City of Albuquerque

Behavioral Health Crisis Triage Planning Initiative

Crisis Triage Services Continuum Recommendations

Final Consultant Report

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Preliminary Draft Outline
Albuquerque Crisis Triage Program Model

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Summary of Consultant Recommendations

The report that follows is the product of a three-month consultation with the City of Albuquerque's Department of Family and Community Services concerning the potential for development and mobilization of a behavioral health crisis triage services continuum. The specific focus of the consultation was to determine the feasibility and desired configuration of a crisis triage service rooted in evidence-based practices that could achieve both client and system-oriented goals that include:

- Increasing the capacity of individuals to regain stability and move towards recovery in the wake of acute problems created by mental illness, substance use disorders and/or developmental disabilities.

- Increasing the efficiency and effectiveness of the Albuquerque community treatment system to promote recovery-oriented alternatives to jail incarceration or psychiatric hospitalization for persons experiencing a behavioral health crisis.

Stimulated by the availability of resources for triage services created by the city's new Public Safety Tax, this consultation included review of existing reports and planning documents, meetings of a newly convened triage work group, site visits to relevant services and programs and ongoing dialogue with key stakeholders from multiple systems.

A description of the work completed during the consultation is included in the body of this report, along with detailed recommendations for Albuquerque to consider related to the desired staff configurations and projected expenses for new each component of the crisis triage services continuum. The specific consultant recommendations related to the creation of crisis triage programming are reviewed in abbreviated format in the summary that follows.

Recommendation #1: Establish consensus on the need for a comprehensive crisis triage services continuum in Albuquerque

Envisioning a formal plan rooted in a broad-based stakeholder consensus for the development of a comprehensive community-based crisis triage services continuum is well within Albuquerque's reach. The recommended configuration for this continuum, outlined in Chart I on page 15 of this report, would provide clear entry and exit points offering a "no wrong door" system of care for individuals experiencing a behavioral health crisis. The continuum would bring together existing and new treatment, supportive service and housing components, creating clear pathways from system entry points through multiple system "front doors," stabilization services, and "back door" linkages to an array of community treatment services and supportive housing. Such a continuum would be well worth the investment of precious human services resources; savings realized from hospital and jail diversion and reduced use of other crisis services can assist in justifying the costs.

Although creation of the complete triage continuum may not be fiscally feasible at the present time, the continuum can be conceptualized in a fashion that encourages mobilization of prioritized components of the system of care as required resources become available. The triage work group that was convened to assist in the crafting of the recommendations contained in this report would serve as an excellent forum for continuing discussion and the triage planning process. Because no one system of care has the capacity or resources to mobilize a comprehensive crisis triage services continuum on its own, the participation of multiple systems and stakeholders willing to promote integration of funding streams and services will be essential to Albuquerque's success in this endeavor.

Recommendation #2: Collect and Analyze Relevant Local Data Across Multiple Systems

Ideally, the precise configuration, scope and scale of a triage services continuum will be rooted in careful analysis of local data from all components of the current systems that encounter individuals experiencing a crisis related to mental illness, substance use disorders and/or developmental disabilities. The process of generating an unduplicated count and clinical profile of the clients within and across existing systems and programs who seek or need help during times of crisis will assist Albuquerque to further describe current system gaps and barriers (including "revolving doors"), identify the number and nature of those making repeated use of services ("frequent flyers") and provide a firm foundation on which to base the desired size and specific nature of new components of the triage services continuum. At the present time, complete, accurate and integrated data concerning the highest users across the multiple crisis system entry points in Albuquerque and Bernalillo County are difficult, if not impossible, to collect. The lack of this data has somewhat hampered the current triage planning process.

Recommendation #3: Coordinate Existing, Multiple Pathways ("Front Doors") to Stabilization Services

Integrating and enhancing the existing "front doors" to crisis stabilization services is an essential first step to ensuring the success of Albuquerque's triage array. The triage work group was clear on the importance of maintaining multiple points of access for people in crisis; while single doorways to services tend to limit access, multiple doorways increase the likelihood that individuals in distress will find and connect to the assistance they need to promote recovery. The existing systems and stakeholders that have regular contact with individuals in crisis (individuals, family members, police and other first responders, treatment and housing providers, homeless service providers, etc.) include:

- The Albuquerque Police Department Crisis Intervention Team
- The University of New Mexico Health Sciences Center Emergency Department
- The University of New Mexico Health Sciences Center Psychiatric Emergency Services
- Albuquerque Metropolitan Community Sobering Services (AMCSS)
- Albuquerque Metropolitan Central Intake (AMCI)

These different programs will be most effective when they are linked by both physical and electronic mechanisms that promote seamless exchange of information on a real-time basis and referrals across programs that increase the likelihood a person will be able to access the precise services they require to promote stability, regardless of their presenting problem or the place in the system that they first appear for assistance. Creating effective mechanisms for communication across "front door" programs will also enable the Albuquerque system to develop and implement protocols to collect information critical to other, related systems planning efforts. For example, data assembled from multiple sources could help to facilitate and inform the process of prioritizing those clients with the highest levels of need for receipt of the most intensive ongoing, community-based services, such as the new Assertive Community Treatment Team (ACT).

Enhancing existing relationships and forging new linkages will require time and effort. Formal Memoranda of Understanding (MOUs) and Qualified Service Organization Agreements (QSOAs) may be required to facilitate this work.

Recommendation #4: Prioritize Development of Missing Stabilization Services that Promote Recovery

As noted above, many essential components of a comprehensive crisis triage services continuum are already in place in Albuquerque. The addition of a number of core services to this existing service array will eliminate the existing gaps and barriers in the crisis response system – particularly in the arena of stabilization services that can help to promote recovery. These currently missing core services include:

- *Sub-Acute Mental Health Triage*: Stabilization services for individuals in crisis whose needs can be managed in a less intensive setting than the UNM-PES and over a period of 72 hours or less
- *Mental Health Respite Beds*: Short-term (2-3 week) respite beds for persons whose crisis is resolving but either are without housing or cannot immediately return to existing community placements
- *Alcohol/Drug/Co-Occurring Disorder Residential Treatment:* 28-30 day treatment options for individuals who have completed their stay at detoxification
- *Alcohol/Drug/Co-Occurring Disorder Transitional Housing*: Intermediate term (6 months to 2 years) housing opportunities for persons who are homeless and in recovery from substance use disorders and co-occurring mental illnesses
- *Integrated Outreach, Case Management, and Linkage Services*: A transitional case management service that can provide essential supports to individuals moving from the crisis stabilization system to mainstream services and housing in the community

Recommendation #4a: Mobilize A New Sub-Acute Mental Health Crisis Triage Unit

One of the most important missing components of the current crisis services array is a sub-acute mental health crisis triage unit. Such a unit would serve multiple functions, including:

- Creation of service efficiencies that yield additional capacity at the UNM-PES through the provision of a less expensive, alternative stabilization setting for individuals who are currently being referred to the PES but are not in need of the level of acute crisis services offered in the hospital setting
- Provision of step-down and hospital diversion services for individuals initially admitted to the UNM-PES who are still in need of additional stabilization assistance at the end of the 23-hour PES length of stay limit and could be referred to triage as a clinically appropriate and less expensive alternative to in-patient placement
- Provision of jail diversion services for individuals with co-occurring mental illness and substance use disorders encountered by the police and who require stabilization of a behavioral health crisis prior to being referred for sobering/detoxification services

This mental health crisis triage unit is described in detail in the body of this report. It would provide 10-12 beds with a recommended length of stay of less than 72 hours. It would be staffed at a sub-acute level, with nursing and mental health staff on site 24 hours a day, 7 days a week.

Recommendation #4b: Mobilize A New Mental Health Crisis Respite Unit

Currently, Albuquerque has limited resources capable of providing short-term, emergency housing alternatives for individuals recovering from a behavioral health crisis who either do not have access to housing or who have not yet achieved a level of stability that facilitates a return to existing housing or residential placements. The creation of a 10-12 bed crisis respite unit offering 2-3 week lengths of stay would facilitate the careful planning and appropriate timing of community re-entry for these individuals. This respite unit is described in greater detail in the body of this report. If these beds are co-located with the sub-acute crisis triage unit and because many respite clients will be transferring from the triage unit as they achieve increased stability, core services required by respite clients could be provided by staff from the triage unit. Configured in this fashion, the respite beds would generate minimal additional costs within the overall crisis services array while creating a valuable new stabilization resource.

Recommendation #4c: Mobilize Intensive "Back Door" Transitional Support Services to Individuals Moving from Crisis Services to Ongoing Mainstream System Care

The effectiveness of a comprehensive array of "front door" crisis stabilization services will be thwarted without formal, functional linkages between stabilization activities and ongoing supportive services for those who need them. A team of outreach, engagement and linkage specialists is essential to helping clients recovering from a crisis to bridge the

gap between triage services and mainstream systems. Services provided by this team would include:

- Development of a discharge plan for each individual admitted to crisis triage services, in consultation with the client and targeted service systems
- Re-linkage of clients to existing providers that have been serving triage clients, including those clients who may be on an inactive status with a designated provider entity
- Linkage of clients who are new to the system to the appropriate community-based services entity
- Assistance with transportation needs in getting to and from appointments with community-based providers
- Identification of housing options for triage clients without stable housing, and assistance in securing access to the desired housing alternative

Because many of the clients seen by both the mental health and alcohol/drug stabilization services have co-occurring disorders and/or require similar types of assistance in accessing ongoing care in the community, this outreach, engagement and linkages team should be cross-trained in both disciplines and maintain the capacity to service clients in either or both system(s).

