Community Dialogues on Mental Health – Greater Albuquerque Region

ACTION TEAM #6
REPORT OVERVIEW

DATE: March 18, 2015

Team Lead: Dr. Paul Hopkins
Team Members: Betty Ann Whiton, Sarah Lee, Michael Robertson, Tom Gagliano, Rosella Gonzales, Virginia Chavez, Lisa Trujillo, Ursula Christopherson, Bella White, Wayne Miller, Yolanda Montoya-Cordova, Kristin Ackerson, Sherry Pabich, Ann Taylor-Trujillo, Jay Crowe

Recommended Action #6	Examine and prioritize recommended long-term actions (#16-22)**.**
PROJECT SCOPE	From November 2014 through March 2015, the team gathered information about each of the seven long-term recommended actions and reviewed implementation implications to determine priorities. Data was obtained by hearing from subject matter experts and conducting research as warranted. Included in this report are 1-page summaries for each action, including: recommended solutions, other considerations, implementation timelines, and costs, when known. The team's report also includes a narrative report on all information gathered. Following is our team's recommended priority for the implementation of the seven long-term actions.
RECOMMENDED PRIORITY OF LONG-TERM ACTIONS	1. Support efforts to create a City- or County- or City/County-run triage center for intermediary stabilization where first responders and others (CETs) can voluntarily bring persons with serious mental illness experiencing disability-triggered stress or crisis rather than inappropriately taking them to jail or the emergency room. Provide linkages to services and community supports to individuals at the triage center. (#18) 2. Consider developing and supporting Community Engagement Teams (CET), a peer- support, early intervention to link persons with serious mental illness (experiencing disability-triggered stress or crisis) to voluntary treatment and other services as an alternative to calling law enforcement and as a supplement to other intervention efforts. CET members would include: (1) Qualified and licensed mental health professional; (2) Case managers, community support workers or core service workers; (3) At least one peer (adult or youth) who lives with mental illness. (#17) 3. Work to assure coordination of care for all individuals transitioning from MDC, MATS, Turquoise Lodge, UNM and other detention and treatment facilities such that, at release/discharge, they receive: (1) a copy of their health records; (2) one month worth of prescriptions, if any; (3) referral to a medical home (could be a behavioral health provider); and (4) an assigned care coordinator (for more complex individuals). For those exiting detention centers or on parole, consider making it a condition of parole that they see their medical home provider within one month of release. (#20) 4. Support all efforts to increase the number of behavioral (and physical) health providers working in Albuquerque and the State to increase services and decrease wait times for diagnosis and medication refills. Support efforts to increase Health Service Corp slots, WICHE scholarships, and loan forgiveness and debt repayment programs. (#22) 5. Work with the State of New Mexico to develop aftercare planning and transitional services for 18 to 25 year olds exiting CYFD custody (i.e. foster care, detention). (#19) 6. Work with APS to support efforts to increase the number of school-based health centers and increase the availability of mental health services provided through school-based health centers (including during non-school hours). Evaluate current APS mental health service outsourcing processes and outcomes for potential enhancements. (#21) 7. Consider using SunVan to provide transportation to and from mental health service providers. (#16)

Community Dialogues on Mental Health – Greater Albuquerque Region

ACTION TEAM #6
RECOMMENDED ACTION #18 REPORT DATE: March 18, 2015

Team Lead: Dr. Paul Hopkins
Team Members: Betty Ann Whiton, Sarah Lee, Michael Robertson, Tom Gagliano, Rosella Gonzales, Virginia Chavez, Lisa Trujillo, Ursula Christopherson, Bella White, Wayne Miller, Yolanda Montoya-Cordova, Kristin Ackerson, Sherry Pabich, Ann Taylor-Trujillo, Jay Crowe

Recommended Action #6	Examine and prioritize recommended long-term actions (#16-22). #18: ***Support efforts to create a City- or County- or City/County-run triage center for intermediary stabilization…***
RECOMMENDED SOLUTION	This recommendation action is deemed a high priority. A proposed implementation of an ABQ Triage/Stabilization Center is based on the Tucson "no wrong door" model and includes: ▪ beginning with a clear vision for the future built upon strong and carefully articulated values, including access for all and a cooperative multi-faceted system of care; ▪ a well-crafted business plan for sustainable operation; ▪ an evidenced-based clinical model with an emphasis on recovery and peer involvement; ▪ importance of collaborative planning among public and private stakeholders; and ▪ strengthening the behavioral health infrastructure by increased funding and greater cooperation among the various parts of the system.
STATUS	More than $2 million to fund such a center has been inserted into a first draft of the NM state budget, although 2015 legislative appropriations are unknown at this time. Whatever cooperative funding that can be made available, especially from city and county resources are strongly encouraged. Bernalillo County's new mental health tax could be a significant resource. The City of ABQ should identify municipal resources to include, and should encourage philanthropic and business support.
COSTS	In Tucson, a $50 million bond election provided $18 million for the center and another $30 million for a psychiatric hospital; $20 million is still required for annual operating costs.
IMPLEMENTATION TIMELINE	5-10 years to fully implement
OTHER CONSIDERATIONS	▪ Albuquerque Chamber of Commerce recently organized and led a "best practices" trip to Tucson, AZ, to examine what has been widely recognized as one of the premier such centers in the country. Twenty-two community leaders, including two members of Action Team #6, participated in this trip. ▪ The Tucson center is operated by the regional behavioral health authority, a public/private partnership, through a capitated (as opposed to New Mexico's fee for service) system, and approximately 80% of its annual $20 million operating cost is funded by Medicaid dollars from the state. ▪ This recommendation has been widely affirmed for a number of years, and several recent task forces (e.g., the Bernalillo County Healthcare Task Force; the Joint City/County/State task force on behavioral health; the Greater Albuquerque Chamber of Commerce mental health task force) have identified the importance of such a resource.

