

REPORT FROM THE
MAY 19, 2016
NORTHERN
NEW MEXICO

FOUR-COUNTY
BEHAVIORAL
HEALTH SUMMIT

July 7, 2016

*Los Alamos County
Rio Arriba County
Santa Fe County
Taos County*

HOSTED BY COMMISSIONER MIGUEL CHAVEZ, CHAIR
SANTA FE COUNTY COMMISSION

ACKNOWLEDGEMENTS

Santa Fe County Commissioner Miguel Chavez and Tony Flores, Deputy County Manager would like to thank all the presenters and participants as well as staff and consultant who helped make this four-county Behavioral Health Summit a success. A special thanks to Tessa Jo Mascarenas (Constituent Services Liaison, District 2) for her invaluable help managing invitations, interacting with the facility, and collaborating with Santa Fe County staff and consultant to develop the agenda, data, and processes for the Summit. Helping Ms. Mascarenas with registration and room set-up and management were Ambra Baca, Jennifer LaBar, Hvtce Miller, Lisa Katonak, and Tina Salazar. Thanks also to the working group facilitators and note-takers, especially Santa Fe County Community Services Department (CSD) staffers Jennifer Romero, Channele Delgado, Anna Bransford, and Michael Spanier. And thanks to Pamela Hyde for helping to develop the agenda and for facilitating the discussions throughout the day.

Thanks also to the morning presenters – Chairman Chavez, Grace Philips, Patricia Boies, and Wayne Lindstrom – for setting the stage for the day’s discussions. Likewise, the panel of county presenters – Commissioner Liz Stefanics, Kyra Ochoa, Judge Alan Kirk, Kim Gabaldon, Lauren Reichelt, and Taos County Manager Leandro Cordova – was critical to helping the panelists understand the many efforts already underway throughout the four-county area.

Finally, thanks to the elected officials who came for all or part of the day, especially to Santa Fe County Commissioner Liz Stefanics for her steadfast support for addressing behavioral health needs in northern New Mexico and statewide. Thanks to Commissioner Stefanics as well as Santa Fe County Commissioner Kathy Holian and Santa Fe County Clerk Geraldine Salazar, all of whom participated and contributed to the discussions throughout the day.

To the many participants who took time from their busy schedules on May 19th and who give their attention every day to addressing their communities’ behavioral health needs, many thanks. Without you, the day would not have been successful; and without you, action to improve the lives of those living with behavioral health conditions in northern New Mexico would not be possible.

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Executive Summary

On May 19, 2016, County Commissioner Miguel Chavez, Chair of the Board of County Commissioners of Santa Fe County, welcomed over 65 participants invited to a four-county meeting in Santa Fe, New Mexico to discuss behavioral health¹ issues, services, and needs in northern New Mexico. The purpose of this four-county Behavioral Health Summit was “to serve as the first of multiple meetings designed to build a collaboration among northern New Mexico counties to address policy and resource gaps and barriers to serving and supporting residents experiencing behavioral health issues, especially those who do or might otherwise interact with publicly funded public safety, criminal justice, and health care systems.”

The morning was spent considering and discussing information from four presentations carefully designed to assure participants started with the same general information, followed by a tightly facilitated process of identifying the areas that needed further discussion to reach agreement and commitments to priority action steps. These presentations included a description of the *Stepping Up Initiative*, designed to reduce the number of individuals with behavioral health issues in America’s local jails. The outcomes of two state task forces (HJM 17 and SJM 4)² that provided data and recommendations about individuals with behavioral health needs in jails and specifically about the housing needs of such individuals were also presented.

- Stepping Up Initiative***
- 1. Convene or draw on a diverse team**
 - 2. Collect and review prevalence numbers and assess individuals’ needs**
 - 3. Examine treatment and service capacity**
 - 4. Develop a plan with measurable outcomes**
 - 5. Implement research-based approaches**
 - 6. Create ways to track progress.**

¹ The term “behavioral health” is used in this report to mean prevention, treatment, and recovery supports for children, youth, and adults with or at risk of experiencing a mental illness (MI) and/or a substance use disorder (SUD). Behavioral health conditions are part of the larger health promotion, prevention, treatment, and supportive services impacting any individual or community.

² The HJM 17 report can be found at <http://www.nmcounties.org/wp-content/uploads/2014/07/HJM17FINAL.pdf>, and the SJM 4 report can be found at <http://www.nmcounties.org/wp-content/uploads/2015/12/SJM-4-Report.pdf>.

The morning presentations and discussions were followed by working discussion groups addressing issues and needs in three areas: prevention and engagement, crisis response, and re-entry and supports. These discussions, along with a panel of county officials and staff in the afternoon, resulted in recommendations about next steps, including:

- Hold a second behavioral health summit to continue the discussions and solidify multi-county commitments; include San Miguel and Mora County representatives. Assure consumers, service recipients, and people in recovery as well as representatives from tribes/pueblos; federal, state, and municipal governments; private funders; and education are included in future discussions.
- Proceed within individual counties to develop plans, programs, and capacity to serve persons with behavioral health needs; share results with other counties.
- Advocate for federal, state, and local resources for additional needed services such as housing; employment and education; peer-run services; medication assisted treatment for addictions; and preventative, rehabilitative, and recovery support services for individuals and families.

Participants also recommended and committed to the following six priority action steps:

PRIORITY ACTION STEPS

1. ***Crisis Triage Center***
2. ***Care Coordination/Navigation***
3. ***Data Capturing and Sharing***
4. ***Universal Screening of Children/Youth & Families***
5. ***Workforce Development***
6. ***Recovery Awareness***

1. Develop and fund a **crisis triage/drop-in center** to include professional and peer-led services.
2. Work collaboratively to address **care coordination/navigation** needs of individuals and families across counties, systems, and providers.
3. Develop capacity to **capture and share data efficiently and effectively**.
4. Assure **universal behavioral health screening** for children/youth and families at critical junctures in children's lives.
5. Develop a plan to address short- and long-term **workforce development** needs.
6. Develop common approaches to helping people understand **recovery is possible**.

Additional meetings and activities to pursue these action steps are being planned.

