Initial System Assessment of Texas Panhandle Local Behavioral Health Systems

Final Report

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TEXAS STATE of MIND

THE MEADOWS MENTAL HEALTH POLICY INSTITUTE FOR TEXAS

Contents

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List of Acronyms

AACAL	Amarillo Area Center for Advanced Learning
ACO	Accountable care organization
ACT	Assertive community treatment
AISD	Amarillo Independent School District
ALMA	Amarillo Legacy Medical
ARAD	Amarillo Recovery from Alcohol and Drugs
BHLT	Behavioral Health Leadership Team
CCISC	Comprehensive Continuous Integrated System of Care
CIT	Crisis Intervention Team
COPSD	Co-occurring psychiatric and substance use disorders
CRCG	Community Resource Coordination Group
CSOC	Children's System of Care
DSHS	Department of State Health Services
DSM-IV	Diagnostic and Statistical Manual, 4th Edition
EBP	Evidence-based practice
EMDR	Eye movement desensitization and reprocessing
ER	Emergency room
FPL	Federal Poverty Level
FTE	Full-time equivalent
HMO	Health maintenance organization
IOP	Intensive outpatient program
ISD	Independent school district
LMHA	Local Mental Health Authority
LOC	Level of Care
LPC	Licensed professional counselor
MCO	Managed care organization
MCOT	Mobile crisis outreach team
MH	Mental health
MHMR	Mental Health Mental Retardation
MMHPI	Meadows Mental Health Policy Institute
MOU	Memorandum of understanding
MVPN	Military Veterans Peer Network
NAIP	Network Adequacy Improvement Project
NAMI	National Alliance on Mental Illness
NOMS	National Outcome Measure Survey
NSDUH	National Survey on Drug Use and Health
PATH	Program for Assistance with Transitions to Housing
PBCC	Permian Basin Community Centers

PBHI	Panhandle Behavioral Health Initiative
PH/BH	Primary health/behavioral health
PTSD	Post-traumatic stress disorder
ROSC	Recovery-oriented system of care
SAMHSA	Substance Abuse and Mental Health Services Administration
SE	Supported employment
SED	Severe emotional disturbance
SH	Supported housing
SHS	Specialty Health System
SMART	Strategic, measurable, achievable, realistic, and time-bound
SMI	Serious mental illness
SUD	Substance use disorder
TPC	Texas Panhandle Center
TRR	Texas Recovery and Resiliency
TTUHSC	Texas Tech University Health Sciences Center
UHS	Universal Health Services
VA	Veterans Administration
VISN	Veterans Integrated Services Network
WTAMU	West Texas A&M University
YES	Youth Empowerment Services

Executive Summary

Through the work of community leaders, multiple stakeholders were convened during 2016 to form the Panhandle Behavioral Health Initiative (PBHI). This broad group of stakeholders (see current membership list in Appendix A) has rapidly developed an impressive shared commitment to coordinate planning, efforts, and resources to improve behavioral health service delivery in the 26 counties of the Texas Panhandle, 21 of which compose the catchment area of The Panhandle Center local mental health authority (LMHA), based in Amarillo, and five (5) of which are part of the catchment area of the Central Plains Center LMHA, based in Plainview.

MMHPI was invited to conduct an initial assessment of behavioral health systems in the Panhandle region. The recommendations are summarized as follows.

System Recommendations center on specific next steps to organize the PBHI to take action. These include:

- Chartering a Panhandle Behavioral Health Leadership Team (BHLT). Key steps would involve:
  - Clarifying the scope of the Leadership Team: 21 counties versus 26 counties.
  - Reviewing membership of the BHLT to ensure effective representation of key constituencies, including rural counties.
  - Engaging key funders in the collaboration, including managed care organizations (MCOs), foundations, and the hospital district.
  - Identifying resources for project management and coordination of the BHLT as well as strategic planning and implementation activities.
- Defining a shared vision and mission through the chartering process, including:
  - Establishing early objectives and deliverables in the charter.
  - Formalizing commitment to the BHLT from county and municipal leaders.
  - Developing bylaws, including a framework for committees and workgroups to make change.
  - Ensuring that all activities recognize the need to balance attention to the needs of the region as a whole, Amarillo (Potter and Randall Counties) specifically, and the rural sub-regions within the Panhandle.
- Organizing strategic planning and collaborative impact strategies:
  - Establishing a strategic plan with measurable and achievable targets, building on the recommendations below.
  - Utilizing a collaborative impact approach to engage a broad array of participants in making improvements in many areas as part of a common vision.
  - Committing to a culture of customer-oriented continuous quality improvement, in which the experiences of individuals and families receiving services inform progress.

- Incorporating improvements at multiple levels of the region, including region-wide, Amarillo-specific, and sub-regional (rural).

Recommendations regarding potential improvement activities in multiple areas were identified and prioritized by community stakeholders. These are further elaborated in the body of the report, and include:

- Crisis system improvement to promote access and engagement,
- Developing the children's system of care (including prevention and early intervention),
- Improving regional access to behavioral health care,
- Improving integration of behavioral health and primary health,
- Improving criminal justice and jail-based services,
- Improving veterans' services,
- Workforce recruitment and retention, targeting medical, nursing, other counseling professions.

Other potential priorities to address and align in the strategic plan include:

- Developing an adult system of integrated care – mental health, substance use, and co-occurring psychiatric and substance use disorders (COPSD);
- Developing a system of care for older adults;
- Increasing family and peer involvement;
- Addressing housing and homeless services;
- Ensuring cultural and linguistic competency;
- Engaging community resources and natural supports;
- Addressing prevention and early intervention.

Purpose of the Report

The Panhandle Behavioral Health Initiative (PBHI) engaged the Meadows Mental Health Policy Institute (MMHPI) to carry out an independent analysis of regional behavioral health systems in order to identify specific actionable strategies to support development of a highly responsive, clinically effective, and efficient community behavioral health system for the population of the entire region, including both insured and uninsured populations. The project objectives focused on evaluating current capacity and providing information on how to identify and prioritize opportunities for system improvement that could be accomplished with better leverage of available local, state, federal, and private resources, with the vision of developing a system of care for the region that:

- Is welcoming, accessible, vision-driven, recovery-oriented, and integrated.
- Increases the quality and effectiveness of service delivery for populations with increasing complexity.
- Improves the efficiency of system operations, resource allocations, and revenue generation processes across available federal, state, and local funding streams.

The primary deliverables for the project and their anticipated timing as proposed, include:

- A draft report, including initial findings and improvement recommendations, provided to the PBHI collaborative membership in June, 2016.
- This final report in September, 2016 that refines the findings and recommendations of the draft report based on further input from PBHI stakeholders and is intended to serve as a basis for continued behavioral health system of care improvement.

Methods and Approach

MMHPI initiated this review in April, 2016 in collaboration with local leaders, with a two-day on-site visit. This visit included meeting with PBHI membership and a series of interviews with key informants. Follow-up interviews were carried out on site and by telephone in early May. An effort was made to interview all PBHI members as well as other important partners in the community, including consumers, family advocates, government officials, law enforcement, and service providers. (See the list of interviewees in Appendix B.) MMHPI also utilized established data sets to provide an analysis of demographic service need data and comparative service provision data for the Panhandle region.

Overall Findings

Local Capacity for Behavioral Health System Leadership and Improvement

The Panhandle Behavioral Health Initiative (PBHI) demonstrates a strong foundation for the development of enduring and successful capacity for behavioral health system leadership and improvement in the Amarillo area and in the Panhandle region as a whole. Within a very short time, an organized group has been formed that is recognized by its participants as having a uniquely broad collaboration across the community that includes political leaders, foundations, private and public sector partners, and representatives from multiple service domains as well as regional partners from as far south as Plainview. All interviewees expressed belief that this collaborative has the potential to make a unique and powerful contribution to improving services.

Local leaders have demonstrated capacity and experience with managing complex community change projects, projects that the community can look to as indications of core capacity and previous success. These include the Senior Care Redesign and the Panhandle 2020 project (with its focus on poverty). The United Way of Amarillo and Canyon is ready and eager to assist in supporting a broad vision-driven collaborative impact approach that is aligned with its own strategic priorities for health and behavioral health improvement in the community. Local foundations have previously collaborated to support a variety of community change activities, including those identified above as well as the Gateway to Health project to advance telehealth in the region. This background suggests a strong foundation of collaboration among funders for future efforts in the behavioral health arena.

In addition to the above, the PBHI has engaged the West Texas System of Care collaborative based in Plainview, which is focused on the multi-county catchment area served by the Central Plains Center (LMHA). This collaborative, successfully organized over the past decade, represents the strongest rural system collaborative that MMHPI has identified to date in Texas. Even though only five (5) counties addressed by the Central Plains Center overlap the 26 counties formally identified as "Panhandle" counties, the learning, wisdom, and experience from the West Texas collaborative will be of great value for the development of a successful regional approach in the Panhandle, particularly for the more rural counties. This collaborative itself is ready to take its own next steps of further development and look beyond its major roots in children's services to create a more organized focus on addressing the needs of adults – especially those at risk of hospitalization and incarceration.

The community partnership at this point is ready to take the emergent PBHI collaborative to the next level and develop a more formalized and sustainable structure for ongoing leadership and more formal mechanisms to organize a collaborative impact process that will make measurable changes in the system. These next steps will be described in the recommendations.

System Strengths, Growth and Improvement Opportunities

The Panhandle is very fortunate to have experienced leaders throughout its region and systems. Many of the individuals interviewed had decades of service and commitment to making the Panhandle communities healthy and thriving. There has been increasing awareness that competitive approaches to solving collective problems harm and limit community efforts and outcomes, and steady progress has been made in developing a collaborative "culture" to address many complex community problems. Examples include Panhandle 2020, Senior Care Redesign, cooperative grant proposals, regional children's system of care development, hospital collaboration through the Coalition of Health Systems, and so on. These approaches are examples of how organized collaborations garner more resources and foster an environment that sets the stage for using global strategies for change such as Collective Impact™ or "collaborative" impact.

These emerging collaborations are especially important in the face of the real challenges facing the Panhandle region as a whole. Many of the counties in the Panhandle are rapidly growing and the growth in resources (especially in terms of health and human services infrastructure and capacity) has not kept pace with the need. This impacts the short-term and long-term planning that has to be done to maintain the Panhandle's quality of life for so many of those who are long-term residents, as well as the many newcomers who continue to arrive in the area, seeking opportunity and community. The culture of the community is changing rapidly in many ways, as expansion leads to increasing complexity and diversity. The region as a whole is facing many challenges: increasing economic challenges of poverty, a growing population of older adults, social challenges such as a very high teen pregnancy rate, domestic violence, significant substance abuse (alcohol, methamphetamine, opioids, synthetic marijuana), high suicide rate, and homelessness, along with the traditional problems with limited and restricted state resources, remoteness from many state services, rural access challenges, and significant workforce shortages, particularly in health and human services. An important example worthy of recognition is that Amarillo is a longstanding resettlement community for Somalian, Burmese, and Vietnamese refugees (and other immigrant populations), which brings diversity and new challenges not only for the re-located families and disenfranchised communities, but also for the community as a whole. Key stakeholders note the importance of incorporating diversity (gender, race, sexuality, religious, etc.) into community planning. And of course, all of these challenges intersect with an increasingly diverse spectrum of individuals and families facing behavioral health (mental health and/or substance use) challenges of all kinds.

Given the challenges faced in the Panhandle generally and in the behavioral health service arena specifically, there has been remarkable progress in many areas of behavioral health care in the region, even without the benefit of an organized community collaboration to enhance

and coordinate disconnected activities. Examples of these positive elements or strengths identified by the many key stakeholders interviewed are presented below.

Texas Panhandle Center (TPC)

Given the resource and state regulatory challenges faced by TPC (like all LMHAs), TPC has done a truly exceptional job making progress in its efforts to design a cutting-edge service array that is responsive to community needs. MMHPI has carried out multiple community assessments in Texas, and the nearly universal view that TPC is "responsive and helpful" as a community partner is striking. This finding is present even when the interviewee has been dissatisfied with service access and specific services, and reflects the culture established by TPC and its leadership team over two decades of establishing a reputation "to do whatever is possible" (within the constraints it faces) to meet the needs of the populations served. Specific activities of TPC that deserve recognition include (and this is far from a complete list) expanding regional access to telepsychiatry (including jail-based services in some jurisdictions), implementing responsive mobile crisis in Amarillo and throughout the region, establishing crisis respite (in collaboration with The Woods Group), developing jail diversion in Randall and Potter Counties, creating a strong culture and capacity for peer support, revitalizing the local NAMI chapter, supporting veterans outreach services, investing in PBHI, and supporting intervention programs in schools both in Amarillo and in the 21 rural counties they serve (e.g., STAR program and School and Family Advocacy).

The Pavilion

The region is fortunate to have extensive inpatient psychiatric capacity for all age groups based in Amarillo under the auspice of Universal Health Services' Northwest Healthcare Systems. This entity functions as an extension of the hospital district and therefore has some capacity for indigent care for local residents, along with accepting private insurances, Medicare, and Medicaid MCOs. The Pavilion operates 106 inpatient psychiatry beds, including two units for adults (general psychiatry and a 28-day program for co-occurring mental health and substance use disorders), children, older adults, and 16 beds for uniformed services personnel (e.g., police, firefighters, military, etc.). It also has a 24-hour assessment center, a short-term partial hospital, and an intensive outpatient program for substance use disorders. Under new leadership, the Pavilion has made strong efforts to be seen as a true community partner through collaborations with the County Mental Health Coordinators, TPC (jail diversion, mobile crisis), Amarillo Recovery from Alcohol and Drugs (ARAD), and other services. Significant areas of development relate to extending the ability of the Pavilion to be a strong regional partner (through a contract with TPC for regional "rapid crisis stabilization" for residents outside of Potter and Randall Counties) and to create or develop more of its community-based services, such as continuing chronic care management, in addition to providing inpatient and partial hospital levels of care. Although these areas of development are still in relatively early stages,

they represent a significant opportunity to leverage more collaborative capacity to address the needs of individuals with complex behavioral health conditions who may fall between the cracks.