Recommendation #5: Co-Locate a Broad Range of Crisis Stabilization Services

As described in the body of this report, co-location of behavioral health crisis stabilization services would not only provide service efficiencies that reduce program costs, but create a fully integrated, "one stop shop" for many different types of behavioral health crises that greatly enhance the effectiveness of a "no wrong door" system. Programs that would benefit from co-location at this site include:

- Sub-acute mental health crisis triage
- Mental health respite beds
- Sobering and detoxification
- Substance abuse and co-occurring disorders residential treatment
- Integrated outreach, engagement and linkage services

Co-location of these services would offer opportunities for the sharing of staff presence and expertise across programs, reducing the need for duplicative staff roles that exist in free-standing programs as well as promoting opportunities for cross-training that greatly enhance staff skills and abilities to assist individuals with multiple problems that typify the crisis triage client. Co-location also provides a less confusing, more user-friendly environment to individuals in crisis; co-located services offering multiple program modalities are better equipped to handle whatever problems a person brings with them through the front door.

Recommendation #6: Create a Hub Facility Master Planning Process to Maximize Opportunities at the Old Charter Hospital

The acquisition of the old Charter Hospital facility in Albuquerque on Zuni SE presents an extraordinary opportunity to create a multi-service hub facility that conjoins an array of crisis stabilization programs activities at a single location. The 86-bed capacity of this well situated building, combined with the space on the grounds that make it suitable for future expansion, offer enormous potential for service co-location of all of the services identified in recommendation #5, above.

Because of the complex issues involved in each of these programs and the need to maximize the efficiencies that can be realized through co-location, a careful and deliberate planning process for uses of the old Charter Hospital facility is critical. Stakeholders from all of the systems that could potentially site or offer services at this hub facility must engage in an extensive collective planning initiative, ideally before the footprint of the facility is significantly altered for any one component of the multi-service site that is envisioned.

Recommendation #7: Blend Resources From Multiple Systems to Achieve Crisis Triage Continuum Goals

The task of mobilizing the crisis triage services array described in this report and the goal of co-locating many components of the array at a hub facility are well beyond the capacity of any one system to fund and operate on its own. Achieving the vision of a comprehensive crisis triage continuum will require addressing the barriers that separate many of the funding streams that currently pay for components of the crisis services system in an independent and disintegrated fashion.

Braiding existing funding streams in ways that can help the local system to move forward with the mobilization of fully coordinated, integrated crisis triage services will require examining what funding streams are currently being used for crisis services and how resources from multiple sources can be combined. These resources should include:

- City of Albuquerque Public Safety Tax revenues
- Existing Medicaid resources
- Additional Medicaid resources that could be captured through new service modalities using new sources of local match funds
- Existing alcohol and drug abuse treatment and prevention resources
- Resources that may become available as a result of funding coordination activities underway at the state level
- Other funding sources, including specialized federal and state grants and local and regional philanthropic entities

A review of available and potential sources of support could be identified as one of the work areas for the hub facility master planning process described in recommendation #6.

Recommendation #8: Evaluate Both Client and System Outcomes Related to Crisis Stabilization Activities

Ongoing evaluation of outcomes related to the crisis triage services continuum will be essential to justify the ongoing support of triage programs. Outcomes for which data will be collected and reports generated must be carefully selected to reflect the identified goals of triage services. Outcomes must also reflect the broad range of goals attached to the triage initiative, including client goals related to regaining stability and moving towards recovery as well as system goals to promote efficient and effective use of public resources.

Outcomes worthy of consideration at *client level* might include:

- Increase in diversion of individuals from jail bookings
- Increase diversion of individuals from inpatient hospitalization
- Increase in re-linkage of clients to existing relationships with treatment providers
- Increase in effective linkages of clients who are new to the system to ongoing, mainstream services
- Decrease in utilization of expensive crisis service modalities by identified "high utilizers"

Outcomes worthy of consideration at a *systems level* might include:

- Increase in co-location of "front door" crisis stabilization services
- Increase in cross-training of staff from multiple systems and the capacity to respond to multiple-problem clients
- Increase in ability to share information and clients across multiple systems to promote effective communication and enhanced service planning and delivery
- Increase in funding that is braided across systems to promote fiscal efficiencies in the delivery of crisis services

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The current level of stakeholder interest in crisis stabilization services and the acquisition of the old Charter Hospital facility, when combined with the new resources made available by the Public Safety Tax, suggests that a rare alignment of energies and opportunities has occurred in Albuquerque that can serve as the catalyst for real systems change. It is rare that a community faces such a remarkable opportunity to enhance its service system to increase the effectiveness with which it can respond to those who are among its most fragile residents.

It is hoped that the current consultation will serve as one more source of stimulation that will help to sustain excitement about and commitment to the emerging potential to enhance Albuquerque's continuum of behavioral health services.

Consultation Background

In 2003, the citizens of the City of Albuquerque voted to approve a new "Public Safety Tax." In his "*State of the City Address*" on November 6, 2003, Mayor Martin Chavez identified behavioral health issues that intersect with law enforcement activities and public safety concerns as one of issues that the resources made available from this tax would help to address. On December 4-5th, 2003, the Mayor hosted a symposium to address in a comprehensive fashion the full spectrum of behavioral health issues in Albuquerque, especially as they impact public safety.

Speaking of this symposium, Mayor Chavez stated:

> *"I believe that much of the intervention monies from the recently passed public safety tax would be well utilized to enact the work product of this symposium. And, while we address mental illness as it affects public safety, I want also to address mental illness as it simply affects day-to-day life in Albuquerque. We need to raise our awareness of the problem and reach out with compassion and understanding to those suffering from mental illness. It is in this fashion that they will be liberated and we will be made more complete and safe as a community….I do not want our jail to be a place where we needlessly lock up those who are really there for behavioral health or brain injury issues and who, with a proper system of support in the community, could return to lives of working, paying taxes, building relationships and adding positively to the fabric of our community."*[1]

This symposium identified a range of behavioral health system gaps and barriers in the local system of care, the responses to which require careful planning and a high strategic approach. As part of this response targeting specifically the relationship of behavioral health care and criminal justice system services, the City requested and received technical assistance from the National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System. David M. Wertheimer, a Senior Consultant at the GAINS Center, visited Albuquerque on June 7th-8th, 2004. Working with a large group of stakeholders assembled by the City's Department of Family and Community Services, Mr. Wertheimer helped to facilitate the development of a comprehensive "systems map" illustrating the interface between the behavioral health and criminal justice systems, highlighting five key "intercept points" at which critical linkages across systems can be established to promote diversion from arrest and/or incarceration to community based treatment and support services. A copy of the materials developed during this systems mapping process is included as ***Attachment 1*** to this report.

This systems mapping exercise helped to highlight that Albuquerque already has in place many of the key components at or near the "front end" of a behavioral health crisis response system. These include:

[1] Albuquerque Mayor Martin Chavez, "State of the City" address, November 6, 2003, West Mesa High School, Albuquerque, New Mexico

- ***The Albuquerque Police Crisis Intervention Team (CIT) Program:*** Following an evidence-based practice model first developed in Memphis, Tennessee, the Albuquerque Police Department has trained many of its patrol-level officers in crisis response techniques. The goal of the CIT program is to provide an informed, humane and appropriate response to individuals experiencing a behavioral health crisis who are encountered by the police. Police officers receive specialized training in mental illness and substance use disorders, de-escalation of individuals in crisis and how to connect citizens to available social service resources. The CIT program seeks to promote diversion of individuals who do not pose significant risks to public safety from arrest, incarceration and ongoing involvement with the criminal justice system.

- ***The University of New Mexico Health Sciences Center Psychiatric Emergency Service (PES):*** The PES reports that it is the only 24-hour a day, 7-days a week Psychiatric Emergency Room in New Mexico. Psychiatric emergency services are provided to all clients who present in PES with an acute psychiatric need. A referral is not required for clients to be seen at PES. Albuquerque Police Department, primary care physicians, emergency rooms, teachers, counselors, other behavioral health facilities, self-referrals and a variety of other sources can refer to PES; anyone in the community feeling unsafe can walk into the service at any time and be seen. If and as needed, referral into the inpatient service or 23-hour crisis stabilization service will occur. Once stabilized, individuals may be referred to the appropriate outpatient level of care; medication management services are available on a daily basis until an outpatient treatment appointment is obtained.

- ***The Albuquerque Metropolitan Community Sobering Services (AMCSS):*** The AMCSS provides 24-hour supervision, observation and support for clients who are intoxicated or experiencing withdrawal. The agency offers clinically managed detoxification characterized by peer and social support structures. AMCSS follows the American Society of Addiction Medicine (ASAM) criteria for treatment and detoxification services. The normal length of stay is 3-5 days, but under certain individual circumstances, an increased length of stay may be authorized. The goal of AMCSS is to not refuse detoxification services to anyone who desires to become clean and sober and meets the core agency admissions criteria.

