CRISIS SYSTEMS OF CARE DEVELOPMENT

A Summary of Consultation to Guadalupe, Taos and San Juan Counties

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9/16/2013
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NOTE: This report is a summary of a 3-month consultation and should not be construed as an evaluation. The consultation was offered to support cross-sector efforts in three counties that have been actively working to improve their local crisis systems. Any recommendations in this report are those of the consultant and do not represent an obligation on the part of the counties.
Introduction

Through its contract with the Technical Assistance Collaborative, Inc., Kappy Madenwald was engaged by New Mexico Behavioral Health Division to offer technical assistance and consultation to three counties where there is substantive interest in implementing/enhancing local Crisis Systems of Care. Improving local response to mental health and substance-use related crises has long been a priority for New Mexico.

House Joint Memorial 17, sponsored by Representative Rick Miera in 2011 addressed this challenge and charged 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. The Collaborative in conjunction with the New Mexico Association of Counties (NMAC) convened stakeholders who invested significant time in developing a set of recommendations that included Community Crisis System Planning.

The HJM17 report identified several factors common to communities with underdeveloped crisis systems:

1. Lack of an organized coalition of key, cross-sector stakeholders
2. Wasted resources: a significant amount of money spent, but within a disconnected system that fails to adequately meet the needs of persons in crisis or their families
3. In the absence of sufficient crisis response services, the public turns to law enforcement to intervene

The report also notes the potential of organizing crisis systems at the local level:

1. It is possible to coordinate resources, enhance existing services and develop innovative, locally-based responses to community mental health crisis needs.
2. Smaller communities are often most effective at providing sensible care because they know who people are and take care of them.
3. 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.
4. Communities are an integral part of people’s lives and by their very nature serve as a critical natural support for a person in crisis and his or her journey towards healing.
5. Local stakeholders are well situated to identify and marshal supports and linkages among service providers because they can identify their community’s unique strengths and challenges. Through these powerful linkages a range of community-based, cost-effective responses can be developed.

Scope of Consultation

The Behavioral Health Collaborative asked that consultation be delivered, in the form of coaching, training and/or technical assistance to Guadalupe, Taos and San Juan Counties, to enable planning and implementation of, or improvements to existing crisis systems. Consultation was available from April 1
through June 30, 2013 and included on-site, telephonic, and email interface as well as the off-site development of resources and curricula. The nature of the consultation differed in each county based on both expressed and assessed priorities. This consultant is indebted to the leadership, talent, and unwavering commitment of Patricia Gallegos (Guadalupe, Taos) and Tami Spellbring (San Juan) whose work in developing and supporting local Crisis System of Care workgroups, and paving the way for this consultation was invaluable. Patricia and Tami have an incredible understanding of the respective counties—the stakeholders, the culture, the strengths and the opportunities and each has over a period of years assisted in identifying a variety of development opportunities and bringing resources to the table at a systems level. Specific to this initiative, they each have championed local training in Mental Health First Aid across many sectors and the general community. This has clearly elevated the nature of the local conversation and promoted a shared language and a shared understanding of the need among those whose support is critical in changing the experience of individuals in crisis and their families.

The HJM17 Task Force is very interested in Crisis System of Care development efforts in each of the counties and would like to know:

- What are the “takeaways”?
- How can the Task Force exploit local efforts to help in other communities?

In the report that follows, I will begin with a summary of the Crisis System of Care framework and then share some information on the work with each county. I will leave it to each county/agency to share additional details as they choose. It is important to note that there were no mandates tied to this consultation. Counties did not receive any financial assistance to implement any of the discussed recommendations. Most importantly, cross-sector conversations are underway that are sensitive in nature and that among other things involve very real, sector-specific and system consideration of policy shifts, costs and risks. The report concludes with a section on overarching recommendations. A list of individuals/groups that participated in the consultation appends the document.

Framework for Consultation and Technical Assistance

In two previous statewide training events\(^1\) New Mexico Counties and state leadership were introduced to a Crisis Systems of Care\(^2\) framework for planning, implementing and organizing crisis system components. The framework is useful at a state, local, agency, program, and even individual-level to understand both the stages and nature of crisis events and the planning and resources necessary to diminish the crisis, coordinate/access resources, mitigate risk, while at the same time avoiding or minimizing any secondary harm. We define a Crisis System of Care as, the organized whole of the behavioral health crisis system. A well-functioning crisis system is made up of an infrastructure of services, systems, processes and pathways that promote early, in-community planning for, response to, and management of behavioral health crises. Crisis Systems of Care are in many ways public health frameworks that are inclusive of the services provided by primary care physicians, hospitals, law enforcement entities, schools, congregate care facilities, social services systems and the actions of consumers, family members and the general public.

