New Mexico

UNIFORM APPLICATION
FY 2009 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/20/2007 - Expires 08/31/2009

(generated on 7-22-2008 12.50.31 PM)

Center for Mental Health Services
Division of State and Community Systems Development
Introduction:
The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane. Rockville. MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.
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STATE NAME: New Mexico  
DUNS #: 837710722

I. AGENCY TO RECEIVE GRANT
AGENCY: New Mexico Human Services Department  
ORGANIZATIONAL UNIT: Behavioral Health Services Division  
STREET ADDRESS: 1190 St. Francis Drive, Suite N-3300  
CITY: Santa Fe  
STATE: NM  
ZIP: 87502-6110  
TELEPHONE: 505-827-2601  
FAX: 505-827-0097

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT
NAME: Pamela Hyde, J.D.  
TITLE: Department Secretary  
AGENCY: New Mexico Human Services Department  
ORGANIZATIONAL UNIT: Behavioral Health Services Division  
STREET ADDRESS: PO Box 2348  
CITY: Santa Fe  
STATE: NM  
ZIP CODE: 87504  
TELEPHONE: (505) 827-2601  
FAX: (505) 827-0097

III. STATE FISCAL YEAR
FROM: 07/01/2008  
TO: 06/30/2009

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION
NAME: Marie Di Bianco  
TITLE:  
AGENCY: Behavioral Health Services Division  
ORGANIZATIONAL UNIT: New Mexico Human Services Department  
STREET ADDRESS: PO Box 2348  
CITY: Santa Fe  
STATE: NM  
ZIP: 87504  
TELEPHONE: 505-827-1630  
FAX: 505-827-0097  
EMAIL: marie.dibiando@state.nm.us
New Mexico

Executive Summary

Please respond by writing an Executive Summary of your current year's application.
Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

I hereby certify that ______________ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.
(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a service area)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:
The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
   (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
   (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.
(2) A condition under subsection (a) for a Council is that:
   (A) with respect to the membership of the Council, the ratio of parents of
   children with a serious emotional disturbance to other members of the Council is
   sufficient to provide adequate representation of such children in the deliberations
   of the Council; and
   (B) not less than 50 percent of the members of the Council are individuals who
   are not State employees or providers of mental health services.

Section 1915:
(a)(1) State will make available to the State mental health planning council for its review
   under section 1914 the State plan submitted under section 1912(a) with respect to the
   grant and the report of the State under section 1942(a) concerning the preceding fiscal
   year.
   (2) The State will submit to the Secretary any recommendations received by the State
   from the Council for modifications to the State plan submitted under section 1912(a)
   (without regard to whether the State has made the recommended modifications) and
   comments on the State plan implementation report on the preceding fiscal year under
   section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at
   a level that is not less than the average level of such expenditures maintained by the State
   for the 2-year period preceding the fiscal year for which the State is applying for the
   grant.

Section 1916:
(a) The State agrees that it will not expend the grant:
   (1) to provide inpatient services;
   (2) to make cash payments to intended recipients of health services;
   (3) to purchase or improve land, purchase, construct, or permanently improve
   (other than minor remodeling) any building or other facility, or purchase major
   medical equipment;
   (4) to satisfy any requirement for the expenditure of non-Federal funds as a
   condition of the receipt of Federal funds; or
   (5) to provide financial assistance to any entity other than a public or nonprofit
   entity.
   (b) The State agrees to expend not more than 5 percent of the grant for
   administrative expenses with respect to the grant.

Section 1941:
The State will make the plan required in section 1912 as well as the State plan
implementation report for the preceding fiscal year required under Section 1942(a) public
within the State in such manner as to facilitate comment from any person (including any
Federal or other public agency) during the development of the plan (including any
revisions) and after the submission of the plan to the Secretary.

Section 1942:
(a) The State agrees that it will submit to the Secretary a report in such form and
   containing such information as the Secretary determines (after consultation with the
   States) to be necessary for securing a record and description of:
(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

______________________________  ___________________
Governor       Date

Pamela S. Hyde, J.D., Cabinet Secretary
1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about:
   (1) The dangers of drug abuse in the workplace;
   (2) The grantee’s policy of maintaining a drug-free workplace;
   (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
   (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will:
   (1) Abide by the terms of the statement; and
   (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central
point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.
5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

<table>
<thead>
<tr>
<th>SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</th>
<th>TITLE</th>
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<tbody>
<tr>
<td>Cabinet Secretary</td>
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APPLICANT ORGANIZATION

New Mexico Human Services Department

DATE SUBMITTED
### DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

<table>
<thead>
<tr>
<th>1. Type of Federal Action:</th>
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<tbody>
<tr>
<td>a. contract</td>
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<td>b. grant</td>
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<td>c. cooperative agreement</td>
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<td>d. loan</td>
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<td>e. loan guarantee</td>
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<td>f. loan insurance</td>
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<th>2. Status of Federal Action</th>
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<tr>
<td>a. bid/offer/application</td>
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<td>b. initial award</td>
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<td>c. post-award</td>
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<th>3. Report Type:</th>
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<tr>
<td>a. initial filing</td>
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<td>b. material change</td>
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**For Material Change Only:**
Year ______ Quarter ______
Date of last report ______

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<th>4. Name and Address of Reporting Entity:</th>
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<tbody>
<tr>
<td>Prime</td>
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<td>Subawardee</td>
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<td>Tier ______ , if known:</td>
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<tr>
<th>Congressional District, if known:</th>
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<th>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</th>
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<tr>
<td>Prime Subawardee Tier ______ , if known:</td>
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<th>Congressional District, if known:</th>
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<th>6. Federal Department/Agency:</th>
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<th>7. Federal Program Name/Description:</th>
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<td>CFDA Number, if applicable: ________</td>
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<th>8. Federal Action Number, if known:</th>
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<th>9. Award Amount, if known:</th>
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| 10. a. Name and Address of Lobbying Entity |
| (if individual, last name, first name, MI): |
| (if individual, last name, first name, MI): |

| b. Individuals Performing Services (including address if different from No. 10a.) |
| (last name, first name, MI): |

| 11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure. |

<table>
<thead>
<tr>
<th>Signature:</th>
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<tbody>
<tr>
<td>Print Name:</td>
</tr>
<tr>
<td>Title:</td>
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<tr>
<td>Telephone No.: ______ Date: ______</td>
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Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)
INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., “RFP-DE-90-001.”

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.
Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601-3619 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11968; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 93-523, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.
II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:
State FY ___X___ Federal FY ______

State Expenditures for Mental Health Services

<table>
<thead>
<tr>
<th>Calculated FY 1994</th>
<th>Actual FY 2007</th>
<th>Estimate/Actual FY 2008</th>
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<tr>
<td>$1446686</td>
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Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.
Note: In previous years CYFD calculated the Children's Set-aside based on the department's individual funding for SED services. The FY07 estimated Set-aside is projected based on New Mexico's current capacity to include a portion of all state funding for children's behavioral health services. The formation of the New Mexico Behavioral Health Collaborative now braids over fifteen funding streams for these services which are reflected in the number presented. The number is based on the dollar amount calculated by VONM (primarily from Medicaid) used to service children with certain severe diagnoses judged by CYFD to indicate SED. New Mexico currently does not have data on functional impairment which should be used in addition to diagnostic information. CYFD is currently piloting the use of the CAFAS in order to systematically gain this information which is a necessary component in determining SED.
III. MAINTENANCE OF EFFORT (MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State’s request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

<table>
<thead>
<tr>
<th>State FY</th>
<th>Federal FY</th>
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</thead>
<tbody>
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State Expenditures for Mental Health Services

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<th>Actual FY 2006</th>
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<th>Actual/Estimate FY 2008</th>
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<tr>
<td>$25,363,793</td>
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MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.
<table>
  <thead>
    <tr><th>Name</th><th>Type of Membership</th><th>Agency or Organization Represented</th><th>Address, Phone and Fax</th><th>Email (If available)</th></tr>
  </thead>
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    <tr>
      <td>Adakai, Frank</td>
      <td>Family Members of adults with SMI</td>
      <td>9816 Academy NW</td>
      <td>Albuquerque, NM 87114</td>
      <td>PH: (505) 897-1489</td>
      <td>navachip@aol.com</td>
    </tr>
    <tr>
      <td>Archer, Nancy Jo</td>
      <td>Providers</td>
      <td>2605 Bosque Entr</td>
      <td>Albuquerque, NM 87120</td>
      <td>PH: (505) 899-1093</td>
      <td>narcher@hogaresinc.com</td>
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    <tr>
      <td>Avidon, Rhonda</td>
      <td>State Employees</td>
      <td>Other</td>
      <td>Santa Fe, NM 87504</td>
      <td>PH: (505) 476-4911</td>
      <td>rhonda.avidon@state.nm.us</td>
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    <tr>
      <td>Blackhurst, Mary Sue</td>
      <td>Providers</td>
      <td>PO Box 358 318</td>
      <td>Third Street</td>
      <td>Santa Rosa, NM 88435</td>
      <td>PH: FAX: (505) 472-4567</td>
      <td>msblackhurst@yahoo.com</td>
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    <tr>
      <td>Bonnell, Judy</td>
      <td>Family Members of Children with SED</td>
      <td>PO Box 278</td>
      <td>High Rolls, NM 88325</td>
      <td>PH: (505) 682-3162</td>
      <td>FAX: (505) 437-1493</td>
      <td>bonnell@highstream.net</td>
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    <tr>
      <td>Chevalier, Frank</td>
      <td>Family Members of Children with SED</td>
      <td>121 Wheat Ridge Dr</td>
      <td>Clovis, NM 88130</td>
      <td>PH: (505) 762-0313</td>
      <td>frankchevalier65@yahoo.com</td>
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<td>Clark, Noel B.</td>
<td>Providers</td>
<td>914 N. Canal Street Carlsbad,NM 88220 PH: FAX:(505) 887-9579</td>
<td><a href="mailto:noel@leaco.net">noel@leaco.net</a></td>
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<tr>
<td>Coburn, Angela</td>
<td>Providers</td>
<td>PO Box 807 903 5th Street Estancia,NM 87016 PH:(505) 384-2811 FAX:(505) 384-2204</td>
<td><a href="mailto:angie_coburn@pmsnet.org">angie_coburn@pmsnet.org</a></td>
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<tr>
<td>Collyer, Cindy</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>PO Box 446 El Prado,NM 87529 PH:(505) 758-9523 FAX:</td>
<td><a href="mailto:chickenlady5@msn.com">chickenlady5@msn.com</a></td>
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<tr>
<td>Crocker, Brenda</td>
<td>Family Members of Children with SED</td>
<td>PO Box 348 Fort Sumner,NM 88119 PH:(505) 355-9179 FAX:(505) 355-9179</td>
<td><a href="mailto:brenda75@plateautel.net">brenda75@plateautel.net</a></td>
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<tr>
<td>Dr Jesus Arguello, Trinidad</td>
<td>Others(not state employees or providers)</td>
<td>P.O. Box 277 Arroyo Seco,NM 87514 PH:613-2008 FAX:</td>
<td><a href="mailto:drsarguello@q.com">drsarguello@q.com</a></td>
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<tr>
<td>Edwards, Mark</td>
<td>State Employees</td>
<td>Social Services ,NM PH:670-5420 FAX:</td>
<td><a href="mailto:Mark.edwards1@state.nm.us">Mark.edwards1@state.nm.us</a></td>
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<td>Falconer, Gail</td>
<td>Family Members of Children with SED</td>
<td>10 Falcon Nest Rd, Moriarty, NM 87035 PH: (505) 832-1966 FAX: (505) 832-1950</td>
<td><a href="mailto:gfallconer@higherspeed.net">gfallconer@higherspeed.net</a></td>
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<td>Finlayson, Gay</td>
<td>Family Members of Children with SED</td>
<td>9118 James Place A, Albuquerque, NM 87111 PH: (505) 291-9284 FAX:</td>
<td><a href="mailto:gfinlayson@salud.unm.edu">gfinlayson@salud.unm.edu</a></td>
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<td>Franowsky, Michelle</td>
<td>State Employees</td>
<td>Criminal Justice, NM</td>
<td><a href="mailto:michele.franosky@state.nm.us">michele.franosky@state.nm.us</a></td>
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<td>Fraser, Douglas</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>PO Box 2214, Los Lunas, NM 87031 PH: FAX:</td>
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<tr>
<td>Garcia, Jenny A</td>
<td>Family Members of Children with SED</td>
<td>315 Sagebrush, Raton, NM 87740 PH: (505) 445-8605 FAX:</td>
<td><a href="mailto:jennyg528@hotmail.com">jennyg528@hotmail.com</a></td>
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<tr>
<td>Gomez, Teresa</td>
<td>State Employees</td>
<td>Social Services, NM</td>
<td><a href="mailto:teresac.gomez@state.nm.us">teresac.gomez@state.nm.us</a></td>
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<td>Hawthorne, Marcia</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>109 Eaton Avenue Socorro,NM 87801 PH:(505) 835-4074 FAX:</td>
<td><a href="mailto:mhawthorne@copper.net">mhawthorne@copper.net</a></td>
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<td>Helwig, Sherry</td>
<td>State Employees</td>
<td>,NM</td>
<td><a href="mailto:sherry.helwig@state.nm.us">sherry.helwig@state.nm.us</a></td>
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<td>Heye, Vivian</td>
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<td>Holland, Pamela</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>PO Box 986 Jamestown,NM 87347 PH:(505) 488-6589 FAX:(505) 488-6589</td>
<td><a href="mailto:zetapholland@wmconnect.com">zetapholland@wmconnect.com</a></td>
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<tr>
<td>Houghton, Woods E.</td>
<td>Family Members of Children with SED</td>
<td>1304 W. Stevens Carlsbad,NM 88220 PH:(505) 887-9114 FAX:(505) 887-3792</td>
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<tr>
<td>Hourihan, Erin</td>
<td>Others(not state employees or providers)</td>
<td>807 w. Apache St. Farmington,NM 87402 PH: FAX:</td>
<td>486-0552</td>
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<td>Hunt, Kathleen</td>
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<td>Silver City,NM 88062</td>
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<td>Hyman, Robert D.</td>
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<td>1513 White St. Alamogordo,NM 88310</td>
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<td>State Employees</td>
<td>,NM</td>
<td>PH: FAX:</td>
<td><a href="mailto:kristine.jacobus@state.nm.us">kristine.jacobus@state.nm.us</a></td>
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<tr>
<td>Kimble, Susie</td>
<td>Providers</td>
<td>2439 Columbia Ave</td>
<td>PH:(505) 382-0314</td>
<td><a href="mailto:Susie.Kimble@psysolutions.com">Susie.Kimble@psysolutions.com</a></td>
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<tr>
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<td>Las Cruces,NM 88012</td>
<td>FAX:(505) 382-3727</td>
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<td>Kinney, Harrison</td>
<td>State Employees</td>
<td>Mental Health</td>
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<tr>
<td>Nakai, Maxine</td>
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<td>Navajo Nation PO Box 709</td>
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<td>Nipp, Cheri</td>
<td>Providers</td>
<td>1424 Deborah Rd. SE, Box #7</td>
<td>PH: FAX:(505) 994-1668</td>
<td><a href="mailto:cheri_nipp@pmsnet.org">cheri_nipp@pmsnet.org</a></td>
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<tr>
<td>Preciado, Carlos H</td>
<td>Family Members of adults with SMI</td>
<td>720 Frontier Drive Las Cruces, NM 88011</td>
<td>PH:(505) 650-7899 FAX:(505) 522-1008</td>
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<td>Raburn, Karen</td>
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<td>2405 Municipal Farmington, NM 87401</td>
<td>PH:(505) 793-6439 FAX:</td>
<td><a href="mailto:krwellnessdoc@DB5.com">krwellnessdoc@DB5.com</a></td>
</tr>
<tr>
<td>Rivera, Dolores</td>
<td>Family Members of Children with SED</td>
<td>PO Box 490 Alcalde, NM 87553</td>
<td>PH:(505) 852-1377 FAX:(505) 852-2790</td>
<td><a href="mailto:dol_rivera@yahoo.com">dol_rivera@yahoo.com</a></td>
</tr>
<tr>
<td>Rodriguez, Santiago</td>
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<td>Salazar, Debbie</td>
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<td><a href="mailto:dsalazar@teambuilders-Counseling.org">dsalazar@teambuilders-Counseling.org</a></td>
</tr>
<tr>
<td>Name</td>
<td>Type of Membership</td>
<td>Agency or Organization Represented</td>
<td>Address, Phone and Fax</td>
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<tr>
<td>Scofield, Frankie</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>PO Box 25 081 N.R.Rd. A.D. Floyd, NM 88118 PH: (505) 478-2525 FAX:</td>
<td><a href="mailto:fscofield@gmail.com">fscofield@gmail.com</a></td>
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<tr>
<td>Scott, Christena</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>2186 Boise Dr # B Las Cruces, NM 88001 PH: (505) 532-5999 FAX:</td>
<td></td>
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<tr>
<td>Simpson, Mark</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>2218 Miguel Chavez Rd, #811 Santa Fe, NM 87507 PH: FAX:</td>
<td><a href="mailto:santamarksimpson@yahoo.com">santamarksimpson@yahoo.com</a></td>
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<tr>
<td>Sturgis, Teri L.</td>
<td>Family Members of Children with SED</td>
<td>245 Van Camp Blvd Los Lunas, NM 87031 PH: (505) 865-7705 FAX: (505) 565-4144</td>
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<tr>
<td>Swatzell, Peter</td>
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<td>70 Bypass Rd #15 Silver City, NM 88061 PH: (505) 538-5059 FAX: (505) 534-2250</td>
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<td>Thomas Morris, Carolyn</td>
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<td><a href="mailto:dr_morris2000@yahoo.com">dr_morris2000@yahoo.com</a></td>
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<tr>
<td>Name</td>
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<tr>
<td>Tom, Robinson</td>
<td>Consumers/Survivors/Ex-patients(C/S/X)</td>
<td>PO Box 1618 Crownpoint, NM 87313&lt;br&gt;PH:(505) 786-7508&lt;br&gt;FAX:(505) 786-2020</td>
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<tr>
<td>Trujillo, Lisa</td>
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<td>HCR 64 Box 4 946 St. Rd 76 Chimayo, NM 87522&lt;br&gt;PH:(505) 351-2532&lt;br&gt;FAX:(505) 351-4008</td>
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<td>Trujillo, Susie</td>
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<tr>
<td>Wendel, Chris</td>
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### TABLE 2. Planning Council Composition by Type of Member

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
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<tbody>
<tr>
<td>TOTAL MEMBERSHIP</td>
<td>46</td>
<td></td>
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<tr>
<td>Consumers/Survivors/Ex-patients (C/S/X)</td>
<td>12</td>
<td></td>
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<tr>
<td>Family Members of Children with SED</td>
<td>11</td>
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<tr>
<td>Family Members of adults with SMI</td>
<td>3</td>
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<tr>
<td>Vacancies (C/S/X and Family Members)</td>
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<tr>
<td>Others (not state employees or providers)</td>
<td>2</td>
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<tr>
<td><strong>TOTAL C/S/X, Family Members and Others</strong></td>
<td>28</td>
<td>60.87%</td>
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<tr>
<td>State Employees</td>
<td>8</td>
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<tr>
<td>Providers</td>
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<tr>
<td>Vacancies</td>
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</tr>
<tr>
<td><strong>TOTAL State Employees and Providers</strong></td>
<td>18</td>
<td>39.13%</td>
</tr>
</tbody>
</table>

**Note:** 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.
State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council’s efforts and related duties as mandated by law:

- reviewing plans and submitting to the State any recommendations for modification
- serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems.
- monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
- the role of the Planning Council in improving mental health services within the State.

<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State’s transformation activities that are described in Part C, Section II and Section III. </STRONG>
In June, 2007, the Behavioral Health Planning Council, a statewide Governor appointed advisory body was redesigned to assist the Collaborative with planning, to provide advice and recommendations on system and policy developments, and to review the State’s mental health and substance abuse federal block grants.

The Behavioral Health Planning Council’s Operating Procedures encompass and regulate the responsibilities and activities of the Council. It is through this manual that the Council establishes the guidelines within which bylaws, the general Council and committees act to implement policy, advocacy and oversight.

The vision of the BHPC is To be a potent voice for children, adults and families and the providers that serve them in New Mexico’s customer-centered, recovery and resiliency focused, coordinated, and quality behavioral health care system.

Planning Council meetings are held every month the 4th Wednesday.

Subcommittees have been established in the following areas:
A. The Executive Committee;
B. Adult Subcommittee;
C. Medicaid Subcommittee;
D. Children and Adolescent Subcommittee;
E. Native American Subcommittee;
F. Substance Abuse Subcommittee;
G. Criminal Justice Subcommittee;
H. Employment Subcommittee;
I. Housing Subcommittee;
J. Neurobiological Subcommittee; and
K. Block Grant Subcommittee.

Each subcommittee has created a mission statement and goals and meets at least quarterly.
New Mexico

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.
1. Adult - Overview of the State’s Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Current Administrative Structure – Adult

The New Mexico Human Services Department (HSD) manages the state and federal funds that provide life’s most basic services to New Mexico’s poorest individuals and families—touching the lives of one in three New Mexicans with food, access to health care, income, work, energy assistance and community services. HSD is the fifth largest state agency with 1,900 employees in 54 office locations statewide and a $3.4 billion budget in Fiscal Year 2007 (FY07). The Department is organized into five divisions led and directed by the Office of the Secretary (OOS): the Child Support Enforcement (CSED); the Income Support (ISD); the Medical Assistance (MAD); the Behavioral Health Services Division (BHSD); and Program Support, which includes the Administrative Services Division, (ASD), Division of Information Technology (DoIT), Office of Human Resources (OHR), Office of Inspector General (OIG) and Hearings Bureau.

The mission of the Human Services Department is:

- To serve New Mexicans by coordinating an integrated network of public and private support to those who need it.
- To reduce the impact of poverty on people served by providing services that prevent or reduce poverty;
- To reduce the impact of poverty on the State of New Mexico;
- To impact positively the social and economic health of New Mexico; and
- To assure low-income and disabled individuals in New Mexico equal participation in the life of their communities.

On July 1, 2007, The Behavioral Health Services Division (BHSD), formerly with the New Mexico Department of Health, joined with the New Mexico Human Services Department (HSD). HSD will ensure the continuation and advancement of mental health programs and services statewide under the auspices of the Behavioral Health Purchasing Collaborative and the aims and goals of the Transformation State Incentive Grant.

BHSD is currently directed by Linda Roebuck, CEO of New Mexico’s Behavioral Health Purchasing Collaborative (the Collaborative) and Mental Health Commissioner for the State of New Mexico. In moving BHSD under the Collaborative CEO, the Division continues it role in providing the necessary infrastructure for the Collaborative, the governing organization of that state’s
transformation of its behavioral health services system. BHSD remains focused on the development, implementation and evaluation of a service system that underscores its focus on transformation and ensure that individuals with behavioral health issues receive the supports and services they need to manage their illness; to support and enhance the recovery process; and to eliminate barriers to self sufficiency and resiliency.

Since May 19, 2004 when Governor Bill Richardson of the State of New Mexico signed HB 271 into law, creating a statutory legal entity charged with overseeing New Mexico’s behavioral health delivery system, the New Mexico Behavioral Health Purchasing Collaborative has:

- Established the 17 member policy-making body that is the Collaborative
- Awarded a statewide managed behavioral health care contract to ValueOptions New Mexico, replacing multiple contracting mechanisms and administrative infrastructures, and consolidating the management and disbursement of over $400 million of federal and state behavioral health funds
- Secured over $200 million of new dollars from Medicaid and the State General Fund, to address the needs of New Mexico consumers and communities, increasing the behavioral health care contract to over $400 million in FY 2008.
- Implemented a structure of 15 Local Collaboratives to give voice to consumers, family members, providers, and other stakeholders as a key element of the behavioral health system transformation in New Mexico
- Restructured the Behavioral Health Planning Council, a statewide Governor appointed advisory body to assist the Collaborative with planning, to provide advice and recommendations on system and policy developments, and to review the State’s mental health and substance abuse federal block grants.
- Developed strategic priorities and critical plans to address those priorities (including children and youth services, supportive housing, substance abuse).
- Created and agreed on 21 performance measures to evaluate progress toward its priorities.

The Vision of New Mexico’s Behavioral Health Collaborative is “Quality Behavioral Health Care Promotes Recovery and Resiliency.” The Collaborative’s Goals reflect the State’s commitment to a consumer and family driven system, which fosters and supports recovery and resilience.

The Collaborative selected ValueOptions New Mexico (VONM) as the Statewide Entity (SE) for the New Mexico Interagency Behavioral Health Purchasing Collaborative (April 2005) and this contract will continue through the end of SFY-2009. VONM is a New Mexico-based organization that serves New Mexican behavioral health consumers, families and providers with
Service Centers and Regional Offices in Albuquerque, Santa Fe, Farmington, Las Cruces and Roswell. ValueOptions New Mexico is responsible for maintaining the New Mexico behavioral health provider network and managing the service delivery system.

In partnership with the New Mexico Interagency Behavioral Health Purchasing Collaborative, ValueOptions New Mexico is committed to a behavioral health service delivery system that is both effective and efficient, while focused on the principles of Recovery and Resiliency. As such, VONM has developed within its organization a consumer driven Department of Recovery and Resiliency which is staffed with a Vice-President and multiple Peer Specialists and Family Peer Specialists throughout the state.

The Value Options contract is managed by the Cross Agency Oversight Team, which is one of seven Cross Agency Teams that comprise the Collaborative’s Steering Team, the operational management team of the Collaborative. The planning assumption for the Collaborative and its member agencies, including the Behavioral Health Services Division, is to align service delivery with the priorities of the Collaborative’s strategic plan. The Collaborative has a clear agenda of strategic priorities for FY09.

The Collaborative approved the Behavioral Health FY 08 Strategic Plan in May 2007. The Plan is one product of a multi-year process that has shaped and will continue to shape the transformation occurring in New Mexico. This input includes town hall forums, Local Collaborative focus group, statewide planning retreats, ongoing efforts of the Behavioral Health Planning Council and its executive committee, and work of the Collaborative’s Steering Team. The Collaborative’s ten Strategic Initiatives established in FY08 and continue through FY-2009 are:

**Consumer Driven Services and System**
- Development and implementation of the Anti-stigma/wellness campaign
- Ongoing support of consumer role in Local Collaboratives and the Behavioral Health Planning Council
- Collaborative-wide approach to consumer engagement

Lead Agencies: BHSD, Children, Youth and Families Department (CYFD)

**Substance Abuse Services**
- Los Lunas (state-of-the-art residential and community-based treatment program to serve as statewide training resource)
- Total Community Approach (pilot sites)
- Expanding the Medicaid Benefit

Lead Agencies: BHSD, Medical Assistance Division, CYFD
Transportation
- Pilot efforts to improve transportation for behavioral health consumers and their families, including consumer-operated options
- Strengthen cross-agency partnerships to improve transportation options for consumers and their families
- Outreach and education to consumers and their families regarding transportation options

Lead Agencies: BHSD, Department of Transportation, Aging and Long Term Services Department (ALTSD), Department of Vocational Rehabilitation, CYFD

Supportive Housing
- Adolescents in Transition
- Persons with Serious and Persistent mental illness
- Increase Housing Units
- Rental Assistance and Wrap Around Services

Lead Agencies: BHSD, ALTSD, CYFD

Children’s Services
- Success in School (school-based behavioral health and adolescent transition)
- Implementation of the Children’s Services Purchasing Plan

Lead Agencies: CYFD, Public Education, Department of Health (DOH)

Services to Native Americans
- Teen Suicide
- Increasing the behavioral health workforce
- Increasing the number of Medicaid eligible Tribal behavioral health providers

Lead Agencies: BHSD, Indian Affairs Department, DOH

Crisis Response and Jail Diversion
- Pilot sites for model crisis response services
- Evaluate and develop plan for funding and implementation

Lead Agencies: BHSD, Corrections, CYFD

Law Enforcement
- Develop a statewide educational plan for law enforcement personnel
- Develop system for assessing and improving law enforcement response

Lead Agencies: BHSD

Evidence-Based Practices and Professional Training
- Veterans – Post Traumatic Stress Disorder Pilot
- Consortium for Behavioral Health Training and Research
- Co-Occurring Disorders
- Design and Implement Services for Older Adults
Lead Agencies: BHSD, ALTSD

Improving Efficiency & Effectiveness
- Quality Management System
- Manage the Value Options Contract
- Optimize services to non-Medicaid eligible
- Non-Medicaid covered services

Lead Agencies: BHSD, Steering Team and Oversight Cross Agency Team, Medical Assistant Division,
New Mexico

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.
Part C. State Plan  
Section I. Description of State Service System  

2. Adult – Summary of Areas Previously Identified by State as Needing Attention  

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Consumer and family engagement remains a key component in New Mexico’s plan for transforming the behavioral health system. From the beginning of the transformation process consumers, family members and advocates have been actively involved in systems planning, defining the parameters of the transformation and identifying opportunities for continued and expanded consumer involvement. Almost 500 local stakeholders including consumers, family members, advocates, and representatives of special populations – Native Americans, persons dually diagnosed with mental health disorder and mental retardation, school-based behavioral health services -- were interviewed as individuals or through focus groups during the completion of the Behavioral Health Needs and Gaps Analysis.