- ***Albuquerque Metropolitan Central Intake (AMCI):*** The AMCI serves as a first point of contact for clients in need of chemical dependency treatment. A team of substance abuse professionals that include licensed mental health counselors, social workers and a registered nurse are available to conduct the assessment interviews. AMCI assessments seek to match client needs with referrals to appropriate treatment providers in the community. Individuals are eligible for AMCI services only if they are not currently receiving chemical dependency treatment or if 30 days have not passed since the individual was discharged from treatment.

The systems mapping exercise also identified a number of missing components of the behavioral health crisis response system that are essential to a seamless continuum of services – especially "front end" services that are essential to the goal of diversion from the criminal justice and/or inpatient psychiatric treatment systems and linkage to ongoing treatment and supportive services. Among these missing components is a crisis stabilization service referred to in many communities as "Behavioral Health Crisis Triage."[2]

In order to assist Albuquerque in the development of a plan for crisis triage services to be funded within the context of resources generated by the new Public Safety Tax, Mr. Wertheimer returned to Albuquerque to facilitate a focused, short-term planning process. On October 28th, Mr. Wertheimer presented an interim consultant report that contained initial recommendations for a behavioral health crisis triage program to serve the residents of Albuquerque and Bernalillo County. This document, representing the consultant's final report, incorporates the input and recommendations made in response to the October 28th interim report document, and has been expanded to include financial and cost estimate data related to the recommended triage services.

Consultation Methodology

The crisis triage consultation process incorporated information gathered from a range of different sources and methods. These included:

1. Review of Existing Reports and Planning Documents

The consultant reviewed available reports and data on the Albuquerque mental health and chemical dependency treatment systems provided by staff from the Department of Family and Community Services. This included the results of the June systems mapping exercise conducted in Albuquerque, as well as material documenting extensive research related to persons with mental illness incarcerated in the Bernalillo County Detention Center that had been prepared for the Metropolitan Criminal Justice Coordinating Council between 1999 and 2002.[3]

2. Discussions with Newly Convened Triage Work Group

The consultant met on several occasions with a Triage Work Group convened by DFCS for the purpose of informing this planning process. This Work Group included

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[2] See, for example, D. Wertheimer, "*Creating Integrated Service Systems for People with Co-Occurring Disorders Diverted from the Criminal Justice System,"* published by the National GAINS Center for People with Co-occurring Disorders in the Justice System, (Summer 2000)

[3] See, for example, E. Derkas and P. Guerin, *"Mental Health Survey: Final Report,"* (August 1999); and, P. Guerin et al., *"Snap Shot Study of the Bernalillo County Detention Center Psychiatric Services Unit Population,"* (September 1999); and, P. Guerin & W. Pitts, *"An Analysis of Individuals Who Received Services in the Psychiatric Services Unit in the Bernalillo County Detention Center Between January 1999 and December 2000,"* (July 2002).

stakeholder representatives from the many systems that become involved with persons experiencing behavioral health crises in Albuquerque/Bernalillo County. A list of those who participated in the Work Group is included as ***Attachment 2*** to this report. The Work Group assisted the planning process by:

- Describing existing program services and system strengths
- Identifying existing gaps and barriers in the "front end" crisis response services continuum
- Providing anecdotal information about the local service system
- Offering feedback on concepts and options related to enhancing or expanding triage services.

3. Data Collection and Analysis

Members of the Triage Work Group were asked to provide additional data to the consultant to help in determining the array, scope and capacity of crisis triage services required in the Albuquerque/Bernalillo County community. Data that was used to inform this work was provided by the following sources:

- Albuquerque Metropolitan Community Sobering Services
- Mental Health Psychiatric Emergency Services of the University of New Mexico Health Sciences Center
- Bernalillo County Metropolitan Court Mental Health Court Program
- Albuquerque Health Care for the Homeless
- Bernalillo County Detention Center

The most current available summaries of the relevant data provided are included as ***Attachment 3*** to this report.

4. Program Site Visits

The consultant visited many of the programs and services currently operating in Albuquerque/Bernalillo County to provide assistance to persons with mental illnesses and/or substance use disorders who are in crisis and may be involved with the criminal justice system. Consultant site visits included:

- Albuquerque Metropolitan Central Intake (AMCI)
- Albuquerque Metropolitan Community Sobering Services
- University of New Mexico Health Sciences Center/Psychiatric Emergency Services
- University of New Mexico Health Sciences Center/Inpatient Psychiatric Services
- Bernalillo County Detention Center
- Bernalillo County Detention Center/Psychiatric Services Unit
- Metropolitan Assessment and Treatment Services Program (MATS – To be located at the old Charter Hospital facility 5901 Zuni SE)

- Albuquerque Health Care for the Homeless
- St. Martin's Hospitality Center

Information gathered from all four components of the planning process was incorporated into the initial draft consultant recommendations contained in this report.

Envisioning a Crisis Triage Services Continuum

At the core of the recommendations that follow is the vision of a comprehensive continuum of "front door" services that can meet the needs of any individual in Albuquerque/Bernalillo County who is experiencing a behavioral health crisis. In addition, the continuum proposed here prioritizes key system goals of maximizing diversion from jail for individuals with mental illnesses and substance use disorders who do not pose a significant risk to public safety and diversion from inpatient psychiatric hospitalization for those that can be stabilized and supported in the community.

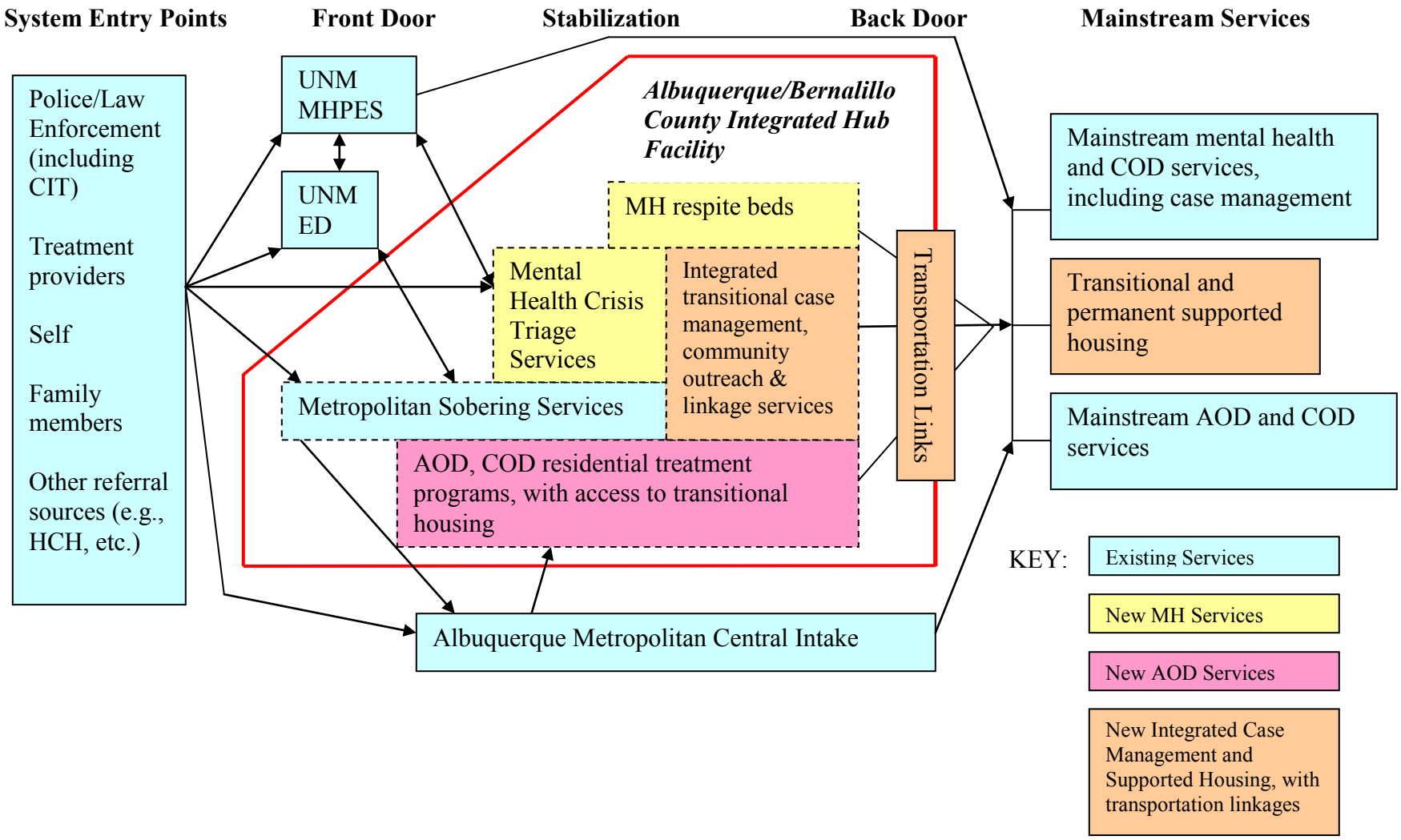
The "front door" described here seeks to offer a "no wrong door" approach to the system: For any individual in the system, any doorway into the system should be the "right" door, regardless of their initial presenting problem or issue. No matter where in the system a person appears, or what the specific nature of their needs are determined to be, the "no wrong door" system should function to connect that individual to the services that they need to promote stability, linkage to ongoing care and a pathway to recovery. Additionally, from the perspective of a person in crisis seeking assistance, the complex cross-system relationships required for a "no wrong door" system should ideally be transparent. The system should be easy to access and free of any barriers to essential services.[4]

The proposed Crisis Triage Services continuum is diagrammed in the chart that appears on the following page. The chart is structured to identify key points in the continuum as follows: System Entry Points, "Front Door," Stabilization, "Back Door" and "Mainstream Services. " The chart is color coded as follows:

- The blue boxes indicate components of the existing service array that are currently in place.
- The yellow boxes indicate components of the continuum that would be mobilized using the specific Public Safety Tax resources that have been prioritized for triage services.
- The purple box indicates new chemical dependency treatment services currently under development.

