UPDATES:

SUBCOMMITTEE REPORTS:
Written by the Chair, Co-chair or Facilitator of each Subcommittee.
Respective agendas from the November meetings are attached.

NATIVE AMERICAN:
At its meeting on Friday, September 29th, the Native American subcommittee passed the resolution to support the extension through legislation of the grandfathering period as specified in NMSA 61-9A.14.3 for an additional two years to allow more time for CADACs and other eligible applicants interested in becoming LADACs to take advantage of the grandfathering process. The resolution subsequently passed the BHPC on November 20, 2009.

SUBSTANCE ABUSE / ADULT:
At its November 17th meeting, the combined Adult and Substance Abuse Subcommittee (ASASC) voted to support the Resolution of the Native American Subcommittee recommending a bill extending the CADAC to LADAC grandfathering provisions until July 2012. ASASC briefly discussed likely healthcare reform and behavioral health legislation and key points from an independent evaluation of mandated community treatment in New York. ASASC also received updates on the presentations to the interim LHHS of reports on SM 71 (Substance Abuse Policy). Strategic planning on substance abuse policy will continue within a workgroup of the Subcommittee.

MEDICAID:
At the October BHPC meeting, Kim Carter, Chair of the Medicaid subcommittee, presented the 9 overarching principles for Medicaid cost containment that were developed by an ad hoc subcommittee. Local Collaboratives as well as BHPC members were given the opportunity to provide input to the principles. After discussion, the recommendations passed unanimously; the document (Attached) was then sent to CEO Homer.

CHILDREN / ADOLESCENTS:
The Children and Adolescent Subcommittee has continued its information and education efforts with a number of key presentations, some of which have overlapped with other Subcommittees. The two most recent presentations were on Maternal Depression (October) and the first stage of the Substance Abuse Plan (November). In November, the CASC formally endorsed the work of the Maternal Depression Working Group which the BHPC subsequently endorsed as well. It was also resolved that the CASC and the BHPC advocate and encourage the implementation of the recommendations contained within the Maternal Depression Working Group’s October presentation (Attached). The CASC is now aligned with the various workgroups engaged in behavioral health related efforts for children and youth. The workgroups are the Infant Mental Health Workgroup, the Adolescent in Transition Workgroup, the Success in Schools Workgroup, the System of Care Project Steering Committee, and the BHPC Finance Committee. At the November meeting, CASC voting members were identified for each of these workgroups. In addition, CASC members will continue to work with members of other subcommittees on developing the next stages of a substance abuse plan. Two-way communication will take place between workgroups and the CASC, with designated voting members participating in each workgroup and reporting back to the CASC. CASC input will then be taken back to the workgroup. CASC is contemplating the development of “job descriptions” to clarify the process.

AD HOC SUBCOMMITTEES:
FINANCE:
The Finance subcommittee met on Tuesday, 1 December 2009 to review the Budget versus Actual expenses for the BHPC and its Subcommittees.
LOCAL COLLABORATIVE:
The Local Collaborative subcommittee has been meeting regularly over the last few months to plan the BHPC LC Summit which will be held on Monday, December 7th in conjunction with the Collaborative Conference. (Agenda attached)

PEER:
The PEER subcommittee participated in the Consumer Wellness Conference on September 24 and 25, 2009. In addition to having a exhibition table, they also conducted a simple survey regarding Local Collaborative engagement (Survey attached).

BEHAVIORAL HEALTH DAY AT THE LEGISLATURE:
This committee is meeting regularly to organized the Third Annual BH Day at the Legislature, which will be held on Thursday, January 28, 2010. We invite you all to join us in the festivities!

SPECIAL PROJECTS:
STRATEGIC PRIORITIES FY11:
We have begun the process of gathering input from the BHPC and its Subcommittees regarding our recommendations for Strategic Priorities for FY11. As you recall, the priorities for FY10 are: Crisis Response, Housing and Transportation.

COLLABORATIVE CONFERENCE AWARDS:
Members of the Executive Committee of the BHPC met on Friday, November 13th to review and make recommendations to CEO Homer regarding the recipients for the 2009 Awards of Excellence. We had several nominations in each category, as follows: MEDIA - 4, PIONEER PROVIDER - 6, ELECTED OFFICIAL - 4 and UNPAID ADVOCATE - 6 and Collaborative Project - 5..

CMHS IMPLEMENTATION REPORT:
The CMHS subcommittee of the BHPC met again - this time to review the 2009 Implementation Report. Their recommendations were sent to the BHPC for its approval and then forwarded to Secretary Falls for her review.

STATE OF THE COUNCIL:
As we did last year, we will be publishing our State of the Council for the Governor, the Purchasing Collaborative members, and the Legislators in early January 2010.

ANNUAL REPORT:
We are providing you with a copy of the BHPC Annual Report.

ATTACHMENTS:
AGENDAS OF THE OCTOBER BHPC AND THE NOVEMBER SUBCOMMITTEE MEETINGS
CADAC TO LADAC RESOLUTION
SM 71 (SUBSTANCE ABUSE POLICY)
OVERARCHING PRINCIPLES FOR MEDICAID COST CONTAINMENT
MATERNAL DEPRESSION WORKING GROUP RECOMMENDATIONS
SUMMIT AGENDA
CONSUMER ENGAGEMENT SURVEY
CMHS IMPLEMENTATION REPORT
ANNUAL REPORT (SEPARATE DOCUMENT)
REPORTS FROM LC 7 AND LC15
Behavioral Health Planning Council Agenda  
Wednesday, October 21, 2009  
Host: 4330 Cutler Ave, NE Albuquerque  
2732 North Wilshire Blvd., Roswell: 2121 Summit Ct, Las Cruces, 37 Plaza la Prensa, Santa Fe

9:00 Welcome  
9:05 Information & Follow-up  
Meeting of Rural State Planning Councils  
Santiago Rodriguez & Lisa Trujillo

9:20 Announcements and Updates  
LC 14, 16, 17, 18  
Letty Rutledge

New subcommittee Chairs  
Collaborative Conference / Awards of Excellence  
BH Day - Thursday, January 28, 2010  
BHPC Meeting - Wednesday, January 27, 2010  
Fall Birthdays[Sept: Lisa Trujillo, Gail Falconer, Jesse Chavez,; Oct: Judy Bonnell; Dec. Michele Franowsky]  

Upcoming Electronic Action Items:  
Substance Abuse Strategic Plan (SM 71)  
CMHS Implementation Plan  
Karen Meador  
Susie Kimble

9:35 LC Fiscal Guidebook  
Suzanne Pearlman

10:10 Introductions  
Chris Wendel

10:20 Medication Fund  
Shawn Quinn, OptumHealth

10:40 Our State Agency Partner  
Public Defender’s Office  
Michele Franowsky

11:00 Action Items (Pending Quorum)  
Approval of August Minutes  
Chris Wendel

Approval of October Agenda  
Medicaid Cost Containment Principles  
Kim Carter, HSD

By-Laws Amendment Proposal  
Frank Adakai

12:00 Lunch

12:30 Networking  
Local Collaborative Updates  
BHPC or LC Member (only 1 per LC)  
Subcommittee Reports:  
Chair/Vice Chair of Subcommittees  
Ad Hoc Subcommittees  
BHPC Member or Representative  
Consumer Survey Results  
Marcia Hawthorne

1:45 Statewide Entity Implementation Update  
Dr. Sandy Forquer, CEO OHNM  
Purchasing Collaborative Update  
Bill Belzner, HSD  
Linda Roebuck Homer, CEO, Collaborative

3:00 Public Comment

3:15 Adjourn
BEHAVIORAL HEALTH PLANNING COUNCIL
ADULT and SUBSTANCE ABUSE SUBCOMMITTEES

Tuesday, November 17, 2009, 11 am to 1 pm

SUBCOMMITTEES AGENDA

11:00 Welcome, Review and Approval of Minutes and Agenda
Announcements

11:15 CADAC to LADAC grandfathering extension: Resolution of Native American
Subcommittee [For approval] Christina Stick

11:30 Other Expected Legislation Karen Meador

11:50 Update and Discussion: Substance Abuse Subcommittee workgroup – Senate Memorial
71 Policy Recommendations (Prevention, Treatment, Law Enforcement, Harm
Reduction) Michael Coop

12:40 Update and Discussion: Workgroup – Senate Memorial 9: Medication Assisted
Treatment for Opiate Addiction Olin Dodson

1:00 Adjourn
Children and Adolescent Subcommittee
Behavioral Health Planning Council
November 17, 2009
Draft Agenda

2:00  CASC Welcome and Introductions

2:15  Approval of Agenda and October Minutes

2:25  Maternal Depression – Vote to Endorse

2:40  Selection of Members to Work Groups

3:10  System of Care Grant Award – Overview and Role of the CASC

3:40  Other roles which could be filled by CASC

  •  Communications
  •  Planning state and national events like recovery month
  •  Point support for LC CASC reps

4:00  Budget Cuts

4:15  Open Space

4:30  Adjourn
The Native American Subcommittee of the Behavioral Health Planning Council
37 Plaza La Prensa
Santa Fe, NM
November 20, 2009