Significant achievements in this area during FY-08 include:

Local Collaboratives:

Over the course of FY-2008, LCs evolved and organized in many different ways, reflecting differences in local communities throughout NM. The Collaborative empowers local communities to organize in the matter that best reflects the unique voices of their local communities. Some highlights include:

Consumer/Family Guidelines for membership in Local Collaboratives were finalized in September 2006 in an effort to reflect diverse local opinions and perspectives, to ensure that consumer and family voices be strong and that such individuals be actively engaged in local planning and other LC activities.

Increased consumer and family voice and stronger connection between Local Collaboratives and the Behavioral Health Planning Council (BHPC) were the motivating factors leading to a change in BHPC membership, effective May 2007 and implemented during FY-2008. The BHPC membership expanded to include three representatives(one consumer, one family member, and one provider or advocate) from each Local Collaborative, in addition to at-large and state staff members appointed by the Governor. A diverse and representative Executive Committee, reflecting the new membership composition, was elected to direct the work of the BHPC.

Leadership level meetings between Local Collaborative and BHPC representatives Collaborative CEO began in December 2007. These meetings are focused on evaluating and recommending improvements to the current LC/BHPC structure, roles, and internal communication.

Purchasing Collaborative:

Office of Consumer and Family Engagement (CAFÉ), formerly the Office of Consumer Affairs, has broadened its focus to work with children, youth, and families across the state.
Through outreach, training, advocacy, and technical assistance, CAFÉ works to increase the involvement of consumers, youth, and families in directing their own recovery and being part of the system change underway in New Mexico. CAFÉ staff members are active partners with Local Collaboratives and the BHPC.

**Focus on Native American Behavioral Health Needs**
Two Native American Local Collaborative, LC 14 and LC 15, and the Native American Subcommittee of the Behavioral Health Planning Council have actively engaged in work to increase outreach to Native Americans, involve tribal communities in behavioral health advocacy, and increase the Native American workforce delivering services.

A new Tribal Liaison position was created and filled by the Behavioral Health Services Division and collaborates work with Tribal Liaisons in other Collaborative agencies.

In response to contract expectations, ValueOptions NM created a Native American Unit, known as Region 6, comprised of five full-time seasoned professionals who are each members of federally recognized tribes and who are familiar with tribal programs, staff, organizational structure and tribal customs and protocols. The Region 6 staff team provides technical assistance to the 31 tribal programs, which are currently contracted with ValueOptions as service providers. These 31 tribal providers are funded for $3,378,873 through Tribal 638 programs, other Indian programs, Urban Indian programs, and prevention programs.

Region 6 staff members work with tribal leaders and their behavioral health program staff to assist tribal programs in obtaining their Medicaid provider numbers and with the Indian Health Service to ascertain their PL 638 status. In FY08, four new tribal programs have become ValueOptions contractors.
New Mexico

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
3. New Developments and Issues
Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

The transformation of New Mexico’s Behavioral Health Service System, under the direction of the Purchasing Collaborative and guided through the Comprehensive Behavioral Health Services Plan and the Collaborative’s Strategic Plan (May, 2007) is a phased approach requiring multiple years to accomplish. Phase Two of this transformation include:

A By-Laws Committee of the Collaborative has been appointed to research, develop, and recommend By-Laws to guide the work of this unique, virtual organization. The development of by-laws for the Collaborative will allow for further clarification of roles, functions, and authority of the Collaborative.

A Legislative Review Team of the Behavioral Health Planning Council, which reviewed the legislative priorities submitted by each of the 15 local Collaboratives (LC’s) and made recommendations to the Behavioral Health Planning Council.

Cross Agency Teams (CATs) were established and refined in response to priorities established in “Taking Stock, Taking Aim,” presented to the Legislature in May 2006. The Cross Agency Teams are coordinated by the Collaborative’s Steering Team, which is comprised of representatives of each CAT and other key Collaborative member agency representatives. The Steering Team, chaired by the Collaborative CEO, meets weekly to coordinate priorities at the Collaborative level, monitor Collaborative progress in all areas, and develop policy recommendations for consideration by the Collaborative. The Cross Agency Teams currently include:

Oversight: provide contract management and oversight of the Statewide Entity Contract. This includes yearly renegotiation of the contract; review of performance and financial audits; creation and monitoring of Corrective Action Plans; and the development, in conjunction with the Collaborative’s Steering Team, of priority work plans in contract-identified focus areas. In FY2008, priority work plans were developed for Success in Schools, Co-Occurring Disorders, Services to Individuals in State Custody; Quality Management System, Core Service Agency Development, and Adolescent Transition;

Quality and Evaluation: is responsible for developing evaluative processes and procedures to monitor the impact of the Collaborative’s work on the Governor’s Performance Measures and to coordinate quality improvement and evaluation efforts across the Collaborative;

Capacity and Program Development’s strategic priority work groups focus on the development, implementation and evaluation of services within each of the Collaborative’s strategic priorities;

Administrative Services coordinates fiscal planning and accountability across the Collaborative,
monitors performance measures, provides oversight of the Transformation Grant and will design the Collaborative’s data infrastructure; and

The Consortium for Behavioral Health Training and Research is a virtual organization, which furthers the use of evidence-based practices statewide, is charged with increasing the quality and quantity of the behavioral work force in New Mexico, and with evaluating identified Collaborative pilot efforts, including the Veterans & Family Services Pilot.

While there have been no significant changes in the goals and objectives outlined in the Collaborative strategic plan, areas of focus within the goals are being specified and prioritized as behavioral health transformation efforts in New Mexico mature. The Behavioral Health Collaborative (the Collaborative) and Behavioral Health Planning Council (BHPC) are moving beyond the integration of department initiatives to strategic planning, organized around the Collaborative five key goals:

1. **Support of recovery and resiliency is expected**
   - Ensure Youth Start Out, and Remain On, the Path to Productive Adulthood through Educational Success and Supportive Families and Communities

2. **Mental Health is promoted**
   - Decrease Suicide Rate Across All Populations
   - Create a Multi-User, Interactive Communication System

3. **Adverse effects of substance abuse and mental illness are prevented or reduced**
   - Identify Community Strengths, Ensure Cultural Competency, Family and Consumer Driven Services at all Levels
   - Promote Use of Culturally Appropriate and Traditional Healing Services for Native Americans Assure Appropriate Number of Practitioners in Rural Service Systems
   - Increase Access to Quality Behavioral Health Care in Rural and Remote Areas of New Mexico

4. **Consumers are assisted in participating fully in the life of their communities**
   - Assure Participation of Consumers and Families in All Local Collaboratives
   - Ensure State Level Changes are Responsive to Local Voices

5. **Available funds are managed effectively and efficiently**
   - Develop an Integrated Plan to Guide Future Direction and Priorities of the Collaborative
   - Build an Integrated Data System Accessible Across All Agencies within the Purchasing Collaborative
   - Develop the Capacity to Support Research and Evaluation Efforts
New Mexico

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.
4. Legislative Initiatives and Changes
Adult - Legislative initiatives and changes, if any.

Highlights of the 2008 Legislative session include:

**Purchasing Collaborative:**
*HB 181* passed during the 2008 Legislature will strengthen the Collaborative as it further clarifies roles and responsibilities and establishes clear avenues for reporting Collaborative progress.

The Collaborative will build upon the work it has already done to create a consolidated legislative agenda and will present a consolidated behavioral budget to the Legislature yearly. Behavioral budgets will continue to be managed by individual agencies, but a consolidated presentation will better highlight behavioral resources and needs statewide. The Collaborative will also report on a quarterly basis to the Legislature through the Legislative Finance Committee. Enhanced data management and oversight of the reporting mechanisms currently in place between the Collaborative and the Statewide Entity will be used to create and update a detailed data and performance profile that will be used by all Collaborative members to ensure consistent reporting and an increased ability to identify and manage areas of concern.

*HB 181* also gives the Collaborative rule-making authority, through the Human Services Department in areas of service delivery standards, quality management, performance measures and other key aspects of service system development as they reflect the rights and responsibilities of consumers and providers.

**Behavioral Health Services:**
*SB 165* passed during the 2008 Legislature provides for additional resources for behavioral health services including:

- $335,600 to Bernalillo county to operate a secure, long-term, statewide multijurisdictional residential rehabilitation and transition facility that admits persons who have been ordered to the facility by a New Mexico court;

- $20,000 for a transitional living program in Bernalillo county that offers temporary shelter, board, living skills education, behavioral health services and social services to homeless and runaway youth who are sixteen to twenty-one years old;

- $10,000 for a community alcohol and drug recovery program in Santa Fe county;

- $5,000 for a Santa Fe transitional living program that provides apartments and life skills development for homeless youth ages sixteen to twenty-one;

- $10,000 for a community drug and alcohol program in El Prado in Taos county;
- $15,000 for community drug and alcohol programs in Talpa in Taos county;
- $40,000 for behavioral health and support services for Native Americans in northwest New Mexico;
- $15,000 to support a day program for persons with severe mental illness using the clubhouse model to facilitate recovery through socialization and life skills training; vocational rehabilitation and employment services; educational and housing services; and reintegration into the greater community;
- $35,000 for rape crisis services in central New Mexico;
- $30,000 for a regional treatment center for alcohol and substance abuse in Eddy county;
- $50,000 for a northern New Mexico traditional healing training program for substance abuse treatment in Rio Arriba county;
- $7,700 for Taos county long-term alcohol treatment services; and
- $7,700 for alcohol treatment services in Talpa in Taos county.

The breadth of projects supported in SB 165 demonstrates both the 2008 Legislature’s understanding of and commitment to supporting the behavioral health service system needs of New Mexico and the Collaborative’s goal of an integrated system of care.
New Mexico

Adult - Description of Regional Resources

Adult - A brief description of regional/sub-State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.
Part C. State Plan
Section I. Description of State Service System

5. Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

The Collaborative has identified six (6) behavioral health services regions, five of which are geographic and one of which relates to Native American communities. Interagency teams work within each one of these six regions to assist recognized local collaboratives within that region to fulfill their roles. VO-NM continues to have staff persons assigned to and living within each one of the five regions and staff for the Native American “region.” (Region 6) These individuals will work with the state staff teams from across and within state agencies to support and interact with local collaboratives as the new behavioral health delivery system unfolds.

The purpose of the 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 Interagency Behavioral Health Purchasing Collaborative initiative. Each collaborative, identified or formed locally and recognized by the State Collaborative, help create and sustain the partnerships among customers, family members, advocates, local agencies, and community groups. They identify needs, help develop a range of resources and ensure the responsiveness and relevance of behavioral health services and supports to improve the quality of life of those affected by behavioral health concerns. The following map displays New Mexico’s Regions and Local Collaboratives:
From a funding perspective, most of the Collaborative’s adult mental health services are provided through the Human Services Department (HSD) through the Medical Assistance Division (MAD) and Behavioral Health Services Division (BHSD). As of July 1, 2007, both MAD and BHSD are now sister divisions under HSD, and continue to utilize a collaborative approach to staffing the design and implementation of behavioral health services approved by the Collaborative and executed by VO-NM in its provider network. Roles and responsibilities include:

- **BHSD** retains its oversight role vis-à-vis the community-based service system in both mental health and substance abuse, with the directive to ValueOptions to serve non-Medicaid clients as a first priority. BHSD continues to provide to a Medicaid eligible client certain critical services, which Medicaid does not include in its benefit package. These services include assistance in securing employment and housing. BHSD continues to work in partnership with its sister division MAD to increase both the type and quality of community-based services for all New Mexicans utilizing the publicly funded behavioral health service system.

- **Division of Health Improvement (DHI)** remains within the Department Of Health, one of the member agencies of the Purchasing Collaborative. DHI remains in partnership with BHSD and has retained the responsible for monitoring the quality of services delivered by the SE and the fee-for-service providers.

- **Medical Assistance Division (MAD)** is responsible for Medicaid managed care programs for eligible adults and children under their Salud! initiative. The HSD also ensures availability of Medicaid fee-for-services activities for recipients who meet criteria outside those of Salud!

The Collaborative have taken a proactive position to ensure that all sub-populations (including individuals with severe mental illness and individuals with very complex needs) are provided services, even in the most rural areas of the state and that they have a voice in their treatment. This means working with family support groups such as the National Alliance for the Mentally Ill (NAMI), Parents for Behaviorally Different Children (PBDC) and other client advocacy and consumer groups. The Behavioral Health Planning Council’s participation and coordination with the Purchasing Collaborative also ensures that goals and objectives specified in the State Mental Health Plan (i.e., the Community Mental Health Services Block Grant) are reviewed routinely and tasks achieved systematically in support of the state’s Plan. Finally, the Local Collaborative system allows for communities to participate in the coordination and development of the publicly funded behavioral health service system in a manner that is unprecedented in the state.
New Mexico

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.
6. Description of State Agency’s Leadership

New Mexico continues to move from a fragmented collection of mental health and substance abuse services to a system managed by a single contracted Statewide Entity (SE) and overseen by the New Mexico Interagency Behavioral Health Purchasing Collaborative (the Collaborative). The SE, Value Options New Mexico (VONM), insures that services continue to be made available, that providers receive payment for their services, that data is collected, and that there is continuous improvement of quality of services.

The Behavioral Health Planning Council (BHPC) is the single advisory council to the Collaborative, the Legislature, and the Governor on all matters affecting behavioral health (mental health and substance abuse) prevention, treatment services, planning, resources (grants, block grants, Medicaid) and advocacy. It monitors and reviews the allocation and adequacy of mental health services within the state on various levels, including legislative priorities established by each of the Local Collaboratives.

The primary leadership role in coordinating mental health services in New Mexico has passed to the Interagency Behavioral Health Purchasing Collaborative (Collaborative), co-chaired by the Secretary of the Department of Human Services, and, in alternate years, the Secretary of the Children, Youth and Families Department (July 1, 2007) and the Secretary of the Department of Health (July 1, 2008). Seventeen statutory designated agencies, the State Public Defender’s Office and the Governor’s Health Policy Coordinator, work to speak with a common voice, to coordinate the array of behavioral health service processes, and to achieve a smooth transition to the new system.

The work of the Collaborative is accomplished under the leadership of the Collaborative Behavioral Health CEO, guiding the work of several cross-agency teams of redirected existing staff focused on overall coordination of efforts across the Collaborative agencies in six substantive areas: SE Oversight; Local Collaboratives; Administrative Support; Policy and Planning; and Workforce, Program Development and Research. The Co-Chairs of the Collaborative report to Governor Richardson. Reporting to the Behavioral Health CEO is the 12-member Working Group staff team, housed in multiple agencies – CYFD (4), the DOH (5), and the HSD (3), with other agencies’ staff participating in specific work efforts and cross-agency teams. The clinical leadership roles of BHSD and CYFD continue and play a critical part in ensuring the success of the Collaborative and its partner statewide entity. A cross agency team structure was developed to address overall planning, common service definitions and requirements, data collection, financing, and transition issues. (See diagram below.)

The Steering Team, which is comprised of the leadership of the Cross-Agency Teams as well as other department management staff, guides the implementation process. Once per month the Steering Team is expanded to include consumers, family members, providers, and advocates, several representing the Behavioral Health Planning Council. The expanded Steering Team effort is one effort among many to ensure that our management process remains sensitive to the wisdom and interests of those it is designed to serve. Another new aspect of the structure is the
consumer engagement group, which meets every two weeks, bringing together state agency consumer and family advocates and specialists, the Office of Consumer Affairs, the Medicaid behavioral health ombuds person and the Recovery and Resiliency Department of Value Options\textsuperscript{2}. The Steering Team works closely with the Behavioral Health Planning Council to create the Collaborative’s Strategic Plan.
The 17 Collaborative agencies are interested in ensuring that this broad new interagency effort is reflected in well-developed local-level collaborative efforts throughout the state. To ensure this occurs, the Collaborative is recognizing a single local collaborative for each of New Mexico's 13 judicial districts, plus a limited number as appropriate for the state's sovereign tribes and pueblos. Local collaboratives have been identified or formed locally and recognized by the state Collaborative to help create and sustain the partnerships among customers, family members, advocates, local agencies, and community groups. They will identify needs, help develop a range of resources and ensure the responsiveness and relevance of behavioral health services and supports to improve the quality of life of those affected by behavioral health concerns.

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Transformation Activities:

1. Improving coordination of care among multiple systems
2. Fully involving consumers and families
New Mexico

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.
Section I. Description of State Service System

1. Overview of the State’s Mental Health System

The New Mexico Behavioral Health System has been undergoing a massive transformation since 2003, when Governor Bill Richardson directed all agencies tasked with the delivery, funding, or oversight of behavioral health care services in New Mexico to work collaboratively to create and purchase a single behavioral health service delivery system throughout New Mexico focused on the improvement and coordination of service provision and delivery. The following agencies became a part of the New Mexico Behavioral Health Collaborative (Collaborative):

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

Those agencies with asterisks (*) contribute funds towards the purchasing of behavioral health services. The Collaborative has five Cross Agency Teams that have explicit agendas. These are:

- **Contract Oversight** – Responsible for contract development, negotiations, and management/monitoring;
- **Administrative Services** – Responsible for provider capacity development, performance measures, grants management, funds mapping, data systems development and implementation;
- **Quality and Evaluation** – Responsible for performance measures and reporting, funds mapping to performance measures, implement and monitor evaluation contracts, and working on continuous quality management and quality improvement;
- **Consortium for Behavioral Health Training and Research** – Academic advisory group development, workforce development and training, development of research agendas, and telehealth initiatives; and
- **Local Collaboratives** – Coordinate with Behavioral Health Planning Council, planning, legislative priorities, consumer/family involvement, and reporting.

In addition to these five Cross Agency Teams, there are numerous cross agency work groups that focus on initiatives such as Supportive Housing, Core Service Agencies, Service Definitions, Cultural Competence, and Early Intervention. These groups differ from the Cross
Agency Teams described above, as they are very focused on specific tasks. These work groups may or may not be ongoing in nature depending on the Collaborative’s priorities and goals. Additional ad hoc cross agency work groups may be developed as needs are identified.

The Behavioral Health Planning Council (BHPC) serves as the primary advisory body to the Collaborative and includes representatives from all areas of the state including consumers, family members, service provider representatives, community advocates, and state staff appointed by the Governor. The goals of the BHPC are to: (1) Improve the continuum of behavioral health services statewide; (2) Ensure that behavioral health services are consumer and family driven; (3) Increase behavioral health education and training to individuals, families, providers and the general public; (4) Increase judicial system educational opportunities; (5) Increase substance abuse and co-occurring mental health services; (6) Improve the behavioral health workforce capacity in New Mexico, including providing input into the peer certification process and all other proposed certifications; (7) Ensure smooth transitions for consumers within the behavioral health continuum; (8) Promote adequate funding to address the needs of the behavioral health continuum; (9) Ensure the availability of appropriate pharmaceuticals; (10) Ensure that behavioral health services are provided in a culturally competent manner; (11) Utilize data and information in their decision-making processes; and (12) Promote the development of appropriate employment and housing opportunities to consumers in the State. The BHPC has five standing subcommittees including Adult, Children, Medicaid, Native American, and Substance Abuse as well as additional ad hoc committees organized around specific issues, tasks, or workgroups.

Another system instituted through the behavioral health redesign process has been that of the Local Collaboratives. Fifteen Local Collaboratives (LCs) are formally recognized by the Collaborative. Local Collaborative membership includes consumers, family members, providers, advocates, and other community stakeholders. Since 2005, LCs evolved and organized in many different ways, reflecting differences in local communities throughout New Mexico. The Collaborative supports local communities to organize in the matter that best reflects the unique voices of their local communities. Leadership level meetings between Local Collaborative representatives, BHPC representatives, and the Collaborative CEO began in December 2007. These meetings are focused on evaluating and recommending improvements to the current LC/BHPC structure, roles, and internal communication.

On July 1, 2005, the Collaborative entered into a four-year contract with ValueOptions New Mexico (VONM) to be the single statewide entity through which all behavioral health funding would flow. VONM is responsible for maintaining the New Mexico behavioral health provider network and managing the service delivery system. VONM works to ensure a seamless system of care that encompasses consumer and community stakeholder input at all levels of service delivery. VONM’s four-year contract with the state ends on June 30, 2009. A Request for Proposals process is currently taking place to identify the statewide single entity for the next four-year grant cycle.

Of the Collaborative agencies, the Children, Youth and Families Department (CYFD) is the agency charged with being the children’s mental health authority in the state. The following is a description of CYFD’s vision, mission, guiding principles, and organizational structure.

**The Vision** – The Children, Youth and Families Department partners with communities to strengthen families in New Mexico to be productive and self-sufficient.
The Mission – CYFD believes in the strengths and resiliency of families who are our partners and for whom we advocate to enhance their safety and well-being. We respectfully serve and support children and families, and supervise youth in a responsive, community-based system of care that is client-centered, family-focused and culturally competent.

The Guiding Principles – CYFD believes that children and families should receive:

- Services that promote and build on individual strengths.
- Early identification and intervention services to address problems as they emerge.
- Access to a comprehensive array of services that are individualized, community-based and whenever possible, in-home, to meet the unique needs and potential of each child and family.
- Full participation and choice in all aspects in the planning and delivery of services.
- Services that are provided in the least restrictive setting and most normative environment and are integrated and linked, both within CYFD and with other child-serving agencies and which use peers, family and natural resources.
- Culturally competent services delivered without regard to race, ethnicity, religion, national origin, gender, sexual orientation, or disability.
- The most effective services that are based on evidence or promising or emerging practices, to achieve positive outcomes.
- Services that insure smooth transitions to adult service systems.

CYFD encompasses three service areas:

- Protective Services – includes statewide central intake for reporting child abuse and neglect; investigations of allegations of child abuse and neglect; foster and adoptive services; teen parent services; and youth services, focusing on youth transitioning out of the foster care system.
- Juvenile Justice Services – includes juvenile probation and parole officers; community corrections services; and detention and reintegration center facilities throughout the state.
- Family Services – includes childcare services; nutrition services; pre-kindergarten programs; early childhood development services; children’s behavioral health; and domestic violence services.
New Mexico

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.
Section I. Description of State Service System

2. Summary of Areas Previously Identified by State as Needing Attention

The New Mexico Behavioral Health Collaborative (Collaborative) anticipated three planning and implementation phases needed to transition to a single behavioral health delivery system. Phase One began in July 2005 with the awarding of a contract to the single statewide entity, ValueOptions New Mexico (VONM) selected through a competitive procurement process. The Collaborative then worked with the VONM to ensure that all services continued to be delivered and providers were appropriately paid for these services. The goals of this phase were to work out potential issues that arose during the transition, implement initial data requirements and processes, and develop goals for Phase Two. Phase One goals also included the development of expectations for local systems of care, and the development of such systems with the help of teams of State and VONM staff. In addition, the first comprehensive statewide plan for behavioral health would be completed by the Collaborative with the help of the Behavioral Health Planning Council and VONM.

Phase Two was anticipated to last up to two years (July 2006-June 2008) and focus on the identification of effective ways to combine multiple funding sources and funding mechanisms to support the desired outcomes of local systems of care and the Collaborative. An important goal of this phase was to develop performance indicators and outcome measures for subsequent phases in order to track progress toward the goals of the Collaborative. In addition, local systems of care were to be formed and effectively operating; and additional resources were to be identified to address unmet needs and identify priorities for service expansion.

Phase Three began July 1, 2008. The system has matured, performance and outcome measures are more clear, and the system can now undertake adjustments based on the results of the previous years. The goal of Phase Three is to revise the initial comprehensive statewide plan for behavioral health, with input from Local Collaboratives, VONM, and the Collaborative. New funding streams would also be identified and secured.

To date, many goals of Phases One and Two have been actualized. The Collaborative worked with VONM over the course of Phase One to ensure that all services continued to be delivered and providers were appropriately paid for these services. Potential issues during the transition were identified during Phase One, and the Collaborative worked with the SE to rectify these issues (e.g., developing over 35 common service definitions and implementing some initial steps to ensure commonality of reimbursement rates for these services). In addition, initial data requirements and processes were identified during Phase One, including 21 performance measures for the Collaborative. However, considerable work is needed to enhance the data infrastructure of the Collaborative, including the creation of a uniform data system.

Expectations for local systems of care were developed during Phases One and Two, with the creation of fifteen Local Collaboratives (LCs) within five common geographic regions (13 judicial districts) and a sixth common “region” for two Native American populations. In addition, several Collaborative staff members were hired to support the newly developed Cross Agency Teams charged with implementing the Comprehensive Plan, including one team focused solely on supporting LCs in their development. The first comprehensive statewide plan for behavioral health was completed during Phase I by the Collaborative with the help of the Behavioral Health Planning Council and VONM. This work included town hall meetings and stakeholder retreats to identify goals, strategies, and priorities, and resulted in a plan that includes the Governor’s Performance Measures, recommendations from the Legislative Finance Committee, and goals...
of the Collaborative. During this phase, the State also applied for and received a SAMHSA Behavioral Health Transformation State Incentive Grant to support the efforts of the Collaborative.

During Phase Two, LCs continued to evolve, and worked toward more stakeholder involvement. For example, LCs throughout the State received funds to encourage greater participation by their local school districts. Resources were identified during Phase Two to address some of the unmet needs and priorities for service expansion. Funds for services were allocated for several projects, including the Wraparound/Clinical Home Project, Comprehensive Community Support Services, and the Total Community Approach. Funds were also allocated to support statewide implementation of evidence-based practices such as MST. The Consortium for Behavioral Health Training and Research (CBHTR) based at the University of New Mexico was created and now leads several evaluation projects, has submitted several federal grant proposals, and is in the process of developing training curriculum for several statewide service initiatives.

Several statewide training initiatives have been completed in order to enhance local provider capacity including Traditional and Western Approaches to Co-Occurring Disorders, Suicide Prevention Training, Early Childhood Behavioral Health Training, and Behavioral Health Integration with Primary Care. Identifying effective ways of combining multiple funding sources to support the desired outcomes is an ongoing effort, as is the development of performance indicators and outcome measures to track progress toward the goals of the Collaborative.

