New Mexico Behavioral Health Purchasing Collaborative Meeting

Thursday, January 12, 2012

Human Services Department
37 Plaza la Prensa
Santa Fe, NM

Video Conference Sites
Farmington
Las Vegas
Las Cruces
Silver City
Roswell
Albuquerque
Thursday January 12, 2012
37 Plaza La Prensa
Santa Fe, New Mexico
1:00 p.m. – 4:00 p.m.

AGENDA

1. 1:00 – 1:10 p.m. (10 mins)
   Call to Order
   • Approval of the NM Behavioral Health Collaborative Meeting Minutes from July 14, 2011 (Decision Item)
   • CEO Updates
   • OptumHealth Contract Amendment 9 (Decision Item)

2. 1:10 – 1:20 p.m. (10 mins)
   Behavioral Health Planning Council (BHPC) Report
   Chris Wendel, Behavioral Health Planning Council

3. 1:20 – 1:35 p.m. (15 mins)
   Directors Reports/Data
   Karen Meador, HSD/Behavioral Health Collaborative
   Geri Cassidy, HSD/Medical Assistance Division

4. 1:35 – 1:50 p.m. (15 mins)
   Contract Management
   Diana McWilliams, HSD/Behavioral Health Collaborative

5. 1:50 – 2:20 p.m. (30 mins)
   Veterans/Trauma
   Harrison Kinney, HSD/Behavioral Health Services Division

6. 2:20 – 2:30 p.m. (10 mins)
   Quality Improvement
   Betty Downes, Quality Improvement Committee

7. 2:30 – 3:10 p.m. (40 mins)
   Legislative Memorials
   Harrison Kinney, HSD/Behavioral Health Services Division
   Karen Meador, HSD/Behavioral Health Collaborative
   Bobbi Lightle, HSD/Behavioral Health Services Division
   Daphne Rood-Hopkins, HSD/Behavioral Health Services Division
   Grace Phillips, NM Association of Counties

8. 3:10 – 3:30 p.m. (20 mins)
   Modernization
   Linda Homer, HSD/Behavioral Health Collaborative
   Julie Weinberg, HSD/Medical Assistance Division

9. 3:30-4:00 (30 mins)
   Public Input

10. 4:00
    Adjourn
2012 Meeting Schedule

Behavioral Health Purchasing Collaborative 2012 Meetings (all meetings will take place at 37 Plaza la Prensa, Santa Fe, NM):

January 12, 2012
April 12, 2012
July 12, 2012
October 11, 2012

Video conferencing available at the following locations, if available:

- **Farmington CSED**
  1800 E. 30th Street
  Farmington, NM  87501

- **Las Vegas CSED**
  2536 Ridge Runner Rd
  Las Vegas, NM  87701

- **Las Cruces CSED**
  653 Utah Avenue
  Las Cruces, NM

- **Silver City CSED**
  3088 32nd St. Bypass Road, Suite B
  Silver City, NM  88061

- **Roswell CSED**
  2732 North Wilshire Blvd.
  Roswell, NM  88201

- **Albuquerque South CSED**
  1015 Tijeras NW Ste 100
  Albuquerque, NM  87104
Tab 1
New Mexico Behavioral Health Collaborative

October 13, 2011 • 1:00–3:30 p.m. • 37 Plaza La Prensa, Santa Fe, New Mexico

Handouts: Copies of the NM Behavioral Health Purchasing Collaborative Meeting public hand-outs may be obtained from the website www.bhc.state.nm.us

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video Conferencing Sites</td>
<td>Farmington NM, Las Vegas NM, Las Cruces NM, Silver City NM, Roswell NM, Albuquerque NM</td>
</tr>
<tr>
<td>Present were:</td>
<td>Sidonie Squier/HSD, Yolanda Deines/CYFD, Linda Homer/BHC, Bette Betts/ALTSD, Kristine Meurer/PED, Daniel Roper/DVR, Deanna Wall/DWS, Rose Baca-Quesada/MFA, Mariana Vigil, NMCD, Frank Fajardo, DDPC, John Block III, GCD, Keith Gardner/Governor’s Office, Patrick Simpson/ACC, Arthur Allison/IAD (via teleconference)</td>
</tr>
<tr>
<td>1. Call to Order</td>
<td>Sidonie Squier, Chair, called the meeting to order at 1:10 pm, with a quorum present.</td>
</tr>
<tr>
<td>• Approval of the NM Behavioral Health Collaborative Meeting Minutes from April 14, 2011</td>
<td>Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – July 14, 2011 A MOTION was made by Deanna Wall and seconded by Frank Fajardo to approve the minutes from the July 14, 2011 Behavioral Health Collaborative Meeting. The MOTION was PASSED unanimously.</td>
</tr>
<tr>
<td>• CEO Updates</td>
<td>Handout-FY12 Collaborative Competitive Grants and Contracts Linda Homer announced the award of 5 new grants to the Collaborative: State Prevention Framework State Prevention Enhancement Award for $600,000 for 1 year State Epidemiological Outcomes Workgroup for $100,000-200,000 for 1 year US Food and Drug Administration for the education and enforcement of laws pertaining to the sale of tobacco products to minors for September 2011 to September 2012 with the option of extension through September 2014 National Institute of Drug Abuse fund UNM Consortium for Behavioral Health Training and Research to study evidenced based practices for the Total Community Approach Model for 3 years SAMHSA Residential Treatment for Pregnant and Postpartum Women Grant for 3 years for $524,000 each year</td>
</tr>
<tr>
<td>Handout-Correspondence to Department of Finance and Administration and Legislative Finance Committee Linda Homer reviewed the consolidated behavioral health budget request that was submitted to DFA and LFC on September 1, 2011</td>
<td></td>
</tr>
</tbody>
</table>
2. Behavioral Health Planning Council (BHPC) Report
   Handout-Behavioral Health Planning Council 2011 Annual Report
   - Chris Wendel, Chair, BHPC highlighted the Behavioral Health Planning Council Annual Report.

3. Directors Reports/Data
   Handout-Directors Reports/Data
   Karen Meador highlighted the Green Report (one page snapshot of the system); Blue Report arranged by Judicial District with a statewide picture with ethnicity, gender and age.
   Geri Cassidy reviewed 5 pie charts how collaborative dollars (claims based does not include administrative costs or invoice deliverables) were spent in FY10 and 11 and breakdown by consumer and dollars served by age group. The pie charts include information for FY10 regarding:
   - Overall collaborative funding
   - Unduplicated Consumers by Age Group
   - Total Dollars by Age Group
   - Adult Total Dollar Amount & Percentage
   - Child Total Dollar Amount & Percentage

4. Consumer Satisfaction Survey
   Handouts- 2011 Consumer Satisfaction Survey PowerPoint; Consumer and Family Satisfaction Project Survey; Youth Satisfaction Survey
   Dr. Betty Downes, Shereen Shantz and Erica Padilla presented the findings from the consumer satisfaction survey.
   - Ms. Shantz presented an overview of the adult portion of the survey that included statistical, demographic and gender related data as well as the scope of inquiries. A task force to determine solutions that the survey identified is currently in development.
   - Ms Padilla presented the youth portion of the survey that included information related to family relationships, access to treatment and school attendance

5. OptumHealth Status – Directed Corrective Action Plan (DCAP and Sanction)
   Handout- Clinical Triggers Sanction Update
   Presenters: Diana McWilliams, Deputy CEO, NM Behavioral Health Collaborative and Mike Evans, CEO for OptumHealth NM
   Diana McWilliams reported the following regarding clinical triggers:
   - January 1 – March 31, 2011 OHNM received invoices in the amount of $3,348,488.83. The adjust amount of these invoices contractually allowable was $2.9 million
   - Out of invoices, OHNM automatically paid $1,734,395.92
   - Since this initial payment, OHNM has paid an additional $643,589.48
   - OHNM has paid $57,261.61 in interest on these claims. The interest was calculated from when the claim was originally submitted back in January – March 2011 timeframe
   - 83% of the original claims has been paid

6. Public Expert Panel Taskforce (Possible Decision Item)
   Handout-Overview of the Behavioral Health Expert Panel White Paper: Findings and Conclusions to Date (PowerPoint); New Mexico Behavioral Health Expert Panel
   - Dr. Steve Adelsheim, presented the findings and conclusion to date for the Behavioral Health Expert Panel (BHEP)
   - Three models were reviewed: 1) Carve In (minimal BHEP support); 2) Carve Out (some BHEP support); 3) Hybrid Carve In
with protection of Behavioral Health Funds (strong BHEP support)

- Brent Earnest, Deputy Cabinet Secretary, Human Services Department presented an overview of Medicaid Modernization
- Cathy Rocke indicated Medicaid’s support for the Panel’s recommendation.

A **MOTION** was made by Keith Gardner and seconded by Sidonie Squire to approve the Behavioral Health Expert Panel’s recommendation for the Hybrid Carve In model. The **MOTION** was **PASSED** unanimously.

7. **Public Input**

Ron Gurley (Las Cruces)
- Expressed concerns about carve in recommendation by the BH Expert Panel and payments to providers

Susie Trujillo (Silver City)
- Ms. Trujillo thanked the Collaborative for video conferencing the meetings and encourages the Collaborative to do more
- Also encourages the Collaborative partner agency representatives attend the subcommittees. The LCs need agency support to get work the done

Kathleen Hunt (Silver City)
- Ms. Hunt is concerned that there is very little Non-Medicaid support for adults with substance abuse, SDMI, SMI and people of middle income that don’t have insurance that can’t get services
- OptumHealth reconciliation process is still very difficult and not working for Border Area Mental Health
- She thanked the Collaborative for video conferencing
- Asked for support for the LCs

Marsha Bowman (Silver City)
- Ms. Bowman thanked the Collaborative for video conferencing
- She is hopeful for more training for treatment foster care training
- She asked if the Consumer Satisfaction Survey for youth and adult was statewide? (Shereen Shantz responded that the survey was statewide and referred her to the appendix to consumer survey handout presented earlier in the meeting)
- Contacts and scope of work not received in a timely manner – hopeful that this can be resolved

Bernadette Pina (Santa Fe)
- Ms. Pina is from Southwest Counseling Services in Las Cruces and is advocating for transitional living services (TLS)
- Asked that funding for TLS not be cut

Patsy Romero (Santa Fe)
- Ms. Romero represented NAMI on expert panel
- She feels there is a lack of data to support a decision re: carve in/carve out model
• Asked that the Collaborative assure that protecting everyone in a hybrid model

Delfy Roach (Santa Fe)
• People with traumatic brain injuries (TBI) many times have behavioral health issues that are misdiagnosed
• Please take into consideration this population with the carve in/carve out hybrid model
• Worked with CYFD on family related issues for the last two years and would like to meet with Secretary Deines

Martha Cook (Santa Fe)
• Representing LC 1 and NAMI Santa Fe
• Shereen Shantz mentioned developing family training program. NAMI has already developed.
• People who represent the legal system (public defenders, judges, social workers) who deal with increasing number of people with MH issues. Not as many providers and are ending up in jail and the detention center. Makes the illness worse important to continue the work done by LCs
• Consumer and Family Advisory Committee not functioning adequately canceled twice this quarter due to lack of participation because notices are not going out in a timely manner

8. Adjourn

There being no further business, the meeting adjourned at 3:43 p.m.
Collaborative Policy Statement
Trauma Informed Care
Preliminary Report

The State of New Mexico believes that responding to the behavioral health care needs of women, men, and children who have experienced trauma is crucial to their overall health and recovery and should be a priority of an integrated healthcare system. Trauma is a pervasive issue that impacts all levels of healthcare and requires specialized knowledge, training, and collaboration among policymakers, providers, and survivors. As medicine and behavioral health move toward deeper integration, trauma-informed principles must be infused into our recovery-based system of care as an overarching philosophy.

The majority of the persons who receive State-funded behavioral health services have been exposed to traumatic events in the form of interpersonal violence, physical, emotional, and sexual abuse, severe neglect, loss, accidents, crime, war, or natural disasters. Trauma has been associated with a range of social problems, including poverty, community violence, and criminal justice involvement, and is costly if not addressed. The potential impact of trauma on individuals may include difficulties such as mental illness, addiction and abuse, personality disorders, physical illness, suicide, self-injury, aggression, and re-victimization.

The State of New Mexico is committed to infusing trauma-informed principles into existing systems of care to include the prevention, assessment, and treatment of trauma in a manner that is based on best practices, culturally and developmentally appropriate, and driven by individual choice. In a trauma-informed system, everyone is educated about trauma and its consequences, and a trauma-informed approach ensures that service systems are integrated and expanded in a manner that promotes resilience and protects the physical and psychological safety of behavioral health consumers and the providers that serve them.

This state-wide trauma initiative shall include a planning process which involves all stakeholders, particularly consumers, universal screening for trauma, treatment protocols/programs that are innovative and effective, consultation, education and support for staff to facilitate the provision of the best possible treatment, and policy development and implementation that demonstrates the New Mexico Behavioral Health Purchasing Collaborative’s recognition of the effects of traumatization. Through collaboration among consumers, family members, advocates, mental health professionals, social and public service agencies, and the community at-large, the State of New Mexico is dedicating itself to creating and expanding a system that will become a national leader in trauma recognition and care.
STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
PROFESSIONAL SERVICES CONTRACT
CONTRACT AMENDMENT NO. 9

This Contract Amendment No. 9 (“Amendment No. 9”) to Contract No. 09-630-7903-0063 is made and entered into by and between the State of New Mexico Interagency Behavioral Health Purchasing Collaborative (hereinafter referred to as the “Collaborative”) and United HealthCare Insurance Company and United Behavioral Health, through their joint venture OptumHealth New Mexico, the Statewide Entity (“SE”), (hereinafter referred to as “SE” or “Contractor”).

WITNESSETH:

WHEREAS, the Collaborative and the Contractor previously entered into Contract No. 09-630-7903-0063-A8 providing for services to be provided to the Collaborative by the Contractor; and

WHEREAS, additional federal funds have become available to the Human Services Department from the Mental Health Transformation Grant, the Crossroads - Support Families Grant and the National Institute on Drug Abuse Grant; and

WHEREAS, the Contractor has agreed to the addition of the federal funds to the contract and the New Mexico Interagency Behavioral Health Purchasing Collaborative voted during its January 12, 2012 meeting to approve Contract Amendment No. 9 for such purpose; and

WHEREAS, Attachment xxx – FY 2012 Funding Table will be amended to reflect the addition of the aforementioned federal funds; and

NOW, THEREFORE, IT IS MUTUALLY AGREED BETWEEN THE PARTIES THAT THE FOLLOWING PROVISIONS OF THE ABOVE-REFERENCED CONTRACT NO. 09-630-7903-0063-A8 (hereinafter referred to as the “Contract”) IS HEREBY AMENDED AS FOLLOWS:

Appendix xxx, FY 2012 Funding Table of Amendment 8, and referenced in Article 6 of the Contract is replaced with Appendix xxx, FY 2012 Funding Table of Amendment No. 9, on behalf of the member agency, the Human Services Department and is attached and incorporated by reference in its entirety into Amendment No. 9 and the Contract. The revisions to the amended Appendix xxx appear in bold text in the Appendix.

All other articles, provisions and terms of the Contract shall remain unchanged.

IN WITNESS WHEREOF, the parties have executed this Amendment No. 9 as of the date of the last signature of the Executive Committee of the New Mexico Interagency Behavioral Health Purchasing Collaborative. The Executive Committee executes this Contract only to the extent of their statutory authority as members of the Collaborative and the Executive Committee.
The records of the Taxation and Revenue Department reflect that the Contractor is registered with the Taxation and Revenue Department of the State of New Mexico to pay gross Receipts and compensating taxes.

TAXATION AND REVENUE DEPARTMENT

ID Number: 03-140568-001

EXECUTIVE COMMITTEE, NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

Yolanda Berumen-Deines, Secretary
Children, Youth and Families Department

Date

Sidonie Squier, Secretary

Date
<table>
<thead>
<tr>
<th>Funding Source (Fed/State)</th>
<th>Total Funding</th>
<th>Direct Services</th>
<th>Indirect Services</th>
<th>Percent Indirect Services</th>
<th>Individuals Served</th>
<th>Programs/Services Provided</th>
<th>Special Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM Corrections Department - Community Programming</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Community Offender Management (Probation and Parole) - General Fund</td>
<td>3,146,200</td>
<td>3,051,814</td>
<td>94,386</td>
<td>3.0%</td>
<td></td>
<td></td>
<td>Individuals under NMCD supervision in the community, either probation or parole, or discharging from prison or jail to community supervision. Outpatient services for BH, Residential Substance Abuse programming and life maintenance services</td>
</tr>
<tr>
<td>Community Corrections Fund - General Fund</td>
<td>2,311,500</td>
<td>2,242,155</td>
<td>69,345</td>
<td>3.0%</td>
<td></td>
<td></td>
<td>Individuals under NMCD supervision in the community, either probation or parole, or discharging from prison or jail to community supervision. Outpatient services for BH, Residential Substance Abuse programming and life maintenance services</td>
</tr>
<tr>
<td>GRAND TOTAL NMCD</td>
<td>5,457,700</td>
<td>5,293,969</td>
<td>163,731</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aging and Long-Term Services Department</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>General Fund</td>
<td>55,572</td>
<td>55,572</td>
<td>0</td>
<td>0.0%</td>
<td>Persons age 55 and older</td>
<td></td>
<td>Provide individual and group peer counseling services. Such services shall be provided in home and community-based settings, including senior centers.</td>
</tr>
<tr>
<td>GRAND TOTAL ALTSD</td>
<td>55,572</td>
<td>55,572</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Services Department</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid: Managed Care, Federal</td>
<td>174,520,000</td>
<td>150,087,200</td>
<td>24,432,800</td>
<td>14.0%</td>
<td></td>
<td></td>
<td>All Medicaid-eligible individuals enrolled in managed care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Projected Amount. Final amounts depend on negotiated rates and actual number of</td>
</tr>
<tr>
<td>Medicaid: Managed Care, State</td>
<td>75,516,000</td>
<td>64,943,760</td>
<td>10,572,240</td>
<td>14.0%</td>
<td>All Medicaid-eligible individuals not enrolled in managed care</td>
<td>Medicaid Behavioral Health Services as identified in HSD/MAD regulations</td>
<td>Projected Amount. Final amounts depend on negotiated rates and actual number of enrolled individuals.</td>
</tr>
<tr>
<td>Medicaid: Coordinated FFS, Federal</td>
<td>28,409,091</td>
<td>27,159,091</td>
<td>1,250,000</td>
<td>4.4%</td>
<td>All Medicaid-eligible individuals not enrolled in managed care</td>
<td>Medicaid Behavioral Health Services as identified in HSD/MAD regulations</td>
<td>Claims and administrative fees are projected amounts subject to variation based on enrollment and utilization trends. Claims for direct services are passed through to HSD for payment. The admin fee is a set amount per month per enrollee, therefore, the percentage of total will vary depending on the relationship between the number of enrollees and total claims paid.</td>
</tr>
<tr>
<td>Medicaid: Coordinated FFS, State</td>
<td>10,504,202</td>
<td>9,254,202</td>
<td>1,250,000</td>
<td>11.9%</td>
<td>All Medicaid-eligible individuals not enrolled in managed care</td>
<td>Medicaid Behavioral Health Services as identified in HSD/MAD regulations</td>
<td>Claims and administrative fees are projected amounts subject to variation based on enrollment and utilization trends. Claims for direct services are passed through to HSD for payment. The admin fee is a set amount per month per enrollee, therefore, the percentage of total will vary depending on the relationship between the number of enrollees and total claims paid.</td>
</tr>
<tr>
<td>TOTAL MEDICAID</td>
<td>288,949,293</td>
<td>251,444,253</td>
<td>37,505,040</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHSD: General Fund Substance Abuse</td>
<td>14,749,220</td>
<td>13,008,812</td>
<td>1,740,408</td>
<td>11.8%</td>
<td>Non-Medicaid-eligible adults (age 18+) who meet certain clinical and financial criteria</td>
<td>Substance Abuse Residential, Outpatient Svcs, Native American</td>
<td>Funds will be expended as directed by BHSD.</td>
</tr>
</tbody>
</table>
## APPENDIX xxx
### FY 2012 Funding Table
#### Amendment No. 9