[4] It is recognized that, if this continuum is created and functions efficiently, it will itself become a successful case-finding mechanism, bringing individuals into the continuum of services and supports who were previously unknown to the system and not receiving care. The implications of this case-finding process include an increase in demand for the resources available for ongoing community-based services in Albuquerque. The implications of this increasing demand for services are complex and will require additional discussion and strategic planning.

Chart 1: Albuquerque/Bernalillo County Community-Based Crisis Triage Services Continuum



- The tan boxes include new mental health/co-occurring disorders treatment services, transportation and supported housing that are, in part, currently under development utilizing Public Safety Tax resources.[5]
- The area inside the red lines indicates components of the triage continuum that would be co-located at a proposed "Hub Facility." (See description, below.)

Specific components of the continuum are described in detail in the following section of this report.

Description of Continuum Components

System Entry Points

Entry points to the continuum include all of the current sources of referrals to crisis services, such as local police, treatment providers, individual clients, family members and other referral sources (such as Health Care for the Homeless). Of particular importance is the creation of the capacity to receive referrals from law enforcement professionals in settings that are police-friendly, easy to access, secure enough to assure police that individuals diverted from jail will not return immediately to the streets and efficient enough to ensure that client drop-off will require less officer "down time" than the process of arresting and booking into jail.

Front Doors

The model specifically identifies multiple front doors to crisis and stabilization services in order to maximize the "reach" of the continuum into the community. Single doorways to services often create the unanticipated consequence of making help more difficult to find and/or limiting access to essential help to persons in crisis. The proposed continuum offers different front doors for use at different times by different referral sources. These include:

- ***University of New Mexico Health Sciences Center Psychiatric Emergency Services:*** The PES would serve as a receiving center for individuals experiencing extremely acute psychiatric crises. Although the PES is currently stretched very close to or beyond its capacity limits, it is anticipated that rapid stabilization and referral from the PES to Crisis Triage Services at the Hub Facility would increase the ability of the PES to manage the volume of referrals coming to its own front door.

- ***University of New Mexico Health Sciences Center Emergency Department:*** The ED would continue to provide a front door option for individuals experiencing acute symptoms related to substance-related intoxication and

[5] The new PACT Team and "Housing First" program are included in this category, although it is recognized that neither of these programs, at their current projected levels of funding and operation, may provide sufficient capacity to meet the demand for treatment services and supported housing that may be created by crisis triage services over time.

withdrawal. Referrals would continue to flow from the ED to Community Sobering Services scheduled for re-located at the Hub Facility.

- ***Mental Health Crisis Triage Services*** *(new service)*: The CTS would provide a sub-acute environment suitable for receiving individuals experiencing a crisis related to mental illness or co-occurring disorders. The CTS would accept referrals both from the PES (of individuals who are stabilized sufficiently to "step-down" to sub-acute services) and from other referral sources that have contact with clients in crisis who do not require the intensity of services provided by the PES. (The CTS would function as both a "front door" and "stabilization" service, and so is further described in the next component of the triage continuum.)

- ***Albuquerque Metropolitan Community Sobering Services:*** AMCSS would continue to provide sobering and detoxification to those in need of these services being referred from any of a number of sources in the community.

- ***Albuquerque Metropolitan Central Intake:*** AMCI would continue to function as a central clearinghouse and front-door linkage service for individuals in need of community chemical dependency treatment referrals who are not currently receiving services.

Ongoing communication across and among these front door services will be crucial, both to expedite referrals on a case-by-case basis to the most appropriate resources available, as well as to coordinate stabilization activities and back door linkages to the next set of services an individual may need. The Front Door components of the system should develop a formal cross-system Qualified Service Organization Agreement (QSOA) and client Release of Information (ROI) procedures that comply with both 42 CFR Part 2 and HIPAA requirements.[6]

Stabilization

Stabilization activities begin both at system entry points and the various "front doors" to the triage services continuum. For example, CIT officers are trained to de-escalate potentially violent or criminal situations, and to assist in promoting sufficient stability to avoid arrest and incarceration. Front door services such as UNM Psychiatric Emergency Services offer services that can result in decreasing client acuity to levels that facilitate diversion from inpatient hospitalization. Albuquerque Metropolitan Community Sobering Services offer individuals a drug and alcohol-free environment to begin the process of recovery from active substance use disorders.

[6] See, for example, DHHS Technical Assistance Publication (TAP) Series 13, *"Confidentiality of Patient Records for Alcohol and Other Drug Treatment,"* Chapter 2, *"Confidentiality of Alcohol and Other Drug Treatment Records and Communicable Disease: Options for Successful Communication and Collaboration,"* DHHS Publication No. (SMA) 95-3018, 1994

However, within Albuquerque's current continuum of services, there are limited stabilization services available that provide the supportive environment required to facilitate ongoing recovery activities. CIT officers are, by design, involved with individuals in crisis for only brief periods of time until they are able to "hand off" the client to the next stabilization setting. Because of its hospital setting, the UNM PES maintains length of stay limits of 23 hours, and has very limited bed capacity. The average length of stay at Sobering Services is 3-5 days, and the absence of appropriate discharge options often results in rapid relapse and re-admission to Sobering for individuals who have barely begun their own recovery process.

The triage consultant strongly recommends that Albuquerque consider a significant expansion of the stabilization component of the crisis triage services continuum. Specific programs that would be included in this stabilization component would include:

- ***Sub-Acute Mental Health Crisis Triage Services (CTS):*** Staffed by a nurse (including a psychiatric nurse practitioner), a mental health counselor and a case aide, the CTS would provide stabilization as well as "front door" services in several different ways. First, the CTS would provide a step-down environment for individuals referred to the UNM-PES who are not yet ready to return to their own places of residence but are no longer in need of the highly intensive level of services provided by the PES. The CTS would offer a secure, sub-acute setting in which to continue stabilization activities that have started at the PES but require a longer period of time to complete. Based on the experiences of other communities that have instituted similar programming, it is anticipated that the average length of stay at the PES would be between 48 and 72 hours[7], but no minimum or maximum lengths of stay would be imposed. Second, the CTS could provide an alternative setting for direct referrals from the system entry points for individuals whose crisis does not appear to present the severity that would require a PES-level of intervention, but who nevertheless require a safe stabilization environment. The creation of a sub-acute CTS unit would both help to alleviate the capacity issues and related pressures on the PES by offering them an alternative to jail or hospital referrals as well as provide a less restrictive diversion option for helping professionals who encounter individuals in crisis who do not require an emergency room-like environment for stabilization.

  In their discussion of this recommendation, the triage work group considered whether access to the sub-acute CTS should be restricted to referrals from the UNM-PES, or whether a more open door policy should be maintained. The group determined that multiple doorways for individuals in crisis are desirable, and that the appropriateness of referrals to the CTS or the PES should be determined on a case-by-case basis. An individual referred to the CTS with more acute needs than the CTS is equipped to handle would be transported to the PES; similarly, individuals ready for sub-acute care at either the front or back end of a PES

[7] The Pierce County (Tacoma), Washington Crisis Triage Service provides variable lengths of stay for individuals in crisis, with the goal of discharging individuals within 72 hours. For further information on the Pierce County model, see: http://www.co.pierce.wa.us/text/services/health/mental/services.htm#CTC

encounter would be transported to the CTS. This process will, of necessity, require an expedited screening process at the front ends of both the CTS and the PES. Individuals will need to be evaluated immediately at the time they present to either program to determine each person's needs and level of acuity and a speedy referral to the most appropriate treatment setting should follow.

Preference for this multiple entry point system for individuals in crisis was identified by the triage work group with the understanding that police officers will likely continue to make most of their referrals to the PES; where law enforcement procedures are concerned, clarity and efficiency are essential. The more user-friendly the process for diverting an individual from jail to treatment, the more likely it is that the policy will be utilized on a regular basis.

The triage work group also discussed the feasibility and desirability of using the triage program (and potentially the respite beds described below) for referrals of individuals exiting from the county correctional facility. Although it is tempting to consider triage as a valuable back door resource for the jail, the consultant strongly discourages making referrals from the jail to respite or triage a regular practice. The availability of triage (or respite beds) in the community should not displace the process of jail discharge planning. Triage is intended for individuals in crisis; ideally, individuals exiting the jail are not in crisis, have been stabilized by the mental health program in the jail and are ready for more permanent housing and treatment options than triage and respite can provide. Furthermore, once triage and respite are identified by the criminal justice system as a viable post-incarceration alternative, both programs run the risk of being rapidly swamped by jail referrals, thereby reducing the accessibility of these services to individuals in the community who are experiencing a crisis.

