

House Joint Memorial 17 Task Force Recommendations

November 2011

House Joint Memorial 17 Task Force Recommendations

Table of Contents

Introduction	1
Guiding Principles	2
System Recommendations	3
Recommendations	4
1. System Improvements	5
2. Regional Crisis Triage Centers	6
3. Respite Services	8
4. Training	9
5. Call Centers	11
6. Warm Lines	12
7. Community Crisis System Planning	13
8. Peer Services	14
9. Criminal Laws	15
Next Steps	17
Task Force Members and Participants	18
House Joint Memorial 17	22

House Joint Memorial 17

The challenge for this task force is to develop humane and effective strategies to reduce the number of people with mental health disorders who require law enforcement intervention or who are in detention facilities.

Representative
Rick Miera

Introduction

One of the greatest challenges facing law enforcement agencies and detention centers in New Mexico and across the nation is how to respond to people who have mental health disorders. House Joint Memorial 17 addresses this challenge and charges the Interagency New Mexico Behavioral Health Purchasing Collaborative with convening stakeholders to develop humane and effective strategies to serve people with mental health disorders in order to reduce the number of people with mental health disorders who are in detention or require law enforcement intervention.

Representative Rick Miera sponsored HJM 17 in 2011. Senators Papen and Beffort sponsored similar memorials in 2009 and 2010. Their collective support and commitment to finding answers shines a light on this critical issue and sets the stage for solutions.

The task force members and participants (listed on page 17) represent a broad range of disciplines and perspectives, as well as urban, rural, and frontier communities. The full task force met five times during the summer of 2011 to review current services and to vet critical components of a statewide crisis system. Their thoughtful effort and generous commitment to discussing and working through these difficult issues was humbling to us. The task force reached consensus on the five Guiding Principles and nine Recommendations contained in this report.

We are especially grateful to the task force steering committee members who met faithfully every Friday afternoon from May through October (350 labor hours) to guide the process and develop this report. In addition to planning the task force meetings and synthesizing the task force recommendations, the steering committee reviewed and incorporated the many written comments received from the Local Collaboratives, stakeholders, advocates, clients, and community members who were not always able to attend the full task force meetings. The complete record of the HJM 17 task force activities including minutes, research, presentations, and written submissions is at:

<https://sites.google.com/a/nmcounties.org/hjm17/home>

These recommendations set forth a road map to reduce the number of people with mental health disorders who are in detention or require law enforcement intervention through improving our mental health system. Each recommendation will require further work to implement. It will take commitment and resources.

Grace Philips, Co-Chair
NM Association of Counties

Daphne Rood-Hopkins, Co-Chair
NM Human Services Department

Jails were made to house the people you are afraid of, but now you want us to house the people you are mad at, the neighbor that frustrates you, the drug addict who won't get well, and the mentally ill.

Ramon Rustin, Chief
Bernalillo County
Metropolitan Detention
Center

On a given day approximately 31% of the inmates at MDC are on the mental health case load. 728 of these are taking psychotropic medications and 129 are acutely mentally ill.

Matt Elwell
Operations Administrator
Metropolitan Detention
Center

Guiding Principles

Peer led and peer driven services are critical to any effective and humane statewide mental health system.

Services should employ the least restrictive environment and maximize client¹ choice.

A crisis system must serve both individuals with mental illness who have insight into their condition and those who do not.

Mental health services must be trauma informed, gender specific, age appropriate, culturally sensitive, language appropriate, and accessible to anyone regardless of literacy level.

These recommendations are for services that would be available to all persons with serious mental illness, their families, and their natural supports regardless of age, socio-economic, or insured status.

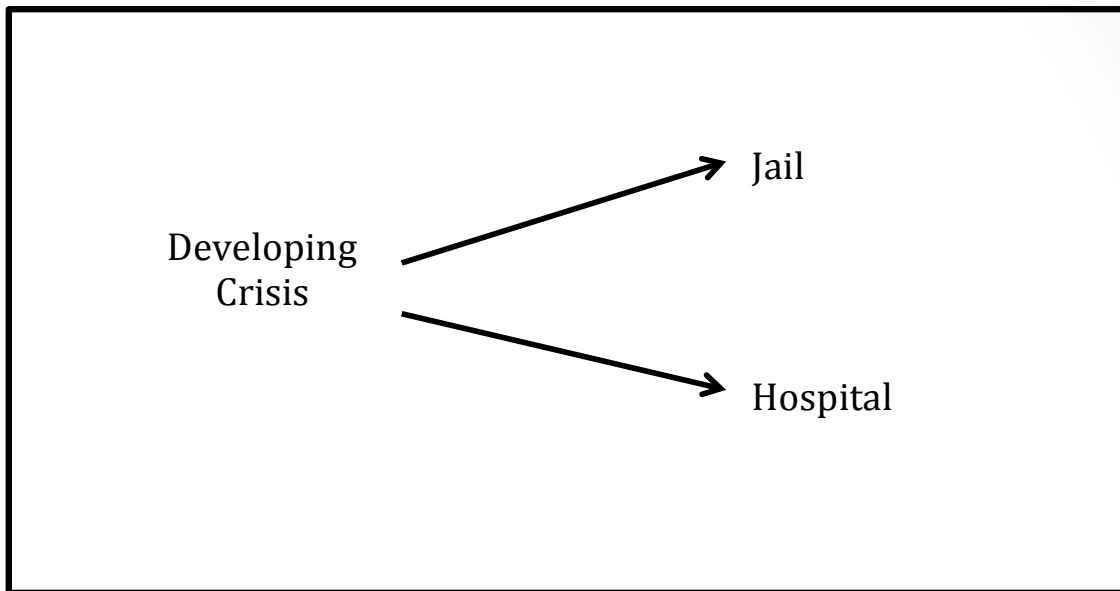
Two-thirds of boys and three-quarters of girls in the juvenile system meet the diagnostic criteria for mental illness and/or substance use disorders. The majority are victims or witnesses to traumatic events and respond to threats self-protectively, sometimes with violence.