<table>
<thead>
<tr>
<th>criteria Svcs; Methamphetamine Treatment</th>
<th>To pay administrative funds for federal grants ($9,538-new MHTG; $1,026-NIDA; $22,348.45-PPW; $52,677-Jail Diversion; $30,512- original MHTG).</th>
</tr>
</thead>
<tbody>
<tr>
<td>116,101</td>
<td>116,101</td>
</tr>
<tr>
<td>2,548,454</td>
<td>2,344,578；203,876；8.0%</td>
</tr>
<tr>
<td>sub-total - BHSD GF Substance Abuse</td>
<td>17,413,775；15,353,390；2,060,385</td>
</tr>
<tr>
<td>BHSD General Fund Mental Health</td>
<td>16,883,606；14,891,341；1,992,265；11.8%</td>
</tr>
<tr>
<td>645,722</td>
<td>594,064；51,658；8.3%</td>
</tr>
<tr>
<td>1,037,993</td>
<td>954,954；83,039；8.0%</td>
</tr>
<tr>
<td>1,056,805</td>
<td>1,016,525；40,280；0.54%</td>
</tr>
<tr>
<td>sub-total BHSD GF Mental Health</td>
<td>19,624,126；17,456,844；2,167,242</td>
</tr>
<tr>
<td>BHSD: Community MH Block Grant - Federal</td>
<td>1,418,868；1,418,868；0；0.0%</td>
</tr>
<tr>
<td>1,418,868</td>
<td>1,418,868；Non-Medicaid-eligible adults (age 18+) who meet certain clinical and financial criteria；Mental Health Outpatient Services；CMH Federal Block Grant requirements. Funds will be expended as directed by BHSD.</td>
</tr>
</tbody>
</table>
### APPENDIX xxx
**FY 2012 Funding Table**  
**Amendment No. 9**

| BHSD: SAPT Block Grant - Federal | 5,152,466 | 5,152,466 | 0 | 0.0% | Treatment: Non-Medicaid eligible adults (age 18+) who meet certain clinical and financial criteria; and targeted community services. | Substance Abuse Residential & Outpatient Services | SAPT Block Grant Federal Requirements. CMH Federal Block Grant requirements. Funds will be expended as directed by BHSD. |
| BHSD: SAPT Block Grant - Prevention Federal | 2,219,300 | 2,219,300 | 0 | 0.0% | Children, families and communities; Prevention: targeted to individuals, families and communities not in need of treatment services. Specific services 0 - 6 year olds; k-6th grade; 12-17 year olds and targeted community services. | Evidence-Based Prevention Programs | Must follow SAPT Block Grant Requirements. Funds will be expended as directed by BHSD. |
| BHSD: Access to Recovery (ATR III) - Federal | 2,193,725 | 2,128,725 | 65,000 | 2.97% | Non-Medicaid-eligible adults (aged 18+) who meet certain clinical and financial criteria | Voucher-based substance abuse treatment referral system | ATR federal requirements. Funds will be expended and invoiced as directed by BHSD. The admin costs have a dedicated purpose to be detailed in LOD. The administrative costs will be comprised of $238,175 for OHNM direct admin and $64,000 for ATR Program Support. |
| BHSD: Jail Diversion Veteran’s Fund - Federal | 393,741 | 393,741 | 0 | 11.8% | Individuals living in Sandoval, San Juan and McKinley Counties with preference to veterans and a focus on Native American Veterans. | BH treatment as a means for jail diversion | JDVF federal requirements. Funds will be expended as directed by BHSD in LOD. $35,000 (8.2%) administrative costs to be paid from state general funds, as directed. |
| BHSD: Data Infrastructure Grant (DIG) - Federal | 12,750 | 12,750 | 0 | | Collection of Collaborative client-level data and technical support for Federal reporting requirements. | DIG Federal regulations. LOD Directive. Preapproval required for expenditure of funds. |
## APPENDIX xxx

**FY 2012 Funding Table**  
**Amendment No. 9**

| BHSD: MH Transformation - Federal | 669,355 | 669,355 | 0 | Persons with mental illness or co-occurring disorders who are homeless or at risk of homelessness; target veterans and Native Americans | Supportive Housing, Comprehensive Community Support Services, Consumer Operated Services. | Federal regulations. Funds will be expended as directed by BHSD in LOD. $30,500 (5.7%) admin costs will be paid from state general funds, as directed. |
| BHSD: Nat'l Inst on Drug Abuse (NIDA) - Federal | 180,000 | 180,000 | 0 | Women who are pregnant or who have given birth within the prior 12 months who have experienced trauma and substance abuse. | Research grant for the evaluation of Total Community Approach programs. | To follow federal regulations. Funds will be expended as directed by BHSD in LOD. $9,538 (5.7%) will be paid from state general funds, as directed. |
| BHSD: Crossroads: Supporting Families - Federal | 392,078 | 392,078 | 0 | | Residential Treatment Pregnant and Post-Partum Women’s Program (PPW) | To follow federal regulations. Funds will be expended as directed by BHSD in LOD. $22,348 (5.7%) will be paid from state general funds, as directed. |
| **Sub-total BHSD Federal Funds** | 12,632,283 | 12,567,283 | 65,000 |
| **TOTAL BHSD** | 49,670,184 | 45,377,557 | 4,292,627 |

| **GRAND TOTAL HSD** | 338,619,477 | 296,821,810 | 41,797,667 |

### Children, Youth and Families Department

| General Fund | 8,741,900 | 8,462,159 | 279,741 | CYFD and non-CYFD involved/referred youth (to age 21); those at risk of CYFD involvement | Mandatory, Priority and Non-Priority services, allocations will be provided by a separate LOD. | HB 2- §4 |
| Sub-Total - GF | 8,741,900 | 8,462,159 | 279,741 | | | |

January 12, 2012
## FY 2012 Funding Table
### Amendment No. 9

<table>
<thead>
<tr>
<th>CYFD and non-CYFD involved/referred youth (to age 21); those at risk of CYFD involvement</th>
<th>Evidence-Based Programs and Training</th>
<th>CYMH Mental Health block grant regulations. LOD Directive.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMH Block Grant - Federal</strong></td>
<td>$350,000</td>
<td>$350,000</td>
</tr>
<tr>
<td><strong>GRAND TOTAL CYFD</strong></td>
<td>$10,114,531</td>
<td>$9,752,980</td>
</tr>
<tr>
<td><strong>FUNDING TABLE GRAND TOTAL</strong></td>
<td>$354,247,280</td>
<td>$311,924,331</td>
</tr>
</tbody>
</table>

Provider services to 224 youth: 24 in Santa Clara Pueblo, 100 in Albuquerque, 100 in Silver City.

SOC Federal regulations. LOD Directive.
<table>
<thead>
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<th>Agency</th>
<th>Program</th>
<th>FY 12 Budget A8</th>
<th>FY 12 Budget A9</th>
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<th>% Change</th>
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<td>NMCD</td>
<td>Comm. Offender</td>
<td>3,146,200</td>
<td>3,051,814</td>
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<td>Community Corrections</td>
<td>2,311,500</td>
<td>2,242,155</td>
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<td>NMCD</td>
<td>Grand Total NMCD</td>
<td>5,457,700</td>
<td>5,293,969</td>
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<tr>
<td>ALTSD</td>
<td>Peer counseling</td>
<td>55,572</td>
<td>55,572</td>
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<tr>
<td>ALTSD</td>
<td>Transformation Grant - Federal</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>ALTSD</td>
<td>Grand Total ALTSD</td>
<td>55,572</td>
<td>55,572</td>
<td>-</td>
<td>0.00%</td>
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<td>HSD</td>
<td>Medicaid: Man Care - Federal</td>
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<td>150,087,200</td>
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<td>Medicaid: Man Care - State</td>
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<td>64,943,760</td>
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<td>Medicaid: Coord FFS Federal</td>
<td>28,409,091</td>
<td>27,159,091</td>
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<td>Medicaid: Coord FFS State</td>
<td>10,504,202</td>
<td>9,254,202</td>
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<td>HSD</td>
<td>Grand Total Medicaid</td>
<td>288,949,293</td>
<td>251,444,253</td>
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<td>HSD</td>
<td>BHSD: GF Sub Abuse</td>
<td>14,494,939</td>
<td>12,784,536</td>
<td>1,710,403</td>
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<tr>
<td>HSD</td>
<td>BHSD: MH Transformation</td>
<td>532,527</td>
<td>502,015</td>
<td>30,512</td>
<td>0.0573</td>
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<tr>
<td>HSD</td>
<td>BHSD: Jail Diversion Veterans Fund</td>
<td>446,418</td>
<td>393,741</td>
<td>52,677</td>
<td>11.80%</td>
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<tr>
<td>HSD</td>
<td>BHSD: DIG</td>
<td>12,750</td>
<td>12,750</td>
<td>-</td>
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<tr>
<td>HSD</td>
<td>BHSD: MH Transformation</td>
<td>532,527</td>
<td>502,015</td>
<td>30,512</td>
<td>0.0573</td>
</tr>
</tbody>
</table>

TOTAL - General Fund | 36,921,800 | 32,810,274 | 4,111,526 | 0.00% | 37,037,901 | 32,810,274 | 4,227,627 | 0.00% | - | 0.00% |

TOTAL - Federal | 11,976,054 | 11,827,865 | 148,189 | 1.26% | 12,632,283 | 12,567,283 | 65,000 | 0.00% | - | 0.00% |
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<tr>
<th></th>
<th>GRAND TOTAL BHSD</th>
<th>CYFD</th>
<th>CYFD</th>
<th>CYFD</th>
<th>CYFD</th>
<th>CYFD</th>
<th>CYFD</th>
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<th>CYFD</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>48,897,854</td>
<td>44,638,139</td>
<td>4,259,715</td>
<td>49,670,184</td>
<td>45,377,557</td>
<td>4,292,627</td>
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<tr>
<td>CYFD General Fund</td>
<td>8,741,900</td>
<td>8,462,159</td>
<td>279,741</td>
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<td>8,741,900</td>
<td>8,462,159</td>
<td>279,741</td>
<td>3.20%</td>
<td>-</td>
<td>0.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYFD Evidence-Based programs/training (CMH BG) - Federal</td>
<td>350,000</td>
<td>350,000</td>
<td>-</td>
<td>0.00%</td>
<td>350,000</td>
<td>350,000</td>
<td>-</td>
<td>0.00%</td>
<td>-</td>
<td>0.00%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>CYFD System of Care - Federal</td>
<td>1,022,631</td>
<td>940,821</td>
<td>81,810</td>
<td>4.80%</td>
<td>1,022,631</td>
<td>940,821</td>
<td>81,810</td>
<td>4.80%</td>
<td>-</td>
<td>0.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>CYFD Grand Total</td>
<td>10,114,531</td>
<td>9,752,980</td>
<td>361,551</td>
<td>10,114,531</td>
<td>9,752,980</td>
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<tr>
<td>GRAND TOTAL - COLLABORATIVE</td>
<td>353,474,950</td>
<td>311,184,913</td>
<td>42,290,037</td>
<td>354,247,280</td>
<td>311,924,331</td>
<td>42,322,949</td>
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</tbody>
</table>

*Amendment 9 Purpose:*

1) Increase the budget by $772,330 by adding funding for three federal grants, as follows:

<table>
<thead>
<tr>
<th></th>
<th>Direct Serv (from Fed. Grant)</th>
<th>Admin costs- 5.7% (from gen fund)</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>MH Transformation Grant:</td>
<td>167,340.00</td>
<td>9,538.00</td>
<td>176,878.00</td>
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<tr>
<td>Natl Inst on Drug Abuse (NIDA)</td>
<td>180,000.00</td>
<td>1,026.00</td>
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<tr>
<td>PPW - Crossroads: Supporting Families</td>
<td>392,078.00</td>
<td>22,348.00</td>
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<td></td>
<td>739,418.00</td>
<td>32,912.00</td>
<td>772,330.00</td>
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</table>

2) To realign the Jail Diversion and original MHTG prog budgets to reflect the admin rate coming from general fund.
Tab 2
Behavioral Health Local Collaborative 12 Otero and Lincoln Counties

- “Soberfest” a community block party celebrating Recovery Month and sobriety was attended by over 900 people
- Bicycle Recycling program continues to provide restored bicycles for people in halfway or recovery houses, the homeless and disabled
- Peer to Peer Warm Line program created a governing board, had to reorganize and is working on a volunteer phone line
- Maintained a presence in our Community Health Council
- Provided informative program on Otero County Detention Facilities by Corrections Chief Virginia Blansett
- Provided informational, thought provoking program by a 4-person panel discussing Restorative Justice (members included Sexual Assault Nurse Examiner, Assistant District Attorney, former school board member, and minister);
- Provided a panel discussing ‘K2, ‘Spice’ and other legal or natural highs’
- Worked to increase attendance and participation by consumers, consumers’ family, advocates and community members, faith leaders
- Negotiated a reduced role for the Administrative Coordinator in an effort to sustain the Local Collaborative

Challenges and future plans include the following:

- Sustaining the Behavioral Health Local Collaborative; our brainstorming has included various fundraising ideas
- Educating our community about behavioral health needs and resources
- Increasing collaboration among all community resources
- Enlarging our membership pool

Report provided by Denise Lang, Administrative Coordinator
## BEHAVIORAL HEALTH PLANNING COUNCIL

### Budget Variance YTD

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Line Item</th>
<th>Budget</th>
<th>Current Mont</th>
<th>Previous Mont</th>
<th>TOTAL</th>
<th>BALANCE</th>
<th>% Utilized</th>
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<td>Council Meetings</td>
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<td>$4,000.00</td>
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<td>$1,045.00</td>
<td>$1,045.00</td>
<td>$2,955.00</td>
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<td>$201.25</td>
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<td></td>
<td></td>
<td><strong>Per Diem</strong></td>
<td>$1,000.00</td>
<td>$85.00</td>
<td>$261.42</td>
<td>$346.42</td>
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<tr>
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<td><strong>Native American</strong></td>
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<tr>
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<td><strong>Substance Abuse</strong></td>
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<td><strong>Mileage</strong></td>
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<td><strong>Adult</strong></td>
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<tr>
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<td><strong>Children</strong></td>
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<tr>
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<td></td>
<td><strong>Medicaid</strong></td>
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<td></td>
<td></td>
<td><strong>Native American</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Substance Abuse</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>Stipend / mileage</strong></td>
<td>$850.00</td>
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<td><strong>Video/Tele Conference</strong></td>
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<td>Behavioral Health Day</td>
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<td>Misc. New Council</td>
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<td>$0.00</td>
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<td>Total Operations</td>
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<td>$1,836.49</td>
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<th>Revenue</th>
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<th>Fiscal Agent</th>
<th>Operations</th>
<th>Total</th>
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<th>% Utilized</th>
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<td>Contracts Funds</td>
<td>BHSD July 11-June 12</td>
<td>$34,100.00</td>
<td>$3,100.00</td>
<td>$31,000.00</td>
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<td>$7,083.64</td>
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<td>Optum Health FY 10 &amp; 11</td>
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<td>Optum Health FY 12</td>
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<td>Carrover from FY 11</td>
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<td>$53,316.32</td>
<td>$3,100.00</td>
<td>$50,216.32</td>
<td>$53,316.32</td>
<td>$11,299.96</td>
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</table>
Local Collaborative 8 Administrative Secretary has fully updated its website! If anyone would like to take a look at it please go to our website. The meeting calendar is on the site.

UCTLC 8 budget has been discussed and we are working well with the roll over money and OPTUM Health dollars are stretching through this year. We are interested in knowing if we can role over what we save this year into next fiscal year? UCTLC8 is now meeting quarterly to save money. The lead team will continue to teleconference monthly. The Lead team has approved funds for Cindy to attend peer specialist training and test.

Since Jennie Garcia’s leave we are working on recruiting a new advocate to help us with consumer work in Raton. Jennie was extremely successful with this in the past.

Our CSA representatives continue to be involved in LC 8 meetings. TCCS in particular is active in the tri-county area for adults and crisis response.

Mapping has been difficult as there are such limited services for adults with the exception of TCCS services. We have a request to have the Mapping sent out not in PDF file and also have the living document with all of what has been done across the state on the Behavioral Health website so we can ask all members to update the mapping on their
own as well as any work I may be able to do. This is a lot of work for me as a consumer.

LC8 has identified its STAR nomination as well as Lifetime achievement nomination. I am also a member of the BHSD Day at the legislation and summit Planning Committee.
LOCAL COLLABORATIVE
PROGRESS REPORT TO THE BH COLLABORATIVE

Local Collaborative # 10---December 16, 2011
Report provided by: Lisa Walraven, LC 10 Coordinator

Business Items conducted at local collaborative meetings this quarter:

- LC Sustainability- LC 10 wants to remain together. The LC 10 counties work well together and want to continue that way. The LC has good rapport with the Health Councils. In De Baca County the Collaborative, Health Council and DWI have been working together to become a unified voice. Harding County is standing up as an LC with direct services improving. Quay County continues to work with remaining Health Council. Many resources have been brought to the communities, along with improvement of direct services.

- Budget for the fiscal year 2012 was completed. The LC understands the task at hand to continue with limited resources, and is committed to finding creative ways to meet the need in the communities within LC 10.

- Mapping documents for the BHPC central database were completed for DeBaca, Harding and Quay Counties.

- Possible grant funding to help combat meth addiction was discussed, in efforts to help people understand what a serious problem that this has become. The Attorney General’s Office training will be utilized as well.

- BH Day at the Legislature was discussed. The collaborative voted to apply for exhibitor space, send consumers/family members to BH Day and selected Elizabeth Sena to be the STAR nominee from LC 10.

Ongoing concerns, issues, etc. that this local collaborative is addressing:

- Stigma among communities regarding behavioral health and those in a crisis situation. De Baca County is doing the 10X10 Wellness with the Senior Citizen’s Center. The Protecting you protecting me curriculum is being used in the Fort Sumner Schools and Tucumcari is working to get in the school systems there. Harding County has scheduled eight monthly meetings highlighting the eight dimensions of wellness.

- LC 10 plans to offer more Mental Health First Aid Trainings.

Special projects of your Local Collaborative currently (e.g. Quality Service Review, Systems of Care, Local Initiatives):

- Transportation continues to be an ongoing concern, with that in mind LC 10 has created a subcommittee to work on potential grand funding from the USDA to be able to provide a consumer run transit program.
Other:
- Quay County sponsored a “Fun Run” in October; the event had over 200 participants and 50 volunteers.
- Harding County hosted a Health Fair.
- Diabetes self-management education services began in November in Quay County.
- An Alzheimer’s care giver support group meeting monthly in Quay has been formed.
- Representatives from the De Baca Family Practice Clinic and the Ministerial Alliance have joined the local De Baca group, expanding LC efforts in the county.

This report will be presented to the Behavioral Health Collaborative for its next meeting.