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1 New Mexico Behavioral Health Collaborative Conference, 2009; New Mexico Behavioral Health Collaborative Symposium, 2012

2 Kappy Madenwald & Steve Day, Technical Assistance Collaborative, Inc.
The use of this type of multi-sector framework for service delivery may be new for many agencies who otherwise not highly reliant on other entities/systems to achieve good results. The multi-sector component is in fact one of the barriers that can impede planning and operationalizing system components.

Crisis Systems of Care are most successful when they attend to all persons regardless of payer source including those actively receiving behavioral health treatment services along with those who are not, never have and don’t ever intend to receive them. It isn’t realistic to expect that law enforcement agencies or schools will review insurance benefits before deciding where to transport a person. If it is too complicated, those systems will revert to using emergency departments or 911.

The Crisis System of Care framework guides state and local governments, communities, and cross-system/sector agencies in broadening the focus from acute crisis response (reliance on narrow number of crisis “experts”; calling 911; transports to emergency departments, hospitalization, involuntary commitment and other coercive measures, use of law enforcement) to an expanding view that equally attends to each phase of a full continuum of state/community-agency opportunity. In addition to acute intervention the five phases of the continuum include: crisis prevention, early intervention, crisis treatment and recovery/reintegration.

Within each phase, the Crisis System of Care model emphasizes the importance of attending to four key components:

1. **The Players** (Consumers and family members, policy makers, mental health and substance use service providers, agencies, child protective, adult protective and developmental disability service systems, hospitals, primary care clinics and physicians, law enforcement officers, court and jail personnel, fire department and EMT personnel, city/county administrators)

2. **The Logistics** (How a person receiving services moves through processes and interventions—right service, least restrictive place, right time, minimizing artificial delays/hazards, streamlining and building in efficiencies; access, movement/pathways, estimating; evaluating; addressing supply/demand; decision-making tools and protocols, information exchange and flow; how providers, programs, agencies, systems interface, problem solve, collaborate, evaluate

3. **The Competencies** (Ability to effectively engage a broad spectrum of individuals and families—representing all ages and all stages of change and treatment readiness; resolution-oriented intervention that is: recovery-consistent, hopeful, person and family-centered, strengths-based, trauma-informed, culturally relevant and special population-informed; risk assessment and mitigation; differential diagnostics; broad knowledge of local choices and resources both formal and informal, use of EBP’s such as crisis resolution, Motivation Interviewing, EMDR, Shared-Decision Making)

4. **The Parts** (I.e. peer-operated crisis services; brief crisis stabilization beds; urgent treatment and psychopharmacological services; community-based mobile crisis resolution/stabilization teams; CIT-trained police officers)
There is a tendency by states and communities to focus exclusively on adding more PARTS and since PARTS often cost money and new money is hard to come by, conversations about improving crisis services can quickly seem futile. The truth is that investing in PARTS without equal attention to players, logistics and competencies doesn’t always end well.

More than one community has discovered that just because you build it, does not mean they will come. It doesn’t mean the people you WANTED to come, will come. And, it doesn’t mean the program will achieve intended objectives. The good news about attending to Players, Logistics and Competencies is that they are generally low cost and can offer incredibly high return on investment.

The three counties that received technical assistance, along with many others in the state, have limited options for timely intervention and resolution services for individuals experiencing a mental health or substance use-related crisis, and have relied highly on default safety net services (law enforcement, jail, emergency departments) to intervene, evaluate and assure individual and community safety. It is also clear that in each county there is a subset of individuals who are very frequently seen by two or more local systems/agencies (law enforcement, jail, emergency departments, detox services, treatment services). However, each is bearing the load, largely on its own and:

- Incurring considerable cost
- Expending considerable time, and
- Managing considerable risk

To the Law Enforcement Agency or Hospital, such frequent contact can feel like a “dump” and can build resentment towards another system that “clearly isn’t doing their job.” More often than not it is more accurate to say that the community strategy and structure for addressing behavioral health crises is under-developed, under-defined, and under-assigned.

When roles are under-defined and under-assigned it leads to too many people across sectors believing (to varying degrees)...  
- It’s not my job
- I don’t have permission
- I don’t have the competency
- I don’t have the time
- I can’t get paid for it

These are very real factors that perpetuate the existence of an under-developed/defined/assigned system and each requires a different mitigation strategy.