Draft Agenda

9:00 am Call to Order, Welcome, Invocation, and Introductions—Frank Adakai, Co-Chair
9:15 am Approval of Agenda and Minutes (Action Item)—Frank Adakai
9:25 am Announcements from the BHPC Chair—Chris Wendell

Previous Business

9:30 am FY 10 Work Plan—Revise and Approve (Action Item)—Christina Stick, IAD
10:15 am BHPC By-Laws Amendment Discussion—Frank Adakai
11:15 am Follow-up to Maternal Depression Presentation Discussion

New Business

11:30 am Announcements and Updates
  • Announcements
    o Stepping Closer to National Healthcare Reform—Impacts to Indian Healthcare—December 2-3, 2009
    o BH Collaborative Summit—December 7-11, 2009
    o BH Collaborative Sanctions Optum Health
  • Updates from other statutory subcommittees; Kim Horan; Optum Health Region 6; State Tribal Liaisons; LC 14—LC 18 and any other programs present

12:00 pm Closing Prayer
RESOLUTION OF THE NATIVE AMERICAN SUBCOMMITTEE OF THE BEHAVIORAL HEALTH PLANNING COUNCIL

WHEREAS, Certified Alcohol and Drug Abuse Counselors (“CADACs”) and Licensed Alcohol and Drug Abuse Counselors (“LADACs”) provide much needed alcohol and substance abuse counseling in rural and tribal communities.

WHEREAS, tribal and rural communities have a larger proportion of CADACs as service providers in their communities, yet only LADACs are able to bill for substance abuse counseling services under Medicaid in New Mexico.

WHEREAS, the 2007 House Bill 731, Counseling and Therapy Licensure Requirements, passed unanimously through the State Legislature to allow experienced and qualified CADAC’s to be grandfathered, for a specified time period, into the state system as LADACs in order to increase access to substance abuse counseling services through Medicaid in tribal and rural communities.

WHEREAS, the grandfathering period ends July 1, 2010.

WHEREAS, fewer than expected CADACs and other practitioners from rural and tribal communities have taken advantage of the grandfathering clause within the time period specified in statute due to limitations in completing the education and clinical supervision requirements needed to be grandfathered.

WHEREAS, tribal and rural communities still struggle to access behavioral health services, and as of September 2009, fewer than twenty-five successful applicants have been grandfathered to LADACs through this system.

WHEREAS, the New Mexico Credentialing Board for Behavioral Health Professionals (“NMCBBHP”), as of September 2009, has over forty pending applications and needs additional time to provide necessary information sessions and test preparatory training. Moreover, the NMCBBHP and other credentialing organizations need additional time and resources to provide adequate outreach to rural and frontier areas of New Mexico.

THEREFORE, be it resolved that the Native American Subcommittee of the New Mexico Behavioral Health Planning Council supports the extension through legislation of the grandfathering period as specified in NMSA 61-9A.14.3 for an additional two years to allow more time for CADACs and other eligible applicants interested in becoming LADACs to take advantage of the grandfathering process.

BE IT FURTHER RESOLVED, that the Native American Subcommittee urges the New Mexico Behavioral Health Planning Council to pass a similar resolution in support of the extension of the grandfathering period for CADACs to LADACs.

Passed 23 to 2 by the Subcommittee on September, 29, 2009.
Passed by the BHPC Adult and Substance Abuse Subcommittee on November 17, 2009.
Passed by the Behavioral Health Planning Council (BHPC) on November 20, 2009.
Introduction

Senate Memorial 71 was referred by the Behavioral Health Collaborative (and the Health Policy Commission as one of its member agencies) to the Substance Abuse Subcommittee of the Behavioral Health Planning Council. As the volunteer advisory body for behavioral health issues to the Collaborative, the Planning Council consists of at least 51% consumers and family members and has broad representation from communities throughout the state. Most of the resulting recommendations are directed to the Collaborative and its member agencies, with one specific legislative recommendation. The present report is submitted as a response to issues that have been considered by the Subcommittee to date. The Subcommittee will continue to study and make recommendations about additional substance abuse issues for the remainder of the current fiscal year as part of a larger substance abuse strategic planning project.

The Substance Abuse Subcommittee formed a workgroup of many individuals to complete this report, and heard presentations and testimony about a range of issues. In addition to volunteer consumers, family members and advocates, representatives from the Human Services Department, Department of Health, Children Youth and Families Department, Corrections Department, Transportation Department, Department of Public Safety, the Health Policy Commission, and the Drug Policy Alliance participated. This workgroup met ten times between July and October. Data were presented by the Epidemiology and Response Division of the Department of Health as follows: comprehensive findings of the New Mexico Youth Risk and Resiliency Survey 2007, Drug Related Trends in New Mexico (including overdose data), and the Burden of Alcohol in New Mexico. Data were also presented by staff of the Harm Reduction Programs of the Department of Health, and by an epidemiologist of the Corrections Department on relevant data on overdose prevention programming and facility based treatment programming respectively. The workgroup consulted with the Sponsor of the Memorial to identify issues of concern that lead to its introduction. Some of those issues have been addressed within this report. The remaining issues will be addressed in further work by the Subcommittee, which will provide on-going reports and recommendations to the Collaborative and to the Sponsor.

Recommendations included in this document represent those about which consensus was reached by the workgroup. Consensus could not be reached on some issues, and other issues came up but could not be sufficiently studied and understood during the time period. These recommendations were approved by vote of the full Substance Abuse Subcommittee, and of the full Behavioral Health Planning Council. Some of the policy recommendations are long term in nature. Other recommendations clearly require funding or other resources that are just not available in the current economic climate. Nonetheless, dialogue and prioritization of these issues can occur so that long-term plans can be made to improve the system as resources permit.
This report covers four areas suggested by the Memorial: Prevention, Treatment, Harm Reduction, and Law Enforcement and Corrections.

The Enormity of New Mexico’s Substance Abuse Problem

Substance abuse is a major problem in New Mexico. New Mexico has the highest rate of early initiation of substance use, before the age of 13, in the nation. It also has the second highest rate of both “past 30 day” adolescent marijuana use and “past 30 day” adolescent cocaine use (Green et al, 2008). New Mexico has the second highest rate of drug-induced deaths in the nation. Its rates of illicit drug overdose deaths and prescription drug overdose deaths are roughly equivalent (Shah, 2009). New Mexico’s total alcohol-related death rate has ranked first, second, or third in the nation for each of the past 24 years, and has been first since 1997 (Roeber, 2009). Even with the substantial reductions in DWI fatalities of recent years, the total alcohol-related mortality rate is still the worst in the nation. Substance abuse and its consequences have major negative impacts on the lives of New Mexicans. The enormity of New Mexico's substance abuse problem calls for strengthening of programming in every area.

Prevention

Comprehensive, effective substance abuse prevention efforts are needed in order to decrease the number of individuals who abuse and become addicted to substances in the future, and to decrease new criminal behavior that is related to substance abuse. New Mexico’s prevention infrastructure that is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of Substance Abuse Prevention (OSAP) of the Department of Health, has funded and supported numerous effective prevention programs, strategies, and practices in many communities of the state. Its planning and implementation of the Strategic Prevention Framework has been replicated by many states, and that program has produced quantified reductions in binge drinking and related high-risk behaviors. Yet it has much work to do to broaden the impact on reducing substance abuse in New Mexico’s communities and to apply skills and evidence of what works to more communities of the state. Additional prevention efforts are funded through other state agencies.

Issue: Lack of Coordination of Prevention System and Services

Substance abuse and related prevention (and early intervention) programs and policy development at the state agency level are spread across several agencies, and often work in isolation from each other. Those programs are housed in a variety of agencies – Department of Health (substance abuse, tobacco use), Department of Finance and Administration (DWI and mentoring), Department of Transportation (traffic safety DWI), Children Youth and Families Department (underage drinking, probation and parole, child welfare), and Public Education Department (drug prevention). Although all those agencies are members of the Collaborative, only three funding streams go through the Statewide Entity and are overseen by the Collaborative – those from the Office of Substance Abuse Prevention (DOH), the Total Community Approach (TCA) prevention programs and methamphetamine prevention programs that fall under the Human Services Department, each of these has different quality and outcome expectations. The cumulative impact of the state’s prevention system – when contrasted with the urgent need to prevent use and reduce high risk behaviors such as binge drinking -- could be more
effective and positive if all of these programs were coordinated in a meaningful way, accountability was consistent, a strategic planning process integrated these efforts, and target groups, quality of strategies, and outcomes of the multiple funding streams were complimentary. As an example of one successfully coordination initiative, efforts of the DWI Czar and the DWI Leadership Team are an excellent example of how an integrated and collaborative strategic plan has addressed a single but multi-faceted issue.

**Policy Recommendation to The Collaborative and Member Agencies:** Develop a single point of oversight and coordination that will bring all substance abuse prevention programs together to better integrate, coordinate, and plan in a comprehensive manner, demonstrate accountability, and equitably distribute prevention resources across New Mexico’s communities.