Do you have questions or comments for the Collaborative?
Local Collaborative # 11
Report provided by: LC 11 members

Business Items conducted at the last local collaborative meeting:

- Reviewing local initiatives and monitoring the progress on activities as well as the budget and spending
- Preparing for presentation to support the jail diversion initiative further for quarterly meeting
- Youth and Family Collaborative preparing media campaign to strengthen families and offer quarterly positive activities for families in community to participate in
- Review of subcommittee information and report out on Legislative day

Ongoing concerns, issues, etc. that this local collaborative is addressing:

- Continued discussion and efforts to develop and incorporate consumer involvement.
- LC is re-structuring the meetings for more consideration of consumers and their needs.
- Prevention has been recognized as an important component in addressing consumer needs as well and will be an essential component in the dialogue.
- Outcome based meetings and a structure in the community to interact, problem solve and work with other groups to support ongoing issues and bring resolutions
- Supporting internal and external agency programs in their efforts to better provide, but not limited to, the distribution of community awareness information and projects that directly impact the safety and wellbeing of the population of children and families we serve. i.e. support of efforts to further obtain more foster and adoptive families and to support efforts to retain the current foster and adoptive families and waiting adoptive families.
- Sustainability issues

Other:

Do you want this report given to the Purchasing Collaborative at its monthly meeting?  Yes  No
Tab 3
<table>
<thead>
<tr>
<th>Service</th>
<th>Unit Type</th>
<th>Units</th>
<th>Consumers Served</th>
<th>Funds Expended</th>
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<td><strong>Statewide</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01) Supported Employment</td>
<td>15 Minutes</td>
<td>2,036</td>
<td>121</td>
<td>$34,476</td>
</tr>
<tr>
<td>02) Residential Detoxification (Adults)</td>
<td>Per Diem</td>
<td>378</td>
<td>60</td>
<td>$75,600</td>
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<td>03) Inpatient Hospitalization Psychiatric (all inpt services)</td>
<td>Varied</td>
<td>9,269</td>
<td>1,035</td>
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<td>04) Transitional Living Services</td>
<td>Per Diem</td>
<td>1,226</td>
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<td>05) Residential Treatment Services (Non-Accredited)</td>
<td>Per Diem</td>
<td>2,661</td>
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<td>06) Residential Treatment Services (Accredited)</td>
<td>Per Diem</td>
<td>13,248</td>
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<td>07) Adult Residential Services</td>
<td>Per Diem</td>
<td>3,157</td>
<td>135</td>
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<td>08) Foster Care Therapeutic TFC I</td>
<td>Per Diem</td>
<td>28,001</td>
<td>514</td>
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<tr>
<td>09) Foster Care Therapeutic TFC II</td>
<td>Per Diem</td>
<td>11,431</td>
<td>234</td>
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<tr>
<td>10) Group Home</td>
<td>Per Diem</td>
<td>4,581</td>
<td>105</td>
<td>$602,338</td>
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<tr>
<td>11) Crisis Intervention</td>
<td>15 Minutes</td>
<td>3,758</td>
<td>845</td>
<td>$80,651</td>
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<tr>
<td>12) BH Day Treatment</td>
<td>Per Hour</td>
<td>30,714</td>
<td>182</td>
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<tr>
<td>13) Skills Training &amp; Development (BMS)</td>
<td>15 Minutes</td>
<td>350,838</td>
<td>999</td>
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<td>14) Psychosocial Rehab Services (PSR) Individual, Grp, or Classroom - Adults</td>
<td>15 Minutes</td>
<td>318,762</td>
<td>1,273</td>
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<td>15) Intensive Outpatient Program SA</td>
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<td>4,125</td>
<td>389</td>
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<td>16) Intensive Outpatient Program MH</td>
<td>Per Diem</td>
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<td>17) Assertive Community Treatment (ACT)</td>
<td>15 Minutes</td>
<td>17,117</td>
<td>202</td>
<td>$636,071</td>
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<td>18) Multi-Systemic Therapy (MST)</td>
<td>15 Minutes</td>
<td>10,964</td>
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<td>19) Psychosocial Rehab (LIFE SKILLS) - Youth</td>
<td>30 Minutes</td>
<td>5,855</td>
<td>50</td>
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<td>15 Minutes</td>
<td>672</td>
<td>23</td>
<td>$13,924</td>
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<td>21) Home Based Services (Family Stabilization)</td>
<td>15 Minutes</td>
<td>81</td>
<td>4</td>
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<td>22) Comprehensive Community Support Services</td>
<td>15 Minutes</td>
<td>197,041</td>
<td>7,108</td>
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<td>23) Respite Care</td>
<td>15 Minutes</td>
<td>7,418</td>
<td>65</td>
<td>$37,050</td>
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<td>24) Methadone Maintenance</td>
<td>Each</td>
<td>31,726</td>
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<td>$475,410</td>
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<td>25) Shelter Care</td>
<td>Per Diem</td>
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<td>283</td>
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<td>26) Indian Health Services - Inpatient Services</td>
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<tr>
<td>27) Indian Health Services - Outpatient Services</td>
<td>Per Diem</td>
<td>2,648</td>
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<tr>
<td>28) Traditional Healing Services</td>
<td>Each</td>
<td>1,840</td>
<td>49</td>
<td>$29,430</td>
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<td>29) Telehealth Services</td>
<td>Varied</td>
<td>1,757</td>
<td>1,013</td>
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<tr>
<td>30) Activity Therapy</td>
<td>15 Minutes</td>
<td>7,456</td>
<td>192</td>
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<td>31) Medication Management/Monitoring</td>
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<td>25,813</td>
<td>11,902</td>
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<td>32) Outpatient Services</td>
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<td>193,291</td>
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<td>33) Outliers</td>
<td>Varied</td>
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<td>3,556</td>
<td>$5,496,236</td>
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**Total**   $46,444,496
### Behavioral Health Collaborative Directors' Report

**Report Title:** Consumers Served by Ethnicity (Blue) Statewide

**Reporting Period:** 07/01/2011 - 09/30/2011

**Service Dates:** 07/01/2011 - 09/30/2011

**Paid Thru:** 10/08/2011

<table>
<thead>
<tr>
<th>Ethnicity/Category</th>
<th>Under 18 Females</th>
<th>Under 18 Males</th>
<th>18-20 Females</th>
<th>18-20 Male</th>
<th>21-64 Female</th>
<th>21-64 Male</th>
<th>65 and over Females</th>
<th>65 and over Males</th>
<th>Total Females</th>
<th>Total Males</th>
<th>Total Consumers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>4,238</td>
<td>5,572</td>
<td>408</td>
<td>601</td>
<td>4,982</td>
<td>4,414</td>
<td>178</td>
<td>186</td>
<td>9,754</td>
<td>10,527</td>
<td>20,281</td>
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<tr>
<td>White (Non-Hispanic)</td>
<td>1,799</td>
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<td>232</td>
<td>240</td>
<td>4,539</td>
<td>3,347</td>
<td>272</td>
<td>234</td>
<td>6,823</td>
<td>6,153</td>
<td>12,976</td>
<td>29.32%</td>
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<tr>
<td>Native American</td>
<td>606</td>
<td>730</td>
<td>68</td>
<td>76</td>
<td>755</td>
<td>794</td>
<td>9</td>
<td>8</td>
<td>1,498</td>
<td>1,600</td>
<td>3,098</td>
<td>6.86%</td>
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<tr>
<td>African American</td>
<td>144</td>
<td>221</td>
<td>21</td>
<td>26</td>
<td>243</td>
<td>244</td>
<td>8</td>
<td>4</td>
<td>487</td>
<td>481</td>
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<tr>
<td>Alaska Native</td>
<td>3</td>
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<td>0</td>
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<td>2</td>
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<tr>
<td>Asian/Pacific Islander</td>
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<td>29</td>
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<tr>
<td>Multiracial</td>
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<td>187</td>
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<td>11</td>
<td>105</td>
<td>61</td>
<td>3</td>
<td>2</td>
<td>254</td>
<td>260</td>
<td>514</td>
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<tr>
<td>Other/Unknown</td>
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<td>1,886</td>
<td>153</td>
<td>176</td>
<td>1,830</td>
<td>1,175</td>
<td>61</td>
<td>40</td>
<td>3,398</td>
<td>3,261</td>
<td>6,660</td>
<td>14.91%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8,206</strong></td>
<td><strong>11,039</strong></td>
<td><strong>887</strong></td>
<td><strong>989</strong></td>
<td><strong>12,456</strong></td>
<td><strong>10,034</strong></td>
<td><strong>525</strong></td>
<td><strong>305</strong></td>
<td><strong>21,999</strong></td>
<td><strong>22,273</strong></td>
<td><strong>44,289</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Unduplicated Consumers With Unknown Gender by Judicial:** 17

Ethnicity is determined from enrollment ethnicity/race information or from medicaid eligibility information. The mapping order is as follows:

1. Enrollment ethnicity of "Puerto Rican", "Mexican", "Cuban", "Other Specific Hispanic" or "Hispanic-Unknown Origin" or eligibility race of "Hispanic" are mapped to "Hispanic"
2. Enrollment race of "American Indian" or eligibility race of "American Indian" are mapped to "Native American"
3. Enrollment race of "African American" or eligibility race of "Black" are mapped to "African American"
4. Enrollment race of "Alaskan Native" is mapped to "Alaskan Native"
5. Enrollment race of ""Asian" or "Native Hawaiian/Pi" or eligibility race of "Asian/Pacific Islander" are mapped to "Asian/Pacific Islander"
6. Enrollment race of "Two or more Races" is mapped to "Multiracial"  
7. Records not previously mapped that have enrollment race of "White" or eligibility race of "Caucasian" are mapped to "White (Non-Hispanic)"
8. All records still remaining unmapped are mapped to "Unknown/Other"

**Note:** Totals represent distinct clients and may not equal sum of rows/columns. A client may receive services in two age groups because of a birthday. Medicaid eligibility may reflect different race codes at different times (e.g. Caucasian at one time and Hispanic or Unknown at another time)  
Gender is based upon sex code entered on claims. An insignificant number of anomalies have been known to occur where a client may be coded with different gender codes. Totals may differ slightly from other report, however, the difference is insignificant.

Reviewed by: P. Vance  
Review Date: 10/31/2011

Page 1 of 1 DRLC-03 Q4 FY11 Statewide
Report Title: DRLC-02 Consumers Served and Expenditures by Fund (Green) Statewide
Paid Thru: 10/08/2011

<table>
<thead>
<tr>
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<th>46-55</th>
<th>56+</th>
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<tr>
<td>September</td>
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<td>November</td>
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<td>October</td>
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</tr>
</tbody>
</table>

Consumer counts within each age group are unduplicated. However, due to consumer birthdates, the consumer may be counted in another age group as a unique consumer within that age group if their birthday during the year caused them to move into another age group category and they received services within that respective age group designation. Total consumers are unduplicated. If a consumer received services in multiple age group categories, they were not counted only once as a unique consumer in the overall total. As a result, the overall total consumer column will not equal the sum total of the age categories. Total consumers are duplicated across funding streams as a consumer may receive services from multiple funding streams.

(1) Consumer counts within each age group are unduplicated. However, due to consumer birthdates, the consumer may be counted in another age group as a unique consumer within that age group if their birthday during the year caused them to move into another age group category and they received services within that respective age group designation. Total consumers are unduplicated. If a consumer received services in multiple age group categories, they were not counted only once as a unique consumer in the overall total. As a result, the overall total consumer column will not equal the sum total of the age categories. Total consumers are duplicated across funding streams as a consumer may receive services from multiple funding streams.

(2) Comm Reinvestment - This amount is embedded with HCO dollar.

(3) Sexual Assault consumer data is received from Providers in the aggregate using age categories that do not match the categories in the Directors Report.

*** Included within HSD/ BHSD consumer served are the Sexual Assault and ATR consumers. These could be duplicated consumers within the age group category.

Due to privacy constraints, the SE is not able to determine if these consumers are duplicated.

Reviewed by: P. Vance
Review Date: 10/31/2011

Page 1 of 1

DRLC-02 Q1 FY12 Statewide
<table>
<thead>
<tr>
<th>Service</th>
<th>Expenditure Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$22,152,298</td>
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<tr>
<td>Residential</td>
<td>$91,893,050</td>
<td>35.48%</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>$12,834,884</td>
<td>4.96%</td>
</tr>
<tr>
<td>Recovery</td>
<td>$39,478,163</td>
<td>15.24%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>$80,756,599</td>
<td>31.18%</td>
</tr>
<tr>
<td>Value Added Services</td>
<td>$9,999,896</td>
<td>3.86%</td>
</tr>
<tr>
<td>Outliers</td>
<td>$1,902,499</td>
<td>0.73%</td>
</tr>
<tr>
<td>Total</td>
<td>$259,017,389</td>
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</table>

Data Source: OptumHealth NM FY11 CI-09 Report

Reviewed by: R. Buser, MD
Review Date: 12/21/11
## Collaborative Funding FY11

### Total Dollars by Age Group FY11

Based on Claims Paid as of 10/08/2011

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Expenditure</th>
<th>% of Total Service Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 &amp; Over</td>
<td>$79,366,094</td>
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</tr>
<tr>
<td>18-20</td>
<td>$9,092,940</td>
<td>3%</td>
</tr>
<tr>
<td>Under 18</td>
<td>$170,558,355</td>
<td>66%</td>
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</table>

### Data Source

OptumHealth NM FYyy CI-09 Report

Reviewed by: R. Buser, MD
Review Date: 12/21/11

Total Dollars for All Age Groups -
### Collaborative Funding FY11

#### FY11 Child Total Expenditure Amount & Percentage

<table>
<thead>
<tr>
<th>Service</th>
<th>Expenditure Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$11,758,624</td>
<td>6.79%</td>
</tr>
<tr>
<td>Residential</td>
<td>$83,823,953</td>
<td>48.38%</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>$10,376,139</td>
<td>5.99%</td>
</tr>
<tr>
<td>Recovery</td>
<td>$20,890,103</td>
<td>12.06%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>$41,163,996</td>
<td>23.76%</td>
</tr>
<tr>
<td>Value Added Services</td>
<td>$4,444,396</td>
<td>2.56%</td>
</tr>
<tr>
<td>Outliers</td>
<td>$818,563</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$173,275,774</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

Data Source: OptumHealth NM FY11 CI-09 Report

Reviewed by: R. Buser, MD
Review Date: 11/21/11

Page 4 of 5

Child $&%
Collaborative Funding FY11
Total Unduplicated Consumers by Age Group FY11
Based on Claims Paid as of 10/08/11

Data Source: OptumHealth NM FY11 CI-09 Report

Reviewed by: R. Buser, MD
Review Date: 10/28/11

Page 5 of 5
Consumer by Age
| Tab 4 |
Tab 5
State Policy: Treatment of Military Trauma Spectrum Disorders

The state of New Mexico recognizes that placing one’s self in harm’s way for their country means risking both physical and emotional trauma. Some of the wounds of war are not visible. Military traumatic spectrum disorders inclusive of post traumatic stress disorder are physical changes to a veteran’s neurology in response to trauma or perceived trauma. This is a very real change in biology that can effect the veteran's "mind, body and soul” and may have rippling adverse effects on the families. In response the state of New Mexico through the Behavioral Health Collaborative is implementing a strategy in cooperation with veteran stakeholders to develop best practices within the civilian, publically funded behavioral health network across the state so as to be able to effectively engage veterans and their families into treatment and to provide a platform for sustained recovery from trauma spectrum disorders.

New Mexico Human Services Department
Implementation of Policy: Major Initiatives

- **Coordination of State Initiatives:** State Advisory Committee comprised of veterans and their families, state agencies, University of New Mexico, National Guard, VA, behavioral health providers, veteran groups and other stakeholders provide advice and consultation in the development and coordination of multiple state initiatives.

- **Pilot Best Practice:** The Collaborative contracts with the Presbyterian Medical Services-Veterans and Family Support Services in Rio Rancho to develop best practices in supporting veterans, National Guard and their families: ([http://www.nmvets.com/program](http://www.nmvets.com/program)). The state through federal competitive grant awards is developing the Access to Recovery program to provide treatment and support to the NM National Guard ([http://atrnm.org/](http://atrnm.org/)).

- **Workforce Development:** The Collaborative through the Statewide Entity, OptumHealth, contracts with 1,200 behavioral providers across the state and has undertaken multiple initiatives to train these providers in treatment of military PTSD.

- **Jail Diversion:** Unfortunately the first point of intervention for PTSD may be after an arrest. The Collaborative is implementing a statewide strategy to promote specialty courts to divert veterans with PTSD from jail into treatment when appropriate.

- **Native American:** The Collaborative has several initiatives to appropriately tailor services for Native American veterans specific to their own tribal community.

New Mexico Human Services Department
Veterans and Family Support Services: Developing Best Practices for Treatment of Military PTSD and support to the Veteran and Their Families

- Developing protocols and service packages tailored to specifically to veterans and their families.
- Trauma Evidenced Based Practices and the military culture.
- Treating the family system.
- VA link: Rio Rancho.
- Telemedicine services.
- Yellow Ribbon’s, vet conferences, stand downs.
- Statewide Training.
- State wide crisis line and Website.

New Mexico Human Services Department
Statewide Expansion of VFSS Pilot Outcomes

- **Best Practices**: VFSS and UNM-Consortium for Behavioral Health Training and Research have developed outcome studies in which performance measures are used to identify best practices.

- **Funding**: BHSD will then incorporate the best practice activities within service definitions that define what a service must encompass in order to be reimbursable within the public system.

- **Change in practice**: Through the training plan BHSD and PMS will engender training statewide on the best practice tied to CQI and ongoing mentoring to facilitate change in practice.

- **Advisory Committee**: BHSD is creating an advisory subcommittee to the SAC comprised of a wide variety of behavioral health providers who serve the military and their families to help the project identify best practices and service linkages.

New Mexico Human Services Department
Access to Recovery & National Guard

ATR Overview: Access to Recovery (ATR) is client choice driven three month voucher program in which both clinical and recovery support services are provided using a state of the art voucher management system (VMS). Individuals with substance abuse disorders are assessed at a Central Intake and then receive a voucher which they can use to purchase substance abuse treatment and support services. Substance abuse is a frequent consequence of PTSD. Over the last two years BHSD has established NM National Guard as a priority client and adapted services to their needs as described in the following bullets:

- The Central Intake in Albuquerque will be linked with the 2nd Judicial Veterans Court to provide substance abuse services for veterans diverted within this specialty court.
- In recent meetings with National Guard Commanders in Roswell, it was learned that the National Guard community had a significant need for substance abuse services. BHSD contracted with clinical and recovery support service (RSS) providers in Roswell to become part of the ATR network. The ATR mobile assessment site is open to see National Guard members as of August 12th.
- The ATR team is providing outreach across 7 other counties to veterans and National Guard members in need of Substance Abuse services. There are 55 vouchers a month set aside for New Mexico National Guard members. Income and insurance requirements have been waived for National Guard members.
- Five Sandoval Indian Pueblo is an ATR Central Intake located on the Santa Ana reservation in Sandoval County. It is be one of the service systems available to Native American Veterans.
Statewide Expansion of Veteran Specialty Courts

- Within VFSS is a federally funded pilot program, Jail Diversion/Veteran First that diverts veterans with trauma disorder from jail into treatment. It operates in Sandoval, Valencia and Cibola counties and will expand into San Juan county this year. It has a specialized focus on working with the tribal communities to develop services for Native American veterans tailored to the specific tribe.

- The state is providing state match funds to expand the project through the creation of a Veterans Court within the 2nd Judicial Court in Bernalillo County. The new court held its first session on November 9, 2011.

- New Mexico has a total population of 2,059,179 of which 1,027,951 (50%) reside in the five (5) counties providing or will be providing within the next year veteran specific jail diversion programs.
Serving Our Veterans Behavioral Health Certificate is designed to train civilian behavioral health and primary care providers, on military orientation and specific issues affecting veterans and their families. It offers 14 self-directed, self-paced online courses that:

- Provide the latest clinical guidelines from the Department of Defense.
- Demonstrate applicable knowledge and skills through real-life examples.
- Emphasize cultural sensitivities to ensure clinical competency.

The Serving Our Veterans Certificate is a public/private partnership among the National Council for Community Behavioral Healthcare, the Department of Defense Center for Deployment Psychology (CDP) at the Uniformed Services University of the Health Sciences, and Essential Learning to ensure that veterans and their families receive the exceptional services. OptumHealth New Mexico, the Behavioral Health Services Division and the Presbyterian Medical Services are planning to sponsor 50 publically agencies to receive this training in FY12.
Workforce Development: Trauma Informed System of Care

New Mexico is developing mechanisms to promote trauma informed behavioral health care throughout the public behavioral health system. New Mexico has facilitated the creation of a core team of behavioral health professionals with significant credentials on trauma treatment and trauma informed care:

- Consortium for Behavioral Health Training and Research, UNM
- University of New Mexico Alcohol and Substance Abuse Program
- Turquoise Lodge Inpatient Detoxification
- Presbyterian Medical Services -VFSS
- Bernalillo Metropolitan Assessment and Treatment Center

The group’s mission is to develop a trauma informed fidelity tool that is adaptable to a wide range of public service environments including primary health care, outpatient and inpatient substance abuse services and jail diversion programs. The second phase of the initiative is to develop a process whereby agencies self assess with trauma informed fidelity scale and then incorporate outcomes for the self review into a continuous quality review process.
Peer Specialists-Vet to Vet

It is very evident that the civilian behavioral health provider must have a “vet to vet” connection to engage veterans into treatment services. The Office of Consumer Affairs (OCA) oversees a certification process whereby peers (consumers of behavioral health services) are certified to be able work within publically funded Community Mental Health Centers. Peer Specialists who are veterans will be eligible to complete a veteran CEU track sponsored by the Office of Consumer Affairs.

The desired outcome is that veterans who experience PTSD can be certified as peer specialists, receive further veterans specific training and can be employed within an publically funded behavioral health agency. This allows the agency to access the workforce to implement vet to vet services. There is both stable state and Medicaid funding for the provision of these vet to vet services which allows for sustainability of the service.
Training the Public Workforce

- **Train First Responders:** In the spring of 2011 BHSD funded the Dona Ana Forensic Intervention Consortium to conduct four seminars for first responders and dispatchers in four locations across the state. The seminars provided basic information about PTSD and TBI; signs indicating that the individual in crisis has both PTSD and TBI that first responders can recognize; and methods for handling these situations in the field.

- **Outreach to Military:** On October 15, 2011 BHSD helped sponsor and PMS participated in the NM Department of Veteran Services 2011 Women Veterans’ Conference and Health Fair in Albuquerque. Representatives from the VA, DoD, state and other veterans’ service organizations presented information about VA and state veterans’ benefits and programs ranging from filing for disability compensation, the new 9/11 G.I. Education Bill, and other benefits.

- **Train Public Behavioral Health Providers:** On October 19, 2011 at the statewide required training for Core Service Agencies funded by BHSD, PMS sponsored an all day track that focuses on clinical issues pre and post deployment effecting military personnel and their families evidence-based and best practices for treating combat trauma/PTSD.