County Leadership (Including Jail Diversion)

Leadership in the City of Amarillo and surrounding counties in the Panhandle clearly recognize the importance of improving behavioral health services. One key example of this is the exceptional commitment of the new (2015) Potter County judge, Nancy Tanner who has taken this issue on as a personal priority. Judge Tanner has established a mental health docket, taken an active role in jail diversion, initiated the exploration of ideas to consider either residential or day rehabilitation services as alternative settings for jail or to address homelessness, taken steps to improve mental health coordination, and continues to exhibit the energy and passion to do much more. In addition, Randall County has been an outstanding partner since 2013 in establishing a jail diversion program. Unfortunately, we did not have an opportunity to speak directly with leadership in all of the representative counties and regret any under-representation in the capacity of those county leaders to support this process as well.

Foundation Support

We were impressed with the presence of multiple foundations at the table (along with leadership from United Way) and the commitment from all of the funders to the importance of addressing behavioral health in the region and identifying meaningful and achievable strategic targets for progress. United Way of Amarillo and Canyon, Amarillo Area Foundation, Bivins Foundation, Harrington Cancer and Health Foundation, and Baptist Community Services all have experience in championing projects (such as Panhandle 2020) that have a broad vision and an important community impact, and are at the ready to contribute their expertise and energy to support PBHI's organizational development.

City of Amarillo: Amarillo Police Department Crisis Intervention Team (CIT)

The City of Amarillo's commitment to funding a team of eight CIT-trained police officers is an impressive contribution to the effort of responding to mental health crises in the most clinically appropriate way and focusing law enforcement crisis response on providing access to services and support. The Amarillo CIT officers are well respected and have a positive, well-functioning collaboration with the TPC mobile crisis team, which assists with the disposition of mental health crises and approval of indigent hospitalization. The City is an important and engaged partner in this effort and is willing to collaborate to find solutions to better address community needs. CIT call data from 2015 indicated that there were over 6,000 calls leading to a total of 1,048 reports. The difference between "calls" and "reports" is that calls might be for any issue in which there is a possibility of a mental health emergency, and reports are generated only when there is an actual CIT intervention. The data indicate that the CIT team averages about

three CIT-reported interventions per day, indicating a high level of activity for the current group of officers in responding to community need.

Amarillo Recovery from Alcohol and Drugs (ARAD), Inc.

This relatively new organization has successfully established itself in the community to address significant gaps in the availability of substance use disorder treatment services for both indigent and insured residents of the Panhandle. ARAD has implemented a well-regarded intensive outpatient program (IOP) that is based at the Salvation Army and engages individuals with significant addiction challenges, including those who are homeless. Their current priority is a fundraising campaign to establish a short-term (30 to 90 day) intensive residential treatment program, as there is no such service in the area. ARAD is presently in discussion with the Bivins Foundation regarding a possible lease for a building to serve those in need of substance use disorder treatment (an agreement has not yet been finalized). Most impressive, they have a plan to be self-sustaining by designing services for insured clients and using the proceeds to support capacity for those who are indigent.

School Services and Other Children's Services

The community has an existing Children's Collaboration Workgroup, organized by TPC, with participation from juvenile justice services, family and protective services, and school districts. This collaboration has generated several positive efforts to address the needs of children in the region, such as the Safe Schools/Healthy Students project. With recent grant funding, and in collaboration with the West Texas System of Care collaboration in Plainview, the region will be embarking on the development of a formal regional children's system of care collaboration, and has recently recruited a staff coordinator for that effort. Further, there is already a strong commitment to providing services in select schools and districts throughout the region. For example, TPC has been opportunistic in leveraging grant and 1115 Waiver funding in order to maintain programs like School and Family Advocacy in the Amarillo ISD, which grew out of the Safe Schools/Healthy Students project and has served over 600 at-risk students to date, linking them to behavioral health services and other resources (see data in Appendix C); and the STAR Program, which is provided in 21 counties as an early intervention program for high-risk children. Further, TPC provides wraparound services for selected high-risk children and families, and has made better-than-average progress in the implementation of YES Waiver Medicaid services to support wraparound for designated families. Further, there are some creative and innovative services in Amarillo, such as Specialized Behavioral Health Services to address the needs of children with complex multiple disabilities, as well as private practitioners with specialized expertise (such as those who work with adolescent sex offenders as part of their general practice). Further, the Amarillo ISD is under the leadership of a new superintendent who, in collaboration with the Director of Student Counseling, is in a position to make a much stronger commitment to addressing behavioral health needs throughout the Amarillo ISD. The

Plainview collaborative has also done an exceptional job in creating a children's system of care partnership involving not only the schools, but also juvenile justice services and the Department of Family and Protective Services; other communities can learn from their accomplishments. We did not have the opportunity to extensively review locally organized children's services in other areas of the region, but we did learn that the Dalhart multi-county region has evolved their Community Resource Coordination Group (CRCG) from a poorly attended placement-focused meeting to a thriving and energetic community collaborative that is looking at systemic approaches for children and beginning to expand attention to other age groups as well.

Behavioral Health Services in Medical Settings and Systems

One of the strongest opportunities for expanding capacity for delivering behavioral health care to the population as a whole is to improve the integration of behavioral health services into primary care settings and develop the capacity of primary care providers to address behavioral health needs through collaboration and consultation. Important opportunities for addressing this issue are clearly present, both for indigent and non-indigent populations.

- **Amarillo Legacy Medical ACO and Heal the City:** Heal the City is an indigent health clinic that is open one night per week (with psychiatric consultation), providing a small but important step to addressing the gap in safety net ambulatory health care in the community. In terms of potential impact on improving behavioral health care, the Amarillo Legacy Medical ACO (ALMA) offers an important contribution. ALMA is a rare ACO that is owned by physician practices rather than hospitals and has already demonstrated significant capacity to leverage health care savings and bonuses through improved cost-effective care. Although it has not tapped the potential positive cost and outcome impact of integrating behavioral health care, it is well-positioned to be a community leader in primary health/behavioral health integration, which would be a significant benefit for the entire community.
- **J.O. Wyatt Community Clinic:** The Wyatt Clinic is a community clinic/group practice under the auspice of Northwest Texas Healthcare System designed to address indigent (as well as Medicare and Medicaid) health care needs in the community as an extension of Northwest's responsibility to carry out the services of the hospital district. They employ a part-time psychiatrist (along with two therapists and one social worker) within a nine-physician multi-specialty group. The clinic serves a population of people with mental health conditions that are, in general, not included in the priority population served by The Panhandle Center: mood and anxiety disorders, trauma-related disorders, and personality disorders.

Coalition of Health Services

The Coalition of Health Services (the Coalition) currently has participation from 12 rural hospitals and the two tertiary hospital systems based in Amarillo (UHS Northwest Texas

Healthcare System and Baptist St. Anthony's Hospital). Informants report that the Coalition (formed in the mid-1990s), with a Board of Directors made up of all participating hospital administrators, has overcome early challenges through concerted and deliberate efforts to become an effective partnership. The Coalition has a helpful working relationship with the state and has acquired state grants to accomplish some significant projects, such as case management services in 32 counties of Health Service Region 1 for families of children with special health care needs who are not enrolled in the Medicaid program. Another project is Gateway to Health Careers, a collaboration among the Coalition of Health Services, AACAL, TTUHSC SimCentral, the Texas Panhandle Coalition for Nursing, and 14 rural school districts to support entry of young people into health careers. The Coalition offers a strong foundation for further engagement in addressing behavioral health needs across the region, particularly to the extent in which they routinely impact cost and outcomes within the provision of community-based health services at the hospital system or hospital district level.

Community Counseling Services

The Amarillo area has some dedicated non-profit organizations that provide counseling services to low-income populations, along with other types of social services and family services, each with an additional focus on working with cultural/linguistic minority populations and traumatized individuals and families (but not with individuals with more serious psychiatric illnesses). In addition, the community has a relatively small but dedicated group of private practitioners, some with unique skills and abilities (e.g., special expertise in working with sex offenders, individuals with eating disorders, and those with personality disorders). There are also regular meetings among local practitioners, such as the monthly LPC meeting, which indicate a capacity for coordination among private practitioners to better serve the community. Two of the counseling agencies we met with are:

- **Family Support Services:** This is a multi-service nonprofit agency, highly regarded in the community, which provides counseling services, behavioral health services (mostly trauma-focused, including trauma-focused cognitive-behavioral therapy, EMDR, and equine therapy), crisis services for sexual assault and domestic violence, an expanding education and prevention department, and a veteran resource center. Of particular note is that this agency has a multi-service drop-in facility where they partner with other agencies and focus on high-risk families and culturally-challenged communities that are *not* included in the priority population addressed by TPC and often fall through the cracks of other services. One of their particular strengths and priorities is developing culturally appropriate prevention and treatment services for Hispanic families and, increasingly, for Somalian, Burmese, and other immigrant sub-cultures in the region.
- **Amarillo Wesley Community Center:** Founded in 1951, this church-supported agency aspires to provide a comprehensive community center. Ninety percent (90%) of the people they serve are Hispanic, ranging in age from six-week old children in day care to

a 98 year old person engaged in older adult services. There are 15 social service programs in the center and their counselors can address the needs of anyone who comes in for any of the programs or requires additional assistance.

Homeless Services

As in most communities, Amarillo has a continuum of care for the purpose of planning and coordinating housing, services, and supports to address the needs of individuals who are homeless. (The most recent point-in-time homeless count is attached in Appendix C.) There is a significant array of homeless shelter services (Salvation Army, etc.) that are demonstrating capacity to provide, at minimum, available shelter to those who need it, as well as offering a welcoming environment for homeless individuals and families who may have behavioral health challenges. The Downtown Women's Shelter provides a remarkable continuum of services specifically for women with substance use disorders and other challenges and their children (approximately 85% of the women have co-occurring mental health conditions, including trauma), ranging from shelter services to initial stabilization, intensive outpatient treatment, and transitional housing. TPC has a Program for Assistance with Transitions to Housing (PATH) program that provides homeless outreach and is able to engage individuals with serious mental illness in Shelter Plus Care. The Guyon Saunders Resource Center (GSRC) is a facility in downtown Amarillo that housed seven nonprofit organizations, many of which provided services specifically to persons with low incomes and living in homelessness. Many of those nonprofits have relocated to other facilities, including Texas Panhandle Centers (TPC) and Regence Health Network (RHN), which have co-located in a different location downtown. Due to the change in scope and/or location for some of the nonprofit tenants of the GSRC, the day room for people who are homeless will also relocate to a facility downtown. The GSRC facility is currently listed for sale.The current space represents a significant opportunity to create a more innovative service array for individuals with behavioral health concerns, including those who are homeless. Finally, Amarillo has an impressive array of homeless services for veterans, including Another Chance House and Housing First services (an evidence-based practice) coordinated by a former leader of the nationally known Pathways to Housing program in New York City. This program model represents one of the most successful ways of providing housing supports to individuals who are the most seriously impaired and most difficult to engage, and who will often not be successful in more traditional group living or higher demand settings.

Finally, at the school system level, Amarillo ISD has a Title IX homelessness program, which was just renewed for three years. Amarillo ISD reports that there are 2,100 "homeless" children (not all of whom might be counted in the homeless count). The program, with 2.5 FTE staff, provides transportation, supplies, school enrollment assistance, support for family transitions, food vouchers, and other services to help these children and their families.

Older Adult Services

The Amarillo area has recently undergone an impressive and comprehensive re-design of older adult services, with a major shift away from – and diminished reliance on – traditional nursing homes to a more person-centered continuum of services ranging from in-home supports to more homelike assisted living and high-need rehabilitation services. Community Baptist Senior Services is a notable example of such an effort and has resources to provide some level of behavioral health support through the continuum of services (though not as much as is needed). Further, there is recognition of the need for psychiatric consultation in order to help older adults be successful in less restrictive settings and Community Baptist Senior Services are working to establish a telepsychiatry program to create access to such consultation in a wide array of settings. There is also telepsychiatry provided through Diamond Health Care for a specialty geropsychiatry intensive outpatient program based in Dalhart.

Veterans Services

There is a strong presence of Veterans Administration (VA) services in the region (a large rural care network spanning 50+ counties, including the entire Panhandle and the eastern part of New Mexico) and the recent reorganization of VISN 17 to be more Texas-focused allows for better regional planning. There is a large ambulatory VA service in Amarillo, considerable investment in transitional housing, and up to 16 contracted inpatient beds at the Pavilion for veterans on the Uniformed Services Unit (in lieu of there being no VA inpatient psychiatry unit in the area). TPC also offers a veterans' peer outreach program as part of the statewide Military Veterans Peer Network (MVPN). The VA places a strong emphasis on evidence-based treatment and training for all staff.

Many of the integrative projects and processes the community needs to develop have been pioneered at the VA, including the following types of programs that might help inform the development of system-wide integrative collaborations:

- A network of beneficial partnerships with a number of community agencies, including formal contracts and MOUs with the Pavilion, Downtown Women's Center, Another Chance House, Alcohol Recovery Center, and Potter and Randall County Public Housing Authorities.
- A Housing First program that has housed 150 homeless veterans in this area alone.
- A recent pre-trial intervention diversion court program with the judge in Potter County.
- A national best practice for suicide prevention that includes a team of five social workers who have integrated privileges as guest clinicians at the Pavilion and private hospitals in Lubbock.
- Extensively developed patient peer support services into VA care lines, connecting to post-traumatic stress disorder (PTSD) and substance use disorder (SUD) care at all sites.