**Policy Recommendation to The Collaborative and Member Agencies:** Develop standards and accountability expectations for TCA and methamphetamine prevention programs that are consistent with those programs funded by the Office of Substance Abuse Prevention (OSAP), and a vehicle for oversight is consistent across all three programs. These would include:
- Prevention provider standards.
- Workforce competency standards.
- Utilization of evidence-based approaches.
- Data driven planning processes, particularly the Strategic Prevention Framework model.
- Evaluation methodologies of meaningful outcomes.

**Issue: Expanded Professionalization of the Prevention Workforce**

In order to effectively prevent and reduce future substance abuse problems, New Mexico must have the most qualified prevention workforce possible. The state currently has 64 Certified Prevention Specialists and 10 Senior Certified Prevention Specialists. The goal should be to have everyone that is implementing substance abuse prevention programs in New Mexico be certified so that only the highest quality program planning and implementation occurs – the stakes are much too high to have anything less.

**Policy Recommendation to The Collaborative and Member Agencies:** Require credentialing of staff providing prevention services funded by the state (with a two year period for staff to gain those credentials when they are not already in place). Training must include Prevention Generalist Training, Prevention Policy, and Prevention Ethics.

**Issue: New Mexico’s Alcohol Related Consequences from Binge and Excessive Drinking**

Underage and excessive adult alcohol consumption and related negative public health consequences are among New Mexico’s worst problems. By many measures, New Mexico’s alcohol-related problems are among the worst in the nation. For the past fifteen years, New Mexico’s death rate from alcohol-related chronic diseases, including cirrhosis, has consistently been first or second in the nation, and 1.5 to 2 times the national rate. New Mexico’s death rate from alcohol-related injury has also consistently been among the worst (first, second, or third) in the nation, ranging from 1.4 to 1.8 times the national rate (NMDOH, 2009). New Mexico’s rates of alcohol dependence and abuse are consistently among the highest in the nation. In 2007, based on the Youth Risk and Resiliency Survey, New Mexico had the highest rate in the nation of high school students reporting drinking before age 13, with almost a third (31%) of New Mexico students reporting this behavior (Green et al, 2008). Given that people who report drinking before age 15 are five times as likely as later drinkers to report alcohol dependence or abuse as adults, these results suggest the importance of preventing underage
drinking in New Mexico (SAMHSA, 2004). Finally, a recent estimate of alcohol-related costs in New Mexico estimated the total cost of alcohol-related problems in New Mexico in 2006 to be $2.5 billion, with the majority of these costs resulting from lost productivity due to alcohol-related premature death and disability (Roeber, 2009). Given this tremendous burden, prevention of excessive drinking – both under age drinking and binge and chronic heavy drinking by adults – is of critical importance to New Mexico. Binge drinking (drinking five or more drinks on an occasion for men, four or more drinks on an occasion for women) is the most prevalent form of excessive drinking in New Mexico (Woerle et al, 2007). Binge drinking is strongly associated with a host of negative outcomes, including alcohol-related injury and death.

Policy Recommendation to The Collaborative and Member Agencies and DWI Czar: Maintain and enhance a strong evidence based comprehensive strategy to prevent binge and excessive drinking, as the primary precursor of most of New Mexico’s alcohol related consequences, including DWI fatalities, suicides, murders, chronic liver disease, fatal falls, and domestic violence.

Policy Recommendation to The Collaborative and Member Agencies: Set aside a minimum of 20% of all discretionary substance abuse funding for substance abuse prevention, in alignment with the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

Issue: Need for Strong Prevention Messages and Programming to Students
Most New Mexico students receive few effective substance abuse prevention messages or programs during their high school years. A Health Education class that is taken by all high school students can provide this and other effective health messages, skills, and information that support a life-long healthy lifestyle. This can reduce the frequency of early health problems and improve long-term mortality rates.

Policy Recommendation to The Collaborative and Member Agencies: Require Health Education with a strong substance abuse prevention component as a graduation requirement.

Issue: Need for a strong community-based, data-driven and accountable prevention planning process
The Strategic Prevention Framework was introduced to New Mexico as part of a SAMHSA grant to the Office of Substance Abuse Prevention of the New Mexico Department of Heath five years ago. It has been successfully used in almost every community of the state since that time, and has now been adopted by the Office of School and Adolescent Health to plan and implement strategies within schools. A simple but rigorous method, it involves establishing clear priorities of focus based on data about the community, and a strong data-driven process to assess causes of the behaviors, target strategies, build capacity, create a strong community plan, and implement and monitor programming with strong accountability.

Policy Recommendation to The Collaborative and Member Agencies: Use Strategic Prevention Framework process to guide prevention planning and implementation initiatives.

Issues: Early Initiation of Substance Use, and Substance Use on Campus
New Mexico has the highest rate of early initiation -- use of substances before the age of 13 -- and the highest rate of self-reported substance use on the school campuses of any state in the nation (New Mexico Youth Risk and Resiliency Survey, 2007).

Policy Recommendation to The Collaborative and Member Agencies: Establish procedures in all agencies that work with children to ensure appropriate screening to identify early use and then make an
appropriate referral to qualified early intervention personnel to address the problem behaviors. Programs that work with families of young children should include components that help families reduce the likelihood of early initiation. Schools should strengthen strategies to prevent use, and create comprehensive safety and wellness plans and interventions that reduce the likelihood of use on campus.

**Issue: Lack of a common framework to talk about behavioral health services and populations**

Currently there is often confusion about what is meant when prevention or intervention is discussed. Substance abuse prevention programming is often confused with relapse prevention strategies. Target populations are often defined by the service they are provided. In an attempt to allow for a dialogue that utilizes the same definitions and creates a common understanding, The Institute of Medicine published a framework in 1993 that is used nationally to categorize behavioral health services by understanding the populations at issue. This framework describes “Prevention”, “Treatment”, and “Maintenance”; the categories represent segments of the population either without a diagnosis, following a diagnosis, and those in long-term programs or in a life-long recovery process.

**Policy Recommendation to The Collaborative and Member Agencies:** Utilize the Institute of Medicine (IOM) framework to describe populations receiving services within a system of care that includes prevention.

**Treatment**

New Mexico’s treatment programs are overseen by the Behavioral Health Collaborative and member agencies. Within the structure of the Collaborative, services appear to be better integrated than before this consolidation within a behavioral health framework that recognizes co-occurring mental health disorders – approximately 40% of all adult behavioral health customers were diagnosed with a substance use disorder in the most recently completed fiscal year. The Collaborative and the more recently received Transformation State Incentive Grant have provided a vision of a comprehensive system, staffing and the opportunity to create a recovery-oriented model of service delivery that can grow more robust over time within the community-based system of care.

**Issue: Infusion of Best or Evidence-Based Practices**

While many best practices are already supported by the Collaborative and its member agencies, further use of those and other best practices can lead to improved substance use treatment services in multiple settings. Evidence-based practice(s) (EBPs) generally refers to approaches that are validated by some form of documented scientific evidence. Different authorities establish criteria for categorizing strength and quality of evidence. Evidence often is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence can be considered valid if all parties agree, as long as they are clearly documented and understood. Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence. Best practices are often more policy or procedure oriented, and generally are not comprehensive program designs. James O. Prochaska, Ph.D. and Carlo C. DiClemente, Ph.D. did an empirical analysis of self-changers compared to smokers taking professional treatments. The participants were found to be using different processes at different times of their challenges with smoking. It was during this research that they noted the six stages of change (the phases people go through) individuals used to change their troubled behavior: pre-contemplation, contemplation,
preparation or determination, action, maintenance, and termination. This approach was rapidly applied
to other substance use issues, and has been embraced in New Mexico by some though is not
universally utilized. Early intervention, treatment and recovery have shown better outcomes when an
individual’s stage of change is integrated into a clinical approach. This recommendation includes that
this is a standard approach to conducting assessments of clients’ commitment to treatment and
establishing the proper approach to use with the consumer. This and some other best and evidence-
based practices are recommended here.

Policy Recommendation to The Collaborative and Member Agencies: Continue development of
treatment and quality standards that assure uniform effective care is provided throughout the state.
- Adopt the Stages of Change model so that its use is expanded throughout the state within all
treatment agencies, and integrate it into Substance Use Assessments so that appropriate treatment
protocols are identified to match the level of consumer readiness for treatment.
- Ensure statewide utilization of Evidence-Based Practices, treatment service standards, quality
improvement and assurance measures, and other appropriate indicators of quality within substance
abuse provider agencies, including inpatient facilities, regardless of funding source.
- Monitor the use and fidelity of evidence-based practices, programs and strategies.
- Utilize standardized screening and assessment tools to determine need, diagnosis, etc.
- Utilize the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model to screen and
provide brief interventions for high-risk alcohol consumption.
- Ensure the utilization of treatment approaches that are strengths based, recovery focused, and
culturally competent, and include gender specific services, trauma informed care, and services that
recognize and accommodate the issues of multi-generational use.

