meetings due to gaps in services before I started the position and it has taken months to make up meetings and fill in for gaps in paperwork. Lack of providers ability to provide enough services--few hours of ILS/ILST and dayhab service is discouraged by provider because of transportation limitations.

Substance Use Disorders

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• Nothing	• Local affordable counseling is not available
Family Member(s)	• Haven't had anything work well in nearby services.	• Finding a nearby therapist or psychiatrist.
Community MH or IDD Service Providers (staff)	• Faster referral system for people needing substance use services.	• Not enough funding to serve everyone.
Concerned Citizens	• prevention programs • N/A	• strategic planning for prevention programs

Positive opportunities and negative concerns that may impact the people in Comal County

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• Not sure; need more resources • None • Winter homeless shelter. Coordination with women's crisis center/homeless coalition • Nothing • N/A • More one on one	• Community outreach; help community be more aware of services • not knowing • Lack of funding or solutions going through MHDD programs. • Nothing • None

	• None • I actually dont know what kind of opportunities MHMR helps with. • Personal care, supportive staff, peer support, MCOT • the ability to ..... inspection thru the right ..... • n/A • to soon to tell • na • Multidisciplinary teams law enforcement MH medical especially in rural areas	• Cuts to social services, and housing programs *SNAP, Social Security, HUD, etc.) • maybe not helping encourage some of us that mhmr has our backs • long waiting for seeing dr. • to much medication • to soon to tell • mental health is a crisis • Lack of resources especially transporyation and housing
Family Member	• Additional providers are necessary to continue to increase the amount of people we serve. • Funding for mental health services • Continued education, awareness, and communication to work toward ending the stigma and increased low-cost resources.	• Stigma • Increase of anxiety and depression • Lack of funds, mental and behavior health are expensive illnesses with a lack of funding especially for those who are lower or middle class economically.
Advocates for children and adults	• Bigger facitilities • An increase in transportation and affordable housing in our area. We do not have a lot of transportation which is a strain on our victims. We also have a lack in affordable housing in our area which makes it hard for our victims do do not have a lot of income.	• Concerned about lack of therapists and psychiatrist • I worry that the current status of the immigration in our country may have an effect on how survivors view us
Business Leader	• Growth of retired professionals available to volunteer in the community.	• Waiting list for services. Lack of transportation.
Community MH or IDD Service Provider	• More MCOT workers coming on board. • Hopefully receiving more funding by cracking down on the balances that the people we serve owe hillcountry. • boarding our area of outreach • None • diverse types of trauma therapy • Person Centered Thinking. CCBHC. • Expansion of services • Better cooperation from co-worker • More funding for our clinic.	• I worry about funding for peers programs and groups that are vital to our individual's recovery. • Long wait times, providers taking people off meds that they've been on for years and it was working for them, providers not listening to the needs of the people we serve. • high turn over due to pay overwork and just plain not having enough hours in the day to complete our work • Not having an actual doctor present for individuals to see in person. Many are uncomfortable about see or speaking to someone over the screen. Be it computer or television. • Lack of affordable healthcare, cuts to social security and other social programs (SNAP, HUD, etc.), lack of

		environmental protections, cuts to education, unaffordable college, unaffordable housing, racist and classist criminal justice system, lack of jobs that pay a living wage, etc. (also known as a system that doesn't work for the majority of people). • too many individuals, not enough staff • lack of opportunities for diverse types of therapies and interventions. • Turnover. Lack of accountability for the quality of services. • Not improving intake process
Concerned Citizen	• No idea?	• Are we really identifying mentally unstable children and adults? If so, how well has the treatment of these individuals been documented to having a positive outcome for the money and resources used?
Education		• Growing population with no access to insurance or provider access in the county
Emergency Health Care Providers (e.g., hospital, emergency room personnel)	• Unsure	• Bed availability for homeless/uninsured. Shelters are very limited, especially for women with no children.
Fire Department	• Increased providers and increase offerings (Art therapy) • The collaborative meeting helps, but I haven't heard of one in a while.	• limited days for access • No cohesion among organizations to come together for a solution.
Law Enforcement	• Maybe a second transportation service for the citizens living in the rural area's of Comal County to help assist with their clinic appointments. • Eventually we will be able to staff our second MHPO position that will help to expand our resources while working with MCOT. • NBPD will soon be adding officers to the MCOT Team. • Obtaining more grant funding to expand Mental Health services out further into the rural communities of Comal County.	• Nothing at this time. • NA • N/A • Nothing at this time.
Local Psychiatrist	• I am not aware of future plans for positive impact. If CCBH is partially implemented, we do not seem to	• I think if we don't advocate for better funding for our organization, e.g. accept expanded Medicaid funding,

	have a good plan for that. We need more staff, better trained staff, and the time to serve the public.	we will not be able to serve the people in need of our services. We also do not take advantage of our own experts, doctors, social workers, etc, who could teach/train our personnel.
Local public health care provider (e.g., federally qualified health centers, local health departments)	• The MHDD clinic in Canyon Lake is closer than New Braunfels • mental health providers for depression, anxiety, and counseling	• Mental health awareness is still • stigma of mental health disorders • low in Canyon Lake
Primary Care Physician	• RESOURCES	• N/A

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• don't know • Adolescent suicide issues	• nothing • Appointments canceled due to other reasons by staff
Family Member	• I feel our community is making changes for the homeless population that will benefit our community • Don't know • none • Training in Person Centered Thinking. This is an area that is lacking at HCMHDD and would change the culture of HCMHDD for the better. • I'm not aware of any.	• I am unsure • The long waits for to get into services and see the Doctor. Too much paperwork when you come in. • the wait to see the doctor • Care coordinators seem overwhelmed and there is high turnover. I would like to have someone that my child trusts in the position so that her needs are known and consistently met. • Staff turn over.
Advocates for children and adults	• There was a really good HIV training I attended that was back in October. Education is always important! • I don't know of any • I am not aware of many opportunities for families with children in services.	• When I was doing full-time advocacy here, I would often hear from parents that the resources we were providing were dead-end roads. People reach out to other agencies for support and help, and are given the run around and are not ultimately being helped. • Our area is growing rapidly and I am worried that the services provided by HCMH may not be able to keep up with demand because they are already stretched. • The staff turn over effects my child. It is hard for them to open up and trust

		when they don't think this person may be here next time they come back.
Local public health care provider (e.g., federally qualified health centers, local health departments)	• None in the other counties	• the lack of access to services
Social Service Providers	• McKenna Foundation is always working with the providers in the community to assist with maximizing the services available • Substance Awareness Coalition in Comal County	• We are just at the beginning of the new school year, our agency counselors already have full caseloads. How are we as a community going to be able to handle the need with such limited resources.
Community MH or IDD Service Provider	• Mental health officers • open access and substance use disorder without a mental health diagnosis • group sessions, family therapy • I am not aware of any • grants and CCBHC	• Wait for intake and doctor • will we be able to provide the services to the additional people that will come into services • Lack of acknowledgement of limited resources. Our county is growing rapidly and the amount of families we are serving is increasing, but we are not adding additional staff. • having far distances to travel for services, long waits for (2-3 months) for doctor's appointments.
Education	• New format for our agency. • more open acceptance of mental health issues, especially in children. • More outreach to the communities about mental health • not sure • none • After school programs	• Enough staff and money to help better pay the "over-worked" staff. Importance of keeping the staff and low turn over. • Unk • Kids and social media- hard to see what they are seeing that negatively impacts them • not sure • the level of emotional disturbance/behavioral health we are seeing in public schools with limited outside resources to refer to • Lack of providers to meet the rapid growth.
Government Representative	• Maybe more parenting classes? Have them also available through schools?	• As these iKids are growing up, I think there will be even more complex problems
Probation and Parole	• It would be nice to have a designated person at Hill County to be Liaison for Juvenile Probation	• Population growth and strain on services

		• The concern I have is the rise of THC oil usage and the self medication to address the mental health needs.
Social Service Providers	• None	• the county is growing faster than the resources can meet

Intellectual Developmental Disabilities

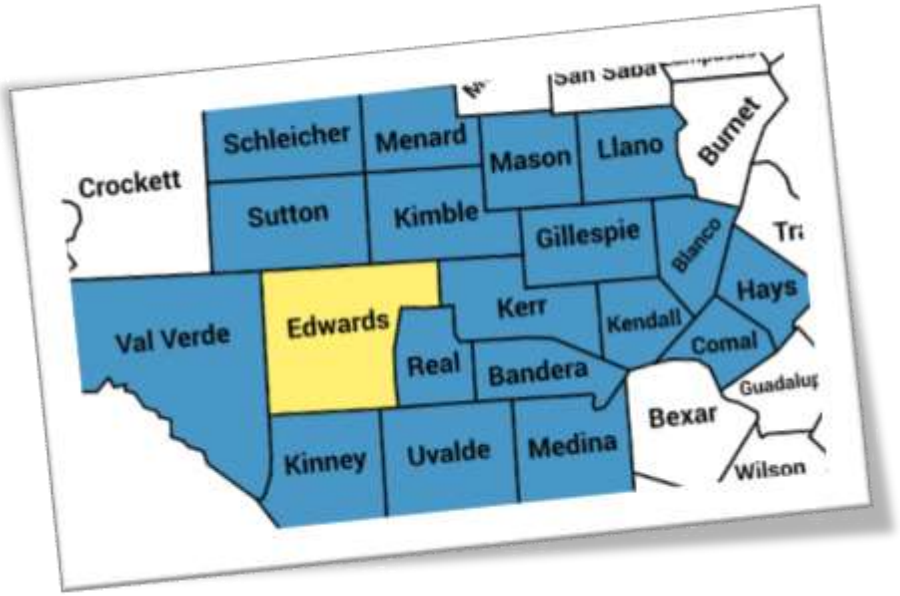
Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• The proposed new building housing both the current center and the ISD High School young adult class. Expansion of space and number of clients that will be able to attend. Expansion of daily activities and classess available to clients. • more quality workers • no comment • Construction and transportation • Better communication. Not all understand your processes or vocabulary • Community Inclusion	• Delay in construction of proposed building. Current building has significant history, but newer facility will show the community what the clients can achieve with expanded opportunities. • Not having enough workers to stay any length of time • no comment • housing and transportation • Communication. on the individuals level of understanding • Lack of funding
Family Member	• I don't know • Maybe see if any of the companies need piece work done again? • Possibility of a new building with opportunity for additional services • Getting, building, a new center! • Nonprofit groups that provide activities in the community. • none	• N/A • Having to wait for services? the Center wait list it took us 12 years. • unable to get respite services even though it was on my son's care plan • Not giving enough money to staff - we need to continue to hire more staff as we grow (we are already growing) to attract more people • The lack of adult housing opportunities. • none
Business Leader	• Too many to list. Need the single source to own the opportunities.	• Will the single source maintain and manage the relationships and services throughout the area for an extended time and not temporarily.
Community MH or IDD Service Provider	• Strike force is a positive impact for our consumers because they are able to bowl independently or with assistance when needed, earn trophies/medals and are able to hang out with their peers. • The variety of entertainment they provide • more funds to do activities	• n/a • There is no known negative concerns • None I can think of • Building being in worse shape than it is now • Finding good employees dedicated to our mission. • Lack of public transportation available and providers who are short staffed

	• None • We will continually have opportunities our county is growing so quickly. • New advocacy program coming to Comal County through Hill Country. • Person Centered Thinking • The TCDD grant should impact what we do and how we do it. The open feeling to change and growth is wonderful. • I am not at this time. We need more community involvement and discussion with services and options in small counties • Anything that can get them out into the community. Whether it be sports,church or any community activities they prefer. • Shift in ideology towards becoming "person centered" at Hill Country.	and not providing transportation services as agreed upon when they became a provider. Directly affects individuals we serve. • None • Availability of certain services in their areas. It doesn't doo them any good to put it on their plan if there is not going to be anyone in the area to provide that service. Unavailability of trustworthy and dependable staff for the salaries and hourly pay provided • We can probably all come up with some but, our focus I feel needs to stay positive. Funding will probably be a big issue along with staffing. • As discussed the Day Habitation options - • Not having the right services they need. • Gaps in services when staff leave and before new staff are hired. Hill Country as an IDD provider is short staffed and providing only limited IDD services.
Education	• I don't know	• N/A

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• Don't understand the question	• Lack of affordable counseling. Our vets with PTSD need help NOW
Family Member	• A local rehab center	• Lack of therapists and psychiatrists taking new patients.
Community MH or IDD Service Provider	• Community awareness is growing.	• Lack of detox services. Having to travel to other counties to get services.
Concerned Citizen	• Don't know • drug free community coalitions working on public health changes	• Apathy. The general public seem to be unconcerned about the problems caused by substance abuse. • lack of substance use treatment providers

Edwards County



- In 2017, Edwards County, TX had a population of 2.11k people with a median age of 49.1 and a median household income of $48,462. Between 2016 and 2017 the population of Edwards County, TX grew from 2,028 to 2,111, a 4.09% increase and its median household income grew from $39,457 to $48,462, a 22.8% increase.

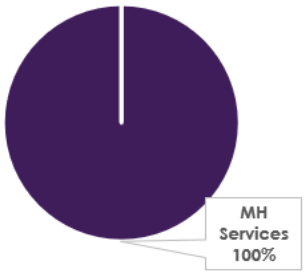
- The 5 largest ethnic groups in Edwards County, TX are White (Hispanic) (55.9%), White (Non-Hispanic) (43.1%), Some Other Race (Hispanic) (1.04%), American Indian & Alaska Native (Non-Hispanic) (0.0474%), and Asian (Hispanic) (0%). 98.5% are U.S. citizens.

- The median property value in Edwards County, TX is $72,800, and the homeownership rate is 86.9%. Most people in Edwards County, TX commute by Driving Alone, and the average commute time is 13.6 minutes. The average car ownership in Edwards County, TX is 2 cars per household.

Priorities identified in Edwards County

Rank	Priorities	%
1	MH Services	100%

Top 3 Priorities identified in Edwards County per Category of Respondents

Top 3 Priorities for Individuals	Top 3 Priorities for Family Members
Top 3 Priorities for the Community	**Top 3 Priorities for Staff**
	

Working and Not Working in Edwards County

Children's Mental Health

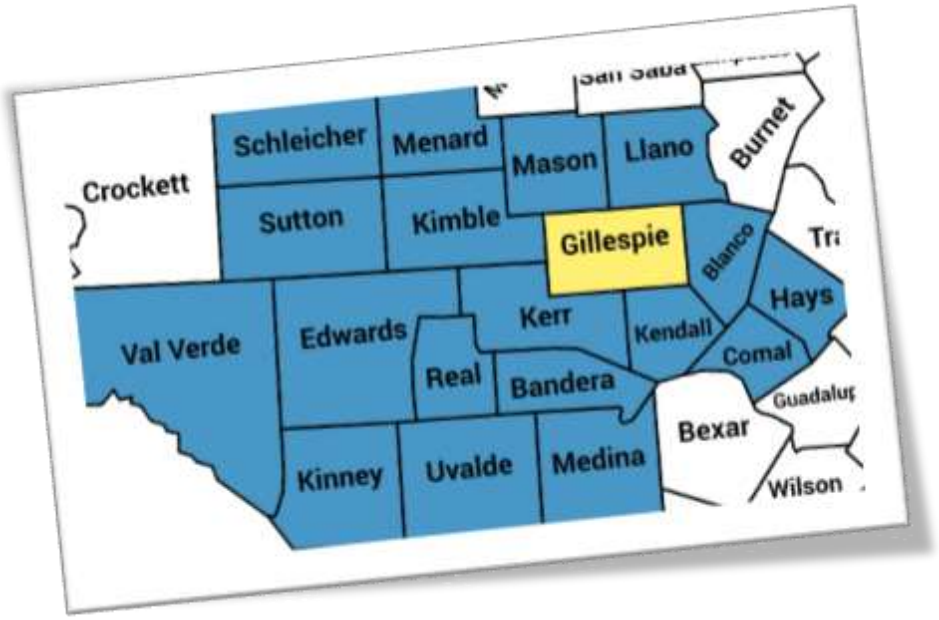
Group Represented	What is Working?	What is Not Working?
Government Representatives	• There aren't any child or adult behavior services here for mental health such as therapy or counseling.	• There are no behavior/mental health therapy/counseling services for adults or children in Edwards County.

Positive opportunities and negative concerns that may impact the people in Edwards County

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Government Representative	• For IDD, there is Service Coordination, but behavioral therapy/counseling services cannot be found in Edwards County.	• There is no access for child or adult behavioral therapy/counseling in our area. Traveling to services such as these is out of the question for many people residing here.

Gillespie County



- In 2017, Gillespie County, TX had a population of 25.9k people with a median age of 50.2 and a median household income of $56,267. Between 2016 and 2017 the population of Gillespie County, TX grew from 25,732 to 25,939, a 0.804% increase and its median household income grew from $55,850 to $56,267, a 0.747% increase.

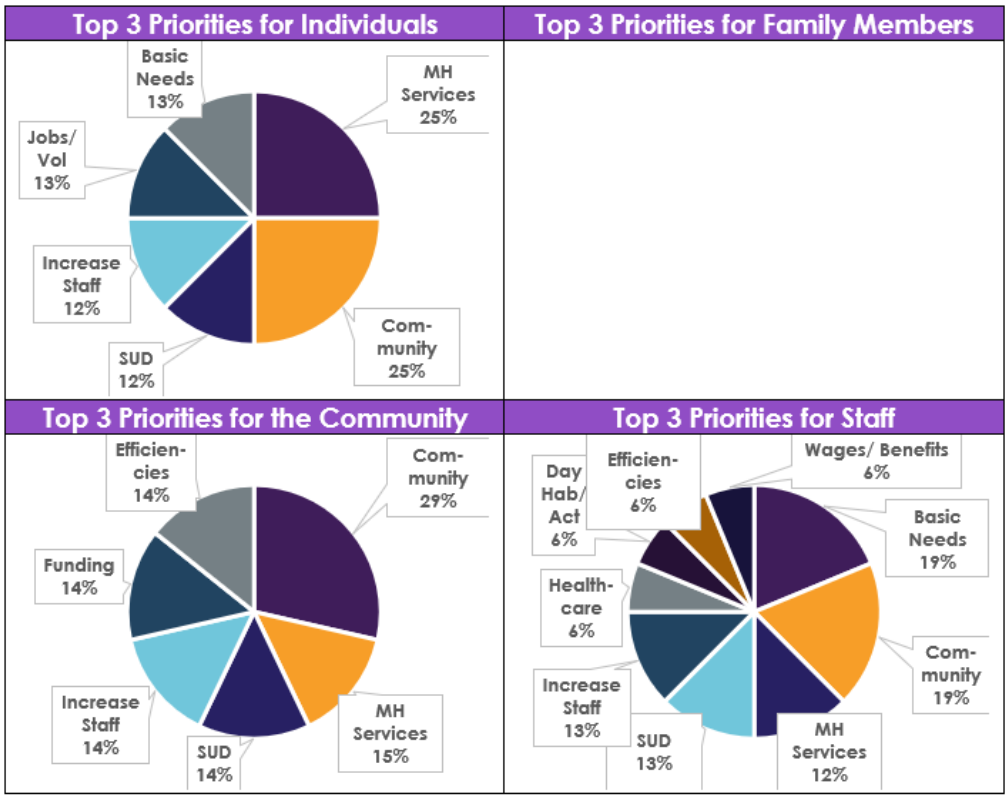
- The 5 largest ethnic groups in Gillespie County, TX are White (Non-Hispanic) (75.6%), White (Hispanic) (17%), American Indian & Alaska Native (Hispanic) (2.42%), Two or More Races (Hispanic) (1.92%), and Two or More Races (Non-Hispanic) (1.63%). 94.5% are U.S. citizens.