- ***Mental Health Respite Beds:*** An effective array of front door and crisis stabilization services is not particularly helpful to a continuum of care if there is insufficient capacity to provide ongoing support to individuals who are identified and diverted from more restrictive settings such as hospitals and jails. During discussions of the Triage Work Group, Albuquerque stakeholders agreed that the absence of this capacity is a critical system gap that must be addressed if the continuum is to succeed in achieving its identified goals. One strategy for addressing this gap/need would be to attach a limited number of longer-stay respite beds to the Crisis Triage Service, creating an environment that can facilitate longer lengths of stay for individuals whose immediate crisis has been substantially resolved but who are either without community-based housing that they can return to or are not yet ready for independent living. These beds would maintain ongoing linkages to the housing programs to which respite residents either would be returning or entering for the first time. Creating a relationship with existing 24-hour shelter programs would also be useful, in order to provide for overflow options when the respite beds are at capacity as well as emergency shelter for individuals leaving respite without a formal housing plan in place.

These respite beds, if located contiguous to the CTS, could be staffed by the crisis triage service. Individuals in the respite beds will no longer need the level of supervision provided in the sub-acute setting. In addition, because individuals in the respite beds will, for the most part, have come from the CTS, staff will already be familiar with the issues and needs of this client group. Using the CTS to staff the respite beds creates significant fiscal efficiencies that are outlined in the cost summaries contained in a later section of this report.

- ***Alcohol/Drug and Co-Occurring Disorders Residential Treatment:*** The crisis triage services continuum should assure access to an intermediate-stay (28-30 day) residential treatment setting in which clients can continue the process of stabilization and recovery that has begun at Sobering Services. [8] Without this type of treatment option, the gains made through successful detoxification are difficult to sustain. The creation of this additional residential treatment capacity in Albuquerque will help to close the documented revolving door at Sobering Services. Fiscal year 2003 data indicates that 53% of those using Sobering Services were repeat customers; consequently, the triage continuum should give priority to creating a viable back door resource for those completing detoxification that reduces the risk of relapse and helps to prepare clients for transitional housing, community case management and community outreach services that can continue to promote stabilization and movement towards recovery. Ideally, this resource would include the capacity for meeting the needs of individuals dealing with both substance use disorders and co-occurring mental illnesses.

Back Door Linkages and Transportation to Community-Based Services

The effectiveness of both the front door and stabilization services and the viability of the crisis triage services continuum will be dependent on successful completion of the transition from stabilization activities to the ongoing, community-based services that may be needed.

Some individuals who experience a behavioral health crisis will not need additional follow-up, aftercare or maintenance services once their crisis has stabilized. Other clients will return to active participation in treatment and supportive services in which they were already enrolled at the time of the crisis. A third group of clients -- those who are either entirely new to the system or have been served at some time in the past – will need either to be connected to services for the first time or re-connected to prior treatment providers, if appropriate. For the second and third groups, ensuring continuity of care in the community will be the responsibility of the ***Integrated Transitional Case Management and Linkage Services***.

[8] Ongoing discussion of creating residential treatment capacity in Albuquerque/Bernalillo County are already underway in other venues; a detailed description of this component of the crisis triage services continuum was therefore placed outside of scope of this report.

This multi-disciplinary Integrated Transitional Case Management and Linkage Services would be available for individuals receiving stabilization services from the CTS, mental health respite beds, Sobering Services or residential treatment program. This service would function as the critical "glue" that helps clients to develop and implement service and treatment plans that successfully bridge the gap between the back doors of stabilization services and the front doors to the mainstream service systems that offer ongoing community-based support to fragile individuals in pursuit of recovery.

The Integrated Transitional Case Management and Linkages Services would, ideally, begin the planning process for linkage to community-based care from the point at which individuals enter stabilization services. A range of short-term services would be provided, including:

- Comprehensive assessment of ongoing treatment, housing and supportive service needs
- Collection of information and initiation of application processes for entitlements
- Linkage (or re-linkage) to ongoing community mental health and chemical dependency treatment services, as needed
- Linkage to supported housing options, as needed[9]
- Transitional case management services to provide support to individuals during any gap period between the client's exit from stabilization services and entry to community-based services

The transitional service would, ideally, do much more than simply devise a generic discharge plan and hand a client a card describing the location of the agency to which they have been referred and the time of their first appointment. Rather, the transitional service should provide a formal, physical link to the next identified service location, accompanying the client to their intake appointment(s) and ensuring that the necessary connections actually are made.

Effective ***Transportation Services*** will be a critical component of this linkage activity. The physical linkage to services will require either effective use of existing public transportation systems, and/or the creation of additional transport capacity for clients that may need to move between locations at a time when public transportation options may not be available.

The back door linkage process will require not only the active participation of the transitional service, but an "open door" policy among community-based providers to which the transitional service will be referring clients who have completed stabilization. Individuals exiting stabilization services should receive priority for access to the ongoing

[9] Access to affordable housing stock remains a critical cross-systems issue for Albuquerque/Bernalillo County communities. For example, the current Albuquerque Continuum of Care Narrative housing gaps analysis identifies unmet needs of 3,692 beds for individuals and 1,416 beds for persons in families with children. (*Continuum of Care Narrative*, Page 18.) Addressing these emergency, transitional and permanent housing needs will be critical to preventing the respite bed program from becoming another "bottleneck" point in the system for individuals who are homeless and awaiting housing placements.

treatment and supports that will help to prevent future crises. This priority status should be established through formal working agreements with community-based agencies and, if necessary, by obligations that are clearly stated in contracts from the entities that provide these agencies with their ongoing funding.

Creation of the Albuquerque/Bernalillo County Integrated Hub Facility

One of the keys to a successful crisis triage services continuum that can manage the full range of behavioral health crises that can occur in a given community is the co-location and integration of a variety of stabilization services and activities.[10] Co-location not only permits fiscal efficiencies related to staff and facility configuration, but affords the co-located components of the system access to the broad array of skill sets, treatment disciplines and service modalities that are most beneficial to clients who often present with multiple problems and complex, co-occurring disorders. Co-located services can help to stimulate a centralized screening, assessment and intake process that increases communication across systems and minimizes the need to ask clients in crisis the same questions over and over again. Co-located services allow for ease of referral across programs and systems (e.g., from crisis triage services to sobering/detoxification and visa versa); for interdisciplinary cross-staffing of complex cases (e.g., comprehensive assessment of a client with co-occurring major mental illness and substance use disorders); and, careful and comprehensive discharge planning with the capacity to access the full array of community-based resources that may be needed, (e.g., clean and sober housing combined with intensive mental health case management).

The old Charter Hospital facility on Zuni SE, recently purchased by the County of Bernalillo, could become precisely the type of "hub facility" at which the full benefits of co-located services can be realized. The triage consultant strongly encourages the City and the County to expand joint planning to incorporate additional components of the crisis triage services continuum such that a complete array of stabilization services could be offered at this single location. Recommended components of the continuum to be incorporated into the "hub facility" would include:

- Albuquerque Metropolitan Community Sobering Services
- Expanded alcohol and drug (and co-occurring disorder) residential treatment programming
- Crisis triage services offering sub-acute stabilization services to persons experiencing a behavioral health crisis
- Respite housing accessible to clients whose crises are being resolved and are awaiting access to appropriate community referrals and placements

[10] For example, in the summer of 2004, Spokane County, Washington opened a "Triage Hub Facility" based on a services co-location model. When the facility is fully functional, it will combine mental health crisis triage services, sobering services, detoxification and a Federally Qualified Community Health Center providing an array of primary care services. For further information, see: file:///W:/ADMIN/External%20Newsletter%20-%2010-13-03.pdf

- Transitional housing for individuals exiting residential chemical dependency and co-occurring disorders treatment
- Integrated transitional community case management, outreach and linkage services

In addition to these services, other components of the treatment system should either be physically located at the hub facility or ensure regular visits to the hub facility (e.g., "outstationed staff") to promote seamless linkages to community-based care. Components of this category could include:

- The proposed Assertive Community Treatment team
- Disability Determination/Entitlement Specialists
- Housing Placement Specialists
- Mental health and chemical dependency agency intake workers
- Pre-trial services staff[11]

Determining Program Design, Staffing Configuration and Costs

The following section of this report provides a preliminary set of cost projections related to the sub-acute triage unit, respite housing services and the transitional case management and linkage services. The cost projections that follow should be considered within the framework of core assumptions related to both fiscal issues and staff configuration.

Core program and staff assumptions include the following:

- The sub-acute triage unit is a 10-12 bed program responsible for the care and stabilization of clients who can be reasonably managed in a sub-acute setting. The anticipated length of stay is $\leq$ 72 hours, but may be extended as deemed necessary based on the condition of each client. Clients who pose an active risk to themselves or others, or who are so gravely disabled as to require ongoing medical supervision, are not appropriate for a sub-acute environment and require a more intensive level of care, probably either in an inpatient psychiatric setting or at the UNM Psychiatric Emergency Service unit. Specific screening criteria to be used to determine placement in an acute versus sub-acute setting will need to be developed among the stakeholder systems responsible for the full range of triage services.