Jeffrey Tinstman
Senior Behavioral Health Administrator
NM Children, Youth, & Families Department

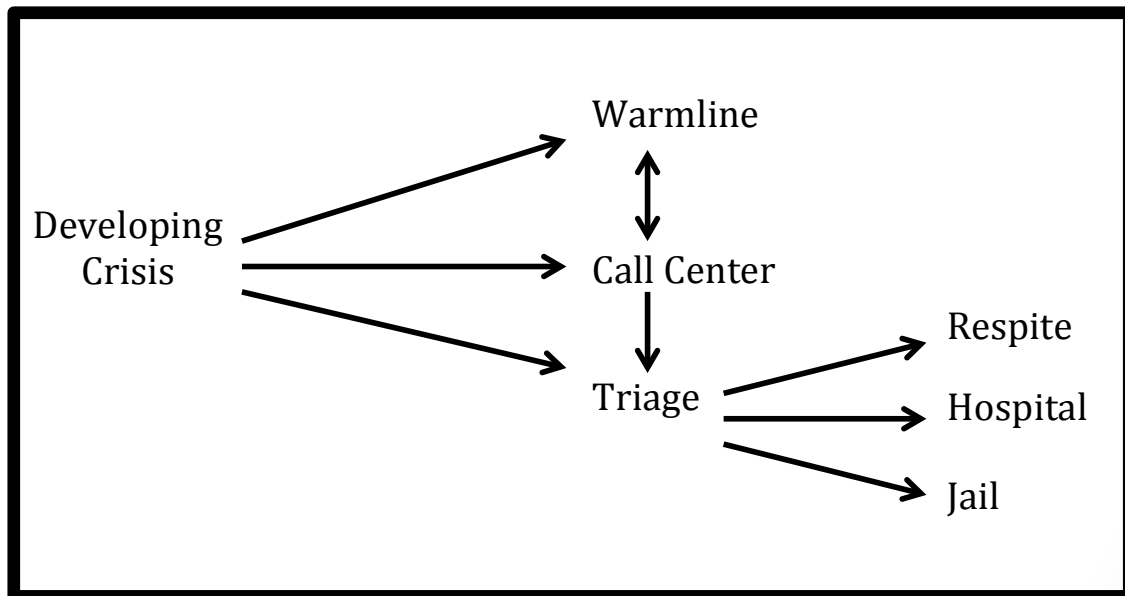
¹ In order to accord respect and dignity to individuals living with a diagnosable mental illness, the HJM Task Force has elected to refer to these individuals as “clients” for the purpose of this document.

System Recommendations

Now



Goal



The system is not broken. It is underfunded and under prioritized.

Recommendations	Page
System Improvements Develop flexible funding streams and payment mechanisms to compensate providers for the critical services described in these recommendations.	5
Regional Crisis Triage Centers Fund regional crisis triage sites to conduct mental health evaluations and provide up to 23 hours of diversion.	6
Respite Services Develop and fund respite care locations throughout the state to serve as a non-clinical alternative to reduce need for hospitalization or incarceration.	8
Training Establish peer training programs and training for family members, natural supports, teachers, students, and first responders.	9
Call Centers Establish a centralized, statewide call center with a single telephone number that is connected to local authorities and behavioral health agencies throughout the state.	11
Warm Lines Expand warm line services statewide that are client-run or client-staffed to provide telephone-based peer support.	12
Community Crisis System Planning Develop broad community coalitions in all communities or counties of the state to enhance and integrate local capacity to respond to mental health crises.	12
Peer Services Use peer services whenever possible to provide and enhance services.	14
Criminal Laws Review criminal statutes to determine whether there are sensible changes that can be made which would reduce costly and often unnecessary, lengthy, and ineffective incarceration of individuals with mental illness.	15

Recommendations

1. System Improvements

Problem

Community mental health centers, Core Service Agencies, and other entities that provide behavioral health safety net services throughout the state cannot bill for providing outreach treatment services in a range of settings throughout the community. Payment mechanisms thus create a disincentive for providers to offer the needed services to address and prevent mental health crisis.

Recommendation

Develop flexible funding streams and payment mechanisms to compensate providers for crisis outreach and other services described in these recommendations. With these changes in funding, contractual requirements can be implemented that increase the accountability for these agencies to provide outreach, engagement and assertive crisis intervention, including provision of assessment, evaluation and care coordination in a variety of settings in the community.

People end up in corrections because of inadequate community services. Funding mechanisms have never aligned to provide community care.

Rodney McNease, Director
UNM Behavioral Health

Discussion

Many of the initiatives recommended by this task force are not funded by the current system even though paying providers for services such as outreach and engagement could ultimately save the system substantial money.

Currently providers cannot easily bill for time spent seeking out and engaging clients who are not actively involved in services. Clients who are mentally ill and who deny their illness need services brought to them. There should be a way for providers to be reimbursed for these proactive services.

Nils Rosenbaum
Crisis Intervention Team Psychiatrist
Albuquerque Police Department

Currently there are inadequate mechanisms for agencies to be reimbursed for staff time to travel to and see individuals outside of the clinic environment. Changing fee structure from the current fee-for-service within a clinic model would enhance the ability of community agencies to provide needed services, especially to those people who are not enrolled and not likely to seek care on their own. Compensating providers for outreach and treatment services that are provided in non-traditional settings would permit them to address the needs of a broader spectrum of the population of people with diagnosable mental illnesses who have difficulty accessing treatment, including homebound elderly, adults with disabilities, and homeless children and youth.