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Introduction

On May 19, 2016, County Commissioner Miguel Chavez, Chair of the Board of County Commissioners of Santa Fe County, welcomed over 65 participants³ invited to a four-county meeting in Santa Fe, New Mexico to discuss behavioral health⁴ issues, services, and needs in northern New Mexico. This meeting followed a previous recent meeting between Taos and Rio Arriba Counties to discuss behavioral health issues in those two counties. The May Behavioral Health Summit was held at the Eldorado Hotel in Santa Fe and included elected officials, persons with lived experience of mental and/or substance use disorders (persons in recovery and their family members⁵), and staff of health and behavioral health providers, law enforcement, courts, criminal and juvenile justice systems, schools, health policy advisory groups, state departments, and interested members of the public. Participants were invited to the Summit by the Santa Fe County Manager's Office and represented or served New Mexico communities and individuals in Los Alamos, Rio Arriba, Santa Fe, and Taos Counties.

The purpose of this four-county Behavioral Health Summit was expressly stated:

to serve as the first of multiple meetings designed to build a collaboration among northern New Mexico counties to address policy and resource gaps and barriers to serving and supporting residents experiencing behavioral health issues, especially those who do or might otherwise interact with publicly funded public safety, criminal justice, and health care systems.

³ See Appendix A for a breakdown and description of Summit participants.

⁴ The term "behavioral health" is used in this report to mean prevention, treatment, and recovery supports for children, youth, and adults with or at risk of experiencing a mental illness (MI) and/or a substance use disorder (SUD). Behavioral health conditions are part of the larger health promotion, prevention, treatment, and supportive services impacting any individual or community.

⁵ Generally, the word "family" means both born and chosen families as well as natural support systems of individuals being served by any health or social services provider.

Chairman Chavez talked with many of his colleagues from Santa Fe and the other three counties before calling this meeting, and staff from the four counties' respective health departments or entities have been working jointly on common service delivery issues, including preparing a proposal in response to a federal funding opportunity to develop an Accountable Health Community to address health issues (including behavioral health needs) by focusing on the social determinants that drive healthcare use and costs and by addressing care coordination and navigation issues common among the four counties. Chairman Chavez and other county

Stepping Up Initiative

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commissioners from the four counties have been working with and through the New Mexico Association of Counties (NMAC) to address the dynamics that result in high numbers of individuals with behavioral health conditions being admitted to criminal and juvenile justice systems (courts and jails/detention centers). Chairman Chavez and NMAC were aware of and engaged in addressing these issues through the *Stepping Up Initiative*⁶ sponsored by the National Association of Counties (NACo), the National Council of State Governments (NCSG) Justice Center, and the American Psychiatric Association (APA) Foundation. This initiative is designed to reduce the number of persons with mental illnesses in America's local jails.

This report describes the process and discussion from the Behavioral Health Summit and proposes some next steps derived from the Summit and related activities in the four counties.

Process and Proceedings

The process for the Summit was designed to assure participants represented multiple critical sectors necessary to identify issues and reach resolution about action steps to address the issues. Therefore, while anyone was welcome to come and listen, participants were selected and invited to attend in order to maximize input from representative perspectives. Likewise, the Summit was not designed as a process to identify or discuss any issue anyone might bring up. Rather, this Summit assumed participants would be intimately involved in various aspects of identifying, serving, and/or supporting persons within the four counties who experience behavioral health issues, and to reach agreement on and commitment to a few critical action

⁶ See <https://stepuptogether.org/> for a fuller description of the *Stepping Up Initiative*.

steps the four counties might be able to take individually or together. The process also assumed this would be the first of several meetings of participants from multiple counties in northern New Mexico to address these issues.

Hence, the morning⁷ was spent considering and discussing presentations from Chairman Chavez, Grace Philips (Legal Counsel of NMAC), Wayne Lindstrom (Director of the State's Behavioral Health Services Division and CEO of the State's Behavioral Health Purchasing Collaborative),⁸ and Patricia Boies (Director of the Health Services Division of the Santa Fe County Community Services Department). These four presentations were carefully designed to assure participants started with the same general information, and were followed by a tightly facilitated process of identifying the areas that needed further discussion to reach agreement and commitments to priority action steps. Lunch time working groups were designed as facilitated discussions in three key areas:

- Prevention and Engagement
- Crisis Response
- Re-entry and Supports.

Each working group was led by a facilitator and included at least one resource person. Notes of the discussions were captured and are summarized in this report.⁹

The goal of these discussions was to identify policy and resource barriers along with specific recommendations to the larger group to: 1) prevent behavioral health conditions and engage individuals and families at risk of or experiencing these conditions; 2) respond to individuals and families experiencing behavioral health-related crises to stabilize and help prevent inappropriate involvement with high intensity publicly funded health and criminal justice systems; and 3) assure that individuals who are served in publicly funded health and criminal justice systems are provided assistance to re-enter the community from these systems and are provided treatment and supportive services to prevent re-entry into high intensity publicly funded systems such as jails, emergency rooms, courts, etc. While the intersection of behavioral health and criminal justice systems was a major impetus for this Summit, the purpose was clearly to address the larger behavioral health needs of individuals and communities so that entry of individuals into these systems because of unaddressed behavioral health needs is reduced or eliminated. Chairman Chavez, the Santa Fe County Manager's Office, and the Santa Fe County Community Services Department recognize the role behavioral health issues play in the overall

⁷ See Appendix B for agenda utilized for the Summit.

⁸ Staff from the State's Children, Youth and Families Department (CYFD) was also in attendance and assisted with answering questions and clarifying state policy issues.

⁹ See Appendix C for a summary of these discussions.

health of the community, so wanted this Summit to address the larger issues while focusing on the intersection of unmet needs and the costs to publicly funded systems.

The Summit was designed to recognize the flow of individuals and health and behavioral health service providers across the four-county region. Chairman Chavez felt it was therefore critical that a panel of counties highlight the working relationships as well as the unique issues and approaches of each of the four counties. This panel included elected officials from Santa Fe and Taos Counties, health/behavioral health staff from Los Alamos, Rio Arriba, and Santa Fe Counties, and a magistrate judge from Los Alamos County. The panel explored the existing and possible relationships among the four counties in addition to other northern New Mexico counties, as well as the challenges and successes each of the counties is experiencing.