Mature crisis systems have depth and breadth, with layers of attention to crisis prevention and mitigation. Any agency or facility (behavioral health provider, school, congregate care setting, law enforcement entity) can operate as a microcosm of the larger crisis system with attention to all five phases and all 4 key elements of the continuum. Even as cross-sector relationships are being formed, agency programs can take steps to pivot-in-place. This is the in vivo opportunity to change what/why/where/how we are doing things—and who we are doing it with—right now, to yield more desirable results. For example, a congregate care facility may be aware of a high volume of mental

| The Players (policy-makers, providers, agencies, systems, partners) |
| The Logistics (access, movement/pathways, supply/demand, information exchange, protocols) |
| The Competencies (solution-oriented, recovery-consistent, family-centered, strengths-based, trauma-sensitive) |
health crises within the facility that they categorize as adverse incidents (i.e. injuries to clients or staff, calls to 911, transfers to emergency departments, treatment terminations). An outpatient treatment provider might notice the disruption to daily operations or need to refer elsewhere when clients have unscheduled, immediate treatment needs/crises. Using a pivot-in-place approach, the agency may identify untapped opportunities for crisis prevention or early intervention with a focus on identifying the players, logistics and competencies needed to do it well. A congregate care facility with a policy of referral to an emergency department when a person is suicidal may see benefit to building in-house competency and confidence in meeting the need. Opportunities like these exist in every agency and there is virtually always a compelling business reason or two to explore them:

- To reduce risk
- To improve health outcomes
- To reduce cost
- To increase customer satisfaction/retention in treatment
- To increase staff workplace and professional satisfaction
- To improve public perception/satisfaction

Over-reliance on Law Enforcement Agencies and over-representation of persons with mental illness and substance abuse conditions involved in the criminal justice system (courts/detention) is a factor through much of New Mexico and each of the counties that received technical assistance. For this reason the Sequential Intercept Model\(^3\) developed by Mark R. Munitz, MD & Patricia A. Griffen, MD, was also used in varying ways to inform conversations and organize systemic understanding. Per the authors, "The Sequential Intercept Model ... can help communities understand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time."\(^4\)

Pre-arrest diversion strategies, development of Law Enforcement Crisis Intervention Teams (CIT’s), referrals to treatment in lieu of conviction, and the use of specialty court dockets are all examples of interventions aimed at promoting treatment and lessening criminal justice system exposure. However, in the absence of a well-developed Crisis System of Care and strong intersystem relationships the results of these initiatives is modest.

Guadalupe County

Fewer than 5000 individuals live in this frontier county that encompasses a little more than 3000 square miles of land. The vast majority of resources are found in the county seat of Santa Rosa and perhaps the richest resource is the steady commitment of local leaders. They care deeply about the people who live in Guadalupe County and in many instances know the individuals who are seeking services or standing

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\(^3\) Sequential Intercept Model graphic: [http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf](http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf)

before a judge. Multi-generational poverty, unemployment/under-employment, sub-standard housing/homelessness, and high rates of substance use are long-standing barriers to treatment and recovery. Because the county is along Route 66 and I-40, it also serves a regular stream of individuals with health needs who are passing through. Guadalupe Medical Center is a 10-bed general acute hospital that has a 3-bed emergency room open that is open 24/7/365. The staff manage physical health care concerns but also see (and feel less equipped to treat beyond medical stabilization) a sizeable number of individuals with mental health and substance use conditions in the emergency department and also provides ongoing primary medical care to a number of individuals with severe, co-existing medical and behavioral healthcare needs. 2 FTE care managers make up the staffing of the local office of Community-Based Service (the local CSA) and between them they serve 150-175 adults on an ongoing basis in addition to responding to new requests for services. A therapist is in the office every other week and medical services are provided through telepsychiatry.

A significant barrier in Guadalupe County is that local control of/leverage power for resources is quite low. The county has limited/no choice of local options for stabilization of behavioral health crises and that exclusion criteria of potential receiving facilities (psychiatric hospitals, detention center) can make placement very difficult. An example shared by leaders is their experience that neither the local jail nor the state hospital will admit a person with a positive, toxicology screen even if it is a residual finding.

The county contracts for jail beds with a privately operated correctional facility. Despite the exclusion criteria, the heads of the police and sheriff’s department report that substance use is a factor in nearly all arrests/detentions.

During this consultation, conversations were largely about adults. Although there are certainly youth who experience behavioral health crises, treatment continuity and local engagement in treatment (Team Builders, Juvenile Probation and School guidance Counselors each play a significant role in this) were not reported as higher priority issues. It was noted however that when youth need hospitalization, they must travel a very long distance to get it.