- **Train Public Behavioral Health Providers:** BHSD and PMS were sponsors of the New Mexico Mental Health Counselor’s Association’s annual conference *Trauma in the 21st Century: A Symposium of the Mind & Body* held on April 29th and 30th by sponsoring 40 attendees.
Next Steps

We still have a long way to go. The next steps in service system development is to continue building on the existing work in order to:

- Identify best practice services and the integration of services into a system of care.
- Develop innovative “pay for performance” practices that lead to best outcomes for the amount of available funding.
- Increase service capacity and access to meet anticipated need.
- Develop data systems track indicators for service need, service capacity and performance outcomes in order to drive system development.
- Increase linkage, coordination and integration with the myriad of veteran/PTSD stakeholders to facilitate accomplishing the previously identified tasks.
Tab 6
The Affordable Care Act: Section 2703. Health Homes – An Opportunity for New Mexico

Behavioral Health Collaborative Presentation
January 12, 2012
Santa Fe, New Mexico
Background

• Health Homes is a new Medicaid State Plan Option through the Affordable Care Act that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions.

• Goals of implementing Section 2703 will be:
  – to expand upon the traditional and existing medical home models to build linkages to community and social supports; and,
  – to enhance the coordination of medical, behavioral and long-term care to treat the “whole person.”
Health Homes: What are they?

• New opportunity for Medicaid programs to provide and pay for six new and previously unreimbursed services:
  1. Comprehensive care management;
  2. Care coordination and health promotion;
  3. Comprehensive transitional care/follow-up;
  4. Patient and family support;
  5. Referral to community and social support services;
  6. Use of Health Information Technology to link services.
Who would receive HH services?

• Medicaid beneficiaries with:
  – Two or more chronic conditions (mental health, substance abuse, asthma, diabetes, heart disease, being overweight); or
  – One chronic condition and at risk for a second; or
  – Serious and persistent mental health condition.

• Must include dual eligibles (Medicare/Medicaid)
Health Home providers must:

- Develop a person-centered care plan that coordinates/integrates clinical/non-clinical healthcare needs/services;
- Use of HIT to link services, communicate across team members, health team, individual and family caregivers, and provide feedback to practices;
- Establish a continuous QI program; and
- Report outcomes to CMS and the state.
What steps are we taking in New Mexico?

- Medicaid has been approved for a planning grant to develop and submit a State Plan amendment.
- Planning Teams: developed Service definitions, examining Practice Models, developed Provider Qualifications & Standards; examining Quality Measures, determining Expenditure Patterns
- Target Health Home program geographically and leverage existing infrastructures
Phased-In Approach

- Phase 1: Provide HH services to eligible Medicaid beneficiaries with serious mental health diagnoses and other behavioral issues through selected Core Service Agencies (CSAs)
- Phase 2: Provide HH services to beneficiaries with complex physical health diagnoses via primary care infrastructure
- Phase 3: Provide HH services to beneficiaries with long-term care needs
Medicaid Enrollment and Behavioral Health Penetration Rate 2011

• 540,000 Enrollees
• 106,000 Enrollees with BH a Diagnosis used BH Service (19.6% penetration)

<table>
<thead>
<tr>
<th></th>
<th>SMI/SED</th>
<th>%</th>
<th>Other</th>
<th>%</th>
<th>TOTAL</th>
<th>%</th>
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<tbody>
<tr>
<td>ADULTS</td>
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<td>31,900</td>
<td>52%</td>
<td>61,500</td>
<td>100%</td>
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<tr>
<td>YOUTH</td>
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## Co Morbid Conditions

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<th>TOTAL</th>
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<td>393</td>
<td>9,144</td>
<td>9,537</td>
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<td>Hyperlipidemia</td>
<td>300</td>
<td>5,686</td>
<td>5,986</td>
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<tr>
<td>Diabetes</td>
<td>242</td>
<td>4,987</td>
<td>5,229</td>
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<tr>
<td>Heart Disease</td>
<td>540</td>
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<td>4,319</td>
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<td>COPD</td>
<td>751</td>
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<td>4,535</td>
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<tr>
<td>Obesity</td>
<td>1,683</td>
<td>3,368</td>
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<td>Diseases of the Arteries</td>
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<td>1,582</td>
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<td>Asthma</td>
<td>710</td>
<td>480</td>
<td>1,190</td>
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<td><strong>Total Conditions</strong></td>
<td>4,721</td>
<td>32,757</td>
<td>37,478</td>
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<tr>
<td><strong># Persons</strong></td>
<td>30,900</td>
<td>29,600</td>
<td>60,500</td>
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</table>
## Distribution of Chronic Conditions

<table>
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<tr>
<th></th>
<th>SMI/SED</th>
<th>% SMI/SED</th>
<th>Other</th>
<th>% Other</th>
<th>Total</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Condition</td>
<td>12,600</td>
<td>21%</td>
<td>10,900</td>
<td>25%</td>
<td>23,500</td>
<td>22%</td>
</tr>
<tr>
<td>2 +</td>
<td>2,600</td>
<td>4%</td>
<td>3,100</td>
<td>7%</td>
<td>5,700</td>
<td>5%</td>
</tr>
<tr>
<td>Total</td>
<td>15,200</td>
<td>25%</td>
<td>14,000</td>
<td>32%</td>
<td>29,200</td>
<td>27%</td>
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## Total Expenditures

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<tr>
<td></td>
<td></td>
<td>Average</td>
<td>Total</td>
<td>Average</td>
</tr>
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</tr>
<tr>
<td>SMI</td>
<td>29,600</td>
<td>$3,255</td>
<td>$87M</td>
<td>$13,370</td>
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<tr>
<td></td>
<td></td>
<td>(20%)</td>
<td></td>
<td>(80%)</td>
</tr>
<tr>
<td>SED</td>
<td>30,900</td>
<td>$4,200</td>
<td>$130M</td>
<td>$3,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(58%)</td>
<td></td>
<td>(42%)</td>
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<tr>
<td>Other</td>
<td>31,900</td>
<td>$1,200</td>
<td>$39M</td>
<td>$10,500</td>
</tr>
<tr>
<td>Adults</td>
<td></td>
<td>(10%)</td>
<td></td>
<td>(90%)</td>
</tr>
<tr>
<td>Other</td>
<td>13,400</td>
<td>$1,300</td>
<td>$17M</td>
<td>$2,400</td>
</tr>
<tr>
<td>Youth</td>
<td></td>
<td>(34%)</td>
<td></td>
<td>(66%)</td>
</tr>
<tr>
<td></td>
<td>106,400</td>
<td>$2,600</td>
<td>$274M</td>
<td>$7,700</td>
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<tr>
<td></td>
<td></td>
<td>(25%)</td>
<td></td>
<td>(75%)</td>
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</table>

The Center for Health Care Strategies provides technical assistance for Aligning Forces for Quality, a national initiative of the Robert Wood Johnson Foundation.
<table>
<thead>
<tr>
<th></th>
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<th>2 – 3 ER</th>
<th>4 – 6 ER</th>
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</tr>
</thead>
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<tr>
<td></td>
<td>#</td>
<td>%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>SMI</td>
<td>15%</td>
<td>9%</td>
<td>3%</td>
<td>2%</td>
<td>8,100</td>
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<tr>
<td>SED</td>
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<td>4%</td>
<td>1%</td>
<td>0.2%</td>
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<tr>
<td>Other Adult</td>
<td>13%</td>
<td>6%</td>
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<td>1%</td>
<td>7,000</td>
</tr>
<tr>
<td>Other Youth</td>
<td>8%</td>
<td>3%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>1,500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>21,200</strong></td>
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</tbody>
</table>
## Hospital Admissions

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<thead>
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<th></th>
<th>1 Admission</th>
<th>2 – 3 Admissions</th>
<th>4 – 6 Admissions</th>
<th>7+ Admissions</th>
<th>Total #</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMI</td>
<td>12%</td>
<td>4%</td>
<td>1%</td>
<td>0.3%</td>
<td>4,700</td>
<td>18%</td>
</tr>
<tr>
<td>SED</td>
<td>5%</td>
<td>2%</td>
<td>0.5%</td>
<td>0.2%</td>
<td>2,200</td>
<td>7%</td>
</tr>
<tr>
<td>Other Adult</td>
<td>10%</td>
<td>3%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>4,250</td>
<td>13%</td>
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<tr>
<td>Other Youth</td>
<td>3%</td>
<td>0.5%</td>
<td>0.1%</td>
<td>0.003%</td>
<td>450</td>
<td>3%</td>
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<tr>
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<td></td>
<td></td>
<td>11,600</td>
<td></td>
</tr>
</tbody>
</table>
So our initial focus will be on:

Persons with SMI, SED or other behavioral health problems and one of the following chronic conditions:

- Asthma
- COPD
- Hypertension
- Hyperlpedemia
- Heart Disease
- Diabetes
- Obesity
Next steps in preparing the Medicaid State Plan Amendment

- Further examining the data for patterns in expenditures by populations and chronic conditions;
- Developing a budget and analyzing where the cost savings will be achieved;
- Developing financial payment methodologies and incentives;
- Studying where and how many health homes will be needed;
- Developing a statewide implementation plan.
Time Frames

- Summer, 2012: Submit a State Plan amendment for health homes for persons with behavioral health problems;
- Fall, 2012: Implement initial Health Homes in Bernalillo County
- By July 2013 – will have gone statewide
- By July 2014 – initiated health homes for other chronic conditions
SENATE MEMORIAL 56

Adolescent Opioid Addiction Treatment Study

New Mexico Behavioral Health Collaborative
Opioid Dependence Core Group

October 2011
Senate Memorial 56

Adolescent Opioid Addiction Treatment Study

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Target Population 4
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Current System of Care 5
Comprehensive Statewide Plan 6
Steps for implementation 9
Executive Summary 13
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Attachment: Copy of Senate Memorial 56

Recovery from alcohol and substance problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.

- Substance Abuse and Mental Health Services Administration
Senate Memorial 56-Vision

Adolescent Opioid Addiction Treatment is requesting the Interagency Behavioral Health Purchasing Collaborative to develop a comprehensive statewide plan for treatment of opioid addiction among adolescents, including steps for implementation of the plan. The service system design within this report has a focus on opioid addiction but it has been built to be applicable to all substance addictions. The Collaborative’s intent within this Memorial is to design a system of care that provides a platform upon which persons with addictions can use to build their sustained recovery. The service system shall be inclusive of evidenced-based, scientific practices tempered by the experiences of persons contending with addictions and their families. It is tailored to cultural and geographic diversity in order to create a New Mexico best practice for the treatment of addiction disorders. Critical to the endeavor is collecting and analyzing performance outcomes according to resource allocation to determine best value in practice. As best value practices are identified the behavioral health workforce shall receive the training and mentoring needed to increase service efficacy and statewide access and capacity.

Statement of Problem

New Mexico has the highest rate of fatal unintentional drug overdoses in the country. New Mexico adolescents are using drugs at younger ages than other youth in the United States (age 12), and are more likely to have tried heroin than their national counterparts (Youth Risk and Resiliency Survey, 2011). An increasing number of high school students report using painkillers to get high: in 2007, 11.7% of students reported this usage, and the percentage increased to 14.3% in 2009 (YRRS, 2011). In a study conducted in 2009 by the Center for Disease Control, 4.7% of New Mexico high school students reported lifetime heroin use, compared to 2.5% of students in the United States. Confirmed unintentional fatal drug over doses in Albuquerque alone have increased from 5 in 2005 to 20 in 2009 with the number is still increasing (Shah, 2011).
Illicit drugs, including black tar heroin, are widely available throughout New Mexico. Our shared border with Mexico, high levels of drug trafficking activity, expanses of uninhabited desert, and the state’s two interstate corridors contribute to readily accessible illegal drugs. Prescription drug abuse is the nation’s fastest-growing drug problem, and the Centers for Disease Control and Prevention has classified prescription drug abuse as an epidemic. Data shows that nearly one-third of people aged 12 and over who used drugs for the first time in 2009 began by using a prescription drug non-medically (ONCDP, 20011). A survey of New Mexico adult Core Service Agencies in 2011 on behalf of the Behavioral Health Services Division found that 61% reported an increase in the number of persons seeking treatment for either heroin or prescription drug abuse/dependency.

### Target Population

New Mexico youth report using opioids (typically, misusing prescription drugs) as early as age 12. Between ages 12 and 17 this misuse may expand to include cheaper and more readily available black tar heroin. Often, opioid abuse is not detected for a year or more, at which point a 17 or 18 year old may be addicted. A sustained recovery typically takes eight years to achieve, if the individual survives. It is common for the initial active addiction process to extend from age 12 to 26, and above. Therefore, the Core Team designated the age range for adolescent or youth to be ages 14 to 24, to range from a typical point in onset of use to the age when the recovery process is likely to be engaged.

### Guiding Principles

- **Culturally Competent** – Services shall be delivered with consideration and adaptation for cultural, racial, ethnic, age and language preferences and will include natural and Informal supports, practice-based and community-defined supports.
- **Trauma Informed** – Behavioral health providers shall be aware of the pervasive, adverse impact of trauma commonly found with persons who are addicted, and the entire system shall be designed to be trauma informed to create a healing environment and evidenced based practices shall be delivered to address trauma in the treatment process.
- **Recovery Oriented** – Services shall be anchored in the person centered approaches that focus on the strengths and resiliency of individuals, families and communities to take responsibility for attaining long-term, sustainable recovery as developed at the 2005 SAMHSA National Summit on Recovery Conference.
- **Clinical Home & System of Care** – Addictions are chronic, complex and relapse prone conditions that impact most areas of an individual’s life. Sustained recovery typically requires an ever changing array of harm reduction, integrated treatment, recovery and natural supports over time. Services are embedded within a system of integrated care managed over an extended period of time through the stages of change and phases of recovery by a clinical home type entity or Core Service Agency.
- **Peer Recovery Community** – Peer to peer support through varied avenues may include peer coaching, navigating and peer driven support groups such as Narcotic Anonymous. Recovery communities are recognized as a critical element that sustains recovery throughout people’s lives. There should be a prominent, supportive linkage between the clinical home type entity or Core Service Agency and the recovery community.

- **Best Value** – Treatment and recovery services paid with public funds should be provided in the most efficient manner, at the appropriate level of intensity for the duration of time required to sustain stable recovery so as to increase accessibility and capacity.

![Guiding Principles of Recovery](image)

### Guiding Principles of Recovery

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery is supported by peers and allies.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality. It can, will, and does happen.

*Source: CSAT White Paper: Guiding Principles and Elements of Recovery-Oriented Systems of Care*

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**Current System of Care**

The publically funded behavioral health service system in New Mexico has great variability in terms of capacity, access, availability and quality. 87% of the state’s geography is rural or frontier where populations are sparse and services may be a hundred miles away and the professional workforce is very limited, if even present. Urban and suburban systems have received reduced or stagnant funding over the last several years so that their capacity does not meet the ever increasing need. Services and agencies tend to be siloed. The integration of behavioral health, physical health and peer recovery communities is not typical. Addiction treatment services for adolescents under the age of 18 are extremely limited throughout the state with many critical service components such as residential detoxification and treatment...
almost completely absent. Harm reduction approaches such as prescribing Narcan to prevent lethal overdoses are being reduced.

On the other hand the New Mexico service system does have brilliant and dedicated service providers, legislators, educators, consumers, family members and advocates who are working hard to expand service access and capacity for addicted youth. In many areas of addiction treatment, New Mexico is a national leader. Grassroots family groups have emerged to bring forth the impact of heroin addiction within their communities and are galvanizing political will to address these issues. Stakeholders are coming together to find solutions for this crisis in healthcare.

### Comprehensive Statewide Plan for Treatment of Opioid Addiction

**Recovery Oriented System of Care**

The Opioid Dependence Core Group identified the following activities to be essential elements of a comprehensive statewide plan for treatment of opioid addiction.

1. **Centralized statewide information and referral (Statewide I & R) center.** The Statewide I & R should provide comprehensive information on substance abuse; the full array of harm reduction, treatment, recovery and support opportunities available statewide; and, how to access these services, supports and opportunities. Multiple modes of communication should be used including the telephone, face-to-face interaction and electronic social networking (website and FaceBook). The Statewide I & R should include a “Warm Line” component of trained volunteers to assist consumers and families through dissemination of information and active listening to make informed decisions around treatment and sustained recovery.

2. **Recovery-Oriented System of Care.** The Recovery-Oriented System of Care should be managed through a clinical home type entity or Core Service Agency to coordinate and integrate an array of treatment and recovery services to support individuals in recovery through the stages of changed and phases of treatment. One agency point of contact should be identified, typically a Recovery Coach or Community Support Worker, and services are then managed by a team approach (e.g. Comprehensive Community Support Service team). Services may include:
   - Outreach, engagement, comprehensive assessment and person centered planning.
   - Peer Coach/Navigator.
   - Family education and linkage to family-to-family support groups.
   - Integration of harm reduction principles.
   - 24/7 Crisis Response specifically designed for persons with addictions.
   - Residential stabilization and detoxification linked with community based services.
   - Medication Assisted Treatment integrated with behavioral treatment best practices.
   - Evidenced based Intensive outpatient programs.
- Other evidenced based and standard outpatient individual, group and family counseling, education and recovery skills development.
- Integrated services for persons with mental health and trauma spectrum disorders.
- Integrated physical health services for persons with chronic healthcare conditions.
- Linkage to supportive sober housing/transitional living without time limitations.
- Linkage to housing, employment and educational support services and opportunities.
- Barrier free transition from youth to the adult provider network.

3. **Linkage to Recovery Communities**: Recovery Communities are peer-operated and driven recovery and support services, based upon social contracts of mutual support throughout the extended recovery process. They are an essential component of the recovery oriented system of care that is typically distinct from but linked to the Core Service Agencies or clinical home type entity.

4. **Linkage to Natural Support**: Family, friends and faith-based elements are often foundation supports people use to enhance resiliency and maintain ongoing recovery. Again, they are separate from the Core Service Agencies or clinical home type entity but they should be recognized, supported and valued.

5. **Funding/Data Management**: The recovery oriented system of care should be outcome oriented and performance data driven with innovative funding to promote and incentivize cost effective service system outcomes for best value.

6. **Workforce Development/Training**: Training/mentoring on evidenced based and promising treatment and recovery practices with adolescents is necessary to expand service access and capacity to meet the service demand statewide across urban, rural and frontier geography. Agencies should also develop skill sets and infrastructure to provide the recovery management process.

7. **Prevention-Healthcare Promotions**: Promote personal, physical, and social wellbeing of individuals, families, and communities to reinforce positive behaviors and health lifestyles.

8. **Recovery System of Care Intersections with Other Systems**: The recovery oriented system of care should intersect with the schools and the Juvenile Justice System and Adult Criminal Justice System to promote clear communication, quick access to the appropriate services and coordination of activities.

9. **Continuous Quality Improvement (CQI)**: CQI process based on the best value premise of cost benefit outcome analysis should be embedded throughout the Core Service Agency or other clinical home type entity to improve performance and enhance outcomes.
Comprehensive Statewide Plan for Treatment of Opioid Addiction

Points of Entry

- Information & Referral
- School
- Medical
- Self/Family
- Outreach
- Other

Linkage with Criminal Justice system (if indicated)

Clinical Home or Core Service Agency

- Engagement
- Comprehensive Assessment
- Person Centered Plan of Care
- Recovery Coach/Team Point of Contact

Family Support and Education & Natural Supports

- Recovery Communities & Faith Based Support

Recovery-Oriented System of Care

- Engagement and Outreach
- 24/7 Crisis Response specifically designed for persons with addictions
- Harm reduction approaches
- Residential stabilization and detoxification linked with community based services
- Medication Assisted Treatment integrated with behavioral treatment best practices
- Evidenced based Intensive Outpatient Programs
- Evidenced based and standard outpatient individual, group and family counseling, education and recovery skills development
- Integrated mental health services for persons with co-occurring mental health and trauma disorders
- Integrated physical health services for persons with chronic health care conditions
- Linkage to supportive sober housing/transitional living without time limitation
- Linkage to housing, employment and education support services and opportunities
- Barrier free transition from youth to the adult provider network
- On-going monitoring and support through Recovery Coach

OUTCOME -Enhanced Resiliency & Sustained Recovery
Steps for Implementation

Creating a comprehensive statewide plan for treatment of opioid addiction among adolescents, including steps for implementation of the plan is a very challenging task. There is no generally accepted existing best practice. Opioid addiction is a chronic, complex, relapse prone disorder that quickly controls most areas of a youth’s life. Sustained recovery typically takes years of tenacious effort by the addicted individuals and their families who are supported by treatment and recovery services within the recovery oriented system of care. The simple fact is that many do not survive. Realistically it will take five to ten years to fully develop a comprehensive treatment system for opioid addiction. What follows are two levels of implementation recommendations. One identifies the immediate tasks that are in varying stages of accomplishment to enhance and expand the system of care within the next year or so. The other describes the extended effort to refine, plan and fund the further development of a recovery orient system of care that provides best value in promoting sustained recovery.