Policy Recommendation to The Collaborative and Member Agencies: Move toward a statewide
system that can provide treatment on demand no matter where client engages with system – No Wrong
Door.

Issue: Treat maternal substance abuse, depression, and other behavioral health issues
Maternal behavioral health issues, especially depression and substance abuse, create great risk for a
lack of maternal-infant bonding and attachment, childhood developmental problems, learning
difficulties, and eventually adolescent substance abuse and poor academic achievement.

Policy Recommendation to The Collaborative and Member Agencies: Explore the feasibility of
implementing appropriate Medicaid billing codes to allow for screening for behavioral health issues
during pregnancy and post partum.
- Explore an extension of the Medicaid coverage period for mental health and substance abuse
services for pregnant and post partum women from 60 days to one year.

Policy Recommendation to The Collaborative and Member Agencies: Develop ways to increase
awareness for consumers, community stakeholders, and to better educate obstetricians, pediatric care
specialists, and primary care practitioners to correctly identify the presence of fetal alcohol syndrome,
fetal alcohol effects, and other drug use, and treat the pregnant mother and then the newborn infant
immediately.

Issue: Lack of broad availability of Medication-Assisted Treatment
Medication-Assisted Treatment (MAT) is pharmacotherapy relating to substance misuse. It combines
pharmacological intervention (use of medications) with counseling and behavioral therapies. This
provides the consumer with a comprehensive approach in the treatment of substance misuse disorders. MAT is clinically driven and focuses on the consumer as an individual and care is provided as such. Effective MAT for alcohol dependence has been shown with the FDA approved medications Naltrexone (ReVia®, Depade®), Naltrexone for Extended-Release Injectable Suspension (VIVITROL®), Disulfiram (Antabuse®) and Acamprosate Calcium (Campral®). Effective MAT for opiate dependence has been shown with the FDA approved medications methadone and buprenorphine (Suboxone, Subutex). When MAT is part of a comprehensive treatment program, results have shown to improve multiple outcomes. MAT is utilized by some providers in New Mexico, but availability and access is limited due to lack of funding, among other reasons.  

**Policy Recommendation to The Collaborative and Member Agencies:** Develop and implement a plan to expand and improve access to medication-assisted treatment, including through public health offices, drug court treatment programs, and for youth in appropriate settings.

**Policy Recommendation to The Collaborative and Member Agencies:** Seek opportunities to expand the use of traditional healing practices that have been proven to be effective in supporting recovery.

**Issue: Integrate and more effectively link School Based Health Centers with the larger Behavioral Health System**

School Based Health Centers can play a much larger role in providing screening, intervention, and brief treatment episodes to youth in need of substance abuse (and mental health services) in New Mexico, and at a much lower cost than the community mental health system. Currently many of those youth, who do not have a diagnosis, receive little or no treatment; a subset of those youth use at a very high risk level and ultimately enter the community-based behavioral health system, whether as youth or as adults. Schools can play an important role in this continuum, intervening while students are still in school. In New Mexico’s current School Based Health Center network, where services are provided on mostly a part time basis, last year 43,713 visits by students occurred; of those, 15,409, or 22%, were behavioral health visits. A clear need exists for a stronger behavioral health component

**Policy Recommendation to The Collaborative and Member Agencies:** Recognize as a core component and integrate the network of School Based Health Centers (SBHC) into the state’s behavioral healthcare system and managed care provider network.

- Ensure that all School Based Health Center staff are trained in the Screening, Brief Intervention and Referral to Treatment (SBIRT) model and ensure that they use all of the most appropriate standardized screening and assessment instruments for adolescents.

**Issue: No Data on Substance Abusing Youth in Juvenile Justice and Child Welfare System**

While we do not have sufficient research on this issue it is clear that juvenile justice system involved youth are experimenting with drugs and alcohol at younger and younger ages, as are many of those in the child welfare system. For the incarcerated substance abusers, many are poly-substance dependent and were given their first drink of alcohol or marijuana cigarette between 6 and 12 years of age. One of the shortfalls of the available data is that it is collected only for youth who are attending school. Many youth entering the juvenile justice system have very sparse school records and are not be accounted for in the YRRS survey data. These are often the individuals who end up with the most serious drug and alcohol problems.

**Policy Recommendation to The Collaborative and Member Agencies:** Conduct research with juvenile justice involved youth using substances to determine most appropriate age for intervention.
Issue: Lack of Full Adolescent Continuum in Some New Mexico Communities
The majority of children and families involved in the Protective Services, Youth and Family Services, and Juvenile Justice Services systems have identified issues regarding the use, abuse and dependence on alcohol or other substances. In FY09 CYFD served 16,808 juvenile justice-involved youth and they accounted for a total of 23,915 referrals. Of these, 5,213 youth had 6,284 referrals for substance abuse related offenses. Statewide, there are significant gaps in the availability of a full spectrum of substance abuse treatment services for youth. Services oftentimes rely upon substance abuse treatment services at either end of the continuum of care, either outpatient or residential treatment. A full continuum of services, to include early intervention, outpatient, intensive outpatient and residential treatment would allow for youth to enter treatment at the appropriate level of care, versus reliance only on the level of care currently available. Intensive wraparound services with youth and their families prevent out-of-home placement and ensure delivery and receipt of behavioral health services from a recovery-oriented and strengths-based perspective in accordance with needs identified through a diagnostic assessment.

Policy Recommendations to The Collaborative and Member Agencies:
- Ensure that a full continuum of substance abuse services for youth incorporating a wraparound approach to care is available in each region of the state, to include early intervention and outpatient, intensive outpatient, and, where needed, residential treatment.
- Increase partnerships with local child protective services and substance abuse services, to include screening, diagnosis and treatment, which address substance abuse-related factors contributing to risk of out-of-home placement and abuse/neglect.

Issue: Inadequate Transition Services for Older Youth
Successful transition of youth with substance abuse needs, especially those involved in the child welfare or juvenile justice systems, is essential in promoting both recovery and resiliency. Annually, approximately 300 youth transition from either juvenile correctional facilities or age out of foster care within the Children, Youth and Families Department (CYFD). A lack of consistent coordination between multiple systems as well as insufficient training for staff working with youth and young adults and service funding has resulted in service disruptions during periods of transition. Within New Mexico there is a significant reduction in behavioral health service use as youth enter adulthood: approximately 45% of those receiving services at age 17 are no longer receiving services at age 18. It is imperative that the substance abuse service array is adequate and provides services that are age and developmentally appropriate to meet the needs of youth transitioning from state custody to the community, youth transitioning to the adult system, or those youth involved in both of these areas of significant transition.

Policy Recommendation to The Collaborative and Member Agencies: Develop and implement substance abuse services statewide for youth transitioning from the children’s behavioral health system to the adult behavioral health system that are age and developmentally appropriate.

Issue: Enhanced Practices for Female Youth
Female youth with substance abuse needs benefit from a comprehensive approach to care to include life skills, trauma issues, relationship issues, parenting, and physical health issues. Gender-specific programming supports the development of a safe and nurturing treatment environment, critical for successful participation in treatment and the recovery process. Many female youth with substance abuse needs, particularly those also involved with the child welfare and juvenile justice systems, also
have a history of sexual or physical abuse or other trauma; indicating the need for treatment based upon a trauma-informed approach to care.

Policy Recommendation to The Collaborative and Member Agencies: Expand gender-specific, trauma-informed substance abuse treatment services for female youth that include life skills, trauma issues, relationship issues, parenting, and physical health issues.

Harm Reduction

The history of high rates of drug use and addiction as well as unintentional drug overdose death in New Mexico have prompted numerous strategies, programs, services, and policies to help save lives in our state. For over a decade, New Mexico state officials, Department of Health staff, legislators, and community providers have embraced a harm reduction approach in addition to traditional substance abuse treatment, prevention, and law enforcement measures to address drug use and addiction. Harm reduction does not aim to replace treatment, but rather to save lives and improve health status of illicit drug users. According to the New Mexico Department of Health, “The Harm Reduction Program works to reduce drug-related harm while enhancing individual, family, and community wellness, primarily through the provision of linguistically appropriate and culturally competent services to injection drug users.”

In 1998, New Mexico passed the Harm Reduction Act which created the first statewide syringe exchange program in the nation. The law allowed for the establishment of state-run syringe exchange programs that not only ensure injection drug users receive clean needles and equipment to prevent the spread of HIV/AIDS, hepatitis C, and other blood-borne illnesses, but also that participants interact with medical staff and receive information on detoxification and rehabilitation services. Last year alone, approximately 3,000,000 syringes were exchanged through our programs saving countless lives and money.