Synopsis of consultation:
- Had a number of initial meetings with key individuals in the community (see addendum for detail)
- Participated in monthly county collaborative meetings and engagement of attendees.
  - Crisis Systems of Care development is a standing part of the agenda.
  - Facilitated discussion
  - Disseminated information
  - Exercise to build awareness of the experience of other agencies/systems in engaging persons with mental health or substance use conditions
- Provided a mini-training building on priorities of the collaborative members and introducing the Crisis System of Care framework along with principles of crisis resolution
- Engaged key county leaders (Police Chiefs, Sergeant who heads local Sheriff’s Department, Hospital Administrator, Director of the CSA, Judges) most of whom are not routinely attending the collaborative meetings
- Along with Patricia Gallegos (Ralph Moya attended some of these meetings as well), met with these sector leaders individually and outside of the monthly collaborative meeting. Focus included:
  - Expanded awareness of the nature of the problem—it is systemic, requires a cross-sector analysis and strategy implementation
Exploration of agency/leader-specific business reasons to do something differently (each had clear and compelling reasons that were primarily focused on ethics and caring for members of the community.)

- Readiness for doing something differently
- Sought perception of the number of individuals who have very high contact with the respective agency, largely due to a mental health or substance use condition. The range of response was between 20-50 individuals. This is an important group for cost/volume of service analysis.
- Sought perception on the percent of time officers/staff members spend on persons with mental illness or substance use conditions (ranged from 35-90%)  
- Discussed value of cross-sector data analysis—costs, volumes, outcomes. (The first analysis—between the Sheriff’s Department and the Hospital occurred shortly after the June meeting)
- Ascertained the value to the leaders whose staff attended the April, 2013 Mental Health First Aid training (well-attended and very well-received and applicable)
- With judges and the hospital administrator, discussed increasing competency in engaging persons with substance use conditions by using tools such as SBIRT and receiving training in Motivational Interviewing.
- Explored harm reduction as a general strategy. This seemed particularly relevant to local leaders given the severity/chronicity of illness among a number of community members

Although the collaborative has been addressing crisis response for quite some time and the members are committed to finding solutions, progress has been slow. The collaborative members articulated where they are stuck: “What prevents us from finding dollars for an intermediate step (pre-ER/pre-hospitalization/pre-law enforcement) of addressing crisis events?”

The group’s answer:
- We haven’t made a clear pitch (to the county, to the state, to each other)
- We are missing the metrics/data
- We don’t have a plan

The group is bull’s-eye accurate and while it seems simple, this is a very common and challenging barrier. Most of the collaborative meeting attendees are not in a position to analyze the metrics or make policy-level changes, though they are well-positioned to help carry out changes once they are articulated. They can assist by promoting the conversation across sectors and articulating the discrepancy between current results and desired results.

Future Considerations for Guadalupe County

1. Continuing to raise awareness, identifying discrepancy, and fostering cross-sector relationships and a sense of local efficacy will be useful in moving to a point of active system change.
2. Keep agency/sector leaders engaged in conversations about and making cross-sector policy shifts that among other things promote local response to crises, diminish risk and increase efficiency.
3. In every way possible, promote cross-sector analysis. The perceived value is low right now, but when the total costs and volumes are understood, business reasons will become clearer and leadership will begin to identify some change opportunities.
4. There is already local conversation about Medicaid/Centennial Care enrollment and the importance of providing education, outreach and assistance with application materials. Big priority.

5. Cross-sector training in Screening, Brief Intervention and Referral to Treatment⁵ (SBIRT); Community Reinforcement and Family Training⁶ (CRAFT) and/or Motivational Interviewing⁷. The focus of training would be on education, treatment engagement, family support, and harm-reduction while at the same time offering professionals a shared language set across disciplines. Patricia Gallegos is assisting with these efforts.

6. Law Enforcement: future considerations that were discussed include:
   a. Rethinking the jail contract
   b. Crisis Intervention Team (CIT) training for officers
   c. If/how to share database across LEA’s

7. Focus on logistics to assure that all parties know about resources that are currently available and how to access them. Despite resource limitations, some are under-utilized (example: urgent services for victims of domestic violence).

8. Different engagement opportunities for different clusters of individuals:
   a. Persons who are passing through town, may have acute needs, but then plan to move on
   b. Frequent users with complex and chronic conditions
   c. First-timers who may benefit from information, education and brief treatment

9. Investing in and developing a cross-sector engagement and treatment strategy for as few as 25 individuals would go a LONG WAY in Guadalupe County in reducing the use of law enforcement, jail beds and the emergency department. Harm reduction techniques, family coaching, assistance with housing and employment, integrated healthcare and peer support might be in that type of service array.

10. Promoting the use of ProtoCall by consumers for both warm line and crisis support. This aligns with any broader harm reduction strategies and in a community with a limited number of behavioral health providers, ProtoCall clinicians can serve as system extenders.

**Takeaways**

1. It is important to have broad representation in Crisis Systems of Care workgroups, but system-level progress is somewhat limited until a sufficient number of decision-makers address policy-level issues and barriers. Relationship development and achievement of cross-sector understanding at a decision-making level is essential and gives permission for the activities of the workgroup that follow.

