## New Mexico Behavioral Health Collaborative Members

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthur Pepin, Director</td>
<td>Administrative Office of the Courts</td>
</tr>
<tr>
<td>Michael Spanier, Cabinet Secretary</td>
<td>Aging and Long-Term Services</td>
</tr>
<tr>
<td>Dorian Dodson (Co-Chair), Cabinet Secretary</td>
<td>Children, Youth &amp; Families Department</td>
</tr>
<tr>
<td>Claire Dudley</td>
<td>Children’s Cabinet</td>
</tr>
<tr>
<td>Joe Williams, Cabinet Secretary</td>
<td>Corrections Department</td>
</tr>
<tr>
<td>Pat Putnam, Director</td>
<td>Developmental Disabilities Planning Council</td>
</tr>
<tr>
<td>Katherine Miller, Cabinet Secretary</td>
<td>Finance &amp; Administration, Department of</td>
</tr>
<tr>
<td>Jim Parker, Director</td>
<td>Governor’s Commission on Disability</td>
</tr>
<tr>
<td>Paul Ritzma, Deputy Chief of Staff</td>
<td>Governor’s Health Policy Advisor</td>
</tr>
<tr>
<td>Sam Howarth, Director</td>
<td>Health Policy Commission</td>
</tr>
<tr>
<td>Alfredo Vigil (Co-Chair), Cabinet Secretary</td>
<td>Health, Department of</td>
</tr>
<tr>
<td>Viola Florez, Cabinet Secretary</td>
<td>Higher Education Department</td>
</tr>
<tr>
<td>Katie Falls (Chair), Cabinet Secretary</td>
<td>Human Services Department</td>
</tr>
<tr>
<td>Alvin Warren, Cabinet Secretary</td>
<td>Indian Affairs Department</td>
</tr>
<tr>
<td>Jay Czar, Director</td>
<td>Mortgage Finance Authority</td>
</tr>
<tr>
<td>Hugh Dangler, Chief Public Defender</td>
<td>Public Defender</td>
</tr>
<tr>
<td>Veronica Garcia, Cabinet Secretary</td>
<td>Public Education Department</td>
</tr>
<tr>
<td>Gary Giron, Cabinet Secretary</td>
<td>Transportation, Department of</td>
</tr>
<tr>
<td>John Garcia, Cabinet Secretary</td>
<td>Veteran Services, Department of</td>
</tr>
<tr>
<td>Ralph Vigil, Director</td>
<td>Vocational Rehabilitation, Division of</td>
</tr>
<tr>
<td>Ken Ortiz, Cabinet Secretary</td>
<td>Workforce Solutions, Department of</td>
</tr>
</tbody>
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Introduction

Now in its fifth implementation year, the Behavioral Health Collaborative leads the transformation of the behavioral health system from a set of services managed and overseen in fragmented ways by multiple departments, into a single service system. The Collaborative manages the behavioral health services, resources and priorities of fifteen state agencies. Efforts to create systems of care that are coordinated at the community level will increase access, breadth of services, improve consumer outcomes and demonstrate accountability, while simultaneously decreasing fragmentation, thereby creating new efficiencies and new opportunities. The complex issues addressed by an integrated service system demand innovative and challenging linkages and cross agency coordination, along with new strategies that create a client-focused recovery model that is responsive to changing circumstances and needs.

The systemic transformation from fragmented services to mature systems of care involves the braiding of multiple state agencies’ visions, resources, expertise, and oversight responsibility. It also demands a change in how and what services are delivered, how providers and consumers interact, and a new process to support the leadership of consumers and families in their own care and decision-making. To complement treatment and recovery and resiliency programs, communities and schools are being engaged to support strong prevention and early intervention strategies.

The ongoing, long lasting and profound transformation of New Mexico’s behavioral health system includes multiple strategies that support consumer-focused recovery. The five principles of transformation are:

- A single behavioral health service delivery system in New Mexico in which behavioral health consumers are assisted in participating fully in the life of their communities;
- The support of recovery and development of resiliency are expected;
- Behavioral health is promoted;
- The adverse effects of substance abuse and mental illness are prevented or reduced;
- Available funds are managed effectively and efficiently.

This systemic redesign of the state’s behavioral health system is intended to create a comprehensive system of care with consumer-driven choices of what the treatment and recovery model contains and emphasizes, and to build community engagement in prevention and early intervention approaches. Cultural competency is emphasized so that every individual’s cultural background is reflected in the decision-making and design of the care, services and supports that are provided. The delivery system will employ a wraparound approach that includes a consistent emphasis on quality of care, clarity of outcome as defined by the consumer or family, and demonstrations of accountability. This will be the result of an effective partnership between the service provider team, the consumer and family members. This report will highlight some of the key elements of the system that is being created and accomplishments of the past year that support the recovery and resiliency system. It will also showcase a few core elements of the transformation of the behavioral health system that are the building blocks of a redesigned, comprehensive, systems approach to providing high quality care.
**What We Did Last Year**

New Mexico is positioned to implement a broad “system of care” perspective across the entire behavioral health continuum through the mechanism of the Core Service Agency, which embodies a wraparound approach and a clinical home for the system’s target populations. Populations include those individuals diagnosed with Serious Mental Illness or Severe Emotional Disturbance, those At Risk of Severe Emotional Disturbance, Chronic Substance Dependency, or Co-occurring Disorders. During the most recently completed fiscal year, 2008-2009, more than 76,000 unduplicated clients received behavioral health services paid through the Statewide Entity (during the year described, the Statewide Entity was ValueOptions New Mexico). A total of $299,794,649 was expended for these services. These funds include Medicaid, Federal Block Grant funds and discretionary grants (including ATR and CoSIG, both described later) from the Substance Abuse and Mental Health Services Administration (SAMHSA), General Fund behavioral health monies from the Department of Health, the Children Youth and Families Department, the Human Services Department, the Aging and Long Term Services Department, the Corrections Department, and the Mortgage Finance Authority.

**Claims Based Services**

The majority of behavioral health services are supported through payments of claims submitted to the Statewide Entity for specific billable services provide to individuals. The following table shows the number of consumers served and the amount of funds paid by the Statewide Entity for those individual claims, representing $221,212,094 of the total expended for services.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Clients</th>
<th>Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization – Psychiatric</td>
<td>1,492</td>
<td>$8,805,725</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>1,492</td>
<td>8,805,725</td>
</tr>
<tr>
<td><strong>Residential</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Detoxification (Adults)</td>
<td>99</td>
<td>89,900</td>
</tr>
<tr>
<td>Transitional Living Services</td>
<td>117</td>
<td>2,322,859</td>
</tr>
<tr>
<td>Residential Treatment Services (Non-accredited)</td>
<td>161</td>
<td>2,786,820</td>
</tr>
<tr>
<td>Residential Treatment Services (Accredited)</td>
<td>781</td>
<td>20,283,874</td>
</tr>
<tr>
<td>Adult Residential Services</td>
<td>522</td>
<td>3,060,445</td>
</tr>
<tr>
<td>Group Home</td>
<td>216</td>
<td>2,378,930</td>
</tr>
<tr>
<td>Shelter Care</td>
<td>594</td>
<td>1,148,873</td>
</tr>
<tr>
<td>Therapeutic Community, Model &amp; Halfway House</td>
<td>293</td>
<td>1,253,297</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>2,783</td>
<td>33,324,998</td>
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</table>
### Clients Served, Cost and Service: Fiscal Year 2008-2009*

#### Intensive Community-Based Services

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Clients</th>
<th>Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Care Therapeutic TFC I</td>
<td>934</td>
<td>16,322,348</td>
</tr>
<tr>
<td>Foster Care Therapeutic TFC II</td>
<td>397</td>
<td>3,555,750</td>
</tr>
<tr>
<td>Intensive Outpatient Program</td>
<td>357</td>
<td>727,917</td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>69</td>
<td>584,310</td>
</tr>
<tr>
<td>Multi-Systemic Therapy (MST)</td>
<td>586</td>
<td>3,602,561</td>
</tr>
<tr>
<td>Infant Mental Health Services</td>
<td>648</td>
<td>1,001,015</td>
</tr>
<tr>
<td>Home-Based Services (Family Stabilization)</td>
<td>372</td>
<td>641,024</td>
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</tbody>
</table>