Other accomplishments of Phase Two include: (1) Obtaining an Executive Order to address licensing and credentialing of the professional workforce, including psychologists, social workers and counseling professions; (2) Enhancing Medicaid service coverage for Multi-Systemic Therapy and Comprehensive Community Support Services; (3) Conducting a residential treatment services study for children and adolescents; (4) Commissioning a provider capacity survey and implementing recommendations from this survey to enhance provider development; (5) Working collaboratively between CBHTR and the new Department of Higher Education to address workforce development of evidence-based practices; and (6) Creating a coordinated legislative process among Collaborative agencies.

Phase Three began July 1, 2008. The Collaborative is currently working on revising the initial comprehensive statewide plan for behavioral health, with input from LCs, VONM, and other stakeholders. Several documents are being developed to inform the comprehensive statewide plan, including the Children's Purchasing Plan, identifying services to be developed, where they should be developed, and the cost of the proposed services. The Collaborative will expend concerted effort during Phase Three on ensuring service development for children in Juvenile Justice Services and/or Protective Services custody, including Adolescent Transition Services; Core Service Agencies; Quality Improvement; and Information Technology Data, Reporting, and Accountability.
New Mexico

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
Section I. Description of State Service System

3. New Developments and Issues

Behavioral Health Planning Council

Increased consumer and family voice and stronger connection between Local Collaboratives and the Behavioral Health Planning Council (BHPC) were the motivating factors leading to a change in BHPC membership, effective May 2007. The 40-member council expanded to 80 members with the inclusion of three representatives (one consumer, one family member, and one provider or advocate) from each Local Collaborative, in addition to at-large and state staff members appointed by the Governor. As a result, the BHPC is more representative of the state’s diversity related to its rural, urban, and frontier areas as well as its ethnic and cultural diversity. A diverse and representative Executive Committee, reflecting the new membership composition, was elected to direct the work of the BHPC.

Medicaid State Plan Amendment

Two significant changes occurred for the children’s system of care as of January 1, 2008. First, Comprehensive Community Support Services (CCSS) replaced Case Management on ValueOptions New Mexico (VONM) service taxonomy for community behavioral health service providers. CCSS is an integrated, centrally managed approach to care with a focus on an individual’s or family’s strengths and informal supports. Its purpose is to coordinate and provide services and resources to children, youth, and their families to promote recovery and resilience. CCSS activities specifically address goals in the areas of independent living, learning, working, socialization, and recreation. CCSS also utilizes consumers as family and peer specialists to support families and youth in navigating the community-based system of care. CCSS is an integral part of implementing the Wraparound Approach in New Mexico’s service delivery system.

Second, the Medicaid State Plan was amended to include MST in its array of basic services. New Mexico has 13 sites throughout the state providing MST services to youth and their families who are involved with the juvenile justice system. Prior to this it was considered an enhanced service and therefore required a prior authorization before service delivery could begin. In addition, VONM was able to raise the rates it pays to providers of MST services, making it cost effective for providers throughout the state. This same Amendment also allowed providers of MST services to deliver the service to Medicaid recipients who are not participants in the managed care Medicaid system (i.e., Native American youth). This year VONM is able to provide start up funds for three additional MST sites in areas of the state that are not currently served, bringing the total number of MST sites to 16.

Assessment Process/Core Service Agencies/CAFAS

One of the initial goals of creating the Behavioral Health Collaborative (Collaborative) was to streamline a fragmented service system ensuring that service definitions were consistent across funding streams. As the system of care has matured, it became evident that the service definition for assessments was not meeting the complex needs of many consumers. This is especially true of children and youth where multiple indicators (i.e., level of functioning, behaviors, family functioning, etc.) may warrant interventions including out-of-home placement or two or more types of behavioral health services. This led to the cross agency service definition work group being tasked with revising the basic diagnostic assessment service...
definition as well as creating a new service definition for enhanced assessments. Enhanced assessments are to involve a thorough evaluation of the individual and family’s clinical and psychosocial needs, functional level, and service recommendations.

This coincides with the implementation of Core Service Agencies (CSAs) and the Child and Adolescent Functional Assessment Scale (CAFAS). CSAs are multi-service agencies that will assure that consumers of behavioral health services will receive comprehensive and integrated care across a range of services. These agencies will help to bridge treatment gaps, promote the appropriate level of service intensity, ensure that community support services are integrated into treatment, and develop the capacity for consumers to have a single point of accountability for identifying and coordinating their behavioral health services. CSAs will ensure that the youth with behavioral health needs receive quality mental health services with a priority focus on: evidenced based practices; promising practices that do not yet meet the evidence-based standard; best practices or national standards with successful outcomes; and cultural diversity. CSAs will be required to provide Crisis Management, Diagnostic Assessment, Comprehensive Community Support Services (CCSS), Psychiatric Services, and Outpatient Treatment.

In order to provide the least restrictive, most appropriate services possible it is imperative that children, youth, and, their families have access to comprehensive assessment services that focus on the strengths, needs, and desires of those receiving behavioral health services. The Behavioral Health Collaborative has also identified the need in their strategic plan to measure their performance by examining the percent of children and youth with improved functional assessments between admission and discharge in community based programs. CYFD contracted with national expert Kay Hodges, PhD to provide training on the use of a functional assessment tool to CYFD staff, VONM clinical and regional staff, and CYFD consultants. Clinical Home providers began administering the Child and Adolescent Functional Assessment Scale (CAFAS) to assist with assessment, treatment planning, and outcome tracking. The CAFAS will be utilized in all CSAs serving children, youth, and their families beginning later this year. Data from the CAFAS will be aggregated and evaluated through the Consortium for Behavioral Health Training and Research (CBHTR). CBHTR will then host “data parties” so that providers can compare themselves to aggregate statewide data and utilize the data for quality improvement purposes.

Data Warehouse Initiative

One of the major challenges New Mexico is experiencing in its system of care is data including collection, evaluation, and utilization. Although, initial data requirements and processes were identified when the Collaborative was created, substantial work is needed to create a data system or warehouse that routinely reports core data to the Collaborative’s partners including providers, Local Collaboratives, and the BHPC. The Collaborative will expend concerted effort during the next fiscal year and beyond on quality improvement through Information Technology (IT) data, reporting, and accountability. Although, several performance indicators and outcome measures have been selected to track progress toward goals. The creation of a fully functioning data system and accompanying reporting processes is necessary to obtain the core data needed to accurately track these measures. In addition, the number of measures is currently unwieldy, and it is necessary to define a core set of dashboard indicators for tracking the success of the Collaborative. The need for the accurate reporting of core data to determine effectiveness of services and identification of consumers served is critical.
New Mexico

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.
New Mexico

Child - Description of Regional Resources

Child - A brief description of regional/sub-State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.
New Mexico

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.
Section I. Description of State Service System

6. Description of State Agency’s Leadership

The Children, Youth and Families Department (CYFD) is the Children’s Behavioral Health Authority for the State of New Mexico. As such, the Cabinet Secretary co-chairs the Behavioral Health Collaborative (Collaborative) on alternating years, FY2008 being one such year. CYFD also is responsible for co-chairing the Children’s Subcommittee of the Behavioral Health Planning Council. In addition to these two on-going responsibilities, CYFD provides leadership in coordinating behavioral health services in several specific areas.

Children’s Trust Fund

The Children’s Trust Fund was created by state statute in 1978 in order to provide the means to develop innovative projects, which address one or more of the following:

- Preventing abuse and neglect of children;
- Providing medical, psychological and other appropriate treatment for children who are victims of abuse or neglect; and/or
- Developing community based services aimed at the prevention and treatment of child abuse and neglect.

The Children’s Trust Fund programs are funded by the sale of marriage license fees, the sale of license plate fees, interest income earned from the fund itself, and the state general fund. In FY2009, the Children’s Trust Fund is sponsoring 14 projects across the state of New Mexico.

Early Childhood System of Care

CYFD is the statewide lead on services to meet the behavioral health promotion, prevention, and treatment needs of infants and young children. Promotion services primarily involve the Home Visiting Program. Home Visiting is a service provided within the home to first time parents. Home visits may begin before the child is born and include the following activities: 1) Assisting families in identifying informal support networks; 2) Providing referrals to community resources as necessary; 3) Providing information on prenatal health, newborn care and child development; and 4) Determining if families have been referred to Medicaid. Newborn and toddler visits are provided during the first three years of the child’s life and include the following activities: 1) Post-partum visits conducted and include assessment of the mother’s well being, specifically in regard to physical, emotional, social supports, and concrete needs; 2) Guiding families, caregivers and adoptive parents through developmental curricula; 3) Assisting families in identifying informal support networks; and 4) Providing referrals to community resources as necessary. Sometimes, promotion services such as the Home Visiting Program also deliver “preventive-interventions”, but if a higher level of care is needed for the family, referrals are most often made to treatment providers.

Infant Mental Health treatment services are an array of developmental, supportive and therapeutic strategies and services designed to ameliorate or reduce the risk of social, emotional and behavioral disorders and disruptions in the relationship between an infant and parent/caregiver, due to infant/toddler and/or parental/caregiver vulnerabilities and/or negative environmental factors that are significantly and negatively impacting the parent/caregiver-infant relationship. Such disorders and disruptions place the infant at risk for more severe behavioral, social, emotional and relationship disturbances, as they get older.
CYFD has been the primary state force behind the New Mexico Association for Infant Mental Health (NMAIMH) since its inception in 2004. CYFD supports NMAIMH in the following initiatives:

- Building a system of care for infant mental health;
- Creating a systematic means for training, educating, and supporting professionals and paraprofessionals in infant mental health through a four-tiered endorsement system;
- Implementing an specialized infant team for Protective Services to work with infants in the foster care system; and
- Developing a specific service definition for infant mental health services so that the services can be provided and reimbursed through Medicaid.

Adolescents In Transition

Successful transition of youth within the various age-defined systems of behavioral healthcare, as well as those transitioning from state custody or those under the supervision of state services, are essential in promoting both recovery and resiliency. As such, the system of care must ensure that the behavioral health service array is adequate to meet the needs of youth aging out of the foster care system, transitioning out of the juvenile justice system to the community, and/or youth involved in behavioral health system into the adult system. In reviewing the service array for youth in transition, it is essential that special attention be paid to those youth and young adults with dual diagnoses of Developmental Disabilities and Mental Illness (DD/MI). CYFD has taken a lead in facilitating the Adolescents In Transition workgroup whose goal it is to develop a system of care to meet the needs of the young adult population (18 to 21 year olds) who continue to need behavioral health services in their transition to the adult system of care.

Innovative Pilot Projects

With the transformation of the behavioral health system of care in New Mexico, CYFD has been relieved of many of its previous duties related to producing Requests for Proposals, contracting with service providers, and monitoring those contracts. As a result, CYFD staff have been able to place significant time and effort into creating innovative projects related to the behavioral health system of care such as the Wraparound/Clinical Home Project and the Supportive Housing Project.

In FY2008, $150,000 was designated in the CYFD budget to initiate a Supportive Housing Project utilizing a Housing First model to assist ten juvenile justice and ten protective services young adults ages 18 to 21 transitioning from the children’s behavioral health system of care to the adult system of care. In a Housing First program, the underlying principle suggests that vulnerable and at-risk populations are more responsive to interventions and social service supports after they secure their own housing. The Housing First approach affirms a person’s right to housing without any “service strings attached”.

A contract was developed with the Supportive Housing Coalition of New Mexico to provide scattered site housing in Albuquerque. The program participants began moving in to their apartments in December 2007. The program offers young adults the opportunity to access and keep rental housing, to access a variety of support services to help them maintain housing without the requirement to comply with services in order to keep housing, and to learn the skills necessary to be a good tenant. The young adults receive assistance with Section 8 housing applications so that when the young adults turn 21 they continue to have access to rental
assistance and they are able to build a positive rental history. To date, the program has been extremely successful, with only one of the young adults terminating the lease agreement and leaving the program.

Another step in developing a comprehensive, integrated, community-based system of care for children, youth, and their families has been the Clinical Home Project. The Clinical Home Project adopted the Wraparound Milwaukee model as the conceptual framework to provide intensive wraparound services with youth and their families. The goals of the project are to prevent out-of-home placement, ensure quality service delivery, and to operate behavioral health services from a recovery-oriented and strengths-based perspective in accordance with needs identified through a diagnostic assessment. The Clinical Home Project involves collaboration between the Children, Youth and Families Department (CYFD), VONM and nine service providers in Santa Fe, Albuquerque and Las Cruces. The Clinical Home Project has served 302 youth and their families. Approximately 90% of these youth are juvenile justice involved youth on probation or parole or involved with post-parole transition services.
New Mexico

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.
Part C. State Plan
Section II. Identification and Analysis of the Service System’s Strengths, Needs, and Priorities

1. Service Systems Strengths and Weaknesses –
Adult - A discussion of the strengths and weaknesses of the service system.

New Mexico continues to go through significant changes in the implementation of its evolving public behavioral health service system. In this time, the State has made significant progress moving from a fragmented collection of often-duplicated mental health and substance abuse services to an integrated system managed by a single contracted Statewide Entity (SE) and overseen by the New Mexico Interagency Behavioral Health Purchasing Collaborative (Collaborative). The voices of consumers, family members, providers, and other stakeholders continue to be increasingly heard at all levels of the process, facilitated by the growth of the Governor’s Behavioral Health Planning Council (BHPC) and the development of fifteen community-based Local Collaboratives (LC).

SFY-09 marks the fourth and final year of the Collaborative’s original contract with ValueOptions-New Mexico. Under the New Mexico Procurement Code, any federal or state funds in excess of $50,000 must be put up for competitive bid at least every four years (one contract year based on an original request for proposal with up to 3 annual contract extensions based on satisfactory performance.)

One of the key opportunities to strengthen New Mexico’s behavioral health service system is the development of the second Request for Proposal for a statewide entity to manage behavioral health funding for the Collaborative. This new RFP, which is slated to be published mid-2008, allows the Collaborative to build upon the experience of the first three contract years to craft a document that reflects what New Mexico has learned and to respond to the specific input received from consumers, family members and other stakeholders. There will be ample time for public review and input to the RFP prior to its official publication. New Mexico expect and welcome high level competition in response to the RFP and look forward to the next phase of system development, which the new contract, slated to begin in July 2010 represents.

The newly reconstituted Behavioral Health Planning Council (BHPC) and it Legislative Review Team (LRT) provides Local Collaborative specific service priorities in the 10 Strategic Priority areas established by the Collaborative and in 4 statewide/system priority areas. The LRT reviewed each proposal and reported recommendations to both the BHPC and the Collaborative in preparation for the 2009 Legislative Session. (January, 2009)

Several key structures have been established in New Mexico’s transforming behavioral health service system which strengthen consumer roles. These include:

The Department of Recovery and Resiliency at ValueOptions NM, the first of its kind for ValueOptions nationwide, represents the commitment of the State of New Mexico and its Statewide Entity to transform the behavioral health services system in NM to an authentic recovery and resiliency based system of care. Led by the Vice President of Recovery & Resiliency, VONM in response to contract obligations, has devoted substantial resources to
creating a system wide presence and network of recovery and resiliency supports, which include training, support, and interventions if necessary to insure that each consumer has the information they need to make an informed choices about their own treatment. Five full-time Recovery and Resiliency staff members work with Peer Specialists assigned to each of the six VONM regions.

A total of 57 Consumer Peer Specialists were first trained through the New Mexico developed curriculum and certified by the Collaborative in 2007. Twenty trainers and another 45 certified peer specialists have been recognized by the Collaborative. Based on training registrations another 100 peer specialists will be certified.

A curriculum to train Family Peer Specialists who can be certified similarly to Consumer Peer Specialists will be completed by a statewide work group of youth and family members in 2009.

Both Certified Peer and Certified Family Specialists meet staffing qualifications for the Community Support Worker position in qualified provider organizations.

The Mental Health Transformation State Incentive Grant (MHT SIG) also continues to play a key role in furthering system change in New Mexico. The challenges of the grant have mirrored the challenges of the Collaborative effort here, i.e. clarification of roles, refining a cross-agency model for financial management, service planning, and performance measurement. Key areas in which the Transformation Grant is evidencing progress are consumer engagement, strategic planning, including a Supportive Housing Plan for New Mexico and Clinical Home Pilot. There continues to be extensive evaluation of the transformation efforts in New Mexico by the MacArthur Foundation, NIMH, and through the grant itself.

As noted above, the systems strengths at this stage of transformation are also its areas of weakness. The effort to imagine and manage a virtual Collaborative is rife with opportunities – for elimination of fragmented service delivery, maximizing the effective use of funding, increasing consumer voice and control, testing unique cross-agency service models (PTSD pilot, Total Community Approach) – and challenges – overcoming “turf” issues, aligning agency and Collaborative priorities, identifying and tracking meaningful performance measures. Specific to BHSD, the opportunities and challenges of the months ahead are to implement the new organizational structure of the Division and strengthen its role in clinical leadership and recovery supports.
New Mexico

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.
2. Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

The transformation of the New Mexico Behavioral Health service system is the result of several key analyses, including a multi-department statewide systemic behavioral health gap analysis/needs assessment (July, 2000) that looked at the existing fragmented, multi-system strategy. A key result of this analysis was the creation of the single statewide behavioral health service delivery system to address the unmet needs and to ensure a seamless system of care that is accessible and continuously available. The new system, which began in July, 2005, is overseen by the Interagency Behavioral Health Purchasing Collaborative (Collaborative) and is administered through a Single Statewide Entity (SE), ValueOptions.

Through various mechanisms, including Cross-Agency Teams (CAT’s) and an expanded role for the Behavioral Health Planning Council, the Collaborative is engaged in a continuous quality improvement process regarding the New Mexico behavioral health system. Data regarding the quantity and quality of behavioral health services being accessed and utilized by children, youth, adults and their families is provided by VO-NM on a continuous basis to Collaborative’s members. Agencies review this information and provide feedback via the Oversight Team. Several service and system development efforts have been initiated as a result of this process, which will continue through SFY-09.

Another key mechanism for identifying and analyzing unmet service needs and critical gaps in services is the Local Collaboratives (LC’s). LC’s utilize local data and information to craft their legislative priorities each year. These priorities inform the yearly legislative agenda of the Collaborative as well as serve as a guide to VO-NM regarding the distribution of reinvestment funds to enhance the system of care.

In developing of the Mental Health Transformation Statewide Grant and the State Infrastructure Comprehensive Behavioral Health Plan, New Mexico used the gap analysis/needs assessment and the New Freedom Commission’s goals as a framework for the state’s transformed behavioral health service system. These goals are:

Goal 1: Americans Understand that Mental Health Is Essential to Overall Health
Goal 2: Behavioral Health Care Is Consumer and Family Driven
Goal 3: Disparities in Behavioral Health Services Are Eliminated
Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice
Goal 5: Excellent Behavioral Health Care Is Delivered and Research Is Accelerated
Goal 6: Technology Is Used to Access Mental Health Care and Information
New Mexico

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.
3. Plans to Address Unmet Needs

State Priorities
The New Mexico Behavioral Health Collaborative’s vision, which began in July through 2005 House Bill 271 (HB271), is a single behavioral health service delivery system 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; and available funds are managed effectively and efficiently.

Three efforts currently underway by the Collaborative are key to system development and will provide the foundation for re-balancing the system-of-care to ensure that all New Mexicans have access to the highest quality, least restrictive behavioral health care possible. These areas of development involve creation of a Children’s Purchasing Plan; the development of a Core Service Agency model of service management; and the creation and implementation of a Collaborative Cultural Competency Plan. An Adult’s Purchasing Plan will be developed in SFY-09 for community-based behavioral health services.

The Local Collaboratives (LCs) CAT continue to ensure the inclusion of strong local voices to guide behavioral health planning and services. CAT members provide community input to the statewide comprehensive behavioral health plan, assist in developing guidelines for the community reinvestment process, implement guidelines to include consumer and family members in the LCs, coordinating membership with the BHPC, and clarifying how the LCs differ from local health councils.

The New Mexico Consortium for Behavioral Health Training and Research (CBHTR) CAT is working in partnership with the Higher Education Department (HED) and a consortium of universities and community colleges to expand the state’s behavioral health workforce, improve and increase training in evidence-based practices, and develop and implement a state services research agenda. The Collaborative has developed an expanded partnership with the Western Interstate Commission on Higher Education (WICHE) through CBHTR. This partnership is focused on statewide behavioral health workforce development and expanded multi-disciplinary training partnerships. The workforce development process to date has included the development of a draft document by WICHE of the state of the behavioral health workforce in New Mexico, along with suggested long-term recommendations. This document has had its initial review by the CBHTR executive council and other state partners, with a plan towards a broader discussion and implementation planning process this summer. In terms of behavioral health training, WICHE has had long partnership with the UNM rural psychiatry training program, a SAMHSA and Annapolis Coalition model program. WICHE and CBHTR are combining forces to link the New Mexico universities and community colleges with behavioral health training to develop regional coordinated training sites in rural New Mexico. Discussions are underway to plan coordinated multi-disciplinary training that will include social work, counseling, psychology and psychiatry trainees. Additional plans include making the UNM rural psychiatry program a WICHE region-wide training program.
Other CBTHR activities include:

- Developing curricula for providers regarding the Wrap Around service model and the delivery of Comprehensive Community Support Services; and

- Evaluating the Conical Home Pilot

The **Policy Development CAT** will finalize the definition of Consumer/Family, develop a legislative process to coordinate legislative initiatives affecting behavioral health and the Collaborative, and identify areas that need Collaborative policies.

The **Communications CAT** is developing a common message around the Governor’s 21 Performance measures, hiring communications and website staff, setting up a website and producing a newsletter with the state identity, and planning and managing events and media relations.
New Mexico

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.
Part C. State Plan  
Section II. Identification and Analysis of the Service System’s Strengths, Needs, and Priorities  

4. Recent Significant Achievements  
Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.  

SFY-09 represents the 4\textsuperscript{th} year and 2\textsuperscript{nd} Phase of the implementation of the unified statewide behavioral health system in New Mexico through the utilization of the Single Entity-ValueOptions-NM. Recent significant achievements over the past year include:  

Interagency Behavioral Health Purchasing Collaborative  
\textit{HB181}, which strengthen the Collaborative through:  
\begin{itemize}  
    \item a consolidated legislative agenda and behavioral health budget;  
    \item quarterly reporting to Legislature; and  
    \item rule-making authority, through the Human Services Department, in the areas of service delivery standards, quality management, performance measures and other key aspects of service system development as they reflect the rights and responsibilities of consumers and providers.  
\end{itemize}  

Local Collaboratives  
Local Collaboratives (LC’s) reflect the Collaborative agencies commitment to a well-developed local-level collaborative efforts throughout the state. The 13 LC’s, which are based on New Mexico’s judicial districts, plus a limited number for the state's sovereign tribes and pueblos have been recognized and continue to develop the knowledge, skills and abilities to increase both community voice and input into the service system as well as increase local services based on identified needs.  

Behavioral Health Planning Council  
The reconfiguration of the Behavioral Health Planning Council (BHPC) increases \textit{consumer and family} voice and stronger connection between Local Collaboratives and the Behavioral Health Planning Council (BHPC) were the motivating factors leading to a change in BHPC membership, effective May 2007. The BHPC membership expanded to include three representatives (one consumer, one family member, and one provider or advocate) from each Local Collaborative, in addition to at-large and state staff members appointed by the Governor. A diverse and representative Executive Committee, reflecting the new membership composition, was elected to direct the work of the BHPC.  

Oversight Team  
The Oversight Team (OT) continues to provide a key role in the unified statewide behavioral health system. The Oversight team roles include:  
\begin{itemize}  
    \item Technical assistance to VO-NM departments on the New Mexico service delivery system, including enrollment, claims, specialized care coordination, and utilization review.  
    \item Site visits to different departments to ensure contract compliance and maintenance of service quality.  
\end{itemize}
• Ensure that the required Medicaid external quality review was completed.
• Assist VO-NM in the development of critical indicator reports and performance measure reports and monitor these reports.
• In addition to developing reports, the OT helped VO-NM draft an enrollment form to ensure that all state and federal reporting requirements are met, including the CMHS Block Grant National Outcome Measures. This process also entailed the development of guidance memoranda which serve as report instructions for the data elements and specifications required that can be revised yearly as needed.

New Mexico Consortium for Behavioral Health Training and Research

The Consortium for Behavioral Health Training and Research in collaboration with BHSD Co – Occurring State Incentive Grant, UNM Center for Rural and Community Behavioral Health, and community behavioral health stakeholders built upon the findings of a 2006 Native American Behavioral Health Needs Assessment to design and implement five regional trainings dealing with Traditional and Western Approaches To Screening And Diagnosis of Mental Health, Substance Abuse, and Co-Occurring Disorders; Traditional and Western Approaches to Counseling Theory: Stages of Change Model and Treatment Planning; Traditional and Western Approaches To Psycho-pharmacology; and Identification Of Local And Statewide Behavioral Health Resources. With a training team of Native American professionals, the trainings reached 500 trainees, many Native American, through 15 training session in the fall of 2007. Related ongoing work will continue in collaboration with the Native American Subcommittee of the Behavioral Health Planning Council and with the Department of Indian Affairs.

Consumer Satisfaction Project (CSP)

The New Mexico Consumer Satisfaction Project (CSP) is a joint effort between the Department of Health Behavioral Health Services Division (DOH/BHSD), Human Services Division Medical Assistance Division HSD/MAD, Value Options-New Mexico Department of Recovery and Resiliency (VO-NM) and Children Youth and Family (CYFD). Its purpose is to assess consumer satisfaction. The Consumer Survey Project (CSP) is designed to promote consumer and family involvement in the community for recipients of behavioral health services. The objectives of the Consumer Satisfaction Survey Project are to show how consumers and families could indicate satisfaction with the inclusion of their voice and their involvement in all levels of the service delivery system.

Additionally, the Project has been almost entirely consumer-driven. New Mexicans in recovery from mental illness and substance abuse lead or play a major part in project coordination, design, implementation, data collection, and information dissemination. The telephonic and face to face survey instruments for adult and child populations are based on the national 28-item Mental Health Statistics Improvement Project (MHSIP) with additional items on substance abuse, housing, and employment in the adult version. It also includes a section where participants can comment either on specific survey items or about their general perceptions of the programs where they receive services. It is available in English and Spanish. The CSP Steering Committee, consisting of representatives from BHSD HSD/MAD CYFD Value Options-New Mexico with consumer leadership from populations, served to guide the project’s overall direction.
New Mexico

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.
5. State’s Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

The State of New Mexico has completed Phase One & Two of the transformation of its behavioral health system, which officially began on July 1, 2005. House Bill 271 (HB271), which was signed into law effective May 19, 2004, mandated a move to a single statewide behavioral health service delivery system that more fully promotes the behavioral health and well-being of children, youth, adults and families; encourages a seamless system of care that is accessible and continuously available; and emphasizes prevention, early intervention, resiliency, recovery and rehabilitation. The new behavioral health service delivery system is administered through a Single Statewide Entity, ValueOptions and overseen by the Interagency Behavioral Health Purchasing Collaborative (Collaborative). Phase One of the New Mexico behavioral health transformation focused on building the fundamental philosophy and infrastructure to enable the transformation to occur while maintaining services. Phase Two is focused on implementing a holistic, integrated system of care (ISOC) approach to substance abuse and mental health services for children, adolescents, adults and their families.

The New Mexico integrated system of care is envisioned as a system that incorporates a broad array of services and supports, is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with consumers and their families at service deliver, management, and policy levels and supports recovery and resiliency.

The remainder of this year will be one of continued action as the Collaborative evaluates and creates plans to build on the results of several key pilot projects, the Veteran and Families Support Project, Total Community Approach, Clinical Home, and the Supportive Housing Pilots.