2. Behavioral health service providers may not be best positioned to lead policy conversations. Credibility and getting a foot in the door with a broad set of stakeholders are important at the early stages of relationship formation as is the ability to leverage resources. Whether it is a hospital CEO, Chief of Police, Judge or behavioral health provider—identify and build consensus with those who are essential in enacting and sustaining system change.

3. Significant progress in Crisis Systems of Care development can be made without major investment in new services. Mental Health First Aid has increased cross-sector understanding, empathy and competency. Additional “common” training can increase the community’s ability to promote prevention and offer crisis support and resolution.

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⁵ For more information about SBIRT: [http://www.samhsa.gov/prevention/sbirt/](http://www.samhsa.gov/prevention/sbirt/)

⁶ For more information about CRAFT: [http://www.motivationandchange.com/family-services/what-is-craft](http://www.motivationandchange.com/family-services/what-is-craft)

⁷ For more information about Motivational Interviewing: [http://www.samhsa.gov/co-occurring/topics/training/motivational.aspx](http://www.samhsa.gov/co-occurring/topics/training/motivational.aspx)
Taos County

Nearly 33,000 people live in this rural and frontier county that encompasses 2200 square miles in north central New Mexico but more than 150,000 more individuals travel to or through towns including Taos, Taos Ski Valley and Red River each year. The rate of suicide exceeds both state and national averages and leaders report high rates of substance use in the county. The sole hospital in the county is Holy Cross Hospital which has 47 inpatient beds, a 12-bed emergency department and no psychiatric beds. Tri-County Community Services, Inc. (TCCS) operates a 7-day residential social detoxification program in the city of Taos. Adults in need of inpatient psychiatric or substance use treatment must travel either Southeast to Las Vegas or South to Santa Fe. Either route may be compromised due to winter weather.

Taos County leaders have a high desire to diminish the need for hospitalization by creating rapid, local, community-based crisis response services. Equally important is a goal of diversion of individuals with mental health and substance use conditions from the criminal justice system and reducing reliance on both 911 and law enforcement. TCCS and Holy Cross Hospital currently partner on several fronts to enhance both the quality of intervention and service continuity. The CEO of TCCS along with two social workers from Holy Cross Hospital have worked methodically and strategically to build relationships across sectors; with private behavioral health providers, city and county government and elected officials, Law Enforcement Agencies, courts and detention. Holy Cross was the recipient of a Lovelace HUGS (High Utilizer Group Services) grant focused on reducing emergency department visits by the highest service utilizers. A review of charts showed that the majority of individuals who frequently used services had mental health or substance use conditions. Using engagement and education on alternatives to the emergency department and assuring rapid access to resources such as enrollment in Medicaid, the program has led to dramatically reduced use of the ED over the past year.

Following the New Mexico Behavioral Health Collaborative Symposium in August of 2012, local leaders drove the formation in December, 2012 of a Taos County Crisis Systems of Care Alliance that meets monthly. It is important to note that this is a shared process by all community agencies/stakeholders along with the entire community and that it is not any single entity’s process. In addition to the activities of the large group, several subgroups are tackling specific areas of interest: Media, Integration, Policy, Education, and Children and Youth. The meetings are efficient and results-oriented and the output in the past 6 months is quite impressive. The CEO of TCCS made an important recommendation early in the process that likely prevented roadblocks by suggesting to leaders in other agencies/sectors that any talk of money be off the table—something along the lines of, “None of us have extra money, there is no new money. Let’s not waste time talking about what we don’t have. Now, how do we address the problems, and each leverage our own resources without money changing hands?” Cross-sector data evaluation has diminished finger-pointing, brought higher level understanding of the nature of the problem and guided decision-making.

The county has taken advantage of resources that have come their way. This includes broad participation in Mental Health First Aid training (with an emphasis on training lay persons in the community). In the fall of 2012, the county brought in Olin Dodson to train in Recovery Oriented Systems of Care (ROSC) during an all-day Taos County Substance Use Summit that was attended by 300 community members and professionals!

The goal of this consultation was to offer technical assistance without getting in the way of either the process or progress and the local leaders were clear about how they wanted to use this consultation period.
Synopsis of Consultation:
1. Meetings with a number of key leaders and stakeholders for orientation to the county and its existing crisis processes and service gaps
2. Response to inquiries about models for mobile crisis intervention: staffing, safety, use of peer specialists, crisis competency, logistics
3. Assistance in responding to a SAMHSA grant that was issued a day before the consultation began. The grant is focused on jail diversion and was a pretty perfect match to the system model that was already under development in Taos County
4. Assistance in organizing the existing array of services and processes into the Crisis System of Care and Sequential Intercept Model frameworks
5. Participated in a Crisis System of Care Alliance meeting
6. Development and delivery of two training sessions:
   a. An overview of the Crisis Systems of Care framework to county leadership on June 20, 2013
   b. A full day training of 45 local service providers on the Crisis Systems of Care framework and the delivery of person-centered resolution-focused crisis services on June 21, 2013.