An important aspect of this recommendation is the development of a comprehensive crisis system that can serve all people, regardless of insurance coverage or ability to pay. With flexible funding streams more crisis service and crisis intervention can occur, reducing the escalation of mental health crisis into more serious and costly situations. State regulations and service definitions need to be reviewed to remove regulatory requirements that impede the flexibility to provide critical services in a cost effective manner.

The current fee-for-service structure does not fit the types of services we need for persons not already engaged with the existing treatment system. Fee-for-service has also been identified nationally as a significant cause of the high cost of health care in the United States. The New Mexico Behavioral Health Purchasing Collaborative is currently studying alternative mechanisms for future health care delivery such as case rates and performance contracting. The Medical Assistance Division (MAD) is exploring waivers that could serve as part of the solution. This recommendation is therefore consistent with ongoing efforts around the country related to future healthcare delivery.

2. Regional Crisis Triage Centers

Problem

Currently law enforcement officers in most areas of the state will take a person who is experiencing an acute mental health crisis to a detention facility because there is no alternative. Hospitals will not hold someone unless they are an imminent threat to themselves or others. In the absence of a safe place in the community for an individual in crisis to be evaluated and stabilized, jails and juvenile detention centers are used for protective custody. This further traumatizes the individual and is not the purpose of incarceration.

Recommendation

Develop and fund regional crisis triage sites where individuals can stay for up to 23 hours to receive immediate stabilization, mental health evaluations, and observation. Law enforcement officers and first responders could take appropriately screened individuals to these sites for assessment and disposition. Individual walk-ins and family referrals would also be accepted.

People are taken to jail because it is easier and quicker than taking them to the hospital. Jail is especially hard on the elderly.

Bette B. Betts, Behavioral Health Director
Aging and Long-Term Services Department

Discussion

State law authorizes law enforcement officers to detain and transport a person for emergency mental health evaluation under a number of circumstances, which include: 1) the person is otherwise subject to lawful arrest; 2) the officer has reasonable grounds to believe the person has just attempted suicide; or 3) the officer believes (or a licensed physician or certified psychologist has certified) that due to their mental illness, the person is likely to harm themselves or others and detention is necessary to prevent the harm.

(NMSA 1978 § 43-1-10). Jails may be used for protective custody under this statute for up to 24 hours, however, the preference is for the person to be taken *“immediately to an evaluation facility...whenever possible...”* *Id.* Funding this recommendation would result in regional crisis triage centers that could receive individuals in need of emergency mental health evaluation and care. The centers could also serve as voluntary evaluation and care sites for individual walk-ins and family referrals. Homicidal or suicidal behavior would not be a requirement for an individual to be taken to a crisis triage center.

Crisis triage centers are not hospitals, but are staffed with licensed clinicians capable of performing mental health evaluations. Trained peers and/or certified peer specialists or mental health promotoras who are supervised by licensed mental health professionals also play an important role in crisis triage by serving as supports and advocates for clients who are at the crisis triage center.

Crisis triage centers would serve to reduce the dependence upon both detention facilities and hospital emergency rooms by providing appropriate and specialized care for people with mental illness and their caregivers in a trauma informed setting. These centers would then do the equally important work of connecting clients to follow-up services in their community.

Sustaining crisis triage sites in smaller and more rural communities might not be feasible; however, regional anchor sites could provide access to such services where no services currently exist. Use of telehealth to support these centers where local clinicians are not available would also make providing such services in rural, Colonias and frontier areas more feasible. In addition, even though they would serve to divert individuals from detention facilities and emergency rooms, triage centers could be located within a hospital or in proximity to a detention facility, so long as the facilities complies with Medicaid funding eligibility requirements.

Veterans with diagnosable behavioral health disorders frequently end up in jail. Their support system suffers the most. There is often domestic violence and family members start drinking themselves. Veterans have been trained not to show weakness, so they don't self identify. They tend to isolate themselves until it is too late.

Alan Martinez, Deputy Secretary
NM Department of Veterans Services

It is important for regional crisis triage centers to be connected with local respite services. (See Recommendation 3). Triage centers would be for an acute crisis and intensive evaluation, while respite would provide soft treatment for clients to transition out of crisis or minimize the severity and escalation of a crisis in a safe, supportive environment. Crisis triage centers would thus serve as one gateway into respite by identifying individuals who can benefit from respite services.

Criteria, screening, training and other components need to be developed to establish appropriate legal and clinical authority for the crisis triage centers. The New Mexico Behavioral Health Purchasing Collaborative is the appropriate authority to develop clinical

and operational standards for triage centers. Practical questions such as how an individual would get home from a regional center also need to be addressed. However, the existing Doña Ana County crisis triage plan is an excellent model upon which to build other regional sites and the HJM 17 task force recommends that the legislature fund the Doña Ana County's proposal.

3. Respite Services

Problem

The absence of sub-acute care to de-escalate potential crisis situations increases the frequency and number of mental health crises in our communities. Hospitals and jails are not appropriate for this lower level of care, but are often the place where individuals are taken by local authorities when they experience a severe crisis.

Recommendation

Develop and fund respite care locations throughout the state to serve as non-clinical alternatives that can reduce the need for hospitalization or incarceration.

Discussion

Respite services are non-clinical options for persons who need a safe place and perhaps short-term, "lower level" care or support to reduce the stressors and risk factors that might otherwise lead to a severe crisis. Respite services often utilize peers and natural supports to staff a safe place for someone to take respite and avoid crisis. Respite can be located in private residences, group home settings, and available community facilities. Successful respite programs have used creative and low-cost ways to provide respite, with a range of service tiers.²

People living with mental illness often end up in jails or emergency rooms because there is no place for them to obtain care **before** they are in crisis. This is especially true on weekends and evenings. Once they are admitted or detained, the setting is not always ideal. Clients report that institutional spaces (such as jails and hospitals) present a stressful environment that creates a barrier to healing. Stress increases the likelihood of crisis and can escalate and elongate the crisis period.