- The respite housing unit is a 10-12 bed program responsible for providing short-term, highly supported residential placements for individuals who: 1) are exiting the sub-acute triage unit and have had their crisis situation stabilized to a significant degree; 2) may not yet ready or able to return to existing housing

[11] The triage work group was clear in recommending that pre-trial services representatives should not be stationed at the hub facility to screen or review every admission for outstanding court involvement, but should be available to assist clients identified by the hub facility programs when referrals of specific individuals are made from the on-site programs to pre-trial services.

placements; and/or, 3) may not have a housing plan in place. The anticipated length of stay is ≤ 2-3 weeks. Ideally, the respite unit would be located adjacent to the sub-acute triage unit within the hub facility. Clients in the respite unit would be jointly served by staff from the sub-acute triage unit, staff from provider agencies at which the clients may be receiving services, and members of the transitional case management and linkage services. Triage unit staff would be primarily responsible for maintaining an appropriate milieu within the respite unit; transitional case management and linkage staff would be primarily responsible for working with each client to develop and mobilize individualized, client-specific discharge plan. Discharge plans would include all needed housing and treatment components.

- The transitional case management and linkage services team is shared and funded jointly by the triage service and the sobering, detoxification and residential treatment programs co-located at the hub facility. The team would carry primary responsibility for developing housing and service plans for individuals being mobilized for discharge from all hub facility programs, and would provide active outreach and engagement services to promote successful linkages to the full array of housing and community-based services. As a shared team, the transitional case management and linkage services would include interdisciplinary members with the capacity to address mental illness, substance use disorders and co-occurring disorders. Ongoing cross-training in mental health and chemical dependency treatment issues would be provided.

- All staff from each of these services recognize that co-location at the hub facility carries with it the responsibility to develop multi-disciplinary capacities and offer supportive interactions to "sister" programs on an as-needed basis. Such interactions would include: 1) case consultations on the circumstances and needs of specific clients; 2) cross-program referrals as deemed appropriate; and, 3) participation in on-site crisis stabilization interventions at the hub facility should such interventions be required. All programs within the hub facility would be linked by an intercom system, with the capacity to request immediate assistance from "sister" programs. All hub facility staff would be trained in crisis response, client de-escalation and "show of force" skills.

Core fiscal assumptions include the following:

- Locating the sub-acute triage, respite services and transitional case management and linkage services within the hub facility that has been described can achieve significant cost efficiencies. For example, staff from the sub-acute unit can also oversee the respite program operations. Transitional case management and linkage services staff present on site at the hub can be used to augment the core staff group operating the sub-acute triage. The transitional case management and linkage staff can serve both the triage/respite client group, as well as those exiting detoxification and residential treatment services that operated at the hub facility.

- Given the high number of individuals that will be seen at the sub-acute triage program that have active substance use disorders as well as major mental illnesses, many of these individuals may move directly from triage to detoxification services. Because of its role as a "front door" to alcohol and drug services, it is reasonable to request that alcohol and drug resources be utilized to help support sub-acute triage staff and program expenses.

- It will be worthwhile to explore the feasibility of accessing Medicaid resources to help offset some of the staff and service costs at the sub-acute triage program. Many of the individuals served at triage will already be Medicaid enrolled; a range of services related to both staff expenses and residential costs may be billable under the terms of existing Medicaid contracts. In addition, if match dollars are not currently available to help capture these Medicaid resources, Albuquerque could exponentially increase the value of the dollars applied to Medicaid-eligible services by providing the required local match share.

The following tables provide initial financial projections related to the sub-acute triage unit, respite housing services and the transitional case management and linkage services.

Estimated Salary Levels (Mid-Range on Existing Scales)

Salaries for the staff positions at the sub-acute triage unit, respite housing programs and transitional case management and linkage services have been calculated based on information obtained from the University of New Mexico and Metropolitan Community Sobering Services. See Table 1, below.

Table 1: Salaries for Triage, Respite and Transitional Services Staff Positions

Position	Base Salary	Benefits	Total Cost (1.0 FTE)
Nurse Practitioner (with prescriptive authority)	$68,848.00	$17,900.48	$86,748.48
Registered Nurse	47,569.60	12,368.00	59,937.60
MA Counselor (licensed)	50,648.00	13,168.00	63,816.00
Mental Health Counselor/Case Manager/Housing Specialist	35,193.60	9,150.00	44,343.60
Substance Abuse Treatment Counselor	34,538.00	12,026.13	46,564.13

Recommended Minimal Staff Configuration

Table 2, below provides information on minimal recommended staffing patterns for the sub-acute triage, respite housing and transitional case management and linkage services. The calculations in the table are based on the following assumptions:

Sub-acute triage and respite services require 24 hour a day, 7 day-a-week staff coverage. The precise configuration of the staffing required varies by shift. The transitional case

management and linkage services are primarily provided during regular weekday shifts, with limited coverage in the evenings. The costs for transitional case management and linkage services would ideally be shared between the mental health and substance abuse services all operating at the hub facility.

Table 2: Staff Configuration and Costs for Triage, Respite and Transitional Services

Staff Position	Day Shift	Evening Shift	Night Shift	Cost***
Sub-Acute Triage & Respite Housing				
Nurse Practitioner/Program Director	1.0 FTE			$86,748.48
Registered Nurse		1.0 FTE	1.0 FTE	167,825.28
MA-Level Mental Health Clinician (Licensed)	1.0 FTE			89,342.40
Mental Health Counselor		1.0 FTE	1.0 FTE	124,162.08
Unit Clerk/Data Entry and Back-Up Counselor**		1.0 FTE		44,343.60
Subtotal for Triage & Respite Housing Staff				*$512,421.84*
Transitional Case Management and Linkage Services*				
Mental Health Counselor*	1.0 FTE	0.5 FTE		$93,121.56
Chemical Dependency Counselor*	1.0 FTE	0.5 FTE		97,784.67
Housing Specialist*	1.0 FTE**			44,343.60
*Subtotal for Transitional & Linkage Services Staff**				*$235,249.83*
Total for All Staff				**$747,671.61**

* Staff and expenses to be shared with other hub facility programs
** Weekdays only
*** Staff costs are calculated as follows:
1.0 FTE x 3 shifts x 7 days/week = 4.2 FTE
1.0 FTE x 2 shifts x 7 days/week = 2.8 FTE
1.0 FTE x 1 shift x 7 days/week = 1.4 FTE
1.0 FTE x 1 shift x 5 days/week = 1.0 FTE

Occupancy and Client-Related Expenses

Table 3, below, seeks to identify occupancy and client-related expenses associated with the sub-acute crisis triage and respite bed services. The calculations are based on the following assumptions:

- Space costs at the hub facility (old Charter Hospital) are calculated at a rate comparable to those currently being paid by the Metropolitan Community

Sobering Services unit: $9.50 per square foot. Each of the 12-bed units (one for triage, a second for respite) is estimated at approximately 3,000 square feet.

- Client-related costs are calculated at $20.00 per client per day, based on full occupancy of 24 beds, 365 days a year (8,760 bed days). Although all triage and respite beds will not be occupied at all times, this figure provides for food and voucher funds to cover modest one-time expenses for program clients on an as-needed basis.

Table 3: Occupancy and Client-Specific Expenses for Triage and Respite Services

Occupancy Costs for Triage (3000 s.f. $9.50/s.f.)				28,500.00
Occupancy Costs for Respite (3000 s.f. $9.50/s.f.)				28,500.00
Food, voucher funds, misc. expenses (estimated at $20.00 per day per person for 24 beds)				175,200.00
Total for Occupancy and Client Specific Costs				**$232,200.00**

Table 4, below, provides summary information for the total estimated costs for mobilization of the co-located sub-acute triage, respite and transitional services programs as described above. Also included are the estimated per-bed day costs, calculated both with and without the addition of the respite unit program.

Table 4: Table Summary Table of Triage, Respite and Transitional Services Costs

Cost for Sub-Acute Triage & Respite Staff	$512,421.84
Cost for Sub-Acute Triage Occupancy and Client Care	116,100.00
Cost for Crisis Respite Occupancy and Client Care	116,100.00
Total Cost for Triage Services without Respite Beds	***$628,521.84***
Total Cost for Triage Services with Respite Beds	***$744,621.84***
Cost for Transitional Case Management and Linkage Services Staff	235,249.83
Total Costs: All Sub-Acute Triage, Respite and Transitional Services	**$979,871.67**
Estimated per bed day costs @ 24 beds for 12 sub-acute triage and 12 respite beds, not including financial contribution or extra work load associated with transitional services for detoxification and residential treatment clients: 8,760 bed days divided by $979,871.67.	$118.86
Estimated per bed day costs @ 12 beds for 12 sub-acute triage only, not including financial contribution or extra work load associated with transitional services for detoxification and residential treatment clients: 4,380 bed days divided by $979,871.67.	$223.71

Facilitating a Staged Approach to Triage Services and the Hub Facility

The crisis triage services continuum that is described in this report would be comprised of a combination of both existing services, services that have been proposed for funding under the auspices of the Public Safety Tax, and services that have been identified as needed but have not yet been assigned to any specific funding stream. Recognizing that not all of the desired components of the triage services continuum will be funded and/or achievable at a single given point in time, the consultant recommends careful "staging" of the mobilization of triage services that insures the overall plan for the triage services and the hub facility anticipates and incorporates the expectation of expansion of its multiple components over time.