- Transformation of all substance use disorder treatment programs into co-occurring disorder PTSD/SUD care.
- Community-based intensive case management for adults with serious mental illness.
- Same-day response programs that provide some of the best measurable access to VA services in the country.
- A local pilot site for primary care/mental health integration that has embedded three full-time social workers, a nurse, and a half-time psychologist.
- Tri-directional video-based care delivery, including substance use disorder care and medication management, between Amarillo, Childress, and Lubbock.

Training Institutions

In the face of significant workforce shortages, the Amarillo area has strong training institutions that are working to expand and committed to supplying an excellent workforce to the region. Although we were unable to speak with all the programs, we did receive information from the leaders of the WTAMU Social Work and Counseling programs about their significant efforts with Texas Tech (TTUHSC) to develop a psychiatry residency program. The greater Panhandle region and West Texas generally have a wide range of training institutions, including the TTUHSC residency, physician assistant and advance practice registered nurse programs, programs for training addiction counselors, and training for psychologists. Amarillo College also offers degree programs in both psychology and social work. There may be an opportunity to leverage this infrastructure through the cross-system psychiatry coordination process, in which Texas Tech (and all of the university systems with medical schools) participates.

Consumer/Family Advocacy and Peer Support/Recovery-Oriented System of Care

Compared to other regions we have evaluated, the Panhandle region has a stronger presence of consumer/family advocacy and availability of peer support. TPC has sponsored the development (with DSHS support) of a Panhandle Recovery-Oriented System of Care (ROSC), which involves building a collaborative for people with lived experience, providers, and other natural community supports to create a strong nexus of "recovery capital" for the community; the ROSC is working to bring both mental health recovery and addiction recovery together within the collaborative. The local NAMI chapter has grown in four years to an effective organization with 75 members. Further, there is availability of certified peer specialists and certified family partners within the TPC continuum of services, with opportunity to build further capacity. The Amarillo Area Mental Health Consumers / Agape Center is an independent, nonprofit peer recovery center run by mental health peers.

These highlighted system strengths provide an excellent base upon which to build. Specific improvement opportunities and recommendations will be provided below. However, an

important aspect of our general findings is that even in the face of expanding resources and new programs, there are continuing, and growing, challenges to be addressed.

AscentHealth Consulting recently conducted a community needs assessment in which behavioral health services were identified as one of the top community priorities along with primary care. Twelve percent (12%) of respondents reported having a behavioral health need and 73% of respondents identified increased access to mental health services as a need (the top-rated need). It was also reported that the number of families presenting to Potter County requesting mental health assistance (e.g., warrants) has expanded from the mid-400s to over 600 in the last year, and only a minority of those presenting are able to connect with helpful services. TPC has been stretched thin through their efforts to expand programs and resources to meet growing needs. In addition, everyone reports a continuing exodus of skilled behavioral health professionals, including nurses and physicians, leaving the region. Further, one of the most common observations relates to the disconnection of services, which can be generally summarized this way: "We all work in a very thinly served region, and we collaborate well when we have occasion to do so, but we do not routinely connect to coordinate and plan services for the region as a whole. In fact, many of us had never met until the PBHI brought us together." This history of fragmented and under-leveraged resources represents a significant opportunity for Panhandle Behavioral Health Initiative to make a major difference.

In the next section, we will provide overall comparative data on the population demographics and needs for behavioral health services in the Panhandle region, as well as a simple comparison of the services provided by TPC to those provided by LMHAs in other regions. This will provide some simple reference data that might be helpful in future planning. Following that section, we will describe specific improvement opportunities that can be targeted early on and provide concrete recommendations to address them.

Panhandle Behavioral Health Needs and Service Capacity

For this report, we have provided key data that frames and supports the areas in which we are identifying improvement opportunities and next steps.

Twelve-Month Prevalence of Mental Health Disorders in Randall County

Mental Health Disorder	Total	Adults	Adults in Poverty	Children	Children in Poverty
County Population[1]	**131,281**	**99,029**	**23,619**	**32,252**	**10,182**
All Mental Illness[2]	34,396	25,946	6,188	8,450	2,668
Mild	13,896	10,482	2,500	3,176	925
Moderate	12,830	9,678	2,308	2,932	854
Severe/Serious	7,670	5,786	1,380	see SED	see SED
Serious Mental Illness (adults)[3]	4,157	4,157	2,053	N/A	N/A
Super-Utilizers (adults)[4]	320	320	158	N/A	N/A
Severe Emotional Disturbance (SED) Youth / Children Only[5]	2,342	N/A	N/A	2,342	889
Children / Youth Most At Risk[6]	234	N/A	N/A	234	89

[1] Population is for 2015, the most recent year for which the Texas State Demographer's Office has population estimates available: http://osd.texas.gov/Resources/TPEPP/Estimates/2014/Preliminary_2014_txpopest_county.pdf. However, the estimate has not yet been broken out by age and so we are using previous age percentage breakouts to estimate the number of adults and children living in the county as of January, 2015.

[2] National estimates of prevalence and severity breakouts are drawn from Kessler, RC et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS_R). *Archives of Gen Psychiatry, 62*(6), 617-627. The data are from a study with adults. Comparable data for all ages of children and youth, from a nationally representative or Texas-representative sample, are not available. However, based on various small studies, as well as on a national study of adolescents, we have estimated that the totals and breakouts are roughly comparable for children and youth, ages from birth to 17 years. However, instead of using an estimate for severe/serious based on Kessler et al.'s adult data, we are using the more precise Holzer estimate.

[3] Estimates of SMI and SED are for 2013 and are taken from the following source: Holzer, C., Nguyen, H., Holzer, J. (2015). Texas county-level estimates of the prevalence of severe mental health need in 2012. Dallas, TX: Meadows Mental Health Policy Institute. In incorporating specific county demographics, Holzer's estimate of SMI is more precise than Kessler's. Estimates are updated with 2015 population data (see above).

[4] These adults are at the highest risk for repeat use of emergency rooms, hospitals, and jails. Cuddeback and colleagues (2006 and 2008) have estimated that 7.7% of adults with SMI need Assertive Community Treatment or Forensic Assertive Community Treatment, or both.

[5] These are children and youth at risk for out-of-home and out-of-district placements.

[6] MMHPI estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These youth need intensive family- and community-based services.

Mental Health Disorder	Total	Adults	Adults in Poverty	Children	Children in Poverty
All Anxiety Disorders[7]	23,762	17,924	4,275	5,838	1,843
PTSD (adults/adolescents)	3,816	3,466	827	350	110
All Mood Disorders[8]	12,472	9,408	2,244	3,064	967
Major Depression (adults/adolescents)	7,412	7,150	1,705	262	83
Bipolar Disorder (adults/adolescents)	733	545	130	188	59
Schizophrenia (adults/adolescents)[9]	615	594	142	21	7
First Episode Psychosis (age 15-34)[10]	23	23	6	N/A	N/A

[7] Adult data are drawn from Kessler et al. (2005), cited above. We are not aware of good data on the prevalence of specific disorders for children. Where we indicate "(adults/adolescents)" in this table, all data for adolescents are drawn from the National Comorbidity Survey Replication-Adolescent Version. Kessler, R.J. et al. (2012). Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication-Adolescents Supplement. *Archives of General Psychiatry, 69*(4), 381-389.

[8] Adult data are from Holzer, C., Nguyen, H., Holzer, J. (2015). Texas county-level estimates of the prevalence of severe mental health need in 2012. Dallas, TX: Meadows Mental Health Policy Institute. Adolescent data are from Kessler et al. (2012), cited above. (Data do not include children.) Estimates are updated with 2015 population data.

[9] After reviewing 34 relevant studies worldwide, McGrath and colleagues (2008) reported a median "period prevalence" (studies of prevalence using periods of between two and 12 months) of 0.33%. However, given that the estimate of serious mental illness in this region of Texas is higher than the national average (due to the region's demographics), we are using the 75th percentile reported by McGrath and colleagues: 0.6% of the adult population. See: McGrath, J., et al. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews, 30*, 67-76, p. 70. Literature on the prevalence of schizophrenia in adolescents is very sparse, perhaps non-existent. Based on the fact that estimates of the incidence (new cases) of schizophrenia include adolescents, we have roughly estimated 0.2% of the adolescent population has schizophrenia over 12 months.

[10] Kirkbride, J.B. et al. (2013). A population-level prediction tool for the incidence of first-episode psychosis: Translational epidemiology based on cross-sectional data. *BMJ Open, 3*, 1-12.

Twelve-Month Prevalence of Mental Health Disorders in Potter County

Mental Health Disorder	Total	Adults	Adults in Poverty	Children	Children in Poverty
County Population[11]	**123,715**	**89,564**	**38,828**	**34,151**	**21,438**
All Mental Illness[12]	32,413	23,466	10,173	8,948	5,617
Mild	13,095	9,480	4,110	3,210	1,913
Moderate	12,090	8,753	3,795	2,963	1,767
Severe/Serious	7,228	5,233	2,269	(see SED)	(see SED)
Serious Mental Illness (adults)[13]	5,728	5,728	3,321	N/A	N/A
Super-Utilizers (adults)[14]	441	441	256	N/A	N/A
Severe Emotional Disturbance (SED) Youth / Children Only[15]	2,774	N/A	N/A	2,774	1,936
Children / Youth Most At Risk[16]	277	N/A	N/A	277	194
All Anxiety Disorders[17]	22,392	16,211	7,028	6,181	3,880

[11] Population is for 2015, the most recent year for which the Texas State Demographer's Office has population estimates available: http://osd.texas.gov/Resources/TPEPP/Estimates/2014/Preliminary_2014_txpopest_county.pdf. However, the estimate has not yet been broken out by age and so we are using previous age percentage breakouts to estimate the number of adults and children living in the county as of January, 2015.

[12] Please note that the prevalence of mental illness is greater in Potter County than in Randall County and that this is generally the case because Potter County has a higher percentage of people living in poverty, a major risk factor for many mental illnesses. National estimates of prevalence and severity breakouts are drawn from Kessler, RC et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS_R). *Archives of Gen Psychiatry, 62*(6), 617-627. The data are from a study with adults. Comparable data for all ages of children and youth, from a nationally representative or Texas-representative sample, are not available. However, based on various small studies, as well as on a national study of adolescents, we have estimated that the totals and breakouts are roughly comparable for children and youth, ages birth to 17 years. However, instead of using an estimate for severe/serious based on Kessler et al.'s adult data, we are using the more precise Holzer estimate.

[13] Estimates of SMI and SED are for 2013 and are taken from the following source: Holzer, C., Nguyen, H., Holzer, J. (2015). Texas county-level estimates of the prevalence of severe mental health need in 2012. Dallas, TX: Meadows Mental Health Policy Institute. In incorporating specific county demographics, Holzer's estimate of SMI is more precise than Kessler's. SMI and SED prevalence estimates were updated with 2015 population estimates.

[14] These adults are at the highest risk for repeat use of jails, emergency rooms, hospitals, and jails. Cuddeback and colleagues (2006 and 2008) have estimated that 7.7% of adults with SMI need Assertive Community Treatment or Forensic Assertive Community Treatment, or both.

[15] These are children and youth at risk for out-of-home and out-of-district placements.

[16] MMHPI estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These youth need intensive family- and community-based services.

[17] Adult data are drawn from Kessler et al. (2005), cited above. We are not aware of good data on the prevalence of specific disorders for children. Where we indicate "(adults/adolescents)" in this table, all data for adolescents are

Mental Health Disorder	Total	Adults	Adults in Poverty	Children	Children in Poverty
PTSD (adults/adolescents)	3,505	3,135	1,359	370	232
All Mood Disorders[18]	11,753	8,509	3,689	3,244	2,037
Major Depression (adults/adolescents)	6,744	6,467	2,803	277	174
Bipolar Disorder (adults/adolescents)	692	493	214	199	125
Schizophrenia (adults/adolescents)[19]	559	537	233	22	14
First Episode Psychosis (age 15-34)[20]	18	10	8	N/A	N/A

drawn from the National Comorbidity Survey Replication-Adolescent Version. Kessler, R.J. et al. (2012). Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication-Adolescents Supplement. *Archives of General Psychiatry, 69*(4), 381-389.

[18] Adult data are from Holzer, C., Nguyen, H., Holzer, J. (2015). Texas county-level estimates of the prevalence of severe mental health need in 2012. Dallas, TX: Meadows Mental Health Policy Institute. Adolescent data are from Kessler et al. (2012), cited above. (Data do not include children.) Estimates are updated with 2015 population data.

[19] After reviewing 34 relevant studies worldwide, McGrath and colleagues (2008) reported a median "period prevalence" (studies of prevalence using periods of between two and 12 months) of 0.33%. However, given that the estimate of serious mental illness in this region of Texas is higher than the national average (due to the region's demographics), we are using the 75th percentile reported by McGrath and colleagues: 0.6% of the adult population. See: McGrath, J., et al. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews, 30*, 67-76, p. 70. Literature on the prevalence of schizophrenia in adolescents is very sparse, perhaps non-existent. Based on the fact that estimates of the incidence (new cases) of schizophrenia include adolescents, we have roughly estimated 0.2% of the adolescent population has schizophrenia over 12 months.

[20] Kirkbride, J.B. et al. (2013). A population-level prediction tool for the incidence of first-episode psychosis: translational epidemiology based on cross-sectional data. *BMJ Open, 3*, 1-12.