Short Term Implementation

1. Centralized Information and Referral Center:

**Recommendation:** It is recommended that representatives of the Opioid Dependence Core Group (Core Group) including the statewide entity (OptumHealth New Mexico), Collaborative Executive Committee agencies (Human Services Department, Children, Youth and Families Department and the Department of Health), the Behavioral Health Planning Council and other stakeholders as identified create a workgroup to design a centralized information and referral center (I & R Center) inclusive of operational implementation and sustainable funding. The system would be the repository of current information on the manifestations and consequences of substance abuse, and the available array of treatment services and recovery options in New Mexico. Information should be presented in such a way as to promote the consumer's and family's ability to make informed decisions around treatment and recovery. Communication mediums should include telephone and texting/e-mail coverage and webpage with FaceBook and other electronic social network linkage. A statewide Warm Line would be developed in partnership with the Office of Consumer Affairs to assist callers who are exploring service options with supportive communication and active listening by trained volunteers.

**Timeline:** Design Completion:3/1/12. Implementation Onset: 7/1/12.

2. Enhance Components of the System of Care

**Recommendation:** It is recommended that representatives of the Opioid Dependence Core Group (Core Group) including the statewide entity, Collaborative Executive Committee agencies, the Behavioral Health Planning Council and other stakeholders as identified create a workgroup to monitor, facilitate, coordinate and enhance the components within Recovery Oriented System of Care as identified below. Many of these initiatives are already in varying phases of development from early design to initial implementation.
Timeline: The Core Group would be tasked to facilitate completing the following activities in FY12:

- Health Promotion: Health Promotions are programs designed to inform the public about health risks of opioid addiction and methods to prevent or reduce them; the programs are often targeted at specific populations.
  - The Collaborative is working with Chris Schueler of Christopher Productions (http://www.christopherproductions.org) in the production of a series of healthcare promotions around opioid addiction. He is developing a youth-to-youth video on the consequences of opioid use by youth who are addicted and in varying phases of recovery. In addition he has developed a companion piece a parents-to-parents video on the signs of addiction and where help can be found. These videos will be widely distributed across the state in numerous venues to increase awareness in the youth and their parents around the severe addictive qualities of opioid, the challenges of recovery once addicted and fatal aspects of opioid use.
  - It has become apparent that many of the youth across the country become addicted through misusing opioid medication prescribed by the family physician. The medical community is currently prescribing massive amounts of narcotics for almost any condition that may have some pain associated with it. There is usually an initial legitimate need but the amount of medication prescribed (often with multiple refills) far exceeds the amount necessary to control the pain. Subsequently partially used containers sit in medicine cabinets. The some youth take the medication from the cabinet and use it recreationally with the friends. They assume that since this is “medicine” it will be safe and do not find out differently until they or their friends are fully addicted. It appears that not enough physicians, pharmacists, parents or the youth understand that these prescriptions can be as lethal as a loaded gun and should be treated accordingly: used only when absolutely necessary and no safer alternative is viable; immediately dispose any remaining unused medication; and no refills without close physician supervision and medical monitoring. The Collaborative will be working with physicians, pharmacists, pharmaceutical companies and other stakeholders to develop healthcare promotions around how to safely and appropriately use these medications.

- Recovery Oriented System of Care Infrastructure Development-Recovery Coach. The Recovery Coach is a newly developed position for individuals employed by a Core Service Agency or another other clinical home type entity who will provide a constellation of services anchored in the elements of Recovery Management. A Recovery Coach may be charged to provide to youth in recovery encouragement and support, information, clarification of goals, skill development, linkage to recovery communities, navigation of the service systems and other supports to promote sustained and stable recovery. Recovery Coaches are ideally people who have achieved extended recovery themselves,
and developed an understanding of the broad principles and approaches of recovery through education and personal experience.

The Statewide Entity, OptumHealth New Mexico, through Collaborative funding shall engage a grant/program developer type entity to seek foundation and/or governmental grants to fund a 3 year pilot study. The study will be evaluated by the University of New Mexico-CBHTR to assess the effectiveness of Recovery Coaches in facilitating recovery in the youth population (ages 14-24). OHNM shall select the pilot sites by public process and shall be inclusive of both youth and adult CSA’s or other clinical home type entities. The Recovery Coach is a critical avenue of embedding Recovery Management into the service system.

- **Medication Assisted Treatment** (MAT) is treatment for opioid addiction that includes FDA approved medication (e.g. methadone, Buprenorphine, naltrexone) for opioid addiction detoxification or maintenance treatment. The medications block withdrawal and are used in combination with counseling and behavioral therapies to provide a whole-patient approach. Research indicates that a combination of medication and behavioral therapies is successful in treating substance-use disorders (CSAT 2008). There is limited access and capacity for MAT for persons under the age of 18 and protocols do not currently exist to link medication services with behavioral health services.

The Collaborative members lead by Human Services Department-Medical Services Division and including the Behavioral Services Division (BHSD); Children Youth and Families Department (CYFD); OptumHealth New Mexico and the Medicaid physical health MCO’s; University of New Mexico Department of Psychiatry; and other stake holders are in the process of developing a best practice in Medication Assisted Treatment that is recognized across behavioral and physical health for adults and youth for the provision of MAT with its integration with behavioral health substance abuse treatment and recovery services. Once the best practice is defined and vetted, UNM’s Department of Psychiatry and Project ECHO shall hold a statewide conference and a series of telehealth training programs for providers in all the aspects of the best practice. It is recommended that the Collaborative update the Legislative HHS Committee on this process as requested.

- **Adolescent Residential Services** for stabilization, detoxification, induction of Buprenorphine acute care and linkage to a community based recovery-oriented system of care is currently absent in New Mexico for youth under the age of 18. This has resulted in youth completing detoxification and stabilization within unsafe environments and creates a barrier to youth beginning the recovery process. The Collaborative is currently
exploring avenues to systemically fund and/or pilot residential detoxification and stabilization for adolescents under the age of 18.

- **Adolescent Intensive Outpatient Programs (A-IOP)** is an evidenced based practice comprised of a series on integrated therapeutic activities including individual and group counseling and family education for adolescents with significant substance abuse issues. Typically there is 9 hours of services per week for 3 to 9 months. CYFD and HSD-Medical Assistance Division have been facilitating the implementation A-IOP statewide since 2009. The Collaborative is exploring avenues to significantly increase access and capacity to A-IOP in FY12 with goal of statewide access in FY13.

- **Harm Reduction**: Harm reduction is a strategy designed to reduce death and injury resulting from opioid use. Relapse is typical in opioid addiction and adolescents are at very high risk of overdose which is not infrequently fatal. The Statewide Entity, the Collaborative and other stakeholders shall evaluate the current status of systemic harm reduction strategy efficacy and shall develop a state wide plan based on this evaluation.

3. Workforce Development / Training

**Recommendation**: It is recommended that the Collaborative create a workforce development and training workgroup comprised representatives from state agency, Office of Consumer Affairs, OptumHealth and its provider network in order to create a 3 year statewide training and mentoring plan to:

- Assist Core Service Agencies develop the skill set and infrastructure to design, implement, manage and fund a recovery oriented system of care.
- Strategically expand capacity and access to evidenced based and promising practices in the treatment of addictions in youth with a focus on opioid dependency within the recovery oriented systems of care.

Currently the Collaborative, University of New Mexico and OptumHealth along with a wide range of other stakeholders are planning a statewide training conference and ongoing mentoring on the best and innovative practices in Medication Assisted Treatment for opioid Treatment this spring or early summer.

**Timeline**: completion of the plan by 3/1/12 within implementation in 7/1/12.

**Extended Process**

**Recovery-Oriented System of Care**
A Recovery-oriented system of care supports self-directed approaches that focus on the strengths and resiliency of individuals, families and communities to take responsibility for their sustained health and recovery. In 2005 the Center for Substance Abuse Treatment (CSAT) convened a National Summit on Recovery in which major stakeholders formulated key elements in a recovery-oriented system of care (CSAT 2005). These are as follows:
• Person-centered;
• Family and other ally involvement;
• Individualized and comprehensive services across the lifespan;
• Systems anchored in the community;
• Continuity of care;
• Partnership-consultant relationships;
• Strengths-based;
• Culturally responsive;
• Responsive to personal belief systems
• Commitment to peer recovery support services;
• System-wide education
• Inclusion of the voices and experiences of recovering individuals and their families;
• Integrated services;
• Ongoing monitoring and outreach;
• Outcome-driven;
• Research-based;
• Adequately and flexibly financed.

Recovery Oriented systems of care is managed or coordinated out a single organization that functions as the clinical home type entity or Core Service Agency. It integrates a combination of services to facilitate sustained recovery from severe addiction disorders. Some of the services are provided by the clinical home or Core Service Agency; and, some services are linked through service coordination, contract, MOU’s or other formal or informal arrangements with the clinical home type entity or Core Service Agency. The Collaborative has several initiatives to explore and develop the agency clinical home within which the Recovery Oriented System of Care management can be embedded. These initiatives include the Core Service Agencies and Health Homes both of which will be impacted by the 1115 Medicaid Waiver and rollout of the Healthcare Reform Act.

### Executive Summary

Senate Memorial 56 *Adolescent Opioid Addiction Treatment* is requesting the Interagency Behavioral Health Purchasing Collaborative to develop a comprehensive statewide plan for treatment of opioid addiction among adolescents, including steps for implementation of the plan. The service system design has a focus on opioid addiction but it has been built to be applicable to all substance addictions. The Collaborative’s intent within this Memorial is to design a system of care that provides a platform that persons with addictions can use to build their sustained recovery. The service system shall be inclusive of evidenced-based, scientific practices tempered by the experiences of persons contending with addictions and their families, and tailored to cultural and geographic diversity in order to create a New Mexico best practice for the treatment of addiction disorders. Critical to the endeavor is collecting and analyzing performance outcomes according to resource allocation to determine best value in practice. As best value practices are identified the behavioral health workforce shall receive the training and mentoring needed to increase service efficacy and statewide access and capacity.

### Issues and Recommendations:

- Opioid addiction has increased significantly over the last several years especially among youth. The consequences have been horrific with New Mexico leading the country in fatal overdoses.
• Opioid addiction is a very complex disorder that quickly controls most areas of the youths’ lives and is very resistant to treatment and prone to relapse.
• Though there are many brilliant and dedicated providers, professionals and advocates the service system is siloed and funding is fragmented and inadequate resulting in services typically be provided in isolation with limited long term effectiveness.
• Addictions are chronic, relapse prone and complex conditions that impact most areas of people’s lives. It typically requires an ever changing array of integrated harm reduction, treatment, recovery and natural supports to sustain stable recovery. Services should be embedded within a system of integrated care managed over an extended period of time through the stages of change and phases of recovery by a clinical home type entity or Core Service Agency.
• Services should be anchored in the person centered approaches that focus on the strengths and resiliency of individuals, families and communities to take responsibility for attaining long-term, sustainable recovery. Linkages to peer to peer and natural supports should be prominently promoted.
• New Mexico is in process of developing its recovery oriented system of care but it is a major undertaking that will require continued focus and political will to accomplish over the next five to ten years.
• In the interim immediate steps can be taken to greatly improve care and increase sustained recovery for many people in New Mexico through the following actions:
  1. Creation of a statewide Information & Referral Center with a warm line.
  2. Coordination of the multitude of efforts currently in process.
  3. Piloting of Recovery Coaches within Core Service Agencies or clinical home type entities.
  4. Development of standardized best practices across payers for Medication Assisted Treatment linked to substance abuse treatment and recovery services.
  5. Development of residential stabilization and detoxification for adolescents linked to the community substance abuse treatment and recovery services.
  7. Development of workforce training/mentoring plan to expand service access and capacity for the services and supports in development.
Members of the Opioid Dependence Core Group

The Collaborative wishes to thank the following members of the Opioid Dependence Core Group for their participation and dedication to finding solutions for the addiction health care crisis in New Mexico:

- **Adelsheim, Steve-MD**
  Professor of Psychiatry, UNM
  Consultant, Behavioral Health Collaborative

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  Psychiatrist
  UNM-ASAP

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  Prevention Staff Manager, Office of SubSTANCE Abuse Prevention

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  Director-School & Adolescent Health Department of Health

- **Courtney-Ortega, Katherine-PhD**
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  Children, Youth and Families Department

- **Jay Crowe, LISW**
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  Albuquerque HealthCare for the Homeless

- **Dodson, Olin-LPCC**
  Consultant

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  UNM-ASAP

- **Donald Hume, CPSW**
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  Director-Recovery Based Solutions

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  New Mexico Solutions

- **Luna-Anderson, Carol-PhD**
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  The Life Link

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- **Strunk, Rosemary**
  Sr. Director of Program Services
  OptumHealth New Mexico

- **Sutherland-Bray, Kathy-M.A.**
  Director- Inside Out

- **Weiss Jennifer**
  President
  Heroin Awareness Committee.

- **Wilcox, Claire- MD**
  Assistant Professor
  Department of Psychiatry,
Professional References

Center for Substance Abuse Treatment Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs TIP 43, SAMHSA, 2008.


New Mexico Youth and Resiliency Survey (YRRS) reports (2011) Produced by the New Mexico Department of Health, New Mexico Public Education Department and the University of New Mexico Prevention Research Center online at: http://nmhealth.org/ERD/HealthData/health_behaviors.shtml


CELEBRATE RECOVERY
SENATE MEMORIAL 56

INTRODUCED BY

SENATORS ERIC G. GRIEGO, PETE CAMPOS, TIM EICHENBERG, DEDE FELDMAN, HOWIE C. MORALES, GERALD ORTIZ Y PINO, SANDER RUE, BERNADETTE M. SANCHEZ AND PETER WIRTH

A MEMORIAL

REQUESTING THE INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE TO DEVELOP A COMPREHENSIVE, STATEWIDE PLAN FOR TREATMENT OF OPIOID ADDICTION AMONG ADOLESCENTS

WHEREAS, in 2005, New Mexico had the second-highest drug-induced death rate in the United States, with nearly thirty deaths for every one hundred thousand persons, compared to a rate of just over eleven deaths for every one hundred thousand persons in the United States; and

WHEREAS, the total unintentional drug overdose death rate in New Mexico increased by one hundred eighty percent between 1990 and 2005; and

WHEREAS, adolescent deaths from opioid overdose accounted for twelve percent of all opioid deaths in New Mexico in 2009, up from two percent prior to 2004; and

WHEREAS, a 2007 national survey, conducted by the Federal Substance Abuse and Mental Health Services Administration, indicated that New Mexico teens between the ages of twelve and seventeen use illicit drugs more heavily than the United States average; and

WHEREAS, according to data collected from the 2009 Youth Risk and Resiliency Survey, fourteen and three-tenths percent of New Mexico students used prescription painkillers to get high that year, an increase of nearly two percent from 2007; and

WHEREAS, New Mexico lacks a system of coordinated and effective care for treatment of opioid-addicted adolescents; and

WHEREAS, there are virtually no outpatient facilities in New Mexico that offer combined medical and psychological treatment of adolescent opioid addiction; and

WHEREAS, there are no inpatient facilities in New Mexico that offer combined medical and psychological treatment of adolescent opioid addiction; and
WHEREAS, a November 4, 2009 study, conducted by the Department of Health in response to House Memorial 9, which was passed in the First Session of the Forty-Ninth Legislature, acknowledged the seriousness of opioid use among adolescents; and

WHEREAS, despite the report's numerous recommendations for an ongoing commitment to addressing this problem, no comprehensive plan for treatment of adolescents has been developed;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE OF NEW MEXICO that the Interagency Behavioral Health Purchasing Collaborative be requested to develop a comprehensive, statewide plan for treatment of opioid addiction among adolescents; and

BE IT FURTHER RESOLVED that the Interagency Behavioral Health Purchasing coordinate in the development of the plan with the Behavioral Health Services Division of the Human Services Department; the Substance Abuse Subcommittee of the Behavioral Health Planning Council; the Children, Youth and Families Department; the Department of Health; and other member agencies of the Interagency Behavioral Health Purchasing Collaborative that are involved in the treatment of adolescents with opioid addiction; and

BE IT FURTHER RESOLVED that the comprehensive plan, including steps for implementation of the plan, be presented to the Interim Legislative Health and Human Services Committee by October 2011; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the Chief Executive Officer of the Interagency Behavioral Health Purchasing Collaborative, the Behavioral Health Services Division of the Human Services Department and the Substance Abuse Subcommittee of the Behavioral Health Planning Council.

Signed and Sealed at The Capitol, in the City of Santa Fe,

[Signature]

John A. Sanchez, President
New Mexico State Senate

[Signature]

Senator: Eric G. Griego
New Mexico State Senate

Lenore M. Navarreta, Chief Clerk
New Mexico State Senate
HM45 Interim Status Report  Presentation to the Behavioral Health Sub-Committee

Karen Meador, Senior Policy Director, Behavioral Health Collaborative & Gabrielle Sanchez-Sandoval, Acting General Counsel, Department of Health

December 2, 2011
Behavioral Health Collaborative (BHC): House Memorial 45 Task Force

This is an interim status report on the work of the HM45 Task Force. A final report will be completed by August 1, 2012.

The Task Force launched its work on August 30th with Representative Kintigh charging the group with the 3 key priorities underlying the Memorial:

- the safety of the community;
- protecting and ensuring civil liberties;
- effective treatment
House Memorial 45 came from: HB497, HB499, HB459

- Roles of the District Attorneys
- Civil Commitment and Criminal Procedure
- Treatment Guardianship processes, including
  - Consent to treatment
  - Role of advance directives
  - Use of treatment guardians in outpatient treatment
BHC: HM45 Task Force Members

- Ann Albrink
- Lorette Enochs
- Fern Goodman
- Frank Fajardo
- Deb Fickling
- Marcia Hawthorne
- Robert Hilgendorf
- Peg Holguin
- Donald Hume
- Nancy Koenigsberg
- David Linke

- Tony Louderbough
- Diana Martwick
- Lindy Mondy
- Jim Ogle
- Desiree Perriguey
- Grace Philips
- Nils Rosenbaum
- Gabrielle Sanchez-Sandoval
- Sheila Silverman
- Rosemary Strunk
- Matt Tinney

New Mexico Human Services Department
BHC: HM45 Task Force Work Process

- Task Force began work August 30th
- Meets for 4.5 hours every other week
- Video conferencing offered in multiple sites

- Common Ground of Understanding
- Seeking Consensus Recommendations
“Seek First to Understand”

- Assumptions of statutory fixes
- Misunderstanding and mis-information

- Work to common understanding of the law, of research and of practice
- Develop clarity about what the problems are
- Then develop the recommendations for solutions
  - Work for the Collaborative
  - Education and training
  - Clarify system barriers or development needed
  - What statutory changes will really make a difference
HM45 Topics Covered

- Mental Health Code
- Competency Statutes and Criminal Procedures
- Likelihood of harm to others
- Myths about Violence and Mental Illness
- Use of Treatment Guardians & Advance Directives
- Adult Protective Services & Intimate Partner Violence
- Behavioral Health Institute: Outpatient services, adult psychiatric services, forensic services
- Recommendations of HJM17
HM45 Topics Remaining For Presentation/Discussion

- District Attorney Roles
- Funding of treatment in mental health courts
- Outpatient Commitment or other coerced treatment issues
- Prevention and Early Intervention
Interim Task Force Developing Areas to Address and Make Recommendations

- Release from hospital and from jail are often critical times
- Good practice already exists in courts and judicial districts and communities in New Mexico
- What gaps exist in the treatment guardianship process and how can those be closed
- How can a greater use of advance directives be encouraged
- Respect for recovery choices and rights have practical application to all these issues
BHC: Further Resources

- Website for Task Force Documents:
  https://sites.google.com/site/hm45taskforce/
- Invitation to Subcommittee Members to participate via video conferencing
- Other Questions?
House Memorial 13

Recommended Gender-Specific Treatment Guidelines for Women and Girls Seeking Substance Abuse Treatment

Presented to
The Legislative Health and Human Services Committee

November 2011
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Introduction:

House Memorial 13 (see Appendix A) asks the New Mexico Behavioral Health Services Division of the Human Services Department to convene a work group to create gender-specific treatment guidelines for women and girls seeking treatment for substance abuse disorders. The HM 13 workgroup was charged with researching, recommending and implementation of treatment guidelines for women and girls. In the passage of HM 19, the New Mexico legislature recognized that substance abuse in women and girls is different than substance abuse for men. HM 13 acknowledge that many women with substance abuse problems may avoid seeking care due to fear of arrest, prosecution and loss of parental rights.