- The median property value in Gillespie County, TX is $269,900, and the homeownership rate is 76.3%. Most people in Gillespie County, TX commute by Driving Alone, and the average commute time is 19.4 minutes. The average car ownership in Gillespie County, TX is 2 cars per household.

Priorities identified in Gillespie County

Rank	Priorities	%
1	Communication/Collaboration/Awareness/Education	23%
2	MH Services	16%
3	Substance Use Services	13%
3	Increase Staff	13%
3	Basic Needs	13%
4	Efficiencies	6%
5	Funding	3%
5	Healthcare	3%
5	Day Habilitation/ Daily Activities	3%
5	Job/Volunteer Opportunities	3%
5	Wages/Benefits	3%

Top 3 Priorities identified in Gillespie County per Category of Respondents



Working and Not Working in Gillespie County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• The peer specialist, group therapy, and care coordinating. • Client receptiveness to being educated	• Everything is finw • Lack of appropriate screening to ensure proper supports are provided
Community MH or IDD Service Providers (staff)	• groups, informational hand outs • We all work together as a team • I am still in training, but have learned a lot so far • Good Support From Director and Clinical staff • therapies offered are helpful to people in service	• We need more Informational group type things. For example, a group for people with depression. A group for people struggling with BPD, classes/group for parents with children who have MH issues. Groups that prepare people for job interviews/professionalism

		• Under staffed / over worked • everything has been great so far • Not enough full time staff and the pay vs responsibilities are heavily disproportionate. New companies in the area have starting wages higher than mine • Program is not funded well and has little support.
Local public health care provider (e.g., federally qualified health centers, local health departments)	• There are some counseling referral options for low-income individuals and families through the place where I work (The Good Samaritan Center) and the Needs Council. For those needing a psychiatrist, MHDD is available to help.	• There is a shortage of appointments available and delays in getting patients help at MHDD can be difficult.
Education	• Consumers • N/A	• Holding on to consumers that do not belong in our care but need to be in a nursing home due to age and physical • nursing equipment is old and outdated. short staffed and trying to get OT is a nightmare. (But how else are things supposed to get done?) Not enough resources to offer patients. No time for community education/training.

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Social Service Providers	• Individual therapy with LPC	• Coordinating sessions within school & parent's schedules

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• Having great consumers	• Lack of communication, lack of much needed staff, holding on to consumer that do not belong in our care but need to be in a nursing home setting due to age and physical ailments.
Community MH or IDD Service Providers (staff)	• Great team work. • Seeing consumers achieve their goal.	• Lack of community knowledge of what services we provide. • Needing help with coverage

SUD

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• none • Celebrate Recovery	• AA, NA, Al-Anon •
Community MH or IDD Service Providers (staff)	• Improvements to the referral system for SUD treatment. Work with good people with good collaboration for shared consumers. SUD program being a separate entity within HCMHDDC.	• Unrealistic metrics/standards co-workers in other departments are held to which reduces/distracts from providing services to consumers and impacts work/life balance. Massive online training and training that may not be relevant to your position. Lack of standardized practice training (i.e. writing PCRP's, clinical notes). MH competency training needs to be improved and made relevant to the position you hold. Need actual training on how to operate Anasazi from the people who know all of it's functions. SOP's are years old and show no indications of being reviewed yearly for currency and relevance, also not prominently referenced and in many cases lack specific enough guidance.

Positive opportunities and negative concerns that may impact the people in Gillespie County

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• being in groups and one on one • Educating and collaborating with other services agencies to take away stigma of "passing the buck"	• too many people • Lack of education with families and communities on how to best support a person living with MI
Community MH or IDD Service Provider	• housing options. some groups. • none • none so far • None • Increase inpatient bed capacity.	• the housing/shelter options are limited. Food and health resources are limited. It would be nice to have a gym/center to allow consumers to work out/exercise to help manage stress and to lead a healthy lifestyle. • none • none so far

		• 1.not enough full time staff and understaffed crisis team, and care coordinators 2. Services not accessible to individuals that work. We expect our clients to get better and get a job, but that makes it hard for them to continue services when they work 8-5 • Lack of available inpatient psychiatric beds. Lack of resources for substance use treatment, homelessness.
Education	• none • Offering gym memberships at a discounted price. Offering vouchers for personal hygiene products. Educational classes for employment/interviews. Support classes for spouses/children/family	• Staffing • having a negative work environment that intervenes with client care.
Local public health care provider (e.g., federally qualified health centers, local health departments)	• More access to all types of counseling. More access to counseling for school students. More care for small children exposed to trauma.	• People are growing up in chaotic, dysfunctional homes and it is becoming a problem when they become adults. The numbers of children experiencing trauma and difficult home lives seems to be growing and they become adults with behavioral issues.

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Social Service Providers	• Education of the general public as to the severity of children's trauma from living in abusive & often unstable environments	

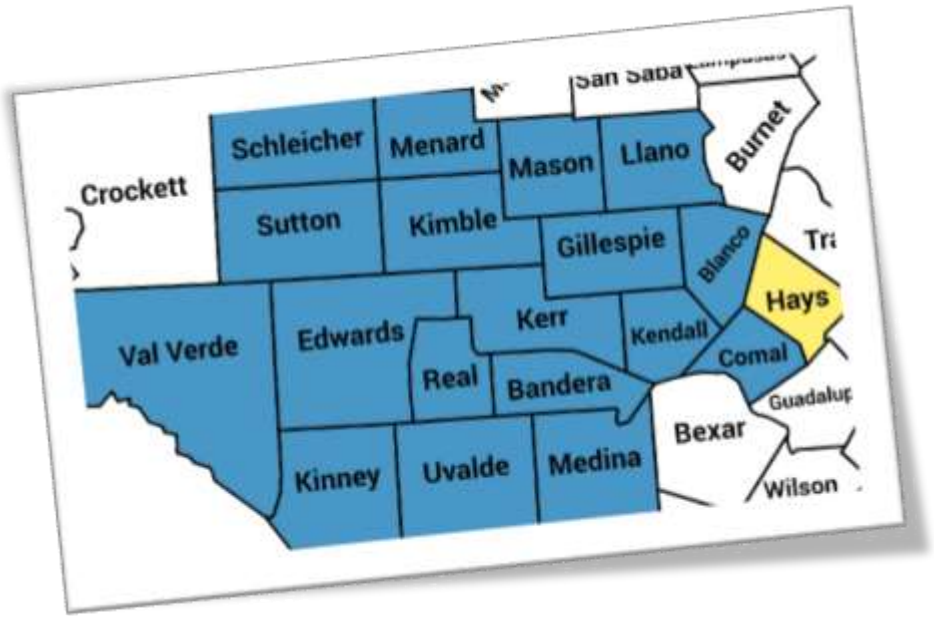
Intellectual Developmental Disabilities

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• n/A	• not having staffed to give optimum care to consumers
Community MH or IDD Service Provider	• More positive community involvement.	• Reduced funding from the government to meet medical needs.

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• none • Building a shelter in Gillespie county	• Resources are unknown to those that desparetly need them. Stigma is always a guge factor. Also, local law enforcement are unaware of our services and often refer some local individuals to Austin/San Antonio. • Cost of housing, availability of jobs locally
Community MH or IDD Service Provider	• Not sure, but would like to see expansion into Veteran specific programs and counseling that can be backed by Veteran service organizations and the VA.	• Employee fatigue/burnout and turn over. This is already an issue. Some employees are operating in multiple roles (basically doing multiple jobs that should be filled my multiple people. I.e. recovery coach doing mcot also) that impacts their main role and takes away from providing services and that in turn creates negative impact on how they are "graded" and the metrics/standards they are held to. Specifically, director that is on call MCOT and also functions as a RC, now they have to juggle all the responsibilities. RC that is on call MCOT, now has to cancel/reschedule appointments that have been made in advance to respond to crisis (this affects their monthly metrics) also, they respond to crisis after hours and then still have to come in for scheduled appointments, plus it takes away from days off, which contributes to burn out.

Hays County



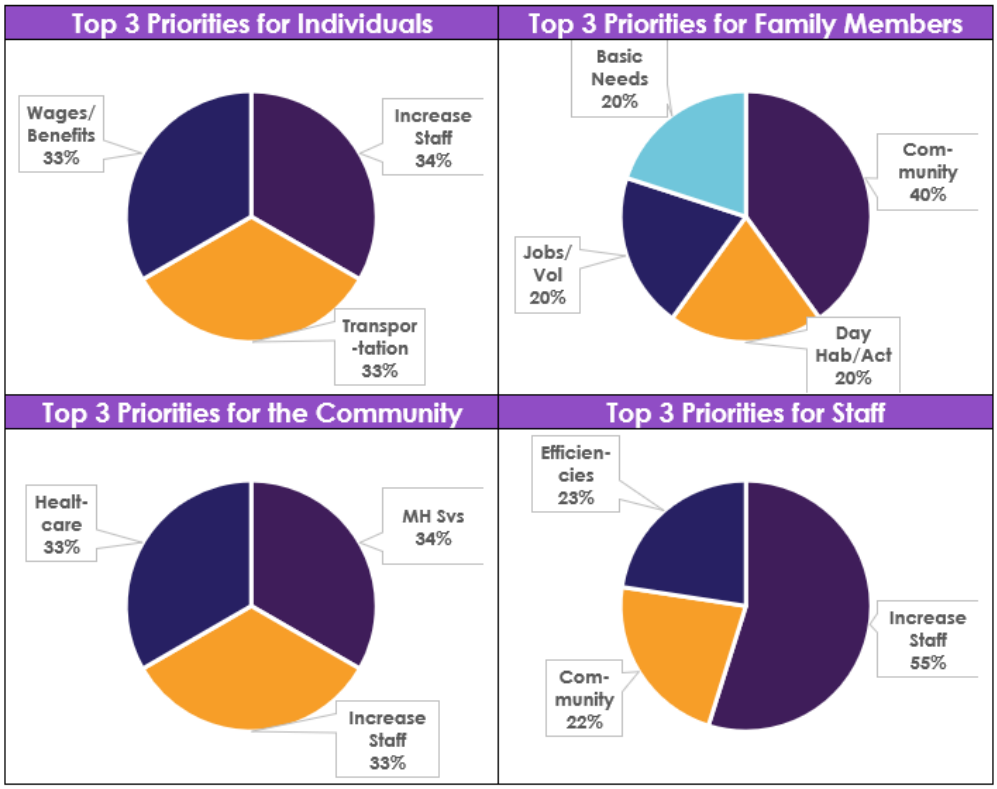
- In 2017, Hays County, TX had a population of 195k people with a median age of 31.3 and a median household income of $62,815.
- Between 2016 and 2017 the population of Hays County, TX grew from 185,686 to 194,843, a 4.93% increase and its median household income grew from $60,495 to $62,815, a 3.84% increase.
- The 5 largest ethnic groups in Hays County, TX are White (Non-Hispanic) (55.3%), White (Hispanic) (32.2%), Some Other Race (Hispanic) (3.81%), Black or African American (Non-Hispanic) (3.48%), and Two or More Races (Non-Hispanic) (1.7%). 94.2% are U.S. citizens.
- The median property value in Hays County, TX is $204,700, and the homeownership rate is 62.1%. Most people in Hays County, TX commute by Driving Alone, and the average commute time is 28.1 minutes. The average car ownership in Hays County, TX is 2 cars per household.

Priorities identified in Hays County

Rank	Priorities	%
1	Increase Staff	25%
2	Communication/Collaboration/Awareness/Education	11%
3	Wages/Benefits	10%
4	Efficiencies	9%
4	MH Services	9%
5	Training	6%
6	Transportation	5%
6	Funding	5%

7	Day Habilitation/ Daily Activities	5%
8	Basic Needs	4%
9	IDD Services	3%
9	Job/Volunteer Opportunities	3%
10	Healthcare	1%
10	New Facilities or Updates	1%
10	Substance Use Services	1%

Top 3 Priorities identified in Hays County per Category of Respondents



Working and Not Working in Hays County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• therpay. all three groups and peer support with staff • Working with peer support working with tccomi Dr. is good as well	• Everything is helpfull so far • Dr. availibility

Family Member(s)	• Nothing	• Clinic dropped the ball on caring for my child after having an emotional crisis in the office while getting counseling
Community MH or IDD Service Providers (staff)	• supportive staff and supervisor working to ensure the best service to individuals and families • Everything is working fine • Helping people and support them. I love my job! • I like being able to set my own schedule and having that flexibility and having my own office space to meet with and talk to my clients that I can decorate. • Crisis services. • Minimal travel to work site • Working well with clients • there are people who want to engage in the services I've been trained to proved • ability to receive low / no cost services • We have good staff • The relationships with staff and individuals.	• Short staff • none • The huge expectations and caseloads. It isn't possible to meet with over 350 people a month and provide proper service. Also, the numbers constantly rising and more people are coming in every day which only makes the case loads bigger and bigger and make it hard for Care Coordinators to be able to keep up with so many clients. They are also being held responsible for hours despite clients not showing up to their appointments is not fair either. It's also a struggle to have to be on call twice a month. It is so MCOT can get a break in the month, which is understanding, but most Care Coordinators already work 8-5 and carry huge caseloads and are overwhelmed with that, and then they are still expected to come to work the next day or on Monday when they did not get a full night's rest or a full weekend break from what is normally a emotionally stressful extra night or weekend? Nights and weekends are normally for Care Coordinators to decompress and relax, and most will want the overtime/overtime pay which is heavily discouraged. Many Care Coordinators do not stay past being crisis trained because they absolutely do not wish to crisis screen/be on call on top of the already large caseloads they are expected to carry, which results in high turn over rates from both of these things. • Continuity of care following missed or delayed appointments across multiple disciplines. • Number of individuals vs. peers • Not enough education in skills training, hill country is very behind in innovative and new methods. Cases

		are so big can serve each client accordingly. • there could be a better work culture that is more collaborative, integrative, and supports team-building and self-care • wait time for services • We do not have enough staff • Communication

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Advocates for Children and Adults	• Telehealth to have the kids i work with get therapy in their area.	• travel time is a big issue trying to meet hours and to provide care for the clients.
Community MH or IDD Service Providers (staff)	• Increased inter-agency collaborations, I enjoy working the population • Having two people on shift	• Funding, frustrating technology, antiquated business practices (mailing in vendor logs, etc.) • Being short staffed, supervisor not making a big enough presence during regular work hours mon-fri. Our on alert option being taken away.

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• none • I have been here 10 years and I love my job. Everything is well but we need more staff. • Right now not too many things but one thing the staff that we have is amazaing even with so much workload. • Everything. What I need is being provided to me. • I have previous experience working in an IDD waiver program, so I am familiar with services and systems.	• none • Short staffed. We need more staff so we can help consumers more, and we can take off work if we need to. • not having enough staff to provide adequate support for our clients. such as outings, everything has changed drastically in the center • Nothing, everything is working • All waiver programs are significantly underfunded in Texas, resulting in lack of doctor's, therapists, professionals and paraprofessionals who are willing to accept the state rate. This means IDD group homes are understaffed and it is difficult to get compliance and quality performance from staff. Very few therapists (ie. speech therapists, etc.) will accept the low state rate. This means that even if a

		therapy is on an individual's IPC, there is no way to guarantee the person will receive the therapy. **Lack of follow through by the state. When a provider agency fails to provide a service that is on the IPC, one can file a formal complaint with the Office of the Ombudsman. However, this state office cannot force the provider agency to follow through with delivering the good or service. The provider agency can be sanctioned (prevented from enrolling new clients), but can not be shut down, if it does a poor job with customer service, or providing any of the services. **There is an entirely different (read lower) standard for IDD services in Texas, compared to any service that operates in a free market. Usually, if a company does a bad job, it ceases to exist. This is not true for IDD services/ provider agencies. C'mon, Texas, we can do better!
Family Member(s)	• Everything • Adult behavioral • The services that we receive are great and providers are easy to work with.	• Availibilty of information concerning Medicaid and SSI. It is difficult to get clarification and consistent information on both. • There are not enough day hab facilities to provide services based on social needs and desires of our citizens. Also, the job situation needs some really concentrated focus. • None
Community MH or IDD Service Providers (staff)	• Good teamwork • The teamwork and communication in the Day Hab. Everyone does everything. Every staff member takes turnes and do not complain about doing what is asked of them. • Having the laptops/desktops in homes for training. Consistent outline of daily expectations for staff and clients. • Everything would work well as long as we have teamwork/ • Strong DD Director who is outspoken, intellectual, and empathetic. • The staff we have working together to service consumers.	• Could use more staff • Lack of staff and communication. Useless training that takes staff away from their job. • Excessive scheduling due to need of employees. Lack of unity between staff in workshop and residential staff. Having more interactions/communication may help us better serve our clients. • Repetitive paperwork it takes away from actual interaction with clients. • Staff shortage. Company offering everything under the sun to participants. But not taking accountability for not providing services.