Poverty, hunger, isolation is what comes with a serious mental health diagnosis. No hopes, dreams, aspirations to stir you up, just pills and pills and more pills - that just isn't the stuff to inspire you to get out of bed! People dealing with mental illness and/or experiencing homelessness get good at hiding. We hide from the police even when we've done nothing wrong because we are scared of them.

Michael Hubert
Office of Consumer Affairs Consultant

An essential characteristic of respite is that it provides a trauma informed environment. It is

² Strong models for respite care programs include: Wild Acre Inns in Arlington, Massachusetts; statewide programs in New York; Peer Support and Wellness Center, a project of the Georgia Mental Health Consumer Network; and others can be found at <http://www.power2u.org/peer-run-crisis-services.html>.

also a voluntary setting where participants can come and go. Unlike inpatient hospitalization, which often disrupts ongoing treatment relationships, respite can provide a supportive environment for someone while they continue their community based treatment and maintain their employment and other day-to-day responsibilities.

Many of these recommendations are interrelated and the link between respite care and crisis triage is especially important. Respite can serve as sub-acute care or a step down service for someone leaving crisis triage or even residential treatment. Respite provides a safe and supportive environment for clients to transition out of crisis or minimize the severity and escalation of a crisis while triage centers (See Recommendation 2) address acute crisis and provide intensive evaluation.

Because respite care does not require licensed clinicians, it can be both effective and economical. Respite care already exists in some locales for the juvenile populations. Respite is in fact the most requested service by families nationwide and it can be effectively used in a broad range of situations to help clients, families, and natural supports.

The task force recommends developing and funding respite care locations throughout the state but the location of specific respite centers should be locally determined. Each community should assess their need and capacity for this type of care. Supervision of respite programs would need to be determined and could fall under existing Core Service Agency infrastructure if funding for this additional responsibility is provided. The New Mexico Behavioral Health Purchasing Collaborative is the appropriate authority to establish clinical and operational standards for this service. Initially funding selected anchor sites in rural and urban areas would provide an opportunity to evaluate the challenges and benefits of respite programs and to inform and refine the development of protocols.

4. Training

Problem

There is a widespread lack of knowledge about mental illness and the skills needed to respond to, and deescalate, a mental health crisis. In the absence of such information, those with mental illness tend to be feared and stigmatized. This leads to an over-reliance on law enforcement intervention responses.

Recommendation

Establish peer training programs and training for family members, natural supports, teachers, students, and first responders.

Ignorance leads to fear and when people are afraid they call the police.

Christine Wendel
Behavioral Health Planning Council

Discussion

Most people are poorly equipped to respond to individuals experiencing mental health crisis. In the absence of adequate skills to handle these situations, law enforcement is often called. Education and training can help any affected person to identify and enhance responses to mental health crisis situations. Yet education and training in mental health issues, including crisis response, has traditionally focused on law enforcement.

Not all mental health workers are equipped to respond to crisis.

Troy Fernandez, Senior Director
Behavioral Health Services
Division OptumHealth

Opportunities for mental health and crisis education should be expanded to include the general population, including schools, community organizations, family members, peer supports and others whose lives are potentially touched by an issue or experience of mental illness. Education and training of natural supports and others is of

particular value to New Mexico's rural and frontier communities, whose isolation leads to fewer mental health resources and trained personnel. Education and training should also be broadly inclusive of first responders, such as Emergency Medical Service technicians, emergency dispatch, fire department personnel, Tribal authorities, and others involved in first responder roles, as well as persons staffing social service agencies, respite centers, and detention facilities, and those assigned to be treatment guardians. Training of behavioral health and primary care (i.e., medical) providers in the recognition and assessment of mental illness in the older adult population who frequently present with multiple and complex mental and medical health problems is also a special need.

Family members, friends, mental health peers, and others are natural supports to people in the throes of a mental health crisis. Many people in communities throughout New Mexico serve in an informal capacity as critical supports to those in crisis, constituting a largely untapped resource to any crisis response system in the state. Trauma informed education and training in de-escalation techniques will increase the ability of people in a natural support role to adequately identify and address mental health crisis situations.

Schools are also a natural and untapped venue to bring needed information and training about mental illness, including mental hygiene. Programs on mental illness and mental hygiene can be integrated into the curricula of schools throughout the state, and should be included in the health education course required for high school graduation. Educational programs geared towards younger audiences should also be provided in grade schools throughout New Mexico.

Families are also victims of this disease and should not get lost in the discussion. Families represent those consumers who lack insight into their illness.

James W. Ogle
National Alliance on Mental Illness
Co-Chair Legislative Committee

Education of the public is a powerful way to dispel the myths and stigma surrounding mental illness, and the fear, sense of helplessness and shame that too often accompanies it. It can also provide important tools for clients who want to engage in advance planning and caregivers who want to work more effectively with their clients. Through education and training, urban and rural communities in New Mexico will be better equipped to address the needs of people experiencing a mental health crisis and to enhance the overall coordination of the network of services available to those in need.

It is also important to develop training programs to help individuals who work with people who lack insight into their illness and who therefore do not seek out help. This requires

training in an intervention methodology. Those who encounter these individuals in their work can be trained in strategies that show promise in helping individuals to seek treatment. Training on best practice or promising strategies that have been studied and shown to be effective, such as those advocated by clinical psychologist, Xavier Amador, through his L.E.A.P.³ institute (<http://www.leapinstitute.org>), could provide natural supports with effective tools for working with these individuals.

It is also critical for clients and their natural supports to be given clear and accurate information and training regarding advanced directives and voluntary treatment guardians so that these tools can be in place when needed.

