

**SUMMARY OF CITY/COUNTY/STATE BEHAVIORAL HEALTH TASK FORCE**  
**RECOMMENDATIONS**

**A. CRISIS STABILIZATION / RESPONSE CENTER**

- Currently UNM-Psychiatric Emergency Room and other local emergency rooms provide acute emergency crisis support. However, this treatment is extremely short-term in scope and service, with no meaningful access to “step down” therapeutic services. Emergency rooms are expensive and designed for handling the emergency but not long-term support.
- People who receive service from the emergency room have no place to go once the immediate crisis is resolved.
- Eligibility for “in-patient” beds is, by design, limited to persons who are in “danger to themselves or others.”
- There is little or no service for persons who are experiencing “sub-acute” (non-emergency). However debilitating mental or behavioral health conditions or symptoms (e.g. major depression, personality disorders, and mental conditions not endangering themselves or others) may be.

**Background**

- The idea of crisis triage /stabilization centers was first introduced ten years ago by a study commissioned by the City of Albuquerque (hereinafter “Wertheimer Report”).
- House Joint Memorial 17 also identified crisis stabilization as a major gap in the behavioral health continuum.
- Other jurisdictions: Tucson; San Antonio; and Pierce County, WA have utilized crisis triage stabilization centers as key components to successful behavioral health continuums.
- These jurisdictions have found that the creation of lower level service models create more opportunities for patients to control symptoms without the cycle of crisis-to-crisis emergency room visits. These centers generally can see patients sooner - without long wait times.

- **Not only does the stabilization center provide a more clinically appropriate environment for longer term maintenance, but other jurisdictions have shown significant cost savings.**

### **Recommendations**

- The center should be a short term (no longer than 5 days) transitional center
- The center should be open 24 hours, 7 days a week
- The center should not be based on any “eligibility requirements” but rather based on “need.” Anybody in the community, regardless of income, should have access to the center
- The center should be accessible both for “step down” services (from emergency rooms or jail), as well as a “drop in” services (persons who are suffering from “sub-acute” mental illness or conditions who are not a danger to themselves or others but are still in need of immediate services).
- The task force recommended a hybrid of both a “medical model” and a “social model.” The medical model stabilization centers concentrate more on the medical aspects of stabilization (triage, psychiatric diagnosis, and medications) while “social models” focus more on addressing the underlying condition, methods of coping and support (peer support, counseling, medication management, linking people to longer term support in the community. (As Representative Rick Miera noted, “medical models are generally more expensive to run and maintain.” “Medical model” centers usually see increased regulation and licensure requirements, and increased infrastructure and liability costs. Currently, UNM Psychiatric Emergency and other emergency rooms do most of the “triage” components (i.e: diagnosis, prescriptions, and more complex therapies).
- The task force recommended that the center have medical resources on site, and strong connections through tele-health to other medical facilities (on-duty nurses to administer medications, perhaps an on-site clinic run by UNM Psych services during peak hours) but should focus on the “step-down” services and providing a “warm handoff” to other resources in the community (e.g. assisting the “newly eligible” in signing up for Medicaid; for persons with Medicaid: coordinating with the client's MCO “care coordinators”; peer to peer support; non-drug therapy support; and a central “resource center” to provide information about connecting people to resources.

- **Diverting people that need stabilization out of the emergency room and into in-patient beds makes more efficient use of scarce resources and fills a need that is not currently being met in our community.**

### **Funding**

- Other jurisdictions have funded stabilization centers through grants (public and private), local governments and through state funding mechanisms. Generally, most centers utilize “blended funding” from a variety of sources
- The success of such a center would hinge on the ability to link clients to more permanent support services in the community, after or concurrent to step down medical stabilization. Given that federal and state funding mechanisms are limited in scope by eligibility requirements, local government funding could provide a “needs based” funding allowing case workers to address a clients' individualized needs without regard to reimbursement issues with Medicaid

### **B. Intensive Case Management**

- Provide trained professionals who would be assigned a client with mental or behavioral health conditions. A case manager would assist clients in connecting to key services in the community (Medicaid, SNAP, housing, SSI, etc.) and would regularly follow up to insure the client has the best opportunity to stabilize before a crisis arises.
- The Albuquerque and Bernalillo County area have a complex array of behavioral health and social services, with many different funding streams contributing to services. Unfortunately, it is quite challenging for citizens and individuals in need to penetrate this complex system and connect with the right services at the right time. Because funding for most services is based on eligibility, or limited to certain programs or categories of need, it is very frustrating and challenging for most individuals to be able to effectively access the appropriate services and benefit from them.
- Case Management is a general term used to describe an array of overlapping services, all of which provide general paraprofessional assistance to individuals in accessing and connecting with services, programs, supports, and benefits. Case managers often act as “navigators” to help people in need to find their way through our complex system, connecting people in need to the right services and resources, and helping them to obtain or meet categories of eligibility, such as obtaining Medicaid, etc. Case Managers help in a holistic manner, assisting people in addressing both social, as well as medical/behavioral health issues. Thus, Case Managers help people to obtain psychiatric assessment and treatment, but also help them to fill

critical social needs such as housing, employment, education, childcare or social activities.