**Subtotal** 3,363 $26,433,925

#### Community-Based Services

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Clients</th>
<th>Expense</th>
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</thead>
<tbody>
<tr>
<td>Supported Employment</td>
<td>304</td>
<td>116,300</td>
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<tr>
<td>Crisis Intervention</td>
<td>1,958</td>
<td>223,290</td>
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<tr>
<td>BH Day Treatment</td>
<td>212</td>
<td>933,843</td>
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<tr>
<td>Skills Training &amp; Development (BMS)</td>
<td>983</td>
<td>4,547,052</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>1,390</td>
<td>713,656</td>
</tr>
<tr>
<td>Psychosocial Rehab (Individual, Group, Classroom)</td>
<td>2,188</td>
<td>5,455,838</td>
</tr>
<tr>
<td>Outpatient Therapies (Individual, Family, Group)</td>
<td>45,624</td>
<td>21,548,434</td>
</tr>
<tr>
<td>School-Based Health Care Center Services</td>
<td>444</td>
<td>107,854</td>
</tr>
<tr>
<td>Case Management/CCSS (Children)</td>
<td>4,345</td>
<td>2,994,555</td>
</tr>
<tr>
<td>Case Management/CCSS (Adult)</td>
<td>5,581</td>
<td>3,470,215</td>
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<tr>
<td>Testing and Forensic Evaluations</td>
<td>2,196</td>
<td>1,342,165</td>
</tr>
<tr>
<td>Respite Care</td>
<td>372</td>
<td>688,750</td>
</tr>
<tr>
<td>Medication Management/Monitoring</td>
<td>3,640</td>
<td>1,081,589</td>
</tr>
<tr>
<td>Methadone Outpatient SA</td>
<td>513</td>
<td>1,063,175</td>
</tr>
<tr>
<td>Indian Health Services &amp; FQHC Facilities</td>
<td>1,587</td>
<td>1,934,641</td>
</tr>
<tr>
<td>Lab Fees/Polygraphs (Corrections Dept.)</td>
<td>48</td>
<td>17,700</td>
</tr>
<tr>
<td>Traditional Healing Services</td>
<td>179</td>
<td>86,760</td>
</tr>
<tr>
<td>Telehealth Services</td>
<td>854</td>
<td>141,809</td>
</tr>
<tr>
<td>Activity Therapy</td>
<td>1,063</td>
<td>227,289</td>
</tr>
</tbody>
</table>

**Subtotal** 73,481 $46,694,915

#### Other

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Clients</th>
<th>Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Miscellaneous Services</td>
<td>2,602</td>
<td>790,159</td>
</tr>
</tbody>
</table>

**Subtotal** 2,602 $790,159

**TOTAL** 76,105 $221,212,094

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*Data in the table above and the two that follow are derived from the Collaborative’s Directors’ Reports DRLC-01, -02, and -03. Unduplicated client totals may not equal sums due to services delivered in multiple months and clients counted in multiple age categories due to birthdates.*
The following table shows, for the claims based services described above, the distribution of those clients receiving services by age and ethnicity during the most recent fiscal year. Almost 43% of clients are under the age of 18; just over half (51.2%) are between the ages of 21 and 64, while only about 2% are 65 years of age or older.

### Consumers by Age Group and Ethnicity*

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>&lt; 18</th>
<th>18-20</th>
<th>21-64</th>
<th>65 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>17,471</td>
<td>1,984</td>
<td>15,945</td>
<td>461</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>7,505</td>
<td>1,029</td>
<td>13,829</td>
<td>682</td>
</tr>
<tr>
<td>Native American</td>
<td>3,643</td>
<td>439</td>
<td>3,055</td>
<td>45</td>
</tr>
<tr>
<td>African American</td>
<td>761</td>
<td>111</td>
<td>1,055</td>
<td>26</td>
</tr>
<tr>
<td>Alaska Native</td>
<td>1</td>
<td>0</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Asian / Pacific Islander</td>
<td>77</td>
<td>9</td>
<td>158</td>
<td>6</td>
</tr>
<tr>
<td>Multiracial</td>
<td>223</td>
<td>27</td>
<td>207</td>
<td>5</td>
</tr>
<tr>
<td>Other / Unknown</td>
<td>4,311</td>
<td>578</td>
<td>5,263</td>
<td>250</td>
</tr>
<tr>
<td><strong>Total by Age Group</strong></td>
<td><strong>33,992</strong></td>
<td><strong>4,177</strong></td>
<td><strong>39,527</strong></td>
<td><strong>1,475</strong></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>76,105</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table below illustrates the distribution of those clients, by ethnicity and gender, during the most recent fiscal year. Just less than half of all clients are Hispanic, about 30% are White, Non-Hispanic, a little over 9% are Native American, and fewer than 3% are African American. Ethnicity of more than 13% of clients is unknown.

### All Consumers by Gender and Ethnicity*

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Females</th>
<th>Males</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>17,157</td>
<td>18,133</td>
<td>35,290</td>
<td>46.37</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>11,839</td>
<td>10,895</td>
<td>22,744</td>
<td>29.89</td>
</tr>
<tr>
<td>Native American</td>
<td>3,407</td>
<td>3,665</td>
<td>7,072</td>
<td>9.29</td>
</tr>
<tr>
<td>African American</td>
<td>891</td>
<td>1,035</td>
<td>1,926</td>
<td>2.53</td>
</tr>
<tr>
<td>Alaska Native</td>
<td>7</td>
<td>9</td>
<td>16</td>
<td>0.02</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>138</td>
<td>110</td>
<td>248</td>
<td>0.33</td>
</tr>
<tr>
<td>Multiracial</td>
<td>220</td>
<td>236</td>
<td>456</td>
<td>0.60</td>
</tr>
<tr>
<td>Other / Unknown</td>
<td>4,519</td>
<td>5,796</td>
<td>10,320</td>
<td>13.56</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>37,136</strong></td>
<td><strong>38,956</strong></td>
<td><strong>76,105</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

Due to a claims lag factor (the time between a claim being filed and the time it is paid) of approximately 11%, an additional $23,297,083 will support claims reimbursements to providers for client services, but the data on those clients are not available. Pharmacy services were supported for a total of $28,531,810.
Access To Recovery - 1,250 have received services for methamphetamine abuse/dependence; 160 providers enrolled in ATR II; 76 are faith-based and 84 are secular. During the most recent fiscal year, 3,329 clients were served.

**Invoice Based Services**

Many other expenditures contribute to the total amount of behavioral health services provided. These are services that do not fall within the traditional, claims based service system that supports unique individual service reimbursement payments to providers. These additional services include a wide variety of initiatives that simply do not fit that payment model. For these services, which are described below, the Statewide Entity pays provider agencies through a monthly invoice system. The client or participant data are not reflected in the data and expenditures reported in the tables above.

**Access to Recovery (ATR) II**: A grant (now in its second funding cycle) from the Center for Substance Abuse Treatment, a unit of SAMHSA, provides wraparound treatment and recovery support services paid through a central intake system, with $14.5 million for a three year period. ATR II has served 6,526 adult clients to date, with a target of 8,700. Of those served, 1,250 have received services for methamphetamine abuse/dependence. A unique component of the program works with National Guard and Veterans and provides multiple wraparound services. There are currently six central intake offices in the following Counties: Santa Fe, Bernalillo, Dona Ana (with mobile assessments in Deming), Otero, and Curry, with an additional site at Five Sandoval Indian Pueblos. These cover the three largest population centers in the state. There are currently 160 providers enrolled in ATR II; 76 are faith-based and 84 are secular. During the most recent fiscal year, 3,329 clients were served.

**Substance Abuse Prevention Services**: Approximately $7 million supports services provided by 42 agencies around the state. Most of these are direct prevention services that target young children and their families, kindergarten through elementary school students, and adolescents in school and community-based program settings. In addition, environmental strategies are implemented in communities, counties, and tribes throughout the state to reduce adult binge and underage drinking that lead to DWI. During the most recent fiscal year, 7,583 individuals were served by recurring, direct service prevention programming. These funds are a combination of State General Fund dollars, discretionary and Federal Block Grant funds (SAMHSA), and Safe and Drug Free Schools funds from the Department of Education (unfortunately these funds are not in the new Federal budget, so will not be recurring after 2010).