Community Dialogues on Mental Health – Greater Albuquerque Region

ACTION TEAM #6
RECOMMENDED ACTION #17 REPORT DATE: March 18, 2015

Team Lead: Dr. Paul Hopkins
Team Members: Betty Ann Whiton, Sarah Lee, Michael Robertson, Tom Gagliano, Rosella Gonzales, Virginia Chavez, Lisa Trujillo, Ursula Christopherson, Bella White, Wayne Miller, Yolanda Montoya-Cordova, Kristin Ackerson, Sherry Pabich, Ann Taylor-Trujillo, Jay Crowe

Recommended Action #6	Examine and prioritize recommended long-term actions (#16-22). #17: *Consider using CET… as an alternative to calling law enforcement and as a supplement to intervention…*
RECOMMENDED SOLUTION	Action Team #6 strongly supports prompt initiation of a pilot Community Engagement Team program in Albuquerque, ideally with support from the NM HSD department and state funding as suggested in the enabling legislation currently being considered in the legislature. Ideally, a CET program would be administratively housed within an existing city and/or county structure or department, and would link effectively with local crisis lines (e.g., Agora; NM Crisis Line), and information and referral services (e.g., United Way; 311). Each team in a CET would include a mental health professional licensed for independent practice, at least one peer who lives with mental illness, and other case mangers and /or community support workers.
STATUS	Legislation to implement a 5-year pilot project, beginning in January, 2016 was introduced this past session but did not pass. Strong interest for CET exists with NAMI and various community leaders.
COSTS	The cost of launching a CET pilot project in Bernalillo County would be $150,000, followed by annual costs of approximately $500,000, to support a six-person team. Public/private/city/state resources.
IMPLEMENTATION TIMELINE	January 2016 – December 2020
OTHER CONSIDERATIONS	▪ Community Engagement Teams are an early intervention through community outreach that links individuals to voluntary treatment or services. In many cases this may reduce involuntary hospitalizations and incarceration. ▪ A principal feature of CET is reducing law enforcement intervention. There is no police involvement in this program; replacing the need to call 911 by calling a dedicated CET phone number. ▪ Benefits of implementing Community Engagement Teams include improving the probability of intervening with a person before his or her first psychotic break and to link such persons with services to allow them to live safely in the community by seeking voluntary treatment. Often this may result in lessening the duration and severity of consequences from severe mental illness.

Community Dialogues on Mental Health – Greater Albuquerque Region

ACTION TEAM #6
RECOMMENDED ACTION #20 REPORT DATE: March 18, 2015

Team Lead: Dr. Paul Hopkins
Team Members: Betty Ann Whiton, Sarah Lee, Michael Robertson, Tom Gagliano, Rosella Gonzales, Virginia Chavez, Lisa Trujillo, Ursula Christopherson, Bella White, Wayne Miller, Yolanda Montoya-Cordova, Kristin Ackerson, Sherry Pabich, Ann Taylor-Trujillo, Jay Crowe

Recommended Action #6	Examine and prioritize recommended long-term actions (#16-22). #20: ***Work to assure coordination of care for all individuals transitioning from MDC, MATS, Turquoise Lodge, UNM and other detention and treatment facilities …***
RECOMMENDED SOLUTION ***Opportunity for the City to lead this transition***	Many gaps and inadequacies in services continue to hamper effective care; therefore, the following priorities are recommended to ensure better transitions from institutional care to the community: ▪ Care coordination services must be further expanded, and there needs to be better coordination of these various services in the broader community to avoid gaps and duplications. MCOs must be held accountable; State resources must be urged. ▪ A triage/stabilization center that engages persons early and provides dependable warm handoffs to a variety of services and treatment providers must be created (see Action #18); ▪ The community is desperately in need of more good and available providers (Action #22); ▪ There is strong need (as stated in #19) for school-based health centers throughout APS, with a behavioral health specialist in each center along with preventive services; ▪ More housing options are still needed for mentally ill persons, including group housing, wet housing, and supportive housing; ▪ Gainful employment opportunities must be expanded for those with mental illness and substance abuse issues.
STATUS	Referenced below in "Other Considerations." Note: The NM Behavioral Health Planning Council may be a resource.
COSTS	Unknown – Our task force is aware of the enormous need and limited resources currently available
IMPLEMENTATION TIMELINE	Costs and timelines are extraordinarily difficult to estimate for meeting these needs. Some costs and timelines may be identified in this report under items (Action #19 and 22)
OTHER CONSIDERATIONS	While there is a long way to go, some improvements are beginning to be implemented in transition services from MDC, MATS, Turquoise Lodge and UNM. Some positive changes now occurring include: ▪ An increase from 1 to 11 care coordinators at MDC to work in discharge planning for inmates; ▪ Implementation of pre-qualification of inmates eligible for Medicaid to expedite their access to services upon release; (**continuous Medicaid enrollment remains a better goal**) ▪ Hiring a social services coordinator at MDC; ▪ Greater cooperation between MATS and MCOs and community agencies through increased discharge planning by care coordinators; ▪ The development of the Fast Track Program at UNMH to work with high needs mental health patients at MDC to assist them through intensive case management in reintegrating into the community; ▪ Increased funding for supportive housing for persons with behavioral health issues, and the development of an RFP for a supportive housing coordinator in the County to further expand housing opportunities; ▪ The effective partnership between UNMH and a variety of community agencies through the Pathways program to provide navigators to assist clients in accessing needed referrals, treatment, and social services.