New Mexico stands on the edge of the most significant opportunity of our transformation. The next months and years will move the state significantly toward the ultimate goal of rebalancing the system of care for all ages. Comprehensive Community Support Services, which became a reality in January 2008, and Core Service Agencies, which are next on the horizon, build on learning’s of the Clinical service utilization and needs in their communities, the Statewide Plan and timeline for system rebalance will truly be reflective of local voices.
New Mexico

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.
Section II. Identification and Analysis of the Service System’s Strengths, Needs and Priorities

1. Service System Strengths and Weaknesses

The behavioral health system of care in New Mexico has been undergoing a major transformation over the last four years with the formation of the Behavioral Health Collaborative (Collaborative), the contracting with a single statewide entity—ValueOptions New Mexico (VONM), and the restructuring of the Behavioral Health Planning Council (BHPC) and Local Collaborative (LC) system. With these changes, the system has become stronger in many areas, and continues to face challenges in others.

System of Care Strengths

In keeping with the New Freedom Commission’s (NFC) second goal, “Mental Health Care is Consumer and Family Driven”, the New Mexico behavioral health system of care has engaged consumers, family members, and local communities in a more consistent and meaningful manner. The Office of Consumer and Family Engagement (CAFÉ) is a new incarnation of the Office of Consumer Affairs and is housed at the Collaborative offices. Its name highlights the change in focus. Through the federal Behavioral Health Transformation State Incentive Grant (TSIG) CAFÉ has grown to include a Family Advocate and a Youth Advocate whose jobs entail ensuring that family members and youth consumers participate in meaningful ways in the system of care. The BHPC has substantially increased its consumer, family member, and advocate representation (62%) through local collaborative appointments. This brought membership from approximately 30 people to approximately 80 people. The BHPC assists with planning and policy development, and reviews the mental health and substance abuse federal block grants. The Collaborative created the Local Collaborative structure, comprised of 15 local stakeholder groups that address behavioral health system change within their local communities, and provide input and recommendations to the Collaborative. Over the last year, LCs continued to evolve, and worked toward more stakeholder involvement. For example, LCs throughout the state were allocated funds to gain greater participation by their local school districts in LC meetings, thus enhancing a more comprehensive and integrated approach to the system of care.

Early on, the Collaborative saw a gap in its system of care in regards to the NFC’s fifth goal, “Excellent Mental Health Care is Delivered and Research is Accelerated”. In an effort to improve access to quality of care for all of New Mexico’s residents with mental and substance use conditions, the Collaborative and the New Mexico Higher Education Department (HED), in partnership with the state’s users and providers of services and the state’s institutions of higher education, created the New Mexico Consortium for Behavioral Health Training and Research (CBHTR). The Consortium has three major goals:

- To improve the access of all New Mexico residents to behavioral health care prevention, early intervention and recovery services that are delivered by a well trained, culturally and linguistically competent workforce, using the best scientific knowledge available.
- To develop behavioral health services research and evaluation capacity that addresses New Mexico’s unique concerns.
- To close the loop between science and practice through policy guidance and technical assistance to the state’s leadership and practice communities, especially to service recipients and their families.
CBHTR now leads several evaluation projects, has submitted several federal grant proposals, and is in the process of developing training curriculum for several statewide service initiatives. One consistent issue facing rural New Mexico is the shortage of licensed and credentialed professional workforce. The Collaborative was successful in obtaining an Executive Order to address licensing and credentialing issues of the professional workforce, including psychologists, social workers and counseling professions.

Another major advancement for New Mexico has been increased access to services through innovative approaches to service delivery. The Total Community Approach (TCA) projects have the goal of developing effective substance abuse prevention, treatment, harm reduction and law enforcement service systems in local communities. Total Community Approach means teaming with local municipalities and targeting resources, from prevention to treatment, to the populations where they are most needed to deal with substance abuse and behavioral health challenges. Three of the sites selected for this project chose to focus on the needs of youth with substance abuse issues. These are:

- **LC 5**—Chaves, Lea, and Eddy Counties. LC 5 is targeting adolescents (ages 13-18) and their families, with substance use issues, in Hobbs. They are implementing MST (Multi-Systemic Therapy) and school-based behavioral health services.
- **LC15**—Navajo Reservation. LC 15 is targeting youth aged 13-24 and their families. They are implementing a case management model based on the Navajo Regional Behavioral Health Authority under the State of Arizona’s Department of Health.
- **LC 8**—is targeting adolescents (grades 9-12) and their families in Colfax County. They are implementing a mobile individual, family, and group treatment approach throughout Colfax County in home and community settings.

The Wraparound/Clinical Home project was initiated with 10 provider agencies. A clinical home is a single case management provider that coordinates all behavioral health services, including clinical supports (intake, assessment, treatment, service planning), community supports (school, social activities, housing), and existing supports (family, neighbors, friends). The goals of the project are to prevent out-of-home placement, ensure quality service delivery, and operate behavioral health services from a recovery-oriented and strengths-based perspective in accordance with needs identified through a diagnostic assessment.

Transition Services employs Regional Transition Coordinators to provide behavioral health case management services to youth and families upon admission to CYFD facilities. Once the youth exits the facility, the Regional Transition Coordinator continues to work with the youth and his/her family at least through the end of their parole. At that time a youth may opt out of services, or continue services voluntarily until age 21. Even if a youth chooses to no longer receive services, he or she may return to services at any point up to his/her 21st birthday.

Another service enhancement activity is the development of a ten-year permanent supportive housing plan that includes an aggressive goal of creating 5,000 new supportive housing opportunities. Currently, 18 youth are being housed in permanent supportive housing in Albuquerque and another two youth are to move into housing in the next few months. To date, the program has been extremely successful, with only one of the young adults terminating the lease agreement and leaving the program.

Finally, the Collaborative has successfully consolidated over $300 million state and federal behavioral health dollars and its management through a single statewide entity under contract with the State of New Mexico, replacing multiple contracting mechanisms and administrative
infrastructures. In addition, it has created a coordinated legislative process among Collaborative agencies so that Collaborative agencies are not competing for legislative funds, but rather are working cooperatively to fund the greater system of care.

System of Care Challenges

On June 30, 2009, the state’s contract with VONM will end. Currently, a new Request for Proposals is being developed and the contract for statewide single entity will be up for bid again. In preparation for the issuance of the new Request for Proposals, the Collaborative conducted a series of stakeholder interviews and public meetings, to obtain feedback about successes and challenges of the transformation over the last three years. One consistent theme emerged across stakeholder groups; change has been long and hard, that progress has been made over the past three years, and that there is a fear of losing these gains.

One significant challenge facing the system of care is that of data. Considerable work is needed to create a uniform data system that routinely reports core data to the Collaborative’s partners. The creation of a fully functioning uniform data system and accompanying reporting process is necessary to obtain the core data needed to accurately track identified performance measures. In addition, the number of measures is currently unwieldy, and it will be necessary to define a core set of dashboard indicators for tracking the success of the Collaborative.

LCs continue to need support in their development, as many have struggled over the past few years to recruit members and achieve goals. This is particularly true in rural communities, who are widely dispersed, and therefore have limited access to LC meetings and difficulty completing requests on short time frames. LCs and other stakeholder groups report that there is sometimes difficulty with consistent and comprehensive lines of communication between the Collaborative and LCs.
New Mexico

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.
Section II. Identification and Analysis of the Service System’s Strengths, Needs and Priorities

2. Unmet Service Needs

As described in the previous section, the state’s contract with ValueOptions New Mexico (VONM) will end on June 30, 2009. A new Request for Proposals is being developed and the contract for statewide single entity will be up for bid again. In preparation for the issuance of the new Request for Proposals, the Behavioral Health Collaborative (Collaborative) conducted the stakeholder meetings and dialogues. Using the feedback from these meetings, the Collaborative identified several areas of growth and improvement on which to focus in the coming years. The following is a list of priority areas in which system of care enhancements/improvements that need to be made.

1. **Local Collaboratives** – Some of the Local Collaboratives (LCs) continue to struggle with issues related to organization, infrastructure, geography, and communication. Some LCs have been able to overcome some or all of these challenges and others have not. The state regularly hears about the needs of LCs in relation to funding, staff, and sometimes guidance in how they are to function on a day-to-day basis.

2. **Consumer, Family, and Provider Voice** – One means the Collaborative established to ensure consumer, family, and provider voice in the system of care was through the LC system. In spite of this, consumers, family members, and providers continue to struggle with the sense that there is a perceived disconnect between the Collaborative and the extent to which it is consumer driven and family focused. The Collaborative recognizes this need to enhance the level of consumer, family, and provider voice in the system of care.

3. **Improve Funding Mechanisms** – As costs increase and capacity increases, the provider network is finding it difficult make ends meet. This is particularly true as the system of care moves toward more home and community based services and is focusing on expanding its services in rural areas. New and innovative funding mechanisms must be found to manage the cost of doing business for providers.

4. **Expand Pilot Projects and Other Needed Services** – The state has been very successful at obtaining federal grants such as the Co-occurring Disorders State Incentive Grant (COSIG), the Screening, Brief Intervention, Referral, and Treatment (SBIRT) grant, and the Access To Recovery (ATR) grant. As these grants come to an end, the state needs to find a way to sustain and integrate the successes that have come as a result of the federal grants. In a similar manner, the state needs to build on the successes found in the Wraparound/Clinical Home Project and the Supportive Housing Project and be able to expand these approaches to service delivery into the system of care.

5. **Improve the Data System** – The need for data was a consistent theme noted during public meetings. Many stakeholders reported it was difficult to provide input without having access to data. In particular, it would be useful for LCs to receive data on gaps in services for children, youth, and families, on an ongoing basis. The need for the accurate reporting of core data to determine effectiveness of services and identification of consumers served was also highlighted, as was the need to present information in easily understood language and to gain broader consumer, family member, and provider input. Several stakeholders highlighted the need for a uniform data system.
6. Improve Training and Workforce Development – Workforce development has been a consistent challenge in a large, rural state like New Mexico. Service providers in rural areas often are unable to find licensed clinical staff that are committed to remaining in a rural or frontier community. Some stakeholders felt that the move toward evidenced based practice was positive, but required significant training and cost. There was also concern that training has been completed on a variety of topics without support and/or resources for implementation.

7. Improve Communication with and Services to Tribal Communities – Some stakeholders reported that the system transformation has been positive for Native communities by creating opportunities for increased funding and services. Other stakeholders noted that many ideas have not been carried through to tribal communities. Several stakeholders noted that LC14, the LC organized around non-Navajo Native peoples, is spread across the state and represents too many interests, including Pueblo and Urban Indians. Other stakeholders highlighted the need for formal government-to-government relationships to be established with the State and tribal communities. In addition, the need for culturally appropriate service planning and implementation was highlighted.
New Mexico

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.
Section II. Identification and Analysis of the Service System’s Strengths, Needs and Priorities

3. Plans to Address Unmet Needs

The previous section identified unmet needs in the New Mexico Behavioral Health System of Care. The following identifies recommended action items or steps that if taken, would address the unmet needs in the system of care.

1. **Further Develop the Local Collaborative Structure** – The state should provide more technical assistance on Local Collaborative (LC) development in order to support LCs in meeting state requests for information and feedback. LCs need to have regionally available computer-equipped office space so that they can carry out the administrative tasks such as communication with LC members and the state, organization of meetings, subcommittee meetings, etc. The statewide single entity should provide support to LCs for transportation and communication. Behavioral Health Collaborative (Collaborative) and other state staff should interface with LCs on a more regular basis. A mechanism needs to be developed to demonstrate how LC input is used and acted upon by the Collaborative. Investigate the creation of additional LCs to cover both smaller regions and unique needs (cultural or geographic).

2. **Consumer, Family, and Provider Voice** – The state and the single statewide entity need to support the development of consumer and family operated services. The order of the Collaborative meetings should be changed, moving public comment to the beginning so that input from consumers, family members, and providers can be acted upon in the same meeting. Provide regular, easily understood orientations to the Collaborative process and the state system of care. Include consumers, family members, and providers in planning, policy development, and implementation processes rather than simply communicating the outcomes or asking for input. Support the development an independent statewide consumer network organization.

3. **Improve Funding Mechanisms** – The Collaborative and the statewide single entity in cooperation with services providers should conduct a rate analysis and change rates to reflect the cost of doing businesses. The contracted single entity should explore and develop creative and flexible funding structures (e.g., capitation, at-risk contracting, and case rates) to enhance access and allow providers to function in a more fiscally stable manner. Provide technical assistance to service providers on creating viable and sustainable financial infrastructures.

4. **Expand Pilot Projects and Other Needed Services** – The state, in cooperation with the single entity should develop a plan explaining how innovative pilot projects, federal grant funded initiatives, and evidence-based practices will be maintained, integrated into the ongoing system of care, and implemented across the state, including rural areas. The state and the single entity should develop a plan for coordinating transportation and alleviating transportation challenges especially in rural areas.

5. **Improve the Data System** – The state will create a uniform data system for collecting and reporting core data. The uniform data system will have the capacity to track identified performance indicators and outcome measures. The state will reevaluate its current 21 performance indicators and outcome measures and reduce the number to 10 concise measures. Data reports should be delivered to LCs, providers, and other community stakeholders in an easily understood format.
6. Improve Training and Workforce Development – As trainings are offered, the state and the single entity should ensure that support and resources for implementation of the training material be available so that there is not a gap between training and implementation. The system of care should create an environment that values promising practices as well as evidence-based practices. The state should identify a structure for the Consortium for Behavioral Health Training and Research (CBHTR) to lead the state’s training and workforce development initiatives. Finally, the state should identify funding to sustain workforce development training efforts.

7. Improve Communication with and Services to Tribal Communities – The state and the single entity will work with tribal communities to develop culturally appropriate strategies for service planning and implementation. The state should develop formal government-to-government relationships with tribal entities. The state will explore the creation of additional LCs to more effectively represent Native communities.
New Mexico

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.
Section II. Identification and Analysis of the Service System’s Strengths, Needs and Priorities

4. Recent Significant Achievements

There have been several significant achievements over the last year to support and enhance New Mexico’s behavioral health system of care for its children, youth and their families.

Supportive Housing Project

In FY2008, $150,000 was designated in the CYFD budget to initiate a Supportive Housing Project utilizing a Housing First model to assist ten juvenile justice and ten protective services young adults ages 18 to 21 transitioning from the children’s behavioral health system of care to the adult system of care. In a Housing First program, the underlying principle suggests that vulnerable and at-risk populations are more responsive to interventions and social service supports after they secure their own housing. The Housing First approach affirms a person’s right to housing without any “service strings attached”.

A contract was developed with the Supportive Housing Coalition of New Mexico to provide scattered site housing in Albuquerque. The program participants began moving in to their apartments in December 2007. The program offers young adults the opportunity to access and keep rental housing, to access a variety of support services to help them maintain housing without the requirement to comply with services in order to keep housing, and to learn the skills necessary to be a good tenant. The young adults receive assistance with Section 8 housing applications so that when the young adults turn 21 they continue to have access to rental assistance and they are able to build a positive rental history. To date, the program has been extremely successful, with only one of the young adults terminating the lease agreement and leaving the program.

Clinical Home/Wraparound Initiative

Another step in developing a comprehensive, integrated, community-based system of care for children, youth, and their families has been the Clinical Home Project. The Clinical Home Project adopted the Wraparound Milwaukee model as the conceptual framework to provide intensive wraparound services with youth and their families. The goals of the project are to prevent out-of-home placement, ensure quality service delivery, and that behavioral health services operate from a recovery-oriented and strengths-based perspective in accordance with needs identified through a diagnostic assessment. The Clinical Home Project involves collaboration between the Children, Youth and Families Department (CYFD), VONM and nine service providers in Santa Fe, Albuquerque and Las Cruces. The Clinical Home Project has served 302 youth and their families. Approximately 90% of these youth are juvenile justice involved youth on probation or parole or involved with post-parole transition services.

Medicaid State Plan Amendment

As of January 1, 2008, Comprehensive Community Support Services (CCSS) replaced Case Management on VONM’s service taxonomy for community behavioral health service providers. CCSS is an integrated, centrally managed approach to care with a focus on an individual’s or family’s strengths and informal supports. Its purpose is to coordinate and provide services ad resources to children, youth, and their families to promote recovery and resiliency. CCSS activities specifically address goals in the areas of independent living, learning, working,
socialization, and recreation. CCSS also utilizes consumers as family and peer specialists to support families and youth in navigating the community-based system of care. CCSS is an integral part of implementing the Wraparound Approach in New Mexico’s service delivery system.

New Mexico has 13 sites throughout the state providing MST services to youth and their families who are involved with the juvenile justice system. As of January 1, 2008, the Medicaid State Plan was amended to include MST in its array of basic services. Prior to this it was considered an enhanced service and therefore required a prior authorization before service delivery could begin. In addition, VONM was able to raise the rates it pays to providers of MST services, making it cost effective for providers throughout the state. This same Amendment also allowed providers of MST services to deliver the service to Medicaid recipients who are not participants in the managed care Medicaid system (i.e., Native American youth). This year VONM is able to provide start up funds for three additional MST sites in areas of the state that are not currently served, bringing the total number of MST sites to 16.

**Transition Services**

Successful transition of youth within the various age-defined systems of behavioral healthcare, as well as those transitioning from state custody or those under the supervision of state services, are essential in promoting both recovery and resiliency. As such, the system of care must ensure that the behavioral health service array is adequate to meet the needs of youth aging out of the foster care system, transitioning out of the juvenile justice system to the community, and/or youth involved in behavioral health system into the adult system.

Over the course of the last year, CYFD has been increasing its focus on youth exiting juvenile justice facilities. CYFD has developed a Transition Unit specifically for this purpose and has hired eight Regional Transition Coordinators who are located throughout the state with offices in Albuquerque, Farmington, Hobbs, Las Cruces, and Santa Fe. The Regional Transition Coordinators start working with youth and their families upon the youth’s commitment to a correctional facility. They develop relationships and resources for the youth creating a clear plan that is in place for them upon their release or parole into the community. Once the youth exits the facility, the Regional Transition Coordinator continues to work with the youth and his/her family at least through the end of their parole. At that time a youth may opt out of services, or continue services voluntarily until age 21. Even if a youth chooses to no longer receive services, he or she may return to services at any point up to his/her 21st birthday.

There are two significant aspects to this project. The most significant aspect is the relationship that is developed between the youth and the Regional Transition Coordinator. The youth knows that she/he can call on the Coordinator at any time for guidance, assistance, or just to talk. Another important aspect of Transition Services is the flexible emergency fund. Youth, through the Regional Transition Coordinator have access to funds to assist them with goods or services that she or he might need to assist them in their re-entry to the community and be successful with their transition plan. Youth have used emergency funds for items such as college tuition, medication, clothing, rent/utilities, tattoo removal, bus passes, or art supplies for therapeutic purposes. Youth participate in positive youth development activities and have presented at statewide conferences sharing their experiences in the project.
Family and Youth Advocates

As a recipient of the Behavioral Health Transformation State Incentive Grant (TSIG), New Mexico has been able to hire individuals into two new positions. These are the Family and Youth Advocate positions. The Family Advocate is responsible for completing the Certified Family Specialist Curriculum so that Family Specialists can be hired by provider agencies to deliver CCSS services in the communities around the state. The Family Advocate attends Local Collaborative meetings around the state to ensure that local and statewide policy makers hear the voices of families. In addition, the Family Advocate responds to constituent calls regarding access to service delivery, challenges or struggles families are having within the system, and issues related to youth in out of state placements.

The second position that has been hired is the Youth Advocate. The Youth Advocate’s responsibilities include supporting youth in engaging in system of care activities such as the Behavioral Health Planning Council, Local Collaborative meetings, and various work groups related to youth as well as developing leadership opportunities in CYFD and the Behavioral Health Collaborative. This is a new position in the state behavioral health system of care and an exciting opportunity for New Mexico to be able to integrate the youth voice into its consumer engagement activities.
New Mexico

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.
Section II. Identification and Analysis of the Service System’s Strengths, Needs and Priorities

5. State’s Vision for the Future

As the Children’s Behavioral Health Authority for the state of New Mexico, the Children, Youth and Families Department (CYFD) has identified the following areas as behavioral health priorities for fiscal year 2009. The priorities support a children’s system of care, as well as the CYFD vision, mission, and principles as described below.

1. Support and Programming for Youth Involved in the Protective Services (PS) and Juvenile Justice Systems (JJS)
2. Standardized Assessments for Children and Adolescents
3. Implementation of Core Service Agencies
4. Substance Abuse Services for Children, Youth and Young Adults
5. Services Focusing on Adolescent Transition
6. Foster Care and Adoption Programs and Supports
7. Gender Appropriate Services that Identify and Treat Issues of Trauma

The Vision – The Children, Youth and Families Department partners with communities to strengthen families in New Mexico to be productive and self-sufficient.

The Mission – CYFD believes in the strengths and resiliency of families who are our partners and for whom we advocate to enhance their safety and well-being. We respectfully serve and support children and families, and supervise youth in a responsive, community-based system of care that is client-centered, family-focused and culturally competent.

The Guiding Principles – CYFD believes that children and families should receive:

- Services that promote and build on individual strengths.
- Early identification and intervention services to address problems as they emerge.
- Access to a comprehensive array of services that are individualized, community-based and whenever possible, in-home, to meet the unique needs and potential of each child and family.
- Full participation and choice in all aspects in the planning and delivery of services.
- Services that are provided in the least restrictive setting and most normative environment and are integrated and linked, both within CYFD and with other child-serving agencies and which use peers, family and natural resources.
- Culturally competent services delivered without regard to race, ethnicity, religion, national origin, gender, sexual orientation, or disability.
- The most effective services that are based on evidence or promising or emerging practices, to achieve positive outcomes.
- Services that insure smooth transitions to adult service systems.

Support and Programming for Youth Involved in the Protective Services and Juvenile Justice Systems

The availability of behavioral health services statewide is a point of focus within both the Protective Services and Juvenile Justice Service Areas of CYFD. As such, CYFD in collaboration with ValueOptions New Mexico (VONM) are committed to enhancing behavioral
health services for these populations. Data related to behavioral health services is an essential aspect of this and should include, but is not limited to the following information:

- Verification of a community-based, accessible, culturally appropriate service array capable of meeting the needs of children who are at risk, in out-of-home placement, or in the Child Welfare and Juvenile Justice System;
- Initial assessment and/or screening within timeframes specified by New Mexico Children’s Code and Medicaid Regulations;
- Defined expectations with quality assurance for the different types of behavioral health assessments (Initial Screening, Diagnostic, Biopsychosocial, Enhanced/Comprehensive, Sexual Offender, Psychological, Forensic);
- Availability of appropriate services for needs of youth in the JJS and PS systems;
- Availability of service providers to participate in PS and JJS case planning efforts, which could include the provision of court testimony;
- Defined expectations with quality assurance for the different types of behavioral health services for youth involved in the PS and JJS systems;
- Timely and efficient linkage of CYFD involved youth with accessible and appropriate behavioral health services; and
- Ensure Judges and related court personnel have necessary information regarding appropriate use of diagnostic, evaluative and forensic assessments to inform their decision making.

Assessments for Children and Adolescents

Thorough and accurate behavioral health assessments/evaluations are essential to providing appropriate treatment services to meet the needs of children and youth. As such, the system of care must ensure the availability and quality of standardized assessments that address both diagnosis and level of functioning for children and youth in the protective services and juvenile justice system, and children and youth with Serious Emotional Disturbance (SED) who are at risk of out-of-home placement and who are already placed in out-of-home care. The system of care also needs to ensure a formalized and standardized process for assessing functional levels of children for purposes of determining required level of supervision, structure and support required to meet each youth’s needs, ensure safety, and maintain placement stability. Finally, the system of care needs to ensure a formalized and standardized process for on-going assessment of both diagnoses and functional levels for youth receiving behavioral health services for purposes of monitoring performance improvement during treatment.

Implementation of Core Service Agencies (CSAs)

Coordinated and accessible services in community-based centers are essential to serving youth and families with complex needs in the least restrictive settings. An integral part of implementing an integrated, community-based system of care for children, youth, and their families is the concept of Core Service Agencies (CSAs). CSAs are multi-service agencies that will assure that consumers of behavioral health services will receive comprehensive and integrated care across a range of services. These agencies will help to bridge treatment intensity gaps, promote the appropriate level of service intensity, ensure that community support services are integrated into treatment, and develop the capacity for consumers to have a single point of accountability for identifying and coordinating their behavioral health services. CSAs will ensure that the youth with behavioral health needs receive quality mental health services with a priority focus on: evidenced based practices; promising practices that do not yet meet the evidence-
based standard; best practices or national standards with successful outcomes; and cultural diversity. CSAs will be required to provide Crisis Management, Diagnostic Assessment, Comprehensive Community Support Services (CCSS), Psychiatric Services, and Outpatient Treatment. It is anticipated that the first CSAs will be identified in July 2008.

**Substance Abuse Services for Children, Youth and Young Adults**

The majority of children and families involved in the behavioral health system of care have identified issues regarding the use, abuse and dependence on alcohol or other substances. As such, CYFD in collaboration with VONM will work to enhance the accessibility and availability of quality substance abuse services statewide.

CYFD and VONM will expand the availability of Intensive Outpatient Programs (IOP) services for youth and families as well as continue the expansion of MST and other evidence-based services in geographic areas that do not currently have access to MST services. CYFD and VONM will collaborate with BHSD to review lessons learned and outcome information from the Co-occurring Disorders State Incentive Grant and Total Community Approach funded projects. CYFD and VONM will support service providers to improve substance abuse screening and assessment for the adolescent population. Such improvements will target youth already engaged in behavioral health services, as well as those youth in need of services.

**Services Focusing on Adolescent Transition**

Successful transition of youth within the various age-defined systems of behavioral healthcare, as well as those transitioning from state custody or those under the supervision of state services, are essential in promoting both recovery and resiliency. As such, the system of care must ensure that the behavioral health service array is adequate to meet the needs of youth aging out of the foster care system, transitioning out of the juvenile justice system to the community, and/or youth involved in behavioral health system into the adult system. In reviewing the service array for youth in transition, it is essential that special attention be paid to those youth and young adults with dual diagnoses of Developmental Disabilities and Mental Illness (DD/MI).

VONM will actively participate with CYFD, Medicaid, the Behavioral Health Services Division (BHSD), Department of Health (DOH), and other Collaborative members in the further development and implementation of the Adolescent Transition Priority Work Plan. VONM and CYFD in collaboration with BHSD will implement recommendations of the Adolescent Priority Workgroup regarding service delivery for target population through the service provider network. VONM will collaborate with the Department of Health in focusing on and enhancing services for the DD/MI population, including care coordination across child-adult service provider/systems and promotion of specialty services for youth and young adults with dually-diagnosed with DD/MI. VONM and CYFD will include recovery and resiliency oriented peer-to-peer support in all service development regarding adolescent transitional services.

**Foster Care and Adoption Programs and Supports**

Adequate behavioral health and supportive services, which focus on trauma, recovery and resiliency, are essential in the promotion and establishment of permanent foster and/or adoptive placements for youth involved within the Children’s Protective Services system. As such, VONM and CYFD will collaborate to ensure that the behavioral health services array is adequate to
meet the needs of youth and family members within foster and/or adoptive family settings. This includes the following activities:

- CYFD and VONM will work with Local Collaboratives to identify the needs of foster and adoptive families and families involved in the child welfare system; and
- VONM will provide specialized training and financial incentives to the network providers who provide or are interested in providing services specific to Reactive Attachment Disorder (RAD), intensive in-home intervention, Posttraumatic Stress Disorder (PTSD), complex and/or development trauma, multiply-diagnosed children, foster care and adoption, and/or other specialized clinical training as identified.