7,583 individuals were served by recurring, direct service prevention programming.
**What We Did Last Year**

*Combining all major program components providing services for children and adults that are overseen by the Behavioral Health Collaborative and managed through the Statewide Entity, 88,716 consumers were served during 2008-2009, with total expenditures of $302,695,493.*

**Men’s and Women’s Recovery Academies:** The Department of Corrections supports the costs of two residential treatment centers for parolees in the amount of $2,900,844. A total of 84 men at one time are resident in the Men’s Recovery Academy, while 48 women are served in the Women’s Recovery Academy. These parolees participate in a six-month treatment program using the Therapeutic Community model. The women’s center provides care in two programs, one for women diagnosed with a co-occurring disorder and one for women with children under age 11 who are primarily dealing with a substance use disorder and whose children reside at the center with their mother. A small half way house on the premises of the Women’s Recovery Academy also provides a range of support services to over a dozen women who are reentering the community.

**Sexual assault programs** served 527 clients. Medication fund expenditures supported another 908 consumers.

Combining all major program components providing services for children and adults that are overseen by the Behavioral Health Collaborative and managed through the Statewide Entity, 88,716 consumers were served during 2008-2009, with total expenditures of $302,695,493.

**Consumer Results**

Responses by consumers to the service delivery system are almost uniformly positive. An anonymous, consumer-driven survey, conducted for the fourth year by the Collaborative during 2009, obtained survey responses from 807 adult consumers. Results show that 87% of responses to questions about access to services were positive; 88% of those surveyed responded positively to appropriateness of services they were offered or received -- 85% of adult respondents said they were satisfied with their services and the manner in which they were provided, while 83% said their services had been effective. A total of 88% responded that they had been empowered through participation in their treatment program.

A total of 1,064 youth and parents responded to a similar survey about children’s services. These families responded similarly, with a 92% positive response rate about their access to services, and a 92% positive response rate to the appropriateness of services they were provided. Families receiving services for their children with a serious emotional disorder reported a 93% satisfaction rate with their experience with their services – and they reported a positive response rate of 89% for the program and service effectiveness. A similar amount (96%) also reported that they had been empowered through their treatment experience to be more pro-active and engaged in decision-making about their treatment planning.
Transition of Statewide Entity (SE) from ValueOptions New Mexico (VONM) to OptumHealth New Mexico (OHNM)

In the summer of 2008, in anticipation of the expiration of the ValueOptions New Mexico contract on June 30, 2009, the Behavioral Health Collaborative began a formal procurement process. A nationally recognized consulting company was engaged to recommend a rigorous and thorough procurement process. This included incorporation of a new contract as the core of the Request for Proposal. Many Collaborative agencies were involved in the evaluation and review process. The RFP was released in August 2008 with proposals due in October; three organizations responded.

Three separate evaluation teams were established, composed of 19 senior level state staff members, including experts in IT, finance, and behavioral health programming. The evaluation process began in October 2008. The teams utilized a consensus scoring system for each RFP factor that ultimately led to the recommendation to award the new contract to OptumHealth New Mexico, a joint venture of United Health Insurance Group (UHIG) and United Behavioral Health. The recommendation was formally approved at a Collaborative meeting in January 2009. Immediately following this decision, state staff worked intensively with OHNM on a formal readiness review process to ascertain that all necessary elements for IT and program implementation were in place. Formal preparation for the readiness review process continued for the five months up to the July 1 start date of the contract; some of the activities continue beyond the inception date of the contract.

The transition to OHNM has proven to be difficult and the Collaborative has taken action to address those difficulties. Serious problems were occurring in six areas of operation: claims, service registration, authorizations, funds mapping, provider file audits, and financial reporting. On October 29, 2009, the Collaborative issued a sanction letter to OHNM. A Directed Corrective Action Plan was created that directed OHNM to take specific actions in the identified areas. Civil monetary penalties and damages were included as part of this action, and a Monitor was appointed by the Collaborative to oversee this phase of activity.

OHNM originally disputed the sanction but eventually agreed to resolve the dispute as announced at the January 7, 2010 meeting of the Collaborative. This resulted in OHNM’s agreement to move forward with a revised and vigorous Directed Corrective Action Plan, which directs activity, under the supervision of the Monitor, in the six areas identified above. OHNM also agreed to pay $1 million, as directed by the Collaborative, to compensate providers for the increased administrative burden caused by these issues. These payments are due to be completed by February 2010. OHNM will also reimburse the Collaborative $30,000 for consultation fees and cover the costs of the professional Monitor appointed by the Collaborative, for a period that will last until the Collaborative is confident that all issues are resolved.
Governor Bill Richardson and the New Mexico State Legislature created the Collaborative during the 2004 Legislative Session as part of House Bill 271. The legislation allows state agencies and resources involved in behavioral health prevention, treatment and recovery to work as one in an effort to improve mental health and substance abuse services and outcomes in New Mexico. This ten-year process is designed to transform behavioral health services for adults, children, youth, and families, and is driven by a focus on recovery and resiliency. During the 2009 calendar year, the Behavioral Health Collaborative met nine times.

**Behavioral Health Collaborative Members**

The Behavioral Health Collaborative is comprised of fifteen state agencies and the Governor’s Office as well as other agency partners. Collaborative members are secretaries and directors from each agency. The following are member agencies and partners of the BHC:

- Administrative Office of the Courts
- Aging and Long-Term Services Department
- Children, Youth and Families Department
- Corrections Department
- Department of Finance and Administration
- Department of Health
- Department of Transportation
- Department of Workforce Solutions
- Developmental Disabilities Planning Council
- Division of Vocational Rehabilitation (PED)
- Governor’s Commission on Disability
- Governor’s Health Policy Advisor
- Health Policy Commission
- Human Services Department
- Indian Affairs Department
- Mortgage Finance Authority
- Public Education Department

**Ex Officio Members and Partnering Agencies**

- New Mexico Children’s Cabinet
- Department of Veteran’s Services
- Public Defender
Behavioral Health Planning Council

The Behavioral Health Planning Council (BHPC; formerly constituted as the Governor’s Mental Health Council) was established to ensure the Collaborative’s success through a range of statutory duties. Duties of the BHPC include:

- Advocating for adults, children and adolescents with serious mental illness or severe emotional, neurobiological and behavioral disorders, as well as those with mental illness or emotional problems, including substance abuse and co-occurring disorders;
- Reporting to the Governor and Legislature on the adequacy and allocation of mental health and substance abuse services throughout the state;
- Supporting the development of a comprehensive, integrated, community-based behavioral health system of care, including mental health and substance abuse services, and services for persons with co-occurring disorders;
- Advising state agencies responsible for behavioral health services for children and adults;
- Reviewing and making recommendations on various plans and applications for the comprehensive mental health state block grant and the substance abuse block grant applications, the state plan for Medicaid services, and any other plan or application for federal or foundation funding for behavioral health services.

Membership in the BHPC consists of consumers, family members, providers, advocates, and representatives of each Local Collaborative (LC), appointed by the Governor in addition to state agency secretaries or directors or their proxies. A diverse and representative Executive Committee directs the work of the BHPC. The BHPC has five statutory subcommittees that meet at least quarterly to work on initiatives and projects for the Council. These include: the Adult Subcommittee; the Substance Abuse Subcommittee; the Child and Adolescent Subcommittee; the Medicaid Subcommittee; and the Native American Subcommittee.
The purpose of the eighteen Local Collaboratives is to develop strong local voices to guide behavioral health planning and services.

**Local Collaboratives (LCs)**

The purpose of the eighteen Local Collaboratives is to develop strong local voices to guide behavioral health planning and services, a key consideration in the planning and design of New Mexico’s Behavioral Health Collaborative initiative. LCs represent local viewpoints and provide advice and guidance to the BHPC. They are vital to the ongoing enhancement of the state’s behavioral health plan, to the collection and reporting of specific data and health indicators, and in ensuring that local consumers, advocates, and provider agencies have a voice in a systematic way that informs the state level transformation efforts.

The Collaborative works to ensure that interagency endeavors are reflected in well-developed, local-level collaborative efforts throughout the state. To be certain this happens, the Collaborative currently supports a single local collaborative for each of New Mexico’s thirteen judicial districts, as well as five LCs that represent the state’s sovereign Tribes, Nations, Pueblos and off-reservation populations. Each Local Collaborative is comprised of consumers, family members, advocates and providers, who contribute to consumer-informed policies and planning.

**LC Major Accomplishments**

- Additional Native American LCs: After formal tribal consultation and ongoing discussions with current Native American LCs, the Purchasing Collaborative voted to confirm three additional Native American LCs. This increased the number of Native American LCs from two to five, and the total number of LCs from fifteen to eighteen.