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ACTION TEAM #6
RECOMMENDED ACTION #22 REPORT DATE: March 18, 2015

Team Lead: Dr. Paul Hopkins
Team Members: Betty Ann Whiton, Sarah Lee, Michael Robertson, Tom Gagliano, Rosella Gonzales, Virginia Chavez, Lisa Trujillo, Ursula Christopherson, Bella White, Wayne Miller, Yolanda Montoya-Cordova, Kristin Ackerson, Sherry Pabich, Ann Taylor-Trujillo, Jay Crowe

Recommended Action #6	Examine and prioritize recommended long-term actions (#16-22). #22: ***Support all efforts to increase the number of behavioral (and physical) health providers working in Albuquerque and the State*** *…*
RECOMMENDED SOLUTION	The Task Force recommends the following actions, some of which are currently underway, to expand the behavioral health workforce: ▪ The City and County should partner with UNM, NMSU, Highlands, and other institutions to help fund and expand programs that provide training and cultural competence for mental health professionals. ▪ City should encourage UNM in its multi-disciplinary approach to training in order to expand the availability and coordination of various kinds of providers in various settings, and to enhance the effectiveness of care coordination in community programs. Support state funding for health care professional training at UNM, NMSU and other state schools, and expand and implement tracking to analyze how many graduates practice in NM. ▪ Encourage the state's behavioral health collaborative to expand efforts to increase the behavioral health workforce in our state, including finding ways of increasing the reimbursement rate for providers.
STATUS	To help identify needs, an inventory of providers in various disciplines is currently underway by UNM.
COSTS	Unknown
IMPLEMENTATION TIMELINE	Unknown
OTHER CONSIDERATIONS	The Task Force supports the following recommendations from 2014 Health Care Workforce Committee Report as they concur with information received from other sources: ▪ Encourage career interest-building programs in NM that recruit students into the health care professions before or during high school and as undergraduates. We especially commend the development of the new Health Professions Charter School being developed in partnership with First Choice Community Health Care. ▪ Support state funding for health care professional training at UNM, NMSU and other state schools, and expand and implement tracking to analyze how many graduates practice in NM. While a 2014 NM Health Care Workforce Committee study indicates that New Mexico has insufficient psychiatrists for our state's population, especially child and adolescent psychiatrists, data indicate there are sufficient numbers of psychiatrists in the greater Albuquerque area. To fill this gap, the Department of Psychiatry at UNM is working closely with various partners to increase and train mental health providers including nurse practitioners, counselors, psychologists, and social workers. Additionally, a recent UNM report on the Landscape of Behavioral Health in Albuquerque recommends increasing the number of providers and programs working in community-based behavioral health, more navigators and more bilingual therapists.

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ACTION TEAM #6
RECOMMENDED ACTION #19 REPORT DATE: March 18, 2015

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Recommended Action #6	Examine and prioritize recommended long-term actions (#16-22). #19: ***Work with APS to support efforts to increase the number of school-based health centers and increase the availability of mental health services provided through school-based health centers…***
RECOMMENDED SOLUTION	Our Team is distressed by the severe lack of dependable mental health services within APS and the significant risk of critical incidents affecting students, teachers and staff that are created by the absence of such resources in the schools. Current school funding formulas apparently provide no resources for mental health services, and this situation needs to be reconsidered by public education leaders at the state and the district level. The absence of such services simply increases the need for our city and county and state leaders to strengthen community services such as those described in this overall report, as well as to demand education leaders increase resources for this vital service to students and staff of schools. **The Team recommends the Mayor's office and APS enlist its lobbyists to pursue changes in the State's education law so that behavioral health services become a mandated component of publicly provided educational services**. Such changes should include expansion of Prevention, Identification and Early Intervention components.
STATUS	Currently funded "counseling" services in the schools are for students' direct educational needs only.
COSTS	Unknown – to be determined by APS based upon best practices and available funding.
IMPLEMENTATION TIMELINE	Unknown – authority/responsibility for this area rests with APS.
OTHER CONSIDERATIONS	APS is home to 90,000 students and is recognized as a source of essential services to Albuquerque residents. It provides prevention and education programs for students and families. APS does now offer early identification of mental health issues, and early interventions and referrals to professional mental health services for identified students and their families, but these need to be increased. Various APS leaders brought to the forefront several overarching issues that the Team believes are critical to addressing APS' needs in this area. 1. APS' internal staffing is such that a multi-faceted approach to addressing the behavioral health needs of its students is, for all practical purposes, limited to outsourcing to community providers. It is recommended that APS pursue a more dynamic model that includes both outsourcing (community-based providers) and internally provided services. APS employed professionals would fill a much needed void in bridging the educational/behavioral health needs of students and in connecting students with community-based providers as needs warrant. 2. Determining the best mix of school internal staffing to community-based providers is beyond the scope of Action Team 6. An exploration of best practice models across the nation is recommended to guide this recommendation further. 3. The existing reimbursement mechanism for school-based health centers is inadequate and serves to disincentive prospective providers. It is recommended that the issue of how to recruit and retain a pool of community providers experienced in working with K-12 students be undertaken. Reimbursement alternatives for 'no show" appointments must be part of the effort.