In addition to the Harm Reduction Act, New Mexico developed a comprehensive overdose prevention program that is now seen as a model for other states. For years, New Mexico has led the nation with the highest overdose death rates from heroin. While overdose deaths from heroin remain a cause of concern, the emerging problem in New Mexico and across the country is the misuse of otherwise legal prescription drugs. A recent report from the New Mexico Department of Health reported a 250% increase in overdose deaths since 2003 caused by a combination of illicit drugs and prescription pain medication. The 2007 New Mexico Youth Risk and Resiliency Survey showed that prescription pain pills are the drug of choice for many teens (11.7%, fourth after alcohol 27%, marijuana 25%, and cigarettes 24%). Programs and policies to address these high rates of drug-related overdose include statewide reporting systems for drug overdose, state-mandated syringe exchange programs, distribution of naloxone to those at potential risk of opioid overdose, and the 911 Good Samaritan policy.

Policy Recommendation to The Collaborative and Member Agencies: Ensure harm reduction education is provided in all service sectors.

- Develop policy-making processes that include harm reduction strategies within a comprehensive approach, and educate all relevant state, city and county agencies and community stakeholders about the reasons for these strategies.
**Issue: Syringe Exchange program effectiveness**
Approximately 3,000 individuals enroll annually in the syringe exchange program operated by New Mexico’s Department of Health, reducing the risk of spreading infectious diseases.

**Policy Recommendation to The Collaborative and Member Agencies:** Document and annually publish data about the effectiveness of New Mexico’s syringe exchange program in reducing the spread of blood born infectious diseases and establish statewide estimates of the costs and benefits of expanded statewide utilization.

**Issue: Overdose Prevention through utilization of Narcan**
New Mexico’s Department of Health operates an overdose prevention program that utilizes Narcan to reverse the effects of an overdose and likely save a life each time it is utilized. The drug has no other effects. DOH reports that 722 overdose referrals using Narcan were documented from January 1 to September 30, 2009, clearly a major public health achievement in saving lives in New Mexico.

**Policy Recommendation to The Collaborative and Member Agencies:** Document and annually publish data about the effectiveness of New Mexico’s Narcan program in reducing the rate of fatal opiate-related overdoses, establish the projected costs and benefits of expanded statewide utilization, and create and implement a plan to broaden the use of this practice into all areas of the state.

**Policy Recommendation to The Collaborative and Member Agencies and the New Mexico Supreme Court:** Develop a standardized training program for judges and criminal justice officials, in collaboration with the Administrative Office of the Courts (AOC), to create a consistent understanding of strengths and weaknesses of various behavioral health treatment services, when these may be clinically appropriate, the needs of people with mental health and substance abuse issues within the court setting, and New Mexico’s harm reduction statutes.

**Law Enforcement and Corrections**
Law enforcement agencies continue to focus considerable efforts on reducing the flow of illegal drugs into New Mexico communities by disrupting drug trafficking organizations and arresting drug traffickers; DWI enforcement, combined with media messages, has dramatically reduced the number of DWI fatalities in New Mexico; and graduates of Therapeutic Communities have achieved a recidivism rate that is half that of other parolees of the prison system.

**Issue: Adolescent treatment services not always available within Juvenile Detention Facilities**
Adolescents in juvenile justice detention facilities do not have universal access to screening, assessment and treatment services that might address some of the contributing risk factors. Providing this range of treatment services in a comprehensive manner can improve a range of youth outcomes.

**Policy Recommendation to The Collaborative and Member Agencies:** Ensure to the maximum extent possible that substance use and related behavioral health screening, assessment and treatment is available when indicated for all adolescents in juvenile detention facilities.

**Issue: Enhance Effects of Therapeutic Communities (TCs)**
Therapeutic Communities provide a relatively long treatment episode (ten months) to inmates who elect to participate. A recent study by the Corrections Department found that the recidivism rate of parolees who successfully graduated from a TC was approximately half that of other parolees of the
prison system. Strategies that can capitalize upon that by connecting graduates of TCs with on-going community support for their recovery will only improve that result.

**Policy Recommendation to The Collaborative and Member Agencies:** Therapeutic Communities (TCs) within the prison system are successful in reducing recidivism rates and lowering costs to our state.
- Improve access for parolees who graduated from TCs to on-going recovery support in the community-based setting, including 12-Step programs.
- Prioritize jobs for successful TC graduates who have returned to the community to help them maintain long-term successful recovery efforts.
- Utilize successful TC graduates in recovery as certified peer support specialists.

**Policy Recommendation to The Collaborative and Member Agencies:** Support the expansion of Drug Court programs, and connect all graduates with the community behavioral health system to sustain recovery.
- Ensure access to medication-assisted treatment within the drug court model.
- Continue the expansion of drug courts for youth.

**Policy Recommendation to The Collaborative and Member Agencies:** Provide medication-assisted treatment during incarceration and pre-release for those who need it.

**Issue: Sustain the Gains of Recent Reductions in DWI Fatalities**
DWI fatalities have decreased in recent years as a result of large Federal grants that have supported increased DWI enforcement and media efforts. These funding streams are nearing an end, but the decrease in loss of life is too important to allow a reduction of activity currently supported by that funding. The current level of DWI enforcement and related media that prevents DWI by increasing the perception of risk of arrest must be sustained in order to avoid a sudden jump in DWI fatalities.

**Policy Recommendation to The Collaborative and Member Agencies, Department of Public Safety and DWI Czar:** Ensure a consistent utilization of DWI enforcement practices, paired with aggressive marketing campaigns that increase the perception of risk of arrest, to sustain the recent gains in reducing DWI fatalities.

**Policy Recommendation to The Collaborative and Member Agencies and Department of Public Safety:** Expand a comprehensive law enforcement strategy to effectively combat the activities resulting from the nexus of drug trafficking and criminal gang involvement.

**Policy Recommendation to The Collaborative and Member Agencies and Department of Public Safety:** Expand the aggressive enforcement of state and Federal laws used to combat drug trafficking in New Mexico.

**Issue: Impact Teams allow Targeted Law Enforcement**
Impact Team operations by State Police of the Department of Public Safety have, through short-term intensive enforcement and round-up efforts, shown immediate impacts upon community quality of life and illicit drug availability. These efforts should be maintained and strengthened when possible.

**Policy Recommendation to The Collaborative and Member Agencies and Department of Public Safety:** Utilize aggressive and effective Impact Team law enforcement operations in communities
where high levels of drug trafficking, violent crimes and substantial property crimes are reducing the quality of life in New Mexico communities.

**Issue: Reentry**

Governor Richardson's Task Force on Prison Reform recommends a more concentrated effort to coordinate state resources and a shoring-up of infrastructures to treat endemic substance abuse and other behavioral health problems among offenders and ex-offenders. The New Mexico Corrections Department releases 4,000 inmates per year; within three years, approximately 1,870 of them will be back in prison. This costs taxpayers and the State of New Mexico an average of more than $31,000 per year for each re-incarcerated offender. Eighty-five percent of New Mexico offenders have substance abuse problems and many have co-occurring disorders, defined as both a diagnosable substance use and mental health disorder. The re-arrest rate of 11.9% (from New Mexico drug court programs) is significantly lower than that of persons released from prison. Cost-per-client day is $27.01, compared to the daily cost of incarceration at approximately $85.59 a day. It is overwhelmingly clear that without successful management of substance abuse issues, successful reentry is difficult at best, and failure is almost assured. Without addressing substance abuse issues – before, during and after – the best intentioned and well-motivated corrections policies will most likely not succeed and the likely result is recidivism and its attendant costs.

**Policy Recommendation to The Collaborative and Member Agencies:** Implement behavioral health recommendations of Governor Richardson's Task Force on Prison Reform, June 24, 2008.

- Drug courts, mental health courts, and other specialty courts, and the associated community resources to make these courts successful, should be expanded.
- Expand treatment options available during incarceration for persons suffering from substance abuse and mental illness and implement a medication assisted treatment pilot at the New Mexico Women’s Correctional Facility.
- Implement a pilot project to ensure treatment for newly released prisoners with co-occurring disorders.
- Expand the capacity and the range of existing evidence-based behavioral health and social services programs to facilitate the triage of appropriate, non-violent offenders into probation, treatment, and supportive services.

**Policy Recommendation to The Collaborative and Member Agencies and Legislature:** Promote policies or legislation allowing judicial discretion to offer treatment instead of incarceration for non-violent narcotics possession of small amounts of illicit substances, based on a substance abuse assessment performed by a licensed behavioral health provider.

**Other Identified Issues Needing Further Study**

**Prevention Issues**

- Identify and support specific effective problem identification and referral services in identified cases of early initiation of substance use with youth.
- Require the utilization of evidence-based prevention practices.
- Review the evidence for the effects of increasing taxes (alcohol tax) on reducing underage and binge or excessive drinking when the price increase reduces availability of alcohol to minors and binge or excessive drinkers; consider a set-aside percentage to fund additional prevention and early intervention programs addressing risky drinking.
Linkage of youth substance use to suicide and possible prevention or intervention options. Suicide is a public health problem of considerable magnitude in New Mexico. It is the second leading cause of death for adolescents and young adults 15-34 years of age and the fourth leading cause of death for adults 35-44 years. The suicide death rate in NM has consistently been one and a half to two times the national rate. In 2006, the age-adjusted suicide rate in NM was 17.1 per 100,000 compared to a U.S. rate of 10.6 per 100,000. Suicide is usually a complication of a psychiatric disorder. Approximately 90% of suicide victims have a diagnosable mental illness at the time of their death, most commonly a mood disorder such as depression or anxiety. Suicide also occurs in persons with various other psychiatric disorders, including schizophrenia, personality disorders, and alcohol and drug use disorders, either alone or co-morbid with another psychiatric illness. Other clinical factors that increase the risk for suicidal behaviors include a history of physical or sexual abuse as a child, a history of head injury or neurologic disorder, and cigarette smoking. Men are more than four times more likely to commit suicide than women. Other socio-demographic risk factors associated with suicide include being age 60 years or older, widowed or divorced, White non-Hispanic or Native American, unemployed, living in social isolation or poverty, and experiencing recent adverse events, such as job loss or the death of a loved one. The best predictor of suicidal behavior is a history of a suicide attempt and current suicidal ideation.