Summary of Presentations

Commissioner Miguel Chavez (Santa Fe County Commission Chair for 2016)

Chairman Miguel Chavez opened the Summit with a welcome and a description of the purpose of the Summit, along with a Santa Fe County perspective. He gave participants key data about persons with behavioral health needs in Santa Fe County and about the national *Stepping Up Initiative*, kicked off in May 2015 by the National Association of Counties (NACo), the Justice Center of the Council of State Governments (CSG), and the American Psychiatric Association (APA) Foundation. This initiative encourages counties and jails to work with state and local agencies and stakeholders on an actionable plan to address the needs of persons with behavioral health issues in local jails. Both Santa Fe (April 28, 2015) and Taos (March 15, 2016) County Commissions have passed resolutions to begin this process in their counties.

- **Approximately 2,500 Santa Fe County adults have a serious mental illness**
- **Approximately 30,000 residents use illicit substances or misuse alcohol or prescription medications**
- **About 60 percent of homeless individuals have some mental health challenge**
- **2 million adults with serious mental illness such as schizophrenia, bipolar disorder, major depression – are admitted to U.S. jails each year; many also have drug and alcohol use problems**

Chairman Chavez also provided information about Santa Fe County's Adult Detention Facility and Sheriff's Department efforts to address the needs of persons with behavioral health conditions. The medical budget (including mental health and addiction services) for the Santa

Fe County adult and juvenile detention facilities is about \$4.5 million annually. Staff includes a psychologist, a medical doctor, two re-entry specialists, behavioral health therapists, nurses and various medical staff. A third re-entry specialist, who will focus on follow-up with external providers post release, is being hired. While drug treatment is provided, medication assisted treatment for substance use disorders (SUDs) is not currently available for jail detainees.

According to Chairman Chavez, of the population of about 500 detainees per day in Santa Fe County detention facilities, about 67 percent are mentally ill – some of whom also have a SUD. The average cost to house an inmate is \$125 per day. Santa Fe County uses electronic monitoring technology for certain offenders as an inexpensive and non-intrusive alternative to traditional sentencing and incarceration. The cost of this program is growing rapidly.

Seventy of Santa Fe County Sheriff's Deputies have completed mandatory two-hour training on mental illness response, and eight have completed an advanced day-long course. Three have completed the 40-hour training to learn Advanced Crisis Intervention Response to Mentally Ill and Impaired Persons. This training supplements and helps support the County's recently funded mobile crisis response team launched in July 2015 by Presbyterian Medical Services – a project that had served to date 244 individuals¹⁰ in the field and an additional 117 walk-in clients in crisis, directing those residents to behavioral health services and relieving the economic burden on publicly funded systems.

Grace Philips (General Counsel, New Mexico Association of Counties)

Ms. Philips provided participants with a summary of the status of New Mexico county detention and mental health hospital data. She utilized the data to make several critical points:

- The length of stay for inmates in county detention facilities is increasing.
- Approximately 2/3 of detainees are incarcerated for new charges while 1/3 are incarcerated for “failure to comply” with probation or parole conditions.
- Jails have become de facto mental health treatment facilities.
- Mental health diagnosis affects the length of stay in county detention facilities.
- Competency to stand trial affects the length of stay in county detention facilities.
- The bail system (detainees’ inability to post even small amounts of bail) affects the length of stay in county detention facilities.
- As of 2013, New Mexico counties were holding and processing more inmates than the New Mexico Corrections Department (NMCD) which operates state prison facilities.

¹⁰ This program served a total of almost 500 individuals by the end of its first Fiscal Year ending June 30, 2016.

NM County Detention Data

Length of Stay is Increasing

- From 2003 to 2010 median length of stay increased 31% for inmates who spent their entire stay in an unsentenced status (from 112 days in 2003 to 147 days in 2010)
- 80 days median length of stay for misdemeanor arrestees
- 70 days median length of stay unsentenced for probation violators
- 114 days median length of stay unsentenced for those booked on warrants

Reasons for Incarceration

- 62% New Charge (20.1% DWI, 16.2% Property)
- 36% "Failure to Comply" (18.1% Probation Violation, 17.1% Warrants, 0.8% Parole)
 - ✓ Annual cost to counties to hold probation violators supervised by the New Mexico Corrections Department (NMCD), Adult Probation Parole Division is about \$35 million

Jails are De Facto Mental Health Hospitals

- # in NM County Jails on prescribed psychotropic medication: Estimate 35% (more than 2,557) on any given day
- Total # of psychiatric beds in hospitals statewide: 491 in eleven cities
- NM Behavioral Health Institute average populations:
 - ✓ 80 individuals in the adult psychiatric unit (121 licensed and 96 operational)
 - ✓ 40 in the forensic unit (116 licensed 64 operational)

Characteristics of Inmates with Serious Mental Illness

- 89% Pretrial
- 33% charged with Misdemeanor
- 25% charged with non-violent Felony
- 42% charged with violent Felony
- 62% competency raised

Mental Health Diagnosis Effects Length of Stay

- Receiving mental health services increases length of stay by 36 days
- Psychotic diagnosis increased length of stay by 121 days

Competency Effects Length of Stay

- 1.8% (91 individuals) had a mental health competency proceeding
- 27.4% found incompetent to stand trial
- Going through competency process increased length of stay by 278%
- 332 days (11 months) median length of stay for those found competent
- 537 days (18 months) median length of stay for those found incompetent

Bail System Effects Length of Stay

- 39% of county jail population is bondable but has not posted bond
 - ✓ 35% of Bernalillo bondable population has bond amount of less than \$500
 - ✓ 11% of Bernalillo bondable population has bond amount of less than \$100

Counties Hold and Process More Inmates than NMCD: (June 30, 2013 Population Comparison)

- 6,043 NMCD Confined Male Inmates 652 High NMCD Confined Female Inmates
 - 7,030 County Male Population 1,405 County Female Population
-
-

Participants asked good questions about these data¹¹ leading to a rich discussion of policies and practices that might be impacted to change the dynamics of detention for persons with mental health and substance use conditions, as well as for persons who are detained largely because of poverty.

Ms. Philips also provided information about two recent legislative efforts to study and make recommendations about these populations and these issues – House Joint Memorial 17 (November 2011) and Senate Joint Memorial 4 (December 2015), both of which Ms. Philips chaired or co-chaired.

The *House Joint Memorial 17* (HJM 17)¹² task force was asked to make recommendations to reduce the number of people with mental health conditions who require law enforcement intervention or who are in detention facilities. The HJM 17 task force report noted the importance of peer-led and peer-driven services; use of the least restrictive environment and maximization of client choice; crisis systems that serve both individuals who have insights into their conditions and those who do not; trauma informed, gender specific, age appropriate, culturally sensitive, language appropriate, and accessible services; and the availability of services for families and individuals regardless of age, socio-economic status, or insurance coverage.