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ACTION TEAM #6
RECOMMENDED ACTION #21 REPORT DATE: March 18, 2015

Team Lead: Dr. Paul Hopkins
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Recommended Action #6	Examine and prioritize recommended long-term actions (#16-22). #21: ***Work with the State of New Mexico to develop aftercare planning and transitional services for 18 to 25 year olds exiting CYFD custody (i.e. foster care, detention).***
RECOMMENDED SOLUTION	The services needed to prevent youth from engagement with the juvenile justice system or continued engagement through the adult criminal justice system are: (1) early identification; (2) timely intervention; (3) continuity of care with effective wraparound services including quick access to care during crises; and (4) follow-up to age 24, preferably age 26. Current law ends CYFD involvement at age 21. A change in the law is required if CYFD is to continue involvement beyond age 21. Otherwise, an agency or service responsible for the 21 to 26 age group needs to be identified. In either case legislation enabling funding for transitional services for the 21 to 26 age group is required. Central to CYFD's service model are: 1) strong relationships between youth and their respective service coordinator; 2) genuine engagement of the youth and his or her family or natural support system in the process; 3) continuity of care; and 4) successful linking with community supports and resources.
STATUS	Currently, CYFD considers age 21 to be the cut off point for young people in its care.
COSTS	Unknown – to be established when/if legislation is passed.
IMPLEMENTATION TIMELINE	Unknown – to be established in proposed legislation.
OTHER CONSIDERATIONS	▪ CYFD indicates that 70% of the young people they serve have serious behavioral health needs, and an even greater percentage are trauma survivors. ▪ CYFD assists young people from incarceration within 60 days of commitment with a staff coordinator to individually plan and oversee the youth's transition to the community after release. ▪ Current youth transition challenges include: (1) lack of available, affordable housing; (2) lack of employment opportunities; (3) inadequate funding for prevention services (Medicaid does not reimburse for the type or level of needed preventative services); (4) strengthening of the MCO system to achieve availability of value added services across all four MCOs and accountability for timely service delivery. There is also need for a network or service directory as a resource for linking transitioning youth to community resources. ▪ There is strong need for effective coordination between the City and County in developing and managing young people's transition into the community with Life Skills training, housing, and employment training.

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ACTION TEAM #6
RECOMMENDED ACTION #16 REPORT DATE: March 18, 2015

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Recommended Action #6	Examine and prioritize recommended long-term actions (#16-22). #16: *Consider using SunVan to provide transportation to and from mental health service providers*
RECOMMENDED SOLUTION	SunVan considers this task as part of their mission; therefore, this action is currently being met. While these services have been available for many years, the availability of this service is not widely known or understood. The Team supports SunVan's plans to produce educational brochures and encourages wide dissemination. The Team also recommends that brochures/publicity be placed at the Metropolitan Detention Center, UNM's Mental Health Center, Kaseman Hospital, and with NAMI.
STATUS	Recommend printing a minimum of 12,000 brochures to accommodate for the recommended distribution.
COSTS	$10,000 for brochures and other promotions (ads, outreach, etc.)
IMPLEMENTATION TIMELINE	We believe this increased public outreach could be accomplished in the next fiscal year, and should be a consistent budget item in future years.
OTHER CONSIDERATIONS	▪ Residents may apply for permission to use SunVan via the internet, with a personal interview as part of this application process. ▪ Once approved, a rider may pay 35 cents per ride or, if frequent rides are required, may purchase a pass for $12 per month for unlimited rides. ▪ SunVan has 70 vans which provide 1000 trips per day to assist Albuquerque residents in personal transportation needs including trips to and from medical and mental health providers. ▪ Federal regulations do not allow SunVan to "favor" disabilities like behavioral health, but consider mental health impairments one of the many conditions that may allow citizens to use this service.

Narrative background follows:

Creating Community Solutions on Mental Health: Moving forward on Long Term Actions

In July, 2013, under the direction of Albuquerque Mayor Richard J. Barry, residents from throughout the greater Albuquerque area began a series of conversations over a twelve-month period to explore ways of improving access to and broadening the scope of mental health services to our community. Out of these conversations emerged 22 principal recommendations based upon needs identified by participants in these meetings. The following seven "**long-term actions**," have now been examined further by a group of community volunteers:

Long-term Actions: ***Requires much effort, coordination and/or resources to implement.***

16. **Consider using SunVan to provide transportation to and from mental health service providers.**
17. **Consider developing and supporting Community Engagement Teams (CET), a peer- support, early intervention to link persons with serious mental illness (experiencing disability-triggered stress or crisis) to voluntary treatment and other services as an alternative to calling law enforcement and as a supplement to other intervention efforts. CET members would include: (1) Qualified and licensed mental health professional; (2) Case managers, community support workers or core service workers; (3) At least one peer (adult or youth) who lives with mental illness.**
18. **Support efforts to create a City- or County- or City/County-run triage center for intermediary stabilization where first responders and others (CETs) can voluntarily bring persons with serious mental illness experiencing disability-triggered stress or crisis rather than inappropriately taking them to jail or the emergency room. Provide linkages to services and community supports to individuals at the triage center.**
19. **Work with APS to support efforts to increase the number of school-based health centers and increase the availability of mental health services provided through school-based health centers (including during non-school hours). Evaluate current APS mental health service outsourcing processes and outcomes for potential enhancements.**
20. **Work to assure coordination of care for all individuals transitioning from MDC, MATS, Turquoise Lodge, UNM and other detention and treatment facilities such that, at release/discharge, they receive: (1) a copy of their health records; (2) one month worth of prescriptions, if any; (3) referral to a medical home (could be a behavioral health provider); and (4) an assigned care coordinator (for more complex individuals). For those exiting detention centers or on parole, consider making it a condition of parole that they see their medical home provider within one month of release.**
21. **Work with the State of New Mexico to develop aftercare planning and transitional services for 18 to 25 year olds exiting CYFD custody (i.e. foster care, detention).**
22. **Support all efforts to increase the number of behavioral (and physical) health providers working in Albuquerque and the State to increase services and decrease wait times for diagnosis and medication refills. Support efforts to increase Health Service Corp slots, WICHE scholarships, and loan forgiveness and debt repayment programs.**

From November, 2014, through March, 2015, "Action Team 6" discussed and gathered further information about these recommended actions, and hereby submits a summary of the information gathered and recommendations for each action area. The items are listed in order of our team's recommended priority.