### **Recommendations**

- Increase city and county funding of case management services, based on determination of need, rather than eligibility. Program strategies such as the UNM Pathways Program and the UNM Fast Track programs offer models which could be replicated and expanded, and may better serve the community if they were more widely available and marketed
- Support a system wide Albuquerque-area behavioral health resource database/list which is maintained and kept up-to-date
- Support a low -level referral/coordination system. EX: 311 information system to provide basic service contact information to callers

### **C. Creation of Community Engagement Teams (C.E.T.)**

- The purpose of CET is to utilize community outreach to engage and link a person with serious mental illness to voluntary treatment and other services.
- The goals of CET would be to reduce the rate of intervention by law enforcement, involuntary hospitalization or incarceration through early outreach to prevent or lessen the mental deterioration of persons with serious mental illness who are unlikely to live safely in the community and to lessen the duration and severity of mental illness of persons with serious mental illness who are unlikely to live safely in the community through early detection and targeted intervention.
- Last year a bill passed the New Mexico Legislature that created the concept of CET teams comprised of trained civilian units (they could be associated with medical entities, community entities, peer to peer groups, NAMI, etc.) that would respond or address crisis calls from clients in the field who are experiencing a mental health crisis.

**The task force recommends that this legislation be re-introduced and recommends that the Legislature appropriate State funds to create CET teams, and to follow up with clients (Case management).**

### **D. Supportive Housing for People with Mental or Behavioral Health Conditions**

- The task force recommended that more resources need to be earmarked for supportive housing. For people with mental or behavioral issues, housing remains a key component for long term stabilization.

- Lack of reliable housing increases the risk of crisis encounters, increased hospitalization /emergency room costs, and is a barrier to have people diverted from jails.
- A recent study shows that persons with behavioral health issues that receive housing assistance decreases overall costs from emergency room visits by 34%; inpatient mental health and mental health visits decreased costs by 84%; outpatient costs decreased by 34%. City of Albuquerque Heading Home Cost Study

### **1. Temporary “Respite” Housing**

- For people transitioning from a crisis stabilization center, psychiatric emergency room, jail, etc., who are in need of temporary housing until a more stable living situation becomes available. This housing would be short-term in nature (e.g. up to 2 weeks).

### **2. Supportive Housing**

- Typically scattered site housing, where clients have support through off-site case managers or on site supervision but live more independently than in a group home setting.

### **3. Supportive Group Housing**

- A group home setting, typically with on-site supervision and support.

### **E. Creation of Mobile Crisis Units**

- Such units are utilized in other jurisdictions to provide services to clients out in the field before a 911 call is made (or in lieu of a 911 call). These teams are often a combination of law enforcement (such as CIT unit) along with a trained mental health professional to engage people with mental or behavioral health issues in a less intensive manner than a standard police response.
- **The task force recommends that APD and Bernalillo County Sheriff’s Office create “mobile crisis units.”**

### **F. Law Enforcement to Establish a “Tiered Response” for Mental/Behavioral Health Calls**

- In conjunction with CET concepts and mobile crisis units, APD's Crisis Intervention Team has been developing a “tiered response” so that not every behavioral health call is automatically responded and addressed by an armed/uniformed law enforcement officer. Instead, protocols are developed to “triage” calls so that the most appropriate law enforcement response is sent to address the issue at hand. For example, if a

person is acting erratically, experiencing a mental health issue, but no crime has been committed, the tiered response could be utilized so that a CET team, the mobile crisis unit, a medical professional, CIT unit would respond to address the situation without unnecessary escalation of the situation.

#### G. **Courts/ Criminal Justice**

Persons with mental illness encounter the criminal justice system more often than persons without a condition. Additionally, this population has higher recidivism rates and they tend to stay in jail and prison longer than a person without a mental health condition. According to a Bureau of Justice Statistics Report nearly 64 % of all persons in local jails has some diagnosed mental illness.