Twelve-Month Prevalence of Adults with SMI and Children with SED in the Texas Panhandle Centers Catchment Area, Relative to Comparison LMHA Catchment Areas, 2015[21]

LMHA/Region	Total Population	Adults with SMI	Adults with SMI Under 200% FPL	Children with SED	Children with SED Under 200% FPL
Texas Panhandle Centers[22]	**409,173**	**15,835**	**8,237**	**8,469**	**4,787**
Randall County	**131,715**	**4,157**	**2,053**	**2,342**	**889**
Potter County	**123,715**	**5,728**	**3,321**	**2,774**	**1,936**
MHMR Services for the Concho Valley[23]	134,301	5,417	3,055	2,464	1,371
StarCare Specialty Health System[24]	334,669	12,995	7,714	6,622	3,957
Permian Basin Community Centers for MHMR[25]	354,638	11,954	6,148	7,406	3,848

Number of Adults with SMI Who Received Ongoing Outpatient Services by LMHA, FY 2015

Adults	Texas Panhandle Centers	Permian Basin Community Centers for MHMR	MHMR Services for the Concho Valley	StarCare Specialty Health System
SMI 200% FPL	**8,237**	6,148	3,055	7,714
LOCs Served	**2,355**	2,295	728	1,293
% in Need	***29%***	***37%***	***24%***	***17%***

[21] Serious mental illness (SMI) refers to adults and older adults with schizophrenia, severe bipolar disorder, severe depression, severe post-traumatic stress, and other disorders that are accompanied by significant problems functioning in several life domains. These conditions require comprehensive and intensive treatment and support. Severe emotional disturbance (SED) refers to children and youth through age 17 with emotional or mental health problems so serious that their ability to function is significantly impaired, or their ability to stay in their natural homes may be in jeopardy.

[22] Texas Panhandle Centers serves Armstrong, Carson, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Potter, Randall, Roberts, Sherman and Wheeler counties.

[23] MHMR Services for the Concho Valley serves Coke, Concho, Crockett, Irion, Reagan, Sterling and Tom Green counties.

[24] StarCare Specialty Health System serves Cochran, Crosby, Hockley, Lubbock and Lynn counties.

[25] Permian Basin Community Centers for MHMR serves Brewster, Culberson, Ector, Hudspeth, Jeff Davis, Midland, Pecos and Presidio counties.

Adult Levels of Care Provided by LMHA, FY 2015

LMHA/ Region	Crisis Continuum		Ongoing Treatment Levels					
Level of Care[26]	Crisis Response	Crisis Transition	Medication Management	Skills Training	Medication & Therapy	Team Based	ACT	Total Non-Crisis
Texas Panhandle Centers	**136**	**9**	**7**	**1,840**	**254**	**218**	**36**	**2,355**
% ongoing LOCs			**<1%**	**78%**	**11%**	**9%**	**2%**	
MHMR – Concho Valley	434	<6	10	673	11	34	<6	**728**
% ongoing LOCs			1%	92%	2%	5%	<1%	
StarCare SHS	666	20	0	955	18	231	89	**1,293**
% ongoing LOCs			0%	74%	1%	18%	7%	
PBCC	1,081	388	14	2,012	63	198	8	**2,295**
% ongoing LOCs			1%	88%	3%	9%	<1%	
Total Served	**2,317**	**417**	**31**	**5,480**	**346**	**681**	**106**	**6,671**
% ongoing LOCs			***<1%***	***82%***	***5%***	***10%***	***2%***	

[26] The "% of LOCs" exclude crisis and crisis follow-up.

Adults with SMI (200% FPL) Known to Have Received Assertive Community Treatment (ACT)

Region	200% FPL SMI Population[27]	Need ACT[28]	ACT Teams	Received ACT[29]	Percent in Need Received ACT
United States	7,495,538	322,308	-	63,445	20%
Arizona	116,710	5,019	-	8,683	173%
Maricopa County[30]	72,217	3,105	15	1,361	44%
California	552,096	23,740		5,227	22%
Colorado	123,567	5,313	~30	3,182	60%
Denver[31]	14,699	632	8	800	127%
Nebraska	42,938	1,846	~3	277	15%
Region 6[32]	17,421	749	1	110	15%
New York	459,945	19,778	79	6,189	31%
New York City[33]	196,743	8,460	12	1,500	18%
Texas	531,573	22,858	-	3,335	15%
Texas Panhandle Ctr.	**8,237**	**354**	**1**	**36[34]**	**10%**
MHMR Services for the Concho Valley	3,055	131	-	<6	<4%

[27] SMI population estimates: Texas estimates are based on Dr. Holzer's refined SMI prevalence estimation methodology. California: state-level estimates are based on applying SAHMSA's 2012-2013 model-based prevalence estimates for serious mental illness among adults 18 years or older (based on the National Survey on Drug Use and Health – NSDUH) to each respective state's 2013 federal census population (adults 18 years or older).

[28] Based on an analysis by Cuddeback, G.S., Morrissey, J.P., & Meyer, P.S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806. The Cuddeback et al. estimate was applied to people with SMI, regardless of income level.

[29] State-level figures are based on state authorized mental health services, including Medicaid enrollees, reported in the SAMHSA's NOMS system in 2012, retrieved from http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.

[30] Mercer Consulting (2014, June). *Service Capacity Assessment: Priority Mental Health Services, 2014.* (Study Conducted for the Arizona Department of Health Services/Division of Behavioral Health Services.) Unpublished Manuscript. Phoenix, AZ: Mercer Consulting.

[31] Data received through personal communication with Roy Starks and Kristi Mock of the Mental Health Center of Denver, March 2014.

[32] TriWest Group (2014). *Omaha Area Adult Mental Health System Assessment: Final Summary of Findings and Recommendations*. Unpublished manuscript.

[33] New York State Office of Mental Health. (2014). (Online Dashboard) Assertive Community Treatment Length of Stay – January 2015. Retrieved from http://bi.omh.ny.gov/act/statistics?p=los on January 13, 2015. This is a low estimate, based on quarterly census data provided by the New York Office of Mental Health.

[34] These numbers, based on data provided by DSHS, are approximate and may not fully coincide with data from Texas Panhandle Center. MMHPI has received approval from TPC to include the DSHS numbers in this report.

Region	200% FPL SMI Population[27]	Need ACT[28]	ACT Teams	Received ACT[29]	Percent in Need Received ACT
StarCare Specialty Health System	7,714	332	-	89	27%
PBCC for MHMR	6,148	264	2	65	25%

Adults with SMI (200% FPL) Known to Have Received Supported Housing (SH), FY 2015

Region/LMHA	Adult Need Under 200% FPL[35]	Adults Receiving SH[36]	Percent of Need Receiving SH
United States	7,495,538	75,875	1.0%
Arizona[37]	116,710	2,383	2.0%
Denver County[38]	14,699	1,650	11.2%
New York State	459,945	4,983	1.1%
New York City[39]	196,743	2,351	1.2%
Texas	531,573	7,826	1.5%
Texas Panhandle Centers	**8,237**	**225**	**2.8%**
MHMR Services for the Concho Valley	3,055	34	1.1%
StarCare Specialty Health System	7,714	99	1.3%
PBCC for MHMR	6,148	167	2.7%

[35] When we have benchmarks for evidence-based practices outside of Texas, we use the total estimated number of people with SMI in each region, applying a 58% factor based on Texas data to estimate the number who are living at/below 200% FPL, in order to better facilitate comparisons to the communities outside of Texas.

[36] LMHA data within Texas are for FY 2015 and were received through personal communication with the Texas Department of State Health Services, September 1, 2016. The data indicate an unduplicated count of adults in one of the four full levels of ongoing care.

Generally, state-level figures are based on state-authorized mental health services, including Medicaid enrollees reported in the SAMHSA's NOMS system in 2012. Retrieved from http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx. New York State and New York City "Received SH" data were estimated based on average lengths of stay and quarterly capacity and occupancy data.

[37] Mercer Consulting (2014, June). *Service Capacity Assessment: Priority Mental Health Services, 2014.* (Study Conducted for the Arizona Department of Health Services/Division of Behavioral Health Services.) Unpublished Manuscript. Phoenix, AZ: Mercer Consulting.

[38] Data received through personal communication with Roy Starks and Kristi Mock of the Mental Health Center of Denver in March 2014.

[39] New York State Office of Mental Health (2013). (Online Dashboard) Residential Program Indicators Report: New York County. Retrieved from http://bi.omh.ny.gov/adult_housing/reports?p=rpi&g=New+York&y=2013&q=Dec+31 on January 13, 2015.

Adults with SMI (200% FPL) Known to Have Received Supported Employment (SE), FY 2015[40]

Region/LMHA	Adult Population Under 200% FPL	Adults Needing SE[41]	Adults Receiving SE[42]	Percent of Need Receiving SE
United States	7,495,538	3,364,000	54,190	1.6%
Arizona	116,710	54,333	12,137	22.3%
Maricopa County[43]	72,217	32,615	7,366	22.6%
California	552,096	249,340	893	0.4%
Colorado	123,567	55,806	1,380	2.5%
Denver County[44]	14,699	6,639	680	10.2%
New York (state)	459,945	207,722	1,634	0.8%
Texas	531,573	240,071	4,525	1.9%
Texas Panhandle Centers	**8,237**	**3,707**	**174**	**4.7%**
MHMR Services for the Concho Valley	3,055	1,375	45	3.3%
StarCare Specialty Health System	7,714	3,471	27	0.8%
PBCC for MHMR	6,148	2,767	89	3.2%

[40] FY15 data for LMHAs were received through personal communication with DSHS, September 1, 2016. The LMHA level data indicate an unduplicated count of adults in one of the four full levels of ongoing care. Data for communities outside of Texas are from 2013 for Arizona and Colorado; for New York and California, data are from 2012 for population data and 2013 for the number of people receiving Supported Employment.

[41] The unemployment rate for people with SMI served in publicly funded mental health systems is approximately 90%, but research shows about 50% of people with SMI want vocational help. These rates were applied to SMI prevalence of each region to determine estimated need for Supported Employment.

[42] State-level figures are based on state authorized mental health services, including Medicaid enrollees, reported in the SAMHSA's NOMS system in 2012. Retrieved from http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.

[43] Mercer Consulting (2014, June). *Service Capacity Assessment: Priority Mental Health Services, 2014.* (Study Conducted for the Arizona Department of Health Services/Division of Behavioral Health Services.) Unpublished Manuscript. Phoenix, AZ: Mercer Consulting.

[44] Data received through personal communication with Roy Starks and Kristi Mock of the Mental Health Center of Denver in March 2014.

Trained Peer Support Specialists by Service Area, FY 2014

Region / LMHA	Adult Need Under 200% FPL	Trained Peer Specialists[45]	Specialists per 100,000 in Need
Texas	**531,573**	**333**	**63**
Texas Panhandle Centers	**8,237**	**8**	**97**
MHMR Services for the Concho Valley	3,055	0	0
StarCare Specialty Health System	7,714	5	65
PBCC for MHMR	6,148	2	33

Unduplicated Number of Children with SED Living at or below 200% FPL Who Were Served by the LMHA, FY 2015

LMHA/Region	Total Child Population Under 200% FPL	Children with SED Under 200% FPL	Children Served in Ongoing Treatment[46]	Percent	Percent Medicaid[47]
Texas Panhandle Centers	**53,624**	**4,787**	**692**	**14%**	**95%**
MHMR Services for the Concho Valley	15,436	1,371	490	37%	93%
StarCare Specialty Health System	43,737	3,957	380	10%	77%
PBCC for MHMR	43,457	3,848	360	9%	49%

[45] Number of FY14 trained peer support specialists by county in LMHA catchment area (not LMHAs). Data obtained on February 13, 2015 via personal communication with Dr. Stacey Manser, University of Texas. Number of Peer Specialists at the LMHA is different.

[46] "Children Served in Ongoing Treatment" data in this column are the unduplicated number served by the LMHA, across the LOCs, C1, C2, C3, and C4, as well as CY (YES Waiver) and CYC (Young Child Services).

[47] Percent of children served by LMHA receiving Medicaid during FY2015. Data reported from DSHS on May, 2016.

Child/Youth Levels of Care Analysis, FY 2015

LMHA/ Region	Crisis Continuum		Ongoing TRR Treatment Levels				Specialized	
Level of Care[48]	Crisis	Transition	Medication Management	Targeted Services	Complex Services	Intensive Family	YES Waiver[49]	Young Child
Texas Panhandle Centers	**31**	**0**	**92**	**305**	**220**	**10**	**2**	**65**
% ongoing/ specialized			**13%**	**44%**	**32%**	**1%**	**0%**	**9%**
MHMR – Concho Valley	33	0	157	252	46	<6	0	35
% ongoing/ specialized			32%	51%	9%	<1%	0%	7%
StarCare SHS	102	0	48	197	96	15	0	24
% ongoing/ specialized			13%	52%	25%	4%	0%	6%
PBCC	321	49	12	298	35	8	0	7
% ongoing/ specialized			3%	83%	10%	2%	0%	2%
Total Served	**487**	**49**	**309**	**1,052**	**397**	**33**	**0**	**131**
% ongoing/ specialized			***16%***	***55%***	***21%***	***2%***	***0%***	***7%***

Capacity Among Adult Inpatient Providers in Potter County

Adult Inpatient Providers and Facilities[50]	Psychiatric Beds	SUD Inpatient Beds
Northwest Texas Healthcare System	72	18

State-Operated Psychiatric Hospital Admissions by Age, FY 2015[51]

Age Group	Texas Panhandle Centers	MHMR – Concho Valley	StarCare SHS	PBCC
Child/Adolescent	**14**	7	14	8
SED 200% FPL	**4,787**	1,371	3,957	3,848
Adult	**89**	60	11	77

[48] The "% of LOCs" include all LOCs for children's services.
[49] The rollout of YES Waiver services for TPC began in the last months of FY2015 and therefore the number represented here (two children) is not reflective of current capacity for YES services going forward.
[50] Source: Unless otherwise noted, capacity data comes from the DSHS 2014 Hospital Survey.
[51] Data received through personal communication with DSHS, May, 2016. Data are for LMHAs and for NorthSTAR.