5. Call Centers

Problem

There is no centralized statewide system for coordinated communication regarding mental health services in New Mexico. With limited avenues to access services, clients and their families often do not know what is available. They may also not know what local options exist to respond to a mental health situation and may be confused about what number to call in a crisis. Confusion and lack of resources can escalate a crisis situation.

Recommendation

Establish a centralized, statewide call center with a single telephone number that is connected to local authorities and behavioral health agencies throughout the state, permitting immediate dispatch of appropriate, existing resources within each local community.

Discussion

A call center or crisis line often serves as the first point of contact for individuals in need of services or information. The function of a statewide call center would be to both respond and refer. Successful models have 24/7 staffing, adequate training for frontline staff and supervisors, links to 911 and EMS, referral services to licensed or senior counselors (who are on-call or have mobile capacity) and to warm lines for non-crisis situations (See Recommendation 6).

We need to develop a road map to guide people on what to do if they or someone they care about needs behavioral health services.

Traci Neff, Administrator
Juvenile Services
San Juan County

Many Core Service Agencies around the state already have operating crisis lines that are accessed through local numbers but their hours of operation vary and each uses its own distinct phone number. A statewide number would enhance existing services by providing an additional means of access. It could be called 24/7 from any location in the state to reach a clinician who can address immediate behavioral health needs and/or route calls to local

³ L.E.A.P. stands for Listen, Empathize, Agree, Partner and describes a strategy for working with people who do not have insight into their mental illness.

behavioral health services. The statewide hotline would provide service where none currently exists while allowing communities with existing services to maintain their local numbers.

Although the details regarding such a statewide service will need to be developed by a dedicated work group, the task force recommends that responsibility for oversight of the call center be housed within a public agency that develops protocols, training requirements, and supervisory models to support call center staff, and that oversees call center operations and monitors response standards and quality protocols. It is critical that the call center have access to current and comprehensive information about local behavioral health services. Because the call center would focus on behavioral health, services would not be limited to responding to incoming calls but would also include making or arranging for follow-up calls for people who have had contact with either crisis or warm line services.

6. Warm Lines

Problem

Although warm lines have been proven effective at mitigating and even resolving crisis, warm lines are only available in limited areas of the state.

Recommendation

Expand warm line services statewide to reduce the likelihood of crises, help individuals to access appropriate resources, and support ongoing and long-term recovery.

Discussion

Warm lines are peer-run or peer-staffed. They provide confidential, telephone-based peer support and resource referral services. The goal of crisis and warm line service is to prevent crisis and use currently available resources effectively. A statewide warm line would use peers for response and support and could include a statewide network of peers to respond to calls through a centralized number (see Call Center Recommendation 5).

*We fail when we are alone,
isolated and scared. Sometimes
we just need someone to call.
More peer services will leave
fewer people for law enforcement
to deal with.*

Douglas Fraser, Consultant

Local Collaboratives that have warm lines in their communities report that they are highly effective, but they are not widely or consistently available throughout the state. This is the case even though they are an economical and effective resource to prevent crisis and improve client quality of life. Investing in training for peer counselors (see Training Recommendation 4) and coordinating warm line access through a statewide call center (see Call Center Recommendation 5) would be a cost effective strategy for providing this critical service to people living with mental illness across the state.

7. Community Crisis System Planning

Problem

Most New Mexico communities do not have an organized coalition of key stakeholders who interact with people who have mental illness. The result is a disjointed system that wastes resources and fails to adequately address the needs of clients and their families.

The larger the community, the deeper the isolation. Smaller communities know one another and tend to take care of each other.

Bobbie Lightle
Behavioral Health Services Division

Recommendation

Develop broad community coalitions in communities throughout the state to enhance and integrate local capacity to prevent and respond to mental health crises.

Discussion

The key stakeholders in a comprehensive mental health system include clients, their families and other natural supports, law enforcement, courts, criminal defense attorneys, district attorneys, detention facilities, local hospitals, medical and behavioral health services providers, state, county, municipal, and tribal governments, schools, Local Collaboratives, providers of services to the elder population and adults with disabilities, including Adult Protective Services, Child Protective Services, Juvenile Justice Services, shelter providers and

With limited resources in rural areas, any services need to be affordable and realistic and they need to be funded appropriately. For example, mobile crisis services is much more feasible in urban areas than in rural or frontier areas where it would be very difficult to sustain.

Chris Tokarski
Mental Health Resources, Inc.

advocates. However communication among all of these stakeholders is often limited or even nonexistent. Communities are in a strong position to identify the needs of a locally based mental health crisis system and to develop effective cost-efficient solutions, but all stakeholders need to have input and accountability. By approaching the development and delivery of mental health care services as a community, it is possible to coordinate resources, enhance existing services, and develop innovative locally-based responses to community mental health crisis needs.

Communities are often unable to deliver adequate, informed mental health crisis response services to those in need. In the face of inadequate or nonexistent mental health crisis services, the public turns to law enforcement to respond to these high-risk, high-stress situations. Public resources for mental health crisis services are particularly stressed in New Mexico's rural and frontier

Partnership and collaboration is very important. We need to come together to work together.

Carolyn Morris, PhD
Native American Affairs, OptumHealth

communities. Despite the fiscal and personnel constraints faced by many communities, communities are best positioned to develop broad community-based coalitions to enhance and integrate local capacity to respond to those experiencing a mental health crisis. Smaller communities are often most effective at providing sensible care because they know who people are and take care of them. Regardless of the size of a community, direct communication among stakeholders can generate practical solutions and make possible a coordinated response to those individuals with serious mental illness who require the most intensive support.

Communities are an integral part of people's lives. For people experiencing a mental health crisis, receiving services in their communities can offer a critical sense of continuity in a situation of high uncertainty – a much needed connection to people and to place. Communities by their very nature thus serve as a critical natural support for a person in crisis and his or her journey towards healing.