	• I'm just getting started but I guess being able to use state transportation to go see consumers • Everyone works really well together as a team. • Working as a team with my only co worker to cover all 19 counties • The one on one relationships with the individuals we serve. The team atmosphere with everyone having a desire to make positive changes. • Dedicated authority/provider staff that serve individuals with IDD. They do so much with limited resources. • Person Centered Practices when utilized. • The implementation of PCT has been very helpful. It would be even more beneficial if providers were obligated to follow the same practices. I hope that this is eventually implemented on a State level. The flexibility of our position regarding our work schedule works really well for all of us by allowing us to manage our stress and schedules depending on what works best for us. • Individuals receiving supports that they want and need. • Staying on top of visits and not waiting for the end of the month, and doing progress notes right after the service occurs • MANAGEMENT! I have to say that one thing that is working well for me is the lower/middle management that is above me and their quick, timely, and efficient communication with me. Any questions or concerns I have that they can handle, they do so. I'd like to personally name those that have really helped the most: Jennifer Eckols, Whitney Waller, Jennifer Marquis, Analaura McCrae, and Jennifer Caruso. • -Leadership is working to define and stabilize services across the board. -Support that is given to me ion my position from my direct supervisor and upper level management.	• The lack of staff needed to service consumers • For me again, I'm just getting started so I feel like I'm still learning this system but so far there is an emormous amount of paperwork and just navigating the data systems. So pretty much learning what information to input and to do it efficiently without wasting so much time. Shouldn't need to write a book to tell a story when there's 50 other forms to fill out. • Too much paper documentation. I feel if we could get a computer system as a central database that everyone can go to and that we can chart in, it would be very helpful. As a nurse, and a new one to this area of nursing, I was SHOCKED to find that unlicensed staff was administering medications ... on a paper MAR at that! I feel a computerized system, especially with medication admin, would cut back on human error so much! • Lack of Service Coordinators often delays work for the rest of the IDD Authority Programs. Also SC supervisors not replying to emails when there are no SC working for certain counties and clients not having a Service Coordinator assigned. Also, MCOT and On-call workers for Counties without MCOT contacting IDD programs such as IDD-CIS for them to resolve MH crisis for IDD individuals. • Not having a system that is the same across the board. Different centers have different ways of doing things. So this is hard when trying to find out what is actually the correct way of doing things. • Temporary wait to receive much needed GR services. • Heavy caseloads which makes it difficult to properly support our individuals and their families. • I realize that staff turnover is inevitable, especially in a field such as this. However, large case loads

	• My center co-workers and my direct supervisor. I am very excited for the new recruitment management system. We got a pay increase for DSP positions in my area. We got computers for the group homes.	make it difficult to dedicate enough time to each person on our case load. It takes longer for anything to happen for the people that we serve because our caseloads are so high. I believe that longevity of staff is such an important key in the implementation of Person Centered Practices, and high case loads that lead to staff burn out is limiting the potential that PCT has. In addition, caseloads and workloads in general are not distributed evenly. Some staff have a plethora of responsibilities while others do not, but our pay only differs slightly. In addition, there is not a lot of room for growth within the company which I believe causes people to work for a small period of time and then leave. I think staff turnover would decrease if the SC department was restructured so that there is opportunity for growth and increased pay depending on your level of responsibility. I believe that knowledge is power, so we need to focus on staff training especially since there are so many new staff. Training needs to be more structured to provide new staff with more support. Training needs to especially include provider obligations so we can better advocate for people we serve when we experience resistance from providers. Training should also include information on Medicaid and Social Security benefits so that families feel supported in this area. I think IDD services also need more support when it comes to MH services. In my experience there is not a lot of overlap between the two, even though I know many people receiving IDD services that would benefit or desire MH services as well (this includes court case management support). • Wearing too many hats. • Not having electronic copies of some PDPs, unorganized filing room • The top thing that seems to trickle into every other "Not Working"

		category I have is TRAINING. While I know many of us were told we would not receive training to our particular role in some transitions made, I am noticing the lack thereof with those coming from NEO and from center to center the knowledge that is inconsistent. I understand that NEO cannot provide that for all positions within HCMHDDC, however, there are poor directions in finding the necessary information and a lot of people in administration give different answers on big issues. If training of what is needed to know in each role was created, including the necessary, true information, that would be HUGE. One things I believe should be included with NNEO (it made my life easier once I understood this and I believe would be monumental for each person joining our staff) is the difference between LIDDA and Provider for the IDD side of the house and the difference between those and LMHA. This basic structure takes out a lot of headache. For example: Who/What position handles what within each center/office? Deadlines for all paperwork and how to do it. Retention timelines for all paperwork we are keeping. • -Ability to find and hire quality staff to provide direct care services. -Ability to work with Service Coordinators in order to provide quality services to individuals. • Lack of appropriate training of all staff at all levels. for example: clear universal up to date policy and procedure. Training for management positions. training on each role for everyone so employees understand who does what. Training for Direct care Professionals: bathing, assisting with toileting, assisting with finances, teaching life skills. Lack of contracts, of any kind- or appropriate and effective response from administrative professionals assigned to contract issues, leaving me out of

		compliance with the state. Pay rates are sad, no clear path for improvement or pay increase for longevity so that staff retention is hard. Contradicting and incorrect information frequently given by administrative staff. unresponsive local Board when I have attempted to address safety concerns with the facility. Safety concerns with my facility. Overwhelming systemic issues at every turn.

Substance Use Disorders

Group Represented	What is Working?	What is Not Working?
Community MH or IDD Service Providers (staff)	• Coordination with team members and with care coordinators. Ability to provide services pretty quickly. The service its self providing counseling for both SUD and mental health. Having an integrated care team is very helpful. Excellent space to provide services. Plenty of referrals.	• Would like to see more set standards in the program. Also ability to do groups and less emphasis on hours when clients do not show. I would like to see a contingency management program set up. Some changes in way things are scheduled.
Primary Care Physician	• counciling	• patient missing appointments

Positive opportunities and negative concerns that may impact the people in Hays County

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• Its all good for me • Dr. availibility and Intake process would benefit if improved	• n/a • Waiting for Dr. 3 months is too long
Family Member	• Based on personal experience, I'm very disappointed.	• That I might not be the only family they have not serve while looking for services because they might think out case is too difficult due to mental health and developmental disabilities.

Community MH or IDD Service Provider	• Unsure • Being there when they need us • none • COPSD and Peer Support are very great programs though the qualifications for COPSD have become more strict, resulting in people not getting the care they need or want. Peer Support offers a great way to build support and a lot of clients happily report they enjoy the groups and Peer Support staff. • If employee retention occurs, partnerships can be better formed in the communities served. • Our clinic will hopefully be fully staffed for the first time in a very long time. This will help clinic and people we serve. • None • the change to CCBHC • more immediate access to services is pending • CCBHC	• people not coming to receive services due to concerns about financial ability to pay • Under staffing • none • I am concerned about the large number of people that continuously come in each day for intake and add to the already enormous caseload of Care Coordinators in which there are normally only two of each for each level of care. Also the psychiatrists having to meet with so many people does not offer the people the care that they desire. There is a high need for more therapist, specifically for trauma and CBT. It is sad that many people have to qualify for this service and it upsets them they see it as we are invalidating them or their feelings and needs despite explanations. • Rapid influx of those served is overwhelming the quality of serves available. • We have a really high turnover with staff members. This negatively impacts staff and people we serve significantly • There is not assistance due to staff being short, not having enough counselors to help clients, and being overworked • the long wait for the initial psych eval with meds • many individuals do not seek out services • Population growth/not sufficient resources

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• CCBHC development, career ladder development, salary increases • NA	• rate of change, it's talked about but with little actions or follow through to follow • Our facility being short staffed
Advocates for children and adults	• Open more positions and have closer clinics in the area they are at.	• not aware of any negative impact for near future

Intellectual Developmental Disabilities

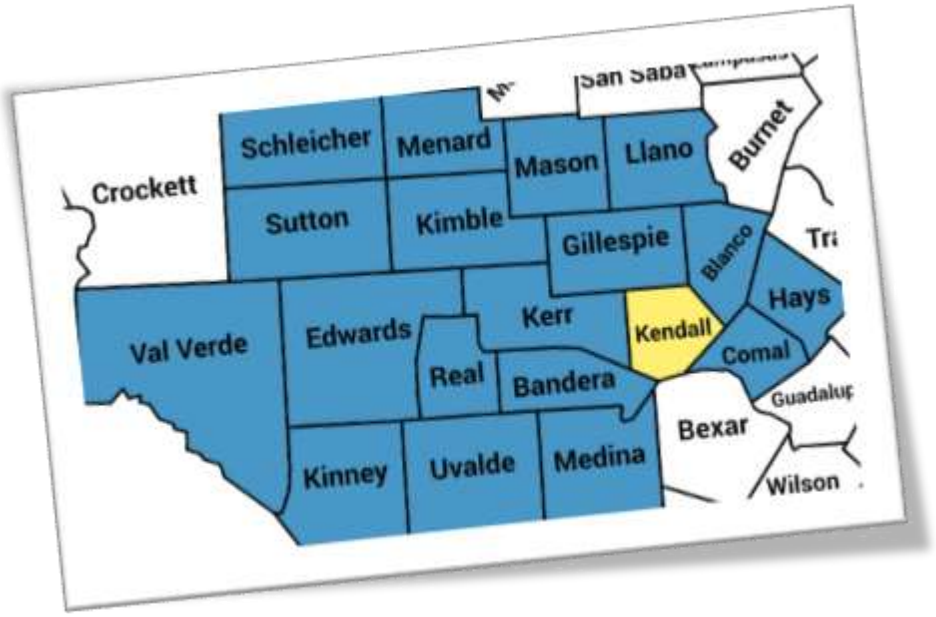
Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• none • More staff • None and if they do they need to be enforced not just promises. • Have patience with process of transitioning into the community from nursing facility. It takes time. • I am aware that Texas is trying to catch up with a mandatory federal legislative change in the next two years. I hope we can do it!	• none • I worry that since we are so short handed that they may close the center and homes we have here. • Very sad to see not enough help (staff). Our children are being affected by this. • None • Cut in any funding for IDD waiver programs or any disability services. •
Family Member	• none • more staff	• Healthcare concerns • individual attention
Community MH or IDD Service Provider	• none • none • Scheduling outings in local parks during nice weather if consumers deserve/behave. Potentially working with local nursing (or similar) to help provide relief staff while allowing them to gain experience in the field. • More client positive interaction. • Opportunities come when we can actually commit to the services we can do. • nothing • I think I'd rather work at one establishment than travel all over to see individuals • Computerize a lot of the paperwork that we do. More activities during day habs. More staff! • Getting IDD workers properly trained as well as all HCMHDD employees getting incentives/bonuses to show their work is appreciated and not send just an email. This will have a positive impact by employees staying in the company and providing a good service to individuals. • More staffing to provide more involvement in the community. • Community inclusion coordinator in NB as an outreach to consumers and their families which will also give opportunities for paid position(s) for individuals we serve.	• none • none • I do not have any concerns at this time. • Short staffed. Different staff coming and going. Then no interaction time due to short staff • Staff morale or past employees comments that stop people from working here. • Lack of staff • That services on their plan aren't being carried out because of being short staffed • A lot of medication mistakes are made because there are not a good set of checks/balances. • The intake process for IDD Services can be very long for individuals 6+ months which often has a negative impact and a negative view of the company. • Lack of training for new hires to insure quality service • High influx of individuals with IDD in Hays/Comal and not having enough resources to meet their needs. • Staff to consumer ratio, caseloads too high making it impossible to properly support individuals and their families. Changes to dayhabs requiring full day community integration as some individuals need more "home based" time due to medical or behavioral or psychiatric

	• Increase in person centered practices knowledge throughout the field • The grant for the advocacy program in Comal County! • Person-Centered Practices - Focusing on the individuals and the supports they want and/or need to live their best possible lives. • Get them involved in learning about the election, make everyone aware of the bimonthly dances at the San Marcos Activity Center • I am aware of "Dayhab Without Walls" and "Electronic Verification Systems." For positivity, I belive the EVS is going to help tremendously. If we are able to invest in a system that makes checking in simple, it will save our staff hours of time that they spend on paperwork and billing to be more engaged with our consumers, providing better service all around. • Medicaid paying for ABA treatment/Behavior Support services for individuals with Autism and under the age of 22. • Employment First, Day Hab with out Walls, Jennifer Eckols!	reasons. Lack of private provider ability to provide a true person centered lifestyle for those living in group homes. Most times providers offer each individual a turn to choose a weekend outing activity that all will participate in. Individuals are not really able to participate in induividualized volunteer, Job or recreational activities on a routine basis due to the provider not having the funds to provide the supports to accomodate a true person centered life. • I think that the people we serve are constantly being negatively impacted because Service Coordinators are stretched so thin that we cannot be as proactive in advocacy and the implementation of services. • Support staff not following through with using Person-Centered Practices to help individuals get better lives. Some may find it to be more work. • We need more knowledge of Medicaid/Medicare so we can assist people in services if they do not have a provider. • STAFF CRISIS. I've seen it, and worry that we will continue to see it. If we cannot build a solid "working class" in our centers at a decent wage that keeps them here, we will never be able to serve our consumers well. • -Lack of direct care staff to provide quality services and implement plans of care. -Lack of Service Coordinators to help guide families and individuals through the maze of services/applications/etc. that are necessary for an individual to access the community. • Our own broken system. Staff retention problems.

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• I think we could provide outpatient services for probation and in the jail. Also a program set up for drug court and I would love to see program for veterans.	• What I have seen starting to develop is clients stopping counseling services not just in SUD, due to having to pay fees. I do not feel we have an adequate way we explain fees to clients and timeliness in explaining insurance to them.
Primary Care Physician	• calling and reminding pts of their appointments. providing transportation of some sort for pts.	• pts that have diseases and no med insurance or $ to pay for specialty consults ,xrays, etc to make an accurate diagnosis and be treated. ie colon Ca

Kendall County



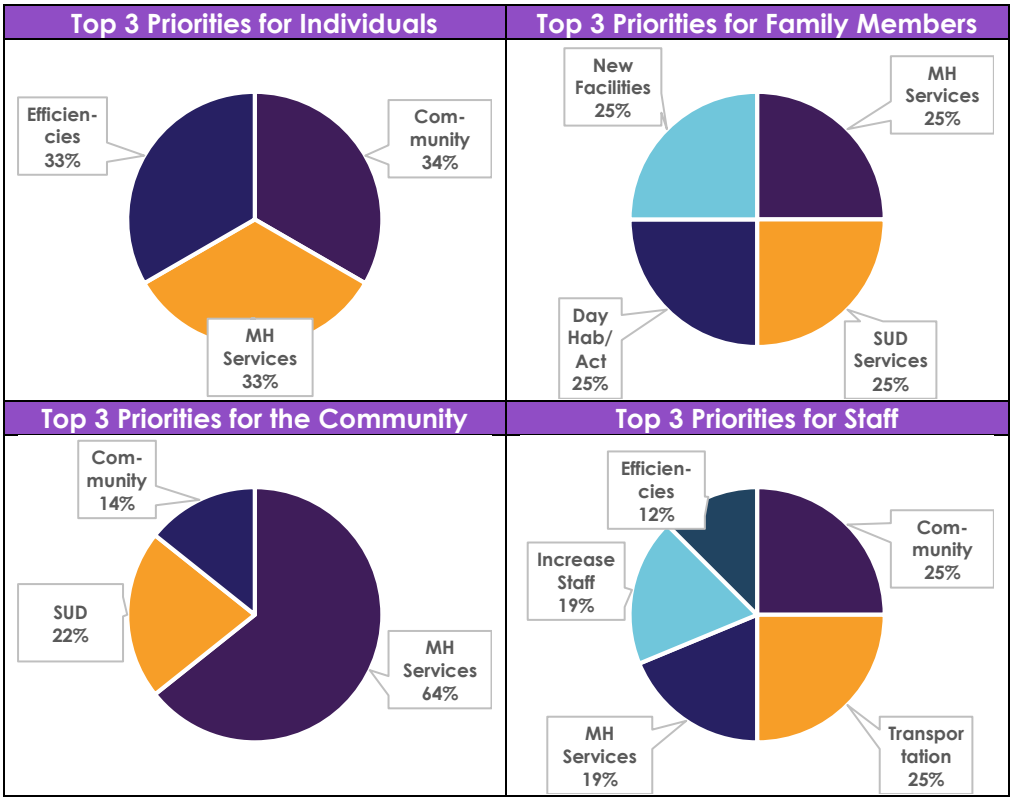
- In 2017, Kendall County, TX had a population of 40.3k people with a median age of 42.4 and a median household income of $81,023.
- Between 2016 and 2017 the population of Kendall County, TX grew from 39,010 to 40,306, a 3.32% increase and its median household income grew from $76,350 to $81,023, a 6.12% increase.
- The 5 largest ethnic groups in Kendall County, TX are White (Non-Hispanic) (73.6%), White (Hispanic) (17.3%), Some Other Race (Hispanic) (3.1%), Two or More Races (Hispanic) (1.98%), and Two or More Races (Non-Hispanic) (1.86%). 96.4% are U.S. citizens.
- The median property value in Kendall County, TX is $297,700, and the homeownership rate is 72.9%. Most people in Kendall County, TX commute by Driving Alone, and the average commute time is 28.8 minutes. The average car ownership in Kendall County, TX is 2 cars per household.

Priorities identified in Kendall County

Rank	Priorities	%
1	MH Services	32%
2	Communication/Collaboration/Awareness/Education	16%
3	Substance Use Services	11%
4	Transportation	9%
4	Efficiencies	9%
5	Increase Staff	7%
6	Day Habilitation/ Daily Activities	5%

6	New Facilities or Updates	5%
7	Funding	2%
8	Training	2%
9	Basic Needs	2%

Top 3 Priorities identified in Kendall County per Category of Respondents



Working and Not Working in Kendall County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• Criminal • It has been working well that we have Joan to do our intake process as she is an avid peer support individual and recognizes the difference peer makes. It is also wonderful to have Bridgette	• Time of responding • I believe we need to further develop peer services to offer 1/1 at the onset of an individuals service so that a solid rapport is built before suggesting group. We also need to identify areas where we can

	scheduling the initial engagement w/ the people we serve as a back to back time with the peer and the CC. The willingness for CC's to suggest peer is also welcomed as is the examples being set for us by both Ashlee and Diana in the clinic setting.	reach/offer a wider variety of groups so that more individuals have wider choices, i.e. arts and crafts, book club, groups for individuals that not only suffer from a mental health illness but are also on the autism spectrum etc. Larger focus on whole health- mental, physical and emotional. More community involvement.
Family Member(s)	• Staff offered social skills Circles In Kerrville.	• Need help finding employment. Supported employment is not offered.
Community MH or IDD Service Providers (staff)	• strong support staff Great team work • Yes • Empathy, unconditional positive regard, listening, good reflextion skills, and skill training based on client's strengths. • Communication with different clinics. • Peer support • Having the flexibility to schedule clients in ways I see fit. • Traveling to where the services is needed. Home visits, community (library,) • flexibility, coworkers, hours, i really like our clients. i like seeing their progress • Team approach to services	• Practitioner turn over in Gillespie, lack of continuity of care, hours not client friendly for those consumers that work. • More available time slots to provide counseling. • Working with quantity or volume instead of quality. This decision is based on the general philosophy of MHDD. • Anasazi at times. • Intakes, not enough provider time, staff shortage, large caseloads, referrals to COPSD/TRA services. • Some people without a qualifying SUD diagnosis could benefit from SUD OP services, but are unable to receive them. • IMR is limited to individual services and I would like other material to have in coaching, prompting and encouraging recovery goals. • it seems we push paper to make the contract. no time to do real work. • Lack of available therapists.
Law Enforcement	• Telepysch • telepsychiatry, mental health officer • Faspsych services	• diversion tactics, options • Lack of communications and follow up from MHDD after an assessment is done.
Education	• Pulse of the communities regards needs and lack of services.	• I observe issues with homelessness in Boerne.
Concerned Citizens	• Service Delivery	• Inter agency on going communication and system connection.