Age Group	Texas Panhandle Centers	MHMR – Concho Valley	StarCare SHS	PBCC
Geriatric	**4**	2	2	1
SMI 200% FPL	**8,237**	3,055	7,714	6,148

State-Operated Psychiatric Hospital Average Lengths of Stay by Age Group, FY 2015[52]

Age Group	Texas Panhandle Centers	MHMR – Concho Valley	StarCare SHS	PBCC
Adult	**116**	91	38	116
Geriatric	**103**	177	0	21
Child/Adolescent	**150**	123	186	62

State-Operated Psychiatric Hospital Days by Age, FY 2015[53]

Age Group	Texas Panhandle Centers	MHMR – Concho Valley	StarCare SHS	PBCC
Adult Days	**10,334**	5,460	418	8,920
Days per 1,000 in Need	**1,255**	1,787	54	1,451
SMI <200% FPL	**8,237**	3,055	7,714	6,148
Geriatric Days	**413**	354	0	21
Days per 1,000 in Need	**50**	116	0	3
SMI <200% FPL	**8,237**	3,055	7,714	6,148
Child/Adolescent Days	**2,105**	863	2,459	496
Days per 1,000 in Need	**440**	629	621	129
SED <200% FPL	**4,787**	1,371	3,957	3,848

[52] Data received through personal communication with DSHS, May 2016. Data are for LMHAs.
[53] Data received through personal communication with DSHS, May 2016. Data are for LMHAs. Data were calculated by multiplying the number of admissions in FY2015 by the average length of stay.

Other Estimated Costs Related to Mental Health Needs in Randall and Potter Counties

Source of Costs[54]	CY 2013 Costs	Comment
Randall County Jail	$2,200,000	Based on the prevalence of SMI in Randall County and a forecasting model estimating the relationship between Texas county prevalence rates and county jail costs.
Estimated Costs: MH Emergency (Randall)	$0[55]	Estimates by MMHPI based on 2013 data.
Total	**$2,200,000**	
Potter County Jail	$3,100,000	Based on the prevalence of SMI in Potter County and a forecasting model estimating the relationship between Texas county prevalence rates and county jail costs.
Estimated Costs: MH Emergency (Potter)	$8,400,000	Estimates by MMHPI based on 2013 data.
Total	**$11,500,000**	

[54] Meadows Mental Health Policy Institute and Texas Conference of Urban Counties. (2015). *Survey of County Behavioral Health Utilization.* Unpublished Document. Dallas, TX: Meadows Mental Health Policy Institute. Estimates were based on a 2012 Texas Health Care Information Collection hospital survey of 580 hospitals and costs from a 2013 Dallas Fort Worth Hospital Council Foundation report.

[55] Mental health emergency services are abstracted from the DSHS 2014 Hospital Survey. At the time of the survey, there were no emergency services provided in Randall County. Recently, the new Northwest Emergency at Town Square began serving residents, starting July, 2016.

System-Level Recommendations

Local Capacity for Behavioral Health System Leadership and Improvement

In order for the Panhandle Behavioral Health Initiative to be effective in improving and transforming the regional behavioral health system through a collaborative impact approach, the first step is to develop an effective, sustainable, representative, organized infrastructure for behavioral health system leadership. Within that organizational framework, the findings of this assessment can be incorporated into a strategic plan and coordination of resources, as well as assigned workgroups, measures of progress, and evaluation of outcomes. The following recommendations address what is needed to make progress toward that initial objective.

Recommendations: What is Needed, Next Steps and Time Frames

(Each of these is addressed within the areas below)

Development of a Behavioral Health Leadership Structure

The Panhandle Behavioral Health Initiative (PBHI) has launched an effective and exciting collaborative that has engaged a broad constituency of stakeholders and is widely viewed as having significant potential to have a powerful and sustainable impact on the regional system of care. However, as of yet, the PBHI remains an informal collaborative. The next step is to take deliberate action to become a formal regional behavioral health leadership team (BHLT), with a defined charter, representative membership, bylaws, workgroups, deliverables, and infrastructure, along with formal recognition by local governing bodies as well as other key community stakeholders. MMHPI can provide very specific consultative guidance and draft materials on how to do this, based on our experiences in other communities. Here are some specific **next steps** that should be addressed **over the next three to four months**.

- **Consensus on BHLT formation.** The PBHI should engage both its own members and a broader array of community stakeholders on developing a working consensus that PBHI should develop a more formal and accountable representative structure for regional behavioral health leadership and strategic planning. This moves the process from being an "initiative" or a "project" to being built to manage change over the long term.
- **Develop an inclusive and representative membership.** The BHLT should not only endeavor to engage existing PBHI participants as representatives of key stakeholder constituencies, but also seek to connect other constituencies (e.g., organized consumer and family voice) and existing collaboratives (e.g., prevention coalitions, Panhandle ROSC, Panhandle SOC children's collaboration, local community collaboratives such as the Dalhart CRCG, and so on) through formal representation at the table.
- **Develop an initial charter document for the BHLT.** Assuming consensus is achieved, the PBHI members should begin the process of chartering the BHLT in a formal way. The chartering usually includes three components: mission/vision and scope, representative membership, and early deliverables (each of these will be covered below). Once the

chartering process is completed and the representative membership identified, the PBHI can transition to having the first "official" regional BHLT meeting. It is a reasonable (though ambitious) target for this first meeting to occur in September or October of 2016.

- **Obtain resources for infrastructure support of the PBHI/BHLT.** Right now, PBHI has made amazing progress in everyone's "spare time." The local leadership group has significant capability in organizing projects like this. Individuals already involved in the process (e.g., Ellen Cowell) may be available to provide some initial facilitation in addressing early steps. However, very quickly there will be a need for more formally dedicated resources to manage all the complex activities that need to take place to improve the outcomes of the collaboration. Foundation support – provided as soon as possible – would be critical to securing these resources, particularly for a staff person (part- or full-time) and resources for administrative support, data collection, evaluation, and analysis.

Scope: Involving Multiple Counties (21 vs. 26) and Funders (Foundations, MCOs, etc.)

A key component of a successful regional collaborative impact approach involves developing clarity about the scope of the collaboration right from the outset. For example, it is important (and already understood) that the scope includes both mental health and substance use disorders, both public and private sector need, both behavioral health services specifically and the overlap of behavioral health into health, criminal justice, schools, etc. In our assessment, we have identified two key areas that should be emphasized: the number of counties included, and the incorporation of multiple funders at the outset.

- **Focus on 21 counties; partner with the other five.** In developing a scope for the Panhandle BHLT, it will be important to have a clear, organizing scope and framework for change, so that progress is not diffuse or inconsistent. There is a clear challenge in having two catchment areas in the region – 21 counties that are traditionally in the TPC catchment area and five counties that are a component of the Central Plains Area. At the same time, many services (e.g., the Pavilion's service area) are organized around the 26-county "Panhandle Region." An effective BHLT needs to balance a broad multi-county collaboration while maintaining the capacity to attend to sub-regional activities in an organized way. This means attending to services that are naturally sub-regional. Examples of this are Amarillo-specific services that involve collaborations with Potter and Randall counties (i.e., jail diversion and mobile crisis/CIT), as well as rural sub-regional services (such as the Dalhart multi-county collaboration referenced above). It is important that the Panhandle BHLT attend first to respecting and organizing within the 21-county catchment area served by TPC, so that TPC's services can be focused throughout the BHLT region. Second, the BHLT will need to attend to the development of local partner collaborations to support sub-regional efforts (Amarillo, Dalhart, other

multi-county regions that are not yet developed). Third, the BHLT should not replace or compete with the existing West Texas System of Care collaboration based in Plainview, which has different and overlapping boundaries. Therefore, the recommended strategy is to define the scope of the BHLT as focused on the 21 counties that belong to TPC, and partnering with Plainview as both a learning partner and for collaboration between the two existing behavioral health leadership teams to discuss services that are of broader regional impact.

- **Involve multiple funders from the beginning.** One of the particular challenges in how Texas organizes behavioral health services is that historically there has been no routine structure and process by which multiple funding streams are coordinated at the local or regional level to create one system of care for the population. To develop such a planning process across all payers (public and private, state and local), it is important that the BHLT begin with defining a scope of inclusion, specifically to engage multiple funders to collaborate in coordinating all of available resources to develop a single system of care for Panhandle residents. This would include county funds (currently spent in jails, probation, etc.), local funds (police, schools, homeless services), local health care funds which address complex populations (hospital district funds, public health dollars, accountable care organizations, 1115 DSRIP funds), state indigent mental health funds (TPC), state indigent substance abuse funds, state protective services and criminal justice funds, public insurers (Medicaid MCOs, Medicare HMOs, etc.), private insurers, human services funds, federal grants, foundations, and others. When developing services, it can be helpful to have multiple insurers at the table, for example, so they can collaborate in designing a service array that will be supported by diverse funding sources, rather than each insurer developing their own network, which too often is neither efficient nor effective in terms of economies of scale. The role of foundations in this partnership is more to support the existing collaboration and to promote sustainability, rather than only to fund gap services. The membership should therefore include these representatives; one of the early deliverables might be to identify all the major behavioral health funding expenditure from all sources that are currently occurring in the region to see how better coordination could produce better results
- **Shared Vision and Mission.** One of the most important early steps for a collaborative or a BHLT is to articulate a clear, value-based, and inspiring mission and vision. The importance of that step is reported in Panhandle 2020, and leadership is ready to help initiate that process for PBHI (and the eventual regional BHLT).
- **Establish a clear aspirational mission and vision.** Use the experience and leadership from Panhandle 2020 to get started. This step can occur even while the consensus on the BHLT development is still emerging. The mission and vision should be built on the experiences of ALL the potential customers of behavioral health services in the Panhandle region, starting with the individuals and families who need help and often

have a hard time getting it. An example of the type of language that some communities use is as follows:

> ***We are working to create a regional system of care where all stakeholders, service providers, service recipients, and funders work in partnership so that people with behavioral health needs, especially those with the greatest challenges, can get help that is helpful whenever they need it, and in which all services make progress to becoming welcoming, accessible, seamless, recovery/resiliency-oriented, trauma-informed, culturally fluent, and integrated (co-occurring or complexity capable).***

- **Engage the whole community.** Part of the vision will need to incorporate behavioral health service delivery, which is the focus of this report. However, we also recommend that there is a purposeful effort to expand the conversation (the MMHPI OK to Say Campaign is an example) and to engage a wider array of community partners such as churches, schools, and businesses in contributing to the overall investment in developing a healthy community that addresses behavioral health as part of all health care and is committed to trauma-informed and healing practices at all levels in order to prevent re-traumatization and associated behavioral health challenges. Other Texas communities have created community events (e.g., Peace of Mind in Tyler) that have been sponsored in part by local congregations and have raised awareness that behavioral health is an issue that affects everyone in the community, just like public safety, emergency medical response, and firefighting.
- **Establish a culture of collaboration.** In a scarce-resourced environment, collaboration is the key to leverage those limited resources to have maximum impact on meeting community needs. Although there are pockets of collaboration between existing behavioral health services, there is no overarching effort by which all of the services and resources come together to determine how to develop a more seamless system of care. PBHI needs to establish that such collaboration is an expectation and seek engagement of leaders at the highest levels in the community (e.g., medical system and hospital system CEOs, political leaders throughout the region, judges) to support and prioritize the collaborations necessary to meet community need.
- **Establish a culture of inclusion.** A large number of people interviewed commented on the importance of the PBHI evolving at a time when there is a need for a broad transformational culture shift in the Amarillo (and Panhandle) community as a whole. Individuals with mental health and substance use disorders are just one of the populations that have been stigmatized in the community in the past. However, as the community expands and modernizes with new economic growth, the need for more community inclusion and sensitivity to the needs of previously marginalized populations becomes more urgent. This framework includes recognition of the diverse needs related to gender, cultural/linguistic minority status, and LGBT status. Rates of trauma, suicide,

and other culture-specific issues can be higher in some of these groups, as well as require specialized treatment models. The increasingly diverse faith community comprises another key set of stakeholders that is increasingly becoming more attuned to mental health issues as well as its ability to address them. PBHI has the potential to address a range of behavioral health issues that can help the Panhandle become an even more adaptive, healthy, and thriving region.

Strategic Planning and Collaborative Impact

It is important to be clear right from the beginning that the Panhandle BHLT will need to get things done. When developing early deliverables, it is important to think about how to demonstrate accountability to community funders and political leaders as well as to BHLT participants. Within this framework, it will be critical to move quickly to create a strategic plan and identify accountable workgroups for each element of the plan as well as measurable achievable targets (SMART goals) within a collaborative impact framework (multiple areas of progress, all different, but all taking steps toward a common vision). The following can be incorporated into the BHLT Charter:

- **Develop a strategic plan with SMART goals.** This plan can be developed before the end of this calendar year using the recommendations of this assessment and (if you wish) obtaining consultation from MMHPI. SMART goals are "Strategic, Measurable, Achievable, Realistic, and Time-bound," so by definition they create a clear and accountable change process for the whole region.
- **Identify priority targets for change.** This assessment identifies many possible priorities that can be addressed in which improvement can occur within available resources. However, despite the temptation to want to tackle everything at once, it will be wiser to get started by prioritizing efforts. Start with areas where there is already a foundation for progress and then over time add more areas to the strategic "plate."
- **Formalize structures and engage empowered partners (a team of "change agents" representing service recipients and front line providers as well as community leaders and program managers) to be accountable for change.** For various topics, it is helpful to develop workgroups that are dedicated to specific improvement areas (e.g., "Crisis Workgroup") and that create opportunities for including as many participants as possible, including service recipients, not just the representatives on the BHLT. This is a lesson learned from Panhandle 2020: find change agents and champions at all levels (including front-line staff) to join in the work. This leverages all available resources to contribute to change.
- **Attend to the importance of sub-regional (rural) collaboratives in addressing issues at the local level.** Among the strategic structures that will need to be developed is the continued evolution of rural collaborations to address local issues. It is important to attend to this for every improvement area so as not to become overly Amarillo-centric.