**Gender Appropriate Services that Identify and Treat Issues of Trauma**

Children who suffer from early neglect and abuse, including repeated caretaker separations, are often characterized by extreme behavior problems that are the most challenging in both outpatient and residential care. These children, who constitute the majority of those children and adolescents who require repeated hospitalizations and extended residential care, do not usually benefit from standard treatment protocols and modalities. Development of trauma specific residential, outpatient and transitional programs that are equipped and willing to treat children with intensive and challenging behavior problems is essential. This category of treatment will help to address the treatment needs of these children and will help to supplement the treatment spectrum for those children who are very difficult to serve and whose needs are typically resolved through out-of-state placement.
New Mexico

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
1. Current Activities

**Criterion 1:** Comprehensive community-based mental health services, **Establishment of System of Care**

Adopted - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

As noted in other sections of this application, New Mexico is transforming the behavioral health service system through the Interagency Behavioral Health Purchasing Collaborative (Collaborative) through a contract with ValueOptions-New Mexico (VO-NM), who serves as the Single Entity (SE) responsible for the implementation of a state-wide, comprehensive system of prevention, intervention and treatment services for persons with behavioral health needs that are community and client-based, strategically focused, culturally-specific, culturally-diverse, and linguistically-appropriate.

The system of care is directed by the Collaborative through the contract with ValueOptions that delineates priorities, initiatives and activities, insuring that the system of care remains intact and without disruption through the transformation efforts. All activities function inside the framework of Evidence-Based Practices, consumer and family member involvement, and cultural competence, with a specific set of directed activities and required linkages for the Native American population in the state. To increase access to services, a strong emphasis is placed on using broad-based telehealth and telemedicine services throughout the rural communities of the state; comprehensive woman’s services; jail diversion; co-occurring disorders; and outreach.

In SFY-09, ValueOptions will continue to subcontract with approximately 60 community-based programs throughout the State’s 33 counties including 25 community mental health centers. In addition, ValueOptions has entered into contractual relationships with approximately 1900 other providers and individual practitioners that were funded by partnering state agencies, including Medicaid, for the delivery of behavioral health services.

The interagency contract with ValueOptions includes approximately $32 million dollars from HSD for both mental health and substance abuse services, which includes a significant portion of both mental health and substance abuse block grant funding. In addition, HSD contracts with a limited number of providers outside the Purchasing Collaborative initiative for forensic evaluations and sexual assault training and medical examinations. Outcome measures for assessing the efficiency and effectiveness of mental health care and substance abuse treatment have been developed in collaboration with the other state agencies involved in the Collaborative and many are now collected on a routine basis. The total community-based budget for the Collaborative, which includes services to the elderly, children and youth, Medicaid recipients and individuals released from a correctional facility is approximately $226 million.

The New Mexico Behavioral Health Institute (NMBHI), located in Las Vegas, New Mexico is the only publicly funded state operated psychiatric hospital in New Mexico. NMBHI, an accredited institution through the Joint Commission for the Accreditation of Hospital Organizations, is committed to keeping individuals in the least restrictive environment suitable
for optimal care. Although the New Mexico Behavioral Health Institute is licensed for 439 beds, only 396 beds are operational as follows:

<table>
<thead>
<tr>
<th>Department</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Psychiatrics</td>
<td>116</td>
</tr>
<tr>
<td>Forensic</td>
<td>96</td>
</tr>
<tr>
<td>CARE Unit for Adolescents</td>
<td>16</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>168</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>396</strong></td>
</tr>
</tbody>
</table>

In addition, the New Mexico Behavioral Health Institute operates a community mental health center with five (5) satellites in outlying rural communities in three counties. The Community Services Program (CSP) operates twenty-nine (29) licensed Adult Residential Shelter Care Beds and fourteen (14) Transitional Living Unit beds.
New Mexico

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

- Health, mental health, and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Support services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other activities leading to reduction of hospitalization.
1. Current Activities

Criterion 1: Comprehensive community-based mental health services, Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

- Health, mental health, and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Support services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other activities leading to reduction of hospitalization.

The Service Requirements Workgroup is a team of state agency staff with providers and other stakeholders who have been meeting for more than a year to review, consolidate, and "right-size" the existing services, service definitions, and service codes used by the Collaborative agencies. Accomplishments to date include, development of standardized services and billing codes, development of utilization guidelines for every HCPCS code for services currently being purchased by state agencies, and incorporation of Certified Peer Specialists into CSS and ultimately into separate peer services. Some of the updated service definitions are:

Comprehensive Community Support Services were added to the State Medicaid Plan in the fall of 2007, with the program being implemented on January 1, 2008. The purpose of Comprehensive Community Support Services (CCSS), where the consumer and family drives service planning, is to coordinate and provide services and resources necessary to promote recovery, rehabilitation and resiliency. Together with the consumer, the Community Support Worker identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the community, as well as strengths which may aid the consumer or family in the recovery or resiliency process. CCSS activities address goals specifically in the following areas: independent living, learning, working, socializing, and recreation. CCSS also includes supporting a consumer and/or family in crisis situations and providing individual interventions to develop or enhance a consumer’s ability to make informed and independent choices. Both Certified Peer and Certified Family Specialists meet staffing qualifications for the Community Support Worker position in qualified provider organizations.

Medication Monitoring for psychoneurotic and personality disorders includes the ongoing review of symptoms, side effects, effectiveness, compliance, and lab reports/results. Also included is prescription renewal and adjustment of medications.
Beginning July 1, 2008 the New Mexico Legislature has appropriated $1 million per year to create a medication fund for people who do not have access to medication programs such as Medicaid, or who are otherwise unable to pay for medications.

- The fund is primarily designed to help people who might become hospitalized, incarcerated or homeless because of a lack of medications to help control their symptoms. The fund was appropriated to address this particular need and will also help the Collaborative evaluate medication funding needs for uninsured New Mexicans. In addition, the fund may be used as a bridge to provide medications until another funding source becomes available, to pay for medications in a crisis situation, or to ease transition from a hospital, jail or prison. The funds are available to treat both mental health and substance use disorders.

- Based upon the data currently available, it is anticipated that the majority of people using this fund will require assistance for 3 months or less, although long term funding may be available for individuals that do not have access to any other source of payment for medications, subject to the funding priorities and appropriation limitations.

**Dental Services** are available for homeless individuals in the three most populated areas of New Mexico as part of a comprehensive set of medical services including psychiatric and nursing. Services provided in these programs include psychiatric diagnostic evaluations, medication management, referrals and liaison to health care providers as well as linkage to other resources.

**Crisis Intervention** services are immediate, crisis-oriented services designed to ameliorate or minimize an acute crisis episode and/or to prevent inpatient psychiatric hospitalization or medical detoxification. Services are provided to adults, adolescents, and their families or support systems who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors, or moods. These services are characterized by the need for highly coordinated services across a range of service systems. Crisis intervention services should be available on a 24-hour, 7-day a week basis. Services can be provided by a mobile team or by a crisis program in a facility or clinic. Crisis intervention services include: crisis prevention, primary assessment, secondary evaluation, acute crisis services and support services.

- **Crisis Services** are a strategic priority of the Collaborative. Developmental efforts led by the Behavioral Health Services Division are focused on: 1) developing a model for behavioral health crisis response system, including jail diversion; identifying pilot sites for implementing and testing the crisis response model; evaluating these pilots; developing a statewide plan for funding and implementation of behavioral health crisis response/jail diversion system. Related efforts are being undertaken to increase behavioral health education for law enforcement personnel and to develop system for assessing and improving law enforcement response to behavioral health consumers. This work builds on the Mobile Crisis Response Team funded through Southwest Counseling, serving Las Cruces and Dona Ana County and the Crisis Intervention Teams in Albuquerque.
Behavioral Health Screening is provided to determine eligibility for admission to behavioral health treatment services, and may include the following: Integrated mental health and substance use disorders screening, mental health screening, alcohol screening and drug abuse screening. The behavioral health screen is a preliminary procedure limited in nature and intended to merely indicate whether there is a probability that a mental health problem and/or drug/alcohol abuse or dependence problem is present. This screen may be accomplished using any one of a collection of nationally accepted standardized screening tools that are appropriately designed for the individuals being screened.

Non-Emergency Transportation is provided when necessary to secure a necessary, covered behavioral health service in or out of the individual’s home community. Transportation is provided by self, a family member, or neighbor, and is reimbursed only if an individual does not have access to transportation services which are available free of charge.

Assertive Community Treatment (ACT) services are therapeutic interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability, increasing the individual’s ability to cope and relate to others and enhancing the highest level of functioning in the community.

New Mexico’s Access To Recovery (ATR) project provides substance abuse treatment and recovery support services through a voucher driven, client choice process. Each individual that is determined eligible for a voucher receives an impartial, comprehensive assessment at a Central Intake site and then chooses, with the assistance of their care coordinator, a provider from a list of participating providers. The individual may have multiple recovery support service providers and may choose a different provider at any point during their treatment.

New Mexico’s Screening, Brief Intervention, Referral and Treatment (SBIRT): provides substance abuse services through primary care health settings, including rural physician’s offices, school-based health centers, and public health offices. It targets rural and ethnic minority, non-addicted users in order to increase access to behavioral health services. Screening, brief interventions, and brief treatment are provided in these settings by licensed behavioral health practitioners. SBIRT is a five year grant that will end in September 2008.

Supported Employment:
Supported Employment offers more than the traditional time-limited vocational service. Supported Employment is envisioned as an alternative for consumers who are seeking more independence and self sufficiency. The Behavioral Health Services Division (BHSD) uses the Individual Placement and Supports model throughout the State which improves consumer’s lives through employment services. As consumer empowerment has steadily increased, so has the demand for employment services. Each year, more consumers become aware that they have the capability to obtain and hold meaningful and productive employment. All supported employment funds have been transferred to VO-NM and are being managed via partnership with BHSD.
Supported Employment for Individuals with Disabilities:
The goal is to provide alternative employment supports for individuals with developmental disabilities who are gaining greater independence and are developing greater natural supports. The objective is for all individuals to have gainful employment and a support system to maintain the employment. Vocational Services are provided in a natural setting to individuals with developmental disabilities who are 22 years of age and older and seeking employment. The program is designed to help individuals transition out of Habilitation/Vocational Programs into a more independent setting. The Interdisciplinary Team (IDT) determines eligibility (criteria for recommendation are based on the following factors: individuals are awaiting DD Waiver services, individuals desire to obtain employment for a minimum of 10 hours per week, there is an opportunity for employment where the recipient earns minimum wage or above, and employment can be obtained in a community-integrated work setting) for the supported employment program. Each participant receives a vocational profile that outlines his or her job vision and goals and how the team can support those goals. Since services occur in a natural setting, individuals are given the opportunity to develop strong natural supports.
The Behavioral Health Services Division endorses and supports the Competitive Employment Services Six Principles as stated in the President's New Freedom Commission Report.

- Eligibility is based on consumer choice.
- Supported employment is integrated with treatment.
- Competitive employment is the goal.
- Job search starts soon after a consumer expresses interest in working.
- Follow-along supports are continuous.
- Consumer preferences are important.

The purpose of Peer Service is to promote consumer socialization, recovery, resiliency, self-advocacy and preservation and enhancement of community living skills as well as to assist consumers with more effectively utilizing the service delivery system (e.g., assistance with developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers) or understanding and coping with the stressor’s of the consumer’s disability.

Support Services
The Collaborative strongly endorses a consumer and family driven system that is recovery/resiliency based. Participation by the consumer/family and the community has proven one successful way to attain that goal. Nationwide requests for information on this administration’s recovery and resiliency programs and activities continue to be received. Consumers train consumers in a number of advocacy and support programs, which allow those trained to work throughout the state to encourage consumer involvement and address issues of stigma and isolation. These programs include Double Trouble and Recovery (DTR), a program of support groups based on the Alcoholics Anonymous model, which address co-occurring mental health and substance abuse issues; Wellness Recovery Action Plans (WRAP), a program through which consumers are trained to work with other consumers on focused recovery planning; and the Warm Line, a part-time consumer-staff help life. These programs are also a coordinated effort of Value Options and the Office of Consumer Affairs. The T-SIG Consumer and Family Specialists, along with other local and national consultants, also provide training to Local Collaboratives on consumer engagement strategies.
Computer Loan Program (CLP) offers technological mainstreaming of rural consumers in all populations, drop-in centers, and supported employment activities, through a computer loan/Internet account program. Consumers receive ongoing qualified technical assistance and skill-building training. Plans are being made to coordinate the pick-up, rebuilding and delivery of the Department Of Health’s and Children Youth and Family Department’s computer assets from statewide inventory of decommissioned units as well as computers donated by VO-NM.

Consumer Grassroots Movement: Citizen Organizers is a model of state-contracted employment. Thirty-eight individuals are regionally selected and trained to be trainers and are responsible for developing and implementing their own behavioral health projects, as well as coordinating community training efforts statewide. Their efforts are in full alignment with ValueOptions Recovery and Resiliency Department’s training, community outreach initiatives and activities. The Citizen Organizer focuses on four basic goals; 1) empowerment of consumers, 2) sharing and teaching of recovery concepts, 3) the development of shared leadership, 4) the creation of grassroots involvement by and for consumer and family advocates. The Citizen Organizer Leadership is a recovery and resiliency technical assistance resource for all Local Collaboratives.

Educational Services
Consumers and family members led the work to develop curricula for Certified Peer Specialists for adults and continue on to lead the curriculum development process for the Family Peer Specialist. Creation of the certified peer specialists is a key element of the Collaborative’s plan to develop Comprehensive Community Support Services (CCSS) as a broadened service, replacing Case Management. The intent of CCSS is to empower consumers and families through a participatory, consumer-centered model. Certified Peer and Family Specialists are seen as prime candidates for the CCS Worker.

The Leadership Academy, a function of the consumer-led and managed Office of Consumer Affairs (part of the Behavioral Health Services Division) focuses on four basic goals; 1) empowerment of consumers, 2) sharing and teaching of recovery concepts, 3) the development of shared leadership, 4) the creation of grassroots involvement by and for consumers. Additional goals include: organizing consumers to provide education to providers regarding consumer values and hope for consumer run service provision; identifying issues that consumers want to work on in their community; providing technical assistance to those consumers that choose to work on these issues; and identifying individuals who can move into leadership roles.

As noted in other sections of this application, persons who become Certified Peer Specialists and Certified Family Specialists meet staffing qualification for the Community Support worker position in qualified provider organizations providing CCSS. This certification allows another employment opportunity for individuals in recovery.

The following table is a list of services offered through the Behavioral Health Collaborative agencies and the number of consumers served.
<table>
<thead>
<tr>
<th>Service Offered</th>
<th>Consumers Served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7/01/2006-6/30/07</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>578</td>
</tr>
<tr>
<td>Residential Detoxification</td>
<td>241</td>
</tr>
<tr>
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<td>Adult Residential Services</td>
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<tr>
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<td>Skills Training and Development (BMS)</td>
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<td>Psychosocial Rehab Services</td>
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<tr>
<td>Intensive Outpatient Program – Substance Abuse</td>
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<td>Intensive Outpatient Program – Mental Health</td>
<td>336</td>
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<td>RN Medication Monitoring</td>
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<td>Other</td>
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</table>

Consumers served by category represent an unduplicated count. Consumers may receive services in multiple categories.
New Mexico

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children
1. Current Activities

**Criterion 2:** Mental health system data epidemiology, **Estimate of Prevalence**

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

**Client Service Profile**

The FY07 service profile includes clients served by the Children, Youth and Family Dept, Medicaid under Human Services Division, and the Behavioral Health Services Division of the Human Services Department. Statewide 72,959 consumers were served in FY2007. Of these consumers, 33,220 were served by Medicaid only, 32,364 were served only by non-Medicaid funding streams (Behavioral Health Services Division of the Human Services Department and Children Youth and Family Department), and 7,375 consumers received services funded by both Medicaid and non-Medicaid sources.

When looking at only the BHSD-funded clients, those diagnosed with Serious Mental Illness (SMI) or other Mental Health (MH) related diagnoses represented 78.1% of the total client population. Included within that count are Clients with co-occurring diagnoses. Overall Clients with Co-Occurring disorders (Mental Health and Alcohol or Drugs) accounted for 25.6% of all BHSD-funded consumers:

![NM Consumers FY2007: Diagnostic Groups](image)

As seen below, those consumers with known Race closely resemble the July 1, 2007 Census Bureau estimate of population by race as published by the Bureau of Business and Economic Research (BBER), University of New Mexico on their website [http://www.unm.edu/~bber/demo/2007table4.xls](http://www.unm.edu/~bber/demo/2007table4.xls)
26.5% of Clients served in FY07 declared themselves Hispanic, 27.64% said they were not Hispanic, and for 45.82%, Ethnicity was unknown

When compared with the general 2006 estimate of the New Mexican population by gender (see http://www.unm.edu/~bber/demo/tot2006.xls), we are serving a proportionally higher number of males than females:
New Mexico

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1
Part C. State Plan

Section III. Performance Goals and Action Plans to Improve the Service System

Performance Goals and Action Plans to Improve the Service System are included in each Action Plan (Section III, Part 2) as well as under each of the other criteria. These Performance Goals and Action Plans to improve the service system follow the Collaborative’s SFY-09 Strategic Plan and are reflected in the Governor’s Performance Measures.

Key targets regarding increasing access to services, increasing numbers of persons served by VO-NM in rural and frontier locations, increasing services to Native Americans, increasing the numbers of individuals with co-occurring disorders, and increasing the number of behavioral health practitioners in high need or shortage areas remain a focus on the SFY-09 contract with VO-NM.
New Mexico

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless
1. Current Activities
Criterion 4: Targeted services to rural and homeless, and older adult populations, Outreach to Homeless
Adult - Describe State’s outreach to and services for individuals who are homeless

On December 20, 2007, the Behavioral Health Collaborative approved a Long Range Supportive Housing Plan for the State of New Mexico. This ten year plan includes an aggressive goal of creating 5,000 new supportive housing opportunities (e.g., tenant-based rent subsidies and assisted project-based units). Other goals of the plan are: Create Locally Based Supportive Housing Partnerships; Create a Supportive Housing “Pipeline” with both public and private funders and housing developers; Create Rental Assistance Opportunities; Develop Best Practice Housing Supports & Services. Capacity building and pilot efforts receive legislative funding that began with a behavioral health supportive housing appropriation in FY08. Two important related initiatives are already underway. These initiatives are made possible by important new partnerships built across the Collaborative with the State, the Mortgage Finance Authority, and the New Mexico Supportive Housing Coalition.

**Housing First: Permanent Supportive Housing for Youth**, a pilot project designed for youth transitioning out of foster care or juvenile justice facilities began placing youth in housing in December 2007. Based in Bernalillo County, 20 youth will receive rental assistance and supportive services through a partnership between the Children, Youth and Families Department and the Supportive Housing Coalition of New Mexico.

**NM Linkages** is a second Permanent Supportive Housing Pilot sponsored by the Collaborative. New Mexico Linkages will provide up to 110 rental subsidies and support services for adults who are homeless or at risk of homelessness and living with behavioral health issues. Linkages began in February 2008 in Grant, Luna, Hidalgo, Bernalillo and Santa Fe Counties and is being administered by the Mortgage Finance Authority, through housing sub-contractors, and Value Options, through identified service providers, in each of the target sites.

**Move-In Assistance and Eviction Prevention Funds** provide funds for persons who are homeless or near homeless to obtain or maintain their housing. These funds are administered by VO-NM in partnership with BHSD staff.
New Mexico

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas
New Mexico's Screening, Brief Intervention, Referral and Treatment (S-BIRT) Cooperative Agreement project provides substance abuse services through primary health clinics. It targets rural and ethnic minority non-addicted populations to increase access to behavioral health services. The major strategies include motivational interviewing and cognitive behavioral therapy for the brief encounters, and sequenced assessments that precede referrals for needed addiction treatment.

The Access To Recovery (ATR) project provides substance abuse treatment and recovery support services using a central intake model to screen and assess clients. Mobile assessors are used to reach individuals in rural areas of the state. Providers have been recruited into the network who travel to remote locations and provide services to those individuals. In addition to substance use treatment services, individuals are offered an array of recovery support services that focus on Life Skills, child care, job development, transportation, housing eviction, acupuncture, mentoring services, and spiritual support.

Total Community Approach (TCA) is a partnership between the New Mexico Behavioral Health Collaborative and local communities most affected by substance abuse. The 2007 Legislature appropriated $3 million of recovery funding for Total Community Approach, which recurs in SFY-09. Four sites were approved for Total Community Approach (TCA) funding. Each site submitted a plan for approval, developed collaboratively by persons representing treatment, prevention, criminal justice, consumers, and advocates. Communities selected were Local Collaborative 4, San Miguel, Mora, and Guadalupe Counties in partnership with Local Collaboratives 9 and 10 (Curry, Roosevelt, Harding, Quay and DeBaca Counties); Local Collaborative 5 (Chaves, Lea and Eddy Counties); Local Collaborative 6 (Grant, Luna and Hildalgo Counties); Local Collaborative 15 (Navajo Reservation). Two additional Local Collaboratives, 1 (Rio Arriba County) and 8 (Taos County) received funding to build capacity to be TCA-ready when additional funding is available.

Los Lunas Substance Abuse Treatment and Training Center is supported by legislative appropriations of more than $10.5 million to plan, design and construct the Los Lunas Substance Abuse Treatment and Training Center – a state-of-the-art substance abuse treatment and training facility that will serve New Mexicans from across the state with a special focus on central New Mexico. This facility, designed with the help of a multi-stakeholder group, including local elected and county officials and community members, will include up to 16 residential beds for women with their children and community-based intensive outpatient services for men, women and adolescents. In addition, the facility will be built with training rooms and telehealth capacity to support communities throughout New Mexico through consultation, distance learning and other training and support for law enforcement professionals, court personnel, and prevention and treatment providers in schools and community agencies. This facility will be the hub of
training support for the TCA sites as well as for other mental health and substance abuse programs statewide.

Center for Rural and Community Behavioral Health is a virtual organization, which furthers the use of evidence-based practices statewide, is charged with increasing the quality and quantity of the behavioral work force in New Mexico, and with evaluating identified Collaborative pilot efforts, including the Veterans & Family Services Pilot.
New Mexico

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults
1. Current Activities

**Criterion 4:** Targeted services to rural and homeless, and older adult populations, Older Adults

**Adult -** Describes how community-based services are provided to older adults

The New Mexico Aging and Long-Term Services Department’s mission is to achieve the highest quality of life for older persons, people with disabilities and their families by enhancing autonomy, health, economic well-being, community involvement, and personal responsibility through identifying behavioral health resources for the ValueOptions funded system of care. The Department houses the divisions of Adult Protective Services, the Aging Network, Consumer and Elder Rights, Elder and Disability Services and the Office of Indian Elder Affairs, which provides advocacy.

The Aging Network Division providers include senior centers, congregate meal sites, adult day care programs, volunteer programs, employment program host agencies, Senior Olympics, the New Mexico Alzheimer’s Association, and others. Aging Network contract providers help families remain together, at home, in their own communities. The contract providers create a safety net for the vast majority of New Mexico’s elders, those who don't qualify for Medicaid but whose resources are limited, and those whose families are stretched to capacity caring for loved ones at home. Employment and volunteer opportunities enable older adults to remain active, vital members of their communities. Financial subsidies offered by the employment programs and by some of the volunteer programs help seniors maintain their economic independence. The Aging Network is the only resource for many senior New Mexicans.

New Mexico’s Older Americans Act funding, and significant state aging network funding, provides for a comprehensive array of services and the administrative infrastructure to deliver those services. The Aging and Long-Term Services Department receives an annual allotment of funds under Title III of the Older Americans Act (OAA), as amended, from the Administration on Aging in the U.S. Department of Health and Human Services. In New Mexico, these funds are allocated to four of the six area agencies on aging based on an approved intrastate funding formula. The Navajo Area Agency on Aging receives Title III OAA funding through the state of Arizona, and New Mexico’s Pueblos and Apache Tribes receive Title VI OAA funding directly from the federal Administration on Aging. New Mexico provides state funds as appropriated by the New Mexico State Legislature to all six of its area agencies on aging. Each area agency plans for, develops, and implements a system of services for individuals age 60 and older, or age 55 and older in the Native American Indian communities. All services are targeted to those with the greatest economic and/or social needs, with particular emphasis on minority older persons with low incomes and older persons residing in rural areas.

The programs within the Consumer and Elder Rights Division assure elderly and disabled citizens of New Mexico protection of their rights to adequate standards of care and access to essential benefits, goods and services. These protections occur through
direct counseling, information and referral, care coordination, legal advocacy, and quality management activities. Services are delivered through five bureaus: the Long-Term Care Ombudsman Bureau, the Aging and Disabilities Resource Center, the Legal Services Development Bureau, Benefits Counseling Bureau, and the Prescription Drug Assistance Program.

The Elderly and Disability Services Division is responsible for the administration of the Disabled and Elderly Waiver program, the Personal Care Option program, the Program of All-inclusive Care for the Elderly (PACE), the Traumatic Brain Injury program, the GAP Program, and Mi Via, New Mexico's Self-directed Waiver program. These programs provide support to enable older adults and individuals with disabilities to remain in their own homes and communities or to return to their homes from a nursing facility or institution. The Division also advocates for each consumer to live in the least restrictive environment, and provides education and training for consumers, case managers, and direct service providers.

In FY 07 Geriatric Behavior Health Specialists surveyed several Community Mental Health Centers regarding service provision service needs of the Centers. Based on survey results, several projects have arisen to transform and improve services: 1) a design, involving the Single Entity and Adult Protective Services, for a service delivery program that includes in-home psychological evaluations, in-home therapeutic treatment, transportation, short-term assistance with medication and long term assistance with treatment and medication; 2) collaboration with the SBIRT (Screening, Brief Intervention, Referral and Treatment) program to incorporate older adults’ mental health needs in to primary care settings through training of providers; 3) a suicide prevention initiative providing best practice trainings on Older Adult Suicide Prevention and Adult Depression and 4) a plan for increased collaboration between the Community Mental Health Services and Adult Protective Services.
New Mexico

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;
1. Current Activities

Criterion 5: Management systems, Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan

SFY-09 is the 4th year of the Collaborative’s contract with VO-NM to implement a comprehensive behavioral health system of care managed by a single entity. Two key goals of this new system includes ensuring that services are cultural competent and are state-of-the-art.

Ensuring that services are *culturally accessible and responsive* is an overarching goal of the Collaborative. A Cultural Competency Work Group has met since December 2006. Accomplishments include the development and implementation of a curriculum to train behavioral health specific English/Spanish interpreters; reimbursement for interpreters at Local Collaborative meetings and the Behavioral Health Planning Council; coordination with ValueOptions’ Cultural Competency Director regarding related contract expectations. The first interpreter training event in December 2007 included 11 trainees from a variety of provider agencies. Most recently the Cultural Competency Work Group has conducted cultural competency focus groups in coordination with Local Collaboratives. The original work group expanded March 2008 to create a statewide planning group, including consumers, family members, providers and Collaborative member agencies. This planning group will meet for four months to design a Cultural Competency Plan for submission to the Collaborative.

The Collaborative has undertaken a *Funds Mapping Project* with the assistance of Collaborative consultant, Dr. Richard Frank, a nationally-known Harvard Behavioral Health Economist. The project involves aggregating financial data to accomplish a system-level financial evaluation.

The Funds Mapping Project allows the Collaborative to analyze how these new arrangements are affecting the flow of funds between the source of payment (e.g., Medicaid, juvenile justice), the services purchased (i.e., outpatient counseling, residential care) and selected populations (e.g., youth, adults)

The tool creates matrices which help the Collaborative examine populations served, services received and payers. For example, New Mexico will be looking at the trends over the past two years and examine patterns in:

1. Expenditures for types of services for selected population groups
2. Types of services purchased by which payers
3. Volume of types of services for selected population groups.