Before proceeding to the action items presentation, it is important to point out a recurring theme common to several of the action items. A common thread raised by several of our subject matter experts is a disconnect between what Centennial Care (NM Medicaid) is designed to provide and what consumers and providers experience on a day-to-day basis. Most negatively impacted is the core area of service coordination, the very service that targets ensuring a coordinated, holistic approach that reduces duplicative services. This frustrates and confuses consumers and overburdens providers that strive to fill the need. This service gap is intensified by the apparent lack of accountability for the service. If this is a Centennial Care imposed obligation then there needs to be mechanisms in place to hold the responsible service providers accountable. Failures in this area result in damages across the system by reducing effectiveness and, thereby, increasing long term costs.

1. Recommendation: Support efforts to create a City- or County- or City/County-run triage center for intermediary stabilization where first responders and others (CETs) can voluntarily bring persons with serious mental illness experiencing disability-triggered stress or crisis rather than inappropriately taking them to jail or the emergency room. Provide linkages to services and community supports to individuals at the triage center.

Interest in a Crisis/Triage/Stabilization (various terms have been used) Center for the Greater Albuquerque community has been widely affirmed for a number of years, and several recent task forces (e.g., the Bernalillo County Healthcare Task Force; the Joint City/County/State task force on behavioral health; the Greater Albuquerque Chamber of Commerce mental health task force) have identified the importance of such a resource. Within the past few months the Albuquerque Chamber of Commerce organized and led a "best practices" trip to Tucson, AZ, to examine what has been widely recognized as one of the premier such centers in the country. Twenty-two community leaders, including two members of Action Team #6, participated in this trip, returning with renewed enthusiasm for the value of such a resource and ideas about how such a center might be created and operated in Albuquerque. The Task Force is specifically aware of further conversations about creating such a center among some county commissioners, city councilors, and county staff persons, and more than $2 million dollars to fund such a center has been inserted into a first draft of the New Mexico state budget currently being drafted. It is very clear to our Team that creation of such a center here is a high priority, and whatever cooperative efforts and funding that can be made available for such a resource are strongly encouraged. It is also clear that the creation of such a resource in Albuquerque is a long-term project that will take 5-10 years to fully implement.

A Triage/Stabilization Center, such as the model center in Tucson, serves as a "single front door" for all behavioral health services, whether sought by a person in need him or herself, or by that person's family, or by referral from law enforcement or other service providers. The concept of "no wrong door" is crucial in such a service to ensure that a person in need of services is not turned away or delayed in access to service and receives a "warm handoff" to ongoing care. The Tucson center, like many others, serves people for up to 24 hours, after which time they are referred to other appropriate providers including outpatient therapy, detox services, inpatient care, partial hospitalization, and related social services. Partnership between the center and other community agencies is closely cooperative, including in some cases co-location in the center's facilities. Law enforcement personnel respond to approximately 75 incidents per month (similar to Albuquerque's numbers) resulting in transporting people to the center, and there does exist an assisted outpatient treatment law in Arizona which may affect Tucson's numbers. A mental health court is located on the premises of the center so that if judicial intervention is required it can be easily accessed. Peers are employed and involved in the center's recovery work, and NAMI works closely with the center.

Such a triage/stabilization center should have all service information available by phone or electronically for all services that human beings need to find help for mental health care from how to access dental services to temporary housing to prescription needs. Each provider of services for people with mental illness should be available with one request at the triage center. Since this is a 24-hour operation it is ideal for consumers and families. Early intervention is an important issue for care and safety because families are at a total loss to locate help. Marketing this center should be extensive: Yellow Page ads, bill boards, flyers at schools, churches and medical facilities are excellent ways to spread the word. NAMI-New Mexico reports having been unable in the past to provide quick and accurate assistance to the needs of callers because of insufficient information of all the services that could assist a consumer or family's needs. Coordinating all these agencies could increase the effectiveness and reduce time substantially.

The Tucson center emerged from a process prompted ten years earlier by circumstances similar to Albuquerque's recent events, including police violent encounters with mentally ill residents. Community leaders began working toward improving services leading eventually to a successful $50 million bond election that provided $18 million for the center and another $30 million for a psychiatric hospital. The center is operated by the regional behavioral health authority, a public/private partnership, through a capitated (as opposed to New Mexico's fee for service) system, and approximately 80% of its annual $20 million operating cost is funded by Medicaid dollars from the state.

Planners and leaders of the Tucson center underscored the vital importance of beginning with a clear vision for the future built upon strong and carefully articulated values including access for all and a cooperative multi-faceted system of care. The Tucson leaders also emphasized the importance of a well-crafted business plan for sustainable operation, and a solid clinical model with an emphasis on recovery. They also emphasized the importance of collaborative planning among the various stakeholders in such a center, including city, county, state, university, law enforcement, and consumers. Albuquerque participants in the Tucson visit were clear that just building a nice building for such a center would be insufficient by itself (as has been the case recently in Las Cruces), but having a centralized facility (whether new construction or a repurposed existing facility) must go hand in hand with strengthening the behavioral health infrastructure by increased funding and greater cooperation among the various parts of the system.