The Behavioral Health Services Division proposes to move toward the gender-specific guidelines and be phased in over the next three years with the substance abuse treatment providers. The first group to fully incorporate the recommendations will be the Substance Abuse Prevention and Treatment Block Grant (SAPT-BG) women’s set-aside funded group. The second phase of providers becoming gender competent will be substance abuse providers funded under the SAPT Block Grant. The goal is to have at least one gender-specific provider in each Behavioral Health Collaborative region in the state. The third wave of gender competent providers will be from the state general funded substance abuse providers. As funds become available, incentive pay is necessary for programs who will spend the additional time and training in developing and maintaining a gender responsive program.

Gender matters. The social, emotional, physical and psychological differences between men and women create different risk factors for the development of substance use disorders, and lead each to treatment for different reasons and with different goals in mind. Women are more likely to enter treatment if they do not need to leave their children behind, for example, and if they are able to remain in treatment with their children, they are more likely to stay. The social value placed by women on relationships (which appears to have a physiological basis as well as a social one) renders attention to relationships a critical component of treatment.

Women and men with substance use disorders are different. Among clients who present for substance abuse treatment services, women have more children living in their homes, are often younger, have lower incomes, and are less likely to be employed than men. Factors such as the heightened scrutiny of substance use during pregnancy, the lack of affordable child care, and social stigma impact women more than men. Important differences also appear to exist among adults in the adverse consequences of substance use.

Gender differences in social and psychological characteristics have important implications for substance abuse treatment retention for females. Females have unique treatment needs in contrast to males, and gender-specific approaches to substance abuse treatment have been developed to address these needs.

Programs that have tailored their assessments, treatment plans and services to the gender-specific needs of women have the opportunity to be designed as women’s gender specific treatment programs.
Requirements to provide women’s gender-specific treatment include groups and education aimed at dealing with relationships, parenting, women’s health, treatment services delivered at times that are convenient for women with child-rearing responsibilities or for women who work and take care of children. Case coordination (Case management/CCSS Comprehensive Community Support Services) is a critical component of service delivery, and outreach is necessary to assist women in attending treatment. Specific services such as child care, transportation, primary health care for women and their children, issue-specific treatment such as counseling for domestic violence or mental health treatment for trauma or childhood sexual abuse are also made available.

Women’s treatment is prioritized by the Center for Substance Abuse Treatment because of the impact that treatment and recovery have not only on the woman herself, but also her family, her children and future generations. This is the reason for the public dollars known as the “women’s set-aside”. The State Single Entity (SE) is allotted by BHSD a certain amount of women’s set-aside money to be spent on women’s treatment as required by the terms of the federal Substance Abuse Prevention and Treatment Block Grant.

The federal center for substance abuse treatment, the Substance Abuse and Mental Health Services Administration (SAMHSA) was identified as a resource that should be utilized in the creation of the state plan and in the development of treatment guidelines.

These treatment practices present a series of guidelines to insure responsiveness to the particular characteristics and needs of women in treatment programs at all levels of care (residential, intensive, outpatient). Some of the specific guidelines may apply differently to programs with different emphases. For example, a primarily short-term crisis intervention and stabilization program will have a somewhat different subset of guidelines that are relevant to it than a longer term program will. These guidelines apply to programs treating women exclusively, or, within a larger mixed gender population of consumers. It is understood that movement towards these guidelines will be a process that will take time and will involve collaborative efforts and changes on the part of providers and funders. Some of the guidelines may require specific regulatory changes or changes in funding mechanisms before they can be fully implemented. Many will require staff training and shifts in philosophy and model.

The purpose of these guidelines is to give direction and facilitate change in the treatment system. At this time they are not fixed standards upon which providers will be judged or criticized. It is likely that they will continue to evolve as they are worked with and as a broader community has an opportunity for input.

Resources:

Guiding Principles for Gender Responsive Treatment Guidelines
(From Covington and Bloom, 2004)

1. Gender: Acknowledge that gender makes a difference.
2. Environment: Create an environment based on safety, respect, dignity.
3. Relationships: Develop policies, practices and programs that are
relational and promote healthy connections to children, family, significant others and the community.

4. **Services**: Address substance abuse, trauma, and mental health issues through comprehensive, integrated and culturally relevant services.

5. **Socioeconomic status**: Provide women with opportunities to improve their socioeconomic conditions.

6. **Community**: Establish a system of comprehensive and collaborative community services.

**Guiding Principles for Behavioral Health Recovery Management**

*(From Boyle, White Corrigan and Loveland, 2005)*

1. **Recovery Focus**: Emphasize hope for high quality of life while managing recurring episodes of illness, client strengths and resilience

2. **Client Empowerment**: Clients are involved in all aspects of service delivery and design.

3. **De-stigmatization of Experience**: Experiences with behavioral health disorders are normalized to the extent possible.

4. **Evidence-based Interventions**: Scientific evidence and broad professional consensus are used to inform interventions at all stages of treatment and recovery.

5. **Service Integration**: Multidisciplinary, multi-agency models are used that integrate services previously provided in isolation from each other.

6. **Recovery Partnership**: The professional role shifts from purely a “treater” to a “recovery consultant” in partnership with the client. Emphasis in the long term continuity of this relationship over time through various episodes of care.

7. **Ecology of Recovery**: The family and community systems are utilized extensively for long term support of recovery. Multiple connections are promoted between the client and community systems to provide support for recovery.

8. **Sustained monitoring and support**: Flexible monitoring and easy re-engagement at an appropriate level of care if necessary is available, rather than rigid traditional “assess, admit, treat, discharge” process.

9. **Continual evaluation**: Assessment and evaluation are continual throughout treatment episodes, as well as between and across episodes of care.
Gender Specific Service Elements from the Guidance to State: Treatment Standards for Women with Substance Use Disorders

1. Outreach – is defined as a planned approach to reach pregnant women and women with dependent children in their environment for the purpose of preventing and/or addressing issues and problems as they relate to the use/abuse of alcohol or drugs and/or encouraging them to use substance abuse treatment services.

2. Engagement – allows the women to embrace the services that are appropriate. Engagement services also help women identify substance use that may be problematic and enhance motivation to pursue care.

3. Screening – is a brief process in which information is gathered, reviewed and used to determine whether a woman potentially has, or is at high risk for the development of a substance use disorder. Screening determines the need for a comprehensive assessment.

4. Assessment – is the process of becoming familiar with a woman’s culture, beliefs, values and experiences as well as her individual and family needs, priorities and resources. The results of a comprehensive bio-psycho-social assessment should determine the level of care and focus of treatment.

5. Crisis Intervention – services are short term services and can be available in person, over the phone, or through other technologies, 24 hours a day, and are aimed at addressing a specific problem and preventing its escalation and effects in various aspects of an individual’s functioning.

6. Continuing Care – is the sustained provision of clinical and recovery support services after a woman has been discharged from a primary treatment episode.

7. Advocacy – is the process of working in partnership with an individual or group of individuals and speaking out on their behalf in a way that represents their best interest.

8. Treatment Planning – focuses on the priorities, strengths, preferences and interest of a woman with a substance use disorder.

9. Substance Abuse Counseling/Education – offers content and structure to assist women in the development of personal knowledge, skills and attitudes necessary for recovery from substance use disorders.

10. Coordinated Case Management – is a participant-centered, goal-oriented approach to accessing and coordinating services across multiple services systems.

11. Life Skills – as part of the treatment and recovery process, service strategies should address each area of impairment, including deficits in basic skills that support routine activities of daily living.
12. Housing Supports and Assistance – access to safe, affordable and substance-free housing is a critical component of treatment and ongoing recovery support. Safe housing is an essential component of recovery that must be addressed by women in any level of treatment including both residential and out-patient treatment.

13. Education and Employment/Vocational Support - consist of strategies to assist women in entering and remaining in the workforce and in achieving resilience, self-sufficiency and improved quality of life for themselves, their families and their communities.

14. Transportation – assistance eliminates a significant barrier to engagement and retention in substance abuse treatment programs, obtaining other treatment related services and achieving treatment and recovery plan goals.

15. Recreational Services - is a major domain of life activity. Development of, or reengagement in safe and healthy recreational activities is crucial for ongoing recovery support.

16. Mental Health – services include screening, assessment, evaluation, treatment, pharmacological interventions, therapeutic counseling, etc.

17. Trauma/Violence – services can be divided into two, overlapping categories: those that are trauma-informed and those that are trauma specific. Trauma-informed services and organizations create safe, supportive environments; Trauma-specific services include individual and group services that directly address the effect of trauma.

18. Medical Care/Primary Health Care – women with substance use disorders and their children often have co-occurring acute and chronic health problems that have been neglected or exacerbated during alcohol and drug use. Medical care/primary health care should be provided onsite or by referral to care providers.

19. Medication-Assisted Treatment – services are indicated and effective interventions for some women with substance use disorders when combined with other gender-responsive counseling and services.

20. Detoxification – is a set of interventions that assist women in overcoming physical dependence on alcohol or drugs by addressing acute intoxication and withdrawal symptoms.

21. Drug Monitoring (testing) – provides an objective assessment of alcohol and drug use.

22. Cultural Competence – A set of academic and interpersonal skills that allow individuals to increase their understanding of and responsiveness to cultural differences and similarities within, among and between groups.
23. **Family Strengthening** – is a strategic approach to building a family support network for women, improving their parenting and resources and improving family dynamics.

24. **Child Care and Child Development Services** – provide for organized supervision as well as bio-psycho-socially appropriate activities that support the healthy growth and development of children.

25. **Parenting Skills and Child Development Educations** – are improved through education about child development and care and skill-building training.

26. **Recovery and Community Support Services (including Faith-Based Organizations)** – are specific services used to extend care for alcohol and drug use disorders, beyond the goal of abstinence, to that of full reengagement with family, friends and community, based on resilience, health, and hope.

27. **Linkages with Social Services and the Child Welfare System** – play critical role in the lives of many women entering treatment. Treatment agencies will coordinate services with collateral agencies as they can play a critical role in providing support during a woman’s recovery process.

28. **Training and Supervision of Gender Competent Counselors** - refers to enhancing a counselor’s existing repertoires of skills and techniques so that the counselor’s effectiveness with women will be enhanced.

29. **Training and Supervision of Gender Specific Outreach Workers** – refers to a style of outreach work that has the capacity to eliminate many of the obstacles that keep significant numbers of women from entering or successfully completing substance abuse treatment.

The workgroup decided to focus on six elements; Screening, Advocacy/Assessment, Coordinated Case Management, Housing Supports and Assistance, Cultural Competence and Trauma/Violence as the first wave of implementation with the treatment guidelines for women and girls entering substance abuse treatment services.
RECOMMENDATIONS:

The Context of the Recovery System of Care

The intent of these guidelines is to emphasize those factors that are of particular importance in the treatment of women. However, many of the treatment approaches that are a part of the general shift to a recovery oriented system of care are also important for women's treatment. Therefore, many of the guidelines recommended here are also appropriate in the larger context of the new recovery based approach to care for all consumers. Therefore, these guidelines are constructed to provide a comprehensive set of practices that, if achieved, will constitute the most up to date best practices in gender responsive treatment and in recovery-oriented treatment in general.

Treatment Guidelines for Gender Responsive Treatment of Women with Substance Use Disorders:

1. Assessment and Engagement
   - Short waiting period for entry to services
   - If greater than one week waiting period occurs, then there will be greater ongoing contacts with client until entry to service.
   - Capacity to include/welcome children throughout assessment process.
   - Initial assessment is completed within two weeks.
   - Contact with peers/other consumers occur early in assessment process.
   - Assistance with transportation is provided when needed.
   - Physical health screening that is gender specific is part of assessment with criteria for securing a full medical assessment of not completed within one year.
   - Written material (English/Spanish) is available that explains program content, requirements, procedures in clear, non-technical language.
   - Where the client has difficulty engaging in the assessment process, there is evidence of outreach and other efforts to facilitate the client’s involvement in the treatment program.
   - The assessment process should extend beyond the initial assessment as the client’s comfort level increases and more information can be collected, resulting in evidence of a revised working assessment and priorities for change that all share.
   - If client does not qualify for services, assistance is provided with alternative care, or connected to an appropriate resource to provide support and assist with searching for services.

2. Recovery Planning
   - An initial recovery plan is developed by the end of the assessment period by the program staff and client, in the client’s words, that the client sign
[off on] and has a copy. The client is an active participant in this process.

- A full individualized recovery plan is completed by the end of a month of care (or 5 outpatient sessions) that expands upon the initial plan and includes concrete, measurable objective(s) in each of the following domains that are identified as priorities in the initial and ongoing assessment. Plans should incorporate a comprehensive scope of services addressing the realities of women’s lives:
  1. Substance use recovery
  2. Mental health issues (co-occurring)
  3. Trauma, grief/loss, and/or PTSD
  4. Domestic violence
  5. Safety
  6. Parenting and reunification plan if appropriate
  7. Relationship/sexuality
  8. Cultural issues
  9. Spirituality
  10. Life Skills
  11. Vocational skills
  12. Legal issues
  13. Gambling
  14. Safe housing

- Each recovery plan list specific strengths and assets of the client including how these will be used to address issues and challenges and achieve recovery objectives.

- The recovery plan should identify clearly those objectives that are critical for discharge from care or transfer to a lower level of care.

- The recovery plan will identify community resources that will need to be developed to support the client’s discharge from the treatment program and continue the recovery process.

- If certain high priority areas of the overall recovery process for a client are beyond the scope of the treatment program, these areas should be included in the recovery plan with identification of how they will be addressed through other community resources.

- The recovery plan is reviewed and revised on an ongoing basis with active participation of the client, goals are achieved or modified, but at a minimum every 90 days.

3. Clinical Treatment Program Design

- General features of treatment program
  1. A therapeutic environment model must be evident that is safe, inviting, non-institutional, homelike, welcoming with appropriate cultural features.
  2. Various treatment and intervention models should be available, depending on individual needs, including behavioral, cognitive, relational, affective and systems approaches.
3. Approaches must be respectful, supportive and empowering, not authoritarian, attacking or demeaning.

4. Treatment must be strength (asset) based, with ongoing opportunities for women to experience, practice and explore positive capabilities.

5. Treatment should include psycho-educational input on the impact of gender on development and functioning in society including the strengths associated with gender.

6. There should be multiple opportunities for empowerment of women within the community and within the program, including opportunities for input to the program operation and design.

7. Treatment in all-women groups and/or with women therapists and counselors must be available at different stages/levels of treatment. This requirement is particularly relevant to co-ed programs.

8. Opportunities are available for significant others or client identified supports to participate in and assist with the client’s recovery.

9. Vocational assessment, training and experience should be available to women within the program (e.g. computer training), including assistance with search for employment, where program duration allows.

10. Volunteer or mentoring opportunities should be available within the organization as the client progresses through and leaves the treatment program.

11. Compensation of consumers for work within the organization is provided if available.

12. Treatment must incorporate unique cultural characteristics, strengths and potential supports for each participant.

13. Program works to maintain, preserve or rebuild the client’s attachment to her child (ren) being sensitive to the client’s choice.

- Specific focus of treatment must include individualized interventions for each area identified in Recovery Planning (2b), using the best available evidenced based approaches for those areas.

- Individualized services should address multiple areas of functioning on an individual, family and community level that all contribute to a woman’s overall quality of life.
1. Mental health and substance abuse issues
2. Practical needs, including housing, financial, transportation, child care, vocational training, education, job placement
3. Parenting education and child development
4. Primary health concerns, including nutrition

- Level of care and modality of care must remain flexible, with different modalities and intensities of treatment available over time in a seamless manner, for example, intensive outpatient, and outpatient, group and individual.

- A flexible approach to hours of treatment provided is used that satisfies criteria prescribed for each level of care by state funders and other payers.

- There should be evidence of efforts to arrange services for other family members if needed.

- Care can be provided in conjunction with an opiate replacement program, if appropriate. Participation in such a program is not a basis for exclusion from treatment program.

- Coordination of care – active coordination of care must take place with other providers with whom client is or will be involved. This process must involve the client, e.g. in care coordination meetings.

- Program collaborates appropriately with CYFD’s or other outside agency’s assessment of client’s parenting ability (with client permission with the exception of mandated reporting).

- Discharge Planning, Aftercare, Relapse Prevention
  1. Planning for discharge from the treatment program should be evident from the initial assessment throughout the treatment process.
  2. Prior to discharge the client will have confirmed appointment with treatment providers who will be providing continuing care in the client’s community.
  3. In addition to treatment providers, a range of supports in the client’s community will be arranged, with the client’s input, prior to discharge. (e.g. childcare, transportation, self-help groups, health care)
  4. By discharge from the program there must be a stable housing plan in place.
  5. Specific relapse prevention interventions and plans must be developed and written with the client in understandable terms.
  5. Re-entry to treatment, if necessary, must be available and accessible.
4. **Recovery Supports**

- Use of peer supports within the program should be established clearly (e.g. women in more advanced levels of treatment monitoring those beginning).
- Links to recovery supports in the community must be identified and begun.
- Each client must be given the option to participate in an appropriate group peer support system (e.g. AA, NA, AlAnon, or other recovery meetings) including having a sponsor or mentor before discharge.
- Client should be assisted to connect to local family support and/or advocacy groups prior to discharge.
- Upon client’s request, assistance provided to engage in faith based supports.
- Program will assist client to develop a vocational plan, or connection to appropriate vocational supports.
- Program must assist client to have a viable housing plan that will support recovery.
- Assistance is provided to help client maximize healthcare coverage.

- Physical setting must include culturally diverse elements and décor.
- There should be a majority of women staff members.
- Staff must reflect the cultural diversity of the consumer population.
- Program must include positive cultural experiences and materials.
- There must be comfortable play space for children in the program and areas for mothers and children to interact naturally, as well as age-appropriate activities designed for children.
- Mothers can bring children to the program and a supervised safe setting is provided for the child with age appropriate activities. (Program reserves the right to screen for safety in these situations).
- When children are present in the program, program has procedures in place to observe parent child interaction in order to assist in building parenting skills if needed.
- Protocols are in place for care of children who are at the program, including emergency procedures, health management or interruptions in parent’s ability to provide adequate care.
- Transportation supports must be available for women.
- Outreach to women with transportation challenges must be an available option.

5. **General Program Environmental Features**

- Program environment/setting must be safe and secure.
- Physical setting of the program must be warm, inviting and comfortable.
6. **Staff Competencies and Training**

- The program must include staff with demonstrated competencies in women’s issues, cultural issues, substance abuse, mental health, co-occurring, trauma and child/family.
- There must be written policy in place regarding physical contact and boundaries between staff and clients, and between clients to prevent re-traumatization.
- A comprehensive staff training program must be in place with the following elements:
  1. Current theory of women’s development from childhood through adulthood
  2. Unique characteristics of women with mental health and substance abuse issues
  3. Key values and principles in working with women
  4. Impact of cultural issues on gender specific programming
  5. The role of trauma and issues of re-traumatizing
  6. Sexuality
  7. Sexual abuse
  8. Family violence
  9. Grief and loss
  10. Gambling
  11. Parenting
  12. Spirituality
  13. Traditional and nontraditional community supports.
- Supports should be in place to enhance staff morale, address staff communication, and provide care for the caregivers.

7. **Program Evaluation**

- Process evaluation should be in place to ensure appropriate utilization of gender responsive treatment services and elements as identified in these guidelines.
- Outcome evaluation is in place to measure short and long-term impact of interventions on program participants.
- Measurements include:
  1. Program participation/completion/discharge
  2. Alcohol/drug recovery/sobriety
  3. Educational attainment
  4. Employment
  5. Housing
  6. Improved family and social relationships
  7. Parenting and reunification with child
  8. Physical Health
  9. Mental Health
  10. Criminal justice recidivism
**Implementation Plan**
First Step: Complete a program assessment.
Program Assessment (complete annually) - All Staff in staff meeting or cross section of all positions in staff meeting.
Clients Assessment (complete annually) - All female clients or a minimum of 50% of female clients (or up to 25), in all stages of treatment; Give in anonymous way to get true answers; Provided in their language and reading level and the program develops goals based on these evaluations.

Area that should be added as goals are program growth area and items that there is large difference between client rating and program rating.

**Implementation: 9 Areas**
- Training
- Supervision
- Documentation
- Environment
- Outcomes
- Treatment Materials/Curriculum
- Community Collaboration/ Resource Development
- Staff evaluations
- Staff/Client Demographics

Goal is to ensure all levels of the program are measured and designed utilizing the Gender Responsive Principles.
The 9 areas are a comprehensive way to ensure fidelity to the GR Principles.