HJM 17 Recommendations

- **System Improvements (Finances and Payments)**
- **Regional Crisis Triage Centers**
- **Respite Services**
- **Training (for Peers, Family Members, Teachers, and First Responders)**
- **Call Centers**
- **Warm Lines**
- **Community Crisis System Planning**
- **Peer Services**
- **Criminal Law Changes (to Reduce Ineffective Incarceration)**

Recommendations included policy, services, and law changes to improve the lives of those who experience serious mental illness as well as their families and natural support systems.

¹¹ The county detention data cited on page 6 are taken from the following New Mexico Sentencing Commission Reports: *New Mexico Prison Population Forecast: FY 2015-2024*, June 2014; *Length of Stay in Detention Facilities: A Profile of Seven New Mexico Counties*, August 2012; *Effect of Mental Health Diagnoses on Length of Stay in Two New Mexico Detention Facilities*, April 2013; and *Effect of Competency and Diagnostic Evaluation on Length of Stay in a Sample of New Mexico Detention Facilities*, April 2013.

¹² The HJM 17 report can be found at <http://www.nmcounties.org/wp-content/uploads/2014/07/HJM17FINAL.pdf>.

SJM 4 Recommendations

- ***Identify population; assess risks and needs***
- ***Inventory available resources and gaps***
- ***Provide for release from detention with services***
- ***Provide for release from detention with housing***
- ***Create secure clinical facilities for “gap” population***
- ***Educate stakeholders re benefits of supportive treatment for persons with SMI***

*Senate Joint Memorial 4 (SJM 4)*¹³ was designed to make recommendations for clinically appropriate housing options for individuals with serious mental illness (SMI) who are in custody in county detention facilities. The SJM 4 task force made recommendations ranging from processes to services needed to address housing issues for persons with SMI.

Patricia Boies (Director, Health Services Division, Santa Fe County Community Services Department)

Director Boies welcomed participants and explained the goals of the Santa Fe County Health Action Plan. Three of the six goals are related to behavioral health: reducing alcohol abuse; reducing drug abuse; and reducing suicide deaths. A fourth goal is related, that of increasing enrollment of residents in health coverage so their health needs (including treatment for mental illness and/or substance use disorders) can be more adequately met.¹⁴ Director Boies described the four-county partnership to apply for a federal Accountable Health Community grant. The proposal for this grant opportunity was submitted to the federal Centers for Medicare and Medicaid Services (CMS) on May 18th, the day before the Summit. County health staff from the four counties have worked together to develop an approach to navigation for clients in need of health care services (including care for mental health and addiction issues). If funded, the grant would assist the four counties in identifying and tracking social determinants that affect health care delivery and health outcomes. These determinants include housing, transportation, nutrition, poverty, education, and other social service needs. Developing this grant proposal together has given the four counties an opportunity to identify common and unique issues within each of the four counties and to learn to work collaboratively to address specific unmet needs of their residents.

¹³ The SJM 4 report can be found at <http://www.nmcounties.org/wp-content/uploads/2015/12/SJM-4-Report.pdf>.

¹⁴ The other two goals of the Santa Fe County Health Action Plan are to increase the consumption of healthy foods and to reduce the number of babies born at a low birth weight.

Wayne Lindstrom [Director, New Mexico Behavior Health Services Division (BHSD) and CEO of the New Mexico Behavioral Health Purchasing Collaborative]

Director Lindstrom described the state of New Mexico's efforts to expand Medicaid in order to provide additional resources to address the state's behavioral health service needs. He also discussed the state's commitment to recovery for adults with mental and substance use disorders and the state's commitment to prevention and early intervention for children and youth. Director Lindstrom described the context for the state's budget difficulties and the impact this situation was having on initiatives such as BHSD's desire to fund crisis response systems within a number of New Mexico communities. Director Lindstrom also described the federal planning grant received by BHSD to develop Certified Community Behavioral Health Clinics (CCBHCs). This process will help to establish provider competencies to be eligible for enhanced Medicaid funding should New Mexico be selected for one of the national demonstration state grants. Along with staff from the Children, Youth and Families Department (CYFD), Director Lindstrom fielded questions about the commitment to families and to at-risk children, youth, and adults to prevent inappropriate admission of such individuals into child welfare systems, emergency rooms, and county jail systems.

Priority Issues for Discussion

Critical Discussion Areas

After the morning presentations, through a variety of short, targeted conversations, participants identified areas of discussion most important to include as the day progressed. These included:

- Prevention for individuals and families
- Crisis centers
- Communication structures across systems
- Coordinated access to resources for families, individuals, first responders, and providers.

Positive Attributes to Build Upon

Two things participants felt were most positive about the geographic area covered in this Summit included the availability of higher education opportunities and collaborative efforts already underway. In addition, families who were being trained to be supporters and opportunities for Medicaid coverage were seen as positives to build on as discussion and planning continue.

Resource Barriers

The biggest resource barriers to meeting county residents' behavioral health needs were:

- Lack of treatment capacity
- Lack of supportive housing units and services
- Behavioral health and other social services workforce (lack of sufficient practitioners as well as education and training needs of current practitioners).

Not enough follow-through and not enough time for planning and capacity building were also identified as resource barriers.

Policy Barriers

Participants identified policy barriers to meeting behavioral health needs, especially:

- Politics regarding the use of taxpayer dollars (tax policies in general resulting in insufficient resources to meet behavioral health and social service needs)
- Criminalization of those with substance use disorders and use of court-ordered actions to get needs addressed (rather than engaging individuals and families to seek help for their needs before criminal processes are necessary)
- Silos among systems
 - One poignant example among many was grandparents raising grandchildren and all the policy and regulatory issues between and among schools, child welfare, behavioral health, social services, law enforcement/criminal justice, and other systems these families may encounter.

These discussion areas, positives to build upon, resource barriers, and policy barriers were noted and taken by facilitators into each of the three working groups described below.