Local stakeholders are best situated to identify and marshal supports and linkages among service providers because they can identify their community's unique strengths and challenges. Through such powerful linkages a range of community-based, cost-effective responses can be developed, including, but not limited to, establishing warm lines, respite centers, community and peer-based training programs, a crisis hotline, and, if affordable, mobile crisis teams.

Everyone is an important member of the community—even if they have a disability. What is being done to stabilize them in the community?

Rick Vigil
Local Collaborative 18 Chair
Former Tesuque Pueblo Governor

8. Peer Services

Problem

Access to peer support and peer run programs for clients in crisis is minimal or nonexistent in most areas of New Mexico.

Recommendation

Use peer support and client run services whenever possible to provide and enhance provider-oriented services, such as use of certified peer specialists to support individuals in the Emergency Room and use of trained peers for respite and crisis triage. Use client run services such as Community Wellness Resource Centers, drop-in centers and warm lines to provide mutual support one to one or in groups.

What I see lacking in this state is peer-to-peer interaction in the crisis area.

Comment by
Local Collaborative 2

Discussion

Clients report that having access to other individuals who have shared experience helps to prevent, deescalate, and minimize the severity of a crisis. Because these individuals may share common experiences, they can understand one another on a very different level

than a doctor or therapist. This insight is a valuable and even critical resource for an effective comprehensive mental health system. Peer support is especially effective for the elderly population, where isolation contributes to exacerbation of mental and medical health problems.

Peer support is an effective and largely untapped resource that should be used whenever possible to provide and enhance services. Peer support can range from a friend talking with a friend or family talking with a family (where there is no salary, no training and no certification) to Certified Peer Support Worker or Certified Family Specialist (where there is a salary, training and State certification) providing support to individuals in a hospital emergency room. Some client services, such as warm line staffing, would require training but not necessarily certification.

Appropriate settings for peer and client run services include: warm lines, crisis triage centers, hospital ERs, service agencies, respite homes, detention and correctional facilities and traditional healing.

The task force recommends incorporating the full spectrum of peer and family support throughout the mental health system. A system enriched with the full spectrum of peer and family support would include service providers in every setting to provide opportunities for mutual peer support groups (e.g. AA, NA, Double Trouble in Recovery DTR, Dual Recovery Anonymous DRA, Depression and Bi-polar Alliance DBSA, etc.). Such groups would meet onsite but they would not be part of the providers programming. All other peer and family support services, whether volunteer or paid peer/family specialist staff within an organization, must have adequate training and supervision.

9. Criminal Laws

Problem

There are a variety of criminal laws that result in the mandatory arrest of people for behavior that is a result of their mental illness. People living with mental illness who are arrested often spend more time in jail than other arrestees due to challenges to competency, their inability to pay bail, and a concern for a risk of noncompliance with terms of their release.

Recommendation

Review criminal statutes to determine whether there are sensible changes that can be made to the system that would reduce costly and often unnecessary and ineffective incarceration of individuals with mental illness.

It is ridiculous to book a defendant and have them spend 180 days straight in a county jail because they slept in a public park.

Robert Work, Attorney
NM Public Defender's Office

Discussion

Although the task force did not reach consensus on any specific revisions to the criminal code, members agreed that this issue warranted further work. Many of the crimes that are presently on the books disproportionately affect people with mental illness. For example, the statute prohibiting battery on health care workers (NMSA § 30-3-9.2(E)) makes a fourth

degree felony out of a crime that, committed on any other person, is a misdemeanor. This is of special concern with juveniles in treatment facilities whose behavioral health system profile includes acting out aggressively with staff or other residents when they feel psychologically threatened. When law enforcement is called the youth is often charged, removed from the treatment facility and placed in detention for the very behavioral responses that caused him or her to be placed in residential treatment in the first place. Individuals receiving health care services are thus more susceptible to habitual offender proceedings (mandatory Department of Corrections time if the State proves prior offenses), and, if not competent to stand trial, a possible commitment to the New Mexico Behavioral Health Institute (NMBHI) for a costly treatment to competence commitment of up to 9 months. The enhanced penalty for battery on a health care worker may not be necessary. If an attack on a health care worker is severe, statutes already exist to charge an individual with felony battery where appropriate. In some jurisdictions, charges such as commercial burglary (NMSA § 30-16-3), are used when a shoplifter has been instructed not to return to a store (with a no trespass order), and may result in a felony charge if that person returns and steals even an item worth one dollar. That too makes them susceptible to habitual offender proceedings and NMBHI commitment for competence.

Misdemeanor offenses can also disproportionately affect people with mental health disorders. Certain charges, such as misuse of public property pursuant to NMSA § 30-14-4 can result in a sentence of 180 days or up to 364 days for simply sleeping in a public park, or a city bus bench. Similarly, criminal trespass for sleeping in a public area, obstructing movement, panhandling, public nuisance, disorderly conduct, indecent exposure (urinating in public), also disproportionately affect mentally ill individuals.

Blowing smoke on or spitting on a teacher or health care worker is a felony, but if committed against any other person it is a misdemeanor (even a Judge).

Robert Work, Attorney
NM Public Defender's Office

The consequences of such criminal penalties can be counterproductive. When arrested, even if a person has a stable residence at the time of their arrest, their home can be lost due to long incarcerations. Social security benefits are cut off, treatment disrupted, and prolonged detention can cause an escalation of future criminal charges when the client is eventually released. Long periods of incarceration are counterproductive to actually helping people in crisis.

Many people living with mental illness experience multiple incarcerations over short periods of time. Due to this, many do not view jail as a punishment. Mental health courts can mitigate the problem of the revolving door and can function as a way to get clients into services. However, people who are so ill that they are considered legally incompetent cannot get any services since all of the mental health court programs require a degree of cooperation from the clients and the ability to plead to a charge to benefit from the program.