Our Team hopes that the Albuquerque Center would begin with a well-planned, well-supported foundation network of services, with a vision for the welfare of the community which values behavioral health for all our residents. Careful planning and braided funding, including city, county and state, Federal, MCOs, and grant funding, should be secured to assure sustainable growth.

Our Center might be launched in an existing building that could easily be populated for the array of services required. The Center would evaluate and anticipate system growth, adding services to fill gaps that might be discovered through regular evaluations. The initial building should have room for growth from the hub of initial implementation to future growth over the next 5 to 10 years.

The Center should facilitate coordination of all services, maintaining careful data to ensure better behavioral health management. It should serve as a single point (both virtually and physically) of contact for community prevention, case management and other services including housing referrals, substance and alcohol abuse, education, training and overall wellness. Coordination of this kind will further encourage warm handoffs and coordination of major stakeholders and treatment centers across the greater Albuquerque community.

2. Recommendation: Consider developing and supporting Community Engagement Teams (CET), a peer- support, early intervention to link persons with serious mental illness (experiencing disability-triggered stress or crisis) to voluntary treatment and other services as an alternative to calling law enforcement and as a supplement to other intervention efforts. CET members would include: (1) Qualified and licensed mental health professional; (2) Case managers, community support workers or core service workers; (3) At least one peer (adult or youth) who lives with mental illness.

Community Engagement Teams provide early intervention through community outreach that links individuals to voluntary treatment or services to lessen the duration and severity of psychotic incidence and to reduce law enforcement intervention. The benefits of implementing Community Engagement Teams include improving the probability of intervening with a person before his or her first psychotic break and to link such persons with services so as to allow them to live safely in the community by seeking voluntary treatment. A principal feature of CET is reducing law enforcement intervention. There is no police involvement in this program beyond an initial 911 call.

Ideally a CET program would be administratively housed witin an existing city and/or county structure, and would link effectively with local crisis lines. Each team in a CET program would include a mental health professional licensed for independent practice, at least one peer who lives with mental illness, and other case managers and/or community support workers.

Legislation is now advancing through the NM legislature to implement a 5-year pilot project in the greater Albuquerque area, and perhaps in other communities as well, beginning in July, 2016. We are told that the cost of launching a CET pilot project in Albuquerque would be $150,000, followed by annual costs of $474,000, to support a six-person team.

3. Recommendation: Work to assure coordination of care for all individuals transitioning from MDC, MATS, Turquoise Lodge, UNM and other detention and treatment facilities such that, at release/discharge, they receive: (1) a copy of their health records; (2) one month worth of prescriptions, if any; (3) referral to a medical home (could be a behavioral health provider); and (4) an assigned care coordinator (for more complex individuals). For those exiting detention centers or on parole, consider making it a condition of parole that they see their medical home provider within one month of release.

While improvements are beginning to be implemented in transition services from MDC, MATS, Turquoise Lodge and UNM, We have a long way to go to achieve an effective care coordination and/or case management process for persons as they leave institutional care. Some of the positive changes now occurring include:

- An increase from 1 to 11 care coordinators at MDC to work in discharge planning for inmates;
- Implementation of pre-qualification of inmates eligible for Medicaid to expedite their access to services upon release;
- Hiring a social services coordinator at MDC;
- Greater cooperation between MATS and MCOs and community agencies through increased discharge planning by care coordinators;
- The development of the Fast Track Program at UNMH to work with high needs mental health patients at MDC to assist them through intensive case management in reintegrating into the community;

- Increased funding for supportive housing for persons with behavioral health issues, and the development of an RFP for a supportive housing coordinator in the County to further expand housing opportunities;
- The effective partnership between UNMH and a variety of community agencies through the Pathways program to provide navigators to assist clients in accessing needed referrals, treatment, and social services.

While these recent improvements do help many people, many gaps and inadequacies in services continue to hamper effective care for residents. Our task force is clear that the following priorities must be addressed to ensure better transitions from institutional care to the community:

- Care coordination services must be further expanded, and there needs to be better coordination of these various services in the broader community to avoid gaps and duplications;
- A crisis triage center that engages persons early and provides dependable warm handoffs to a variety of services and treatment providers must be created;
- The community is desperately in need of more good and available providers (see #22 below);
- There is strong need (as stated in #19 above) for school-based health centers throughout APS, with a behavioral health specialist in each center along with preventive services;
- More housing options are still needed for mentally ill persons, including group housing, wet housing, and supportive housing;
- Gainful employment opportunities must be expanded for those with mental illness and substance abuse issues.

Costs and timelines are extraordinarily difficult to estimate for meeting these needs. Some costs are identified at other places in this report. Our task force is aware, however, of the enormous need and limited resources currently available.

4. Recommendation: Support all efforts to increase the number of behavioral (and physical) health providers working in Albuquerque and the State to increase services and decrease wait times for diagnosis and medication refills. Support efforts to increase Health Service Corp slots, WICHE scholarships, and loan forgiveness and debt repayment programs.