Working Group Discussions

Participants chose the working group they wanted to spend time in during the lunch hour and into the early afternoon. Once the groups were formed, facilitators, resource people, note

takers, and participants were introduced. Highlights of each of the three groups are noted below.¹⁵

Prevention and Engagement

This group of over a dozen individuals discussed the importance of screening and engaging individuals and families very early, before behavioral health problems appear, but when families, children, and youth may be at risk because of family histories, traumatic experiences, and lack of resources. Home visiting programs and universal screening programs were highlighted. Availability of these programs upon the birth of a child and regularly as children age would help to identify earlier those children and families in need of supportive services. In addition, these programs would be able to address emerging clinical as well as social service needs that may result in youth/young adults interacting with intensive health care systems such as emergency rooms or with law enforcement and criminal justice systems, either as juveniles or as young adults. The role of school-based health clinics and schools in general was noted. This group also underscored the importance of support for families as well as children and youth. In addition to screening and early identification of needs, this working group identified lack of case management or navigation assistance to help children/youth and families to receive the comprehensive services they need without duplication of assessments and other services.

This group identified workforce issues as a barrier to prevention and engagement of persons at risk of behavioral health issues. The group noted the lack of sufficient practitioners as well as the need for training of current practitioners to identify, treat, and make appropriate referrals for mental health and addiction issues. The group discussed economic and tax policies negatively impacting availability of resources for programs and services. Sharing resources and increasing collaboration among providers and systems were identified as ways to stretch scarce resources.

Finally, the prevention and engagement working group talked about the critical importance of raising awareness about emotional and mental health being an aspect of overall health. Helping the public and those at risk understand that mental illness and substance use disorders are just like many other health conditions, that is, preventable, treatable, and able to be managed as either a short or long term condition with the right treatment and supports. Negative public attitudes about mental and substance use disorders need to change. Individuals experiencing these disorders as well as their families and the general public need help understanding and accepting that recovery is possible. Recovery is not a “cure” for a long term mental or substance use disorder, and like other health conditions, relapse is sometimes a reality. However, with the right education, traditional or alternative treatments, and supportive services in the community, persons experiencing mental or substance use disorders can manage their symptoms and lead

¹⁵ See also Appendix C for the notes taken from the flip charts maintained during each group session.

productive lives in the community. The more individuals can understand the nature of these disorders and ways to manage them, the more they can plan an individualized approach to manage their own path to wellness, just like persons with diabetes, heart conditions, hypertension, or other long term health conditions.

Crisis Response

This working group consisted of approximately 20 individuals who identified the types of behavioral health crises individuals, families, and communities experience. The group felt that law enforcement personnel are often first responders. These professionals may have a hard time knowing whether a crisis call is behavioral health related or not, yet must respond with little time, information, or resources to know how best to deal with those involved in the crisis situation as well as those nearby who may be impacted. Crisis calls involve all ages from children as young as eight years old to adults and seniors, making assessments difficult.

The group discussed the need for a facility or campus where individuals and families can go to get help and to which first responders can transport an individual in crisis for assessment and assistance in meeting their immediate needs and linking them to longer term services. The group discussed the Tucson model as a crisis triage center and the Arizona Living Room model as a peer-run approach. Discussion occurred about the role of families, especially family-to-family training opportunities. The Santa Fe County Teen Court was identified as a good model for younger individuals in crisis with law enforcement involvement.

This working group also discussed the need for coordination of systems within a geographic area so individuals with significant needs are not discharged from one location after general business hours and told to go to another service provider that will not be open until the next morning. This period is a high risk time for substance use, relapse, or further interactions with law enforcement or the public without assistance from service providers.

This group, like the prevention and engagement group, identified lack of political will and insufficient or poorly aligned funding as critical impediments to addressing the needs of those in crisis. Santa Fe County's recent funding of a mobile crisis team was noted as a positive first step, but coordination with 911/emergency response networks and other service providers is still a work in progress that needs further attention by county and provider leaders to resolve.

Re-Entry and Support

This working group consisted of approximately 20 participants who identified systems from which re-entry to the community takes place. These include jails, prisons, the state hospital

(Behavioral Health Institute), residential care, hospital emergency rooms or behavioral health units, and systems serving veterans with behavioral health issues after they are discharged from the military. The role of family and other natural helpers for those with behavioral health needs was acknowledged, along with the difficulty such individuals face when no family or other helpers are available or able to assist in transitions. Obstacles include transportation, housing (transitional and permanent), lack of employment or educational opportunities, lack of skill or information to access benefits, and structural and social barriers such as lack of community understanding and acceptance. A critical need is help navigating systems for such individuals.

This group identified the need for assessment and connection to community resources prior to discharge or release, significant 24-hour personal support during a transitional period after discharge or release, and particular needs of youth given multiple systems involved. This group also identified examples of programs in the community to address some of these needs, ranging from behavioral health providers to federal government programs.

The group also discussed ways counties can assist, by being a convener and planner, establishing desired outcomes and measuring progress, rethinking structures, and providing or coordinating training opportunities. The counties can work together to engage managed care organizations and providers of services, develop common program approaches and expectations for critical services such as care coordination/navigation, and combine resources where the need is bigger across geographic areas than one county can address alone.

Recommended Priority Action Steps

After the working groups' rich discussions, the participants came together for reports from each of the three groups about their top priority recommendations for action. The charge to the groups was to identify two or three recommendations a county should take or the four counties should take together to address the needs of persons with behavioral health conditions in their communities. The priorities identified by the three groups include the following:

Prevention and Engagement

- Universal screening of children and families at ages 0 – 6 months, in kindergarten (age 5), and in high school, with special emphasis on at-risk children/youth/families; this includes appropriate referral and provision of needed services identified during screening.
- Economic interventions to develop workforce and bring more providers into communities.

- Raising awareness that recovery is possible, people can get better and lead productive lives, and people can and must be engaged in their own care and treatment.

Crisis Response

- Crisis triage/treatment center incorporating services and information for individuals, families, and first responders.
- Peer-led Living Room model crisis program.

Re-Entry & Support

- Shared data among caregivers/providers/systems about common clients.
- Care coordinators and/or managed care organizations (MCO) meeting and engaging with clients while still in the respective facilities (jail, prison, hospital, etc.).
- Provision of Medicaid services in detention facilities.¹⁶

Participant-Identified Recommendations

Participant discussion after the reports from the working groups led to additional recommendations, including the following:

- Use data to drive priorities (for example, reduce opioid overdose deaths).
- Capture and share information regarding programs and available resources across counties, providers, and systems.
- Add two other counties in Judicial District 8 (that is, Mora and San Miguel Counties) to the discussion of multi-county coordinated efforts.