This section of the report describes how some components of this staging process might unfold based on the use of existing services, currently anticipated resources and potential future revenues.

Existing Services

Existing, funded programs and services that would become full partners in the crisis triage continuum would include:

- The Albuquerque Police Department Crisis Intervention Team
- The University of New Mexico Health Sciences Center Emergency Department
- The University of New Mexico Health Sciences Center Psychiatric Emergency Service
- The Albuquerque Metropolitan Community Sobering Services
- The Albuquerque Metropolitan Central Intake
- Community mental health treatment providers (who will be receiving "back door" referrals)
- Community substance abuse treatment providers (who will also be receiving "back door" referrals)

New Services Funded with Public Safety Tax Revenues

Several components of the stabilization service could be funded, at least in part, with revenues generated by the new Albuquerque Public Safety Tax. These include:

- The Crisis Triage Services (sub-acute services co-located at the hub facility)
- Mental Health Respite Housing (co-located at the hub facility)

In addition, it is anticipated that other programs funded by Public Safety Tax revenues will also become extensively involved in receiving referrals from the crisis triage and respite programs. Planning is already underway for dedicating Public Safety Tax resources to both an Assertive Community Treatment Team and a housing program based in the evidence-based practice model known as "housing first." Both the ACT team and the housing program should be developed with the expectation that a significant number

of referrals – particularly those involving the highest users of the most expensive and restrictive services in the region – will be coming from the crisis triage and stabilization services.

Potential Future Revenues and Treatment System Growth

As significant and important as the ACT Team and "housing first" program will become, it is unlikely that the limited capacity being created in these programs will be able to accommodate the full demand for services that will be identified at the front door and stabilization components of the system over time. The local system will need to study carefully who is coming through its front doors, what the nature of their ongoing treatment, supportive service and housing needs are and the extent to which these individuals are eligible for publicly funded services and housing.

Albuquerque should anticipate that additional resources will be required in the future to meet the full range of needs identified in the populations that come in through the newly integrated front doors to the system, including:

- Additional capacity to provide community-based mental health services at varying intensities
- Additional capacity to provide residential treatment for chemical dependency and co-occurring disorders
- Additional housing capacity of several different varieties, including clean and sober living and low-barrier, service enriched housing that utilizes a "housing first" or "harm reduction" model of care

As the system captures critical demographic and statistical information about the needs of individuals identified by new triage and stabilization programming, system planners will need to begin to identify the revenue streams that can be utilized to support these new client groups.

Strategies to Begin Mobilizing a Crisis Services Continuum Before All Available Resources Are In Place

Recognizing that there is significant local interest in mobilizing as many of the components of the crisis triage services continuum as possible within the constraints of the resources that are available at the present time, the following strategy, with a preliminary service model and related cost estimates, is offered as an interim configuration of services that can begin to move the system towards a comprehensive hub facility model. This interim configuration is predicated on the assumption that sobering services will move to the old Charter Hospital facility sometime during the next calendar year.

1. Provide mental health staff enhancements at sobering/detoxification services in the form of an on-site mental health professional, 24 hours a day, 7 days a week. The daytime shift would consist of a nurse practitioner (with prescriptive

authority), with mental health counselors filling the other two shifts. The expectation for sobering/detoxification that would accompany this enhancement is an increased willingness to admit and work with clients manifesting more acute symptoms of mental illness, including suicidal ideation.

2. Mobilize a 12-bed respite program at the hub facility for persons with co-occurring substance use and mental health disorders who have completed their treatment at sobering/detoxification and/or any residential treatment program developed to serve clients leaving the sobering/detoxification program. These beds would be utilized to provide an alternative to a return to the streets for those clients who do not have housing options at the time they would be discharged from care.

3. Provide staffing of the co-occurring disorders respite program with 1.0 FTE mental health counselor and 1.0 FTE chemical dependency counselor, 24 hours a day, 7 days a week. These staff positions would oversee operations of the respite program, as well as share responsibility for working with respite clients to secure housing and treatment placements in the community.

4. Reserve an additional 12-bed unit at the hub facility, contiguous to the respite bed program, for future development of the sub-acute mental health triage program. Once funded and mobilized, the sobering/detoxification mental health enhancement staff would relocate to the triage program (while continuing on a consulting basis with the co-located sobering/detoxification services), and respite program staff would become part of the core staff for the sub-acute triage program, while continuing to staff the respite program clients.

5. As resources become available, further enhance the work of all hub facility programs with the addition of the outreach, engagement and transition services described in earlier this report. These services would also be based at the hub facility, and would assist sobering/detoxification, residential treatment, sub-acute triage and respite bed program staff in securing community placements for clients exiting the hub facility programs.

Cost estimates for the first three components of the interim service configuration described above are provided in Table 5, below:

Table 5: Interim Configuration Cost Estimates

Cost Centers	Day Shift	Evening Shift	Night Shift	Cost
Sobering/Detox Mental Health Enhancement				
Nurse Practitioner	1.0 FTE			$86,748.48
Mental Health Counselor		1.0 FTE	1.0 FTE	124,162.08

Respite Bed Staff				
MH Counselor	1.0 FTE	1.0 FTE	1.0 FTE	186,243.12
CD Counselor	1.0 FTE	1.0 FTE	1.0 FTE	195,569.35
Subtotal: Staff Costs				*$592,723.03*
Other Operating Costs				
Occupancy (3000 s.f. $9.50/s.f.)				$28,500.00
Food, voucher funds, misc. expenses (estimated at $20.00 per day per person for 12 beds)				87,600.00
Total Cost				**$708,823.03**

Creating a Hub Facility Master Plan

Through both the current triage planning process and the acquisition of the old Charter Hospital facility, the City of Albuquerque and County of Bernalillo have embarked on important planning and program development activities related to the configuration of "front end" services to persons dealing with behavioral health crises. These planning efforts are particularly significant in that they are or and should be informing the rich array of services and supports that could be co-located in a central hub facility.

The City, County and allied stakeholders would benefit from the creation of a single, integrated discussion of how best to configure and mobilize a comprehensive array of crisis stabilization services, including those located at the Charter Hospital/hub facility. Ideally, a Hub Facility Master Plan will emerge that maximizes the enormous potential of this 86-bed resource and the array of services that are already in place or planned for development and mobilization in the near future.

The consultant strongly recommends the creation of a detailed Hub Facility Master Plan to maximize the opportunity to identify and address both current and future service system needs. Key components of this master planning process would be focused on both the physical configuration of the facility and the cross-system relationships that would need to be established to ensure effective hub operations. Work groups of the master planning process could include:

Physical plant configuration and management: This group would determine what services/programs should be co-located at the hub facility, how the physical plant should be configured to maximize the use of available space, etc.

Program design and cross-system relationships: This work group would examine the nature of the programmatic relationships that are needed to ensure the delivery of seamless, integrated services, including the construction of MOUs and QSOAs, the feasibility of creating a centralized screening, assessment and intake process, which programs/services should be invited to send out-stationed representatives to hub on a regular basis, etc.

Long-range site development: Because the old Charter Hospital property includes a large amount of space that is not currently developed or in use, this work group would explore options for future development of the facility, including the feasibility of locating transitional housing units in immediate proximity to the full array of hub facility programs.

Evaluation: This work group would define specific client and system level goals for the hub facility and design an evaluation process to help all involved stakeholders to determine the extent to which the programs and hub facility are meeting community expectations and desired outcomes.

Attachment 1

Albuquerque Systems Mapping Exercise
June 7-8, 2004

Potential Strategies Identified for Specified System Intercept Points

INTERCEPT 1: Law Enforcement

1. More CIT training – increase knowledge of how to get help
2. Create mobile crisis team – civilian members an option
3. 24 hr. crisis triage facility with information system sharing capacity - accessible to all referrals.
   e.g., crisis bed availability at old Charter Hospital with triage for medical problems and MH/AOD assessment function and referral services, including eligibility review and linkage to ICM/PSU Team.

INTERCEPT 2: Jail/Booking/Initial Determination

1. Determination of previous/current benefits at point of intake
2. Real time jail notification of MH status, with involvement of pre-trial services (including metro court computer system summons record).
3. Coordinated, centralized, 24/7, system of care and intensive case management (reaches into areas 1, 3, & 4) (perhaps) for individuals known to PSU. Has jail-based MH component, linked to primary care and related services (e.g., HCH) offers early link to continuum of care (could be ACT Team).
4. More case management and pre-trial services (2 & 3)

INTERCEPT 3: Jail/Court Forensic Evaluation

1. Create ACT program for those found incompetent and prioritization of treatment for this group (ACT Team and others)

INTERCEPT 4: Re-Entry

1. Expedite reconnection to entitlements/benefits for those returning to community
2. Pre-release case management for those transitioning to community (and/or problem)

INTERCEPT 5: Community Support

1. Downtown ambassadors (Downtown Action Team) have information on range of housing and support and services.
2. Information clearinghouse for criminal justice system use on services, supports and housing resources available.
3. Frequent flier information system and resources network for contact information to re-link consumers to services.