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Community MH or IDD Service Providers (staff)	• Manager is very helpful and supervisor, co-workers are kind. Being able to help others. • I have great support from my immediate supervisor. Everyone in the Kendall clinic is extremely kind and thoughtful towards each other and towards the individuals we serve. I have witnessed several individuals come in struggling with anger or symptoms of mania and the staff does everything they can to help them and make sure they still get their needs met. • knowing I can help make a difference in someone's life just by being there and supporting them. • knowing that i understand what the families face having a child with a Mental Health and all the barriers they face. • getting to know each individual that we serve and finding out what makes each one unique	• Having to meet hours and being held to the same standards as others when they can see kids at school anytime like child coordinators and us as family partners cant see parents anytime like they can. Parents will not see you if they know they don't have to. If I ask for a day off having to meet these hours. • Our department works with contracted providers who provide services to the children and families in our program. These contracted workers require access to Anasazi and it is sometimes challenging for IT to respond in a timely manner. In the last six months, we have lost two providers (in rural areas where it is challenging to find providers) because they have stated the process to get set up with RDS takes too long. • Being held to the same standards as a child coordinator by making hours when a child coordinator can see a child almost anytime and its mandatory verses a family partner that seeing a family partner is not mandatory. Parents are busy and dont have the time to be seen. Also not having a childrens doctor at our clinic in the moment. • the wait the families have before getting there children help with skills and Dr visits there is to long of a wait period. • communication from staff that have been here for a long while

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Family Member(s)	• There are none	• Need more intellectual and developmental disability services, a place or event for older MHMR adults can go to socialize with each other, to get to be friends with!

Law Enforcement	• Good relationship / response from local MHA	• The wait for an inmate to be admitted into a state hospital is too long
Government Representatives	• School system	• Students are not given the attention and resources needed .

Substance Use Disorders

Group Represented	What is Working?	What is Not Working?
Social Service Providers	• For those individuals with health insurance there are good options in Kerr County for both residential and outpatient care.	• Kerr County attracts a good number of people in early recovery from substance use disorders due to the treatment options that are here. But ongoing non-clinical recovery social services are lacking to help people get back to a full life. There were efforts to establish a Recovery Oriented System of Care but that fell short of establishing a Recovery Community Center which is needed. Beyond Kerr County and those counties along I-35, there are very few of any type of services, treatment or recovery. When transfer is needed from a substance use disorder facility to the crisis unit for psychiatric stabilization, the process is very difficult and having a psychiatrist evaluation already done seems to hold no weight with less credentialed staff of the crisis unit. Having the benefit of a psychiatrist who has already assessed the individual should make for a very simple process but that is not the case.
Government Representatives	• Support agencies	• Increase in incidents
Concerned Citizens	• It is great that these services are provided I think the services for adults and children are great to have.	• I think there needs to be more positions like counselors, therapists, peer support. I know that is a tough thing when I give MHDD as a resource when they go and have to be on a wait list.

Positive opportunities and negative concerns that may impact the people in Kendall County?

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• More follow up • Wider variety of group services- arts and craft, book club gardening etc.	• Don't know
Family Member	• Don't know	
Community MH or IDD Service Provider	• extended hours, staff retention • Not sure of any. • Group and getting involved in the community. As a MHPS I would increase groups if I was able to obtain more hours. One group session with eight people = three hours minimum. • Becoming CCBHC certified. • CCBHC; different grants • I think more community outreach/educational programs would be beneficial for this community. • Limited community resources in small counties. • don't know enough about CCBCHS but I would assume that. • Expansion of HB 13.	• staff turn over, poor continuity of care • Lack of therapist trained to address Trauma. • If caseloads increase, the quality of care will decrease. Therefore, the number of case loads needs to be practical or there is liability that a client may fall through the cracks. • Comparative lack of pay/benefits deterring students from going into the mental health field. • Funding issues • Limited amounts of community resources (i.e. shelters, food banks etc.) • Not having insurance prevents a lot of our clients from leaving services and using PCP's once they are in maintenance stage. • overload • Limited staffing at various locations.
Concerned Citizen	• television use for jail diversion and interface with Kendall County Mental Health Clinic.	• Keeping up with rapid population increase .Addressing s ubstance issues. Interfacing with School District.Overcrowing
Education	• Very special interested parties involved in the needs assessment and services provided.	• Biases regards ethnicity, social status, and vocations., or lack of employment.
Law Enforcement	• n/a • a committee formed to bring many entities together • None	• n/a • business as usual • Lack of communications between the court, MHDD staff and this jail nurse.

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• That we are more person centered and that there are groups available. • I enjoyed reading Ross's recent e-mail about buying (as opposed to renting) properties and how there seems to be a big movement toward making sure the children, adults, and families we serve feel they are coming to a place that is visually appealing, as opposed to feeling that they have to go to a run-down unit. • Groups will be helpful and also Person Centered. • having more help	• The change in staff all the time. • None at this time. • Not having a doctor for children at the moment and only having a doctor when we do have one just for 3 days and not 4 or 5. • not sure

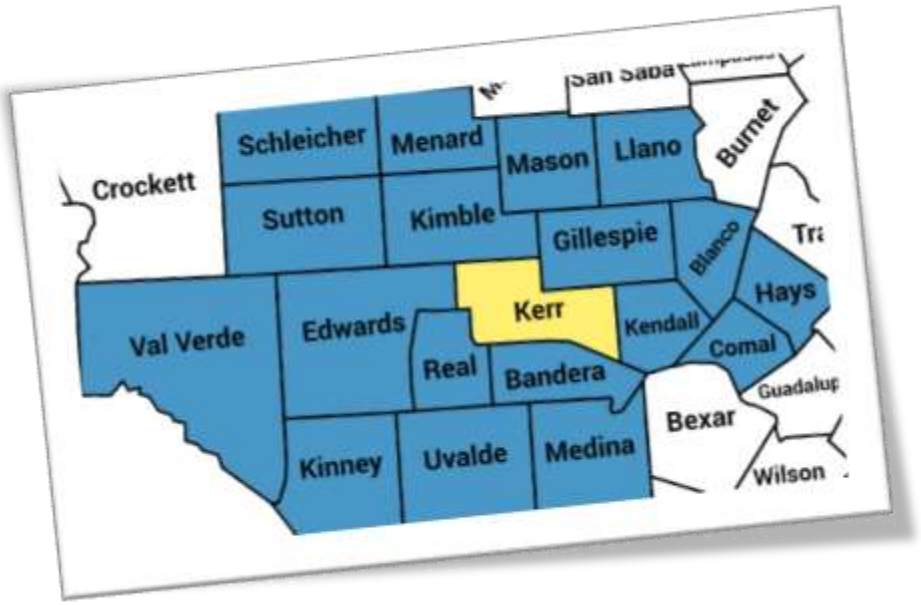
Intellectual Developmental Disabilities

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• job opportunities, opportunities for them to expand into the community and mingle with the community, opportunities to be seen for more than just a person with an intellectual disability.	• none
Government Representative	• Recognize their needs and address them by providing the needed space , equipment , funds and staff personal to try an create a respected member of society allowing them, to the best of their abilities, to live a happy and productive life .	• Many clients are embarrassed to seek help because of the societal stigma they feel it places on them . The MHDD role is to provide the necessary treatment in a caring and positive way helping the client to become a contributing member of the community .
Law Enforcement	• unaware of any	• We have too many that are brought to jail instead of a mental health treatment facility

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Concerned Citizen	• N/A	• I believe there are no other providers in Kendall county that are free or sliding scale so those that cannot afford help usually do not get it.
Government Representative	• I'm not aware	• Not aware
Social Service Providers	• Kerrville city government has been very proactive to support substance use recovery but tangible services are needed. A Recovery Community Center could provide a place to bring services together to benefit many people in early recovery.	• See my comments in #6 about transferring an individual to the crisis center who has already been evaluated by a psychiatrist.

Kerr County



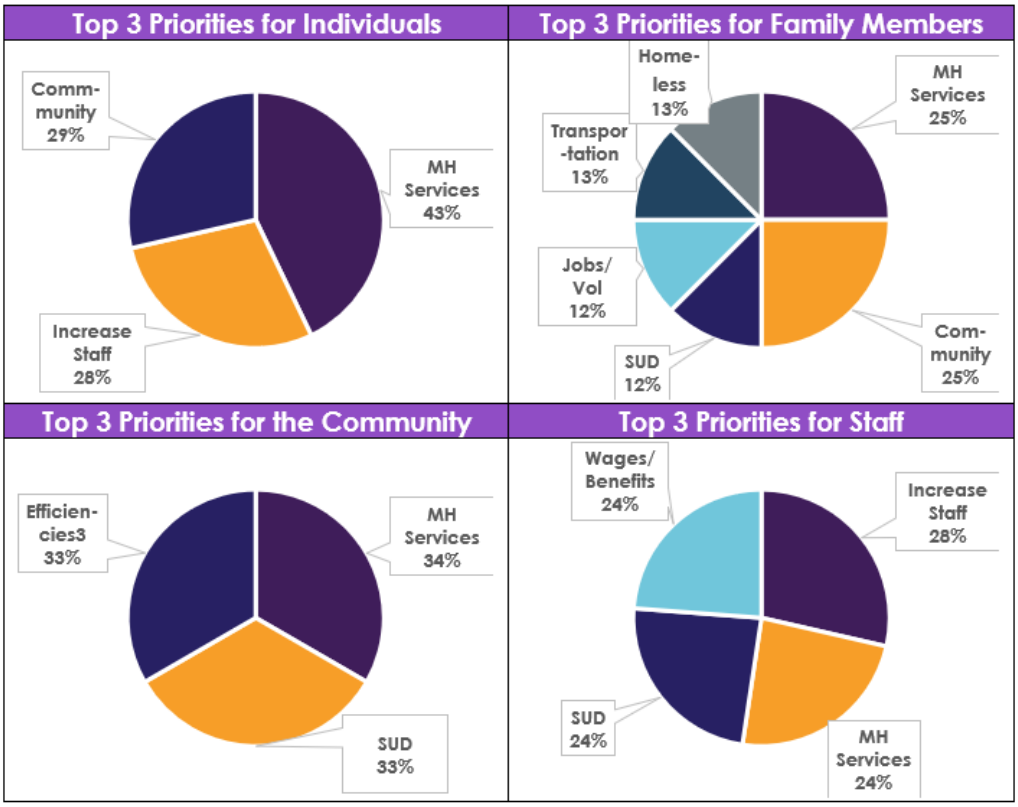
- In 2017, Kerr County, TX had a population of 50.8k people with a median age of 47.8 and a median household income of $48,698.
- Between 2016 and 2017 the population of Kerr County, TX grew from 50,505 to 50,761, a 0.507% increase and its median household income grew from $44,261 to $48,698, a 10% increase.
- The 5 largest ethnic groups in Kerr County, TX are White (Non-Hispanic) (69.9%), White (Hispanic) (20.7%), Some Other Race (Hispanic) (4.02%), Black or African American (Non-Hispanic) (1.42%), and Two or More Races (Non-Hispanic) (1.34%). 95.5% are U.S. citizens.
- The largest universities in Kerr County, TX are Schreiner University (288 degrees awarded in 2017) and Conlee's College of Cosmetology (14 degrees).
- The median property value in Kerr County, TX is $164,000, and the homeownership rate is 71.2%. Most people in Kerr County, TX commute by Driving Alone, and the average commute time is 19.1 minutes. The average car ownership in Kerr County, TX is 2 cars per household.

Priorities identified in Kerr County

Rank	Priorities	%
1	MH Services	16%
2	Substance Use Services	12%
2	Increase Staff	12%
2	Communication/Collaboration/Awareness/Education	12%
3	Transportation	7%
3	Efficiencies	7%

4	Wages/Benefits	6%
4	Training	6%
4	Basic Needs	6%
5	Funding	4%
6	Healthcare	2%
6	Day Habilitation/ Daily Activities	2%
6	Job/Volunteer Opportunities	2%
6	Homeless Services	2%
7	IDD Services	1%

Top 3 Priorities identified in Kerr County per Category of Respondents



Working and Not Working in Kerr County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• Peer support groups, home visits (emergency) 24/7 Crisis Hotline • Counselor who did my intake was helpful, Joan Cortez • still to soon to tell • Peer support, Individual counseling • group meetings, individual counseling • Peer support • I love group therapy • My weekly meetings w/care coordinator and peer support specialist. Doing the WRAP, getting my medication filled at the clinic. The quality visits with N.O.s • Everything, self esteem mental health is now great. • Both of them • I use our camera set up to talk with our consumers to complete their disability applications.	• turn over of employees and/or doctor • I went in to do intake on December 30th. Was there went clinic opened at 0800. There was no staff to due intake because of call-ins/planned vacations. Went in on a Tuesday for second try. Was there when clinic opened. Staff was quick and was out of clinic by 1030. Received one call to set up appointment with my counselor on Tuesday and called her back on Wednesday. Have not heard back and appointment hasn't been scheduled. I was told that office coordinator would call me to set up appointment with doctor. I haven't heard from her. I understand from friends that have gone through services that it can take a while to see doctor or counselor. However, I feel that should be communicated to me through staff not my peers that I know from community. Even if it will be a month before a patient is seen, staff should give a courtesy call. I work in scheduling and even if we don't know when a Doctor will be able to see a patient, we call the patient and let them know that we have the referral and we are working on getting them schedule. We keep the patient in the loop so they are wondering where they are in the process. I feel lucky that I have a friend who had gone through this process so I had realistic expectations but I could see how this could be very upsetting and frustrating to someone not knowing what is going on or where they are in the process or if they were forgotten about. • not sure yet • I feel like there could be more time spent per individual. • None • n/a

		• Everything is working good • N/A • nothing right now • nothing at this time • There are too applicants for me too handle by myself. There needs be more Consumer Benefit Officers.
Family Member(s)	• Support from MHDD and others • Locations sufficient to serve my county and surrounding counties • Person Centered Practices	• very pleased • Locations understaffed, calls not always returned, concerns about staff burnout • Not enough qualified staff to perform the jobs.
Advocates for Children and Adults	• The young people that were trying to help calm down the client were doing their best but by having the client keep repeating her story only increased her anxiety. • N/A	• It would have been more benificial if staff had been available to begin with, when the client has to keep repeating her story, she became more anxious and frustrated and depressed! It just validated her unworthiness. • Everything, there is not enough availability in hospitals, time and seeing a doctor that is not on a screen. There needs to be more resources in this area and if there are resources let the public know. The suicide rate is climbing as well, I know there is MCOT but that team so also be used as Prevention and not case management like the case managers in the clinic.
Community MH or IDD Service Providers (staff)	• Working with individuals towards their goals. • Some consistent staff in the clinic. • Services Offered • BEING ABLE TO PROVIDE THE INDIVIDUALS THAT I WORK WITH THE SKILLS NEEDED TO ASSIST THEM IN THE ABILITY TO MAINTAIN INDEPENDENT LIVING • Continuity with other staff. • Having LCDC and copsd, peer support is a huge asset, csu, NP face to face • Other HC staff can be very supportive and can be fantastic resources. • Team approach in Gillespie County. • Availability of services, Patient Assistance Program medications, reasonable sliding scale, a	• Large case load and scheduling • Canceling Dr. appointments when consumer ANSA/CANS has expired or did not batch. • Pay level of Care Coordinators • KEEPING STAFF • Properly trained staff. • not enough doctor time for children services and level one care coordinators caseloads are extremely large. • 1. Lack of proactive oversight / feedback (i.e. feedback is largely reactionary and must be sought out) 2. Lack of procedural resources (e.g. when does a crisis ANSA expire and need to be re-assessed) 3. Technological barriers (Anasazi is not intuitive, slow internet) • The system is broke. Person Centered approach is not being

	movement towards Person Centered Thinking practices, etc. • Education and reeducation about the importance of the personal recovery process; and making the decision to recover • at times, we get great report on our clients, and much of the time, they are in a timely manner. Also, I have many staff members, who are compassionate about our clients, and give wonderful support to each other. • I honestly cant think of thinking that is working well. Maybe that we provide them with a solid follow-up plan, or we try to. • Dedicated staff. Staff willingness to change what we are doing.	utilized as trained. Other in the clinical setting are making decisions for the individuals. Individuals do not understand that they make the decisions regarding their care. My belief is that this is because The particular questions being asked here are not implemented with the staff. We are not effectively or efficiently using Person Centered Thinking and language with staff or indiviudal's who choose our services. • The amount of time it takes for a new individual to receive an initial psych eval, high turnover rate due to pay and burnout, lack of communication, lack of uniformity between clinics, unpleasant or unsympathetic support staff, confusing collections practices, etc. • Patients need additional Psychotherapy. Counseling on an outpatient basis to solidify psychological gains and support choice to recover • Often, we do not get a full, complete, and at times, report on our clients. That makes preparing for them, and taking care of them, a challenge, not to mention, it makes us look foolish. If pts. come from a clinic, there is usually no report. We could use more staff for call ins. • Dont have enough DCS/unreliable staff, staff with MH issues causing issues, treatment team meetings are incredibly hostile, hostile work environment created by team members; large amount of repeat admissions; not enough sober/substance abuse support; only one therapist available for 16 clients; not enough NEO training for DCS to know how to do their jobs; not enough stimulation for the clients, boredom creates chaos; inappropriate admissions (IDD- not enough structure; aggressive clients- not enough staff; med-seeking- no restraint chairs, clients act out to get meds and there's no way to avoid sedating them with medications if

		they bang their heads on walls etc). Clinics too crowded, not enough docs, clients have to pull the suicide card to get admitted to get on meds asap instead of going through clinic and not being seen by doc for 30-60 days sometimes; Staff burnout is a real thing and time off for MENTAL HEALTH IS FROWNED UPON!!! We need 1 day a month for mental health and self-care, and it shouldnt put your job at risk to put your MH first. • Location. Area is too large to tackle problems quickly.
Law Enforcement	• Crisis workers respond to scene when called. • MHDD CRISIS HOTLINE	• Requesting medical clearance. Other counties are bringing/or causing individuals to come to Peterson Hospital then getting an ED from Kerr magistrate and having us transport. There are not enough local beds. We are spending way too much time transporting to other towns for beds. MHDD needs to have the availability to transport mental health patients without disrupting law enforcement. Law enforcement needs a local location to take an individual for screening on an Peace Officer's Emergency Detention so they can get back to protecting the public. • The lack of crisis response MHDD employees to handle the call volume of the consumers in active crisis
Primary Care Physician	• referrals to MHDD outpt clinic on Water st	• I usually get the run around when I call the crisis hotline - I have a person in San Antonio telling me my patient does not meet criteria to be assessed in office when I am the provider!!!! Out of 4 times calling them they only sent out a person to do an assessment two times, this is not OK.