- Behavioral Health Day: On February 26, 2009, LC and the BHPC celebrated the Second Annual Behavioral Health Day at the Legislature. This event acknowledged LC consumers and families who made great contributions, and honored them on the Senate floor, thus bringing advocacy efforts to the attention of lawmakers.

- Legislative Priorities Process: For the third consecutive year, Local Collaboratives submitted their Legislative Priorities to help streamline behavioral health advocacy efforts. As part of the legislative priority process, as requested by the Purchasing Collaborative, the Behavioral Health Planning Council requested all LCs to identify their top three legislative priorities, which were: crisis services; supportive housing, and transportation.

A survey of LC members conducted during the year demonstrated substantial growth in the role and importance of LCs in creating effective and comprehensive systems of care in local communities. LCs have a substantial voice in legislative, BHPC and BHC priorities, and consumers have a strong leadership role at the local level.
Core Service Agencies (CSA) will become a cornerstone of the enhanced treatment system in New Mexico.

Core Components

The Behavioral Health Collaborative has developed numerous systemic components that will create more efficient provision of services, and will create more lasting and substantial outcomes for consumers. Some major elements of the new system, designed to support a consumer-driven comprehensive system of care and wraparound models for both youth and adults are described below. These efforts will provide much of the major system development over the next several years.

Core Service Agencies

Core Service Agencies (CSA) will become a cornerstone of the enhanced treatment system in New Mexico, providing a single point of accountability for consumers’ recovery. Planning and training for Core Service Agencies is on-going. Full implementation will begin later in 2010; currently 11 pilots are underway across the state, and all sites will be identified by summer 2010. Agencies will comprehensively address the most complicated behavioral health issues, those presented by very high need behavioral health consumers across the State. The prioritized high need populations include adults diagnosed with a serious mental illness (SMI), chronic substance dependence, co-occurring disorders (serious mental illness plus substance dependence), children with a severe emotional disturbance, and children at risk of severe emotional disturbance. At least one Adult and one Children’s Core Service Agency will be established in each Local Collaborative region (these may be the same agency in some communities), though in the first phase five adult and six children’s agencies will initiate the program. Ultimately 21 youth-serving and 23 adult-serving agencies will be designated.

Core Service Agencies will function in substantially different ways from traditional approaches to community mental health services. These agencies must guarantee a comprehensive screening within two days to one week for high risk and symptomatic individuals seeking services. Appropriate services must begin within a set time frame, depending upon the category of consumer symptoms identified. Clients with emergent issues, those that suggest the possibility of a crisis, must be offered same-day services. Consumers presenting with other urgent or crisis situations must be provided assessment services within 48 hours and service implementation within 24 hours after the assessment is completed. Enhanced diagnostic assessments will result in a detailed service plan, a crisis plan, a recovery and resiliency plan, and where appropriate, an advance mental health directive. Each of these plans is built around the consumer and his or her natural supports, inclusive of family, peer, and other systems with which they interact. These plans will include psychiatric and counseling services, crisis services, and community supports. Each of these categories of service will include specified elements such as; 24-hour telephone crisis support, next-day appointments including weekends, and numerous other elements that are part of the flexible wraparound recovery and resiliency support service model. A multi-disciplinary team, consisting of agency staff and others selected by the consumer, which might include family, peers or others who can assist the consumer, will prepare these plans. The goal of this comprehensive model is for consumers to guide their own recovery. Core Service Agencies will not have the ability to stop serving consumers. For example, agencies are responsible for outreach to consumers who fail to make appointments, so they help to re-engage a consumer with their treatment and recovery. Agencies must establish performance benchmarks for this and other issues that arise. Some of the comprehensive wraparound service continuum may be provided by other community agencies.
CCSS provides multi-disciplinary planning for client-driven solutions that take into account all types of life factors and contingencies that impact recovery.

A key element of the new CSA structure, the service definition for Comprehensive Community Support Services (CCSS), was developed as a significant tool to assist consumers and families develop their own comprehensive approach to long-term recovery planning and self-care management. Built on a team approach to supporting wellness by addressing all major areas of need, CCSS provides multi-disciplinary planning for client-driven solutions that take into account all types of life factors and contingencies that impact recovery. CCSS services include:

- Assistance in the development and coordination of a behavioral health service plan, which entails a recovery/resiliency management plan, a crisis management plan, and an advance directive when needed;
- Assessment and support in crisis situations;
- Service and resource coordination with the goal of attaining access to rehabilitative and medical services;
- Assistance with the development of interpersonal and community coping skills;
- Encouragement in the development of natural support systems at the workplace or at school;
- Assistance in learning to monitor symptoms and self-management skills;
- Assistance in maintaining stable housing;
- Multi-disciplinary follow-up to ensure CCSS needs are being met.

CCSS services are intended to utilize multiple types of service or support, only some of which are provided by licensed behavioral health care providers. The new services provide a more comprehensive approach, based on recovery and resiliency principles, that includes consumer-selected or -designed elements such as community support workers who may be peer support specialists for self-directed recovery goals, transportation planning, crisis self-management plans, emergency protocols for crises unresponsive to self-management, etc. These and other included services allow for a more self-directed approach that can ultimately reduce the number of new episodes and relapses and sometimes the severity of crises and their consequences. These also provide a more effective support system, which allows the consumer who is in recovery from a serious mental illness or addiction, to participate in his or her community more productively.
Veterans and Family Support Services

Targeted to provide behavioral health services to those serving in the military, whether pre- or post-deployment, and to veterans and their families, a pilot project in Sandoval County was expanded in 2009 to include Native American veterans in San Juan and McKinley Counties. Veteran and Family Support Services (VFSS) is a legislatively-funded program focusing on providing triage, case management, and behavioral health referral services to veterans, military and their families, with brief treatment provided as needed. Services are provided in the community, in homes, and within a community-based community mental health center office. Outside of normal operating hours, there is a toll free number and a 24-hour crisis line. During the past year of the project, 136 new individuals were served, roughly two-thirds male and one-third female. The three most common presenting issues were (1) Post Traumatic Stress Disorder (PTSD), (2) social and family issues, and (3) financial issues. The most frequently provided services include individual therapy, family or couples therapy, and case management. Other services included psychiatric consultation, housing and employment referrals, and crisis intervention services. Telephone case management services are provided on a statewide basis.

The demographic background of participants is varied – just under 40% are Anglo, 21% are Hispanic, 7% Native American, 4% Asian American, and 25% reported their ethnicity as “other.” Servicemen and women, veterans, and their families are offered comprehensive treatment options tailored to their needs. A satisfaction survey completed in spring 2009 showed that 86% of participants felt the program had helped them or helped them a lot with their concerns. This program has shown great promise and provides a model for the state to triage the needs of individuals and match them to appropriate services efficiently and effectively. Now expanded to San Juan and McKinley Counties, the roughly one-million-dollar project will become a cornerstone of the state’s system of care for adults.

Crisis Services and the Jail Diversion Project

Crisis services are an essential and systematic element needed to address behavioral health issues. These services stabilize and de-escalate situations, which often reduces severity, length, and costs of behavioral health crises. While most behavioral health crises do not involve harm to others, it is also true that the criminal justice is often, especially in rural communities, as much a part of the behavioral health system as are behavioral health providers. Jail diversion programs play an additional role within this framework, allowing consumers engaged with law enforcement due to their symptoms to enter into a recovery-based intervention rather than the law enforcement and judicial systems, where they are unlikely to receive proper care. Currently there is little jail diversion or crisis system service programming in our state.

The Collaborative recently received a competitive grant from the SAMHSA for providing Jail Diversion services for Veterans and Native Americans in pre-conviction status. It is being
integrated into the system already developed for the Veterans Services project in Sandoval County and expanded into McKinley and San Juan Counties. This will allow for those individuals who are primarily suffering from severe behavioral health issues that have become involved with the justice system to get treatment for the cause of their behaviors and avoid jail and other consequences if treatment is followed successfully. This grant project complements a year-long program to train law enforcement officers to implement the Crisis Intervention Team model in Sandoval County. Approximately 200 officers will complete training during the program, and about 60 will be certified to provide mental health crisis intervention services on-site as part of the law enforcement first response to crises in the community. The goal for these officers is to have the best tools and practices to de-escalate mental health crises and provide for stabilization of the situation in order to increase safety and incidence of positive outcomes for consumers and others involved in these crises. These projects include crisis response, pre-trial coordination, wraparound services and housing supports to allow for more successful court and alternative results.