Utilize school health offices as community center for behavioral health services for youth in order to increase access and provide more effective means for intervention and brief treatment services.

Study the feasibility of broad universal screening for behavioral health issues for youth and adults.

Issues concerning particular populations
- The population suffering from chronic substance abuse and homelessness.
- Co-occurring developmental disabilities and substance abuse.
- Substance abuse issues in the geriatric population.
- Substance abuse issues among veterans.

Study and develop a clear understanding of the relationship of substance abuse issues to crisis response, housing, and transportation, the three strategic priorities of the Behavioral Health Planning Council.

Request DOH to study and produce position papers on innovative harm reduction strategies, including:
- 911 amnesty for adolescents who report overdose situations.
- The provision of OTC availability of Narcan.

Corrections Issues
- Corrections and Parole Board shall consider holding parolees harmless for possession of Narcan or of clean syringes; and integrate effective harm reduction strategies into their operating procedures.
- Consider the creation of an exemption for Corrections hiring of staff within the TCs so as to maintain the needed number of staff to operate the current TCs.
- Ensure access to community based behavioral health services to those leaving the judicial or prison system with a history of substance abuse or mental health disorders.
Participants in the Ad Hoc Workgroup of the Substance Abuse Subcommittee

PURCHASING COLLABORATIVE MEMBERS

HUMAN SERVICES DEPARTMENT / BEHAVIORAL HEALTH SERVICES DIVISION
Karen Meador
Daphne Rood-Hopkins
Karan Northfield
Olin Dodson
Marizza Montoya-Gansel

DEPARTMENT OF HEALTH
Office of Substance Abuse Prevention
   Yolanda Cordova
   Susan Bosarge
   Coy Burk
   Karen Cheman
   Pamela Espinoza
Harm Reduction Program
   Raymond Aragon
Tobacco Use, Prevention and Control
   Larry Elmore
Office of School Adolescent Health
   Jim Farmer
Epidemiology and Response Division
   Danielle Henderson
   Tierney Murphy
   Jim Roeber

CHILDREN, YOUTH AND FAMILIES DEPARTMENT
Jeffrey Tintsman
Kristin Doellinger Jones
Eloisa Gonzales

AGING AND LONG-TERM SERVICES DEPARTMENT
Rhonda Avidon

DEPARTMENT OF CORRECTIONS
Charles King
Pam Brown

HEALTH POLICY COMMISSION
Lisa Marie Gomez

PUBLIC EDUCATION DEPARTMENT
Daniel DePaula
DEPARTMENT OF FINANCE AND ADMINISTRATION
DWI Programs
   Liza Luboff

DEPARTMENT OF TRANSPORTATION
Traffic Safety Bureau
   Glenn Wieringa

BHPC / LOCAL COLLABORATIVES MEMBERS
Christine Wendel, Chair
Mary Sue Blackhurst, LC 4
Susie Trujillo, LC 6
Gail Falconer, LC 7
Pamela Drake, San Juan Community Partnership, LC11

NON PURCHASING COLLABORATIVE MEMBERS

DEPARTMENT OF PUBLIC SAFETY
Herman Silva

OFFICE OF THE DWI CZAR
Christine Thomas

ADVOCATES
Julie Roberts, Drug Policy Alliance
Arturo Gonzalez, Ph.D, Sangre de Cristo Community Health Partnership
Paula Feathers, Southwest Prevention Center
Kathy Sutherland-Bruaw, New Mexico Connections to Wellness
Frank Magourilos, New Mexico Certification Board Behavioral Health Professionals
Shelley Mann-Lev, Santa Fe Public Schools
Nadine Tafoya, Nadine Tafoya & Associates

FACILITATORS AND REPORT PREPARATION
Michael Coop, Coop Consulting, Inc.
Natalie Skogerboe, Coop Consulting, Inc.

The opinions, findings, and conclusions or recommendations expressed in this report do not necessarily reflect the views of the individual organizations listed above.

Appendices

* New Mexico Youth Risk and Resiliency Survey, 2007, Green, Dan, Epidemiology and Response Division, New Mexico Department of Health
* Drug-Related Trends in New Mexico, Shaw, Nina, Epidemiology and Response Division, New Mexico Department of Health

* The Burden of Alcohol in New Mexico and Next Steps to Reduce It, Roeber, Jim, Epidemiology and Response Division, New Mexico Department of Health

Summary of Recommendations in Response to Senate Memorial 71

* Available on the website for the Behavioral Health Collaborative, on the page for the Behavioral Health Planning Council’s Substance Abuse Subcommittee: http://www.bhc.state.nm.us/BHCollaborative/subCommitteeMtg.html
Summary of Recommendations in Response to Senate Memorial 71

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<th>Legislature</th>
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<tbody>
<tr>
<td>DEVELOPMENT OF A SINGLE POINT OF OVERSIGHT AND COORDINATION THAT WILL BRING ALL SUBSTANCE ABUSE PREVENTION PROGRAMS TOGETHER TO BETTER INTEGRATE, COORDINATE, AND PLAN IN A COMPREHENSIVE MANNER, DEMONSTRATE ACCOUNTABILITY, AND EQUITABLY DISTRIBUTE PREVENTION RESOURCES ACROSS NEW MEXICO’S COMMUNITIES.</td>
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<td>REQUIRE CREDENTIALING OF STAFF PROVIDING PREVENTION SERVICES FUNDED BY THE STATE (WITH A TWO YEAR PERIOD FOR STAFF TO GAIN THOSE CREDENTIALS WHEN THEY ARE NOT ALREADY IN PLACE). TRAINING MUST INCLUDE PREVENTION GENERALIST TRAINING, PREVENTION POLICY, AND PREVENTION ETHICS.</td>
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<td>MAINTAIN AND ENHANCE A STRONG EVIDENCE BASED COMPREHENSIVE STRATEGY TO PREVENT BINGE AND EXCESSIVE DRINKING, AS THE PRIMARY PRECURSOR OF MOST OF NEW MEXICO’S ALCOHOL RELATED CONSEQUENCES, INCLUDING DWI FATALITIES, SUICIDES, MURDERS, CHRONIC LIVER DISEASE, FATAL FALLS, AND DOMESTIC VIOLENCE.</td>
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<td>SET ASIDE A MINIMUM OF 20% OF ALL DISCRETIONARY SUBSTANCE ABUSE FUNDING FOR SUBSTANCE ABUSE PREVENTION, IN ALIGNMENT WITH THE SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT.</td>
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<td>REQUIRE HEALTH EDUCATION WITH A STRONG SUBSTANCE ABUSE PREVENTION COMPONENT AS A GRADUATION REQUIREMENT.</td>
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<td>USE STRATEGIC PREVENTION FRAMEWORK PROCESS TO GUIDE PREVENTION PLANNING AND IMPLEMENTATION INITIATIVES.</td>
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<td>ESTABLISH PROCEDURES IN ALL AGENCIES THAT WORK WITH CHILDREN TO ENSURE APPROPRIATE SCREENING TO IDENTIFY EARLY USE AND THEN MAKE AN APPROPRIATE REFERRAL TO QUALIFIED EARLY INTERVENTION PERSONNEL TO ADDRESS THE PROBLEM BEHAVIORS. PROGRAMS THAT WORK WITH FAMILIES OF YOUNG CHILDREN SHOULD INCLUDE COMPONENTS THAT HELP FAMILIES REDUCE THE LIKELIHOOD OF EARLY INITIATION. SCHOOLS SHOULD STRENGTHEN STRATEGIES TO PREVENT USE, AND CREATE COMPREHENSIVE SAFETY AND WELLNESS PLANS AND INTERVENTIONS THAT REDUCE THE LIKELIHOOD OF USE ON CAMPUS.</td>
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<td>UTILIZE THE INSTITUTE OF MEDICINE (IOM) FRAMEWORK TO DESCRIBE POPULATIONS RECEIVING SERVICES WITHIN A SYSTEM OF CARE THAT INCLUDES PREVENTION.</td>
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## Policy Recommendations