For example, a regional crisis workgroup may want to focus on crisis response and developing a crisis continuum (including telepsychiatry) in Amarillo as the regional hub; however, each local region also has to consider how to collaborate to respond to local crises through activities related to local law enforcement, schools, emergency departments, transportation services and so on. It would be reasonable to think that there would be four to five rural behavioral health sub-regional collaboratives in the 21-county region in addition to foci in Amarillo and collaboration with Plainview.

- **Gather and utilize data to strengthen the impact of the work.** The Panhandle BHLT will be an important coordination point for gathering data that is meaningful to the community as a whole, as well as gathering data to measure specific improvement. Examples of community-wide data that are relevant:
  - Data on the prevalence of behavioral health issues in all segments of the region and all economic strata. This emphasizes that this is a problem for the community as a whole, not just for indigent care.
  - Data on total behavioral health-related expenditures from all sources (including, for example, costs in the emergency room, costs in the jail, etc.) and the financial impact of unmet behavioral health needs on the community (jails, schools, businesses, social services, health costs, etc.).
- **Feedback to state leadership.** An important component of early strategic planning is to simultaneously seek improvements that can occur at the local or regional level without any new support from the state, while at the same time seeking opportunities to identify specific ways in which the state can be more supportive of local efforts. This is particularly opportune because of the work of the House Select Committee on Mental Health. Feedback to the state is often conceptualized as seeking funds. However, it is at least as important to identify costly regulatory barriers and administrative requirements that interfere with local progress and that can be eliminated (leading to greater efficiency), as well as administrative policy changes that could facilitate the efforts of local collaboratives like PBHI by recognizing and rewarding the results of its efforts.

Culture of Customer-Oriented Continuous Quality Improvement for All

We strongly recommend that PBHI (and ultimately the BHLT) formally adopt the structures and processes of customer-oriented continuous quality improvement as a foundation for all change. For those familiar with customer-oriented value-based business practice, and continuous quality improvement as an organizational culture and process to implement it, this approach will be familiar: *Every customer counts. It is our goal that every customer – especially the most challenging customers – get their needs met in a responsive and successful manner. We always think creatively to find new solutions within available resources. We learn how to do this by paying close attention to our customers' experiences, both positive and negative. We*

continually use those stories to measure where we are, to define where we need to improve, and to measure progress.

In scarce-resourced systems, it is easy to get used to the idea that there are some people that just cannot be helped. The Potter County Mental Health Coordinator shared frustration with how many families ask for help for their loved one and they have to be told: "There is nothing we can do right now – he has a drug problem, not a mental health problem; *or*, he is not yet committable so we can't force him to get help; OR, you don't have the right insurance, etc." We recommend that PBHI move beyond that perspective – as a community – and to begin evaluating how to respond to everyone in need. The sooner people get help, the less it costs and the better the outcomes are later on. Here are some specific recommendations:

- **Use real stories to inform change.** Many BHLTs routinely share customer experiences in order to involve the membership in thinking about improvement opportunities as well as successes. This can be built as a routine agenda item and BHLT "staff" can learn how to show the members how to use "root cause analyses" to find steps for improvement.
- **Learn how to improve services one client or family at a time.** Sometimes it is daunting solve how to fill a big gap, but if everyone pulls together to address the needs of one person or family, then over time it becomes easier to identify smarter resource allocation for a larger cohort. For example, if we wanted to help one family whose loved one was in serious trouble, but unwilling to come for "help" and not yet committable, what might we do? If it was your family member, what would you want? Practice doing something once, and see what can be learned.
- **Collect data that supports this perspective.** One marker that shows that a customer-oriented quality improvement culture has been adopted is that it becomes as important to track and collect data on the people who fall through the cracks as it is to collect data on the people who are served. The first step may be to establish a regional "care coordination" capacity to track individuals in behavioral health crisis to see the extent to which everyone can (or cannot) be connected to something helpful, including both hospitalization and ongoing care, for both indigent and insured, throughout the region. The Potter County Mental Health Office already collects this information, but it would be helpful to bring this information together from across the region to emphasize that every story is important and to allow the community to collectively identify ways to improve.

Targeted Subsystem Improvement Recommendations

Organizing Improvement in Multiple Domains

Within the strategic plan discussed in the previous section, using a Collective Impact™ or collaborative impact approach, there should be multiple areas of improvement targeted, each with specific SMART goals and assigned workgroups or committees with clear objectives and

deliverables. The following sections identify some potential areas of improvement and some specific targets within each area.

Our recommendation is that – at least at first – the PBHI does not attempt to address ALL of these areas. Rather, it makes sense to select a few priorities from the list below on which to get started, develop workgroups (or formally engage existing workgroups and collaborations) that address priority areas (such as an Access Workgroup, Crisis Workgroup, Children's System of Care Workgroup (which currently exists), Primary Health Integration Workgroup, Substance Abuse/Mental Health Integration Workgroup, Prevention Workgroup, Workforce Workgroup etc.). After that, add additional areas of improvement over time as the overall BHLT develops its capacity to engage and organize change across the community. In the spirit of collaborative partnership with PBHI, TPC leadership has begun to consider what might be the most important priorities for the regional initiative, with attention as well to the recently released (May 2016) DSHS Texas Statewide Behavioral Strategic Plan 2017-21. It is also important for PBHI to align selected priorities with current regional initiatives such as the Regional Children's System of Care development and the recently announced Texas Veterans Initiative award.

The top three identified priorities TPC leadership suggested to MMHPI include:

- **Access and Engagement:** Both routine and crisis, for all age groups and for all behavioral health needs. This has particular relevance to crisis services improvement, access for children and youth in the children's system of care, and access to service for veterans.
- **Behavioral Health Workforce Recruitment and Retention:** Throughout the region, including all levels and types of providers, as well as peer specialists.
- **Prevention and Early Intervention:** Looking at all forms of holistic, trauma-informed prevention strategies for behavioral health conditions at the school and community levels. This focus is complementary to the existing children's system of care development process.

TPC also flagged the importance of addressing **behavioral health needs in the criminal justice system (including jail-based services)**, attention to **health and wellness for the behavioral health population**, and the need for **improved services for individuals and families with complex behavioral health conditions who are homeless**. Attention to these priorities is included in the following recommendations.

Recommendations Regarding Potential Improvement Activities

Each area below will include a brief description of what is needed, followed by a list of possible improvement targets that could be addressed by an appropriate workgroup. Note that these areas are not listed in order of recommended priority. Identifying which specific recommendations to prioritize for action involves engaging the entire BHLT in strategic planning to build on the suggested areas of focus provided to us by TPC and others (as described above,

and in the Executive Summary and the Conclusion) in order to choose specific and achievable targets for collective action.

Crisis System: Welcoming Access to a Helpful Continuum

The starting place for crisis system design is to adopt the vision that every individual or family in the community should be able to know how to get help when in crisis as soon as possible, regardless of problem or payer source. In addition, crisis system response should create welcoming opportunities to ask for help before involving law enforcement. In short, law enforcement should not be the universal first responder to crises, but should be involved only in those instances where public safety is immediately at risk. Further, every community should work to establish a comprehensive continuum of crisis services that includes not only hospitalization but all levels of crisis diversion, partial hospital services, intensive outpatient, and continuing crisis intervention and case management, for both adults and children/adolescents. Improvement areas to consider:

- Develop a regional (or local) guide for where to call for help, possibly including a universal behavioral health help line. Provide guidance for responding to individuals from different age groups (children, youth, adults, older adults). This has to include a plan for response to those requests within the community partnership (see below).
- Develop a collaborative mechanism for care coordination or tracking of individuals who present in crisis to see who does or does not get connected to an appropriate immediate or ongoing service, and use that information for performance improvement purposes. This includes tracking responses to requests for indigent hospitalization as well as tracking continuing care for those in crisis who are not hospitalized or who have a brief admission and are then discharged.
- Improve access to and availability of Mental Health Peace Officers in the region through broader access to training across sheriff and police departments, as well as identifying and tracking the times when the existing Amarillo Police Department CIT is unavailable, to determine the degree to which additional MHPO resources may be needed.
- Consider establishing a behavioral health crisis assessment "hub" through coordination of existing resources between the Pavilion's assessment center and partial hospital, TPC MCOT, crisis respite, Wyatt Clinic, AGAPE, local counseling agencies and counselors, and other supports. This effort would consider how to move the crisis response protocols from "assess for admission and/or emergency detention" to provision of (voluntary and involuntary) crisis intervention and stabilization (including medication) as an effort to avoid admission, and provision of continuing crisis intervention and follow-up. This would be connected to the recommendation in the next bullet, which would be constructed as part of the hub.
- Expand access to and capacity of crisis diversion beds. This could occur through either strengthening the existing crisis respite program to work with people who have greater

acuity, or to develop a separate, multiple funder-supported (including MCOs) crisis stabilization unit (such as exists in Lufkin), supported by telepsychiatry. The same strategy could be used to develop crisis bed capacity for children and adolescents. Note that The Woods Group has experience providing a wide array of crisis diversion services in approximately 30 Texas communities and would be a helpful design partner to consider what might be needed in the region and, potentially, to help build diversion services to scale.

- Create a regional strategy for tele-mental health evaluations in regional emergency departments.
- Develop a mechanism for continuity of engagement with families who request help for their loved ones, but their loved ones are not committable. The goal of this continuity is to build a relationship with the family to find strategies to help engage the person in care.
- Promote easier access to crisis response by identifying specific situations when MCOT would be a more appropriate first responder than CIT.

Children's System of Care

Value-based children's system of care (CSOC) collaborations are an evidence-based approach for coordinating multiple local system resources to meet the needs of children and families with complex needs. This model for formal collaboration is supported by HHSC in various communities around the state and represents an opportunity for local communities in the Panhandle region to develop better leverage for limited resources. TPC is to be commended for initiating the development of this model in the Panhandle Region, in partnership with the West Texas System of Care in Plainview, which is a model for initiating this approach in rural communities.

- Build on current collaborations between TPC, schools, juvenile justice, child protective services, and providers to engage the broad range of partners within PBHI to create a shared vision and values for the emerging regional children's system of care collaborative. A recommended value framework might begin with family-centered, trauma-informed care, using "wraparound" principles.
- Take steps to encourage the Amarillo ISD, other school districts, juvenile justice services, and family and protective services to adopt and implement this vision within their own work, in partnership with existing behavioral health and intellectual disability service providers. TPC already has a strong platform for this value base and can therefore be a resource for disseminating training and information, along with the West Texas System of Care partners in Plainview. Specialty Behavioral Health Services has consultative expertise within this collaboration for working with children with extreme challenges.
- Open discussion of prevention and early intervention for mental health and substance abuse issues (including suicides and opioid overdoses) into the school systems. Expand

Mental Health First Aid™ training to broaden its reach within school systems in the region, perhaps beginning with Amarillo ISD. The "OK to Say" message may help to break down barriers to early identification of children suffering from mental health and/or substance use conditions, suicide risk, or the effects of trauma, and identifying potential mechanisms for intervention.

- Consider opportunities for tele-mental health and/or telepsychiatry consultation within schools and/or connected to local school health clinics.
- Work with local health system partners to identify pediatricians who can be provided with organized behavioral health consultation to help them with screening, identifying, and medicating children with relatively uncomplicated behavioral health needs.
- Develop consultative efforts to expand competency in addressing adolescent substance use issues within current adolescent counseling services. Expand co-occurring services at the Pavilion adolescent unit and, within the collaboration in the children's system of care, endeavor to initiate an adolescent intensive outpatient afterschool program for adolescents with substance use issues.

Adult System of Care: Mental Health, Substance Abuse and Co-occurring Psychiatric Substance Use Disorders (COPSD)

Value-based collaborations are an evidence-based approach to services for adults. One example of such a model (which can also apply to children's services) is the Comprehensive Continuous Integrated System of Care (CCISC), which leverages all components and resources in a system to better meet the needs of individuals and families with complex challenges of all kinds. A system of care does not begin and end with police and crisis response; a system of care emphasizes continuity of engagement and services to support positive outcomes and ongoing recovery.

In spite of some very strong service elements and an excellent continuum of services established by TPC within the constraints of the DSHS contract, there is no true system of care in the Panhandle region. System of care values typically include services that are welcoming, accessible, person-centered, recovery-oriented, trauma-informed, culturally competent, and integrated (mental health/substance abuse/primary health), and are planned in such a way that all community services collaborate to share ownership of the whole population so that it is less likely that anyone falls between the cracks. That is the opportunity the Panhandle BHLT has to develop over time. System of care design for adults includes collaboration with primary health, criminal justice, and housing/homeless services as well as improvements within the behavioral health provider system itself. The intersystem collaborations are discussed in later sections. Specific improvement areas within behavioral health services include:

- For adult mental health services, bring all public and private service providers together to articulate the extent of community need, develop a vision for how services can be designed to meet the needs of the population as a whole, and identify improvements in

addressing gaps through improved collaboration between providers and targeted community investments.

