CREATING A CRISIS STABILIZATION UNIT COLLABORATIVE: NEW MEXICO

"It is extremely useful to behavioral health policy makers to involve providers to figure out how to make state policies work locally."

–Jaymes Fairfax-Columbo, Project Co-Director

VISION

New Mexico's Behavioral Health Services Division (BHSD) was looking for ways to support the development of existing and emerging crisis stabilization units (called crisis triage centers or CTCs) in the state to build its crisis continuum of care and prepare for 988 implementation. The purpose of the grant was to convene a learning collaborative of CTC operators and their stakeholder organizations including consumers, law enforcement, and emergency responder agencies to develop a CTC implementation strategy and uniform set of outcome data.

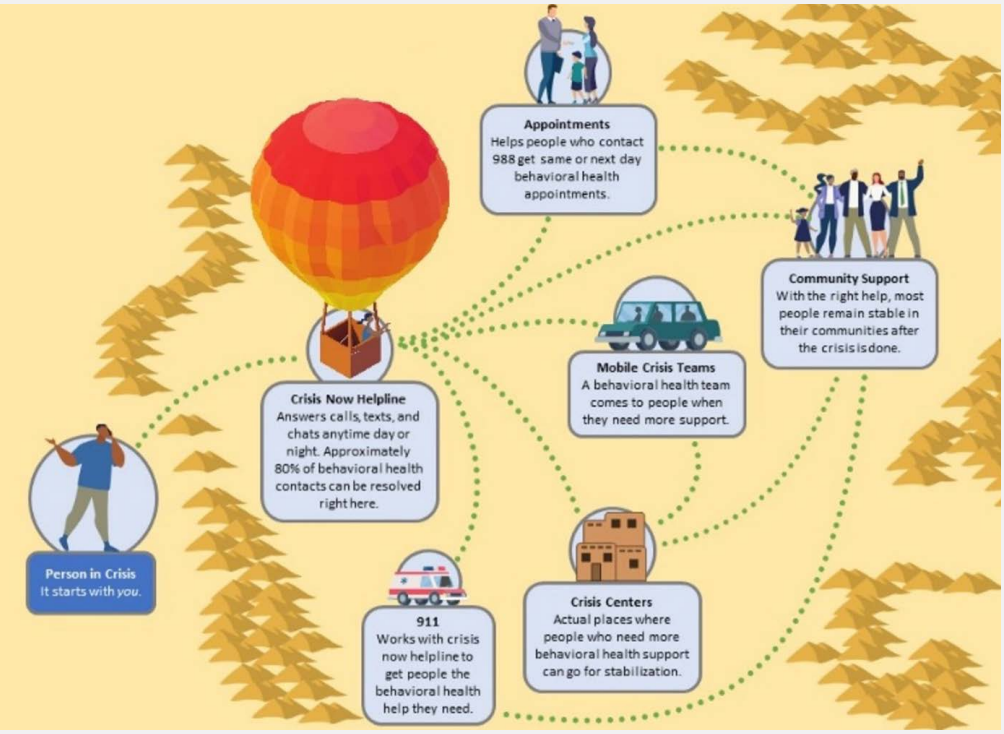
As they met to outline implementation strategies, the learning collaborative focused on operational challenges, some unique and some common, to communities in this geographically and culturally diverse state. CTCs offered one another ideas to navigate implementation barriers to state regulations through acceptable alternatives. One developing CTC for example, was stymied by a requirement for fully certified kitchen. Another developing CTC shared that they navigated this requirement by coordinating with another state agency to import hot meals rather than spend many months and thousands of dollars to build a commercial kitchen. Over the course of the past year, BHSD's expectations for this process evolved from a uniform implementation strategy and data set to an endorsement of operational themes. For example, though the aspiration for the state in implementing CTCs was to emulate "no wrong door," it was recognized that resource constraints and some state laws may prevent that from currently being fully attainable. Instead, the focus should be on helping CTCs be as accessible as possible in the short-term, while collaborating with the State to fully implement "no wrong door" in the long-term. These themes allow CTCs the flexibility to work closely with local partners including law enforcement, emergency responders, and consumer organizations while integrating within the larger statewide crisis systems. Two CTCs came on-line during the year, due in part to the advice and support of the learning collaborative.