Navigating the criminal justice system is difficult, intimidating and stressful for anybody charged with a crime but for a person with mental illness it can be a Kafka-esqe nightmare. The goal of the criminal justice system is to assign penalty to illegal action -and not primarily to advocate or address the long term stability of a defendant with mental illness. Thus, it is no surprise that once a defendant is released from jail, diverted from jail, found incompetent to stand trial, or otherwise dealt with by the criminal justice system they typically leave with no support whatsoever. This inevitably leads to recidivism, trips to the emergency room and the streets.

Diverting persons with mental illness from the criminal justice system not only has moral dimensions, but has shown to achieve better therapeutic results for the defendant, that in turn reduce recidivism and expensive emergency room stays.

In response to this cycle of mental illness, New Mexico Courts have been leaders in creating “diversion” courts such as Drug Court, Mental Health Court, Homeless Court and Veteran's Court. These models are successful and should be maintained.

##### **1. Mental Health / Homeless / Veteran's Court**

- The task force recommends that the Courts continue to enhance the specialty courts addressing persons with mental and behavioral health issues.
- For any court that deals with clients with mental conditions, special care should be taken to insure that the court fundamentally understands the stigmatizing effect of criminalizing mental illness and that these conditions are not necessarily decisions by the defendant. The courts cannot structure the compliance plan on the traditional probation models of incentive and fear based compliance. In short, mental health courts need to construct to ensure that the defendant be referred, placed, or

monitored in the most therapeutic environment to address the defendant's underlying conditions.

- The Courts needs more case management resources to follow up with clients before they de-compensate and re-offend.

## **2. Reform and Streamline the Bench Warrant Process**

- If a person fails to appear before the court for any crime, a bench warrant is automatically issued, including for petty misdemeanors. In the case of the severely mentally ill, failure to appear is sometimes the norm rather than the exception. When law enforcement encounters a person who has bench warrants, their discretion is taken away and they must arrest the individual. This creates a cycle of incarceration for people with mental illness without meaningful treatment.
- The task force recommends that the Courts and the N.M. Legislature take a fresh look at the bench warrant process and find common sense methods to address the unique challenges faced by persons with mental illness in navigating the criminal justice system.

## **3. Additional Financial and Human Resources to “Competency” and Treatment Guardianship Programs.**

- Persons with mental conditions are frequently diverted from criminal culpability because they are not competent to stand trial. Before such a determination is made the defendant must be evaluated by contracted medical professionals. Currently this program is underfunded, which creates backlogs, especially in the District Court, in performing evaluations, with some defendants waiting over six months before an evaluation is performed.
- **The task force recommends that the N.M. Legislature find resources to ensure that competency evaluations are being funded properly and are being conducted in the timeliest manner.**
- Similarly, on the civil side of the law, New Mexico's Treatment Guardianship program (which allows the court to appoint another person to make medical decisions for a person with mental health issues so severe that they do not have the capacity to provide “informed consent”) is woefully underfunded and is in disarray.
- **The task force recommends that the New Mexico Legislature appropriate the resources so that this program can function properly.**

#### H. **Medicaid**

- Prior to the passage of the Affordable Care Act and the State of New Mexico's decision to expand Medicaid a large portion of folks with mental or behavioral health issues were not eligible for health care through Medicaid. Now, many are presumptively eligible.
- **The task force recommends that State of New Mexico provide more outreach, accessibility and streamline the process for signing the “newly eligible” up for Medicaid.**
- Similarly, many of the persons leaving MDC, especially those with mental conditions, are presumptively eligible for Medicaid, which would allow them to receive medical services in the community to prevent another mental crisis or re-incarceration. The Task Force recommends that N.M. Human Services Department implement protocols and procedures to efficiently sign this population up for Medicaid.
- **The task force recommends that N.M. HSD restore “case management” as a billable service under Medicaid and no longer restrict case management to “core service providers.”**

#### I. **Prevention**

- The task force recommends that the State of New Mexico and Albuquerque Public Schools explore programs to detect and intervene on childhood behavioral health problems through programs such as “Mental Health First Aid,” school nurse programs, the use of mental health assessment tools, and voluntary mental health screenings.

#### J. **Resource Matching and Public Education**

- Currently the behavioral health resource network in Albuquerque is not robust and there is a tremendous need to augment these scarce resources. Unfortunately, the public is largely unaware of these resources. Moreover, behavioral health providers in the community may be unaware of other similar resources or other supportive services in the community as well.
- The existing program needs support for promotion/publicity, maintaining up to date and comprehensive resources for both mental health and Substance Use Disorder resources (including location, information on services offered, criteria for programs, cost/insurance, demographic served; also need to include Opioid Treatment Programs as a resource that is tracked and provided to callers).



- **The task force recommends that the state, county/city expand and strengthen existing mental health crisis line. (ABQ's 311 line focused on behavioral health with an updated clearinghouse for resources and assistance).**