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<td><strong>TREATMENT</strong></td>
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<td>Continue development of treatment and quality standards that assure uniform effective care is provided throughout the state.</td>
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<td>▪ Adopt the Stages of Change model so that its use is expanded throughout the state within all treatment agencies, and integrate it into Substance Use Assessments so that appropriate treatment protocols are identified to match the level of consumer readiness for treatment.</td>
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<td>▪ Ensure statewide utilization of Evidence-Based Practices, treatment service standards, quality improvement and assurance measures, and other appropriate indicators of quality within substance abuse provider agencies, including inpatient facilities, regardless of funding source.</td>
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<td>▪ Monitor the use and fidelity of evidence-based practices, programs and strategies.</td>
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<td>▪ Utilize standardized screening and assessment tools to determine need, diagnosis, etc.</td>
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<td>▪ Utilize the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model to screen and provide brief interventions for high-risk alcohol consumption.</td>
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<td>▪ Ensure the utilization of treatment approaches that are strengths based, recovery focused, and culturally competent, and include gender specific services, trauma informed care, and services that recognize and accommodate the issues of multi-generational use.</td>
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<td>Move toward a statewide system that can provide treatment on demand no matter where client engages with system – No Wrong Door.</td>
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<td>Explore the feasibility of implementing appropriate Medicaid billing codes to allow for screening for behavioral health issues during pregnancy and post partum.</td>
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<td>Explore an extension of the Medicaid coverage period for mental health and substance abuse services for pregnant and post-partum women from 60 days to one year.</td>
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<td>Develop ways to increase awareness for consumers, community stakeholders, and to better educate obstetricians, pediatric care specialists, and primary care practitioners to correctly identify the presence of fetal alcohol syndrome, fetal alcohol effects, and other drug use, and treat the pregnant mother and then the newborn infant immediately.</td>
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<td>Develop and implement a plan to expand and improve access to medication-assisted treatment, including through public health offices, drug court treatment programs, and for youth in appropriate settings.</td>
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<td>Seek opportunities to expand the use of traditional healing practices that have been proven to be effective in supporting recovery.</td>
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<td>Recognize as a core component and integrate the network of School Based Health Centers (SBHC) into the state's behavioral healthcare system and managed care provider network.</td>
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<td>▪ Ensure that all School Based Health Center staff are trained in the Screening, Brief Intervention and Referral to Treatment (SBIRT) model and ensure that they use all of the most appropriate standardized screening and assessment instruments for adolescents.</td>
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### BEHAVIORAL HEALTH PLANNING COUNCIL REPORT
TO THE PURCHASING COLLABORATIVE - THURSDAY, 3 DECEMBER 2009

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<tr>
<td>Conduct research with juvenile justice involved youth using substances to determine most appropriate age for intervention.</td>
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<td>Ensure that a full continuum of substance abuse services for youth incorporating a wraparound approach to care is available in each region of the state, to include early intervention and outpatient, intensive outpatient, and, where needed, residential treatment.</td>
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<td>- Increase partnerships with local child protective services and substance abuse services, to include screening, diagnosis and treatment, which address substance abuse-related factors contributing to risk of out-of-home placement and abuse/neglect.</td>
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<td>Expand gender-specific, trauma-informed substance abuse treatment services for female youth that include life skills, trauma issues, relationship issues, parenting, and physical health issues.</td>
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#### HARM REDUCTION

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<td>Ensure harm reduction education is provided in all service sectors.</td>
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<td>- Develop policy-making processes that include harm reduction strategies within a comprehensive approach, and educate all relevant state, city and county agencies and community stakeholders about the reasons for these strategies.</td>
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<td>Document and annually publish data about the effectiveness of New Mexico’s syringe exchange program in reducing the spread of blood born infectious diseases and establish statewide estimates of the costs and benefits of expanded statewide utilization.</td>
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<td>Document and annually publish data about the effectiveness of New Mexico’s Narcan program in reducing the rate of fatal opiate-related overdoses, establish the projected costs and benefits of expanded statewide utilization, and create and implement a plan to broaden the use of this practice into all areas of the state.</td>
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<td>Develop a standardized training program for judges and criminal justice officials, in collaboration with the Administrative Office of the Courts (AOC), to create a consistent understanding of strengths and weaknesses of various behavioral health treatment services, when these may be clinically appropriate, the needs of people with mental health and substance abuse issues within the court setting, and New Mexico’s harm reduction statutes.</td>
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#### LAW ENFORCEMENT & CORRECTIONS

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<th>Policy Recommendations</th>
<th>Collaborative &amp; Member Agencies</th>
<th>DWI Czar</th>
<th>NM Supreme Court</th>
<th>Dept. of Public Safety</th>
<th>Legislature</th>
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<td>Ensure to the maximum extent possible that substance use and related behavioral health screening, assessment and treatment is available when indicated for all adolescents in juvenile detention facilities.</td>
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<td>Therapeutic Communities (TCS) within the prison system are successful in reducing recidivism rates and</td>
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<td>lowering costs to our state.</td>
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<td>• Improve access for parolees who graduated from TCs to on-going recovery support in the community-based setting, including 12-Step programs.</td>
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<td>• Prioritize jobs for successful TC graduates who have returned to the community to help them maintain long-term successful recovery efforts.</td>
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<td>• Utilize successful TC graduates in recovery as certified peer support specialists.</td>
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<td>Support the expansion of Drug Court programs, and connect all graduates with the community behavioral health system to sustain recovery.</td>
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<td>• Ensure access to medication-assisted treatment within the drug court model.</td>
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<td>• Continue the expansion of drug courts for youth.</td>
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<td>Provide medication-assisted treatment during incarceration &amp; pre-release for those who need it.</td>
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<td>Ensure a consistent utilization of DWI enforcement practices, paired with aggressive marketing campaigns that increase the perception of risk of arrest, to sustain the recent gains in reducing DWI fatalities.</td>
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<td>Expand a comprehensive law enforcement strategy to effectively combat the activities resulting from the nexus of drug trafficking and criminal gang involvement.</td>
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<td>Expand the aggressive enforcement of state and Federal laws used to combat drug trafficking in NM.</td>
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<td>Utilize aggressive and effective Impact Team law enforcement operations in communities where high levels of drug trafficking, violent crimes and substantial property crimes are reducing the quality of life in New Mexico communities.</td>
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<td>Implement behavioral health recommendations of Governor Richardson’s Task Force on Prison Reform, June 24, 2008.</td>
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<td>• Drug courts, mental health courts, and other specialty courts, and the associated community resources to make these courts successful, should be expanded.</td>
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<td>• Expand treatment options available during incarceration for persons suffering from substance abuse and mental illness and implement a medication assisted treatment pilot at the New Mexico Women’s Correctional Facility.</td>
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<td>• Implement a pilot project to ensure treatment for newly released prisoners with co-occurring disorders.</td>
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<td>• Expand the capacity and the range of existing evidence-based behavioral health and social services programs to facilitate the triage of appropriate, non-violent offenders into probation, treatment, and supportive services.</td>
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<td>Promote policies or legislation allowing judicial discretion to offer treatment instead of incarceration for non-violent narcotics possession of small amounts of illicit substances, based on a substance abuse assessment performed by a licensed behavioral health provider.</td>
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OVERARCHING PRINCIPLES FOR MEDICAID COST CONTAINMENT
A document of the Behavioral Health Planning Council with input from the Local Collaboratives

This document offers a list of overarching principles that the Behavioral Health Planning Council asks the Collaborative and the Human Services Department to take into account when deciding what Medicaid cost containment measures to implement. These principles are as follows:

1. Any decisions made should take into consideration their effect on the infrastructure of rural and frontier areas, as well as the resource and service disparities between urban areas and rural/frontier areas.
   - “. . . in rural and frontier environments limiting [comprehensive community support] services (CCSS) to Core Service Agencies (CSA) would severely reduce options for those with very limited resources and would ultimately reduce access to the primary mental health care system and therefore increase costs.”
   - “There is a huge lack of mental health providers that are qualified to provide services as outlined in the Medicaid regulations for these areas. . . . If Medicaid rates are cut and the Wal-Mart approach continues to be implemented in these areas, limited and vital resources already in place may have to close. . . .Transportation is also a major issue in rural and frontier areas.”
   - “The further north, the lack of resources grows. Pueblos such as Picuris are lacking many resources because of lack of these services and no transportation to compensate.”

2. Increase the use of community-based and evidence-based services while reducing out-of-home/out-of-community placements.
   - “Use funds to develop transitional/crisis facilities in every community for consumer stabilization vs. short-stay hospitalization. This model would reduce cost of inpatient hospitalization, will keep consumer in his/her community, reduce staff cost and transportation issues, and allow continuity of care within the consumer’s hometown.”
   - “Residential care is a necessity and needs to be better balanced, not cut. More outpatient and support services are needed to help balance the cut in residential services. Perhaps each region could be allowed to come up with their own plan to reduce costs.”

3. Insist in-state care be provided to those currently receiving services out-of-state.
   - “If [more in-state services are not made available], could the in-state services that are currently available be maintained at a higher function while outpatient and support services are increased?”