Future Considerations for Taos County
- The county will learn in September whether it has been awarded a SAMHSA grant but local leaders are hoping to move forward with some aspects of the crisis system redesign either way.
- Improving data quality: Efforts to cull data revealed gaps/integrity questions about what data is collected and how it is coded and there is interest in several sectors in improving both the quality of and ability to query the data.
- The Lovelace HUGS grant has yielded important information on impacting ED diversion—much is applicable to the Crisis Systems of Care development.
- TCCS is working directly with ProtoCall to transition some aspects of 24/7 crisis response.
- Taos County is in the midst of developing a Rapid Access Network made up of professionals (MH/SU providers, clergy, and peer specialists), specific resource providers (food pantries, entitlement specialists, and housing) and trusted community lay-persons. Rapid Access Network providers will be available face-to-face within 24 hours AFTER an initial crisis intervention service to provide as indicated by need: continued stabilization, social support and assistance, or facilitate urgent access to a needed resource. The success will rely on individuals who are willing to volunteer their time (professionals will bill when they are able).
- The Second Annual Taos County Substance Use Summit is scheduled for fall, 2013.
- Although taken off the table as the Crisis System of Care planning process began, funding will be needed for some of the envisioned expansion.
  o The county would like to have several local crisis stabilization beds so that individuals can receive bed-based crisis services in their own community.
  o TCCS plans to outreach to individuals with mental health or substance use conditions who are frequently arrested and who have historically not sought formal services. The work is time-intensive, mobile and is focused on engagement rather than active treatment and individuals who are targeted for the service are unlikely to be Medicaid recipients (even if they are eligible). Though it isn’t perhaps an immediate concern for TCCS, funding this type of service over the long run will become necessary for sustainability.

Takeaways
• Taking the “money issue” off the table is a way to get to speed relationship development and to get to do-able, cost-neutral actions quickly.
• The hospital Social Worker who manages the Lovelace grant worked with the information technology department to develop an immediate, secure notification system when a person enrolled in the ED diversion program (who has given consent) is registered as a patient. An automated, low-cost, behind-the-scenes program sends a text message to several key providers who can then coordinate a plan to engage the individual in problem-solving. Leaders are considering a comparable strategy for notification a call is made to 911 about a person involved in the jail diversion initiative.
• Taos County leaders took a non-linear, multi-faceted approach as the Crisis System of Care Alliance got underway. They expect and get high participation (rather than a passive audience), accommodate a range of priorities through the successful development of sub-groups, focus on relationships and building intrinsic motivation, disseminate information in multiple ways and at multiple levels, and dig into cross-sector data even when it requires some degree of “doing it by hand.” The result has been that a lot of things are sticking.
• Taos County is working to leverage a broad set of community resources and experts rather than narrowly focusing on categorical behavioral health services as the “solution” to every crisis. Just because a person has a mental illness or substance use condition does not mean that it is the root of a particular crisis event. This is a whole-person strategy that also engages the broad community in developing (rather than being on the sidelines of) solutions.

San Juan County

San Juan County in the northwest corner of the state has a population of just under 130,000 individuals living within 5500 square miles of land. More than 60% of the land is Navajo Nation Reservation. Note that despite efforts to involve leadership from Navajo Nation behavioral health services, it could not be arranged during this consultation period. This is significant since a disproportionate number of persons in the emergency department, local inpatient unit and in the hospital are Navajo. The population in metro areas such as Farmington easily doubles on weekends and other times with the influx of the reservation residents going back and forth and shopping, eating, and accessing services.

San Juan Medical Center is the sole acute care hospital in the county and surrounding Four Corners region. The 254-bed facility includes a 13-bed inpatient psychiatric unit for adults. The hospital also provides outpatient behavioral health services. A steady number of adults and youth with mental health and substance use conditions are seen in the 26-bed emergency department and the inpatient admission rate is high. Youth assessed to need inpatient psychiatric treatment are referred to hospitals in Albuquerque, Las Cruces, and even Texas, and are generally transported by helicopter. Presbyterian Medical Services (PMS) is a CSA for adults and youth. Four Winds Recovery Center provides inpatient detoxification and residential substance use treatment services. Law Enforcement agencies can refer individuals for detoxification services in lieu of jail. In 2004 a 1-stop shop for youth providing assessment, referral and emergency shelter services (up to 72 hours). It is a nice example of a cross-sector initiative designed to prevent youth from falling through cracks. Childhaven, another CSA for youth also operates a shelter.