Panel of Counties

After the working group reports and the participant discussion about recommended priority action items, the group heard from a panel of county officials, including the following:

- **Santa Fe County** – Liz Stefanics (County Commissioner) and Kyra Ochoa (Manager, Health Care Assistance Program)

¹⁶ Note: This action step would take federal and state law and policy changes to accomplish.

- **Los Alamos** – Alan Kirk (Municipal Judge) and Kim Gabaldon (Social Services Manager, Community Services Department)
- **Rio Arriba** – Lauren Reichelt (Director, Department of Health and Human Services)
- **Taos** – Leandro Cordova (County Manager)

Santa Fe County highlighted the work they are doing to support additional re-entry specialists at the County Detention Center, contracts for a mobile crisis team and additional behavioral health services for persons with serious mental illness interacting with law enforcement, and additional efforts to align provider practices, analyze and address service delivery gaps, address alcohol and opioid abuses and overdose deaths, and increase pre-natal care for at-risk women. They also noted their work to address some of the behavioral health needs emerging from the state's efforts to constrain Medicaid spending and address concerns the state identified among behavioral health providers. Santa Fe County also led the development of the four-county proposal for an Accountable Health Community submitted to the Centers for Medicare and Medicaid Services (CMS) on May 18, 2016.

Los Alamos County described the unique role the judicial system is playing in getting social work and counseling support for juvenile offenders rather than probation officers to assure these offenders have their behavioral health needs met. This program has seen significant success in preventing re-offending. Likewise, the County is addressing some of the service needs of low-income County residents, even as the County has higher per capita income than most other New Mexico counties. Los Alamos County noted the importance of the collaboration with the other counties surrounding it geographically for access to services and sharing of positive service examples and lessons learned.

Rio Arriba County described its work to develop a client navigation system operated by the County to assure at-risk individuals receive the services they need and that those services are coordinated, efficient, and effective. The County is implementing a data system to identify and address social determinants affecting health (including behavioral health) care for low-income individuals residing or receiving care in the County. Rio Arriba County hopes the four-county collaboration will assist in the navigation of services for individuals and families receiving care across county lines, and help provide better access to services often provided in one county for the whole region.

Taos County described the challenges of being a small county in a judicial district (Judicial District 8) adjacent to the three counties in Judicial District 1 with which Taos County often collaborates. Taos County is interested in learning from the other three counties and in assuring residents have appropriate crisis and supportive services available locally while having access to longer term services such as residential care in nearby counties. Taos County also believes

that collaboration with other Judicial District 8 counties would serve Taos County and the three counties in Judicial District 1 well.

The result of the panel of counties was a commitment to continuing to work together to build on each county's successes, to learn from each other, and to address service needs that may be better addressed regionally more than within one county alone.

Multi-County/Regional Collaboration – Reasons and Challenges

County panelists and Summit participants identified reasons for addressing issues across four or more northern New Mexico counties rather than within each county, including achieving economies of scale, acknowledging when one county's decisions affect other counties or the region as a whole, sharing of best practices, and being person-centered rather than jurisdictionally centered, especially when individuals move from one jurisdiction to another for care or for personal reasons. Panelists and participants also noted that children need the best start possible regardless of county of residence and that sharing information across providers is critical to helping children and families succeed and to reducing recidivism in various systems.

Challenges to cross-jurisdictional efforts were identified as territoriality, distance, finite resources leading to competition, unique needs and cultural differences in each county, and lack of public support for cross-county work leading to risk aversion of county decision-makers. Participants felt that multi-county efforts are critical to the overall health and behavioral health of northern New Mexico residents and should be pursued, especially for low-income or at-risk populations.

Others to Be Included in Future Discussions

Since this Summit was designed as a by-invitation-only initial meeting, participants were asked to identify others who should be included in future meetings to build on this first Summit.

Participants felt that the next meeting should include the following categories:

- City elected officials, especially mayors' offices
- More state officials, especially the Governor's office and state legislators
- Federal officials (congressional and executive branch representatives)
- San Miguel and Mora County representatives
- More members of the judiciary
- Pueblos/Indian tribes and providers
- More physicians and other practitioners
- Homeless service providers
- Managed care organizations
- Early childhood leaders/representatives
- Public education (K-12 and higher education representatives such as

- Funders (for example, foundations)
- Consumers/service recipients/persons in recovery

- University of New Mexico, Highlands University, Northern New Mexico College)
- Faith community leaders/representatives

Priority Action Steps and Commitments to System Changes – Summary of the Day

Considering the input received during the day along with previous work done by state task forces, each individual county, and participants at this Summit, recommended next steps are:

- Hold a second behavioral health summit in one of the other counties in northern New Mexico such as Rio Arriba County to continue the discussions and solidify multi-county commitments to action; include San Miguel and Mora County representatives in future summits and in collaborative efforts affecting northern New Mexico.
- Assure consumers, service recipients, and people in recovery have prominent roles and voices in future summits and in action planning and implementation.
- Include representatives from tribes/pueblos; federal, state and municipal governments; private funders; and education in future summits.
- Proceed within individual counties to develop plans, programs, and capacity to serve persons with behavioral health needs; share efforts with other counties.
- Advocate for federal, state, and local resources for additional services including, but not limited to: a) permanent supportive housing and housing specifically to support recovery; b) medication assisted treatment and opioid overdose prevention; c) supported employment and education; d) peer-run services; and e) preventative, rehabilitative, and recovery support services for individuals and families.

With these processes as next steps and with a commitment to priority action steps for system changes identified below, the counties involved in this Summit can build on their successes and address many of their residents' unmet behavioral health needs.

1. ***Crisis Triage Center*** – Develop and fund a crisis triage/drop-in center that includes professional, clinical, and peer-led services; provides information for individuals, families and first responders; and addresses the needs of persons with mental health and/or substance use problems, including detoxification, care coordination, and supportive services.

2. **Care Coordination/Navigation and Provider Alignment** – Work collaboratively to address care coordination/navigation needs of individuals and families across counties, systems, and providers, including but not limited to provider and payer alignment around key processes and responsibilities (for example, community providers and payers such as MCOs taking responsibility to coordinate community-based services for an individual before he/she leaves a detention, health care, or residential treatment facility.)
3. **Data Capturing and Sharing** – Develop capacity to capture and share data efficiently and effectively about programs and resources and about individuals being served across multiple systems and providers; utilize these data to improve systems and more effectively serve individuals and families.