Next Steps

Jail diversion is good social and fiscal policy. It saves taxpayer dollars by reducing our jail population and recidivism rates, while providing mental health consumers with needed care in non-detention settings.

Barri Roberts
Executive Director
Forensic Intervention Consortium
Bernalillo County

- **Charge the New Mexico Behavioral Health Purchasing Collaborative (NMBHPC) to:**
 - establish funding for the recommended system components;
 - adopt flexible funding/payment mechanisms to compensate providers for client outreach and engagement services;
 - draft and adopt clinical and operational standards for triage centers and respite care;
 - work with state and local governments to establish a centralized call center;
 - establish clinical standards and protocols for a centralized call center;
 - establish warm line services that are accessible statewide;
 - establish and fund cost-effective and outcome-driven respite options in urban, rural, frontier and Native communities;
 - request that the Public Education Department develop mental health training modules, which include anti-stigma components for a mandatory health curriculum targeted for elementary, junior and senior high school students and their teachers;
 - provide Mental Health First Aid training around the State to clients, families, natural supports and all first responders.
- **Fund the Doña Ana County crisis triage center and use their model to inform development of other regional centers.**
- **Charge state elected officials to create coalitions in their communities that include representation from the stakeholders identified in Recommendation 7 in order to enhance and integrate local capacity to prevent and respond to mental health crises.**
- **Include “Peer and Family Support” language in any future behavioral health memorials or legislation.**
- **Convene a task force to consider the public defender recommendations for changes in the Criminal and Children’s Code described in Recommendation 9.**

Task Force Members and Participants

HJM 17 Sponsor

Representative Rick Miera
District 11 (Bernalillo)

HJM 17 Steering Committee

Bette B. Betts, Behavioral Health Director
Aging & Long-Term Services Department

Michael Coop, Consultant
Coop Consulting, Inc.

Troy Fernandez, Senior Director
Behavioral Health Services Division
OptumHealth

Michael Hubert
Community Development Specialist
Office of Consumer Affairs Consultant

James W. Ogle
National Alliance on Mental Illness - NM
Co-Chair Legislative Committee

Grace Philips, Attorney
New Mexico Association of Counties

Jennifer Rabinowitz
Loss Prevention Coordinator
New Mexico Association of Counties

Daphne Rood-Hopkins, Clinical Manager
Behavioral Health Services
Human Services Department

Jeffrey Tinstman
Senior Behavioral Health Administrator
Children, Youth & Families Department

Arianna Trott, Consultant
Coop Consulting, Inc.

Christine Wendel, Chair
Behavioral Health Planning Council

Task Force Members and Participants

Anne Albrink, Esq., Consumer
National Alliance on Mental Illness

Suzy Ashcroft
Advocate LC 16

Sam Baca
NM Behavioral Health Collaborative
Local Collaborative Cross Agency Team

Joe Baca, Sheriff
Sierra County Sheriff's Office

Rebecca Ballantine, Tribal Liaison
DWI Prevention Program
Sandoval County

Chuck Benson
Lakota Traditional Counselor LC 16

Randall Berner, Clinical Director
Five Sandoval Indian Pueblos, Inc.

Steven Blue Horse
Lakota Traditional Counselor LC 16

Mark Boschelli, Administrator
Behavioral Health Clinical Services
Presbyterian Medical Services

Lupe Bryan
Five Sandoval Indian Pueblos, Inc.

Jim Burleson, Executive Director
NM Sheriffs and Police Association

Susan B. Cave, PhD
Office of Susan B. Cave

Miguel Chavez, Senior Advocate
Disability Rights New Mexico

Martha Cooke, Advocate
National Alliance on Mental Illness

Jacqueline Cooper, Acting Chief
2nd Judicial District
Office of the Public Defender

Brian Coss, Instructor
LEA Advanced Training Bureau Department
of Public Safety

Jeff Cumbie, Detective
Violent Crimes Unit
Albuquerque Police Department

Corinne Dominguez, Director
Community-Based Services
Behavioral Health Institute

Gordon Eden, Secretary
Department of Public Safety

Matthew Elwell, Operations Administrator
Metropolitan Detention Center
Bernalillo County

Frank Fajardo, Manager
NM Office of Guardianship

Chuck Franco, First Gentleman *
Office of the Governor

Michele Franowsky
2nd Judicial District
Office of the Public Defender

Shannon Freedle, Chief Executive Officer
TeamBuilders

Cynthia Gachupin
Pueblo of Jemez Tribal Court

Alfred Casamento, Director
Sandoval County Detention Center

Teresa Gomez
Presbyterian Medical Services

Ron Gurley, Executive Director
Forensic Intervention Consortium
Doña Ana County

Peg Holguin, District Attorney
2nd Judicial District

Kim Horan, Native American Liaison
Behavioral Health Services
Human Services Department

David Jablonski, Director
Probation and Parole
NM Corrections Department

Troy D. Jones, Executive Director
New Mexico Behavioral Health Institute

Sheila Lewis, Executive Director
NM Women's Justice Project

Bobbie Lightle, Program Manager
Behavioral Health Services
Human Services Department

Lisa Lujan, Director
Adult Psychiatric Division
Behavioral Health Institute

Michael Lucero
A New Day Youth and Family Services

Gregg Marcantel, Deputy Secretary
NM Department of Public Safety

Elizabeth Martin, Senior Director
NM Behavioral Health Collaborative
OptumHealth

Alan Martinez, Deputy Secretary
NM Department of Veterans Services

Linda Mathes-Diabo, Director
A New Day Youth and Family Services

Margaret McCowen, Director
Governmental Relations
Mesilla Valley Hospital

Rodney McNease, Director
Behavioral Services
University of New Mexico

Karen Meador, Senior Policy Director
Behavioral Health Services
Human Services Department

Carolyn Morris, PhD, Director
Native American Affairs, OptumHealth

Traci Neff, Juvenile Service Administrator
Juvenile Detention Center
San Juan County

Tomi Pino
Five Sandoval Indian Pueblos, Inc.