- Identify opportunities to expand access to structured psychosocial rehabilitation programming in the community, associated with peer support. This can be a reimbursable group program (such as Rainbow House in Odessa) or a clubhouse program. Either program can be further supported by peer support and case management. The space being vacated by Guyon Saunders Drop-In might be an opportunity to develop structured skill-building service components for Amarillo area residents with psychiatric disabilities.
- For substance use disorder services, continue to invest in ARAD's efforts to develop a short-term residential program and expand that vision to include a comprehensive continuum of services that supports a recovery-oriented system of continuing care as well as support for individuals with the "chronic disease" of addiction. This would include sober living options, recovery coaching, case management, and development of "natural" community supports (including in the business community) that are emerging in the regional recovery-oriented system of care. The experiences of other communities in Texas that are making progress in developing a recovery-oriented continuum of services may be instructive for the Panhandle.
- Individuals with co-occurring psychiatric (including trauma) and substance use disorders (COPSD) are highly prevalent in the Panhandle, yet very few co-occurring services are available compared to the need. It is important to develop a system of care that recognizes that co-occurring conditions are an expectation. The CCISC model provides an approach for building capacity into ALL services for the delivery of integrated services to individuals with COPSD, within base resources. It would be strongly recommended for the Panhandle BHLT to adopt this approach. Further, it would be helpful for both mental health and SUD programs to provide routine cross-consultation to allow more people to received needed care within a single setting.
- Improve collaboration among psychiatrists and other medical providers in addressing behavioral health conditions. With limited psychiatry coverage, collaboration and teamwork become even more important. Telepsychiatry capacity is an important component of overall collaboration, as improving technology helps distant prescribers feel like they are "present" in the community and supports rural providers' capacity and willingness to provide psychiatric medications. All prescribers can be brought together to work collaboratively so that fewer people fall through the gaps in services. This partnership can involve primary health providers as well; this will be discussed below.

Older Adult System of Care

The Amarillo area can be commended for its recent efforts to engage in the comprehensive re-design of older adult services, making dramatic progress to move away from traditional nursing

home services and create an array of options that provide more homelike and community environments as well as rehabilitation opportunities. Unfortunately, there has not been adequate provision of behavioral health supports for older adults in these settings, which leads more older adults to require higher levels of care than would otherwise be necessary. In addition, while there is a surprisingly rich array of older adult-specific behavioral health services in the region, including three inpatient units and a partial hospital program (in Dalhart), as well as at least two different telepsychiatry programs specializing in geropsychiatry, these services are not fully coordinated with one another. Improvement opportunities include:

- Establish a regional geropsychiatry collaboration to coordinate availability of services and resources for all major older adult service providers. Develop a business model that promotes resource pooling to achieve more cost-effective outcomes within current older adult services.
- Expand the availability of existing telepsychiatry services for geriatric patients so that all service providers and communities can utilize those resources.
- Explore a business plan for implementing a geriatric partial hospital or intensive outpatient program in Amarillo, perhaps at the Pavilion, along the lines of the one that has been developed in Dalhart.
- Engage primary care physicians and nurse practitioners serving the geriatric population, particularly in congregate living settings and nursing homes, to have access to protocols for common psychiatric diagnoses and psychopharmacology (along with ready access to psychiatric consultation), in order to properly use medications in accordance with federal and state regulations. This would lead to more successful outcomes for these individuals in terms of being maintained in less-restrictive settings.

Regional Access to Behavioral Health Care

As limited as services are in Amarillo, they are even more limited in the smaller communities in the Panhandle. TPC has done an exceptional job attempting to allocate resources for both adults and children throughout its 21-county service area. However, even with these efforts, and with the expansion of telepsychiatry, the availability of behavioral health services is still inconsistent and limited. This provides an important opportunity for the Panhandle BHLT, as follows:

- Engage rural communities in identifying, prioritizing, and quantifying their level of behavioral health need and how unmet need affects their hospital district, jails, schools, and other community services. This would provide a proactive framework for developing behavioral health access plans for all communities in the Panhandle.
- Within the regional collaborative, consider how to design telehealth access to both medication and counseling, both directly and through consultation to local prescribers/providers, as a core service for every county, with volume matched to population size and level of need.

- Advocate to address regulatory barriers that prevent billing for telepsychiatry services in Amarillo and other communities in the region.
- Citizens in rural communities could be better informed and served if they had a guide – perhaps titled "Pathways to Services – How to get help when you need it" – that clearly spelled out how to access services. SAMHSA has recently released a website which TPC has reviewed and which may provide a platform for this type of resource. Many people (in Amarillo as well as in rural areas) simply do not know what to do when they have a problem. Local response could engage natural supports from churches and other community organizations. The Plainview collaborative has some excellent examples of successful approaches.
- Identify specific target areas for regional collaboration. For example, in East Texas there is a successful 12-county collaboration that has developed common practices and protocols around law enforcement response to behavioral health crises, with the goal of minimizing arrest and maximizing diversion throughout the region. Existing collaborations in related areas, such as the Coalition for Health Services, can be engaged to focus collective energy on addressing behavioral health within the existing collaboration.

Integration of Behavioral Health and Primary Health

Although the Panhandle region has a few "pockets" where primary health services are integrated into behavioral health settings (through 1115 Waiver projects) and behavioral health services are co-located within primary care (e.g., Wyatt Clinic, Heal the City), it is quite striking that even within relatively sophisticated care models (such as the ALMA ACO) for primary health and population management, and where the community is itself at risk for high costs and poor outcomes (as in the various hospital districts in the region), attention to behavioral health issues within routine primary health settings is generally absent. Recent improvements in the understanding of population health indicate that unmet behavioral health and social needs are the expectation in a chronically medically ill population and perhaps contribute the most to high cost and poor outcomes. Within this framework, investment in behavioral health services should occur as part of health care funding in any community or population. This vision leads to substantial improvement opportunities for the Panhandle region, as follows:

- Set a vision for integrating behavioral health services within all population health services in the region as a way of building capacity within limited resources by achieving better outcomes at lower costs.
- Engage interested primary health provider system partners in this collaboration and use initial partners to engage and attract others over time. The President of the Amarillo Legacy Medical ACO (which has neither behavioral health capacity nor an approach for integrating behavioral health within its covered lives) is a good person to champion this approach. The Coalition of Health Services is an existing collaboration that may be

interested in taking steps in this direction. The J.O. Wyatt Clinic, within Northwest Texas Healthcare Services, represents a component commitment from within that larger system to address behavioral health needs within its population.

- Begin to collect data on the prevalence of behavioral health conditions in existing primary care settings. Attempt to identify the contribution of unmet behavioral health needs to real costs and payment incentives (e.g., frequent emergency room visits and preventable medical readmissions). Use this data to create a business case for potential investment in behavioral health capacity as well as for the purpose of more effective regional planning for the next iteration of the 1115 Waiver and for the future use of Network Adequacy Improvement Project (NAIP) funding (improvement partnerships for complex health populations between hospital systems and Medicaid MCOs).
- Review access policies within regional hospital districts that may create costly barriers to continuing health care for indigent populations with complex and co-occurring health and behavioral health needs.
- Consider the use of available toolkits (e.g., the Center for Integrated Health Solutions Organizational Assessment Toolkit for Integration) to assist primary care provider systems in identifying early steps to improving the recognition of and intervention for mental health and substance use conditions as part of working toward becoming integrated person-centered medical homes.
- Develop pilot programs for the implementation of best-practice collaborative care approaches within primary care, using limited behavioral health provider resources as consultants to support capacity-building within primary health settings, including pediatric and geriatric practices.
- Expand training on wellness coaching to existing peer support specialists and demonstrate cost-effectiveness of wellness coaching, community health workers, and promoters in working with individuals with complex health, human service, and behavioral health needs in the region.

Criminal Justice and Jail-Based Services

There is an existing philosophy in Potter and Randall counties to promote jail diversion as well as some early efforts to build jail diversion capabilities. This is a foundation upon which to build more systematic jail diversion strategic assessment, planning, and implementation in counties throughout the region. The Sequential Intercept Mapping approach is a best-practice methodology for looking at all the "intercept points" in the interface between the criminal justice and behavioral health systems, from the point of initial law enforcement contact through pre- and post-booking activities, jail-based services, application of therapeutic justice principles within specialty and routine court dockets, transition planning and development of a full array of step-down services, and ongoing community corrections collaboration with behavioral health services, for both adults and juveniles. Within a formal collaboration that

focuses on criminal justice diversion under the auspice of the Panhandle BHLT, this type of mapping can lead to specific improvement strategies at one or more intercepts. There is now a national movement among counties – The Stepping Up Initiative – to engage more and more counties across the nation in this effort. Specific improvement steps might include:

- Develop a specific workgroup to focus on criminal justice/behavioral health collaborations in the region. Organize efforts, county by county, to engage in sequential intercept mapping followed by identifying specific improvement strategies at the various intercepts. Some opportunities that may be identified are listed in the next bullets.
- Through routine screening in each county justice system, identify the prevalence of behavioral health needs in a manner that produces actionable data on volume and cost.
- Identify opportunities for law enforcement policies and procedures that promote diversion to crisis intervention (and crisis stabilization beds) in lieu of arrest for selected charges.
- Improve the capacity of the current mental health docket in Potter County to be more successful with its clients by obtaining training and technical assistance on the use of best practice jail diversion interventions for high-need individuals with serious behavioral health conditions.
- Improve jail-based behavioral health services throughout the region through continued expansion of telepsychiatry in the jails as well as through partnering with local hospital districts. Demonstrate return on investment for local communities through the provision of appropriate levels of behavioral health services within the jail.
- Develop organized procedures for transitions from jail to community care as part of county and regional care coordination tracking.
- Initiate outpatient competency restoration programming as a pilot.
- To reduce recidivism and promote community safety, develop county-specific and region-wide training and implementation of best-practice community corrections risk assessments and matched interventions for adults and juveniles with behavioral health needs under probation supervision.
- Create a "business case" for multi-county investment in structured residential services that could provide appropriate treatment and rehabilitation for individuals with serious psychiatric disabilities and/or co-occurring substance use disorders. (Examples exist in other regions).

Veterans Services

There is a strong set of ambulatory care and housing support services provided in the region for veterans, as well as investment of Veterans Administration (VA) resources to purchase inpatient beds. However, the VA resources are not comprehensively incorporated into the overall community collaboration and are thus underleveraged to help fill system gaps. In addition, the

VA can partner with the community as a whole on other improvement efforts listed in these recommendations to improve overall capacity for delivering services to veterans in need. Improvement opportunities include:

- If the VA is a prominent partner in the Panhandle BHLT, the region would have better access to available resources and political support for the needs of veterans in the region. The Texas Veterans Initiative project award is a natural opportunity to build this collaboration under the auspices of the BHLT.
- VA services can benefit from regional initiatives such as the development of COPSD capacity, expansion of behavioral health capability within primary health care, children's services (for veterans and their families), and the expansion of a continuum of crisis services in the region, among others.
- Current VA resources invested in inpatient care might also contribute (along with other funders) to developing crisis stabilization beds, partial hospital services, continuing crisis intervention, jail-based and specialty court services, collaborative regional telepsychiatry capacity, and so on.

Family and Peer Involvement

The Panhandle region has developed a strong base of peer support specialists, including certified parent partners, and has a successful ROSC collaborative and an emergent and capable NAMI Chapter. These strengths can be built upon to expand both service capacity and customer voice within service system design. Improvement areas include:

- Ensure NAMI and consumer/peer support representation on the Panhandle BHLT.
- Develop a mechanism to regularly solicit consumer and family voice into the customer-oriented quality improvement process and to engage their participation in workgroups and advocacy.
- Identify opportunities and resources to formally expand peer support specialist training for mental health consumers and the parents of children with serious emotional disturbances, as well as to develop training and job opportunities for recovery coaches within emerging substance use disorder services. Formally engage peers who represent culturally diverse communities.
- Expand opportunities for peer support positions in multiple service provider organizations.
- Consider mechanisms for strengthening the advocacy efforts of individuals and families, by helping them share their stories in churches, social organizations, and in local and county government. Mental illness and substance use disorders affect everyone and the more this is recognized, the greater the political will to address these issues will be.

Housing and Homeless Services

There is an existing continuum of shelter services that seems to provide adequate emergency shelter for up to 600 homeless people (in Amarillo). There are also some excellent services that help motivated individuals make progress toward recovery. However, there are still many service gaps. Further, the relocation of the Guyon Saunders Center may represent an opportunity to improve the available service continuum for individuals with behavioral health conditions who are homeless. Improvement opportunities include:

- Within the overall homeless count, identify the prevalence of individuals with various types and severity of behavioral health needs, including those with such severe impairment that they cannot be readily engaged at all.
- Build on the existing "drop-in" model of services to incorporate more structured rehabilitation and engagement/outreach services that are able to "meet people where they're at." These services could potentially be co-located with crisis stabilization beds in the space formerly occupied by Guyon Saunders Center.
- Using the existing Pathways to Housing program for veterans as a model, consider how to develop scattered-site permanent supported housing for individuals with the most severe impairments who are homeless, an intervention that has been demonstrated to save local resources when properly implemented.

Workforce Recruitment and Retention: Medical, Nursing, Other Counseling

Although there is universal acknowledgement of the scarcity of providers in the region, there is currently no behavioral health workforce development strategy or plan. This is a critical area for improvement and should be developed similar to how the community might attract key personnel in other industries.

- One key step will be to create a strong community-supported effort to develop a psychiatric residency program under the auspice of Texas Tech. Currently, Midland-Odessa is further along in developing such a program than the Panhandle and could serve as a model for the region.
- Engage all behavioral health training programs, nursing programs, and physician assistant programs in the region to form a workforce collaborative. Within this collaboration, develop a strategic plan to identify all the steps that can be taken to improve recruitment, internship opportunities, access to capable supervision, teamwork and collaboration, and development of attractive career paths to promote retention. Note that the literature on recruitment emphasizes the importance of this type of community in attracting and retaining professionals.
- Seek opportunities to encourage behavioral health career paths in nursing and physician assistant programs.