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Family Member(s)	• Nothing my son's doctor teleconferences in and there are no services besides counseling to help with his autism or behavioral issues.	• not having programs that is shaped to help him as an individual
Community MH or IDD Service Providers (staff)	• n/a • kerrville Clinic	• n/a • N/A
Local Psychiatrist	• Willingness of other providers of care to communicate.	• Difficulty accessing services, cost of medications. Bureaucratic barriers that interfere with initiating or remaining in care. Inflexibility of some institutions, such as schools, to do things differently. Insurance companies not paying or reimbursing differently for general medical vs. psychiatric medical care. Stigma around mental illness and substance use leading to families to delay care until crisis. Silos of funding between State Hospitals, LMHAs, DD services and TDCJ/Jails and general medical providers causing interruption of care even if started. Confusion for patients and providers about how to access the complicated system. Lack of funding and lack of consistency/accountability for medicaid MCOs.
Education	• Staff engaged in the process. Active parent involvement.	• Understaffed. Not all staff properly trained to support behaviors.

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• educational classes	• staffing
Family Member(s)	• Opportunities for community inclusion are provided, along with fellowship with peers.	• Too much drama among peers and/or staff - makes my son very anxious, not wanting to attend dayhab
Community MH or IDD Service Providers (staff)	• Being able to work as a team with my coworkers and not have any awk • IT works well together, no troubles with each other.	• The physical "abuse"/issues with the consumers/clients. • Understaffed.

	• wardness. • COMMUNICATION IN OUR CENTER(SOC) IS GOOD, COULD BE BETTER. • -Key strong team members -The apparent vision/goals of the company • Working one on one with consumers on the goals that they have chosen. I also enjoy learning from them and how they see the world around them. It is rewarding to see their achievements and help me to see how I can improve. • I enjoy working with my coworkers and the individuals that we serve. • at the moment none as this center is SOOO short staff, not one person is a team player • Interactions with consumers, access to resources, scheduling • Committed colleagues/peers Having PCT trainers on staff/regularly scheduled training Having buy-in on changing the culture from direct reports • While it is not ideal, the current program of foster care, group homes, and dayhabs works well for the majority of persons served.	• NEED BETTER COMMUNICATION THROUGHOUT THE ENTIRE COMPANY, PAYROLL SOFTWARE NOT ADEQUATE, STAFF SHORTAGE, PAY COULD BE A LOT BETTER • -Staff shortages -Limited access to training that would help understand "how the gears turn" in regards to our organization, billing, healthcare and so on. -Lack of "experts" on the above mentioned and also housing -Space for operations -A low number of diverse community activity opportunities • Having a shortage of staff which limits the amount of time I can work individually with consumers. • The need for additional staff to work both residential and day/hab locations to better serve our individuals. Communication between programs. • no team players, no one wants to be responsible for our clients, and assist them with their goals • Communication, organization at times • Paper charting Communication - in many different ways... Across the 19 counties, lack of technology to do so, lack of top down/bottom up communication, misconceptions from prior leadership Silos between departments • I am very concerned about the new program that we saw in Oregon. Doing away with dayhabs and group homes for many of our people served. The idea behind it sounds logical, but the execution can break it. The cost could be overwhelming and the changes could push persons served into situations they cannot handle.
Law Enforcement	• Nothing	• Transporting mentally ill out of the county over 100 miles drawing from our law enforcement abilities here.

Substance Use Disorders

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• MHDD - All Services • AA, living in sober living house, working t/steps and trusting God. • Going to meetings and working with my sponsor.	• n/a • N/A • The living situation as far as the facility and some of the different personalities that are in charge and setting the rules.
Advocates for Children and Adults	• providing positive input to my clients through motivational interviewing techniques, as well as helping their parents cope and understand the issues at hand.	• Getting some of my parents to work toward the same goals I provide for some of their children.
Community MH or IDD Service Providers (staff)	• Experienced psyc staff • Communication with staff and clinics. Having staff that care about the individuals served. • Dual Recovery Group	• No meetings, No training classes to address drug abuse and TX of these patients • Limited resources in the community for individuals • Referrals
Local public health care provider (e.g., federally qualified health centers, local health departments)	• one on one case management	• not being able to consistently meet with the individual

Positive opportunities and negative concerns that may impact the people in Kerr County

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• Everything on answer (5) • None • dont know yet • Involving animals as therapy • n/a • Weekly peer support • The people here assist you very good • N/A • just about everything • Counseling and mental health meds	• Not having services • Communication and follow-up • dont know • scheduling • n/a • That some are not aware of peer support • none • N/A • nothing right now

	• I may get help in this dept. This would allow me to complete more applications to serve more consumers.	• The length of time it takes to see the Dr. • Not aware of any.
Family Member	• Dont know • Community mental health grant for Comal County, Mental Health First Aid and Person-Centered Thinking training available, potential for increase in CSU funding, potential to build a CSU in Uvalde • CCBHC	• no concerns • I have concerns that CCBHC initiatives will not be implemented in an organized fashion, cost our company too much, spread already overworked staff even more thinly, and negatively affect employee turnover/retention, which seems to already be an issue. • Loss of 1115 Waiver Funding
Community MH or IDD Service Provider	• Transition to CCBHC • ? • CCBHC requirements • HOUSING • New resources becoming available to those we serve as well as our agency. • better technology especially with telehealth. • CCBHC (e.g. broadening funding streams, improvements in success measurements) • I am aware that individuals who hold licenses will be working with a group of care providers to ensure that person centered approaches are implemented and maintained. This starts with the licensee approaching the cc with respect and dignity, utilizing their strengths and weakness as demonstration to what we are anticipating will occur with clientele. • I am excited and optimistic about the direction we are taking with Person Centered Thinking and approaches, opening up the population we serve, and better starting pay and pay increases for recovery coaches. I have also heard colleagues discussing the possibility of extending or changing clinic hours to offer better availability to those who work 8-5 jobs and need our services. • I feel that Outpatient Therapy during first 2- 3 weeks is crucial. OSAR registration for Inpatient Substance Abuse is is critical as well. Therefor Inpatient facilities should have better	• Lack of funding for MH services. Less resources(hospitals and programs) • Limited pool of LPHA or Dr. • Pay level of Care Coordinators • ACCESS TO A DOCTOR QUICKER • The ability to pay fair wages to the employees and have staff available to provide services. • the large caseloads people can easily fall through the cracks and they work hard but it is a lot to keep up with • Remnants of past company culture / resistance to change. • I must contemplate this further. • Dwindling PAP medication availability, and if there is any lack of follow-through. It also continues to concern me that there are little to no pay raises as an organization. I think this contributes highly to our high turnover rate. It is also my understanding that care coordinators are still highly overworked in a lot of our clinics which also negatively impacts care on the people we serve. Refusal to implement PCT skills are also a concern. • Statewide Temporary Housing is an issue in my community; We are experiencing more homelessness with the population we serve. We also are experiencing and influx of patient from other regions wanting to remain in our ares county , sometimes in spite of there being no temporary placements for them

	Interface with OSAR withing 7-10 days. This will help patients in need at least get screened and placed of list if applicable to receive co - occurring/ substance abuse treatment in a timely fashion, • Education; Also, Sunday Services are a huge plus, even when patients are not believers in Christ, they do feel inspired and at times more motivated to do their program. • none at this time other than peer support opportunities. • CCBHC and PCT	• Many times, the challenge is where do they go from here. ?? State is always a waiting list, and home is not the answer for many. • The level of substance abuse is on the rise like never before. We are seeing more addicting, violence-inducing substances and I dont think MHDD even remotely knows how to handle some of this stuff. Meth isnt the worst thing out there anymore! Flakka is on the rise, and we arent prepared for it. Psych isnt psych anymore, its substance abuse and our facility isnt set up for it. • We just take too long to get something done.
Advocates for children and adults	• Better communication between staff. If a PA's leaving, it would be great if they left notes in the files about possible med changes forthe next PA so that a solution is not a shot in the dark. Also, communication vetween staff and CSU Doctors taking a patient off of two meds at the same time right before the holidays led to Cath's crash along with a couple of emotional upheavals and no meds to help her with her anxiety. • Well, I read in the newspaper were Law Enforcement is wanting to start a team like MCOT. From my prospective that was what MCOT was going to be but there was not and office or nurse on the team. Law Enforcement should be able to sign a warrant for MH purpose and be able to place individuals in care of a Psychiatrist. I know the problem is that we only have 16 beds but we need to think of making a bigger facility that will help those. Plus a Detox center would be helpful as well. Which would reduce the amount of those that show up to the hospital for Detox when the need of the ER is being misused.	• I have personally witnessded when some of the staff will treat the clients with distain when the clients attempted to advocate for themselves. That was Janice & Chris, both nurses & a former PA Brenda. Tara from Peer support was awesome, she brought in a feeling of calmness and reassurance. • A lot of them feel there is not hope and help. We need more resources. The problem in this area is drug use and we need more detox hospitals in the area with concerns.
Law Enforcement	• Not familiar with any. • adding a mental health officer to the local Sheriff's office to work hand in hand with MHDD/APS to local crisis situations	• Not enough local beds to serve them. • Not enough case counselors at the local MHDD office. Not having a psychiatrist on hand 5 days a week

		at the local MHDD office. patients being turned away and rescheduled weeks away from original appt.

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Family Member	• none	• the fact that we lack all types of services and resources due to the county refusing to accept that we need it
Community MH or IDD Service Provider	• n/a • None	• I believe the no group home subject. Not quite understanding why that is happening. • None
Education	• Local Head Start programs. The ability to build a cohesive network of community partners.	• Lack of funding. Understaffing. Lack of community support.
Local Psychiatrist	• Joint programs/carve outs that allow crossover between systems. Sequential intercept model of care for courts and justice system. Improved collaboration between State Hospital and LMHAs on formulary and the increased strength that may occur from joint advocacy efforts between LMHAs and State Hospitals. Also partnering between LMHAs and medical systems to empower the medical systems to work together to advocate for patient care.	• Funding/lack of funding to pull down federal medicaid dollars into Texas. Worsening conditions for the funding of rural hospital systems and the stress that causes. The ongoing problem with vaping, concentrated cannabinoids in youth and young adults, the methamphetamine use and the concern that the state hospitals are still struggling.

Intellectual Developmental Disabilities

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• food banks, churches, etc	• low pay, employee turnover, not enough positions
Family Member	• Am excited to see what the new Person Centered Care plan will entail, and how it will impact IDD services • Unaware of any at this time. • -Advertising venues for staff recruitment such as Facebook and the newspaper -Volunteer recruitment	• SOC does not have adequate staff, too much internal turmoil, feel like some staff do not interact with consumers enough • The sedentary lifestyle and the sudden turnover of coworkers causing others to get burnt out. • Unaware of any at this time.

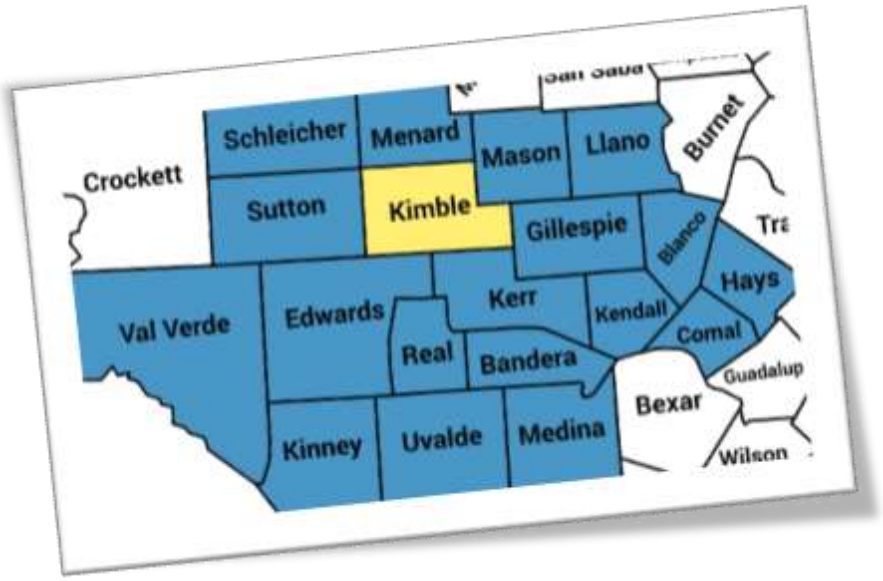
	• Kerrville growth in business. • community & social skills, give clients more opportunity while attending day hab • Supported employment, community integration • I could be wrong in what I foresee in question 6 and the changes could be positive	• OUR COMPANY WANTING OUR INDIVIDUALS OUT IN THE COMMUNITY MORE WHEN THEY ARE NOT PHYSICALLY ABLE TO • -Turnover due to pay and burnout - Continued staff shortages and increased services provided to our individuals ---+Decreased opportunities to community activities due to staff shortage -Lack of applicants for Host Home providers/quality Host Homes • Lack of staff. • lack of communication on management, and following through with their actions, they are NOT willing to help their staff in filling in where needed. the special opportunity center has really turned into a dump. • changing the dynamics for some of consumers that require more structure, have more limitations • changing the dynamics for some of consumers that require more structure, have more limitations • The disconnect between the What we do and the Why. Lack of communication (see above). Lack of understanding/application of PCT. • See number 6
Community MH or IDD Service Provider	• Ability to brainstorm with my coworkers/company to continue thinking of activities.	
Law Enforcement	• A mobile team to assist in making calls and keeping people out of jail and out of our medical hospital.	• Keeping people on their meds, and not enough local mental health beds for civil committments

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• n/a • N/A • I am new her so I am not sure.	• No free Detox from substance abuse in Kerr County • n/A • I am new here so none at this time

Community MH or IDD Service Provider	• Not aware of any • Positive changes to integrate substance use treatment • More groups at Clinic	• Lack of knowledge on detoxing patients • Lack of housing opportunities • na
Advocates for children and adults	• Providing parenting classes for a lot of the parents children I serve.	• Parents not knowing and understanding the impact of the drug problems we have among teens.
Local Public Housing Authority, non-profit homeless service providers, non-profit and for-profit housing providers, or recovery homes	• many points of access for services	• the long waiting time to see someone

Kimble County

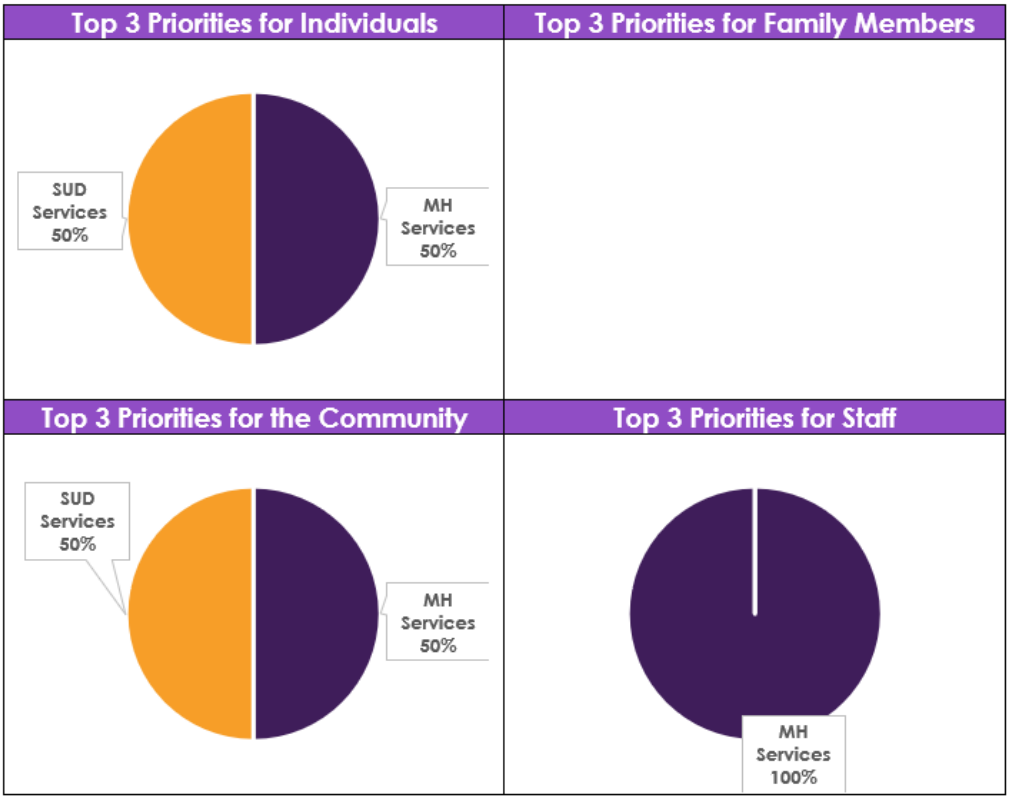


- In 2017, Kimble County, TX had a population of 4.43k people with a median age of 52.6 and a median household income of $41,095.
- Between 2016 and 2017 the population of Kimble County, TX declined from 4,453 to 4,432, a -0.472% decrease and its median household income declined from $41,263 to $41,095, a -0.407% decrease.
- The 5 largest ethnic groups in Kimble County, TX are White (Non-Hispanic) (74.3%), White (Hispanic) (16.2%), Some Other Race (Hispanic) (5.89%), Two or More Races (Hispanic) (1.26%), and Two or More Races (Non-Hispanic) (1.15%). 97.3% are U.S. citizens.
- The median property value in Kimble County, TX is $107,200, and the homeownership rate is 75.1%. Most people in Kimble County, TX commute by Driving Alone, and the average commute time is 19.9 minutes. The average car ownership in Kimble County, TX is 2 cars per household.