These matrices are based on data assembled across agencies for the period before and after the introduction of the Statewide Entity (SE). With this information the Collaborative is able to analyze the changing service and spending patterns that stem from the new organizational arrangements. The matrices are designed so that they will integrate data from the state administrative data systems. Ultimately these matrices will be combined with a vector of outcome indicators, such as, homelessness, incarceration, DWI, employment, school performance, etc. This will permit a type of input-output analysis of the effect of changes in
funding flows and service composition on key outcome indicators. The Funds Mapping information will assist the Collaborative in determining which financial strategies it wants to maintain or redirect as it manages its direction overtime.

**Training facility in Los Lunas, New Mexico:** A major success during the legislative session in FY07 was appropriations to develop a state of the art residential and community-based treatment programs in Los Lunas. This will serve as a statewide resource for training professionals, law enforcement, and courts, with a focus on enhancing basic services and supports statewide. Training will be offered through telehealth capacity to support smaller communities through consultation and distance learning, and other training and support for treatment and law enforcement throughout New Mexico. The Los Lunas Substance Abuse Treatment and Training Facility will be a public/private partnership, with a panel of local and national experts participating in planning the program.

**Center for Rural and Community Behavioral Health**
The mission of the center is to address health care disparities through: health services research and evaluation; capacity building; training and workforce development; and through increasing access to quality behavioral health services that are holistic, cost-effective and provided with respect to the unique cultures within the communities of New Mexico.

The center's current program priorities include: expansion of the rural psychiatry residency programs within the Department of Psychiatry and rural training in primary care programs; supporting training and workforce development for all levels of behavior health practitioners with a focus on evidence-based interventions; improving behavioral health/primary care interface and training; expanding expertise in, support for and use of telehealth/telemedicine for direct service, training and consultation; addressing Native American behavioral health issues; expanding behavioral health services research and evaluation; supporting the development of Rural and Community Psychiatry Network of New Mexico (RCPNNM); supporting the development and implementation of the New Mexico Consortium for Behavioral Health Training and Research (NM-CBHTR).

**Evidence Based Practices**
In addition to CBHTR’s work to ensure fidelity and the expansion of Evidence-Based Practices in New Mexico, the Behavioral Health Services Division is leading planning for a Collaborative-sponsored, national Evidence-Based Practices Conference to be held in Albuquerque in December 2008.

_____________________________
New Mexico

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;
Crisis Services are a strategic priority of the Collaborative as noted in other sections of this application.

State staff from the Behavioral Health Services Division along with other collaborative agencies and ValueOptions initiated Disaster Services in New Mexico through two national events and worked with collaborative partners to serve Katrina victims displaced in New Mexico.

The Collaborative’s network of behavioral health care for disaster had its initial test during the Hatch Floods in August 2006. The Behavioral Health Services Division, as the designated grant applicant, procured $69,000 in emergency funding from FEMA to increase behavioral health services to the victims of the flood. Project Adelante was contracted by ValueOptions to the Ben Archer Health Center to provide outreach workers in Hatch and Alamogordo. Project Adelante completed 2,188 visits for both individuals and groups and utilized Promotoras in these activities. Highlights of the project included two “Dia del Niño” (Day of the Child) celebrations and one Community Feed.

BHSD staff continue to work with VO-NM in establishing policies and procedures to be utilized during any emergency that requires behavioral health services, interventions and support in communities.

Finally, Local Collaboratives will be instrumental in highlighting the training needs for community providers regarding mental health through their local assessments, to commence in SFY-2008. Upon analysis of this information, BHSD and the Purchasing Collaborative will focus future training efforts to address community needs.
New Mexico

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System

1. Current Activities
Criterion 5: Management systems, Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

As noted throughout this application, the New Mexico behavioral health service system continues its transformation under the BH Purchasing Collaborative and the utilization of the Single Entity- ValueOptions to manage the network of community-based mental health and substance abuse services. The movement of BHSD under HSD consolidates several key funding streams for publicly funded behavioral health service system, including Medicaid, Community Mental Health Services Block Grant (CMHSBG) and Substance Abuse Treatment and Prevention Block Grant (SAPTBG).

On July 1, 2008, ValueOptions entered into its 4th year as SE for the New Mexico behavioral health service system. Given the breath and depth of this transformation in the state, VO, under the direction of the NM Purchasing Collaborative, was instructed to insure that funding mechanisms remained in place to insure continuing care to all persons served by the community-based system of care on June 30, 2005. As such, block grant expenditures such as the CMHSBG were allocated across the system of care based on historical funding patterns.

BHSD continues to partner with VO in determining the most effective allocation of CMHSBG funds. This includes the on-going allocation of these funds across the 5 regions for direct mental health services for adults in community mental health centers and providers (34); support of community-based mental health services for children; support for the Behavioral Health Planning Council; planning activities and administration. Please see Table 4 for details.
### Name of Performance Indicator: Increased Access to Services (Number)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
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<td>FY 2007 Actual</td>
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<td>FY 2009 Target</td>
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<tr>
<td>FY 2010 Target</td>
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<tr>
<td>FY 2011 Target</td>
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</table>

**Table Descriptors:**

**Goal:** Implement a coordinated system of care that ensures the delivery of state covered services for behavioral health consumers, both Medicaid and non-Medicaid.

**Target:** Increace number of persons utilizing the community-based behavioral health service system that is recovery-focused

**Population:** Persons needing behavioral health services utilizing the publicly funded system of care

**Criterion:**
- 2: Mental Health System Data Epidemiology
- 3: Children's Services

**Indicator:** Data from statewide entity regarding number of unduplicated individuals served in the publicly funded behavioral health system

**Measure:**
- Numerator – GPM 4.2. k1 Number of individuals serviced annually in substance abuse and mental health programs through the statewide entity
- Denominator – Same as numerator only for prior year

(GPM-Governor's Performance Measures)

**Sources of Information:** Statewide Entity, ValueOptions, Management Information System.

**Special Issues:**

The NM Behavoiral Helath Collaborative (the Collaborative) continues to has as a key goal of replacing a formally fragmented behavioral health care delivery system in the state with a single behavioral health care system to minimize confusion for providers and for consumers and their families, and to minimize ineffective or duplicative administrative costs throughout the system. Utilizing the single entity (ValueOptions- NM) responsible for managing public behavioral health funds from a variety of federal and state sources, this Collaborative goal is being met, resulting in more efficient and more effective services and improved access to care for consumers, as well as better use of taxpayers’ money.

**Significance:**

It is expected that through the braiding of funds and the reduction of administrative costs and procedures, the transformed system of care in New Mexico will reach more of those needing behavioral health care, but unable to access it. Service utilization as reported by the statewide entity continues to indicate that this is the case.

**Action Plan:**

The Collaborative and its member agencies continues to monitor behavioral health services access through a variety of oversight structures with ValueOptions-NM (VO-NM). Staff of the member agencies review monthly and quarterly reports provided by VO-NM and provide analysis to the Oversight Team, which provides feedback to both VO-NM and the Collaborative's Steering Team. This process continues to be refined through SFY-09.
ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

<table>
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<tr>
<th>Fiscal Year</th>
<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
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<tr>
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<tr>
<td>FY 2007 Actual</td>
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<tr>
<td>FY 2010 Target</td>
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</tr>
<tr>
<td>FY 2011 Target</td>
<td>N/A</td>
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</table>

Table Descriptors:

Goal: Adult Goal 1B Reduced utilization of psychiatric inpatient beds.
Target: To measure of state mental health hospital readmissions.
Population: Adults with a serious mental illness
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services
Indicator: Number of patients-in-residence in New Mexico Behavioral Health Institute who are SMI.
Measure: Numerator – Number of persons with an SMI diagnosis, aged 18+, who are readmitted to New Mexico Behavioral Health Institute within 30 days of discharge.
Denominator – Number of persons with an SMI diagnosis, aged 18+, discharged from New Mexico Behavioral Health Institute during the past year.
Sources of Information: Governor's Performance Measure 4.2.i.1 and 2
Special Issues: The New Mexico Behavioral Health Institute has changed to a single payer source for the Medicaid program. This source is emphasizing shorter length of stays for in-patients. • As the hospital has reduced the length of stay for our patients to meet the expectations of our payer source, the readmission within 30 days of a previous discharge rate has increased from 2% to approximately 9% for this fiscal year. This is the only major factor that has changed within our system within the last year. The length of stay has become shorter at the same time the number of readmissions within 30 days has increased. More patients have multiple short admissions than in the past. • There have been problems with obtaining appointments for some of the patients after patients have been discharged from the facility. • In addition, many of the patients have lost benefits after being in-patients and do not have access to medications after discharge. This is due to the waiting period to re-establish eligibility for SSI/SSDI and that the patients are unable to afford out-of-pocket cost for the proper medications.

The Collaborative continue to coordinate with VONM to identify other potential resolutions to the issues and will be tracking, as part of the Governor's performance measures, 7-day and 30-day follow up with persons discharged from NMBHI. (GPM 4.1.i.1 and 2) Preliminary data indicates an increase in follow up at 7 days from 35% of the population to 36% with a similar increase in the 30 day follow up. (From 57% follow up at 30 days to 58%).

Significance: A major outcome of the development of a community-based system of care is expected to be reduced utilization of state-operated psychiatric inpatient beds.
Action Plan: New Mexico Behavioral Health Institute is committed to keeping individuals in the least

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restrictive environment suitable for optimal care. The medical staff will be reviewing the issue to determine more specific causes and actions to take to improve both aspects of care: shorter length of stay and reduced readmission within 30-day rates. The New Mexico Behavioral Health Institute will continue to use more aggressive pharmacological treatment and increase interaction with local mental health community treatment programs.
Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

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Table Descriptors:
\[\text{Goal:}\] Adult Goal 1C Reduced utilization of psychiatric inpatient beds.
\[\text{Target:}\] To measure the state mental health hospital readmissions for 180 days.
\[\text{Population:}\] Adults with a serious mental illness.
\[\text{Criterion:}\] 1: Comprehensive Community-Based Mental Health Service Systems
3: Children’s Services

\[\text{Indicator:}\] Number of patients-in-residence in New Mexico Behavioral Health Institute who are SMI.
\[\text{Measure:}\] Numerator – Number of persons with an SMI diagnosis, aged 18+, who are readmitted to New Mexico Behavioral Health Institute within 180 days. Denominator – Number of persons with an SMI diagnosis, aged 18+, discharged from New Mexico Behavioral Health Institute during the past year.

\[\text{Sources of Information:}\] NMBHI

\[\text{Special Issues:}\] The New Mexico Behavioral Health Institute has changed to a single payer source for the Medicaid program. This source is emphasizing shorter length of stays for in-patients. • As we have reduced the length of stay for our patients to meet the expectations of our payer source, the readmission within 180 days of a previous discharge rate has increased from 2% to approximately 11% for this fiscal year. This is the only major factor that has changed within our system within the last year. In other words: the length of stay has become shorter at the same time the number of readmissions within 180 days has increased. More patients have multiple short admissions than in the past. • There have been problems with obtaining appointments for some of the patients after patients have been discharged from the facility. • In addition, many of our patients have lost benefits after being in-patients and do not have access to medications after discharge because of the waiting period to re-establish eligibility for SSI/SSDI and cannot afford out-of-pocket cost for the proper medications.

\[\text{Significance:}\] A major outcome of the development of a community-based system of care is expected to be reduced utilization of state-operated psychiatric inpatient beds.

\[\text{Action Plan:}\] New Mexico Behavioral Health Institute is committed to keeping individuals in the least restrictive environment suitable for optimal care. The medical staff will be reviewing the issue to determine more specific causes and actions to take to improve both aspects of care: shorter length of stay and reduced readmission within 180-day rates. The New Mexico Behavioral Health Institute will continue to use more aggressive pharmacological treatment and increase interaction with local mental health community treatment programs.
ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

<table>
<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
<th>(5) FY 2009 Target</th>
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</table>

Table Descriptors:

Goal: Implement Supported Housing, utilizing the Housing First model, for adults in targeted populations statewide.

Target: Expand "Linkages" (New Mexico's Supported Housing model) from 30 units at 3 pilot sites (for adults) and 20 units at one site (for CYFD young adults) to additional sites in New Mexico.

Population: Two target populations have been selected: Adults with SMI and Young Adults aging out of the CYFD JJS/CPS systems of care.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
            3: Children's Services

Indicator: Number of persons (adults and young adults) participating in Linkages.

Measure: Number of persons (adults and young adults) participating in Linkages.

Sources of Information: Data on Linkages participants (adult and young adult) are provided to the Collaborative's Supported Housing Coordinator through monthly reports.

Special Issues: The New Mexico Behavioral Health Purchasing Collaborative continues to support efforts around the implementation of the state-wide housing plan. This plan focuses efforts on the development of affordable housing stock, increasing rental assistance through state and federally supported vouchers and increasing availability and quality of supportive services that enable consumers to obtain and maintain housing of their choice.

Significance: Supported Housing is a key EBP in attaining the goals of the President's New Freedom Commission. Additionally, several of the Local Collaboratives (LC's) have identified affordable housing as a key community issue whose resolution will support a recovery-oriented behavioral health service system.

Action Plan: The Collaborative partners continue to work with national experts in the design, implementation and evaluation of Supported Housing in New Mexico. Pilots established in SFY-2008 will be expanded in SFY-2009 as funding becomes identified and available for these efforts.
**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

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<thead>
<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
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**Table Descriptors:**

**Goal:**
To implement EBP for supportive employment using the Comprehensive Community Support Services (CCSS) Crosswalk and SAMHSA Fidelity Outcome Performance Measures.

**Target:**
Consumers of Behavioral Health Services to include substance abuse, mental illness and SMI populations

**Population:**
Baseline to be established in SFY-2009.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:**
Percent of adults, and youth in competitive employment and are receiving services (CCSS) to support that employment. CCSS Crosswalk

**Measure:**
Numerator: Number of adults and youth receiving supported employment services who are in competitive employment.
Denominator: Number of adults and youth receiving supported employment services

**Sources of Information:**
VO-NM data

**Special Issues:**
Supported employment services to persons in competitive employment settings fully promote independence and recovery.

**Significance:**
The implementation of EBP for Supportive Employment for SMI populations is aligned with the findings in the President's New Freedom Commission. New Mexico, as part of its transformation of the publicly funded behavioral health service system, will focus efforts on implementing EBP for Supportive Employment amongst the Purchasing Collaborative's partner agencies, which includes the Division of Vocational Rehabilitation.

**Action Plan:**
Initiate the use of screening and measurement tools for Supported Employment as an Evidenced-based practice. Identify ways in which providers would be better able to support competitive supported employment and provide ongoing supports. Identify job development needs and take action. Collaborate closely with State Entity, CAFÉ, and Collaborative to ensure that Consumers have significant increase in competitive and self-employment throughout the state.
**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

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**Table Descriptors:**

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<th>Goal:</th>
<th>Increase utilization of ACT across the system of care</th>
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<tr>
<td>Target:</td>
<td>Increase the number of persons receiving ACT services</td>
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<tr>
<td>Population:</td>
<td>Persons utilizing the publicly funded behavioral health system</td>
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<tr>
<td>Criterion:</td>
<td>1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services</td>
</tr>
<tr>
<td>Indicator:</td>
<td>Number of persons utilizing ACT services which are funded through the Collaborative's Single Entity- VO-NM. This includes medicaid and non-medicaid enrolled participants.</td>
</tr>
<tr>
<td>Measure:</td>
<td>Number of persons served by ACT teams</td>
</tr>
<tr>
<td>Sources of Information:</td>
<td>City of Albuquerque data; VO-NM; ACT Enrollment data;</td>
</tr>
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</table>

**Special Issues:**

In SFY-2008, 2 ACT teams were providing services in New Mexico. It is anticipated that the number of teams will increase to 6 total in SFY-2009. Given enrollment restrictions under the ACT EBP, it is anticipated the number of persons receiving ACT services will be less at the 4 new ACT teams.

**Significance:**

ACT services in New Mexico provide a level of care in the general behavioral health system that unavailable to most persons. VO-NM has dedicated reinvestment funding for start-up costs for 3 of the new ACT teams being established in SFY-09. The City of Albuquerque has also dedicated funding to supporting an additional team in Albuquerque. ACT-New Mexico will be conducting a time study to establish both medicaid reimbursable services provided under the ACT model and those costs that are not medicaid reimbursable. The Collaborative will be reviewing this time study data to insure on-going support of the ACT services in appropriate communities in the state.

**Action Plan:**

Please see narrative on ACT services
**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

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**Table Descriptors:**

**Goal:**
This EBP will be explored in the future

**Target:**

**Population:**

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children’s Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**
### Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA) (Percentage)

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<th>(1) Fiscal Year</th>
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<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
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</table>

### Table Descriptors:

**Goal:**
Goal 1A Develop a system of care that provides integrated treatment for co-occurring disorders throughout the service system at all levels of care.

**Target:**
To increase access for individuals with co-morbid psychiatric and substance use disorders, paying particular attention to the SMI population.

**Population:**
Adults diagnosed with mental health and substance abuse or addiction.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:**
Number of persons receiving integrated treatment of co-occurring disorders (MISA).

**Measure:**
Numerator - the number of clients with co-occurring disorders who received behavioral health services during the fiscal year. Denominator - the total number of clients who received behavioral health services during the fiscal year.

**Sources of Information:**
Co-occurring state incentive grant (COSIG) and ValueOptions New Mexico Management Information Systems.

**Special Issues:**
As New Mexico begins Year Five of the COSIG grant, the focus is on state-wide sustainability of efforts in implementation of evidence-based treatment. Services identified for intensive effort are IOP and CCSS. The project team will collaborate intensively with one of its successful implementation programs, The Life Link, to develop and test an IOP EBP fidelity measure and to collaborate in a pilot project to develop evidence-based practices in IOP at two rural treatment programs.

COSIG is helping sponsor a COD training series for Native Americans through the UNM Center for Rural and Behavioral Health. We are also sponsoring a pilot project in jail diversion for individuals with COD and helping to develop COD services at two rural drug courts. Another significant project will involve collaborating in New Mexico’s part of the National Cross Site Recovery Study.

**Significance:**
The COSIG hopes to be a leader in the development of integrated treatment for co-occurring disorders. The importance of recognition and access to appropriate integrated services for co-occurring disorders has a particularly profound impact upon individuals experiencing both mental health and substance abuse issues. It is imperative for this population to receive integrated treatment in a cohesive manner in order to successfully support their recovery process.

**Action Plan:**
SFY:2009 Action Plan: 1. Support the on-going implementation of EBP’s at the Life Link, First
Nations, Rehoboth McKinley and YDI, including weekly training and technical assistance.

2. All-day site fidelity assessments at the Four Implementation Sites at 6 month intervals (through 6/30/08)


4. Implementation of Re-entry Pilot Project for parolees with COD returning to the Albuquerque and Santa Fe areas. Partnership with Corrections Department and Community Corrections.

5. Training and technical assistance for DWI treatment centers. Collaboration with Local DWI Grants Program/DFA and the DWI Affiliates.

6. COD Education Project for consumers and families. A primary objective of the grant. (In planning)

7. Sponsorship of COD trainings in Native American communities. A collaboration with UNM Center for Rural and Community Behavioral Health.

8. Sponsorship of a COD track at the first annual Purchasing Collaborative's Behavioral Health Conference, to be held on December 1-4, 2008 in Albuquerque.
ADULT - GOALS TARGETS AND ACTION PLANS
Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA)
Foot Notes

*Transformation services activity: co-occurring services
**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

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**Table Descriptors:**

**Goal:** New Mexico will participate in the implementation of EBP after SFY-2009

**Target:**

**Population:**

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems

3: Children’s Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**
### Name of Performance Indicator:
Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

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### Table Descriptors:
**Goal:** New Mexico will participate in the implementation of this EBP after SFY-2009

**Target:**

**Population:**

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children’s Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**
Name of Performance Indicator: Client Perception of Care (Percentage)

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Table Descriptors:
Goal: Goal 1F People in New Mexico will receive services and interventions delivered in a timely, culturally competent manner, which promotes recovery and increased quality of life.

Target: New Mexico will improve quality and appropriateness of care provided.

Population: Adults with a serious mental illness.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems  
3: Children's Services

Indicator: Percentage of consumers that report satisfaction with treatment.

Measure: Numerator: Number of positive responses reported in the outcome domain on the adult consumer survey.  
Denominator: Total responses reported in the outcome domain on the adult consumer survey.

Sources of Information: Annual Consumer Satisfaction Project consumer survey.

Special Issues:  
- New Mexicans in recovery from mental illness and substance abuse lead or play a major part in project coordination, design, implementation, data collection, and information dissemination.  
- The telephonic and face to face survey instruments for adult and child populations are based on the national 28-item Mental Health Statistics Improvement Project (MHSIP) with additional items on substance abuse, housing, and employment in the adult version. It also includes a section where participants can comment either on specific survey items or about their general perceptions of the programs where they receive services.  
- It is available in English and Spanish.

Significance: A major outcome of the development of a community-based system of care is quality and appropriateness of care.

Action Plan: Consumer Satisfaction Project (CSP): The NM Consumer Satisfaction Project (CSP) is a joint effort between the Department of Health Behavioral Health Services Division (DOHBHSD), Human Services Division HSD/MAD, Value Options Department of Recovery and Resiliency (VO) and Children Youth and Family (CYFD). Its purpose is to assess consumer satisfaction. The Consumer Survey Project (CSP) is designed to promote consumer and family involvement in the community for recipients of behavioral health services. The objectives of the Consumer Satisfaction Survey Project are to show how consumers and families could indicate satisfaction through the inclusion of their voice and their involvement in all levels of the service delivery system. The Project has been almost entirely consumer-driven. Information from 739 face to face surveys are being entered and analyzed for 2008.
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

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Table Descriptors:
Goal: Increase percent of adults with serious mental illness in competitive employment of their choice (Governor's Performance Measure (GPM) (4.2.b)
Target: To increase number of adults being served by ValueOptions in competitive employment
Population: Adults served by ValueOptions
Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
Indicator: Percent of adults served by ValueOptions in competitive employment of their choice
Measure: Increase in/no change in # employed at date of last service compared to first service.
Sources of Information: Enrollment and encounter data (VO)
Annual report
Adult Consumer Satisfaction Survey
Special Issues: Calculated for those adults who indicate that employment is important to their recovery.
Definition of terms: Active client is an enrolled person who has received 1 or more services during reporting period. SMI: Individual who meets severity criteria (selected diagnoses) and functionality (GAF) of 50 or less.
Significance: Supports goals of the President's New Freedom Commission.
Working is an important factor to New Mexico’s consumer population; in fact as stated in the Consumer Satisfaction Survey, “84% say that some form of work helps with behavioral health issues. 76% say that their treatment team helped make their work life better.” (Consumer Satisfaction Survey FY 07). Therefore,
Action Plan: The State Entity (SE) shall continue to examine and improve performance of ongoing implementation of supported employment initiatives (as noted under the Supported Employment EBP Section of the NOM's)and small business development, and shall work with the Collaborative and BHSD to identify and implement strategies that will further develop and improve competitive employment outcomes for consumers.
Additionally Collaborative member agencies will continue to coordinate efforts of the New Mexico Employment Institute (NMEI)(utilizing Olmstead and DD funds primarily) to coordinate these efforts with VO-NM's supported employment services during SFY-2009. The BHSD Supported Employment Manager will continue her liaison role between the two entities.
Transformation Activities:

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

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Table Descriptors:

Goal: Reduce percent of adults served who have contact with the adult correctional systems (GPM 4.2.g.2)

Target: To establish baseline of percent of adults who have contact with the adult correctional systems who are served by public behavioral health service system.

Population: Adults being served by the Purchasing Collaborative through the SE-ValueOptions

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: Percent of adults served who have contact with the adult correctional system

Measure: Numerator: number of adults whose date of first probation occurs after date of second service encounter.

Denominator: number of all adults with 2 or more encounters during reporting period.

Sources of Information: VO encounter data

NMDOC date of first probation and date of Assignment to Supervision

Special Issues: Governor's Performance Measure

Significance: Access to appropriate behavioral health services by NMDOC persons has been a key issue in New Mexico and has been included as one of the Governor's Performance Measures for on-going attention.

Action Plan: Action Plan:

The SE shall promote coordination between adult and juvenile detention facilities and its behavioral health providers to establish a process to communicate the behavioral health needs of detainees at intake and discharge to establish a continuity of care between the two entities and shall facilitate that coordination if requested.

1. The SE shall provide cross training, as requested, to promote and facilitate the coordination between adult and juvenile detention facility staff and providers regarding service availability, referrals, and eligibility criteria to promote coordination and access to services upon release.

2. The SE shall ensure assessment and appropriate services for all New Mexico Corrections Department (NMCD)-referred adults to the extent resources are available, and shall work with the Collaborative to implement criteria to prioritize NMCD-referred adults to prevent recidivism to the extent possible.

3. The SE shall work with NMCD to arrange care coordination of incarcerated individuals identified by the Collaborative as having high needs as these individuals transition back into the community from prison to ensure continuum of care.

E. Coordination with Adult and Juvenile Judicial System Regarding Court-Ordered and/or Parole Board-Ordered Treatment. The SE shall establish policy and procedures at the provider network level that address the establishment and maintenance of professional relationships with magistrate, municipal, and district judges and parole board members regarding cases that contain behavioral health elements.
1. These policies and procedures shall encourage the development and implementation of the following elements:
   a. Education of judges and parole board members regarding appropriate referral procedures, consumer eligibility, resource availability and clinically and medically appropriate treatment alternatives;
   b. Review of assessments, court orders and/or conditions of probation or parole that order individuals into behavioral health services to ensure that the level of treatment intervention is medically, clinically, and/or psychosocially appropriate to assessed consumer need and is within the authorized licensed capacity and resource availability of the provider;
2. The SE shall work with NMCD, providers, the Courts and the Adult Parole Board to educate the criminal justice system on behavioral health services and to facilitate requests for modification to court orders or conditions of parole when clinically indicated.
### Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

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### Table Descriptors:

**Goal:** Increase percent of adults with mental illness and/or substance abuse receiving services with decent, safe and affordable housing (Governor's Performance Measure- 4.2.d.1.a).

**Target:** To measure of adults with mental illness and/or substance abuse in stable housing.

**Population:** Adults being served by the Purchasing Collaborative through the SE-ValueOptions.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems 
3: Children's Services

**Indicator:** Increase in/no change in # of clients in stable housing situation at date of last service compared to first service.

**Measure:** As defined by the Adult Consumer Satisfaction Survey subscale for housing. Calculated for those clients who indicated that housing was important to their recovery (Question 48 on MHSIP Consumer Satisfaction Project). Average Proportion Positive for a group.

**Sources of Information:**
- Enrollment and encounter data
- Adult Consumer Satisfaction Survey
- Annual report

**Special Issues:** The statewide Housing Plan will address various housing issues, including increasing housing stability of those persons receiving behavioral health services by the Purchasing Collaborative through the SE-ValueOptions. Please see section on Supported Housing.

**Significance:** Supports goals of President's New Freedom Commision.

**Action Plan:** The statewide Housing Plan continues to guide the development and implementation of housing options during SFY-2009. Please see pages for more detail.
### Transformation Activities:

**Name of Performance Indicator:** Adult - Increased Social Supports/Social Connectedness (Percentage)

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**Table Descriptors:**

**Goal:** To enable individuals with serious mental illness to increase utilization of social supports to enhance recovery.

**Target:** To increase number of individuals with serious mental illness utilizing social supports.

**Population:** Adults with SDMI

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems  
3: Children's Services

**Indicator:** Percentage of Consumers who report positively on the social connectedness subscale under the MHSIP consumer satisfaction survey.

**Measure:** Numerator: Number of positive responses reported in the Social Connectedness subscale on the adult consumer survey.  
Denominator: Total responses reported in the social connectedness subscale on the adult consumer survey.