**Evaluation:**
- Site visit is conducted once program feels they have developed in all 9 areas.
- Two trained site visitors conduct the visit and look at objective and subjective items on all 9 areas.
- If all items are met program is certified as a Gender Responsive Program.
Reference Sources:

DMHAS, "Women's Services: Developing Preferred Practices in Programming and Services, Literature Review of Best Practices";

CSAT, "Comprehensive Treatment Model for Alcohol and Other Drugs-Abusing Women and Their Children" and "Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs";

"Helping Women Recover: Creating Gender-Responsive Treatment"; Covington and Bloom, "Gender-Responsive Treatment and Services in Correctional Settings";

Boyle, White, Corrigan & Loveland, "Behavioral Health Recovery Management: A Statement of Principles";

DMHAS, Draft Standards of Practice for Recovery-Oriented Behavioral Health Care;

TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, SAMHSA/CSAT Treatment Improvement Protocols;

TIP 2: Pregnant, Substance-Using Women, SAMHSA/CSAT; Addressing The Needs of Women and Girls:

Developing Core Competencies for Mental Health and Substance Abuse for Services Professionals, SAMHSA, 2011

House Memorial 13 introduced by Representative Mimi Stewart

House Memorial 13 Work Group Members

Bobbie Lightle, NM Human Services Department, BHSD Women's Services Coordinator (chair)

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Marizza Montoya-Gansel, SAPT Block Grant Clinical Director

Technical Consultants
Karen Northfield, Optum Health, Manager Quality Improvement, Al Villapiano, Inflexxion, presentation of Current & Future ASI-MV Utilization in New Mexico

Consumer Panel - 6 women currently are receiving substance abuse treatment.
A MEMORIAL

REQUESTING THE BEHAVIORAL HEALTH SERVICES DIVISION OF THE
HUMAN SERVICES DEPARTMENT TO CONVENE A WORK GROUP TO CREATE
GENDER-SPECIFIC TREATMENT STANDARDS AND RULES FOR WOMEN AND
GIRLS SEEKING TREATMENT FOR SUBSTANCE ABUSE DISORDERS.

WHEREAS, research clearly demonstrates that women and girls face unique barriers when seeking
and receiving treatment for substance abuse disorders as compared with men; and

WHEREAS, women and girls face personal and systemic barriers that prevent them from seeking
and receiving treatment for substance abuse disorders; and

WHEREAS, personal barriers include the fear of reprisal from family members, the fear of not
being able to care for their children or losing custody of their children, the fear of making life
changes and the fear that treatment may not be kept confidential; and

WHEREAS, systemic barriers include a lack of health insurance or other financial assistance to pay
for treatment, a lack of linguistic and culturally accessible services, being placed on waiting lists for
treatment, the absence of treatment options for women and girls who are pregnant and the inability
to obtain child care and transportation while sustaining employment and managing the requirements
of other

systems of which they may be eligible, such as temporary assistance for needy families; and

WHEREAS, despite evidence that gender-specific treatment provides better outcomes for women
and girls with substance abuse disorders, most traditional treatment is designed for men; and

WHEREAS, in recognition of the unique needs of women and girls, many states are now
establishing gender-specific treatment standards; and

WHEREAS, a comprehensive model for the treatment of women, girls and their families has been
developed to be used as a flexible guide that can be adapted to address community needs in building
comprehensive treatment programs for women
and girls with substance abuse disorders and to develop gender-specific treatment programs that will encompass all of a woman's or a girl's needs when recovering from a substance abuse disorder; and
WHEREAS, the development of gender-specific treatment best practices will help meet the unique needs of women and girls to overcome the barriers they face when seeking treatment for and recovering from substance abuse disorders; and
WHEREAS, gender-specific best practices will move New Mexico toward a vision that all women and girls can receive individualized, high quality, research-based treatment for substance abuse disorders that will improve the chances of successful recovery and cultivate the healthy development of children and families; and
WHEREAS, the development of gender-specific treatment best practices will build on the existing capabilities and strengths of New Mexico's services to women and girls; and
WHEREAS, creating gender-specific treatment best practices for women and girls with substance abuse disorders will allow better communication to health care providers regarding concrete expectations and a general vision for improved services to women and girls; and
WHEREAS, gender-specific treatment best practices are necessary to address the needs of New Mexico women and girls seeking treatment for substance abuse disorders, including clinical treatment, clinical support and community support services; treatment services that are culturally fluent, female-specific and family-centered; and treatment methods that are individualized, nonjudgmental, trauma sensitive, Respectful and based on a woman's or a girl's unique strengths as well as her needs, preferences, experiences and age; and
WHEREAS, gender-specific treatment best practices will help provide guidelines for New Mexico to help women and girls with substance abuse disorders find pathways to successful recovery that can last throughout their lifetime;

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE
STATE OF NEW MEXICO that the behavioral health services division of the human services department be requested to convene a work group to create gender-specific treatment standards and rules for women and girls seeking treatment for substance abuse disorders; and

BE IT FURTHER RESOLVED that the work group research, recommend and implement best practices; and

BE IT FURTHER RESOLVED that the work group be requested to submit a report with recommendations to the legislative health and human services committee by December 1, 2011; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the secretary of human services and the chair of the legislative health and human services committee.
House Joint Memorial 17 Task Force
Recommendations
The challenge for this task force is to develop humane and effective strategies to reduce the number of people with mental health disorders who require law enforcement intervention or who are in detention facilities.

Representative Rick Miera
Introduction

One of the greatest challenges facing law enforcement agencies and detention centers in New Mexico and across the nation is how to respond to people who have mental health disorders. House Joint Memorial 17 addresses this challenge and charges the Interagency New Mexico Behavioral Health Purchasing Collaborative with convening stakeholders to develop humane and effective strategies to serve people with mental health disorders in order to reduce the number of people with mental health disorders who are in detention or require law enforcement intervention.

Representative Rick Miera sponsored HJM 17 in 2011. Senators Papen and Befort sponsored similar memorials in 2009 and 2010. Their collective support and commitment to finding answers shines a light on this critical issue and sets the stage for solutions.

The task force members and participants (listed on page 17) represent a broad range of disciplines and perspectives, as well as urban, rural, and frontier communities. The full task force met five times during the summer of 2011 to review current services and to vet critical components of a statewide crisis system. Their thoughtful effort and generous commitment to discussing and working through these difficult issues was humbling to us. The task force reached consensus on the five Guiding Principles and nine Recommendations contained in this report.

We are especially grateful to the task force steering committee members who met faithfully every Friday afternoon from May through October (350 labor hours) to guide the process and develop this report. In addition to planning the task force meetings and synthesizing the task force recommendations, the steering committee reviewed and incorporated the many written comments received from the Local Collaboratives, stakeholders, advocates, clients, and community members who were not always able to attend the full task force meetings. The complete record of the HJM 17 task force activities including minutes, research, presentations, and written submissions is at:

https://sites.google.com/a/nmcounties.org/hjm17/home

These recommendations set forth a road map to reduce the number of people with mental health disorders who are in detention or require law enforcement intervention through improving our mental health system. Each recommendation will require further work to implement. It will take commitment and resources.

Grace Philips, Co-Chair
NM Association of Counties

Daphne Rood-Hopkins, Co-Chair
NM Human Services Department

Jails were made to house the people you are afraid of, but now you want us to house the people you are mad at, the neighbor that frustrates you, the drug addict who won’t get well, and the mentally ill.

Ramon Rustin, Chief
Bernalillo County Metropolitan Detention Center

On a given day approximately 31% of the inmates at MDC are on the mental health case load. 728 of these are taking psychotropic medications and 129 are acutely mentally ill.

Matt Elwell
Operations Administrator
Metropolitan Detention Center
## Guiding Principles

<table>
<thead>
<tr>
<th>Guiding Principle</th>
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<td>Peer led and peer driven services are critical to any effective and humane statewide mental health system.</td>
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<td>Services should employ the least restrictive environment and maximize client choice.</td>
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<td>A crisis system must serve both individuals with mental illness who have insight into their condition and those who do not.</td>
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<td>Mental health services must be trauma informed, gender specific, age appropriate, culturally sensitive, language appropriate, and accessible to anyone regardless of literacy level.</td>
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<td>These recommendations are for services that would be available to all persons with serious mental illness, their families, and their natural supports regardless of age, socio-economic, or insured status.</td>
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Two-thirds of boys and three-quarters of girls in the juvenile system meet the diagnostic criteria for mental illness and/or substance use disorders. The majority are victims or witnesses to traumatic events and respond to threats self-protectively, sometimes with violence.

Jeffrey Tinstman  
Senior Behavioral Health Administrator  
NM Children, Youth, & Families Department

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1 In order to accord respect and dignity to individuals living with a diagnosable mental illness, the HJM Task Force has elected to refer to these individuals as “clients” for the purpose of this document.
The system is not broken. It is underfunded and under prioritized.

Barri Roberts, Executive Director
Bernalillo County Forensic Intervention Consortium
### Recommendations

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Recommendations

1. System Improvements

Problem
Community mental health centers, Core Service Agencies, and other entities that provide behavioral health safety net services throughout the state cannot bill for providing outreach treatment services in a range of settings throughout the community. Payment mechanisms thus create a disincentive for providers to offer the needed services to address and prevent mental health crisis.

Recommendation
Develop flexible funding streams and payment mechanisms to compensate providers for crisis outreach and other services described in these recommendations. With these changes in funding, contractual requirements can be implemented that increase the accountability for these agencies to provide outreach, engagement and assertive crisis intervention, including provision of assessment, evaluation and care coordination in a variety of settings in the community.

Discussion
Many of the initiatives recommended by this task force are not funded by the current system even though paying providers for services such as outreach and engagement could ultimately save the system substantial money.

Currently providers cannot easily bill for time spent seeking out and engaging clients who are not actively involved in services. Clients who are mentally ill and who deny their illness need services brought to them. There should be a way for providers to be reimbursed for these proactive services.

Nils Rosenbaum
Crisis Intervention Team Psychiatrist
Albuquerque Police Department

People end up in corrections because of inadequate community services. Funding mechanisms have never aligned to provide community care.

Rodney McNease, Director
UNM Behavioral Health

Currently there are inadequate mechanisms for agencies to be reimbursed for staff time to travel to and see individuals outside of the clinic environment. Changing fee structure from the current fee-for-service within a clinic model would enhance the ability of community agencies to provide needed services, especially to those people who are not enrolled and not likely to seek care on their own. Compensating providers for outreach and treatment services that are provided in non-traditional settings would permit them to address the needs of a broader spectrum of the population of people with diagnosable mental illnesses who have difficulty accessing treatment, including homebound elderly, adults with disabilities, and homeless children and youth.
An important aspect of this recommendation is the development of a comprehensive crisis system that can serve all people, regardless of insurance coverage or ability to pay. With flexible funding streams more crisis service and crisis intervention can occur, reducing the escalation of mental health crisis into more serious and costly situations. State regulations and service definitions need to be reviewed to remove regulatory requirements that impede the flexibility to provide critical services in a cost effective manner.

The current fee-for-service structure does not fit the types of services we need for persons not already engaged with the existing treatment system. Fee-for-service has also been identified nationally as a significant cause of the high cost of health care in the United States. The New Mexico Behavioral Health Purchasing Collaborative is currently studying alternative mechanisms for future health care delivery such as case rates and performance contracting. The Medical Assistance Division (MAD) is exploring waivers that could serve as part of the solution. This recommendation is therefore consistent with ongoing efforts around the country related to future healthcare delivery.

2. Regional Crisis Triage Centers

Problem
Currently law enforcement officers in most areas of the state will take a person who is experiencing an acute mental health crisis to a detention facility because there is no alternative. Hospitals will not hold someone unless they are an imminent threat to themselves or others. In the absence of a safe place in the community for an individual in crisis to be evaluated and stabilized, jails and juvenile detention centers are used for protective custody. This further traumatizes the individual and is not the purpose of incarceration.

Recommendation
Develop and fund regional crisis triage sites where individuals can stay for up to 23 hours to receive immediate stabilization, mental health evaluations, and observation. Law enforcement officers and first responders could take appropriately screened individuals to these sites for assessment and disposition. Individual walk-ins and family referrals would also be accepted.

Discussion
State law authorizes law enforcement officers to detain and transport a person for emergency mental health evaluation under a number of circumstances, which include: 1) the person is otherwise subject to lawful arrest; 2) the officer has reasonable grounds to believe the person has just attempted suicide; or 3) the officer believes (or a licensed physician or certified psychologist has certified) that due to their mental illness, the person is likely to harm themselves or others and detention is necessary to prevent the harm.
(NMSA 1978 § 43-1-10). Jails may be used for protective custody under this statute for up to 24 hours, however, the preference is for the person to be taken “immediately to an evaluation facility...whenever possible...” Id. Funding this recommendation would result in regional crisis triage centers that could receive individuals in need of emergency mental health evaluation and care. The centers could also serve as voluntary evaluation and care sites for individual walk-ins and family referrals. Homicidal or suicidal behavior would not be a requirement for an individual to be taken to a crisis triage center.

Crisis triage centers are not hospitals, but are staffed with licensed clinicians capable of performing mental health evaluations. Trained peers and/or certified peer specialists or mental health promotoras who are supervised by licensed mental health professionals also play an important role in crisis triage by serving as supports and advocates for clients who are at the crisis triage center.

Crisis triage centers would serve to reduce the dependence upon both detention facilities and hospital emergency rooms by providing appropriate and specialized care for people with mental illness and their caregivers in a trauma informed setting. These centers would then do the equally important work of connecting clients to follow-up services in their community.

Sustaining crisis triage sites in smaller and more rural communities might not be feasible; however, regional anchor sites could provide access to such services where no services currently exist. Use of telehealth to support these centers where local clinicians are not available would also make providing such services in rural, Colonias and frontier areas more feasible. In addition, even though they would serve to divert individuals from detention facilities and emergency rooms, triage centers could be located within a hospital or in proximity to a detention facility, so long as the facilities complies with Medicaid funding eligibility requirements.

It is important for regional crisis triage centers to be connected with local respite services. (See Recommendation 3). Triage centers would be for an acute crisis and intensive evaluation, while respite would provide soft treatment for clients to transition out of crisis or minimize the severity and escalation of a crisis in a safe, supportive environment. Crisis triage centers would thus serve as one gateway into respite by identifying individuals who can benefit from respite services.

Criteria, screening, training and other components need to be developed to establish appropriate legal and clinical authority for the crisis triage centers. The New Mexico Behavioral Health Purchasing Collaborative is the appropriate authority to develop clinical

Veterans with diagnosable behavioral health disorders frequently end up in jail. Their support system suffers the most. There is often domestic violence and family members start drinking themselves. Veterans have been trained not to show weakness, so they don’t self identify. They tend to isolate themselves until it is too late.

Alan Martinez, Deputy Secretary
NM Department of Veterans Services
and operational standards for triage centers. Practical questions such as how an individual would get home from a regional center also need to be addressed. However, the existing Doña Ana County crisis triage plan is an excellent model upon which to build other regional sites and the HJM 17 task force recommends that the legislature fund the Doña Ana County’s proposal.

3. Respite Services

Problem
The absence of sub-acute care to de-escalate potential crisis situations increases the frequency and number of mental health crises in our communities. Hospitals and jails are not appropriate for this lower level of care, but are often the place where individuals are taken by local authorities when they experience a severe crisis.

Recommendation
Develop and fund respite care locations throughout the state to serve as non-clinical alternatives that can reduce the need for hospitalization or incarceration.

Discussion
Respite services are non-clinical options for persons who need a safe place and perhaps short-term, “lower level” care or support to reduce the stressors and risk factors that might otherwise lead to a severe crisis. Respite services often utilize peers and natural supports to staff a safe place for someone to take respite and avoid crisis. Respite can be located in private residences, group home settings, and available community facilities. Successful respite programs have used creative and low-cost ways to provide respite, with a range of service tiers.

People living with mental illness often end up in jails or emergency rooms because there is no place for them to obtain care before they are in crisis. This is especially true on weekends and evenings. Once they are admitted or detained, the setting is not always ideal. Clients report that institutional spaces (such as jails and hospitals) present a stressful environment that creates a barrier to healing. Stress increases the likelihood of crisis and can escalate and elongate the crisis period.

An essential characteristic of respite is that it provides a trauma informed environment. It is

2 Strong models for respite care programs include: Wild Acre Inns in Arlington, Massachusetts; statewide programs in New York; Peer Support and Wellness Center, a project of the Georgia Mental Health Consumer Network; and others can be found at http://www.power2u.org/peer-run-crisis-services.html.

Poverty, hunger, isolation is what comes with a serious mental health diagnosis. No hopes, dreams, aspirations to stir you up, just pills and pills and more pills - that just isn't the stuff to inspire you to get out of bed! People dealing with mental illness and/or experiencing homelessness get good at hiding. We hide from the police even when we've done nothing wrong because we are scared of them.

Michael Hubert
Office of Consumer Affairs Consultant
also a voluntary setting where participants can come and go. Unlike inpatient hospitalization, which often disrupts ongoing treatment relationships, respite can provide a supportive environment for someone while they continue their community based treatment and maintain their employment and other day-to-day responsibilities.

Many of these recommendations are interrelated and the link between respite care and crisis triage is especially important. Respite can serve as sub-acute care or a step down service for someone leaving crisis triage or even residential treatment. Respites provide a safe and supportive environment for clients to transition out of crisis or minimize the severity and escalation of a crisis while triage centers (See Recommendation 2) address acute crisis and provide intensive evaluation.

Because respite care does not require licensed clinicians, it can be both effective and economical. Respite care already exists in some locales for the juvenile populations. Respite is in fact the most requested service by families nationwide and it can be effectively used in a broad range of situations to help clients, families, and natural supports.

The task force recommends developing and funding respite care locations throughout the state but the location of specific respite centers should be locally determined. Each community should assess their need and capacity for this type of care. Supervision of respite programs would need to be determined and could fall under existing Core Service Agency infrastructure if funding for this additional responsibility is provided. The New Mexico Behavioral Health Purchasing Collaborative is the appropriate authority to establish clinical and operational standards for this service. Initially funding selected anchor sites in rural and urban areas would provide an opportunity to evaluate the challenges and benefits of respite programs and to inform and refine the development of protocols.

4. Training

Problem
There is a widespread lack of knowledge about mental illness and the skills needed to respond to, and deescalate, a mental health crisis. In the absence of such information, those with mental illness tend to be feared and stigmatized. This leads to an over-reliance on law enforcement intervention responses.

Recommendation
Establish peer training programs and training for family members, natural supports, teachers, students, and first responders.

Discussion
Most people are poorly equipped to respond to individuals experiencing mental health crisis. In the absence of adequate skills to handle these situations, law enforcement is often called. Education and training can help any affected person to identify and enhance responses to mental health crisis situations. Yet education and training in mental health issues, including crisis response, has traditionally focused on law enforcement.
Opportunities for mental health and crisis education should be expanded to include the general population, including schools, community organizations, family members, peer supports and others whose lives are potentially touched by an issue or experience of mental illness. Education and training of natural supports and others is of particular value to New Mexico’s rural and frontier communities, whose isolation leads to fewer mental health resources and trained personnel. Education and training should also be broadly inclusive of first responders, such as Emergency Medical Service technicians, emergency dispatch, fire department personnel, Tribal authorities, and others involved in first responder roles, as well as persons staffing social service agencies, respite centers, and detention facilities, and those assigned to be treatment guardians. Training of behavioral health and primary care (i.e., medical) providers in the recognition and assessment of mental illness in the older adult population who frequently present with multiple and complex mental and medical health problems is also a special need.

Family members, friends, mental health peers, and others are natural supports to people in the throes of a mental health crisis. Many people in communities throughout New Mexico serve in an informal capacity as critical supports to those in crisis, constituting a largely untapped resource to any crisis response system in the state. Trauma informed education and training in de-escalation techniques will increase the ability of people in a natural support role to adequately identify and address mental health crisis situations.

Schools are also a natural and untapped venue to bring needed information and training about mental illness, including mental hygiene. Programs on mental illness and mental hygiene can be integrated into the curricula of schools throughout the state, and should be included in the health education course required for high school graduation. Educational programs geared towards younger audiences should also be provided in grade schools throughout New Mexico.

Education of the public is a powerful way to dispel the myths and stigma surrounding mental illness, and the fear, sense of helplessness and shame that too often accompanies it. It can also provide important tools for clients who want to engage in advance planning and caregivers who want to work more effectively with their clients. Through education and training, urban and rural communities in New Mexico will be better equipped to address the needs of people experiencing a mental health crisis and to enhance the overall coordination of the network of services available to those in need.

It is also important to develop training programs to help individuals who work with people who lack insight into their illness and who therefore do not seek out help. This requires
training in an intervention methodology. Those who encounter these individuals in their work can be trained in strategies that show promise in helping individuals to seek treatment. Training on best practice or promising strategies that have been studied and shown to be effective, such as those advocated by clinical psychologist, Xavier Amador, through his L.E.A.P.\textsuperscript{3} institute (http://www.leapinstitute.org), could provide natural supports with effective tools for working with these individuals.