Priorities identified in Kimble County

Rank	Priorities	%
1	MH Services	60%
2	Substance Use Services	20%
3	Transportation	20%

Top 3 Priorities identified in Kimble County per Category of Respondents



Working Not Working in Kimble County

Adult Behavioral Health of Adult Mental Health

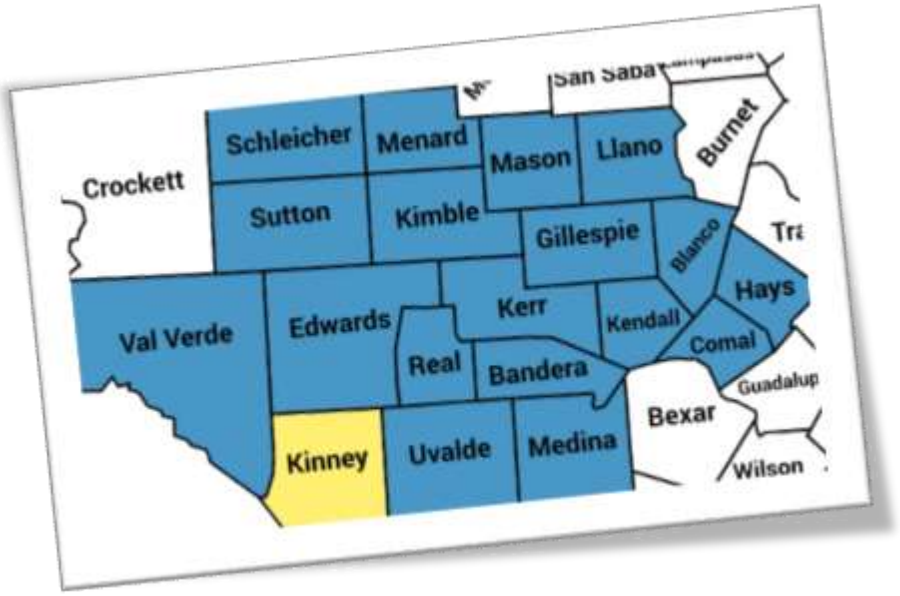
Group Represented	*What is Working?*	*What is Not Working?*
Individuals Receiving Services	• Clinic teams I working well together to provide the best service possible.	• Limited resources, not enough staff to provide the assistance needed, limitations on medications that we are able to prescribe i.e. Seroquel and Lexapro
Community MH or IDD Service Providers (staff)	• Collaboration with other agencies	• Travel for crisis
Judicial Representative	• People willing to help	• Lack of programs to refer

Positive opportunities and negative concerns that may impact the people in Kimble County

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• Broadening of services we can refer to.	• Heavy Case Loads on individual staff members making it difficult for consumers to receive the services that they need.
Community MH or IDD Service Provider	• Local ministerial alliance in the communities	• lack of services due to not enough staff or unable to be seen due to caseload or crisis calls.
Judicial Representative	• Staff is willing to try	• Not enough people to provide services

Kinney County

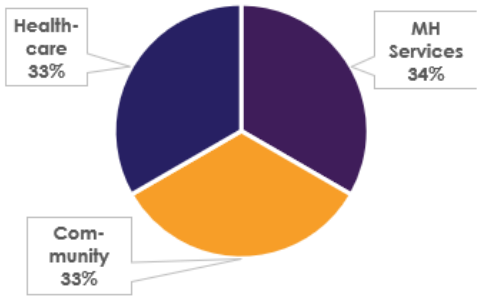


- In 2017, Kinney County, TX had a population of 3.63k people with a median age of 41.1 and a median household income of $34,926.
- Between 2016 and 2017 the population of Kinney County, TX grew from 3,578 to 3,631, a 1.48% increase and its median household income grew from $34,398 to $34,926, a 1.53% increase.
- The 5 largest ethnic groups in Kinney County, TX are White (Hispanic) (58.7%), White (Non-Hispanic) (38.1%), Some Other Race (Hispanic) (2.97%), American Indian & Alaska Native (Hispanic) (0.165%), and Black or African American (Non-Hispanic) (0.11%). 88.8% are U.S. citizens.
- The median property value in Kinney County, TX is $64,200, and the homeownership rate is 77.3%. Most people in Kinney County, TX commute by Driving Alone, and the average commute time is 17.3 minutes. The average car ownership in Kinney County, TX is 3 cars per household.

Priorities identified in Kinney County

Rank	Priorities	%
1	MH Services	34%
1	Communication/Collaboration/Awareness/Education	33%
1	Substance Use Services	33%

Top 3 Priorities identified in Kinney County per Category of Respondents

Top 3 Priorities for Individuals	Top 3 Priorities for Family Members
Top 3 Priorities for the Community	**Top 3 Priorities for Staff**
	

Working and Not Working in Kinney County

Children's Mental Health

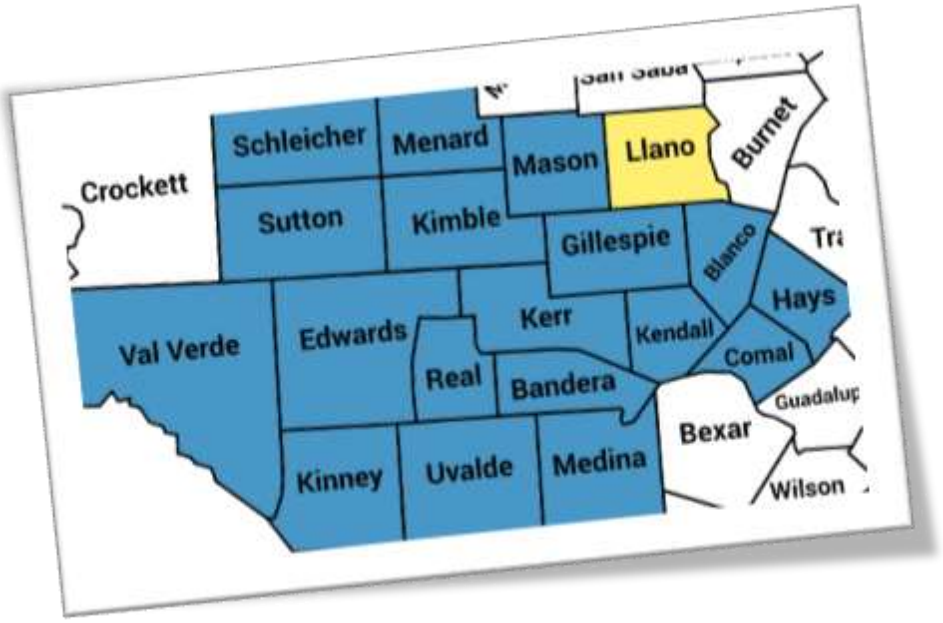
Group Represented	What is Working?	What is Not Working?
Judicial Representative	• Personal contact; acquiring expertise; quick results	• Time hurts especially on the weekend; anxious patients with no answers

Positive opportunities and negative concerns that may impact the people in Kinney County

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Judicial Representative	• Medical facility in Uvalde will help a bunch; shorter drive; quicker service	• Lack of service, lack of answers

Llano County



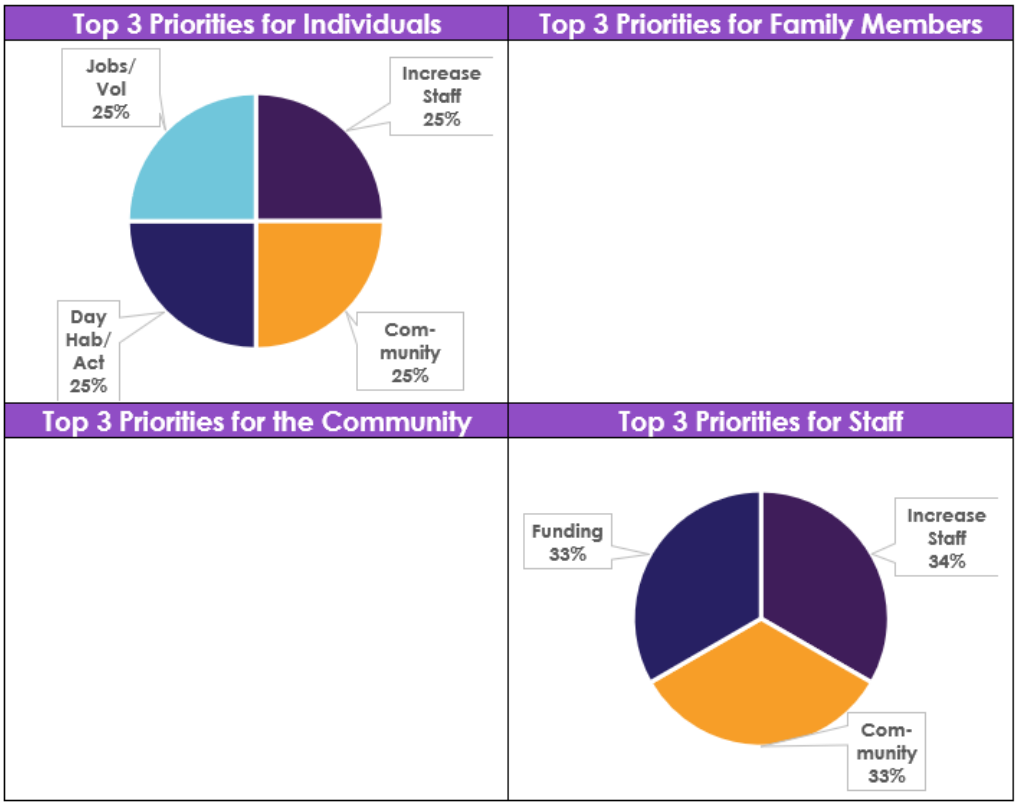
- In 2017, Llano County, TX had a population of 20.2k people with a median age of 57.1 and a median household income of $50,524.
- Between 2016 and 2017 the population of Llano County, TX grew from 19,624 to 20,195, a 2.91% increase and its median household income grew from $48,562 to $50,524, a 4.04% increase.
- The 5 largest ethnic groups in Llano County, TX are White (Non-Hispanic) (87.1%), White (Hispanic) (6.53%), Two or More Races (Non-Hispanic) (1.8%), Some Other Race (Hispanic) (1.31%), and Two or More Races (Hispanic) (1.15%). 97.8% are U.S. citizens.
- The median property value in Llano County, TX is $184,500, and the homeownership rate is 76.6%. Most people in Llano County, TX commute by Driving Alone, and the average commute time is 22.1 minutes. The average car ownership in Llano County, TX is 2 cars per household.

Priorities identified in Llano County

Rank	Priorities	%
1	Increase Staff	18%
1	Communication/Collaboration/Awareness/Education	18%
2	Funding	12%
2	Job/Volunteer Opportunities	12%
3	MH Services	6%
3	Substance Use Services	6%

3	Day Habilitation/ Daily Activities	6%
3	Transportation	6%
3	New Facilities or Updates	6%
3	Training	6%
3	Basic Needs	6%

Top 3 Priorities identified in Llano County per Category of Respondents



Working and Not Working in Llano County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Community MH or IDD Service Providers (staff)	• Peer support groups Support from staff • collaborative documentation. individuals we serve seem to appreciate knowing what information goes into the notes that we create. • Although we are short staff, everyone comes together to make sure that everyone is supported. • AMH	• Lack of appropriate space and competing needs for the space we have • limited curriculum • Lack of staff • Intake is difficult / substance abuse - gathering better information at intake

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Outreach, Screening, and Referral (OSAR) provider serving the area	• Being able to see children at school	• The schools say they are missing too much school if I see the student once a week even if its court ordered or a necessity due to the child's behaviors.

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• Everything is working fine for me. • I do most of the transportation. I enjoy working with the consumer .	• Nothing • sometimes be sort staff
Community MH or IDD Service Providers (staff)	• Everything is good. • Direct communication • All seems to be working well. There seems to be more communication among staff, parents and community supports. • I love the people I serve and the staff I work with. There could not be a better environment for me. • 1 on 1 interaction with our individuals.	• none • Lack of communication • Keeping up with transportation, billing for transportation. • Low pay • ratio of client to staff.

Positive opportunities and negative concerns that may impact the people in Llano County

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• Food banks and food pantries Free meals from local churches Help with utilities from local non profits • Heart Math application that we learned about in Klamath. • having the staff to meet needs	• Too few staff to see clients with the frequency they require • limited resources in rural counties • not having enough spots open for individual for intake and therapy

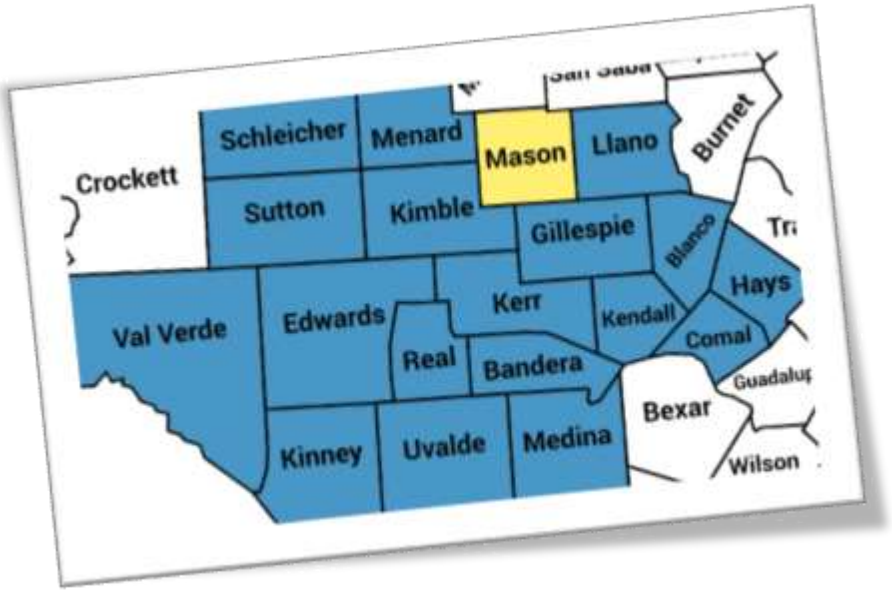
Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Outreach, Screening, and Referral (OSAR) provider serving the area	• More support groups	• the high number of sexual abuse/assault cases in the area in recent years

Intellectual Developmental Disabilities

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• Education • relias training	• Employement • funding cuts
Community MH or IDD Service Provider	• self center . . . Where we work with the client to better themselves and be able to manage in society. • group homes enough staffing that will able us to give a better quality of service • Workforce, finding employment for clients who want to work. • unknown • funding of organization	• none • In order to provide the quality of services the pay needs to increase • Finding employers who are opened minded about hiring clients with IDD. • Lack of public interest, lack of things for the people we serve to do. • no funding , clients will not have the support they need.

Mason County

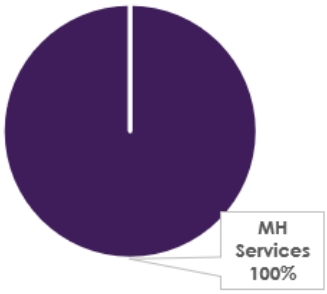


- In 2017, Mason County, TX had a population of 4.12k people with a median age of 48.9 and a median household income of $40,949.
- Between 2016 and 2017 the population of Mason County, TX grew from 4,064 to 4,122, a 1.43% increase and its median household income grew from $38,496 to $40,949, a 6.37% increase.
- The 5 largest ethnic groups in Mason County, TX are White (Non-Hispanic) (71.9%), White (Hispanic) (14.6%), Two or More Races (Hispanic) (5.07%), Some Other Race (Hispanic) (3.3%), and Asian (Non-Hispanic) (2.5%). 92.4% are U.S. citizens.
- The median property value in Mason County, TX is $156,400, and the homeownership rate is 73.1%. Most people in Mason County, TX commute by Driving Alone, and the average commute time is 19.3 minutes. The average car ownership in Mason County, TX is 2 cars per household.

Priorities identified in Mason County

Rank	Priorities	%
1	MH Services	100%

Top 3 Priorities identified in Mason County per Category of Respondents

Top 3 Priorities for Individuals	Top 3 Priorities for Family Members
Top 3 Priorities for the Community	**Top 3 Priorities for Staff**
	

Working and Not Working in Mason County

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Law Enforcement	• Tele psych	• No beds

Substance Use Disorders

Group Represented	What is Working?	What is Not Working?
Law Enforcement	• out patient services	• Availability of beds
Judicial Representative	• Not a lot.	• Securing long term commitment for individuals with substance abuse issues.

Positive opportunities and negative concerns that may impact the people in Mason County

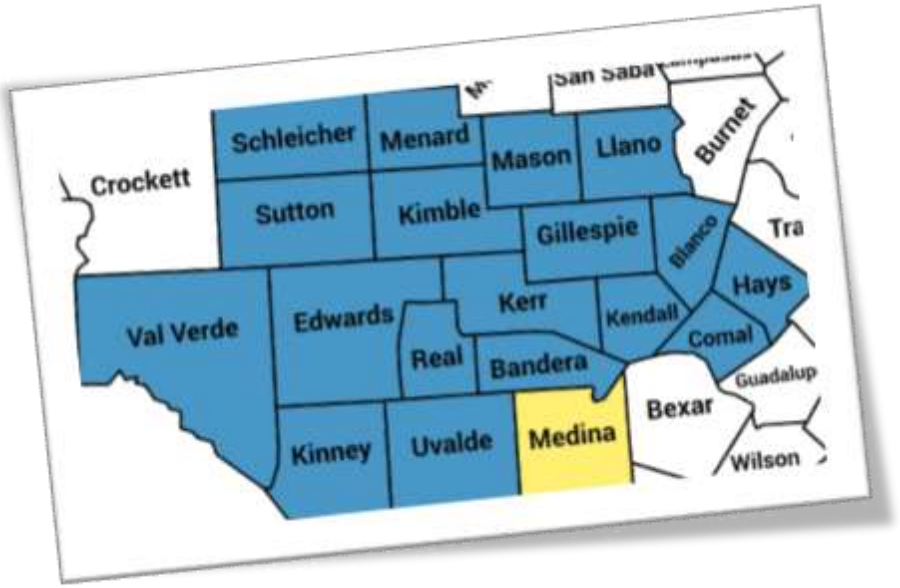
Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Law Enforcement	• Ma	• There are no beds

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Judicial Representative	• None	• Not enough support from the state.
Law Enforcement		• Lack of treatment (long term)

Medina County

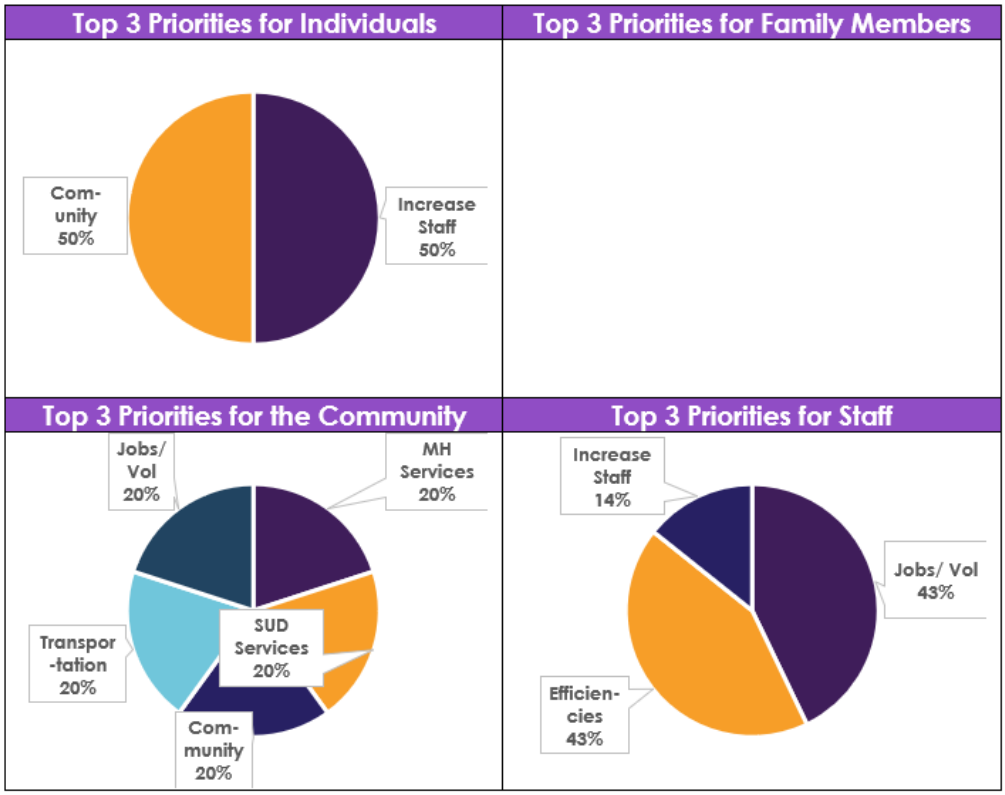


- In 2017, Medina County, TX had a population of 48.5k people with a median age of 38.8 and a median household income of $59,305.
- Between 2016 and 2017 the population of Medina County, TX grew from 47,920 to 48,548, a 1.31% increase and its median household income grew from $58,333 to $59,305, a 1.67% increase.
- The 5 largest ethnic groups in Medina County, TX are White (Hispanic) (45.9%), White (Non-Hispanic) (44.5%), Some Other Race (Hispanic) (3.72%), Black or African American (Non-Hispanic) (2.35%), and Two or More Races (Hispanic) (1.2%). 97.2% are U.S. citizens.
- The median property value in Medina County, TX is $134,400, and the homeownership rate is 82.1%. Most people in Medina County, TX commute by Driving Alone, and the average commute time is 30.6 minutes. The average car ownership in Medina County, TX is 2 cars per household.