- Expand clinical supervision and case consultation, for both trainees as well as early-career professionals, through the creation of a "supervision collaborative" across seasoned, experienced practitioners as well as through access to telehealth supervision.
- Use data on recruitment and retention to develop formal community targets to steadily attract and retain behavioral health professionals, including those who provide services (including counseling services) through telemedicine.
- Develop career path internships for undergraduate students in the region to attract people who have grown up in the Panhandle to pursue behavioral health careers.

Cultural and Linguistic Competency

As previously noted, there are some strong social and community services targeted to various cultural and linguistic groups, including immigrant populations. More broadly, there is increasing recognition of the diversity of population in the region and the need to respond to that diversity. However, as in most communities across the nation, there are very limited behavioral health resources available to those with cultural and linguistic backgrounds that differ from the mainstream population. Suggestions for progress include:

- Begin to gather data on the prevalence of individuals with behavioral health needs from various cultural groups, whenever service data is being tracked. This can help establish a baseline of need and availability of response upon which to measure progress.
- Consider cultural and linguistic diversity in recruiting providers, peer specialists, and key staff, as well as in identifying and engaging individuals with diverse cultural and linguistic backgrounds from the region to pursue careers in behavioral health.
- Provide training to all behavioral health practitioners on strategies for working with individuals who may present from key diverse populations.
- Identify and develop needed translation resources.

Cultural competency development extends as well to mindsets and welcoming approaches to care for people with "special needs" and other unique service populations. Examples include individuals from the LGBT community, substance-using pregnant and parenting women, victims of sexual assault, and so forth. To improve competencies in these areas, suggestions include:

- Gather data on prevalence and need.
- Provide system-wide and regional training on best practices as prioritized alongside other critical needs.
- Support relevant community conversations to address stigma and misconceptions.

Engaging Community Resources and Natural Supports

Although we did not specifically evaluate this potential capacity, it is an important area for regions like the Panhandle to consider. Other Texas communities with similar challenges are making progress in these areas as well. Improvement areas to consider include the following:

- Engage the faith communities. Many communities in Texas have begun to talk openly about behavioral health issues in churches, and pastors are providing education and support that behavioral health conditions are indeed illnesses requiring treatment, including some clergy who share their own lived experience. Communities such as Tyler have hosted large multi-denominational gatherings to talk about mental illness awareness in the community as a whole. Some churches are opening up to receive Mental Health First Aid Training™ for clergy and key members of the congregation. Other communities (e.g., San Antonio) have formalized interdenominational mental health task forces, which allow multiple churches a chance to meet and coordinate resources and events.
- Engage the business community. Recognizing that mental health and substance use issues contribute to lower productivity and unhealthy businesses, numerous initiative around the nation support the idea that smart businesses need to promote mental health and addiction recovery in their businesses and in their communities. This line of thinking is key to why significant business leaders around the state have made behavioral health contributions a priority, including helping to launch and sustain MMHPI. Face It is a national organization that originated in Sioux Falls, South Dakota that raised millions of dollars from local businesses to support recovery in the community and has a methodology for making the "business case" in any community. Further, last fall, several prominent national businesses disseminated the Working Well: Leading a Mentally Healthy Business. These materials are opportunities for the Panhandle to generate more support and resources for region-wide efforts that fit the culture of a strong pro-business environment.

Prevention and Early Intervention

In the Panhandle, as in all regions of Texas, there are a number of existing prevention collaboratives as well as a regional Prevention Resource Center. We did not explore these in our assessment. However, these are opportunities to build upon, as follows:

- Obtain the regional Prevention Resource Center assessment. It provides a wealth of information about community capacity and need, with a particular focus on the impact of substance use disorders.
- Identify the regional prevention coalitions. These exist in all communities to varying degrees and usually focus on addressing teenage drinking and opioid use. The regional BHLT can consider bringing all community prevention efforts together to form a more powerful regional prevention and early intervention coalition that could be tasked with developing a regional prevention and early intervention strategic plan.
- Strategic prevention efforts should be holistic. Addressing trauma early on, including within schools, can help build resiliency and thus prevent the onset of multiple

behavioral health conditions as well as reduce the risk of delinquency, suicide, and bullying.

- Research on school discipline practices indicates that implementation of best practices such as trauma-informed schools and positive behavioral supports reduces adverse outcomes among youth.
- Engaging youth to reach out to other youth is a powerful strategy in building prevention and early intervention efforts. Consider how to make it easy for youth to ask for help when they sense a peer is in trouble or at risk. Youth peer mentors can provide important engagement efforts that bridge the gap between youth and formal services.

Conclusion

The Panhandle region has substantial initial capacity for organizing a regional behavioral health leadership team with a formal strategic plan and achievable metrics of progress. Even with limited resources and current challenges, there is substantial strength to build on and many areas where improvement is possible in the short run. Further, there is clearly opportunity for the behavioral health leadership collaboration to grow over time and become stronger, better resourced, and able to undertake more challenging projects. We have provided an extensive list of recommendations to show readers how many opportunities are possible. However, it is important not to be overwhelmed by all the things that could be done. We recommend identifying and then taking action on a few priorities that seem achievable and important. Examples of priority areas that have been identified for attention by stakeholders in our interviews, and align with current initiatives and activities, include:

- Crisis system improvement to promote access and engagement,
- Developing the children's system of care (including prevention and early intervention),
- Improving regional access to behavioral health care,
- Improving integration of behavioral health and primary health,
- Improving criminal justice and jail-based services,
- Improving veterans' services, and
- Workforce recruitment and retention, targeting medical, nursing, other counseling professions.

Even within this shortened list of priorities, it will be important to select achievable areas of focus from within the recommendations. Start small and demonstrate success with early wins and achievements. It will take time to achieve the full potential and address all of the components of the delivery system that have potential for improvement. However, even with a few initial changes, you will be saving lives, saving families, and making a difference to the people of the Panhandle.

Appendix A: Panhandle Behavioral Health Initiative Membership

Name	Position / Organization
Baker, Dr. Teresa	Assoc. Professor OB/GYN, TTUHSC
Brotherton, Kay	Director of Projects & Special Change Initiatives, Central Plains Center
Carlisle, Anette	Civic Leader
Castle, Samantha	Executive Director, Pavilion
Chase, Coby	Dir. Of External Affairs, Meadows Mental Health Policy Institute
Cornett, Kathy	Marketing/Communications
Cowell, Ellen	Consultant, Cowell Group
Coyne, Mary	Vice President, AscentHealth Consulting
Dalrymple, Steve	President and CEO, Baptist Community Services
Davis, Gainor	Executive Director, Harrington Cancer & Health Foundation
Day, Judy	President and CEO, Bivins Foundation
Gilmore, Diann	Executive Director, Downtown Women's Center
Gilmore, Dr. Perry	Consultant, ARAD
Green, Dr. Leigh	School Professional Counseling, WTAMU
Hale, Jennifer	Student Family Advocate, AISD
Hammer, Dr. Ed	Clinical Professor/LPC, TTUHSC Pediatrics
Hawley, Henry	Administrative Officer, VA Mental Health Service
Johnson, Major Harvey	Executive Director, Salvation Army
Keister, Dr. Alan	Primary Care Physician
Lambert, Dr. Michael	Executive Director, Veterans Administration Psychiatry
Lusby, Dr. Stacia	Psychiatrist, J.O. Wyatt Clinic
Miller, Camille	Executive Director, Texas Health Institute
Mormon, Tracey	Dir. Of Guidance & Counseling, AISD
Netherton, Margie	President, NAMI
Noffsker, Katie	Executive Director, United Way Amarillo/Canyon
Pitner, Gary	Executive Director, Panhandle Regional Planning Commission
Renshaw, Dr. Kaye	LPC
Rogers, Dr. Gerald	LPC
Rush, Dr. Jave	Psychiatrist
Santer, Dr. Jennifer	Director of Social Services, Salvation Army

Name	Position / Organization
Schertler, Bud	Executive Director, Texas Panhandle Centers
Severn, Susan	Grants Program Officer, Bivins Foundation
Street, Laura	Board Director, Meadows Mental Health Policy Institute
Stoughton, Casie	Director of Public Health, City of Amarillo
Stribling, Clay	Executive Director, Amarillo Area Foundation
Tanner, Nancy	Judge, Potter County
Trusler, Ron	Executive Director, Central Plains
Tudyk, Jessica	Director of Grants, Amarillo Area Foundation
Womack, Jim	Executive Director, Family Support Services
Wood, Jennifer	Assistant Professor Social Work, WTAMU
Witherspoon, Carolyn	Executive Director, Coalition of Health Services

Appendix B: Panhandle Behavioral Health Initiative Interviews

Name	Title/Position	Organizational Affiliation
Susan Barros	Senior Director of Community Impact	United Way of Amarillo and Canyon
Beverly Bonnell	Mental Health Director	Wesley Community Center
Kay Brotherton	Director of Projects and Special Change Initiatives	Central Plains Center
Anette Carlisle	Civic Leader and Director	Panhandle 2020
Samantha Castle	Executive Director	Pavilion
Kathy Cornett	Marketing and Communications	
Mary Coyne	Vice President	AscentHealth Consulting
Ronda Crow	Chief Nursing Officer	Moore County Hospital District
Steve Dalrymple	President and CEO	Baptist Community Services
Gainor Davis	Executive Director	Harrington Cancer and Health Foundation
Karen Day	LPC	Specialized Therapy Services of Amarillo
Judy Day	President and CEO	Bivins Foundation
Shyla Dubois	MH Coordinator	Potter County *(at the time of interview)*
Diann Gilmore	Executive Director	Downtown Women's Center
Dr. Perry Gilmore	Consultant	Amarillo Recovery from Alcohol and Drugs
Dr. Leigh Green	Chair, Professional Counseling	West Texas A&M University
Karen Jeffers	Director of Nurse Navigators	Baptist Community Services
Sgt. Neil Jensen		Amarillo Police Department Crisis Intervention Team
Jennifer Hale	Student Family Advocacy Program	Amarillo ISD
Dr. Ed Hammer	Clinical Professor/LPC	TTUHSC Pediatrics
Paul Harpole	Mayor of Amarillo	
Henry Hawley	Administrative Officer, Mental Health Service	Veterans Administration
Major Harvey Johnson	Executive Director	Salvation Army

Name	Title/Position	Organizational Affiliation
Dr. Alan Keister	President of Medical Staff Director	Amarillo Legacy Medical ACO Heal the City Clinic
Dr. Stacia Lusby	Psychiatrist	J.O. Wyatt Clinic
Libby Moore	Behavioral Health Director	Texas Panhandle Centers
Tracey Morman	Director of Guidance and Counseling	Amarillo ISD
Bill Mosteller	Director of Jail and Crisis Services	Texas Panhandle Centers
Margie Netherton	President	NAMI Texas Panhandle
Donald Newsome	Quality Management Director	Texas Panhandle Centers
Katie Noffsker	Executive Director	United Way of Amarillo and Canyon
Sara Northrup		Texas Panhandle Centers
Jerry Parker	CEO	The Wood Group
Gary Pitner	Executive Director	Panhandle Regional Planning Commission
Dr. Kaye Renshaw, LPC	Private Practitioner	
Veronica Rosas	Executive Director	Amarillo Wesley Community Center
Dr. Jave Rush	Medical Director	Pavilion Day Hospital and Golden Phoenix Geropsychiatry Program
Dr. Gerald Rogers	Private Practitioner	
Stacy Sandorskey	Director of Children's Services	Texas Panhandle Centers
Dr. Jennifer Santer	Director of Social Services	Salvation Army
Bud Schertler	Executive Director	Texas Panhandle Centers
Timi Smart, LMSW		Dalhart Senior Care Solutions
Robert Smith	VP Regulatory Services	Baptist Community Services
Clay Stribling	President and CEO	Amarillo Area Foundation
Nancy Tanner	Judge	Potter County
Ron Trusler	Executive Director	Central Plains Center
Carolyn Witherspoon	Executive Director	Coalition of Health Services
Jim Womack	Executive Director	Family Support Services
Dr. Jennifer Wood	Assistant Professor of Social Work	West Texas A&M University

Appendix C: Additional Data Provided by Stakeholders

Note: These data have not been vetted or verified by MMHPI and are included as requested by PBHI as an additional reference for local planning purposes.

Data Type	Amarillo Independent School District Student & Family Advocate Report: March 2016	Amarillo Independent School District Student & Family Advocate Report Year to Date: October 2015-March 2016
Total Enrolled	**100**	**611**
Reason for Referral		
Self-Harm/Harm to Others	28	105
Drug/Alcohol	1	11
Grief	55	40
Family Conflict	14	153
Behavior Issues	51	298
Past Psychiatric Inpatient Hospitalization	7	38
Previous Involvement with Law Enforcement	3	24
Insurance		
Current Medicaid	48	263
Low Income/Uninsured	11	65
WRAPAROUND Services Provided to Students and Families		0

Amarillo Homeless Count

Estimated Point in Time Count – January 21, 2016	
Population	**Count**
Total Unsheltered Count	33
Total Sheltered Count	622
Total	**655**
Unsheltered Adults	30
Unsheltered Children in Families	3
Total	**33**
Sheltered Adults	445
Sheltered Children in Families	23
Total	**468**
Transitional Housing Adults	30
Transitional Housing Children	32
Total	**62**
Permanent Supportive Housing Adults	71
Permanent Supportive Housing Children	21
Total	**92**