Long term care and maintenance subcommittee of the Behavioral health committee

Meeting notes 7/22/14

Charter:

Describe desirable approaches to stablization all the way from abstinence to harm reduction

Ways to keep people safe—can propose "unconventional" solutions eg housing first, wet houses

What we are not doing: describing existing resources; crisis intervention

Subcommittee members:

Jill Marshall: grew up in ABQ, lived and worked in TX for 16 yrs. Worked in psych hospital at Texas Tech, Texas youth commission for capital offenders and youth substance abuse; has worked in dual dx, intellectual disabilities; now program director for Los Lunas Community DD waiver for DOH; BA in music therapy and finishing masters in Public health.

Doug Fraser: "dreaded consultant". For 10 yrs has worked on mental health issues with state. Has chaired several local collaboratives. Worked with UNM dept of psych for 4 yrs. Worked with leadership council for reducing disparities at Georgetown. Consumer-advocate.

Miriam Komaromy, MD (subcommittee lead): Internal Med and addiction med; former med director for Turquoise and for Alb Health Care for the Homeless; now associate director for ECHO Institute at UNMHSC; direct Integrated Addictions and psychiatry teleECHO program, training CHWs

Katrina Hotrum, directs Dept of Substance Abuse Programs (DSAP) for Bernalillo County; tech assistance for our committee.

Harris Silver, MD: absent

Jessica Gonzales, staff for councilor Brad Winter; assisting committee, helping us gain action to information and resources

Outlines of types of services we can consider:

- Prevention
- Identification of persons at risk and Triage/referral
- Harm reduction
- Assessment
- Treatment (psychosocial and medical)

Types of services and programs we discussed in this meeting:

A. Prevention:

Identifying families/children at increased risk for childhood trauma (which underlies so many types of BH disorders and SUDs): UNM Family Med working on identifying ACEs (through the comprehensive needs assessment performed by the Medicaid Managed Care Organizations) to help identify those at increased risk for early childhood trauma, and hopefully then intervene to decrease risk. (Miriam)

Could also do this assessment/intervention through the schools. Offer parenting classes and resources for parents. Hospitals offer maternity classes. Do they address risk of abuse, caregiver stress? Is there more we could insert to help with awareness? (Katrina)

CYFD does home visitng, so does FIT program (birth to 3). But many pediatricians aren't aware—clients only identified once there is a problem. Attach parenting training to subsidized day care. Currently available if you qualify for FIT program (Family infant and toddler), but not otherwise. (Jill)

If you reached entire population of people on TANF, subsidized day care, etc and mandated 2 nights per year of parenting classes, could help with education, self-identification of families at risk. Give the info re resources before family is in crisis. Could you link this to time of vaccination or other mandated services? Autism screening assessment is standard at 18 months—could do something similar for social/emotional delay; could offer/mandated screening for risk of childhood trauma, or could mandate offering education/support. (Katrina)

B. Identification of persons at risk and Triage/Referral

Community Engagement Teams (CETs): Doug Fraser describes teams made up of providers and peers who would reach out to clients is need and offer them services. Potential clients could be identified by referral from community agencies or by family/community members/ clients contacting team. Spectrum between offering services and forced treatment; promotes use of behavioral health advanced directive in order to help client specify desires in case s/he ends up in more intensive/less voluntary level of care. Teams would be geographically located by neighborhood; would not be agency based, and would include peers and professional care providers. This model promotes social cohesion; could also apply to children and families; mental health first aid training could be used to raise awareness among community members. Legislature passed bill to create these CETs but was vetoed. (Doug)

Alternative model could be to center teams around ACT teams, with less intensive levels of care that could be led by RN, or by CHW. These could work with clients needing less intensive levels of care, and client could be referred "up" if more intensive counseling/psychiatric/crisis intervention services are needed. (Miriam)

Importance of accurate diagnosis: need to sort out brain injury from temporal lobe epilepsy, vs mental illness or SUD; must start with accurate diagnostic assessment ; accurate diagnosis guides everything else (Doug)

Criminal justice system is main provider of services for behavioral health problems. Need to address recidivism. Look at all ages. In early intervention work you see lots of kids who are at risk due to

parents who have addiction, intellectual disability, mental illness; their kids tend to progress through system into criminal justice system. How do we prevent this progression? (Jill)

How do you **educate community about who needs help and how do they get help**? Mental health First aid type training—especially if it includes SUD—can help raise awareness—but where do clients then look for help?