CROSS INTERCEPT RECOMMENDATIONS

1. Access to permanent supportive housing = Housing First (independent housing with supports that follow.
2. Transitional supportive housing (ability to stay longer, whatever is most appropriate).
3. Emergency shelter/housing with supports

GAP Funding while waiting for benefits – diverted or

Summary of Action Steps for Intercept Point 1: Law Enforcement/Front Door

Desired Action Step: Crisis Triage Services

Goal: Creation of 24 hr. crisis triage facility with information system sharing capacity - accessible to all referrals. (e.g., crisis bed availability at old Charter Hospital with triage for medical problems and MH/AOD assessment function and referral services, including eligibility review and linkage to ICM/PSU Team.)

1. **What should the program look like?**

   - On-site services in order to stabilize and transition to service referrals
   - Social and medical detox, providing basic medical triage
   - Co-located services, as needed
   - Methadone services (controlled substances), as needed
   - Psychiatric crisis services
   - Assessment and referral (screening for needed services)
   - Connection to housing
   - Gender specific services, as needed
   - Connects people to services (including public benefits)

2. **Who is eligible for it?**

   - Primarily individuals 18 years & older with mental health or co-occurring disorders, but create appropriate connection to services for youth.
   - Anyone who encounters law enforcement **(Give law enforcement priority placement for individuals they refer to triage.)**
   - Anyone who asks for help
   - Anyone accessed by law enforcement as appropriate for triage services
   - Also, anyone in the community (people with psychiatric crisis, co-occurring crisis, and substance abuse.
   - Develop prioritization system, but serve everyone.

3. **How is the program accessed?**

- Referrals from "everywhere" – law enforcement, outreach team, ER, downtown ambassadors, family, general community
- Create ability to pick up clients and transport potential clients to appropriate services.

4. How long do services/housing last? What happens then?

- Evaluate case by case to determine length of stay, but long enough to connect to appropriate services.

5. What are the desired outcomes?

- Connected to appropriate services at time of discharge
- Diversion from jail

6. How will the program's success be evaluated?

- Immediate stabilization, so no longer in crisis
- Connection to appropriate services
- Population in jail is lowered
- Evaluate volume of referrals and condition of clients at time of referrals over time
- Decrease in frequent flyers and access if "frequent flyers" are filtering through connected services (are they accessing services)

NEXT STEPS

1. What is required to make your program happen?

- Need a building and campus big enough to co-locate services
- 24/7 staff, including medical personnel and case managers
- Integrated information system
- New $$$$, plus evaluate use of existing $$$$ to insure that funds are being spent in the appropriate places.

2. What the steps in the process?

- Define what type of place is needed (space, accessibility, co-location of services)
- Find a "home" that is accessible
- Identify staffing needs and match staffing patterns to services that will be provided
- Identify existing service providers to insure that services created at 24 hour triage does not duplicate existing services)

3. Who needs to be at the table?

- Providers of existing services (i.e., detox, psychiatric services, case management, ER, community-based service providers)
- Salud
- Housing
- UNMH and other hospitals
- Neighborhood associations
- City/County ($$$$)
- Law enforcement (CIT – Crisis Intervention Team)
- Consumers
- EMS and other public safety
- Foundations

4. Who could/should/will take responsibility for moving the program forward?

- City of Albuquerque – Mayor's Office, Department of Family and Community Services, City Council
- County – Jail
- Criminal Justice System
- State Agencies (DOH, HSD, etc.,)

Attachment 2

Crisis Triage Work Group Participants

Name	Organization/Agency
Edwina Abeyta	FIC
Peter Boyles	Pretrial Services
Adan Carriaga	Metropolitan Detention Center DWI Program
John Dantis	Bernalillo County
Dwight Dias	Sobering Services
Elizabeth Endean	UNM Psychiatric Center
Judie Harris	St. Martin's Hospitality
Gary Jackson	TLS, Inc.
Kevin Kinzie	Bernalillo County DWI Program
Nancy Koenigsberg	Protection and Advocacy
Larry Kronen	Attorney
Maurice Martin	HAC/ADAPT
Rodney McNease	UNM Hospitals
Joseph Miller	Southwest Center for Family Development
Sigrid Olson	Health Care for the Homeless
Jan Olstad	Albuquerque Police Department
Sherry Pabich	NAMI
Michael Passi	Department of Family & Community Services
Lee Pattison	St. Martin's Hospitality Center
Barbara Quintana	Albuquerque Division of Behavioral Health
Michael Robertson	Homeless Advocacy Coalition
Kelly Camlin Shinger	TLS, Inc.
Lisa Simpson	The Crossroads
Mary Stiel	COA/FCS
David Trembath	COA
Valorie Vigil	Department of Family & Community Services
Cyndi Yahn	Health Care for the Homeless
David Wertheimer	*Consultant/Facilitator*

Attachment 3

Summary of Available Data

This attachment briefly summarizes data sets from Bernalillo County Sobering Services, the University of New Mexico Health Sciences Center Psychiatric Emergency Services and Albuquerque Health Care for the Homeless that were provided to assist the triage planning process. These data sets summarize basic demographic information related to client admissions to these programs.

Bernalillo County Sobering Services
June 2003 – June 2004

Admissions

Sobering recorded a total of 2204 admissions. Of these admissions:

- 83% were male, 17% female
- 86% were between the ages of 25 and 54
- 92% have incomes of less than $10,000 per year
- 21% were veterans
- 34% were Hispanic (the largest single group, followed by Whites at 33% and Native American at 22%)
- 55% (partial year data) were homeless
- 40% (partial year data) were taking some form of medication
- 53% were readmissions, individuals already known to sobering

The largest sources of referrals (35%/n=768) were from local hospitals, and most of these came from University of New Mexico Health Sciences Center. Of these, approximately 95% came from the UNM Emergency Room, and 5% from the UNM Psychiatric Emergency Services.

The second largest group of referrals to sobering services is self/relative referrals (34%/n=748), followed by referrals from other agencies (19%/n=414). Referrals from local law enforcement comprise 8% (n=170) of the total referrals. These individuals are transported to sobering by the officers themselves, or are picked up by a sobering services driver once referred by the police.

Discharges

The majority of individuals discharged from sobering (56%/n=1227) are referred to 12-step programs in the community. The second largest group (21%/n=456) is referred to inpatient services. Eighteen percent (n=386) are referred to various outpatient programs.

University of New Mexico Health Sciences Center
Mental Health Psychiatric Emergency Services
January 2004 – August 2004

Admissions

The MHPE reported a total of 5,064 encounters between January and August. This is an average of 633 encounters per month. Of these encounters:

- 45% were male, 55% were female
- 38% were Caucasian/White (the largest single group, followed by Hispanic at 34%). Unlike sobering services, Native Americans comprised only 3.6% of the total sample.

In relation to method of reimbursement:

- The largest plurality of the sample (38%/n=1913) was Medicaid or Medicare eligible.
- The second largest group in the sample (30%/n=1509) was "self pay" (virtually 100% uncompensated care)
- 22% (n=1132) were covered by UNMcare
- 8% (n=395) had private insurance

In relation to time of admission ("time registered"):

- 13.9% (n=704) of admissions were made between midnight and 8:00 a.m.
- 54.71% (n=2771) of admissions were made between 8:00 a.m. and 4:00 p.m.
- 31.38% (n=1589) of admissions were made between 4:00 p.m. and midnight
- 63.99% of the admissions were made between the hours of 7:00 a.m. and 5:00 p.m.

The top five specific diagnostic categories assigned to those admitted were:

- 12.59% Depressive Disorder NEC
- 8.03% Affective Psychosis NOS
- 5.88% Psychosis NOS
- 5.15% Paranoid Schizophrenia-Unspecified
- 5.12% Prolonged Post-Traumatic Stress

When all of the various alcohol and drug related diagnoses assigned as primary are added together, they represent a total of 15.12% of the individuals admitted.

Albuquerque Health Care for the Homeless
Behavioral Health Program
July 2003 – June 2004

Behavioral Health Program Encounter Information

HCH reported 6, 425 encounters and contacts in the behavioral health program, with an unduplicated count of 793 users. Of this group:

- 58.8% were male, 41.2% were female
- 41.2% were White
- 8.5% were American Indian
- 8.4% were Black
- 0.6% were Asian

In relation to the housing status of their behavioral health clients, HCH reported that their clients spent the night prior to their encounters in a variety of different settings. The most frequently reported settings included:

- Shelters
- Doubled up with acquaintances, friends or family
- On the streets
- In transitional housing
- In permanent supportive housing

Ranked in descending order of frequency, HCH behavioral health clients have been diagnosed with the following disorders:

- Alcoholism
- Depression
- Schizophrenia, Paranoid Type
- Schizophrenia, Undifferentiated
- Schizoaffective Disorder
- Bipolar
- PTSD Chronic
- Major Depression
- Polysubstance Dependence
- Cocaine Abuse
- Opioid Dependence
- Borderline Personality Disorder
- Anxiety