According to multiple participants, the San Juan County HJM 17 Steering committee got off to a strong start with broad representation and a high degree of enthusiasm. In the past several months, interest has waned with the group feeling stuck in assessment mode and not getting too much in the way of
decisions/implementation. The intent of the work group remains a desire to expand the options for individuals in crisis in order to decrease use of law enforcement, jail, and the emergency department. Based on several individual conversations, longstanding habits/policies and under-developed relationships may be among the barriers to change. While the committee has not seen the big ticket, cross-sector results it has hoped for, the group likely underestimates the impact the process has had in smaller, but very meaningful ways that will drive momentum.

- Outside of the meeting a low-key initiative was developing between the Farmington Police Department and PMS to pilot an intervention strategy with a group of individuals with mental health or substance use conditions who are frequently arrested and jailed. Of the 25 individuals identified only 3 were receiving PMS treatment services (and only 5 ever had) but collectively the community has incurred significant costs. It began in July, 2013.

- The CEO of PMS also initiated a query request of all of the law enforcement agencies, the jail and the hospital with a goal of quantifying and understanding the group that makes up the highest cross-sector service utilizers. The CEO of San Juan Regional Medical Center has agreed to analyze hospital costs for these same high volume service utilizers.

- Momentum is building within a couple of the local Law Enforcement Agencies who are actively exploring options for Crisis Intervention Team (CIT) training. A Sergeant within the San Juan County Sheriff’s Department has developed specialized expertise in training officers to engage individuals with mental health and substance use conditions.

- A strong relationship has formed between a Veteran’s Justice Outreach Specialist and the Adult Detention Center Inmate Liaison. The Outreach Specialist began engaging inmates who qualify for VA services while they were in detention and through collaboration with the Inmate Liaison and others has found community services, housing and residential treatment for a number of individuals.

- Behavioral health leadership from San Juan Medical Center and the CEO of Childhaven recently collaborated in the development of urgent appointment slots held at Childhaven and accessible to ED Social Workers

- The Adult Detention Center Inmate Liaison along with the facility’s Health Administrator used a basic problem solving framework and over a period of several weeks made a number of no-cost, in-house changes that improved care and care coordination. Building cross-sector liaison relationships with behavioral health care providers to improve timely exchange of medical information is a top priority for the facility. They both credit the Mental Health Task Force meetings as spurring these in-house actions

Synopsis of Consultation:
- Participated in a series of 1:1 meetings with local leaders and stakeholders
- Participated in HJM 17 Task Force meetings
  - Facilitated discussion
  - Introduced Crisis System of Care and Sequential Intercept Model frameworks
  - Discussed dynamics of crisis, focusing on resolution vs. assessment, and promoting person-centered and voluntary care
  - Provided resources
  - Provided didactic presentation
- Met individually with Chiefs of local LEA’s, and the CEO of PMS and San Juan Regional Center followed in June by a joint meeting of these sector leaders. Focus of each meeting varied, but was a mix of the following topics: resource dissemination, understanding the nature of the problem,
promoting cross-sector data/cost analysis and identifying business reasons to change policy/practice, discussion sector-specific strategies, and expanding crisis response options that are voluntary in nature and diminish use of law enforcement, jail and the emergency department.

- Met twice with the Inmate Liaison from the adult detention center and discussed a number of strategies for improving the criminal justice and mental health system interface.

Future considerations for San Juan County
- Three very promising indicators are present in San Juan County
  - Momentum is building in San Juan County even if it isn’t big and shiny enough to be readily apparent.
  - There is an emerging group of cross-sector change leaders
  - There have been a number of somewhat small but very significant practice shifts in multiple sectors
- As these elements coalesce larger scale opportunities will become clearer
- Cross-sector policy guidance and permission will speed the process
- Comparing rates of hospitalization (and rates of involuntary hospitalization), jail diversion strategies and like practices with those of other counties might be very useful. Longstanding practices can feel a lot like unchangeable rules when in fact the county may have quite a bit of policy leeway.