This project will reduce costs by getting consumers earlier care, and reduce the number of arrests and prosecutions for individuals in need of behavioral health services who become involved with the justice system primarily because of behavioral health issues. At $394,000 each year for five years, the additional SAMHSA funding in conjunction with exceptional technical support from the national Gains Center will facilitate the expansion of specialized jail diversion across the state for veterans who experience behavioral health disorders precipitated by war induced Post Traumatic Stress disorder and Traumatic Brain Injury that is linked to each Core Service Agency.

Families and Organizations Collaborating for a United System (FOCUS), will be developing capacity and infrastructure for integrated, community-based, culturally competent, family-driven, and youth-guided behavioral services to children and youth with serious emotional disturbances and their families.

**System of Care Grant and the larger System of Care for Children and Youth with Behavioral Health Needs**

New Mexico successfully applied for and received a competitive grant for a new project known as the Families and Organizations Collaborating for a United System (FOCUS). Directed by the Children Youth and Families Department (CYFD), this System of Care grant will support New Mexico’s ambitious transformation to embed system of care (SOC) philosophies statewide. In this effort, collaborating agencies will be developing capacity and infrastructure for integrated, community-based, culturally competent, family-driven, and youth-guided behavioral services to children and youth with serious emotional disturbances and their families.
Intensive SOC implementation will focus on three anchor-sites that reflect the geographic and ethnic diversity of the State: Highland Cluster School District in Albuquerque, Local Collaborative 6 (LC6; Grant, Hidalgo, and Luna Counties) and Santa Clara Pueblo. All were chosen because of existing strong local SOC planning and development initiatives, and are poised to hit the ground running. The Highland Cluster is located in a low-income urban area with an ethnically diverse student body of 8,550 students (55% Hispanic, 33% White, 5% Native American, and 7% other). The LC6 counties cover over 10,000 square miles in the low-income, rural/frontier southwest part of the state bordering Mexico, and include a large Hispanic (74%) and immigrant (11%) population. Santa Clara Pueblo covers over 57,000 acres, with 2,700 community members residing on tribal lands or in adjacent communities. Two-thirds of households speak Tewa (a native language) or Spanish in the home, 28% of the residents are under 18, and over one-third of the population lives in poverty. It is anticipated that 224 unduplicated children and youth will receive services annually (1,120 total for the project) through FOCUS using a children’s Core Service Agency or clinical home model – a single provider responsible for coordinating care across multiple systems, including diagnostic and evaluation services, wraparound approaches, individualized service plans, family advocacy, peer support, linkage to residential services, intensive home-based services, emergency services, intensive day treatment, therapeutic foster care, and youth-to-adult services.

FOCUS will promote SOC Transformation by significantly expanding SOC-related training and technical assistance across the state through collective learning. This is a six-year project with funding of $9 million. Year one is a planning year for the project. While the FOCUS project only impacts a small number of consumers because of its limited geographic reach, it does allow the CYFD to broaden their emphasis within this model to include earlier intervention strategies and even some prevention strategies. Both of which can reduce the severity of the eventual diagnosis, lessen secondary consequences of the behavioral health issue for the individual child or adolescent and their family, keep symptoms to a lower level, and reduce the number of children needing institutionalized care for their diagnosis. CYFD can then employ those early intervention strategies that demonstrate effectiveness and SOC implementation lessons learned across other communities of the state.

FOCUS will promote SOC Transformation by significantly expanding SOC-related training and technical assistance across the state through collective learning.
CYFD has also worked through the Collaborative structure with other agencies and greater public input to develop strategies that emphasize clinical treatment responses to youth behavioral health issues, rather than a juvenile justice response, unless it is absolutely necessary. As most children and youth behavioral health services are funded by Medicaid, there are many less intense and enhanced services that are not funded sufficiently to provide to all who need them. The new FOCUS grant will allow some of these services to be developed on a limited basis within the SOC model, which will at least prepare the groundwork for an expanded service system in the future when there is not such a critical shortage of new funding for the state.

This will also occur within the context of the roll out of the new CSA model, which includes a "no eject, no reject" philosophy. This overlap of new initiatives will allow a more comprehensive and more accountable approach to creating a system of care within the communities covered by the FOCUS project. The Collaborative and CYFD, in particular, are continuing to develop and implement strategies that are trauma informed and gender specific, emphasizing their utilization to improve outcomes for sub-populations. Substantial planning and system development work has been accomplished through the Collaborative to help older youth who are receiving services in the children’s system successfully transition to the adult system of care upon turning 21 years of age. Eligibility requirements differ upon reaching 21, so this has been a longstanding, major barrier for older youth who need continuing care as they age out of the children’s system, especially those who need long term care support services. While not all issues are resolved, much progress has been made do develop approaches that accommodate these consumers.

Expanding the knowledge of these medications among primary health care providers will continue to be a priority, as this is a crucial community-support element in long-term recovery efforts.

Primary Care and Medication Assisted Treatment

Community health centers, particularly in rural areas of the state, integrate primary care and mental health services. Primary health care clinics are a focus of future system development in order to successfully address the need to develop strategies to effectively manage medication assisted treatment protocols, including prescribing of these medications, for clients throughout the state, and especially in rural areas. Primary care doctors and providers are the principle prescribers of these drugs in many instances. The Collaborative must ensure essential medication management and develop processes to provide crucial medications (such as suboxone and buprenorphine) for mental health and substance abuse treatment. Expanding the knowledge of these medications among primary health care providers will continue to be a priority, as this is a crucial community-support element in long-term recovery efforts.
Significant Initiatives

Numerous other initiatives provide essential infrastructure components, provide core services through processes outside of the Core Service Agency model, support recovery and resiliency using evidence-based and promising strategies, and build community engagement in prevention and intervention. Some of those are described below.

Office of Consumer Affairs

The Office of Consumer Affairs (OCA) was staffed with a program manager during 2009 to advance consumer- and family-driven services through training and education that support and empower individuals in the recovery process, and to establish a venue, vehicle and voice in statewide behavioral health policy and initiatives. The vision of OCA is to ensure the voices of New Mexican consumers and family members are heard and included in all major decisions pertaining to mental health and substance abuse issues. The mission is accomplished through the following strategies: training, program development and evaluation, advocacy, funding, consumer/family engagement, and the dissemination of information. Programs focused on consumers, youth and families include:

- **Certified Peer Specialist Training:** a state-approved certification process that allows peers to work within an eligible, certified agency to provide peer services to individuals and their support network according to very specific rules and regulations in order to enhance the recovery and resiliency of others with Severe Emotional Disturbances, Serious Mental Illness and/or chronic substance abuse; 85 peer specialists were trained during 2009; almost all of those have taken the professional certification test and been certified, or are taking the exam early during 2010.

- **Parallel process which provides Family Peer Specialist Training is being implemented by the Children Youth and Families Department. It will offer a state-approved certification process that allows peers to work within an eligible certified agency to provide peer services to families according to very specific rules and regulations in order to enhance the recovery and resiliency of others with Severe Emotional Disorders, Severe Mental Illness and/or chronic substance abuse;**

- **Consumer Satisfaction Survey:** the state engages in an annual survey of consumers who receive publicly funded behavioral health services throughout the state to rate and comment on the quality, access and effectiveness of behavioral health services. This tool is used to inform the state on where improvements can be made to more adequately meet the needs of consumers. The project is consumer driven, with additional participation of family members;

- **Leadership Academy:** provides training on empowerment and self-help, education, leadership skills, such as public speaking and holding effective meetings, community involvement and networking, individual and group goals and action plans. In 2009 approximately a total of 175 Consumers of Behavioral Health Services attended these workshops in Silver City, Clovis,
In cooperation with OptumHealth New Mexico, the Collaborative established a multicultural committee structure to oversee implementation of cultural and linguistic initiatives involving four key advisory committees specific to Hispanic, Tribal, Disability, and Lesbian, Gay, Transgender, Bisexual (GLTB) communities.

Behavioral Health Day at the 2010 Legislative Session

Albuquerque and Santa Fe. A new pilot training entitled Self Help and Mutual Recovery Groups was conducted in Silver City with an attendance of 50 Consumers of Behavioral Health Services. This training is scheduled to continue throughout 2010 with two in each region throughout the state;

- Drop in Centers: these provide a place for consumers of behavioral health services to go during the 5:00 PM to 5:00 AM: times when other assistance may not be available. Financial assistance is provided to some drop-in centers so that peers can run the facility. In 2009 technical assistance was provided to a drop-in center to develop an Employment Network to expand employment services to individuals who are eligible for the “ticket to work” program sponsored by the Social Security Administration.