**Sources of Information:** Annual Consumer Satisfaction Project consumer survey

**Special Issues:**  
- New Mexicans in recovery from mental illness and substance abuse lead or play a major part in project coordination, design, implementation, data collection, and information dissemination.  
- The telephonic and face to face survey instruments for adult and child populations are based on the national 28-item Mental Health Statistics Improvement Project (MHSIP) with additional items on substance abuse, housing, and employment in the adult version. It also includes a section where participants can comment either on specific survey items or about their general perceptions of the programs where they receive services.  
- It is available in English and Spanish.

**Significance:** A major outcome of the development of a community-based system of care is quality and appropriateness of care.

**Action Plan:** Consumer Satisfaction Project (CSP): The NM Consumer Satisfaction Project (CSP) remains a joint effort between the Human Services Division HSD/MAD and BHSD, Value Options Department of Recovery and Resiliency (VO) and Children Youth and Family (CYFD). Its purpose is to assess consumer satisfaction. The Consumer Survey Project (CSP) is designed to promote consumer and family involvement in the community for recipients of behavioral health services. The objectives of the Consumer Satisfaction Survey Project are to show how consumers and families could indicate satisfaction through the inclusion of their voice and their involvement in all levels of the service delivery system. The Project has been almost entirely consumer-driven. Information from 736 face to face surveys are being entered and analyzed for 2008.
**Name of Performance Indicator:** Adult - Improved Level of Functioning (Percentage)

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**Table Descriptors:**

**Goal:** To enable individuals with serious mental illness to manage and maintain recovery.

**Target:** To increase number of consumers who report an improved level of functioning

**Population:** adults

**Criterion:**

1: Comprehensive Community-Based Mental Health Service Systems
2: Children’s Services
3: Targeted Services to Rural and Homeless Populations

**Indicator:** Percent of adults who report positively on the functionality scale of the annual Consumer Satisfaction Survey (MHSIP)

**Measure:**

Numerator: Number of positive responses reported in the functionality scale on the adult consumer survey.
Denominator: Total responses reported in the functionality scale on the adult consumer survey.

**Sources of Information:**

To be developed - Sources could include Consumer Satisfaction Project-Self-report on MHSIP; VO data

**Special Issues:**

- New Mexicans in recovery from mental illness and substance abuse lead or play a major part in project coordination, design, implementation, data collection, and information dissemination.
- The telephonic and face to face survey instruments for adult and child populations are based on the national 28-item Mental Health Statistics Improvement Project (MHSIP) with additional items on substance abuse, housing, and employment in the adult version. It also includes a section where participants can comment either on specific survey items or about their general perceptions of the programs where they receive services.
- It is available in English and Spanish.

**Significance:** A major outcome of the development of a community-based system of care is quality and appropriateness of care.

**Action Plan:** Consumer Satisfaction Project (CSP): The NM Consumer Satisfaction Project (CSP) remains a joint effort between the Department of Health Behavioral Health Services Division (DOHBHSD), Human Services Division HSD/MAD, Value Options Department of Recovery and Resiliency (VO) and Children Youth and Family (CYFD). Its purpose is to assess consumer satisfaction. The Consumer Survey Project (CSP) is designed to promote consumer and family involvement in the community for recipients of behavioral health services. The objectives of the Consumer Satisfaction Survey Project are to show how consumers and families could indicate satisfaction through the inclusion of their voice and their involvement in all levels of the service delivery system. The Project has been almost entirely consumer-driven. Information from 693 face to face surveys are being entered and analyzed for 2008.
Name of Performance Indicator: Consumer Participation in LC

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Table Descriptors:

**Goal:** Consumer play an active and authentic role in the Local Collaborative membership and leadership

**Target:** Increase consumer engagement in Local Collaborative process. Baseline will be established in SFY 2008.

**Population:** Adult consumers

**Criterion:** 5: Management Systems

**Indicator:** Percentage/number increase of consumers and family members active in Local Collaboratives.

**Measure:** Numerator: Number of consumers and family members active in Local Collaboratives. Denominator: Number of members active in Local Collaboratives.

Baseline will be established in SFY-2008.

**Sources of Information:** LC Membership Matrix; Consumer engagement plans

**Special Issues:** Communication infrastructure and linguistic and cultural competence. Transportation, rural and frontier areas. Funding to support consumer engagement and participation in Local Collaboratives. Additionally, there are multiple Local Collaboratives with varying degrees of consumer and family members involved in the process. SFY-2009 targets are based on the SFY-2008 baseline data.

**Significance:** The primary intent of the BH Transformation and goal of the NFC is that the system be "consumer and family driven."

**Action Plan:**

- Beginning at the community level, and up to the BHPC level and beyond, continue to identify and expand consumer and family representation and participation in all activities at all levels and at all stages by creating opportunities and through timely and efficient communication.
- Develop and implement Consumer Engagement Plans and other LC activities with on-going support from state staff; revisit Membership Matrix and LC assessments on a regular basis; trainings; anti-stigma. Local Collaborative self-assessment is being completed as part of the MHT-SIG evaluation. Consumer engagement plans and membership target will be developed based on assessment data.
- Specific target activities for SFY 09 include:
  1. Increase in consumer/family representation on BHPC to require Local Collaborative (LC) representation on BHPC
  2. Establish guidelines for BHPC sub-committees as they advise Collaborative on strategic plan, evaluation, implementation of strategic priorities
  3. Consumer workgroup as an ad hoc committee of the BHPC – advocacy, training, leadership development
  4. Training for BHPC members emphasizing leadership, consumer engagement, cultural
competency, and evidence-based practices
5. Establish and enact legislative priorities as a consolidated legislative package across Collaborative agencies and LCs
7. Develop and maintain data base to track legislative priorities, legislative response statewide across LCs
8. Cross agency coordinated behavioral health legislative budget request
And:
1. Design and implement survey (twice yearly) of Local Collaboratives (LCs) to assess effectiveness and consumer voice
2. Create consumer engagement tool kit and train Local Collaboratives in its use
3. Consumer engagement plans developed by each LC
4. Legislative priorities developed by each LC and forwarded to BHPC and Collaborative
5. LC leadership for identified collaborative efforts on a local level, e.g. Total Community Approach
6. Develop procedures for tracking LC membership and level of involvement
ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Mental Health System Data

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Table Descriptors:

Goal: To establish the Collaborative's Behavioral Health Purchasing Plan that increases access, maximizes resources and identifies priorities and is based on mental health system data.

Target: To utilize mental health system data, including incidence/prevalence data, as a key element in the implementation of the Collaborative's Behavioral Health Services Purchasing Plan. Targets to be set after baseline is established in SFY-2009.

Population: Adults being served by the Purchasing Collaborative through the SE-ValueOptions

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Population-based behavioral health service needs data for each region, including Incidence/Prevalence data for each region


MH/SA Numerator: Population being served by SE-ValueOptions in each of 5 regions

Denominator: Number of population in need of behavioral health services as determined through national incidence/prevalence data models for state (substance abuse & Mental Health)

Sources of Information: Population-based BHS needs data Incidence/Prevalence) through DOH-Epi. Epi has identified approx, 22K 18-64 year old adults who are below 150% of poverty, are uninsured and have an SA disorder. Epi is developing I/P for MH population.

VO enrollment data

Special Issues: The Collaborative has commissioned a Behavioral Health Purchasing Plan which will enable the rational purchase of behavioral health services in each region that accounts for regional needs, current funding levels and will guide the allocation of resources. One key factor in this evaluation process will be the inclusion of population-based behavioral health service needs data.

Significance: Consolidation of behavioral health services funding under VO and the Purchasing Collaborative requires a common approach to allocation of these resources.

Action Plan: The Collaborative's Behavioral Health Services Purchasing Plan for adult services will be developed in SFY-2009. One key element of this plan with focus on the collecting and reporting of population-based behavioral health needs data for each region. It is anticipated that this Plan will be shared with Collaborative members, the Behavioral Health Planning Council, Local Collaboratives and VO-NM to guide behavioral health services system improvements.
Name of Performance Indicator: Rural Services

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Table Descriptors:

Goal: Increase percentage of individuals in rural and frontier locations with access to appropriate behavioral health provider (Governor's Performance Measure 4.4.s)

Target: Increase percentage of individuals in rural and frontier locations with access to appropriate behavioral health provider

Population: Adults being served by the Purchasing Collaborative through the SE-ValueOptions who are in rural and frontier locations

Criterion: 4: Targeted Services to Rural and Homeless Populations

Indicator: Increase in the number of adults in rural and frontier locations with access to appropriate behavioral health provider.

Measure: Percentage of individuals with 1 provider within 60 miles for rural counties and individuals with 1 provider within 90 miles for frontier counties.

Sources of Information: Geo-Access tracking for Medicaid members to be expanded in SFY-2008 for other payor sources and the Collaborative

VO-data

Special Issues: Under Governor Richardson's Healthy New Mexico - Governor's Performance and Accountability Contract, Goal 4 is to Improve Behavioral Health through an Interagency and Collaborative Model. Task 4.4 focuses on increasing rural, frontier and border access to behavioral health services. Geo-access tracking has established percentages for Medicaid members. SFY-2008 will focus on expanding this tracking to other payor sources.

Significance: NFC goal of Eliminating Disparities in Mental Health Services. As noted, New Mexico is engaged in a system-wide transformation of the behavioral health service system, which is being guided by the Comprehensive Behavioral Health Plan. This Plan is part of the state-wide Healthy New Mexico Initiative, which includes the Governor's Performance Measures. This goal is also shared with the MHT_SIG. T-SIG efforts and specific objectives for enhancing services in rural communities are focused specifically on Native American rural and frontier communities. A detailed inventory of behavioral health needs and resources is being completed and related training for consumers, families and providers will be implemented and evaluated as a result, by MHT-SIG evaluator. Work is being done by the NA Subcommittee of the BHPC, Indian Affairs Department and UNM-Centers for Rural and Community Behavioral Health.

Action Plan: As noted above, the geo-access tracking for Medicaid members will be expanded in SFY-2008 for other payor sources and the Collaborative. State and VO staff involved in this project will be included.
Name of Performance Indicator: Screening for Co-Occurring Disorders

Table Descriptors:
Goal: Develop a comprehensive community based system of care in which persons receive care for both substance abuse and psychiatric disorders.
Target: To ensure that adults are screened for both substance use disorders and mental health in community-based behavioral health provider system. (Governor's Performance Measures 4.2.f.1 and f.2)
Population: Adults served by ValueOptions
Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
Indicator: Governor's Performance Measures 4.2.f.1 and f.2- Percent of adults presenting with psychiatric issues who are screened for substance abuse and percent of adults presenting with substance abuse issues who are screened for psychiatric issues.
Measure: GPM 4.2.f-1 and 4.2.f-2

(GPM 4.2.f-1)
Numerator: # of adults screened for substance abuse
Denominator: # of adults presenting with psychiatric issues

GPM 4.2.f-1)
Numerator: # of adults screened for psychiatric issues
Denominator: # of adults presenting with substance abuse

Sources of Information: VO Chart audits as reported to Purchasing Collaborative Oversight Committee

Special Issues: SFY-2009 measure will focus on adults receiving BHSD-funded services. Expansion of this measure to all adults served by the Purchasing Collaborative will be explored.

Significance: A key goal of the Intergency Behavioral Health Purchasing Collaborative is the expansion of the community-based service system that has "no wrong door" for consumers needing behavioral health services, which will require providers to be able to adequately screen for both substance abuse and mental health disorders. Additionally, research indicates that at least 30% of the population served by the Purchasing Collaborative through the SE-VO could have a co-occurring substance abuse and psychaitric condition.

Action Plan: VO is currently utilizing a chart audit process to report on the Purchasing Collaborative's Oversight Committee on BHSD funded clients.
**Transformation Activities:**

**Name of Performance Indicator:** Targeted Services to Homeless Populations

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**Table Descriptors:**

**Goal:** To significantly reduce the State mentally ill/co-occurring homeless census by appropriately housing and providing effective, accessible mental health treatment services. (Governor's Performance Measure 4.2.d.2)

**Target:** To stabilize and improve the functioning level and quality of life of homeless persons who are being served by the Purchasing Collaborative through the SE-ValueOptions.

**Population:** Homeless adults who are being served by the Purchasing Collaborative through the SE-ValueOptions.

**Criterion:** 4: Targeted Services to Rural and Homeless Populations

**Indicator:** Number of adults who are homeless at enrollment for behavioral health services who become housed during treatment.

**Measure:** This measure has been changed in SFY-2008 to better reflect the efforts of the Purchasing Collaborative to serve homeless persons with behavioral health needs.

**SFY-2008:** Baseline of persons being served by the Purchasing Collaborative through the SE-VO who are homeless at enrollment. Baseline of number of persons whose housing situation changes during enrollment. Targets will be set after SFY-2008 baseline data is obtained.

**Sources of Information:** SE data

**Special Issues:** The NM Mortgage Finance Authority is a Collaborative member agency. They administer the HUD Shelter Care funds in close collaboration with the Collaborative’s statewide entity. Please see Pages ______ regarding New Mexico’s Supported Housing Plan and information on the NM Poverty Task Force.

**Significance:** [G 2] Homelessness is a major deterrent in providing an integrated continuum of mental health services. Assuring access to case management services for persons diagnosed with a serious mental illness is a critical service for the homeless population. Both the President's New Freedom Commission Report Goal 2 and the HUD report on Chronic Homelessness have identified housing as a key critical factor/service in a responsive mental health system.

**Action Plan:**

ACTION PLAN:

Please see Pages ______ regarding the New Mexico Supported Housing Plan.
*Transformation infrastructure and service activity: both relating to supported housing.
New Mexico

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 1: Comprehensive Community-Based Services

Establishment of a System of Care – NFC Goals 1.2, 2.1, 3.2, 4.3, 5.2

The New Mexico Children, Youth and Families Department (CYFD) is identified as the state behavioral health authority for children and is one of the core agencies making up the state’s Behavioral Health Collaborative. CYFD is mandated to serve children and youth in state custody through its Protective Services and Juvenile Justice Services Divisions. In addition, CYFD Family Services Division through ValueOptions New Mexico (VONM), the single statewide entity, funds behavioral health services to children and their families who are not eligible for Medicaid but who are in need of public behavioral health services.

As the Children’s Behavioral Health Authority for the state of New Mexico, CYFD has identified seven areas as behavioral health priorities for FY2009. These priorities support a children’s system of care, as well as the CYFD vision, mission, and principles. Four of these seven areas apply to this application. They are: 1) Ensuring thorough and accurate behavioral health assessments and evaluations for children and adolescents; 2) Implementation of Core Service Agencies (CSAs); 3) Substance abuse services for children, youth, and young adults; and 4) Development of services focusing on adolescent transition.

Assessments for Children and Adolescents
Thorough and accurate behavioral health assessments/evaluations are essential to providing appropriate treatment services to meet the needs of children and youth. As such, the system of care must ensure the availability and quality of standardized assessments that address both diagnosis and level of functioning for children and youth in the protective services and juvenile justice system, and children and youth with Serious Emotional Disturbance (SED) who are at risk of out-of-home placement and who are already placed in out-of-home care. The system of care also needs to ensure a formalized and standardized process for assessing functional levels of children for purposes of determining required level of supervision, structure and support required to meet each youth’s needs, ensure safety, and maintain placement stability. Finally, the system of care needs to ensure a formalized and standardized process for on-going assessment of both diagnoses and functional levels for youth receiving behavioral health services for purposes of monitoring improvement during treatment.

The work plan for the coming year includes the following tasks/action items:

- Staff from CYFD, Medicaid, and VONM will collaborate to establish a uniform evaluation process.
- Staff from CYFD, Medicaid, and VONM will collaborate to implement a standardized functional assessment tool (Child and Adolescent Functional Assessment Scale, or CAFAS).
- On-going training and support will occur around the utilization and implementation of the CAFAS.
- Members of the judicial/legal system will be trained on types and appropriate uses of assessment/evaluations for children and youth.
- Provider agency staff will be trained on culturally appropriate assessment and differential diagnosis i.e., Posttraumatic Stress Disorder/Trauma, Attention Deficit Disorder, Oppositional Defiant Disorder, and on identifying co-occurring disorders by VONM.
• CYFD and VONM will collaborate to standardize behavioral health referral packets.

**Implementation of Core Service Agencies (CSAs)**

Coordinated and accessible services in community-based centers are essential to serving youth and families with complex needs in the least restrictive settings. An integral part of implementing an integrated, community-based system of care for children, youth, and their families is the concept of Core Service Agencies (CSAs). CSAs are multi-service agencies that will assure that consumers of behavioral health services will receive comprehensive and integrated care across a range of services. These agencies will help to bridge treatment gaps, promote the appropriate level of service intensity, ensure that community support services are integrated into treatment, and develop the capacity for consumers to have a single point of accountability for identifying and coordinating their behavioral health services. CSAs will ensure that the youth with behavioral health needs receive quality mental health services with a priority focus on: evidenced based practices; promising practices that do not yet meet the evidence-based standard; best practices or national standards with successful outcomes; and cultural diversity. CSAs will be required to provide Crisis Management, Diagnostic Assessment, Comprehensive Community Support Services (CCSS), Psychiatric Services, and Outpatient Treatment. It is anticipated that the first CSAs will be identified in July 2008.

The work plan for implementation of CSAs throughout the state include the following:

• CYFD in collaboration with VONM will identify a plan for developing and/or providing services in those areas where a minimum accessible service array does not exist.
• CYFD and VONM will collaborate with behavioral health partners to develop a plan to enhance the service array to appropriate, accessible and adequate levels statewide through the CSA model.
• CYFD and VONM will collaborate with behavioral health partners to define eligible populations for the CSA; priority will be given to youth in the Protective Services and Juvenile Justice Systems, SED youth, as well as those at-risk of out-of-home placement.
• Training will be delivered for service providers who have not yet received such training in the wraparound approach to service delivery and system of care principles.
• CYFD and VONM will prioritize utilization, and support the increased availability of these services, especially evidenced based and promising practices, over those with no supported outcome research.
• CYFD and VONM will coordinate and support on-going training and staff development of providers in the CSA model. Such training will be related to evidenced-based and best practices for community-based behavioral health case management, and will include CYFD staff from Family Services Regional Transition Services, Protective Services, Juvenile Justice Field and Facilities Services, as well as consumers and family members.

**Substance Abuse Services for Children, Youth and Young Adults**

The majority of children and families involved in the behavioral health system of care have identified issues regarding the use, abuse and dependence on alcohol or other substances. As such, CYFD in collaboration with VONM will work to enhance the accessibility and availability of quality substance abuse services statewide.
CYFD and VONM will expand the availability of Intensive Outpatient Programs (IOP) services for youth and families as well as continue the expansion of MST and other evidence-based services in geographic areas that do not currently have access to MST services. CYFD and VONM will collaborate with BHSD to review lessons learned and outcome information from the Co-occurring Disorders State Incentive Grant and Total Community Approach funded projects. CYFD and VONM will support service providers to improve substance abuse screening and assessment for the adolescent population. Such improvements will target youth already engaged in behavioral health services, as well as those youth in need of services.

**Services Focusing on Adolescent Transition**

Successful transition of youth within the various age-defined systems of behavioral healthcare, as well as those transitioning from state custody or those under the supervision of state services, are essential in promoting both recovery and resiliency. As such, the system of care must ensure that the behavioral health service array is adequate to meet the needs of youth aging out of the foster care system, transitioning out of the juvenile justice system to the community, youth involved in behavioral health system into the adult system, and/or youth involved in any of these areas of significant transition. In reviewing the service array for youth in transition, it is essential that special attention be paid to those youth and young adults with dual diagnoses of Developmental Disabilities and Mental Illness (DD/MI).

VONM will actively participate with CYFD, Medicaid, the Behavioral Health Services Division (BHSD) and other Collaborative members in the further development and implementation of the Adolescent Transition Priority Work Plan. VONM and CYFD in collaboration with BHSD will implement recommendations of the Adolescent Priority Workgroup regarding service delivery for target population through the service provider network. VONM will collaborate with the Department of Health in focusing on and enhancing services for the DD/MI population, including care coordination across child-adult service provider/systems and promotion of specialty services for youth and young adults with dually-diagnosed with DD/MI. VONM and CYFD will include recovery and resiliency oriented peer-to-peer support in all service development regarding adolescent transitional services.
New Mexico

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

- Health, mental health, and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Support services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other activities leading to reduction of hospitalization.
Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 1: Comprehensive Community-Based Services

Available Services – NFC Goals 1.2, 2.2, 3.1, 3.2, 5.2

The state of New Mexico continues to implement a comprehensive and integrated system of care through the Behavioral Health Collaborative (Collaborative) and ValueOptions New Mexico (VONM). Services are funded through Medicaid, legislative general funds, and federal funds for specific projects and programs, including the Mental Health Block Grant. The available services include the following:

- **Screening/Assessment/Evaluation** – screening for mental health and substance use, functional assessments, and comprehensive diagnostic evaluations;
- **Clinical Services** – individual, family, and group therapy, medication management/psychiatric services, crisis intervention services, and individualized treatment planning;
- **Non-Clinical Community-Based Services** – comprehensive community support services, life skills training/development, behavior management services, activity therapy; and experiential wilderness therapy;
- **Evidence-Based/Promising Practices** – multi-systemic therapy (MST), functional family services (FFT), therapeutic foster care (TFC), and use of the wraparound approach;
- **Support Services** – travel/transportation, behavioral respite services;
- **Early Intervention Services** – home visiting program, infant mental health services; and
- **Residential Services** – shelter care, group home, and residential treatment centers.

**Wraparound/Clinical Home Project**

As a strategic priority, VONM and the Collaborative created the Clinical Home Project. Clinical Home is a model for providing behavioral health care in a coordinated manner. In a Clinical Home, a designated provider helps a youth consumer and his/her family coordinate and manage all of their care. Clinical Home uses a wraparound approach to service delivery based on the Milwaukee Model. The program’s goals include minimizing out-of-home placements, supporting families, building on their strengths, helping them to access an array of services, coordinating care, and delivering services in a cost effective manner. Community support workers are the cornerstones of the system. They perform strength-based assessments, assemble the child and family team (CFT), conduct plan-of-care meetings, help determine needs and resources with the youth and family, assist the team in identifying services to meet those needs, arrange for community agencies to provide specific services, and monitor the implementation of the case plan. The CFT is a system of support that includes the family’s natural supports (such as relatives, church members, and friends) and systems people (including probation or child welfare workers).

Ten providers in Albuquerque, Las Cruces, and Santa Fe were selected to implement the Clinical Home Project. The project began providing services to families in May 2007 and to date has served 302 families. Of the 368 families who were referred for project, 302 were accepted, representing an 82% acceptance rate. Of those families accepted into the project, 92% were involved in the juvenile justice system and eight percent were involved in the protective services system. Almost two thirds, or 63% of the families served lived in the Albuquerque area.
Multiple positive outcomes were reported in a qualitative outcome evaluation of the Clinical Home Project. Professional stakeholders (service providers and staff of the juvenile justice system) identified continuity, coordination of care, the inclusive nature of treatment planning and care provision, utilization of natural supports, and greater accountability as major positive aspects to the approach. Service providers appeared to be gaining skills in coordinating and communicating with both natural and formal support systems. In addition, professional stakeholder attitudes about the youth and their families were also changing. Most youth and families involved in the project perceived it as a better option for youth. Youth spoke highly of their community support workers, characterizing them as highly accessible people whom they could turn to in a time of need. Clinical Home offers youth someone with whom they could talk, enables them to participate in treatment planning, supports efforts at anger management and developing other coping skills, and provides assistance with transportation, financial problems, and job seeking. Youth and family members reported that Clinical Home impacted their relationships in the home setting positively and described how youth had become helpful and respectful. In addition, some youth stopped hanging out with friends who were considered to be negative influences and both youth and families cited a decrease in legal troubles.

System of Care/Rebalancing Plan

It has long been recognized that New Mexico’s System of Care relies too heavily on out-of-home treatment including residential treatment centers, group homes, psychiatric hospitalization, out-of-state placement, and therapeutic foster care. As a result and due in part to the success of the Clinical Home Project, the Behavioral Health Planning Council and the Behavioral Health Purchasing Collaborative are promoting a Systems of Care approach to children’s behavioral health services. The core values and principles stress child-centered, family-focused, and strengths-based care; home, school, and community-based services; community based management; and cultural competence. The desired outcome is a rebalancing of services focused on keeping youth with their families and in their local communities.

There are multiple aspects to this plan. These include integrating the wraparound approach as a regular part of the service delivery system, increasing access to evidence-based and promising practices such as MST and FFT, and focusing on Local Collaboratives identified needs, desires, and gaps in service. Local Collaboratives are being asked to evaluate their local community’s actual service delivery system as well as their planning and development work, using the guiding principles of systems of care and wraparound as standards against which they can measure themselves and their communities.

VONM has already made significant progress in rebalancing the children’s system of care. There was a dramatic decrease in out-of-home treatment between 2006 and 2007. The trend related to increased utilization of community-based services and reduction in out-of-home residential treatment saved the state approximately $11 million between FY2007 and FY2008. In addition, the amount of money spent per child for out-of-home residential treatment has decreased by approximately $1,500. This money is being reinvested in community-based services including additional three additional MST sites and three new FFT sites with community-based providers.
Comprehensive Community Support Services/Certified Family Specialist

Comprehensive Community Support Services (CCSS) is a new service that was approved in the Medicaid State Plan as of January 1, 2008. It replaces the previous service of case management. The intent in changing the service and its definition is to create a service that is more community based, consumer driven, and oriented towards recovery and resiliency. The purpose of CCSS is to coordinate and provide services and resources to individuals/families necessary to promote their recovery and resiliency. CCSS identifies and addresses the strengths as well as the barriers that impede the development of skills necessary for an individual or family in their recovery and resiliency process to function independently in the community. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. CCSS also includes supporting an individual and family in crisis situations; and providing tailored interventions to develop or enhance an individual’s ability to make informed and independent choices. CCSS allows New Mexico service providers a mechanism to implement wraparound services with youth who otherwise may be placed in residential treatment. CCSS has also been identified as one of the mandatory services that Core Service Agencies (CSAs) must provide.

CCSS also provides for a new type of service provider within community based agencies called a Certified Family Specialist (CFS). The CFS is a peer support worker who has experience in navigating any of the child/family-serving systems, this includes having a good understanding of how these systems operate in New Mexico, or previous experience advocating for family members who are involved with the child/family behavioral health systems.

Child and Adolescent Functional Assessment Scale (CAFAS)

In order to provide the least restrictive, most appropriate services possible it is imperative that children, youth, and their families have access to comprehensive assessment services that focus on the strengths, needs, and functioning of those receiving behavioral health services. The Behavioral Health Collaborative has also identified the need in their strategic plan to measure their performance by examining the percent of children and youth with improved functional assessments between admission and discharge in community based programs. CYFD contracted with national expert Kay Hodges, Ph.D. to provide training on the use of a functional assessment tool to CYFD staff, VONM clinical and regional staff, and CYFD consultants. Clinical Home providers began administering the Child and Adolescent Functional Assessment Scale (CAFAS) to assist with assessment, treatment planning, and outcome tracking. The CAFAS will be utilized in all CSAs serving children, youth, and their families beginning later this year. Data from the CAFAS will be aggregated and evaluated through the Consortium for Behavioral Health Training and Research (CBHTR). CBHTR will then host “data parties” so that providers can compare themselves to aggregate statewide data and utilize the data for quality improvement purposes.
New Mexico

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children
Section III. Performance Goals and Action Plans to Improve the Service System

Criterion 2: Mental Health System Data Epidemiology

Estimate of Prevalence – NFC Goals 1.2, 3.1, 3.2

Prevalence estimates provide a standardized basis for defining the need for services in a population. Prevalence data are most useful when combined with the number of individuals who actually receive services. The combination of the two can generate indicators of unmet need and disparities in care.

The Consortium for Behavioral Health Research and Training (CBHTR) in collaboration with the Human Services Department initiated a project and contracted with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program to develop prevalence estimates for individuals with behavioral health needs for the state of New Mexico. Epidemiologists who generated prevalence estimates have developed a technology specifically for this purpose.