Takeaways
- A significant portion of individuals that have frequent law enforcement involvement may not be known to and may be purposefully not using formal treatment providers. This reinforces the importance of a public health approach to developing crisis systems of care. This approach might include: Alternatives to formal treatment services (peer supports, supported housing, and supported employment), analyzing data for disparities that might signify a need to make services more culturally relevant/accessible, and developing crisis resolution competency throughout non-traditional systems such as law enforcement, detention staff, and school personnel.
- Crisis Systems of Care meetings are very useful but it is important to not rely upon them as the place where decisions get made.
  - Empower and encourage Pivot-in-Place analysis
  - Change-momentum can come from any sector and since there are many opportunities ways of strengthening crisis systems of care, start where there is energy and interest.
  - Don’t miss the small low-cost, no-cost opportunities to address gaps in care at the agency or system level. Often this is about logistics, habits or patterns that have been in place for a long time.
- Track these various accomplishments as a Task Force and use the Crisis System of Care and/or Sequential Intercept Model frame to begin describing the system: what exists now, what is in progress, what is on the radar. The visuals serve at least two purposes. They are evidence of progress and they help in identifying gaps.
- As one task force member said: “It is getting clear: anywhere there is a gap, there is an issue that is costing the individual and the community, and there is an opportunity. Everything we do should be centered around the needs of an individual”
Overarching Recommendations

Policy Guidance

Counties and/or specific sectors (i.e. law enforcement, detention, and hospitals) may benefit from guidance on law, policy and rule interpretation. In some cases, there is significant difference in interpretation of laws, rules and policies at a county level without necessarily an understanding that in other parts of the state (or country) other people are doing it differently. A few examples:

- HIPAA, as it applies to cross-sector data analysis
- HIPAA, as it applies to interface between the criminal justice system and behavioral health treatment providers (see addendum)
- If and how Law Enforcement Agencies and hospitals initiate involuntary evaluations
- Whether a detention center has the prerogative to decline taking a person into custody under certain circumstances

Here is an example of a HIPAA policy guidance that lacks New Mexico-specific analysis, but is nonetheless a useful starting point: https://www.bja.gov/Publications/CSG_CJMH_Info_Sharing.pdf

Here is an example of a state-specific resource that includes issue analysis of a number of MH/CJ system issues and recommendations for providers in the state of California: http://www.cdc.gov/COMIO/docs/MENTALLY_ILL_IN_JAILS_PAPER%20.pdf

Offering assistance and/or incentivizing cross-sector cost and volume analysis.
This is almost always a big hurdle to get over for agencies not accustomed to sharing what they may view as proprietary information. But, it is a game-changer.

Cross-Sector Forums
For disseminating information on systems-level innovations, addressing some of the law/rule/procedure questions and brainstorming strategies.

Crisis Service Delivery under Centennial Care
As the state launches Centennial Care and a choice between multiple Managed Care Organizations, it is important to assure that any current crisis intervention services delivered in the community can continue. It must be feasible for counties to offer safety net crisis intervention services without needing to adhere to different rules for different payers. This differs considerably from the delivery of other behavioral health services where provider panels and business rules can vary from BHO to BHO. It isn’t reasonable to expect that Law Enforcement Agencies, hospitals and other systems will use diversionary crisis services if they cannot be used consistently and regardless of payer source. The State may be interested in the Massachusetts model. There are 5 or more Managed Care Organizations in Massachusetts, but one of them—Massachusetts Behavioral Health Partnership has sole responsibility for procuring, overseeing and evaluating all of the Emergency Service Program sites in the state. They also lead in state-level crisis systems of care initiatives with other state agencies.

Funding “Engagement”
In a state where involvement of the criminal justice system and rate of involuntary treatment is high, it is suspected that distrust is an issue for a sizeable number of individuals who might be targeted for criminal justice and ED diversion services. An important early tool is outreach and engagement—an
approach that has been very useful in homelessness initiatives. It isn’t realistic to think that individuals with high distrust will move swiftly into active treatment. Figuring out a strategy for purchasing this type of engagement and perhaps rewarding outcomes may prove fruitful.

Summary

Building the initial momentum can be the most difficult. As these (and other) counties get Crisis Systems of Care activities off the ground, dissemination to other counties will be useful. This includes dissemination of sector-specific analyses/models/successes: Hospitals, law enforcement, schools, jails, Core Service Agencies, etc.

It has been my pleasure to spend time in Guadalupe, Taos and San Juan Counties and to interact with local talent. That each county is at a different stage in the Crisis Systems of Care development process should not be interpreted as being ahead or behind. Like many initiatives this work is idiosyncratic to a community. The process is iterative and while it matures in breadth, depth and complexity it is continuous quality improvement in action.

Please let me know if I may be of further assistance as New Mexico continues its focus on developing Crisis Systems of Care across the state.

Respectfully Submitted,

Kappy Madenwald
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  - John Fitzgerald,
  - Senora Campos, Director of Nursing
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- David Chavez, Juvenile Probation
- The Honorable Richard Gutierrez, Judge, Santa Rosa Municipal Court
- The Honorable Moncayo, Judge, District Court
- Chief Angelo Romo, Santa Rosa Police Department
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- Sgt. Kevin Burns, San Juan County Sheriff’s Department
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- Chief Kyle Westfall, Farmington Police Department
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