JAIL DIVERSION APPROACH

CTCs minimize the involvement of law enforcement and justice agencies with individuals experiencing a mental health crisis by making crisis services immediately available. Anyone can walk-in to CTCs to request help with a crisis without the involvement of law enforcement.

If law enforcement encounters an individual experiencing a mental health crisis, they can transport them to a CTC voluntarily as an alternative to arresting them or taking them to an emergency room for psychiatric

FIGURE 1: NEW MEXICO'S CRISIS NOW CONTINUUM OF CARE



evaluation. This allows for individuals in behavioral health crisis—but who are not in need of coerced care or detention for public safety—to have their needs more appropriately met. Often overlooked and yet critically important to ending a repeated cycle of police encounters and incarcerations, CTCs provide follow-up case management and referral to ongoing treatment.

MEASURING PROGRESS

The project measured its progress in achieving collaboration and consensus across CTCs. While the desired outcome of the learning collaborative shifted from adopting uniform strategies to identifying common principles, participants expressed satisfaction with meetings and level of engagement. A second outcome was that participants engaged stakeholders outside of meetings and were able to elevate their concerns to appropriate individuals on the State level who could help them navigate implementation issues in the short-term and work towards long-term revision of policies that might allow CTCs to better serve the needs of New Mexicans.

BHSD expected that the learning collaborative would recommend a single set of CTC measures. CTCs were already capturing performance and outcome data, such as the number transports and time spent by law enforcement to transfer custody of individuals to the CTC. While the project outlined these and other metrics, the learning collaborative focused more on helping CTCs to identify the data most important to their own community and in building a business case for their development, continuance, and/or expansion.

INTEGRATION WITH CRISIS SYSTEM

The CTCs invite representatives from their consumer peer community, law enforcement, and first responders to learning collaborative meetings. Other stakeholders and subject matter experts attend as needed. The learning collaborative has served as a platform to coordinate activities with other related efforts.

The project has integrated with an overall statewide continuum of crisis care by serving as the conduit between CTCs and state crisis systems. The learning collaborative has met with Open Beds, a bed registry operator that BHSD will seek to increasingly utilize in coming years. Mobile crisis teams in the state work closely with CTCs and in some cases are operated by the same provider. New Mexico's primary crisis call center (soon to become a 9-8-8 operator) regularly attends learning collaborative meetings. CTCs report working

regularly with hospital emergency departments to make referrals, and several are co-located with ambulatory detox settings.

Some CTCs have medical staff that can "medically clear" individuals for admission. Other CTCs are social model programs that must have clients medically cleared by other providers prior to accepting them at the center. Still others have capacity to triage individuals to appropriate level of care if the CTC is not able to meet the individual's medical or psychiatric needs. All CTCs in the state are located on or close by to a medical facility that can address medical issues.

BEHAVIORAL HEALTH EQUITY

CTCs provide an early gateway to mental health care in New Mexico. Whether individuals arrive on their own or they are transported by first responders, they will have the same access to care and follow up services. Two impediments continue to challenge BHSD in achieving equity. Individuals without cars in rural areas have difficulty getting to CTCs. The learning collaborative has proposed a less intensive "CTC-lite" model for frontier areas to bring them closer to people in need, as well as are working to identify transportation alternatives that might allow for CTCs to be more accessible to these individuals. Native Americans' reluctance to seek mental health care based on past experiences and distrust of state services may also impede BHSD's efforts to improve health equity.

PROJECT LEGACY

CTCs and their stakeholders want to continue the learning collaborative after TTI funding ends. BHSD plans to continue to act as convener for the group. As CTCs continue to evolve and as community awareness of their services grow, the project anticipates that there will be a reduction in arrests and psychiatric detentions and fewer overdoses.

WHAT HAVE CSU LEARNING COLLABORATIVES TAUGHT US?

Policies developed at the state level do not address every contingency nor meet the needs of every community. The learning collaborative served as a platform to solve problems and overcome obstacles to implementing policies and integrating systems. It also supplied an opportunity for the State to learn the unanticipated consequences of policies from providers. Ultimately, the learning collaborative provided a framework for the State and providers to learn from each other, identify the critical issues that underscore policies to make crisis care accessible and effective.

For further information on this project, contact Jenny Felmley, PhD, at *jenny.felmley@state.nm.us*.

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