Priorities identified in Medina County

Rank	Priorities	%
1	Job/Volunteer Opportunities	21%
2	Communication/Collaboration/Awareness/Education	16%
2	Efficiencies	16%
3	Increase Staff	11%
3	Transportation	11%
4	MH Services	5%
4	Substance Use Services	5%
4	Day Habilitation/ Daily Activities	5%
4	Wages/Benefits	5%
4	Basic Needs	5%

Top 3 Priorities identified in Medina County per Category of Respondents



Working and Not Working in Medina County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Community MH or IDD Service Providers (staff)	• Great coworkers who are very friendly and helpful. Small office so that it's easy to find someone when help is needed. I just started so I am in training. • Teamwork • able to use my discretion time off as needed (have a sick family member) and mgmt is supportive of this. • Team work between staff members. • person centered • What works well for me is creating my own schedule. This means that if	• There is a LOT of computer based training and a delay in getting all the training needed to start seeing clients even for experienced staff. • No communication • work overload, cannot get help from mgmt with this (even though i told them it affects billing by giving me so much work), so it all just piles up and no one seems to care. • Taking too long between intake and people being seen for psych eval. • privacy

	I'm out in the field, I don't have to stop at 12 noon to take a lunch. Individual client services are not intended to be cut-off at a specific time.	• What is not working is pulling out my lap top in every situation when I meet with an individual. It draws attention to our session if we are in public. The laptops are heavy to cart around everywhere.
Law Enforcement	• the local MHDD is great to help prevent Crisis, however while in Crisis the best action for the consumer is the Bexar County Hospital System	• MHDD still requires medical clearance for someone in Crisis, so why use them.

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• the schedule	• nothing
Advocates for Children and Adults	• Overall we have one of the best teams, as we work well together and problem solve and provide resolutions to help each other out among QMHP's	• In need of more assistance at times like family partner. In children services we deal with both child and parents- two different issues many times that need to come together and not just be "fixed"
Community MH or IDD Service Providers (staff)	• schedule	• so far its good

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• There are times when I am unable to take off work and HCMHDD has been helpful in getting my sister where she needs to be. • All Is Working Awesome!! • Communication with families • The support of our Administration and the tools given to do our jobs.	• I don't think i have any complaints thus far. • All Is Well!! • Knowledge to the public/school system
Advocates for Children and Adults	• when in contact with individuals, they appear to be happy with the services they are receiving by their provider	• seems to be a disconnect between LIDDA and providers
Community MH or IDD Service Providers (staff)	• Person center thinking • Getting to know the individuals we service by going on respite outings with them in our community.	• the pay we receive. • The condition of the files left by ex-employees

	Helping them reach their goals or objectives makes it all worth it. • Being hands on with the individual and seeing how theu progress every day. • knowledgeable, experienced co workers. Synergy with non profit Tex Spice sheltered workshop • Activities planning and execution for consumers. Teamwork of direct support staff.	• Not knowing their triggers or what causes the individual to have behavioral issues. • Every thing working right now. • could use an additional car type vehicle for one person transports • Inconsistency of management expectations. Undermining of confidence in decision making.

Positive opportunities and negative concerns that may impact the people in Medina County

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• A dedicated Substance Abuse program and amped up MCOT • Improve better intake process • heard that we may have a centralized person for insurance verification and one that handles record release so i may finally be able to catch up on all my other jobs if this does happen. • ???	• None that I am aware of. • Not enough Doctor Time • that i am not able to do all my work that affects billing/charging for services and getting everything else done that affects there assessments etc. in Anasazi • Don't know. • My concerns are that people may become completely responsible for their own transportation. If needed, staff should be able to count for 806 & 807 time if they have have scheduled appointments with the doctor/counseling.
Law Enforcement	• Emergency Room direction by STRAC	• Drug abuse has been harder to provide services

Children's Mental Health

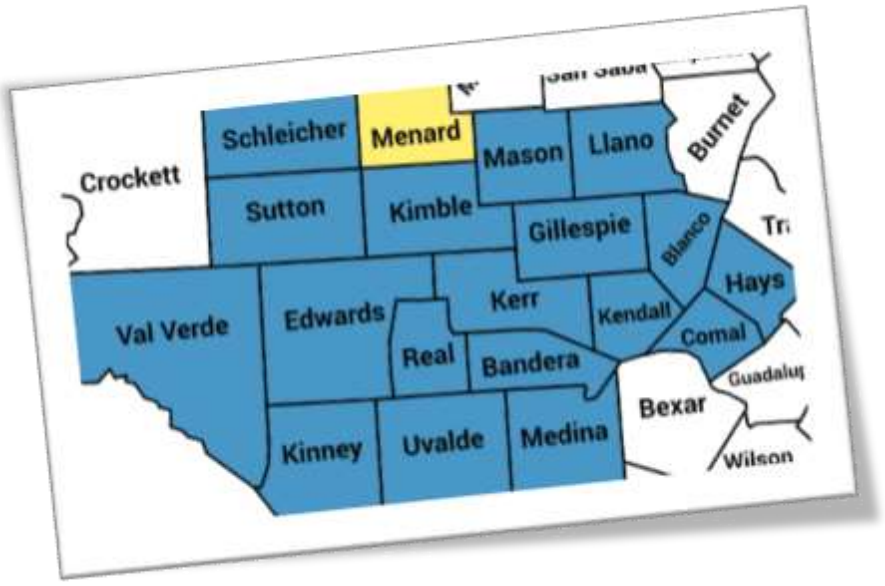
Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• none	
Community MH or IDD Service Provider	• support	• not sure

Advocates for children and adults	• As of now not aware of many as we are in a rural area	• We are in a rural area so a lot of resources are outside of agencies. With limited help due to limited pay range

Intellectual Developmental Disabilities

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• I don't think that I am aware of them. • It would benefit people • All the positive training we are given as well as the support	• I don't know of any • NA
Community MH or IDD Service Provider	• new staff • Being able to help them find jobs in what they like to do. • That they are able to get out into the real world and be able to work in the community. • technology/ medical advances. Government funding? • Supplemental training for staff.	• changes to the agency. • Not being able to help them reach their goals because of someone/something keeps them from reaching that goal. • That they want get to work in the community. • people losing benefits - red tape to regain • Increase of the ratio of consumers to staff.
Advocates for children and adults	• none	• changes coming through Medicaid and lack of community resources in rural areas

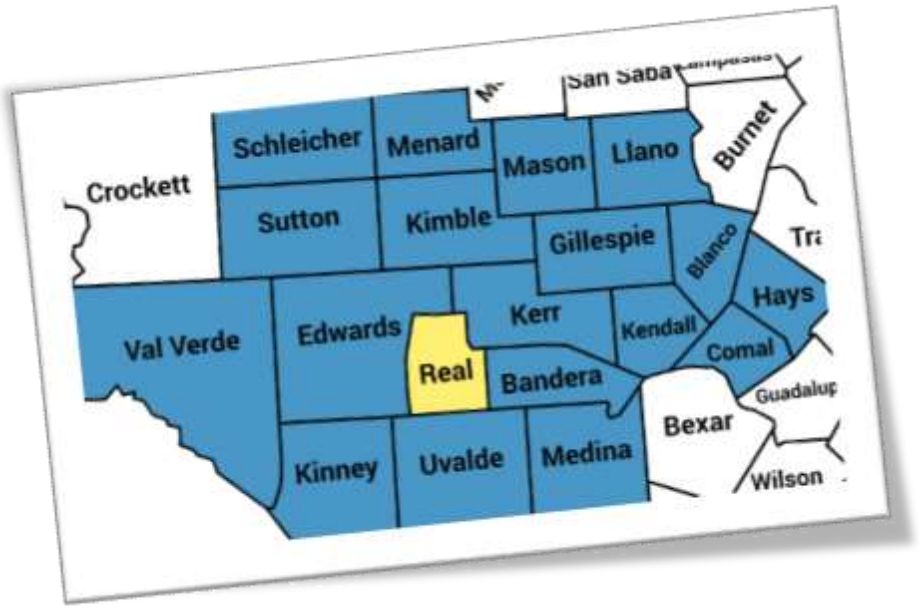
Menard County



- In 2017, Menard County, TX had a population of 2.12k people with a median age of 49.1 and a median household income of $37,917.
- Between 2016 and 2017 the population of Menard County, TX declined from 2,163 to 2,123, a -1.85% decrease and its median household income stayed from $37,917 to $37,917, a 0% change.
- The 5 largest ethnic groups in Menard County, TX are White (Non-Hispanic) (59%), White (Hispanic) (21.3%), Some Other Race (Hispanic) (7.68%), Two or More Races (Hispanic) (7.35%), and Two or More Races (Non-Hispanic) (2.54%). 95.1% are U.S. citizens.
- The median property value in Menard County, TX is $60,800, and the homeownership rate is 66.7%. Most people in Menard County, TX commute by Driving Alone, and the average commute time is 28.2 minutes. The average car ownership in Menard County, TX is 2 cars per household.

No Responses

Real County

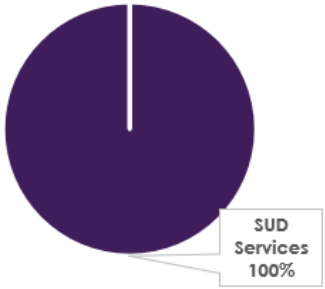


- In 2017, Real County, TX had a population of 3.36k people with a median age of 54.3 and a median household income of $36,493.
- Between 2016 and 2017 the population of Real County, TX grew from 3,348 to 3,358, a 0.299% increase and its median household income declined from $37,059 to $36,493, a -1.53% decrease.
- The 5 largest ethnic groups in Real County, TX are White (Non-Hispanic) (80%), White (Hispanic) (18.6%), Some Other Race (Hispanic) (1.22%), Black or African American (Non-Hispanic) (0.208%), and Asian (Non-Hispanic) (0.0298%). 96.8% are U.S. citizens.
- The median property value in Real County, TX is $105,100, and the homeownership rate is 76.8%. Most people in Real County, TX commute by Driving Alone, and the average commute time is 14.4 minutes. The average car ownership in Real County, TX is 2 cars per household.

Priorities identified in Real County

Rank	Priorities	%
1	Substance Use Services	100%

Top 3 Priorities identified in Real County per Category of Respondents

Top 3 Priorities for Individuals	Top 3 Priorities for Family Members
Top 3 Priorities for the Community	**Top 3 Priorities for Staff**
	

Working and Not Working in Real County

Substance Use Disorders

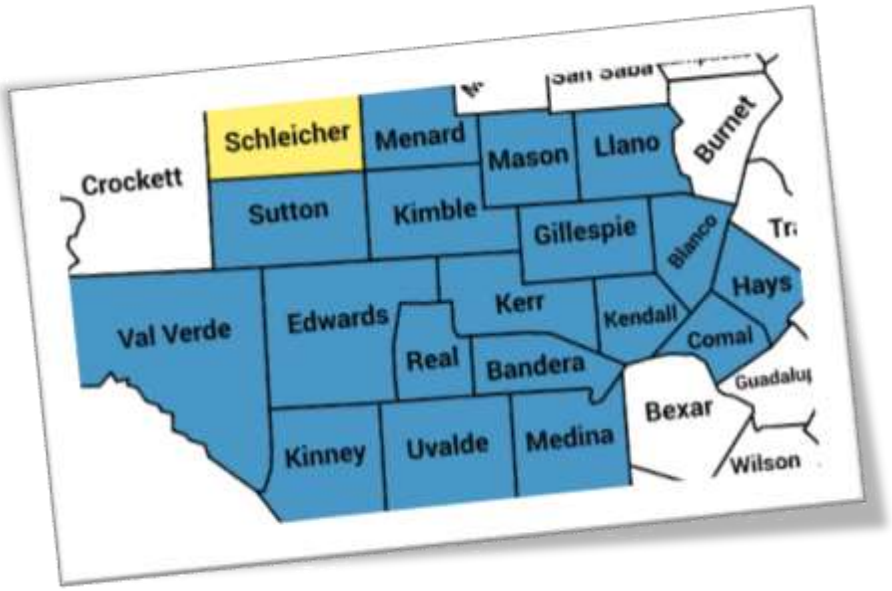
Group Represented	What is Working?	What is Not Working?
Judicial Representative	• We have an AA program available through one local church to assist with Alcohol abuse	• We have no programs currently available in Real County for other drug related substance abuse.

Positive opportunities and negative concerns that may impact the people in Real County

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Judicial Representative	• Not sure.	• The amount of substance abuse in our County.

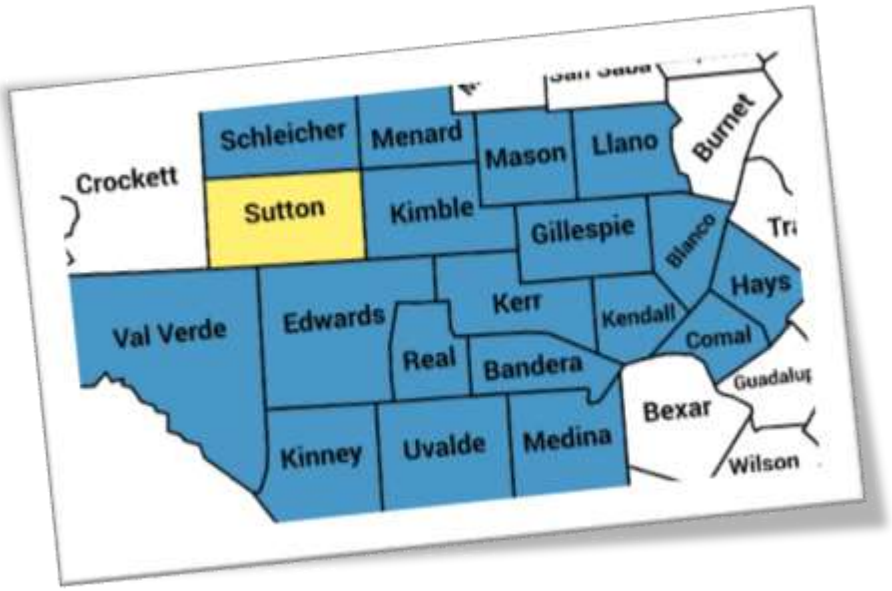
Schleicher County



- In 2017, Schleicher County, TX had a population of 3.12k people with a median age of 35.2 and a median household income of $63,432.
- Between 2016 and 2017 the population of Schleicher County, TX declined from 3,171 to 3,122, a -1.55% decrease and its median household income grew from $59,766 to $63,432, a 6.13% increase.
- The 5 largest ethnic groups in Schleicher County, TX are White (Non-Hispanic) (47.7%), Some Other Race (Hispanic) (35.8%), White (Hispanic) (16%), Black or African American (Non-Hispanic) (0.288%), and Asian (Non-Hispanic) (0.128%). 90.4% are U.S. citizens.
- The median property value in Schleicher County, TX is $72,900, and the homeownership rate is 76.9%. Most people in Schleicher County, TX commute by Driving Alone, and the average commute time is 27.6 minutes. The average car ownership in Schleicher County, TX is 2 cars per household.

No Responses

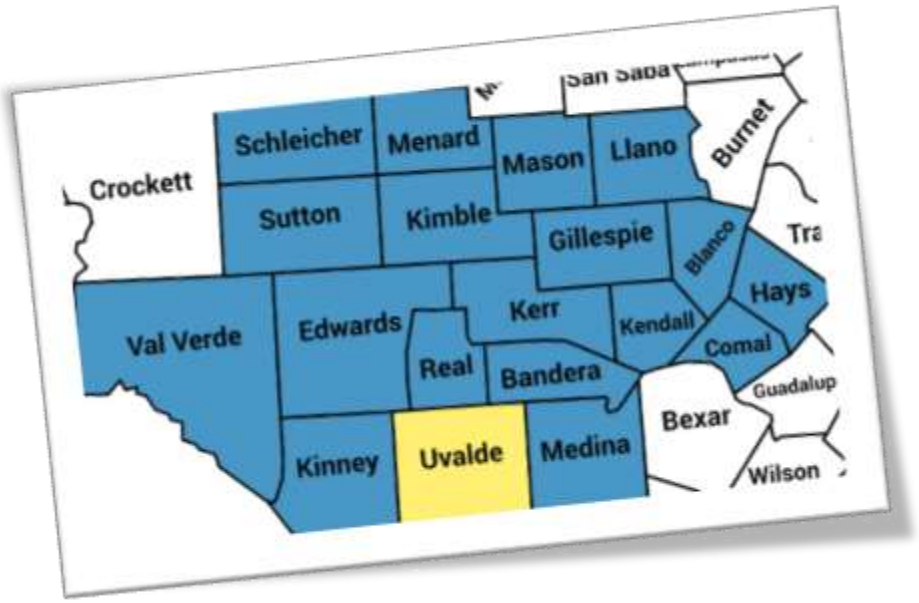
Sutton County



- In 2017, Sutton County, TX had a population of 3.89k people with a median age of 40.2 and a median household income of $60,996.
- Between 2016 and 2017 the population of Sutton County, TX declined from 3,936 to 3,894, a -1.07% decrease and its median household income grew from $54,567 to $60,996, a 11.8% increase.
- The 5 largest ethnic groups in Sutton County, TX are White (Non-Hispanic) (39.2%), White (Hispanic) (30.1%), Some Other Race (Hispanic) (28.6%), Native Hawaiian & Other Pacific Islander (Non-Hispanic) (1.03%), and Black or African American (Hispanic) (0.488%). 93.3% are U.S. citizens.
- The median property value in Sutton County, TX is $95,500, and the homeownership rate is 68.2%. Most people in Sutton County, TX commute by Driving Alone, and the average commute time is 18.8 minutes. The average car ownership in Sutton County, TX is 2 cars per household.