4. Increase use of peer and family specialists in CCSS as a way to manage costs.

* Items are listed in no particular order of importance
• “An increased use of peer and family specialists would definitely be a way to help manage costs and to reduce recidivism.”

5. Examine alternative revenue resources (e.g., co-pays/cost sharing) as a strategy where allowed by law and regulation
   • “Most Medicaid consumers cannot afford to pay for co-pays. This would put an added burden on providers. Perhaps the eligibility requirements for Medicaid should be reviewed and amended. Those that would be affected could probably afford a co-pay.”
   • “While Local Collaboratives and communities are constantly exploring self-sustainability and plans to manage their resources, the state should look at raising taxes on tobacco and alcohol with a specific focus on . . . behavioral health. If this is already in place, it should be increased.”

6. Support recovery services to help consumers stay in recovery.
   • “The implementation and addition of Recovery Support Services would definitely be beneficial and could help to keep treatment costs down in the long run.”

7. Reevaluate those Medicaid regulations and requirements that are not consistent with cost containment initiatives (e.g., number of and/or duplicative assessments, evaluations, etc.) Address areas in Medicaid regulation where there is redundancy or waste.
   • “The use of master’s level interns . . . should be revised to help agencies to provide more services. Proper supervision, training and technical support should be a priority with any these services, but could potentially help to reduce costs tremendously. . . . The Medicaid requirements for agencies who are not CMHCs, FQHCs, or CSAs to have independently licensed clinicians should be waived, especially for the rural and frontier areas where there are not enough clinicians.”

8. According to FY10 MAD projections (5/5/09), behavioral health services are approximately 2% of the total Medicaid budget. Therefore, any cost containment that affects behavioral health services should not exceed more than 2% of the total Medicaid budget.

9. Any cost containment measures should not be enacted unless the measure’s impact on other costs has been fully considered.
   • “. . . limiting [therapy] sessions to a number such as 20 would be a waste of money and could defeat the purpose of treatment. Limited sessions, prior authorizations and continued stay requests for outpatient services will add to the paperwork requirement of clinicians all over the state who are already overloaded, which ultimately creates burn out and affects the quality of care for clients. Due to the reduction of higher levels of care, the length of stay for outpatient services has increased dramatically . . .”
   • “Limiting behavioral health therapy sessions to 20 per year . . . may be manageable if there is room for exception when there is both a demonstrable need and a therapy that has been shown to require more intense delivery to be effective (e.g. Dialectical Behavioral Therapy) in order to avoid more expensive inpatient, emergency room and other avoidable uses of the health care system.”
Resolution of the Child and Adolescent Subcommittee of the New Mexico Behavioral Health Planning Council

Whereas, the Maternal Depression Working Group has the goal of promoting mental health and well-being, and preventing mental health crises, for all New Mexican mothers, infants and families, and;

Whereas, the Maternal Depression Working Group was formed to respond to the high prevalence of maternal depression in New Mexico, gaps in access to timely care for low income women including those on Medicaid, and a need for a system to meet unique needs of maternal mental health and;

Whereas, the Maternal Depression Working Group, with multi-disciplinary members and leadership from the Department of Health and Governor’s Women’s Health Office, has members from public and private sector providers, support programs, state and local agencies, university faculty, and;

Whereas, literature review shows maternal depression responds well to treatment, having greater success when identified and treated early in its course, and with links to supportive programs. When untreated, research indicates untoward outcomes for mother, infant, and family; and;

Whereas, Medicaid and the Statewide Entity (Optum Health) need to take steps to implement the following measures to close gaps for low income women including those on Medicaid 1) extend access to mental health evaluation and care to 12 months after delivery; 2) promote prenatal and postpartum mental health screening, including appropriate billing codes for such screening; 3) promote training for mental health providers in screening, treatment and linkage to community systems of care; 4) assure client access to information about perinatal depression symptoms and how to get help; 5) link with community programs that avert undiagnosed or untreated depression; and 6) use client data systems of Medicaid and Optum Health to monitor the levels of use of such care, and;

Whereas, in a time of budget shortfall, it is understood that successful progress will take time, and;

Whereas the members of the Maternal Depression Working Group stand ready to assist the steps above including training, technical assistance, information for the public, research, grant writing, and networking community systems of supportive care, and;

Therefore let it be resolved, that on this day, (insert date), the Child and Adolescent sub-committee of the New Mexico Behavioral Planning Health Council (BHPC) endorses the work of the Maternal Depression Working Group and encourages the New Mexico BHPC to also give it’s endorsement so that this work can continue to make a difference; and

Therefore let it be further resolved, that the Child and Adolescent sub-committee of the New Mexico BHPC and the New Mexico BHPC advocate and encourage the implementation of the recommendations contained within the Maternal Depression Working Group’s presentation of October 20, 2009 and proposal to the sub-committee.
December 7th BHPC/LC Summit Agenda

7:00 – 8:30  LIGHT CONTINENTAL BREAKFAST  break out area
7:45 – 8:30  Local Collaborative Get Together
(optional opportunity – take your breakfast to meeting)

Large Room
8:30-10:00  WELCOME – Chris Wendel
BHPC Highlights: Chris Wendel
LC Highlights: Suzanne Pearlman

Special Presentation  Sustaining Transformation: Ready or Not…
Wanda Finch, LICSW, CAS, CDR, US Public Health Service
SAMHSA/CMHS/DSSI, Community Support Programs Branch
Leslie Schwalbe, MPA, Behavioral Health Consultant and Advisor to the
CMHS Mental Health Transformation State Infrastructure Grant Program.

10:00 – 11:00  Behavioral Health System 101 – Susie Kimble
•  Education and information on the Purchasing Collaborative, Planning
  Council, Statutory Subcommittees, Local Collaboratives
•  Asking what LCs need

11:00 – 11:15  BREAK

11:15 – 12:30 pm  Workshops
Workshop A  Mental Health First Aid  Michael DiBernardi
Workshop B  Facilitation 101  Mary Ann Shaening
Workshop C  Establishing Community Partnerships - Panel  LC 4- Yolanda Cruz,
  Marino Rivera; LC 6 – Beverly Annis-Allen; LC 9 Tony Bustos

12:30 - 2:00  LUNCH
Special Recognition – The John Henry Award
Systems of Care Grant Award – Marisol Atkins, CYFD

2:00 – 3:00  Six Concurrent Workshops
1. Supportive Housing: Partnership with 2 local collaboratives  Jane McGuigan
2. Cultural Services to Incarcerated Youth  Roshanna Lucero
3. Gang Trends and Intervention  Keahi Kimo Souza
4. Traditional Healers: Community work  Albino Garcia & Laura Alonzo de Franklin
5. Rain Cloud Off Reservation; Strengthening Our Voices  Gwendolyn Packard
6. Mental Health Jail Diversion Program  Edwina Abeyta

3:00 – 3:15  Break

3:15 – 4:15  Six Concurrent Workshops
1. Center For Self Advocacy; Individuals with Disabilities  Cynthia Burkheimer
2. Systems of Care Wraparound; LC 6  Andy Anderson
3. Crisis Intervention and Law Enforcement  Ron Gurley
4. Gardening at Crossroads; Rehabilitation Center for Women  Woods Houghton
5. SOAR; Helping People Experiencing Homelessness & Disabilities  Lisa Huval
6. Family Centered Substance Abuse Treatment  Donna Sue Spear

4:15  Back to Large Room – Closing Remarks and Wrap Up
A Questionnaire to Help us to Better Help You

Name of the town/city where you live: ______________________________

1. Have you been diagnosed with one or more mental illnesses? Circle one.
   a. One
   b. One or more
   c. None

2. Are you satisfied with the services you receive?
   a. Yes
   b. No

3. Do you have a voice regarding your care?
   a. Yes
   b. No

4. Are you aware of your Local Collaborative?
   a. Yes
   b. No

5. Do you belong to your Local Collaborative?
   a. Yes
   b. No

6. Are you aware of the Behavioral Health Planning Council (BHPC)?
   a. Yes
   b. No

7. **OPTIONAL:** Are you interested in obtaining more information or becoming more involved? Please write down your address, phone or email address.____________________________________________________________
   ______________________________________________________________

If interested, you will be contacted by someone on the BHPC Consumer Ad Hoc Team.

*Thank You*
November 30, 2009

The Honorable Bill Richardson
Governor of New Mexico
State Capitol Building, Room 400
Santa Fe, New Mexico 87501

Honorable Governor Richardson:

The New Mexico Behavioral Health Planning Council (BHPC), in its role as the single statewide advisory body for the behavioral health system for children, adolescents and adults has conducted a review of the SFY-09 Implementation Report for the Community Mental Health Services (CMHS) Block Grant.

Reviewers are pleased to note that there are no concerns or recommendations on the SFY-09 Implementation Report.

The Council values and welcomes the opportunity and responsibility given to each and everyone of us as a group and individually, in pledging support to the changes and challenges for the transformation of behavioral health services for our state. The leadership from your Office and the Collaborative improves overall behavioral health services in New Mexico.

Respectfully submitted,

Christine Wendel
Chair, Behavioral Health Planning Council