While a 2014 NM Health Care Workforce Committee study indicates that New Mexico has insufficient psychiatrists for our state's population, especially child and adolescent psychiatrists, data indicate there are sufficient numbers of psychiatrists in the greater Albuquerque area. This assessment is shared by the Department of Psychiatry at UNM, where Dr. Tohen, the department chair, indicates that they are working closely with various partners to increase and train other mental health providers including nurse practitioners, counselors, psychologists, and social workers. A recent UNM report on the Landscape of Behavioral Health in Albuquerque recommends increasing the number of providers and programs working in community-based behavioral health, more navigators and more bilingual therapists. That same study reported a significant problem in wait times and access to non-profit programs and to inpatient, residential, and intensive outpatient services. The Department of Psychiatry through its Division of Behavioral Community Health is currently conducting an inventory of providers in various disciplines, and this inventory will strengthen our data about needs. The Department recognizes that "where you train is where you work," so training opportunities are vital.

Our Task Force talked with representatives of NMSU and Highlands who confirmed they would like to increase capacity of their training programs, since they receive twice as many applicants as they have available training slots, but they are concerned there are insufficient jobs available for their

graduates. CNM does offer a BSW program, and does feed some students into the other academic programs. Cultural competence is an important factor in training behavioral health professionals in New Mexico, and NAMI's survey of the states indicates that our state, like the rest of the country, does not have an adequately trained professional community in diverse cultural characteristics.

The 2014 Health Care Workforce Committee Report offers many recommendations for increasing the number and skills of behavioral health workers, and our Task Force especially supports the following recommendations from that report since they concur with information we have received from other sources:

- Encourage career interest-building programs in NM that recruit students into the health care professions before or during high school and as undergraduates. We especially commend the development of the new Health Professions Charter School being developed in partnership with First Choice Community Health Care.
- Support state funding for health care professional training at UNM and NMSU and other state schools, and expand and implement tracking to analyze how many graduates practice in NM.

The Task Force also recommends the following actions, some of which are currently underway, to expand the behavioral health workforce:

- The City and County should partner with UNM, NMSU, Highlands, and other institutions to help fund and expand programs that provide training and cultural competence for professionals.
- Encourage UNM in its multi-disciplinary approach to training in order to expand the availability and coordination of various kinds of providers in various settings, and to enhance the effectiveness of care coordination in community programs.

Our Team did not undertake cost calculations for this recommendation, recognizing that such calculations must be left to the educational institutions themselves.

5. Recommendation: Work with APS to support efforts to increase the number of school-based health centers and increase the availability of mental health services provided through school-based health centers (including during non-school hours). Evaluate current APS mental health service outsourcing processes and outcomes for potential enhancements.

Team 6 has benefitted in assessing this recommendation from members of the team with direct experience in APS, as well as by a presentation to us by Leslie Kelly, APS Director of Counseling. Two things must be noted at the outset: first, school-based health centers are not run by APS, but by contractors who rely for funding upon fee for service payers and so are often insufficiently staffed to serve the needs of students and families; and second, APS has zero actual regular budget for mental health services and relies primarily upon specialized grants which come and go for special services such as drug alternatives, training foster parents in mental health first aid, or working with students with disability or special education needs. There are currently only 7 APS employed psychologists who concentrate their work on "threat assessments" and developing, in cooperation with school social workers, individualized education plans for students. Currently funded services in the schools are <u>for the students' educational needs only</u>, and actual mental health services must be sought from outside the system or from contractors engaged by APS and funded by grants or fee-for-service arrangements.

Ms. Kelly notes that there are 90,000 children enrolled in the APS system, and her ideal would be to have a ratio of one counselor for every 250 children—a total of 360 full-time counselors employed

by the schools. Ms. Kelly advised our team that the following priorities should be considered for funding and implementation:

1. A prevention/early intervention curriculum operationally funded (not grant funded and changing every 4 years);
2. Professional development for all staff who work with students—i.e., mental health first aid, trauma informed care, including substitutes or stipends for 6,000 teachers (substitutes at $100 per day; stipends at $20 per hour)
3. Crossroads counselors in every middle and high school (average salary $76,000 x 33=$2,508,000 annually)
4. Non special education social workers to coordinate mental health services and school interventions for students in need (150 social workers x $76,000=$11,400,000)
5. Creation of a mental health task force/council that meets regularly to address mental health needs and to build a mental health component in conjunction with community supports

Ms. Kelly also noted the importance of having in the community outside APS available respite care for critically ill children, more beds for students needing hospitalization, and coordinated care for all young people and their families in need of services.

Action Team 6 is not in a position to evaluate the above recommendations as stated. We are clear that it is important for schools to strengthen relationships with local mental health agencies, and to include charter schools in plans whenever possible. Ms. Kelly's presentation did bring to the forefront several overarching issues that the Team believes are critical to addressing APS' needs and responsibilities in this area.

1. APS' internal staffing is such that a multi-faceted approach to addressing the behavioral health needs of its students is, for all practical purposes, limited to outsourcing to community providers. It is recommended that APS pursue a more dynamic model that includes both outsourcing (community based providers) and internally provided services. APS employed professionals would fill a void in bridging the educational and behavioral health needs of students and connecting students with community based providers as needs warrant.

   Determining the best mix of school internal staffing to community based providers is beyond the scope of Action Team 6. An exploration of best practice models across the nation is recommended to guide this recommendation.

2. The existing reimbursement mechanism for school-based health centers is inadequate and serves to disincentive prospective providers. It is recommended that the issue of how to recruit and retain a pool of community providers experienced in working with K-12 students be undertaken. Reimbursement alternatives for 'no show" appointments must be part of this effort.