No Responses

Uvalde County



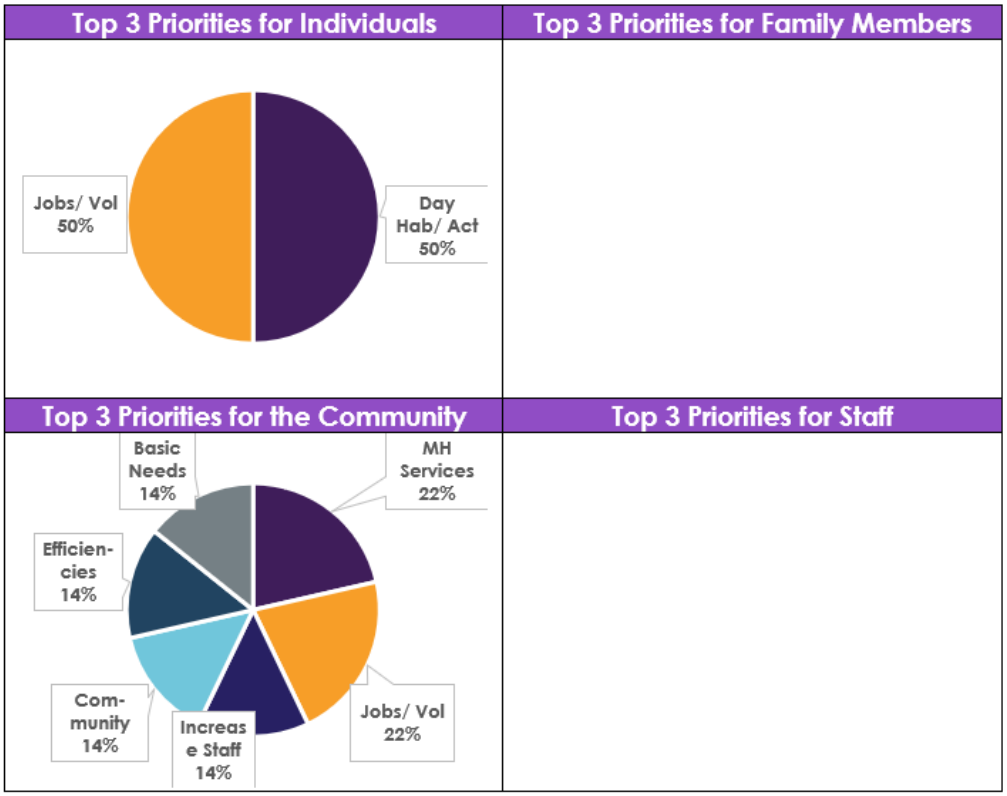
- In 2017, Val Verde County, TX had a population of 49k people with a median age of 31.7 and a median household income of $44,609.
- Between 2016 and 2017 the population of Val Verde County, TX grew from 48,862 to 48,976, a 0.233% increase and its median household income grew from $44,170 to $44,609, a 0.994% increase.
- The 5 largest ethnic groups in Val Verde County, TX are White (Hispanic) (76.6%), White (Non-Hispanic) (15.9%), Some Other Race (Hispanic) (3.71%), Black or African American (Non-Hispanic) (1.09%), and Two or More Races (Non-Hispanic) (0.807%). 87.1% are U.S. citizens.
- The median property value in Val Verde County, TX is $94,500, and the homeownership rate is 63.2%. Most people in Val Verde County, TX commute by Driving Alone, and the average commute time is 18.3 minutes. The average car ownership in Val Verde County, TX is 2 cars per household.

Priorities identified in Uvalde County

Rank	Priorities	%
1	Job/Volunteer Opportunities	18%
2	MH Services	14%
3	Increase Staff	9%
3	Communication/Collaboration/Awareness/Education	9%
3	Efficiencies	9%
3	Basic Needs	9%
4	Substance Use Services	5%

4	IDD Services	5%
4	Funding	5%
4	Day Habilitation/ Daily Activities	5%
4	Transportation	5%
4	New Facilities or Updates	5%
4	Training	5%

Top 3 Priorities identified in Uvalde County per Category of Respondents



Working and Not Working in Uvalde County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• I provide coping skill and help my clients decrease symptom. I have a lot of positive responses from my clients who utilize skills such as deep breathing, getting out in the community and En-Vivo activities.	• I have found linking and referring is challenging for a lot of my clients. I have to walk them through everything. My clients also struggle with remembering to utilize mystrength.com. and
Community MH or IDD Service Providers (staff)	• Nothing • The communication between staff members works well here.	• Med ed • Having difficulty keeping staff in all areas.
Emergency Health Care Providers (e.g., hospital emergency room personnel)	• MHMR is usually prompt with coming to evaluate patients in crisis • We do now have a pain specialist which should help with an alternative to opiods; Adult behavioral health the FQHC now has a psychiatrist on staff • Grants be given to assit with the pt placement • Having local crisis workers who can respond to calls from the Emergency Department. They work well with our local judge for emergency detentions. the electronic signatures have also been working better.	• Unfunded patients end up spending an extended amount of time in the ED before placement can be found for them. • Placement for inpatient services is limited for adult and children requiring this type of service. • Long placement times Numerous amount of patients that hold up our er rooms • Inconsistencies in the process by crisis workers. Would be helpful to see them arrive within the specified or said time as well as provide an update routinely so that the ER knows where in the process they are.
Law Enforcement	• I don't understand the question	• What's not working I can say the fact that the same individual who demonstrated help somehow slipped through the cracks.
Judicial Representative	• We have a felony post adjudication specialty court that has a MH case worker. That is working well.	• Need more MH counselors. A MH counselor who is solely dedicated to working with our adult probation program would be great.

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Community MH or IDD Service Providers (staff)	• Management • Small caseload/paid travel mileage • Leadership	• Having to do Crisis 10 days a month on top of regular hours. • Don't have money in budget • HR Hiring process, taking too long to fill out vacancies. Also not competitive salaries with other agencies.

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• I am able to stay at home to care for my special needs son	• lack of community resources for the special need people
Family Member(s)	• Not sure • getting along with co workers.	• Understanding and accessing my child's services • n/a
Community MH or IDD Service Providers (staff)	• Pretty much everything. • Having a team to reach out to when having questions or need assistance with an unfamiliar task. • Having individuals being referred to our program	• Being short staffed. • Lack of training and meetings. • individuals being unaware of our services

Substance Use Disorders

Group Represented	What is Working?	What is Not Working?
Emergency Health Care Providers (e.g., hospital emergency room personnel)	• not to much, we're lacking staff & facilities in this area for this problem.	• we do not have the needed facilities & staff for this problem.

Positive opportunities and negative concerns that may impact the people in Uvalde County

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• Crisis unit	• No concerns
Community MH or IDD Service Provider	• Dont know • I know that we have food banks that help people, but I'm not sure about what other opportunities there are.	• Not enough Drs would like to have a once in a while face to face • One of the concerns that I have is the lack of a homeless shelter because we have several people both in services and in the general public who are homeless for one reason or another.
Emergency Health Care Providers (e.g.,	• Assistance for placement of unfunded patients	• none • Reimbursement to pay for ongoing services.

hospital, emergency room personnel)	• Not aware of any, I do know there is pursuit of developing a 45 bed inpatient unit in uvalde and it is my understanding that the city or county has pledge property for the facility. • None • as listed above	• Na • as listed above
Judicial Representative	• I know the Supreme Court Commission on Mental Health is seeking to provide education on legislative issues that could benefit/result in increased services	
Law Enforcement	• Not aware of any opportunities	• Not sure

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• My families are constantly requesting more face to face CBT services. • networking with other agencies • Hopefully approval of couple of quarterly hours for advocacy and prevention.	• We are constantly deviating people to LOC 2 since the refuse to visit with staff over the screen. • Burn out/negative coworkers • Consumers are not happy with CBT services.

Intellectual Developmental Disabilities

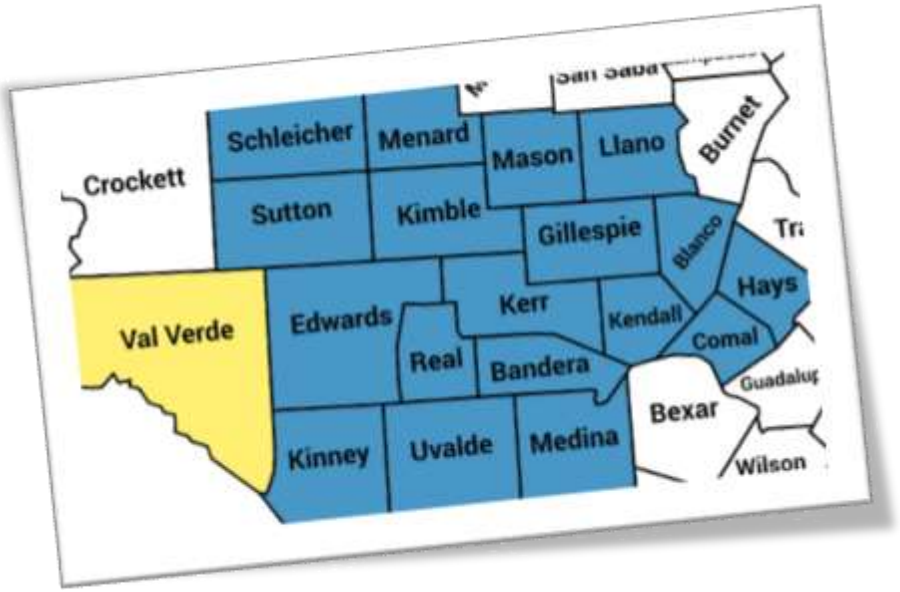
Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• day hab facilities	• lack of resources in the area for people with intellectual disabilities available.
Family Member	• I am not aware of any. • being able to depend on themselves.	• staffing, training, etc. • n/a
Community MH or IDD Service Provider	• Not many. • Changes to come in the day habilitation service. Not only will this be a positive impact for the individuals we serve but for our community. In the hopes that our community will understand and gain more knowledge of IDD and see that the people we serve are not limited when it comes to them wanting to	• Uvalde community can sometimes be very negative towards our clients that would love to have a job. • Lack of employees. We are always short staff and it is very difficult to get applicants. We need to be fully staff in order to provide service based on each individual's needs. We are over working our staff due to being shorthanded, were it is

	work or achieve other independent goals. • n/a	now causing some to consider resigning. • funding to support programs that serve our individuals

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Emergency Health Care Providers (e.g., hospital, emergency room personnel)	• n/a	• n/a

Val Verde County

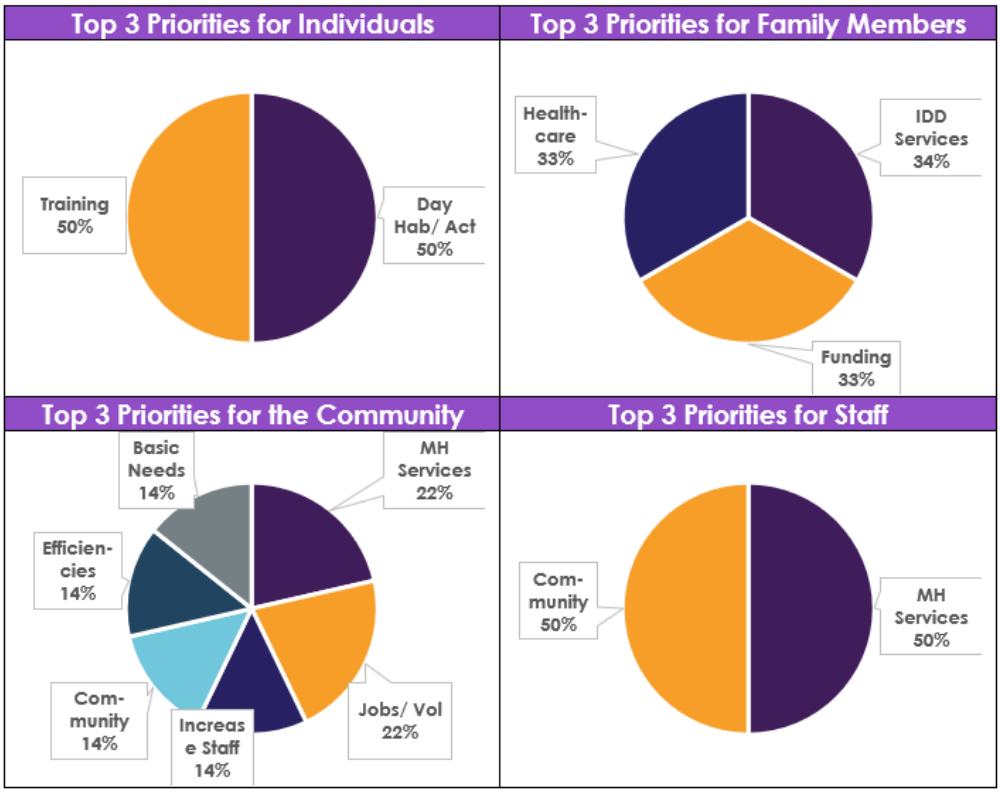


- In 2017, Val Verde County, TX had a population of 49k people with a median age of 31.7 and a median household income of $44,609.
- Between 2016 and 2017 the population of Val Verde County, TX grew from 48,862 to 48,976, a 0.233% increase and its median household income grew from $44,170 to $44,609, a 0.994% increase.
- The 5 largest ethnic groups in Val Verde County, TX are White (Hispanic) (76.6%), White (Non-Hispanic) (15.9%), Some Other Race (Hispanic) (3.71%), Black or African American (Non-Hispanic) (1.09%), and Two or More Races (Non-Hispanic) (0.807%). 87.1% are U.S. citizens.
- The median property value in Val Verde County, TX is $94,500, and the homeownership rate is 63.2%. Most people in Val Verde County, TX commute by Driving Alone, and the average commute time is 18.3 minutes. The average car ownership in Val Verde County, TX is 2 cars per household.

Priorities identified in Val Verde

Rank	Priorities	%
1	Communication/Collaboration/Awareness/Education	25%
2	MH Services	13%
2	IDD Services	13%
2	Funding	13%
2	Healthcare	13%
2	Day Habilitation/ Daily Activities	13%
2	Training	13%

Top 3 Priorities identified in Val Verde County per Category of Respondents



Working and Not Working in Val Verde County

Adult Behavioral Health of Adult Mental Health

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• I did receive the help with a psychiatrist but the [Staff] does not understand the consumers needs. • All is working great	• [Staff] is not not understand the consumers needs.
Family Member(s)	• Family partners, services and supports, Therepies (BT), progress in living skills, staff and service host home is working well.	• None
Community MH or IDD Service Providers (staff)	• Curriculum used: IMR	• Cancelling appointments due to working crisis.

		• Pay in not good. I believe the service I provide and the audits I pass is meeting all productivity es and deserve to have a raise
Government Representatives	• Reviewing data concerning progress of assistance availability for possible responder listing and use.	• n/a

Children's Mental Health

Group Represented	What is Working?	What is Not Working?
Community MH or IDD Service Providers (staff)	• Support the parents and help them with information they need for community resources and school.	• Not enough resources.

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals Receiving Services	• not sure, not yet, lack of services	• Waiting for hiring process, looking for right person to work, transportation
Community MH or IDD Service Providers (staff)	• N/A I haven't been here long enough. patience the coworkers are very helpful and willing to help. • Flexibility to complete work. Office environment. Relationship with Service Coordination co-workers and supervisors. Support from upper management. • good office environment, great supervisor, good/supportive relationship with MH and IDD Depts	• n/a haven't been here long enough • Having short staff creates more work and overwhelmed. No balance in amount of work per month. Not enough training within a reasonable time. Being in the same building with other departments (IDD/MH). Need more resources and tools to make work easier. • large caseload

Substance Use Disorders

Group Represented	What is Working?	What is Not Working?
Community MH or IDD Service Providers (staff)	• know some knowledge need more information	• know some need more information

Other Counties

Working and Not Working

Intellectual Developmental Disabilities

Group Represented	What is Working?	What is Not Working?
Individuals receiving services	• Everything, the convenience of workshop • Things are going well right now but, would be a lot better if we had more staff.	• Staff shortage • None
Community MH or IDD Service Providers (staff)	• Staff really seem to care for the consumers	• Need more service coordination management involvement
Outreach, Screening, and Referral (OSAR) provider serving the area	• Committed providers	• Lack consistent of affordable housing, minimum wage for in-home providers, lack of funding for respite care, and challenges to applying for benefits in a consistent way.

Substance Use Disorders

Group Represented	What is Working?	What is Not Working?
Family Member	• Peer recovery coaching.	• Not being able to provide recovery support services in some of the rural areas I work in.

Positive opportunities and negative concerns

Adult Behavioral Health of Adult Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• the clinic has potential • Learning how to live with a diagnosis and have a safety plan will help them to begin to use coping skills that work for them before a full blown crisis happens.	• The clinic need to do outreach to really understand the needs of the population • Individuals not being self sufficient
Family Member	• None	• None
Community MH or IDD Service Provider	• The new program HCMHDD is trying to implement: CMHBCH or something like that.	• People do not like/resist change.

Government Representative	• Increased availability of providers and their assistance possibilities.	• Persons not being able to be assisted due to negative funding, either personally or assisted.

Children's Mental Health

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• I'm not aware of any right now,but i will do some research.	• None that i know of.

Intellectual Developmental Disabilities

Group Represented	Positive Opportunities	Negative Concerns
Individual receiving services	• Job opportunities • more staff • Day Programs	• To actually get CFC MCO services. Affraid of not getting CFC MCO services. • Because of staff shortage clients upset for not being able to get out more in the community. • None
Community MH or IDD Service Provider	• N/A Haven't been here long enough • Services that will assist clients to become independent. (Employment).	• N/A Haven't been here long enough • Law making. Congress. Funds. • size of caseload may affect quality of services
Outreach, Screening, and Referral (OSAR) provider serving the area	• Small respite grant funding from HHSC through ADRCs.	

Substance Use Disorders

Group Represented	Positive Opportunities	Negative Concerns
Community MH or IDD Service Provider	• not very many • Community Coalitions in rural counties which can assist key stakeholders in the community and other community members concerned with preventing and reducing substance use/misuse issues affecting the community.	• not enough lpha for intakes and the intake system we have now is not working, need to go back to the old way. hillcountry just does not pay n the turnaround is big and people are not getting the services they need always short staff • Communities not willing to admit the community have a substance use/misuse problem and the problem erode the community.