It is also critical for clients and their natural supports to be given clear and accurate information and training regarding advanced directives and voluntary treatment guardians so that these tools can be in place when needed.

5. Call Centers

Problem
There is no centralized statewide system for coordinated communication regarding mental health services in New Mexico. With limited avenues to access services, clients and their families often do not know what is available. They may also not know what local options exist to respond to a mental health situation and may be confused about what number to call in a crisis. Confusion and lack of resources can escalate a crisis situation.

Recommendation
Establish a centralized, statewide call center with a single telephone number that is connected to local authorities and behavioral health agencies throughout the state, permitting immediate dispatch of appropriate, existing resources within each local community.

Discussion
A call center or crisis line often serves as the first point of contact for individuals in need of services or information. The function of a statewide call center would be to both respond and refer. Successful models have 24/7 staffing, adequate training for frontline staff and supervisors, links to 911 and EMS, referral services to licensed or senior counselors (who are on-call or have mobile capacity) and to warm lines for non-crisis situations (See Recommendation 6).

Many Core Service Agencies around the state already have operating crisis lines that are accessed through local numbers but their hours of operation vary and each uses its own distinct phone number. A statewide number would enhance existing services by providing an additional means of access. It could be called 24/7 from any location in the state to reach a clinician who can address immediate behavioral health needs and/or route calls to local

\textbf{We need to develop a road map to guide people on what to do if they or someone they care about needs behavioral health services.}

Traci Neff, Administrator
Juvenile Services
San Juan County

\textsuperscript{3} L.E.A.P. stands for Listen, Empathize, Agree, Partner and describes a strategy for working with people who do not have insight into their mental illness.
behavioral health services. The statewide hotline would provide service where none currently exists while allowing communities with existing services to maintain their local numbers.

Although the details regarding such a statewide service will need to be developed by a dedicated work group, the task force recommends that responsibility for oversight of the call center be housed within a public agency that develops protocols, training requirements, and supervisory models to support call center staff, and that oversees call center operations and monitors response standards and quality protocols. It is critical that the call center have access to current and comprehensive information about local behavioral health services. Because the call center would focus on behavioral health, services would not be limited to responding to incoming calls but would also include making or arranging for follow-up calls for people who have had contact with either crisis or warm line services.

6. Warm Lines

Problem
Although warm lines have been proven effective at mitigating and even resolving crisis, warm lines are only available in limited areas of the state.

Recommendation
Expand warm line services statewide to reduce the likelihood of crises, help individuals to access appropriate resources, and support ongoing and long-term recovery.

Discussion
Warm lines are peer-run or peer-staffed. They provide confidential, telephone-based peer support and resource referral services. The goal of crisis and warm line service is to prevent crisis and use currently available resources effectively. A statewide warm line would use peers for response and support and could include a statewide network of peers to respond to calls through a centralized number (see Call Center Recommendation 5).

We fail when we are alone, isolated and scared. Sometimes we just need someone to call. More peer services will leave fewer people for law enforcement to deal with.

Douglas Fraser, Consultant

Local Collaboratives that have warm lines in their communities report that they are highly effective, but they are not widely or consistently available throughout the state. This is the case even though they are an economical and effective resource to prevent crisis and improve client quality of life. Investing in training for peer counselors (see Training Recommendation 4) and coordinating warm line access through a statewide call center (see Call Center Recommendation 5) would be a cost effective strategy for providing this critical service to people living with mental illness across the state.
7. Community Crisis System Planning

Problem
Most New Mexico communities do not have an organized coalition of key stakeholders who interact with people who have mental illness. The result is a disjointed system that wastes resources and fails to adequately address the needs of clients and their families.

Recommendation
Develop broad community coalitions in communities throughout the state to enhance and integrate local capacity to prevent and respond to mental health crises.

Discussion
The key stakeholders in a comprehensive mental health system include clients, their families and other natural supports, law enforcement, courts, criminal defense attorneys, district attorneys, detention facilities, local hospitals, medical and behavioral health services providers, state, county, municipal, and tribal governments, schools, Local Collaboratives, providers of services to the elder population and adults with disabilities, including Adult Protective Services, Child Protective Services, Juvenile Justice Services, shelter providers and advocates. However communication among all of these stakeholders is often limited or even nonexistent. Communities are in a strong position to identify the needs of a locally based mental health crisis system and to develop effective cost-efficient solutions, but all stakeholders need to have input and accountability. By approaching the development and delivery of mental health care services as a community, it is possible to coordinate resources, enhance existing services, and develop innovative locally-based responses to community mental health crisis needs.

Communities are often unable to deliver adequate, informed mental health crisis response services to those in need. In the face of inadequate or nonexistent mental health crisis services, the public turns to law enforcement to respond to these high-risk, high-stress situations. Public resources for mental health crisis services are particularly stressed in New Mexico’s rural and frontier areas.

The larger the community, the deeper the isolation. Smaller communities know one another and tend to take care of each other.

Bobbie Lightle
Behavioral Health Services Division

With limited resources in rural areas, any services need to be affordable and realistic and they need to be funded appropriately. For example, mobile crisis services is much more feasible in urban areas than in rural or frontier areas where it would be very difficult to sustain.

Chris Tokarski
Mental Health Resources, Inc.

Partnership and collaboration is very important. We need to come together to work together.

Carolyn Morris, PhD
Native American Affairs, OptumHealth
communities. Despite the fiscal and personnel constraints faced by many communities, communities are best positioned to develop broad community-based coalitions to enhance and integrate local capacity to respond to those experiencing a mental health crisis. Smaller communities are often most effective at providing sensible care because they know who people are and take care of them. Regardless of the size of a community, direct communication among stakeholders can generate practical solutions and make possible a coordinated response to those individuals with serious mental illness who require the most intensive support.

Communities are an integral part of people’s lives. For people experiencing a mental health crisis, receiving services in their communities can offer a critical sense of continuity in a situation of high uncertainly – a much needed connection to people and to place. Communities by their very nature thus serve as a critical natural support for a person in crisis and his or her journey towards healing.

Local stakeholders are best situated to identify and marshal supports and linkages among service providers because they can identify their community’s unique strengths and challenges. Through such powerful linkages a range of community-based, cost-effective responses can be developed, including, but not limited to, establishing warm lines, respite centers, community and peer-based training programs, a crisis hotline, and, if affordable, mobile crisis teams.

8. Peer Services

Problem
Access to peer support and peer run programs for clients in crisis is minimal or nonexistent in most areas of New Mexico.

Recommendation
Use peer support and client run services whenever possible to provide and enhance provider-oriented services, such as use of certified peer specialists to support individuals in the Emergency Room and use of trained peers for respite and crisis triage. Use client run services such as Community Wellness Resource Centers, drop-in centers and warm lines to provide mutual support one to one or in groups.

Discussion
Clients report that having access to other individuals who have shared experience helps to prevent, deescalate, and minimize the severity of a crisis. Because these individuals may share common experiences, they can understand one another on a very different level.
than a doctor or therapist. This insight is a valuable and even critical resource for an effective comprehensive mental health system. Peer support is especially effective for the elderly population, where isolation contributes to exacerbation of mental and medical health problems.

Peer support is an effective and largely untapped resource that should be used whenever possible to provide and enhance services. Peer support can range from a friend talking with a friend or family talking with a family (where there is no salary, no training and no certification) to Certified Peer Support Worker or Certified Family Specialist (where there is a salary, training and State certification) providing support to individuals in a hospital emergency room. Some client services, such as warm line staffing, would require training but not necessarily certification.

Appropriate settings for peer and client run services include: warm lines, crisis triage centers, hospital ERs, service agencies, respite homes, detention and correctional facilities and traditional healing.

The task force recommends incorporating the full spectrum of peer and family support throughout the mental health system. A system enriched with the full spectrum of peer and family support would include service providers in every setting to provide opportunities for mutual peer support groups (e.g. AA, NA, Double Trouble in Recovery DTR, Dual Recovery Anonymous DRA, Depression and Bi-polar Alliance DBSA, etc.). Such groups would meet onsite but they would not be part of the providers programming. All other peer and family support services, whether volunteer or paid peer/family specialist staff within an organization, must have adequate training and supervision.

9. Criminal Laws

Problem
There are a variety of criminal laws that result in the mandatory arrest of people for behavior that is a result of their mental illness. People living with mental illness who are arrested often spend more time in jail than other arrestees due to challenges to competency, their inability to pay bail, and a concern for a risk of noncompliance with terms of their release.

Recommendation
Review criminal statutes to determine whether there are sensible changes that can be made to the system that would reduce costly and often unnecessary and ineffective incarceration of individuals with mental illness.

Discussion
Although the task force did not reach consensus on any specific revisions to the criminal code, members agreed that this issue warranted further work. Many of the crimes that are presently on the books disproportionately affect people with mental illness. For example, the statute prohibiting battery on health care workers (NMSA § 30-3-9.2(E)) makes a fourth
degree felony out of a crime that, committed on any other person, is a misdemeanor. This is of special concern with juveniles in treatment facilities whose behavioral health system profile includes acting out aggressively with staff or other residents when they feel psychologically threatened. When law enforcement is called the youth is often charged, removed from the treatment facility and placed in detention for the very behavioral responses that caused him or her to be placed in residential treatment in the first place. Individuals receiving health care services are thus more susceptible to habitual offender proceedings (mandatory Department of Corrections time if the State proves prior offenses), and, if not competent to stand trial, a possible commitment to the New Mexico Behavioral Health Institute (NMBHI) for a costly treatment to competence commitment of up to 9 months. The enhanced penalty for battery on a health care worker may not be necessary. If an attack on a health care worker is severe, statutes already exist to charge an individual with felony battery where appropriate. In some jurisdictions, charges such as commercial burglary (NMSA § 30-16-3), are used when a shoplifter has been instructed not to return to a store (with a no trespass order), and may result in a felony charge if that person returns and steals even an item worth one dollar. That too makes them susceptible to habitual offender proceedings and NMBHI commitment for competence.

Misdemeanor offenses can also disproportionately affect people with mental health disorders. Certain charges, such as misuse of public property pursuant to NMSA § 30-14-4 can result in a sentence of 180 days or up to 364 days for simply sleeping in a public park, or a city bus bench. Similarly, criminal trespass for sleeping in a public area, obstructing movement, panhandling, public nuisance, disorderly conduct, indecent exposure (urinating in public), also disproportionately affect mentally ill individuals. The consequences of such criminal penalties can be counterproductive. When arrested, even if a person has a stable residence at the time of their arrest, their home can be lost due to long incarcerations. Social security benefits are cut off, treatment disrupted, and prolonged detention can cause an escalation of future criminal charges when the client is eventually released. Long periods of incarceration are counterproductive to actually helping people in crisis.

Many people living with mental illness experience multiple incarcerations over short periods of time. Due to this, many do not view jail as a punishment. Mental health courts can mitigate the problem of the revolving door and can function as a way to get clients into services. However, people who are so ill that they are considered legally incompetent cannot get any services since all of the mental health court programs require a degree of cooperation from the clients and the ability to plead to a charge to benefit from the program.
Next Steps

• Charge the New Mexico Behavioral Health Purchasing Collaborative (NMBHPC) to:
  - establish funding for the recommended system components;
  - adopt flexible funding/payment mechanisms to compensate providers for client outreach and engagement services;
  - draft and adopt clinical and operational standards for triage centers and respite care;
  - work with state and local governments to establish a centralized call center;
  - establish clinical standards and protocols for a centralized call center;
  - establish warm line services that are accessible statewide;
  - establish and fund cost-effective and outcome-driven respite options in urban, rural, frontier and Native communities;
  - request that the Public Education Department develop mental health training modules, which include anti-stigma components for a mandatory health curriculum targeted for elementary, junior and senior high school students and their teachers;
  - provide Mental Health First Aid training around the State to clients, families, natural supports and all first responders.

• Fund the Doña Ana County crisis triage center and use their model to inform development of other regional centers.

• Charge state elected officials to create coalitions in their communities that include representation from the stakeholders identified in Recommendation 7 in order to enhance and integrate local capacity to prevent and respond to mental health crises.

• Include “Peer and Family Support” language in any future behavioral health memorials or legislation.

• Convene a task force to consider the public defender recommendations for changes in the Criminal and Children’s Code described in Recommendation 9.

Jail diversion is good social and fiscal policy. It saves taxpayer dollars by reducing our jail population and recidivism rates, while providing mental health consumers with needed care in non-detention settings.

Barri Roberts
Executive Director
Forensic Intervention Consortium
Bernalillo County
## Task Force Members and Participants

### HJM 17 Sponsor
Representative Rick Miera  
District 11 (Bernalillo)

### HJM 17 Steering Committee

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<td>Behavioral Health Director</td>
<td>Bette B. Betts</td>
<td>Aging &amp; Long-Term Services Department</td>
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<tr>
<td>Consultant</td>
<td>Michael Coop</td>
<td>Coop Consulting, Inc.</td>
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<td>Senior Director</td>
<td>Troy Fernandez</td>
<td>Behavioral Health Services Division</td>
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<td>Community Development Specialist</td>
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<td>Consultant</td>
<td>Michael Coop</td>
<td>Coop Consulting, Inc.</td>
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<tr>
<td>National Alliance on Mental Illness - NM</td>
<td>James W. Ogle</td>
<td>Office of Consumer Affairs Consultant</td>
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<tr>
<td>Co-Chair Legislative Committee</td>
<td>Grace Philips</td>
<td>Attorney</td>
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### Task Force Members and Participants

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Organization</th>
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</thead>
<tbody>
<tr>
<td>Esq., Consumer</td>
<td>Anne Albrink</td>
<td>National Alliance on Mental Illness</td>
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<tr>
<td>Advocate LC 16</td>
<td>Suzy Ashcroft</td>
<td>Advocate LC 16</td>
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<tr>
<td>NM Behavioral Health Collaborative</td>
<td>Sam Baca</td>
<td>NM Behavioral Health Collaborative</td>
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<td>Local Collaborative Cross Agency Team</td>
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<tr>
<td>Sheriff</td>
<td>Joe Baca</td>
<td>Sheriff</td>
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<tr>
<td>Tribal Liaison</td>
<td>Rebecca Ballantine</td>
<td>Tribal Liaison</td>
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<td>DWI Prevention Program</td>
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<td>Sandoval County</td>
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<tr>
<td>Advocate LC 16</td>
<td>Chuck Benson</td>
<td>Lakota Traditional Counselor LC 16</td>
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<tr>
<td>Clinical Director</td>
<td>Randall Berner</td>
<td>Five Sandoval Indian Pueblos, Inc.</td>
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<tr>
<td>Clinical Director</td>
<td>Steven Blue Horse</td>
<td>Lakota Traditional Counselor LC 16</td>
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<tr>
<td>Administrator</td>
<td>Mark Boschelli</td>
<td>Behavioral Health Clinical Services</td>
</tr>
<tr>
<td>Medical Services</td>
<td>Lupe Bryan</td>
<td>Five Sandoval Indian Pueblos, Inc.</td>
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</tbody>
</table>
Jim Burleson, Executive Director  
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Office of Susan B. Cave

Miguel Chavez, Senior Advocate  
Disability Rights New Mexico

Martha Cooke, Advocate  
National Alliance on Mental Illness

Jacqueline Cooper, Acting Chief  
2nd Judicial District  
Office of the Public Defender

Brian Coss, Instructor  
LEA Advanced Training Bureau Department of Public Safety

Jeff Cumbie, Detective  
Violent Crimes Unit  
Albuquerque Police Department

Corinne Dominguez, Director  
Community-Based Services  
Behavioral Health Institute

Gordon Eden, Secretary  
Department of Public Safety

Matthew Elwell, Operations Administrator  
Metropolitan Detention Center  
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Frank Fajardo, Manager  
NM Office of Guardianship

Chuck Franco, First Gentleman *  
Office of the Governor

Michele Franowsky  
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TeamBuilders

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Lisa Lujan, Director  
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Albuquerque Police Department

Ramon Rustin, Chief  
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Chief General Counsel  
New Mexico Department of Health

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Human Services Department

Silvia Sierra, Director  
Doña Ana County Health & Human Services Department

Patrick Simpson, Deputy Director  
Administrative Office of the Courts

Susan Sisneros, Probation & Parole  
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Alfonso Solis, Chief of Police  
Roswell Police Department & Acting Secretary of Corrections

Judge Mary L. Marlowe Sommer  
First Judicial District Court

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Shirley Villegas, System of Care Trainer  
New Mexico Family Network

Marianna Vigil, Acting Program Manager  
New Mexico Corrections Department

Robert Work, Attorney  
Mental Health Division  
Office of the Public Defender

Wanda Yazzie  
Evercare, UnitedHealthcare
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Local Collaborative 2  
(Bernalillo)  
Local Collaborative 3  
(Doña Ana)  
Local Collaborative 4  
(Mora, San Miguel, Guadalupe)  
Local Collaborative 5  
(Chaves, Eddy, Lea)  
Local Collaborative 6  
(Grant, Luna, Hidalgo)  
Local Collaborative 7  
(Catron, Socorro, Sierra, Torrance)  
Local Collaborative 8  
(Taos, Colfax, Union)  
Local Collaborative 9  
(Curry, Roosevelt)  
Local Collaborative 10  
(Harding, Quay, DeBaca)  

Local Collaborative 11  
(San Juan, McKinley)  
Local Collaborative 12  
(Lincoln, Otero)  
Local Collaborative 13  
(Cibola, Valencia)  
Local Collaborative 14  
(Mescalero & Jicarilla Apache Nations, Acoma, Laguna, Isleta & Zuni Pueblos, To’hajiilee, Alamo & Ramah Chapters of Navajo)  
Local Collaborative 15  
(Navajo Nation)  
Local Collaborative 16  
(Sandoval Pueblos)  
Local Collaborative 17  
(Off Reservation)  
Local Collaborative 18  
(Northern Pueblos)  

* designates Ex Officio member.
House Joint Memorial 17

Sponsored by Representative Rick Miera

Requesting the interagency Behavioral Health Purchasing Collaborative and its member departments to study the needs of and available resources for people with mental health disorders in crisis situations and to develop strategies to improve services, treatment and care outside of law enforcement and detention in order to reduce the number of people with mental health disorders who are in detention facilities or require law enforcement intervention.

- Whereas, one of the greatest challenges facing law enforcement agencies and detention centers is how to respond to people who have mental health disorders; and

- Whereas, law enforcement agencies are the first-line responders to people with mental health disorders who are not receiving necessary treatment and care; and

- Whereas, current statute permits people with mental health disorders to be taken to detention facilities for protective custody regardless of whether they have committed criminal acts warranting arrest; and

- Whereas, many people with mental health disorders are held in detention facilities for misdemeanor charges due to a lack of available treatment or community support; and

- Whereas, the burden for addressing mental health issues in New Mexico communities has been left to counties where detention centers have become de facto mental health facilities; and

- Whereas, few detention centers are equipped to deal with this population; and

- Whereas, individuals with mental health disorders can be traumatized by incarceration; and

- Whereas, the current situation exposes the state and local governments to substantial liability; and

- Whereas, individual agencies cannot provide the solution to this problem because it is a systemic problem that required collaboration and development of strategies among federal, state, county, and municipal governments as well as health care providers and advocacy organizations;

Now, therefore, be it resolved by the legislature of the State of New Mexico that the interagency Behavioral Health Purchasing Collaborative, through the behavioral health planning council, be requested to convene stakeholders to develop humane and effective strategies to serve people with mental health disorders in order to reduce the number of people with mental health disorders that require law enforcement intervention and to reduce the number of people with mental health disorders in detention centers; and
Be it further resolved that stakeholders include but not be limited to representatives from the New Mexico association of counties; the New Mexico municipal league; the department of health; the human services department; the training and recruiting division of the department of public safety; the again and long-term services department; the corrections department; the administrative office of the district attorneys; the administrative office of the courts; the public defender’s office; the sheriffs and police chiefs association; the New Mexico behavioral health institute at Las Vegas; the New Mexico hospital association; disability rights New Mexico; and two individuals living with serious mental illness identified by the interagency Behavioral Health Purchasing Collaborative; and

Be it further resolved that the interagency Behavioral Health Purchasing Collaborative be requested to report its findings to the appropriate interim legislative committee by December 1, 2011; and

Be it further resolved that copies of this memorial be transmitted to the directors of the New Mexico association of counties, the New Mexico municipal league, the New Mexico behavioral health institute at Las Vegas, the New Mexico hospital association, disability rights New Mexico and the national alliance on mental health, New Mexico; the chief executive officer of the interagency Behavioral Health Purchasing Collaborative and the secretaries of health, human services, public safety. Aging and long-term services and corrections.
Tab 8