**Cultural and Linguistic Competency**

New Mexico serves as home to some of the oldest Native American and Hispanic communities in the United States where almost 67% of the state’s population is non-white; more than a third of state speaks other languages besides English; and where the state’s diversity is one of its greatest assets. The New Mexico Behavioral Health Purchasing Collaborative has made significant efforts to ensure that consumers and families receive quality behavioral health services from providers trained in cultural and linguistic competency to appropriately meet the needs of New Mexico’s diverse populations, particularly in rural, border, tribal and frontier areas of the state. Efforts include:

- New Mexico was selected as one of six states to conduct a Policy Academy to Eliminate Disparities, which resulted in the establishment of six policy priorities in the Collaborative’s Statewide Plan to Eliminate Disparities, including (1) behavioral health workforce development, (2) recruitment and retention, (3) licensing boards, (4) outreach, (5) organizational, and (6) provider self-assessment;

- The Collaborative co-sponsored six Ferias de Salud (health fairs) across the state involving 24 practicing Mexican traditional healers including traditional healing workshops and more than 2,400 community participants in three communities;
Co-Occurring Disorders

The diagnosis of co-occurring disorder usually refers to the presence of both a severe mental illness and a substance abuse disorder. People with mental illnesses are also prone to develop problems with alcohol and drug use and are often more sensitive to the negative effects of alcohol and drugs. The result is that one of every two individuals with severe mental illness has the additional problem of abuse or dependence related to alcohol or other drugs. During the past year, the Collaborative has worked with local, regional and national experts within the field of behavioral health to focus on increasing, expanding and improving provisions of behavioral health services specifically for those diagnosed with co-occurring disorders.

Treatment is provided through the Intensive Outpatient Program, which targets specific behaviors with individualized behavioral interventions. This is an on-going initiative that has been supported by a competitive grant from SAMHSA for several years, which has focused on increasing agency capacity to assess, identify, and treat co-occurring disorders and on improving protocols, standards and policies related to this issue. Although the funding has supported substantial training and procedural programs at a small number of community behavioral health agencies in a pilot phase, the lessons learned are being applied statewide. Initiatives over the last year include:

- Contracting with University of New Mexico-Department of Psychiatry for the creation of a manual for family practitioners, nurse practitioner, physician assistants and other prescribers on
Significant Initiatives

protocols for safely and therapeutically prescribing psychotropic medications for person who have co-occurring psychiatric and substance use disorders and are still using;

• Training of at least 200 practitioners through the last two Collaborative Behavioral Health conference sessions on co-occurring disorders;

• Creation of an “Integrated Services for Co-Occurring Disorders Intensive Outpatient Program-Implementation Manual” and development of an Intensive Outpatient Program-Adult Fidelity Tool. Co-SIG personnel have used these tools to completed fidelity review with IOP providers from across the state to assist them in developing Continuous Quality Improvement Plans to increase fidelity over time;

• Contracting with the University of New Mexico-Extension for Community Health Outcomes (ECHO) to train Community Health Workers to be able to work closely with prescribers of Suboxone for persons with opioid dependence in order to provide necessary support and adjunction services. In addition, CoSIG will fund a the development of a website designed by Project ECHO that will function as technical and educational resource on opioid addiction and the use of mediation assisted treatment;

• Providing technical support in the development of the Los Lunas Substance Abuse Treatment and Training center;

• The pilot work at The Life Link, Rehoboth McKinley, First Nations, and YDI will continue and is intended to cover the entire statewide network of BHSD providers, eventually more than 30 providers.

Substance Abuse Prevention

New Mexico’s substance abuse prevention initiatives, directed by the Department of Health’s Office of Substance Abuse Prevention and managed by the Statewide Entity, support 42 projects in community-based coalitions and agencies which are located in 33 communities throughout the state, including seven programs that serve Native American tribal residents. Also among these recipients are non-profit community prevention coalitions and agencies, one county government, two colleges, and three school districts. New Mexico’s prevention system and programs have been recognized as a national model by SAMHSA’s Center for Substance Abuse Prevention, and have consistently produced and documented successful outcomes in communities.

Substance Abuse Prevention – Strategic Prevention Framework

Thirteen community-based projects across the state completed their fourth year of a five-year discretionary grant from the Center for Substance Abuse Prevention of SAMHSA. This project aims to reduce and prevent binge drinking, underage drinking, and drinking and driving. It uses a range of community strategies based on the most effective, research-based, public health approaches to these substance abuse problem behaviors – intended to reduce these behaviors across the entire population of each community in the project. These strategies include:

• Utilization of media;

• Coordination with law enforcement agencies to increase the perception of risk of binge and underage drinking and drinking and driving;

• Provision of retailer education; and

• Ensuring compliance with alcohol sales laws; and

• Other community mobilization strategies.
Over 7,000 residents from these communities (that make up over three quarters of the state’s population) completed a standardized survey each of the last two years about the effects of the project. The results showed a decrease in the incidence of binge drinking by approximately a third from 2008 to 2009 -- a reduction in the average number of days of binge drinking from 1.2 to 0.8. The percentage of people in SPF communities who reported binge drinking in the past 30 days showed a statistically significant reduction from 32.2% in 2008 to 17.0% in 2009.

The graph displays statistically significant reductions in SPF communities when residents reported driving under the influence of alcohol, while comparison communities had a statistically significant increase (Figure 1).

**Substance Abuse Prevention -- Access to Tobacco by Minors**

The Synar program is a federally required compliance monitoring process for the rate of illegal retail sales of tobacco to underage youth. Every state in the nation must keep their compliance rate (rate of retailers who refuse sales to underage youth) above 80% or risk losing their Federal Block Grant for both treatment and prevention, which constitute the largest portion of base budget funds for both substance abuse treatment and prevention services in the state. Of 1,195 retailers throughout the state, 254 were checked by prevention providers in every county of the state, using underage youth who ask to purchase cigarettes over the counter to assess whether a retailer would check their ID and sell tobacco products to them or not. This program is complemented by an ongoing education program targeting these same retailers about the law regarding sales and its consequences to retailers. The state’s prevention providers undergo extensive training and are closely monitored by the Department of Health’s Office of Substance Abuse Prevention to ensure high quality implementation of these programs. New Mexico produced an exceptionally low rate of illicit sales of 7.4% in 2009. The previous year’s rate of illegal sales was an even lower 6.3%.
Substance Abuse Prevention -- Direct Services

Community based programs throughout the state use a range of prevention education strategies working with groups of youth and adults to prevent future use of substances of all types. This is accomplished through comprehensive program designs that address a range of risk factors and protective factors. Another substantial number of programs employ youth development strategies with adolescents to create protective factors around school, family, elders, culture, traditional practices, positive peer influences, and caring adults as mentors. These programs are rigorously evaluated every year to improve quality and demonstrate accountability. Over 7,500 participants received direct prevention services during 2009, with positive outcomes documented from the statewide aggregate data.

Services to Older New Mexicans

Sandoval Senior Connection program has been serving an average of 27 clients per month through the services of 24 Peer Counselors.

Sandoval Senior Connection: funded by the Aging and Long Term Services Department, this program provides peer counseling services to older adults, aged 55 and up in Sandoval County, through recruiting, training and supervising volunteer peer counselors who are also older adults. The program also provides aging and mental health education to the older adult population through various Sandoval county Senior Centers and other community-based venues. The program has been serving an average of 27 clients per month through the services of 24 Peer Counselors. The majority of clients served are over 80 years of age.

The Collaborative initiated and approved the formation of an interagency Clinical Multi-Disciplinary Team (MDT), facilitated by the Behavioral Health Director of the Aging and Long-Term Services Department. The purpose of the team is to provide clinical consultation regarding clients with mental health and/or substance abuse problems who have high and complex needs whose behaviors put them at severe risk to themselves or others; may be using services that cross several departments; and whose needs seem to exceed the capacity of our current service system. Standing members of the team are independently licensed clinicians representing the Human Services Department, Department of Health, Department of Corrections, Office of Guardianship, Aging and Long-Term Services Department and the Statewide Entity. The MDT has received 31 referrals since its inception in September 2008; most indicate a severe lack of placements and services in New Mexico for clients with mental illness and behavioral problems that are difficult to manage.
Quality Improvement Initiatives: As a result of the formation of the Quality Improvement Work Group, including representation from a number of Collaborative departments, the FY 2010 Priorities includes a separate Developmental Priority -- appropriate access to services for older consumers with a behavioral health disorder. The QI Work Group will work with the Statewide Entity to establish baseline data from the current Behavioral Health provider sites on the age categories listed for the 2010 Performance Measures of 50-64, 65-74, 75-84 and 85+. This is the first time such information has been available and actively monitored and use for strategic priority determination and longer term service planning.