PRIORITY ACTION STEPS

1. **Crisis Triage Center**
2. **Care Coordination/Navigation**
3. **Data Capturing and Sharing**
4. **Universal Screening of Children/Youth and Families**
5. **Workforce Development**
6. **Recovery Awareness**

4. **Universal Screening of Children/Youth and Families** – Work collaboratively to assure behavioral health screening for children/youth and families at critical junctures in children's lives; use this screening information to identify and take steps to address individual, family, and community needs at the earliest stage possible, especially for at-risk children/youth and families; use this screening information to advocate for additional resources and services.

5. **Workforce Development** – Work with higher education to develop a plan to address short- and long-term workforce development needs, for current workforce and to create the workforce of the future.
6. **Recovery Awareness** – Work collaboratively to develop common messages and approaches to engage at-risk individuals and families as well as the general public to understand that recovery is possible and that individuals and families can make and implement plans and choices to address their behavioral health needs.

Additional meetings and activities to pursue these action steps are being planned.

APPENDIX A – CATEGORIES OF BEHAVIORAL HEALTH SUMMIT PARTICIPANTS

Participants at the Summit were invited to represent specific sectors to assure robust discussions that would serve as the basis for further discussions with more public participation at a later date. For this initial Summit, the participants who registered included the following¹⁷:

¹⁷ Note: Individuals often represent more than one category. Participants were categorized as they signed in, and each participant was counted only once. Some participants were also people in recovery or family members of persons receiving services or who need services, even though they were not categorized as such for this purpose. To the extent individuals did not register or sign in, their sector is unknown.

APPENDIX B – SUMMIT AGENDA

Santa Fe County Behavioral Health Summit In Conjunction w/ Regional Partners

Behavioral Health: Changing the Model – A Beginning . . .

May 19, 2016; 9:00 a.m. – 4:00 p.m.

Eldorado Hotel, Santa Fe

AGENDA

8:30 – 9:00 a.m.	Arrive, Register, Get Settled (Coffee Provided)
9:00 – 9:45 a.m.	Welcome and Introductions – <i>Stepping Up Initiative</i> Basics <i><u>PURPOSE:</u> This is the first of multiple meetings hosted by Santa Fe County to build a collaboration among northern New Mexico counties to address policy and resource gaps and barriers to serving and supporting residents experiencing behavioral health issues, especially those who do or might otherwise interact with publicly funded public safety, criminal justice, and health care systems.</i>
9:45 – 10:30 a.m.	Behavioral Health Gaps and Needs – Perspectives of Counties and the State of New Mexico
10:30 – 10:45 a.m.	BREAK
10:30 – 11:45 a.m.	Discussion: Examine Service Capacity and Identify Policy and Resource Barriers
11:45 – 12:15 p.m.	BREAK (Box Lunch Available)
12:15 – 1:30 p.m.	Working Lunch – Content Discussion Groups and Emerging Themes <ul style="list-style-type: none">- Prevention and Engagement- Crisis Response- Reentry and Support
1:30 – 1:45 p.m.	BREAK & RECONVENE
1:45 – 2:15 p.m.	Emerging Themes & Priorities
2:15 – 3:15 p.m.	Panel of Counties – Challenges and Opportunities
3:15 – 4:00 p.m.	Themes, Action Steps, Commitments
4:00 p.m.	ADJOURN

APPENDIX C – FLIP CHART NOTES FROM THE THREE WORKING GROUPS

Prevention and Engagement – Jennifer Romero, Facilitator

Brainstorming ideas of what a single county could do (or done as a four-county collaboration)

- Intervention for those in system
- Education
- Detox treatment/ Alt. healthcare
- Creating healthy environments/ support
- Comprehensive screenings/ Early childhood intervention
- School based health clinics
- Alternative services
- Target early (elementary)
- Addressing basic needs
- Providing resources to healthcare system
- Proper identification of MI by practitioner
- Secondary prevention: providing naloxone
- Bringing good paying jobs back into community
- Economic interventions /Workforce development
- Case management
- Collaboration amongst agencies
- Provide resources to families
- Post-natal visits/ screening for maternal health and infant health (universal)
- Intervention in schools
- Utilize the under-utilized programs
- Preserving the health of parents
- Political will raise revenues
- Public Acceptance
- Resources
- How to connect assessment to services?
- Raise awareness that recovery is possible and reduce stigma

Most important recommendations

- Comprehensive screenings/ Early childhood intervention at 0-6 months, kindergarten, and high school (Same for youth and adults; screening would include whole family; same for SUD and MI)
- Economic interventions to develop providers and workforce (Same for youth and adults; same for SUD and MI)
- Raise awareness that recovery is possible and reduce stigma (Different for youth and adults, geared more for adults; may be different approach for SUD and MI)

Barriers: lack of providers, funds, collaboration, politics

How to resolve barriers: share resources, providers, encourage education in the fields of SW, counselors, therapists and retrain them in NM, build relationships

Crisis Response – Anna Bransford, Facilitator

Types of Crisis

- Domestic Issues
- Disturbance of the Peace
- Overdoses
- Suicide Threats

Most Critical Types of Crisis

- Law Enforcement receives a lot of Domestic Issues and Disturbance of the Peace calls. Many from family members / loved ones.
- Law Enforcement many times has a hard time knowing if crisis is Behavioral Health Related.
- Many times the individual is not in compliance with taking medications, keeping doctor appointments.
- Crisis calls can be adults and children even as young as eight years old.

One or two things the four counties can or should do to prepare for and respond to crisis identified

- NAMI checklist – more distribution as well as family to family training community wide
- Alignment of services outside of Santa Fe and Albuquerque
- Law Enforcement would like to see a facility / place to drop off the individual rather than the detention center or Christus St. Vincent. A better place where individual could be triaged (i.e. Tucson type Crisis Triage Center).

One or two challenges in achieving what can be done above?

- Funding / Commitment (lack of political will / alignment of funding)
- Resources (from 6 p.m. to 6 a.m.) for Law Enforcement. If patient is discharged at 8 p.m. and told to go to Life Link for example, the challenge is where they go or what they do until Life Link opens in the morning. (i.e. Self-Medicating, Relapse, etc.)