Need entry point/assessment for need for both BH and SUD treatment; inadequate outpatient treatment for SUD, especially if treatment other than IOP is needed. No clear way of learning what types of BH or SUD services are available, no standardization of the content/level of the services available. No decision point in which patient is doing poorly in outpatient setting and recommendation to go into inpatient treatment. No system-wide assessment of what level of care is provided in various treatment settings. could develop a voluntary system-wide way to assess and match patients to various treatment services.

For SUD: Other states mandate licensure of both inpatient and outpatient addiction treatment. Texas uses ASAM criteria to slot people into services. (Katrina and Miriam)

How about a **hotline for BH and SUD** services? Katrina says could be liability issue, need to call 911—how do you rely on layperson's assessment of severity of problem, what if the person is really dying and you suggest referring to counseling. 311-type line; can use a disclaimer to reduce liability, "if you think this is an emergency call 911". Do other cities/states have something like this? (Miriam)

How do we reach most disenfranchised populations? In Valencia Cty collaboration between CYFD, local law enforcement , other community agencies—discuss topical issues and collaborate to develop services and interventions (Doug and Jill)

C. Harm Reduction

1. Ideas include widespread distribution of naloxone (Narcan) for overdose prevention; drop in centers for people with BH disorders or Substance use Disorders (SUD). Safe injection facilities? (Miriam)

D. Treatment

Trauma-informed Care (TIC): Brian Isaakson and Doug Fraser worked with Harrison Kinney on Trauma Informed Care, and Doug worked on TIC with teambuilders until it was shut down. (doug)

Valencia County had Bruce Perry training, and Sequoia is doing Building Bridges training on TIC (Jill)

University Mental Health services do not seem very well designed to meet the needs of the community, in spite of getting a lot of public money. They need to provide a lot more access to integrated psychiatric and psychosocial (counseling) treatment. Used to do this years ago, but no longer seems like a goal/focus to provide non-crisis services to meet community needs. May be partly due to difficulty attracting and retaining treatment providers (Miriam and Doug)

Could write a **behavioral health waiver** for the state. Need more options to residential services. Would be a Medicaid wiaver and would get a federal match. Would allow patients with severe behavioral

health problems to obtain services in the community (attendant care, etc) avoiding institutionalization. People end up incarcerated and there is nowhere to send them. (Jill)

Need for more **residential treatment options** for people who are not dangerous or very severely impaired, but need help to stay stable (med management, safe living environment, payee services). Consider licensing **mental health Board and Care homes**; these exist in Las Vegas NM, and are used a lot in other states (eg CA).. Because pts don't need assistance with 2 ADLs the programs don't get medicaid reimbursement, and patients pay with SSi, for instance; not currently licensed and so subject to a lot of abuse and lack of standardization. Could also work without mandated regulation; Licensure and basic standards are needed, but not undue burden—don't want to require so many services that no one can provide these within patient's income. (Miriam and Katrina)

What about **treatment guardian assessment/services?** Hard to recruit and train them. Should they have to be professionals. Controversial—civil rights/self-determination vs severe unmet need. May not get help until part of criminal justice system, which is very undesireable (Doug and Miriam)

Jim Ogle from NAMI and Doug met at Roundhouse with Jim Ogle testifying for kendra's law and Doug testifying against it. Doug now sees the need for mandated treatment in some cases. (Doug)

For SUD: need more **Medication Assisted Treatment (MAT)**

Other considerations we discussed:

Recovery and Resiliency: Does UNM Dept of psych endorse these concepts? Is there an endpoint to recovery from mental illness, e.g permanent recovery? More of a chronic relapsing state, with potential for high-functioning plateaus. Seems the same for SUD. Does Recovery really make sense as a concept or does it place unrealistic expectations on people with mental health disorders ar SUD? Is promoting resiliency more realistic, for instance? (Doug)

FIC Forensic Intervention Consortium

We don't spend enough money on mental health; main foci should be counseling, medications, and case management; and maybe also residential options (Doug)

Our recommendations need to be presented in a way that lay-persons can understand them, avoid jargon and complexity so they are more accessible (Jessica)

Tasks for next meeting:

Katrina will research residential care facilities

Miriam will look into regional mental health/SUD hotline

Doug: will send me his schema for Community Engagement Teams; will also gather resources about how to do system wide education on TIC

Jill: will look into options available through FIT program and home visiting and also behavioral health waiver in other states, issue of federal match, and criteria

Jessica: gather info on Kendra's law, mandated treatment, treatment guardians—what is happening now and what is being considered

Next meeting scheduled for 8/1 at 3:30 at MATS

Plan: review and add to discussion and notes from 7/22 meeting; report on results for individual research; identify more types of services we should be exploring