Total Community Approach

The Total Community Approach (TCA) funds projects within six Local Collaboratives to implement coordinated evidence based substance abuse treatment and prevention programs that are planned by local stakeholders. Priorities and distribution of funding are determined locally. Funding across the six communities is $3 million appropriated by the Legislature during 2008. Some highlights of the supported programs include:

- Implementing a central intake model to target adults with alcohol and substance abuse issues in Las Vegas, with expansion underway into Mora and Guadalupe Counties; evidence based programs supported include the MATRIX model (the Matrix model is one of the best researched, effective programs for providing a comprehensive model of care for intensive treatment for illicit drug addiction), Community Reinforcement Approach (CRA, another highly effective and well researched treatment model), Community Reinforcement Approach and Family Training (a family focused model based on CRA that involves family members in creating client treatment success), and Integrated Dual Disorder Treatment (for substance abuse and mental health disorders); Crisis Intervention Training (CIT) was provided to over one hundred law enforcement officers and first responders; prevention programs include family and parent training using Dare To Be You, an evidence based prevention model program, for families of first offenders, and the Responsible Retailing for Alcohol Program, which provides compliance monitoring and education to retailers; home visiting by promotoras is coordinated with other parenting support and educational programs for at risk families (Local Collaborative 4);

- Implementing multi-systemic therapy (MST) and school-based behavioral health services targeting adolescents and their families with substance use issues in Hobbs, plus training the model in Carlsbad and Roswell; the Adolescent MATRIX model for youth in the Hobbs Alternative Learning Center; the Project Success early intervention education and skills building program for alternative school students in Hobbs; Crisis Intervention Training (CIT), a model program utilizing law enforcement personnel to respond to behavioral health crises, has been provided to law enforcement staff and other first responders in Lea County (Local Collaborative 5);

- Implementing a case management model, “Youth Treatment Care Coordination”, on the Navajo Reservation to prevent and reduce substance abuse for youth (ages 13-24) and their families; Project Northland, an evidence based prevention curriculum, is being utilized in fourteen school sites (Local Collaborative 15);

- Developing partnerships to implement a comprehensive, family-focused continuum of care in Hidalgo County, and specifically...
Significant Initiatives

During the current fiscal year 1,600 individuals received services for methamphetamine use, abuse and addiction through this initiative. Currently there are nine communities and ten agencies in New Mexico receiving these dollars to treat and prevent methamphetamine addiction.

Statewide Methamphetamine Treatment Initiative

The State Legislature funded New Mexico’s Statewide Methamphetamine Treatment Initiative in 2006. It provides a continuum of services from prevention to recovery to stop the growing methamphetamine problem. Approximately $3 million is annually allocated to the communities most affected by the consequences of this drug. In 2007, pilot programs were developed in the northwest, southeast, southwest and central regions of the state. During the current fiscal year 1,600 individuals received services for methamphetamine use, abuse and addiction through this initiative. Currently there are nine communities and ten agencies in New Mexico receiving these dollars to treat and prevent methamphetamine addiction.

Services include:

- Two mobile crises units, one each in the two most populous counties in the state (Bernalillo, Dona Ana);
- Two MA specific prevention projects, one each in the northwest and southwest regions;
- A jail based MA treatment program for women; Two residential treatment programs (one is for women only);
- Six of the providers provide the Matrix Model intensive outpatient service (IOP) in seven of the communities;
- Adult drug courts and local law enforcement agencies collaborate closely with all ten providers.

serving consumers through a broad service spectrum implemented in Adult Drug Court, a MATRIX Treatment Program, and youth leadership programming; and a new Adult Drug Court in Grant County (Local Collaborative 6);
- Implementing mobile individual, family and group treatment protocols, including the MATRIX model, to target adolescents (grades 9-12) and their families in Colfax County; focus on youth referred by law enforcement, Juvenile Probation, or who are identified and referred as high risk by the school district; treatment programs are also provided to adolescents through Drug Court mechanisms (Local Collaborative 8);
- Provided CIT training to over thirty law enforcement personnel in Rio Arriba County; development of a centralized assessment and referral model to utilize in Rio Arriba County; implementation of a standardized assessment protocol (Local Collaborative 1).
Significant Initiatives

**Community-based Corrections Treatment Initiative**

The Department of Corrections provides funding to support individuals in the Community Corrections and Probation and Parole programs. Provided by 27 community treatment agencies, mental health and substance abuse treatment services are offered to individuals classified as high risk or high need, for example sex offenders or drug court clients. An estimated 85% of the probation and parole population have mental health or substance use needs of treatment. Reimbursed primarily through the traditional claims payment system by the Statewide Entity, $3,789,865 supports these services.

**Supportive Housing Initiative**

New Mexico’s Supportive Housing Initiative targets high need, high frequency users of jails, emergency rooms, and other high cost inpatient and outpatient services. Multiple national studies have demonstrated that permanent supportive housing programs can significantly reduce emergency room costs by 34% to 74%; reduce police contact cost by up to 66%; reduce incarceration time and costs by up to 76%; and, reduce shelter and outpatient visits by up to 98%. The Supportive Housing Initiative was funded by Legislative allocations in 2008 and 2009 ($750,000 and $681,000 respectively), and aims to enhance the State’s capacity to provide interim rental housing assistance and supportive services to numerous populations experiencing behavioral health and related issues so that they may successfully enter and complete recovery programs that lead to a stable life. It also aims to increase the available housing stock for behavioral health clients. Through a range of strategies, it has accomplished the following:

- Provided housing pre-development capital to four non-profit developers for the creation of 49 new supported housing units in Santa Fe, Albuquerque, and Las Vegas; and provided additional funding of $90,000 from BHSD to support 1.5 FTE who assisted with these projects;
- Housed 30 chronically homeless individuals each year with severe mental illnesses in Albuquerque, Santa Fe and Silver City (for approximately 18 months), with additional wraparound support services provided, until they are able to live independently and are eligible for Federally funded Section 8 housing;
- Developed and manages a statewide database that integrates information from 21 New Mexico public housing authorities that provide Section 8 Housing Choice Vouchers to disabled individuals; this creates increased access to subsidized housing for persons receiving behavioral health services;
Significant Initiatives

- Provided staff support to the New Mexico Department of Veterans Services to successfully seek and obtain 215 new Veterans Administration for Supportive Housing (VASH) vouchers, which pays for housing for homeless veterans;
- Advocated successfully for a set aside of 46 new special needs supportive housing units, through tax credit incentive points in the 2009 Qualified Action Plan of the New Mexico Mortgage Finance Authority, which will be built by 2011 in Albuquerque, Hobbs, Santa Fe, Belen, Los Lunas, and Farmington; the Collaborative also selected and is training five local Lead Agency coordinators for these developments who will ensure access to and coordination of wraparound and support services by qualified disabled residents of each unit;
- With additional funding from CYFD of $167,000 for its Transitions Program, the Initiative coordinated and provided housing and support services for twenty youth in Albuquerque ages 18 to 21 who are aging out of foster care or from the juvenile justice system.

The Collaborative has approved a service code and definition for traditional Native American services.

Native American Services

The Collaborative has approved a service code and definition for traditional Native American services. The state’s coalition of tribal providers and the Statewide Entity are collaborating to employ this service code with Native American and/or tribal providers to better capture the extent of their traditional activities that operate as behavioral health interventions.

New Mexico’s substance abuse treatment block grant, funds $4.3 million for client services providers throughout the state. This includes five Native American and/or tribal agencies, who receive about 30% of this funding. This past year, additional support was also provided to Navajo Nation’s new 72-bed residential facility located in Shiprock.