What can a single or four counties do to overcome the challenges identified?

- Tucson Campus Model (Crisis Triage Center)
- Continued Teen Court for younger individuals.

Two Recommendations the group wants to make for the BH Summit

- Campuses (Tucson Model) – Alignment of Funding, organize with insurances, and collaborate regionally. (High hanging fruit)
- Living Room Model – Peer run facility, simplistic, low cost design. (Low Hanging Fruit)

Resource(s) that should be at the table

- Police Chaplain Jose Villegas – key person in working with Crisis Situations. The group felt that he should be someone at the table to provide insight.

Re-Entry and Support – Michael Spanier, Facilitator

Examples of Systems (from which re-entry takes place)

- Jails
- Probation and Parole
- Prisons
- Behavioral Health Unit (BHU) @ the hospital (follow-up is critical)
- Las Vegas (State Hospital) Behavioral Health Institute
- Residential Care
- Emergency Room (ER)
- Santa Fe Recovery
- Combat Zone

Identification of Obstacles/Challenges

- Not everyone has family to navigate system
- Transportation
- Homelessness
- Addictions – Lack of family support due to isolating behavior
- Employment
- Education
- Communication Barriers/Breakdowns
- Lack of Community Awareness
- Trauma
- Legal Requirements/Lack of Legal Access
- Lack of skill in accessing benefits
- Lack of skill to acquire necessary identification (i.e. Drivers Licenses)
- Health/Illness
- Structural/Social Barriers
- Discrimination/Stigma

Identification of Opportunities

- Capturing population and resources
- Transitional Program
- Model House (Oxford)
- Building Relationships (Such as with a Caregiver/Advocate)
- Daily Support (1st 24 hours are critical to success of transition)
- Risks/Needs can be assessed during incarceration
- Transition of Youth that are circling the system
- Implement Pilot programs
- Pathways System – Can provide data to enhance collaboration and better track clients and outcomes that will support justification for additional resources

Questions

- Where are wrap-around services?
- Who is coordinating services?
- Who is establishing a process?

- Where is intensive case management being done and is it being covered?
- What are the funding sources?
- Who is at the table?
- Do we have enough resources in the community that we can identify?
- Role of MCO's/Medicaid?

Program Examples

- ❖ Life Link
 - Provides comprehensive case management
 - Behavioral Health Assessment
 - Housing/Temporary Housing
 - Home Visits
 - Intensive Case Management System
 - Can be on Program for eight years
 - Obtained grant (three years) funding from SAMSHA
- ❖ Social Security Administration
 - SOAR Program – System Outreach and Recovery Program thru SAMSHA Grant – 70% success rate
- ❖ Interfaith Shelter
- ❖ VA's/VAH's – Out of system – difficult to reach out to provide services

What are the best ways for the County/Counties to move forward?

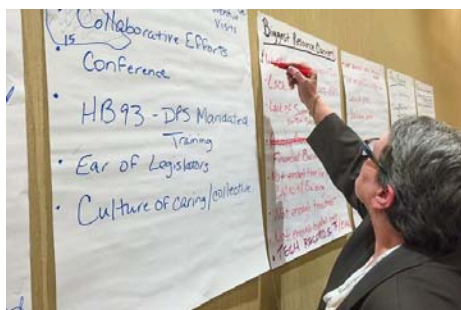
- ❖ County can:
 - Be a convener
 - Be a Planner
 - Establish desired outcomes
 - Rethink structures
 - Bring providers to the table
 - Coordinate Training – Train the trainer
 - Measure progress
- ❖ Fire Department can provide case management/medical care resources

Actions (Move from Talk to Action)

- Service providers need to meet with clients directly
- Enhance Care Coordination (MCO's? Providers? Counties?)
- Provide Transportation (such as from/to jails, facilities, hospitals)
- Implement comprehensive case management

APPENDIX D – PRESS REVIEW OF BEHAVIORAL HEALTH SUMMIT

THE SANTA FE REPORTER



Pamela Hyde reviews notes from a behavioral health summit.

Heads Together on Mental Health

May 19, 2016, 5:00 pm

By [Steven Hsieh](#)

There are probably 200 things that need to happen to improve mental health care in Northern New Mexico, says Pamela Hyde, President Obama's former appointee to head the Mental Health and Substance Abuse Services Administration. "The question is, What are one or two things we can do right now?"

Hyde spoke with SFR during a daylong meeting she facilitated at the Eldorado Hotel downtown. For the better part of Thursday, a diverse mix of professionals—including police, nurses, firefighters, judges, health care providers, corrections workers, hospital administrators, mental health advocates and county-level elected officials—gathered in an open convention room to share ideas on treating behavioral health issues. They sipped coffee and ate roast beef sandwiches. Santa Fe County officials organized the invite-only summit to improve collaboration with Rio Arriba, Taos and Los Alamos counties and fix the region's mental health system, one that was decimated by the 2013 behavioral health shakeup that forced many local nonprofits to close their doors, in favor of an out-of-state corporation that has since pulled up stakes here. During a late afternoon panel discussion, representatives from the four counties shared what has worked in their communities. Los Alamos Municipal Judge Alan Kirk touted two programs that connect youth and families to basic resources like food and clothing, as well as mental health services. "Anytime you can get a group to collaborate, you add strength," Kirk tells SFR.

Rio Arriba Health and Human Services Director Lauren Reichelt spoke about Pathways, a care-coordination model that focuses on specific groups of people, from pregnant women with substance abuse problems to frequent ER visitors.

Taos County Manager Leandro Cordova said he has been taking cues from some of the bigger counties in the room. "Santa Fe County has been working on this for a while," Cordova tells SFR. "We can learn from them instead of re-inventing the wheel and wasting taxpayer dollars."

Led by Hyde, the 60 or so attendees brainstormed seven priorities for the counties to work on, which were plastered over a wall on easel-sized paper. The ideas ranged from broad, like "economic intervention," to specific, like implementing campus-style triage systems to address crises and offering universal behavioral health screening for youth.

The group's recommendations will eventually be compiled into a report. But first, Hyde says, "more work will be done" to narrow the scope of their broader priorities.

County Commissioner Miguel Chavez, who sponsored the summit, says he hopes this will be the first of four meetings, though no additional sessions have been scheduled yet.

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