Our Team is distressed by the severe lack of dependable mental health services within APS and the significant risk of critical incidents affecting students, teachers and staff that are created by the absence of such resources in the schools. Current school funding formulas apparently provide no resources for mental health services, and this situation needs to be reconsidered by public education leaders at the state and the district level. The absence of such services simply increases the need for our city and county and state leaders to strengthen community services such as those described in this overall report, as well as to demand education leaders increase resources for this vital service to students and staff of schools. This said, the Team recommends that the Mayor' office and APS enlist its

lobbyists to pursue changes in the State's education law so that behavioral health services become a mandated component of publicly provided educational services.

6. Recommendation: Work with the State of New Mexico to develop aftercare planning and transitional services for 18 to 25 year olds exiting CYFD custody (i.e. foster care, detention).

CYFD ordinarily considers age 21 to be the cut off point for young people in its care. CYFD assists young people from incarceration within 60 days of commitment with a staff coordinator to individually plan and oversee the youth's transition to the community after release. CYFD indicates that 70% of these young people have serious behavioral health needs, and an even greater percentage are trauma survivors. Central to their service model are: 1) strong relationships between youth and their respective service coordinator; 2) genuine engagement of the youth and his or her family or natural support system in the process; 3) continuity of care; and 4) successful linking with community supports and resources.

Services may include education, vocation, SSDI, mental health services, Medicaid, and residential placement. Assistance includes networking with core agencies: All Faiths, Open Skies, YDI, and UNM. Nine month to one year supervision is also provided after release. Youth may be referred to Reintegration Centers located in ABQ, Carlsbad and Eagle's Nest when a suitable family setting is not available for return. Youth in foster care also are eligible for transition assistance including school, therapy, medications and limited housing assistance. CYFD also operates a Wraparound Cares Project aiming to provide Communities of Care facilitators to assist youth with mental health diagnoses in accessing community services.

APS also has limited services for APS special needs students ages 18-21. These services are mandated by Federal law and determined by an IEP to determine which services will most benefit each student. This program, however, serves a very limited number of students because of financial constraints within APS.

The services needed to prevent youth from engagement with the juvenile justice system or continued engagement through the adult criminal justice system are: (1) early identification; (2) timely intervention; (3) continuity of care with effective wraparound services including quick access to care during crises; and, (4) follow-up to age 24, preferably age 26. Current law ends CYFD involvement at age 21. A change in the law is required if CYFD is to continue involvement beyond age 21. Otherwise, an agency or service responsible for the 21 to 24 or 26 age group needs to be identified. In either case legislation enabling funding for transitional services for the 21 to 24 or 26 age group is required.

Current youth transition challenges include: (1) lack of available, affordable housing; (2) lack of employment opportunities; (3) inadequate funding for prevention services (Medicaid does not reimburse for the type or level of needed preventative services); (4) strengthening of the MCO system to achieve availability of value added services across all four MCOs and accountability for timely service delivery. There is also need for a network or service directory as a resource for linking transitioning youth to community resources. We are told that the State is completing an online Network of Care resource that will be available in the near future.

Because the service needs of youth transitioning out of CYFD cut across a variety of sectors (behavioral health, housing, education and employment) it is beyond the scope of Team 6 to estimate the associated funding requirements. A proposal that identifies who will be served and the scope of services is required to establish funding requirements and to identify potential service providers. It is recommended that the City take the lead in this effort through development of such a proposal to serve as the basis for intergovernmental discuss of how to tackle this issue.

7. Recommendation: Consider using SunVan to provide transportation to and from mental health service providers.

Members of Action Team #6 gathered further information about this recommendation primarily through interviewing Albuquerque SunTran managers Bruce Rizzieri and Annette Paez. We were surprised and pleased to discover that SunTran already considers this task part of their mission. SunVan has 70 vans which provide 1000 trips per day to assist Albuquerque residents in personal transportation needs including trips to and from medical and mental health providers. Federal regulations do not allow SunTran to "favor" disabilities like behavioral health, but consider mental health impairments one of the many conditions that may allow citizens to use this service.

Residents may apply for permission to use SunVans on the internet, and a personal interview is a part of this application process. Once approved, a rider may pay 35 cents per ride or, if frequent rides are required, may purchase a pass for $12 per month which allows unlimited rides. A personal care assistant may ride free with the resident if required. Scheduling for trips is managed by computer and ordinarily runs within 5 minutes of specified pick up time to and from appointments. Drivers are trained and service oriented to serve all kinds of riders including persons with mental illness.

While these services have been available for mental health patients for many years, the availability of this service is not widely known or understood. Action Team 6 affirms the City for providing this service and believes that while the recommendation is currently being met, the availability needs wider publicity. The Team supports Sun Tran's plans to produce educational brochures that are currently being planned, and hopes that wide dissemination of these brochures will take place. The Team also recommends that brochures and other publicity will be placed at the Metropolitan Detention Center, UNM's Mental Health Center, Presbyterian Kaseman Hospital, and with NAMI. Members of Team 6 intend to prepare an article on this service in the NAMI newsletter.

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This report has been prepared by Action Team 6 members including Lisa Trujillo, Ursula Christopherson, Thomas Gagliano, Bella White, Wayne Miller, Betty Whiton, Yolanda Montoya-Cordova, Kristin Ackerson, Sherry Pabich, Sarah Lee, Any Taylor-Trujillo, Virginia Chavez, Rosella Gonzales, Jay Crowe, Michael Robertson. Thanks to these volunteers for the many hours spent gathering information and examining these issues, as well as to the many Albuquerque citizens who participated in the Community Conversations process. We dedicate our efforts to the thousands of families in our community who face the challenges of mental illness daily. Paul E. Hopkins, team leader.

3/18/15