Success in Schools

The Success in Schools Committee was convened in 2005 to address the social and emotional needs of students with behavioral health issues. The Committee’s central philosophy is that effective school-based and school-linked behavioral health services improve student academic achievement, school attendance, and safety. The Success in Schools Committee advises the Children and Adolescent Subcommittee of the Behavioral Health Planning Council on issues of student behavioral health and System of Care implementation involving schools. This Committee reports its activities quarterly to the Collaborative and Behavioral Health Planning Council.
This effort is jointly supported and facilitated by the Department of Health (DOH) Office of School and Adolescent Health (OSAH) and Public Education Department School (PED) Family Support Bureau. The Committee’s membership consists of participants from Medicaid, DOH OSAH regional and administrative staff, PED Special Education Department, the Statewide Entity, Parents for Behaviorally Different Children, and staff from school districts statewide – and diverse statewide representation of school personnel, special education and behavioral health providers, and community providers. This year the Committee produced the “Technical Assistance Document for New Mexico Behavioral Health Professionals (A Quick Guide)”, providing guidance to support the coordination of school and behavioral health systems and behavioral health care for students. The information in this guide will be released as smaller technical assistance documents in 2010.

### Sexual Assault Programs

The Coalition of Sexual Assault Programs, Inc., receives slightly less than a million dollars annually to provide a statutorily required medical fund that pays up to $150 for victim medical treatment, and pays for forensic evaluations. The sexual assault medical treatment includes: physical treatment for injuries, ambulance service and emergency room visit. The Coalition also pays the full cost for the forensic medical exam, which collects and documents the factual evidence of injuries and trauma, including any necessary x-rays, pays for an interview of the patient, and provides follow-up testing and physician fee. There were 1,350 individuals served from January through October 2009. The Coalition also provides extensive training to Specialty providers and to the Community Mental Health Center Sexual Assault Coordinators.

Five Specialty Sexual Assault Providers are funded through the Statewide Entity to implement strategies to: prevent sexual assault; reduce the stigma associated with reporting an assault; train advocates; and, to respond to the needs of victims and their families. They provide training to a broad range of providers across the state, law enforcement entities, the judiciary, and to the education system.

### Problem Gambling Initiative

Collaborative agencies, the New Mexico Gambling Committee, and the Statewide Entity have developed prevention and treatment standards for compulsive gambling, and have created a focus on identifying and treating this addiction. The New Mexico Council on Problem Gambling operates a 24-hour, bi-lingual helpline for problem gamblers. Phone-based crisis intervention is linked to referrals for a range of services that are appropriate for each caller based on their location and their needs. During the latest year, 46% of the callers were from Albuquerque, almost three quarters were women, 44% of callers to the hotline were Hispanic, and slightly over half were not married.
Substance Abuse Treatment Outcomes

Client outcomes are successfully being measured among many substance abuse clients. Changes in client status are tracked throughout the year using a statewide protocol - the Addiction Severity Index-Multimedia Version (ASI-MV). Over 115 provider sites across the state are currently loading data to a web-based data center in which outcomes are compared across the state. The use of the ASI-MV has been expanded effective 2010. All agencies serving Medicaid clients who are experiencing substance abuse problems are required to administer the ASI-MV to those clients.

The client outcomes from 2009 in the highest severity groups who received substance abuse treatment were studied. The following positive outcomes were indicated:

- Over 80 percent (80.4%) of the clients with severe alcohol problems reported that they had made significant improvements;
- Sixty-one percent (61%) of the clients with severe drug problems made significant improvements.

The state is achieving its “Governor’s Performance Indicator” performance target in the area of alcohol improvement and continues to work towards its drug performance target in its system improvement efforts. The following graph demonstrates that clients who have made improvements with their alcohol problem are also making notable improvement gains in their medical, employment, legal, family and social and psychology life domains.

Alcohol Change & Other Domain* Change from Initial to Follow-Up Assessment—Statewide
Quality Service Review

Quality Service Review (QSR) is a tool for practice improvement for frontline service providers; and, at the same time, it supports the state’s movement towards building local systems of care for adults and for children. During 2009, the QSR protocols for adults and for children were modified to meet New Mexico’s needs and then were piloted within four Local Collaboratives. QSR uses case review & stakeholder interview methods to assess the child or adult consumer status, caregiver capacities and the core functions of a provider’s practice model. In each of the pilot sites, this included extensive analyses of complex consumer cases to determine where needs were being met and where there were gaps or weaknesses in how services were delivered in a comprehensive fashion to consumers and families. These analyses were “debriefed” at the community level as soon as they were completed and used to develop quality improvement strategies in the local systems of care. QSR connects practice to results and results to frontline working conditions in local sites.

The goal of the QSR project is to create a true improvement plan with action steps that allow each community to determine its own plan to provide better services for consumers and their families. By working with local community members, the process to examine how the local system of care is working becomes clear, and community members learn how to implement these strategies themselves. This creates feedback loops for the provider community to learn where and under what circumstances their practices are strong, where they are weak, and develop strategies to constantly improve their clinical and wraparound practices based on this first hand knowledge gained in their own community.

The QSR project is built on several key concepts – the child or adult client is an active participant in determining their service program and in evaluating its success; services should match the needs of the child, adult, and family, and adapt as circumstances change; services should improve a child’s functioning and well-being while reducing the risk of harm; service systems can learn, change, and improve practices and results. In the Spring and Summer of 2010, all 11 programs who have been initially designated as Core Service Agencies will be trained in Quality Services Review. Onsite reviews will occur and program consultation will be provided to the programs and their local Collaboratives.
Consortium for Behavioral Health Training and Research

The Consortium for Behavioral Health Training and Research (CBHTR) is a virtual institute founded by the New Mexico Behavioral Health Collaborative and the New Mexico Higher Education Department (HED). CBHTR was created to strategically use a partnership of the state’s institutions of higher education to improve the quality of behavioral health care services. The goals are to: (1) improve access to culturally and linguistically competent prevention, early intervention and recovery services; (2) develop behavioral health services research and evaluation capacity that addresses New Mexico’s unique concerns; and (3) close the gap between science and practice through policy guidance and technical assistances to the state’s leadership and practice communities. Over the past year CBHTR has engaged in multiple activities related to workforce development, training, and research, including: overseeing the development of curriculum for the Wraparound Training Institute and Comprehensive Community Support Services; data and evaluation projects related to the Veteran’s and Family Support Service Project, the Total Community Approach, the Child and Adolescent Functional Assessment Scale, and Quality Services Review; training, including the Native American pipeline development; system development including telehealth coordination and Research and Evaluation Network coordination; and numerous grant writing activities.

CBHTR curriculum development activities over the past year included the creation of the Wraparound Training Institute, including a three-tiered training curriculum focused on training providers, youth, and families in the approach, which is a youth and family-centered team-based, individualized treatment planning and care coordination approach. CBHTR also developed a training curriculum for Comprehensive Community Support Services (CCSS), a recovery- and resiliency-oriented system of care-focused, care-management service that is Medicaid reimbursable and is being rolled out statewide. CBHTR data and evaluation efforts include coordination of data collection and dissemination of the Child and Adolescent Functional Assessment Scale (CAFAS), a functional assessment instrument used for service planning, monitoring, and outcome assessment. CBHTR serves as the lead evaluator for the Total Community Approach (TCA) pilot project, a community-driven substance abuse prevention and treatment initiative in six communities; and is the lead evaluator of the Veterans and Family Support Services (VFSS) project. CBHTR has also been involved in the Quality Service Review (QSR) pilot. CBHTR training efforts include the Native American pipeline development project aimed at increasing skills and building the capacity of providers working in tribal communities. CBHTR also engages in significant grant writing activities on behalf of the Collaborative with the goal of securing resources to enhance the current behavioral health system. Two recent successful proposals awarded to the state include the System of Care Grant and the Jail Diversion Grant.
Conclusion and Further Directions

The Behavioral Health Collaborative continues to develop a system of services that will provide comprehensive and effective behavioral health care to New Mexico’s citizens who are suffering from mental illness and substance use disorders, and the multiple consequences to families and communities that result. This on-going work is occurring in a difficult environment. The state’s economy is fragile, and the state budget is burdened by major shortfalls. The Transformation State Incentive Grant from SAMHSA, which has funded many of the staff who work across the Collaborative, comes to an end in September 2010. Medicaid, which supports key service costs, is also facing major shortfalls in funding and may undergo restructuring over the next several years. Nonetheless, the state will continue to study and to create more efficient structures that best support an effective, consumer and family focused behavioral health system that improves outcomes for consumers. It also will work to create more emphasis on preventing and intervening early. Together these efforts will permit more of New Mexico’s citizens to live healthy and productive lives in their communities.