Jeanne Quintero
3rd Judicial District
Office of the District Attorney

Barri Roberts, Executive Director
Forensic Intervention Consortium Bernalillo
County

Linda Roebuck, Director
NM Behavioral Health Collaborative

Nils Rosenbaum, MD
Crisis Intervention Team, Psychiatrist
Albuquerque Police Department

Ramon Rustin, Chief
Metropolitan Detention Center

Gabrielle Sanchez-Sandoval
Chief General Counsel
New Mexico Department of Health

Shereen Shantz
Consumer Affairs
Human Services Department

Silvia Sierra, Director
Doña Ana County Health & Human
Services Department

Patrick Simpson, Deputy Director
Administrative Office of the Courts

Susan Sisneros, Probation & Parole
Children, Youth & Families Department

Alfonso Solis, Chief of Police
Roswell Police Department &
Acting Secretary of Corrections

Judge Mary L. Marlowe Sommer
First Judicial District Court

Jana A. Spalding
OptumHealth

Christopher S. Tokarski, Executive Director
Mental Health Resources, Inc.

Susie Trujillo
Gila Regional Medical Center

Shirley Villegas, System of Care Trainer
New Mexico Family Network

Marianna Vigil, Acting Program Manager
New Mexico Corrections Department

Robert Work, Attorney
Mental Health Division
Office of the Public Defender

Wanda Yazzie
Evercare, UnitedHealthcare

Local Collaborative 1
(Santa Fe, Rio Arriba, Los Alamos)

Local Collaborative 2
(Bernalillo)

Local Collaborative 3
(Doña Ana)

Local Collaborative 4
(Mora, San Miguel, Guadalupe)

Local Collaborative 5
(Chaves, Eddy, Lea)

Local Collaborative 6
(Grant, Luna, Hidalgo)

Local Collaborative 7
(Catron, Socorro, Sierra, Torrance)

Local Collaborative 8
(Taos, Colfax, Union)

Local Collaborative 9
(Curry, Roosevelt)

Local Collaborative 10
(Harding, Quay, DeBaca)

Local Collaborative 11
(San Juan, McKinley)

Local Collaborative 12
(Lincoln, Otero)

Local Collaborative 13
(Cibola, Valencia)

Local Collaborative 14
(Mescalero & Jicarilla Apache Nations,
Acoma, Laguna, Isleta & Zuni Pueblos,
To'hajiilee, Alamo & Ramah Chapters of
Navajo)

Local Collaborative 15
(Navajo Nation)

Local Collaborative 16
(Sandoval Pueblos)

Local Collaborative 17
(Off Reservation)

Local Collaborative 18
(Northern Pueblos)

* designates *Ex Officio* member.

House Joint Memorial 17

Sponsored by Representative Rick Miera

Requesting the interagency Behavioral Health Purchasing Collaborative and its member departments to study the needs of and available resources for people with mental health disorders in crisis situations and to develop strategies to improve services, treatment and care outside of law enforcement and detention in order to reduce the number of people with mental health disorders who are in detention facilities or require law enforcement intervention.

- Whereas, one of the greatest challenges facing law enforcement agencies and detention centers is how to respond to people who have mental health disorders; and
- Whereas, law enforcement agencies are the first-line responders to people with mental health disorders who are not receiving necessary treatment and care; and
- Whereas, current statute permits people with mental health disorders to be taken to detention facilities for protective custody regardless of whether they have committed criminal acts warranting arrest; and
- Whereas, many people with mental health disorders are held in detention facilities for misdemeanor charges due to a lack of available treatment or community support; and
- Whereas, the burden for addressing mental health issues in New Mexico communities has been left to counties where detention centers have become de facto mental health facilities; and
- Whereas, few detention centers are equipped to deal with this population; and
- Whereas, individuals with mental health disorders can be traumatized by incarceration; and
- Whereas, the current situation exposes the state and local governments to substantial liability; and
- Whereas, individual agencies cannot provide the solution to this problem because it is a systemic problem that required collaboration and development of strategies among federal, state, county, and municipal governments as well as health care providers and advocacy organizations;

Now, therefore, be it resolved by the legislature of the State of New Mexico that the interagency Behavioral Health Purchasing Collaborative, through the behavioral health planning council, be requested to convene stakeholders to develop humane and effective strategies to serve people with mental health disorders in order to reduce the number of people with mental health disorders that require law enforcement intervention and to reduce the number of people with mental health disorders in detention centers; and

Be it further resolved that stakeholders include but not be limited to representatives from the New Mexico association of counties; the New Mexico municipal league; the department of health; the human services department; the training and recruiting division of the department of public safety; the aging and long-term services department; the corrections department; the administrative office of the district attorneys; the administrative office of the courts; the public defender's office; the sheriffs and police chiefs association; the New Mexico behavioral health institute at Las Vegas; the New Mexico hospital association; disability rights New Mexico; and two individuals living with serious mental illness identified by the interagency Behavioral Health Purchasing Collaborative; and

Be it further resolved that the interagency Behavioral Health Purchasing Collaborative be requested to report its findings to the appropriate interim legislative committee by December 1, 2011; and

Be it further resolved that copies of this memorial be transmitted to the directors of the New Mexico association of counties, the New Mexico municipal league, the New Mexico behavioral health institute at Las Vegas, the New Mexico hospital association, disability rights New Mexico and the national alliance on mental health, New Mexico; the chief executive officer of the interagency Behavioral Health Purchasing Collaborative and the secretaries of health, human services, public safety, aging and long-term services and corrections.