The total state household population in 2006 was 1,915,213 individuals. The following prevalence estimates focus on the 1,138,082 individuals in low-income households, which comprises almost 60% of the household population. The proportion of the low-income household population is significantly higher for children and adolescents than adults (71% v 55%). These prevalence estimates are even narrower, focusing on low-income individuals with serious behavioral health disorders or about 4% of the entire state population. The rationale for narrow focus on low-income individuals with serious behavioral health disorders is that this population constitutes the core target population for public behavioral health services.

Estimates of the need for services may be combined with counts of individuals served to provide indicators in two areas: 1) Indicators of the equitability of services (penetration rates); and 2) Indicators of unmet need.

The following three tables show prevalence estimates of youths with serious emotional disorders (SED) by gender, age group, and race/ethnicity.

Table 1: Estimates of youth with SED by Gender

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>15,314</td>
<td>14,829</td>
<td>30,143</td>
</tr>
</tbody>
</table>

According to Table 1, there are no significant differences between male and female groups in the estimates of SED across the state.

Table 2: Estimates of SED by Age Group

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>00-05</th>
<th>06-11</th>
<th>12-17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>10,684</td>
<td>10,043</td>
<td>9,412</td>
<td>30,143</td>
</tr>
<tr>
<td>% for each group</td>
<td>35%</td>
<td>33%</td>
<td>31%</td>
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</tr>
</tbody>
</table>
The youngest group (00-05) had the largest estimates at 35%. The second age group (06-11) comprised 33% of the total child and adolescent SED population across the state. The oldest group had the smallest SED percentage (31%). These groups did not differ significantly in size across the state.

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>White-NH</th>
<th>Native-NH</th>
<th>Other NH</th>
<th>Hispanic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total</td>
<td>6,793</td>
<td>4,242</td>
<td>1,251</td>
<td>17,857</td>
<td>30,143</td>
</tr>
<tr>
<td>% for each group</td>
<td>23%</td>
<td>14%</td>
<td>4%</td>
<td>59%</td>
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</table>

Over 59% of the estimated youth SED population was Hispanic, and 23% was White, Non-Hispanic. Native Non-Hispanic accounted for 14% of the estimated youth SED population and Other accounted for 4%.

The above estimates are based on 2006 data. In 2006, New Mexico served 27,480 unduplicated SED youth out of an estimate of 30,143 based on the above data. This represents a 91% service penetration rate.
New Mexico

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1
New Mexico

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

- Social services;
- Educational services, including services provided under the Individuals with Disabilities Education Act;
- Juvenile justice services;
- Substance abuse services; and

- Health and mental health services.
New Mexico

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.
New Mexico

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless
New Mexico

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas
New Mexico

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;
New Mexico

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;
New Mexico

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved
**Name of Performance Indicator:** Increased Access to Services (Number)

<table>
<thead>
<tr>
<th></th>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
<th>(5) FY 2009 Target</th>
<th>(6) FY 2010 Target</th>
<th>(7) FY 2011 Target</th>
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<tbody>
<tr>
<td>Performance Indicator</td>
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<td>29,783</td>
<td>35,170</td>
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<td>--</td>
</tr>
<tr>
<td>Denominator</td>
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<td>N/A</td>
<td>--</td>
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</tr>
</tbody>
</table>

**Goal:** Increase access to services for children and youth identified as SED.

**Target:** Between FY2006 and FY2007 the total number of youth served increased by eight percent. The projection for FY2008 is based on the number of youth served through May 31, 2008. This represents an 18 percent increase of the number of youth served. The target for FY2009 is based on a 10 percent increase in the number of youth served.

**Population:** Children and youth up to age 18 who are identified as severe emotional disorders

**Criterion:** 2: Mental Health System Data Epidemiology  
3: Children’s Services

**Indicator:** The total number of youth served in the behavioral health system as reported on Table 2a of the URS tables.

**Measure:** The measure for this NOM is the total number of youth served. Projections and targets for FY2009 are based on data accumulated through May 2008, the percentage increase from FY2006 and FY2007, and the projected percentage increase from FY2007 to FY2008.

**Sources of Information:** ValueOptions New Mexico (VONM) provides the state with the total number of unduplicated clients served by age.

**Special Issues:** There has been significant confusion in the state regarding a standardized definition of SED. VONM reported that they had received mixed messages and guidance from the state in this regard. Earlier this year, staff from the Children, Youth, and Families Department and staff from Medicaid met to develop a statewide, standardized definition that will be used from this point forward in identifying youth with SED. The numbers identified above utilize the federal definition of SED as found on the SAMHSA website.

**Significance:** The data indicates that there was over an eight percent increase in the number of youth served between FY2006 and FY2007 and a projected 18 percent increase between FY2007 and FY2008. It is unclear if this is due to an improved service delivery system or whether it is due to improved reporting capacity.

**Action Plan:** The Children, Youth, and Families Department (CYFD) has identified seven priority work areas for the coming year. Several of these priority work areas are related to increased access to children and youth with behavioral health needs. These include: 1) Cooperation and Support on the Resolution of Legal Issues; 2) Implementation of Core Service Agencies (CSAs); 3) Substance Abuse Services for Children, Youth and Young Adults; and 4) Services Focusing on Adolescent Transition.

1) In February 2006 the CYFD entered into an agreement with the ACLU in regard to youth involved in the Juvenile Justice System. As a part of that agreement, CYFD agreed to increase access for juvenile justice involved youth to community based behavioral health services especially for those at risk of out-of-home placement (i.e. residential treatment, etc). CYFD has been actively engaged in improving access to a comprehensive array of appropriate and culturally relevant community based services.
2) Core Service Agencies (CSAs) is a concept that has been in development since the inception of the Behavioral Health Collaborative. The goals of this initiative include reducing duplication and fragmentation of mental health services and helping to bridge treatment gaps and increase access to the children’s system of care. CSAs are required to provide the following services: crisis management, diagnostic assessment, comprehensive community support services, psychiatric services, and outpatient treatment. CSAs will increase access to and coordination of appropriate community based services for children and youth. The first CSAs will be identified in July 2008 and will begin operation as such shortly thereafter.

3) In the coming year, VONM will be required to expand the availability of Intensive Outpatient Programs (IOP) for youth and families experiencing substance use problems and concerns. In addition, VONM is expected to continue to expand the number of Multi-Systemic Therapy (MST) sites, especially in underserved areas.

4) Adolescents who are transitioning to adulthood in the behavioral health system in New Mexico too often lose access to services. As a result, the Behavioral Health Collaborative has identified four strategies to address the needs of adolescents transitioning to adulthood. These include the following: a) Promoting comprehensive transition planning in six domains for all 15 year olds and those 16 year olds. Domains include housing, employment, education, supportive relationships, health and behavioral health, and life skills. b) Securing Transition Coordinators specifically focused on connecting young people to adult services and supports for youth age 16 and 17 year olds. Transition coordination services would be provided up to age 21 years. Transition coordination would include efforts in all six domains. c) Creating a variety of options for housing that meet the different strengths, independent living skills, and development levels of the youth. d) Creating other supports for youth to assure that youth have access to information to assist them in their transition including adult and peer mentors.
**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
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<tr>
<td>Fiscal Year</td>
<td>FY 2006 Actual</td>
<td>FY 2007 Actual</td>
<td>FY 2008 Projected</td>
<td>FY 2009 Target</td>
<td>FY 2010 Target</td>
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<td>Performance Indicator</td>
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**Table Descriptors:**

**Goal:** National Outcome Measure is not applicable.

**Target:** National Outcome Measure is not applicable.

**Population:** National Outcome Measure is not applicable.

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems  
3: Children's Services

**Indicator:** National Outcome Measure is not applicable.

**Measure:** National Outcome Measure is not applicable.

**Sources of Information:** National Outcome Measure is not applicable.

**Special Issues:** CYFD requested clarification from SAMHSA on whether or not state operated RTC's were considered "state psychiatric hospitals" as defined in the criterion. SAMHSA clarified that they were not. Therefore, since the state of New Mexico does not operate any psychiatric hospital services for children, this National Outcome Measure is not applicable.

**Significance:** National Outcome Measure is not applicable.

**Action Plan:** National Outcome Measure is not applicable.
### Transformation Activities:

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>2006 Actual</th>
<th>2007 Actual</th>
<th>2008 Projected</th>
<th>2009 Target</th>
<th>2010 Target</th>
<th>2011 Target</th>
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**Table Descriptors:**

**Goal:** This NOM is not applicable to New Mexico as the state does not maintain publicly funded psychiatric inpatient beds.

**Target:** This NOM is not applicable to New Mexico

**Population:** This NOM is not applicable to New Mexico

**Criterion:**
- 1: Comprehensive Community-Based Mental Health Service Systems
- 3: Children's Services

**Indicator:** This NOM is not applicable to New Mexico

**Measure:** This NOM is not applicable to New Mexico

**Sources of Information:** This NOM is not applicable to New Mexico

**Special Issues:** This NOM is not applicable to New Mexico

**Significance:** This NOM is not applicable to New Mexico

**Action Plan:** This NOM is not applicable to New Mexico
Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

<table>
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<th>Actual</th>
<th>Projected</th>
<th>Target</th>
<th>Target</th>
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</table>

Table Descriptors:

Goal: Use of TFC will decline in favor of in-home treatments. Children in New Mexico will receive evidence based services and interventions delivered in a timely, culturally competent manner, that promotes recovery and increased quality of life.

Target: The target is an eight percent decrease in the number of SED children and youth placed in TFC services in FY2009.

Population: SED youth receiving Therapeutic Foster Care services.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: The denominator for FY2006 and FY2007 is the total number of youth served utilizing the federal definition of SED. The numerator for FY2006 and FY2007 is the actual number of youth who received TFC services. The target performance indicator for FY2009 is the mean of the percent decrease from each of the previous years. The numerator is the anticipated number of youth that will be served in TFC services in FY2009.

Measure: The performance indicator is measured as a percentage.

Sources of Information: ValueOptions New Mexico (VONM) provides data on the total number of children who have received TFC services in each fiscal year.

Special Issues: One issue that has been identified is that because the number of children and youth served each year is increasing at a dramatic pace, the total number of youth receiving TFC services is also increasing. Regardless of its evidence-base, TFC is an out-of-home treatment modality. Because of this, New Mexico is endeavoring to decrease the utilization of this service overall. Because of this, the State is choosing to measure the performance indicator as a decrease in the overall percentage of youth receiving this service as opposed to a decrease in the overall number of individuals receiving the service.

Significance: While TFC is an evidence-based approach to the care of youth with SED, it is also considered an out of home placement, although less intrusive/restrictive than placement in a residential treatment center (RTC). In an effort to rebalance the children’s service delivery system to one that is more reliant on family driven, community based care, there is a desire to decrease its reliance on TFC.

Action Plan: The State plans to continue to reduce its reliance on TFC as a preferred service. It is likely that as the total number of youth served increase, the number of youth served in TFC will increase as well, even as the overall percentage of youth receiving this service decreases.
Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

<table>
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<tr>
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<th>Denominator</th>
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</thead>
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<td>1.68</td>
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<td>FY 2007 Actual</td>
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<td>29,783</td>
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<td>FY 2009 Target</td>
<td>657</td>
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<td>FY 2010 Target</td>
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</tr>
<tr>
<td>FY 2011 Target</td>
<td>N/A</td>
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</tbody>
</table>

Table Descriptors:

Goal: Increase both the number of SED youth receiving MST services and the percentage of SED youth receiving MST services.

Target: The target for this performance indicator is an increase to 0.17% of the total number of SED youth receiving MST services or 657 unduplicated youth.

Population: Children and youth under the age of 18 who are SED and have a history of juvenile justice involvement.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems 3: Children's Services

Indicator: The Denominator is the total number of SED youth served utilizing the federal definition of SED. The Numerator for FY2006 and FY2007 is the actual number of youth receiving MST services. The FY2008 Numerator is a projection of youth receiving MST services based on data through April 30, 2008. The target for FY2009 is a projection of the number of youth who will receive MST services (Numerator) and the projected number of SED youth served overall (Denominator).

Measure: The performance indicator is measured as a percentage.

Sources of Information: ValueOptions New Mexico (VONM) claims data.

Special Issues: VONM has had some difficulty accurately reporting the number of youth receiving services identified as SED. This is due, at least in part, to inconsistency around the statewide definition. This has been addressed and the state is moving forward with a clear statewide definition for SED.

Significance: Two improvements have been made in the last year that enhances providers’ ability to serve youth with MST services. First, Medicaid State Plan Amendment became effective January 1, 2008 changing the status of MST services from an enhanced service to becoming a core service thus allowing more youth and families to access the service. Second, VONM was able to increase the rates for MST services making it more cost effective for providers to offer this service without additional support from the Mental Health Block Grant or State General funds.

Action Plan: VONM will support three new sites for MST services in the coming year. There are 13 sites currently serving youth bringing the total number of MST sites to 16.
CHILD - GOALS TARGETS AND ACTION PLANS

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

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<thead>
<tr>
<th>(1) Fiscal Year</th>
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<th>(7) FY 2011 Target</th>
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<td>Denominator</td>
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<td>29,783</td>
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</table>

**Table Descriptors:**

**Goal:** The system of care will continue to provide Functional Family Therapy (FFT) services to SED youth while transitioning the service to the provider community.

**Target:** The target is based on a percentage of the total number of SED youth projected to be served in FY2009. The target is significantly lower than in past years as the service is undergoing a transition from being a state operated service to one operated in the provider community.

**Population:** SED youth under the age of 18 and their families

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** The numerator is the total number of youth served in each fiscal year. The denominator is the total number of SED youth served in a fiscal year based on the federal definition of SED.

**Measure:** The performance indicator is measured as a percentage.

**Sources of Information:** Children, Youth and Families Department, Juvenile Justice Services FFT services data.

**Special Issues:** For the last three years, New Mexico has been operating FFT services through its juvenile justice probation and parole offices. In March 2008, CYFD executive management made the decision to support the development and expansion of FFT through the community provider network, contracted through ValueOptions New Mexico (VONM). This decision allows the community provider network to further develop its capacity to provide this evidence-based practices and CYFD to transition the FFT positions into Behavioral Health Clinician positions, supporting the capacity of juvenile justice service personnel to provide behavioral health services and implement more flexible direct service provision and/or clinical case management with community behavioral health service providers for youth involved in the juvenile justice system. VONM is using cost savings from decreasing residential and out-of-home treatment services to support community providers in developing this service.

**Significance:** While it is likely that this will reduce access to FFT services in the short term, the service will be managed more effectively and efficiently in the public sector. In the long term, this will have a positive impact on service delivery as community based services are more responsive to consumer needs.

**Action Plan:** In FY2009, VONM is contracting with three community-based youth service providers in the state to provide FFT services in local communities. These providers are located in Albuquerque, Clovis, and Las Cruces. VONM is supporting these agencies with the financial start up necessary for training, licensing fees, and supervision which can be extremely costly to relatively small not-for-profit organizations. It is anticipated that after these agencies initiate service, VONM will be able to contract with providers in other communities to deliver this service in additional regions of the state.
**Name of Performance Indicator:** Client Perception of Care (Percentage)

<table>
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<tr>
<th>Fiscal Year</th>
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<th>FY 2007 Actual</th>
<th>FY 2008 Projected</th>
<th>FY 2009 Target</th>
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<td>657</td>
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</table>

**Goal:** Families of children receiving behavioral health services in New Mexico will report continuing improvement in their level of satisfaction with the services provided.

**Target:** The target for this NOM in FY2009 is that 86 percent of families surveyed will report positive outcomes as a result of the behavioral health services the family receives.

**Population:** Families of children and youth receiving public behavioral health services.

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems 3: Children’s Services

**Indicator:** The numerator is the number of families reporting positively about outcomes on the Consumer Satisfaction Survey. The denominator is the total number of family responses regarding outcomes.

**Measure:** This performance indicator is measured as a percentage.

**Sources of Information:** Survey data from the annual New Mexico Consumer Satisfaction Survey Project.

**Special Issues:** New Mexico’s Consumer Satisfaction Survey asks five of the six Mental Health Statistical Improvement Project (MHSIP) questions identified as being related to outcomes. The MHSIP questions are not asked in the suggested order. Because of this, there is concern about the validity of the results. It is not clear as to why there is a spike in the data for 2007.

**Significance:** The proportion positive for FY2008 indicates a significant drop in families’ perception of care from FY2007, but it does not represent a significant drop from 2006. New Mexico consistently strives for a consumer and family driven system of care that includes positive ratings about outcomes.

**Action Plan:** New Mexico will move towards using the original MHSIP and YSSF survey in 2009 to ensure the consistency in its use across states and so that the validity and reliability of the instruments are not compromised. Each year, the New Mexico Consumer Satisfaction Project Steering Committee reviews what worked well from the previous surveys and what did not work well from the previous surveys. New Mexico sent two representatives to the recent Technical Assistance Meeting on Consumer Satisfaction Surveys. As a result of this training, the representatives will work with the steering committee to ensure that the survey we use is scientifically valid and reliable and that the both New Mexico and SAMHSA will be able to compare and contrast its results with that of other states.
Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

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<td>FY 2009 Target</td>
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</table>

Table Descriptors:

Goal: Increase the number of youth who have been treated by the public mental health system, to maintain school attendance, return to school in the case of expulsion or drop out, and complete school.

Target: Establish baseline by year end 2007 utilizing the New Mexico Youth and Families Consumer Satisfaction Survey.

Population: Youth who have been involved with or are at risk of involvement with the Juvenile Justice System and/or the Child Welfare System and who are designated as severely emotionally disturbed.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

Indicator: The number of children and youth who have received mental health services during the fiscal year or prior fiscal year who are reported by family interview to have maintained attendance at school. Baseline will be established in 2007.

Measure: The percent of children who are reported to have maintained school attendance through consumer survey questions designed to address National Outcome Measures; Adopted for 2007 Youth and Family survey and available for 2007 Implementation Report to SAMHSA.

Sources of Information: CYFD will rely on New Mexico Youth and Family Annual Survey which has been structured to capture educational information in 2007. No administrative data is currently available for this NOM.

Special Issues: CYFD is entering its second year of participation in the New Mexico Consumer Satisfaction Project (CSP). The centerpiece of this project is a MHSIP type survey and report to stakeholders on the survey findings. CYFD is working with the CSP to design survey changes which will improve stakeholders' ability to discern differences in client care perceptions.

Significance: Improving school attendance is a major concern to all citizens of New Mexico. SED children are at greater risk of expulsion and dropping out. Maintaining or improving school attendance is an important outcome of effective mental treatment and is considered a priority of the New Mexico Behavioral Health Collaborative.

Action Plan: The New Mexico Behavioral Health Collaborative has placed school attendance and success on
a priority list in the New Mexico Behavioral Health Strategic Plan. The goal is stated as follows: Children with behavioral health problems are successful in school, engaged in civic life and adequately prepared for successful adulthood.

The Plan
a. Create a process for information sharing among the Public Education Department (PED), Children Youth and Families Department, and other Collaborative agencies serving children and younth. Identify PED’s criteria for success in school and apply to children and youth experiencing behavioral health problems to develop a baseline. Make success in school a required outcome of every individualized treatment plan for children and youth experiencing behavioral health problems and ensure follow-through based on treatment plan goals and benchmarks. Increase the number of School-Based Health Centers that offer behavioral health services. Develop standards for behavioral health services in schools f. Train teachers, school officials, parents and providers to support success of children and youth experiencing behavioral health problems, whether in traditional educational settings or other learning environments.

g. Enhance transitional living support for older youth through: service development and financing; provider capacity building; coordination with adult services. Increase in: Percentage of parents of children and youth experiencing neuro-biological and/or emotional disturbance who report that their children are successful in school. Percentage of children and youth experiencing behavioral health problems who are successful in school based on the Public Education Department’s criteria for school success for all children. Number of youth age 15 – 19 with behavioral health diagnoses who report meaningful civic involvement. Percentage of children experiencing behavioral health problems who transition from childhood to adulthood with housing, education or employment, and independent living skills.

Post Incarceration Transition Project: CYFD has implemented a program to better address the needs of our highest risk youth in a comprehensive community based system of care. Service providers are being brought into the weekly transition meeting to present on their services, Leverage of Integrated System of Consumer Support, (LINCS), Juvenile Community Corrections (JCC), Parole Empowerment Partners (PEP), Access To Recovery (ATR). Glen Damian from NMHU presented on a Post School Outcomes Survey and Beth Bustos, JJS Education Specialist, is assisting in having the youth complete the survey to better assess needs.
**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

<table>
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<tr>
<th>(1) Fiscal Year</th>
<th>(2) FY 2006 Actual</th>
<th>(3) FY 2007 Actual</th>
<th>(4) FY 2008 Projected</th>
<th>(5) FY 2009 Target</th>
<th>(6) FY 2010 Target</th>
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</tbody>
</table>

**Table Descriptors:**

**Goal:** Decrease contact with the Juvenile Justice system and arrests following behavioral health treatment.

**Target:** Establish baseline by end of calendar year 2007.

**Population:** Youth who have been involved with or are at risk of involvement with the Juvenile Justice System and who are designated as severely emotionally disturbed.

**Criterion:**
1: Comprehensive Community-Based Mental Health Service Systems
3: Children's Services

**Indicator:** Percent of youth who have been arrested following mental health treatment.

**Measure:** Sample of youth and families who report contact with the Juvenile Justice System and or arrest following treatment.

**Sources of Information:** New Mexico Youth and Family Annual Survey. No administrative data is currently available for this NOM.

**Special Issues:** New Mexico CYFD has experienced challenges in administratively measuring contact with the Juvenile Justice System of those youth who have had previous mental health treatment. CYFD will rely on consumer survey data for this measure.

**Significance:** Juvenile Justice System administration is a primary focus of New Mexico Children Youth and Families Department. Incarceration and contact with Juvenile Justice is an indication of possible behavioral health problems and family and community disruption. Decreasing this contact is a major treatment effectiveness outcome indicator.

**Action Plan:**

**Action Step:** Increased use of evidence based practices which have shown to be effective with juvenile offenders.

CYFD has incorporated into the New Mexico Youth System of Care a number of evidence based practices shown to reduce rates of new arrest following treatment. Multisystemic Therapy and Functional Family Therapy are two such treatments now in wide use in New Mexico. Other promising initiatives by CYFD include the Youth Transition Project and the broad implementation of wraparound services cited in other sections of this application. In addition CYFD, The Collaborative and VONM are all encouraging and supporting the introduction of additional evidence based practices which if aimed at the adolescent population will need to demonstrate reduced rates of arrests following treatment.

MST has reduced arrests following treatment in New Mexico. CYFD maintains a contract to measure post treatment outcomes at six and twelve months. New Mexico's experience in this area is consistent with research results. In research studies the following results were reported (Henggeler et al., 1991, 1992 and 1993):

MST youth reported significantly less peer aggression than did non-MST youth.
MST youth reported significantly lower use of alcohol and marijuana than did non-MST youth.

MST families showed significantly more family cohesion than did non-MST families. Fifty-nine weeks after treatment began

Significantly fewer MST participants had been arrested than had non-MST participants (42 percent versus 62 percent).

MST participants had spent significantly fewer days in incarceration than had non-MST participants. Twenty percent of MST participants had been incarcerated, compared with 68 percent of non-MST participants.

Almost two-and-one-half years after treatment began, significantly fewer MST participants had been arrested than had non-MST participants (61 percent versus 80 percent).

MST proved just as effective with youths of different races, ages, genders, and levels of prior arrests or incarceration. It also was just as effective for youths with differing types of family relations, peer relations, or behavior problems.
### Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

<table>
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<tr>
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<th>Performance Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>(1)</th>
<th>(2)</th>
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### Table Descriptors:

- **Goal:**
- **Target:**
- **Population:**
- **Criterion:**
  1: Comprehensive Community-Based Mental Health Service Systems
  3: Children’s Services

### Indicator:

- **Measure:**
- **Sources of Information:**
- **Special Issues:**
- **Significance:**
- **Action Plan:**
**Name of Performance Indicator:** Child - Increased Social Supports/Social Connectedness (Percentage)

<table>
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**Table Descriptors:**
- **Goal:**
- **Target:**
- **Population:**
- **Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems
  3: Children’s Services
- **Indicator:**
- **Measure:**
- **Sources of Information:**
- **Special Issues:**
- **Significance:**
- **Action Plan:**
## Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

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### Table Descriptors:
**Goal:**
**Target:**
**Population:**
**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems  
3: Children's Services  
4: Targeted Services to Rural and Homeless Populations

**Indicator:**
**Measure:**
**Sources of Information:**
**Special Issues:**
**Significance:**
**Action Plan:**
Name of Performance Indicator: Provide Co-occurring Disorders Treatment

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Table Descriptors:
Goal: Establish baseline. Identify and treat youth with co-occurring disorders (COD). Integrated COD treatment is a NM Children's BH system transformation activity. NFG: 2.1, 2.4, 4.3, 5.2. Comprehensive BH Plan Goal and NM Performance Measure 6 & 17.

Target: Report on number of youth assessed to have mental health and substance abusing co-occurring disorders. Provide a statewide system of integrated, evidence based services for SED/NBD youth with co-occurring disorders.

Population: SED/NBD children and youth receiving services in the public New Mexico behavioral health system.

Criterion: 1: Comprehensive Community-Based Mental Health Service Systems

Indicator: Numerator: Number of youth identified as experiencing a co-occurring disorder. Denominator: Youth identified as SED/NBD in the New Mexico public behavioral health system.

Measure: Number of youth identified as experiencing co-occurring disorders. Baseline tabulation is not currently available for FY06. Baseline is being constructed for calendar year 2007.

Sources of Information:
- CYFD FACTS: Juvenile Justice Involvement
- Medicaid/ValueOptions: Data Base reporting on co-occurring population and services.
- Interviews with COSIG Implementation Team.

Special Issues: The establishment of a baseline of youth identified as having a co-occurring disorder as projected in the CYFD 2007 MHBG Application has been delayed due to enrollment data collection challenges experienced by VONM.

Pilot Project: CYFD has collaborated with the New Mexico Co-occurring State Incentive Grant project team to identify a youth provider pilot site in order to implement a COD demonstration project. Now in its fourth month the pilot participants are being trained in evidence based practices which are shown to be effective for this population.

Significance: Transformation Activity: The establishment of an evidence based, co-occurring treatment system for youth is a state behavioral health system transformation activity. Such a system addresses a major gap in services in New Mexico as well as a performance issue which is high on the list of federal, state and local concerns. A COD youth service system is a complex piece of cooperative work amongst multiple levels of providers and systems. Most of the successful programs are comprehensive—or what some would call 'ecological': they address the multiple problems of children, youth, or families wherever they arise—in the family, the community, the health-care and school systems, and the housing and labor markets. They tend, insofar as possible, to deal with the roots of those problems, rather than just the symptoms, and they are typically inspired by some of the best thinking we have on the causes of violent crime, delinquency and of child maltreatment.

Action Plan: In FY07 New Mexico’s Children Youth and Families Department began tracking the population...
of youth who were diagnosed as have a co-occurring mental health and substance abuse disorder. The tracking of this population is being done through enrollment and diagnostic data provided by VONM. A baseline began to be assembled beginning in February 2007. Full baseline tabulation is not currently available.

In FY06 CYFD worked with Medicaid and ValueOptions in the NM Behavioral Health Collaborative, Oversight Team process to define, begin to identify and track those clients categorized as SED/NBD on the one hand and a subset of those clients reporting or demonstrating a substance abuse issue on the other. An immediate goal of this process is to establish baseline data regarding characteristics of this population. Beyond tracking the New Mexico co-occurring youth population, CYFD will collaborate with the Human Services Department, Behavioral Health Services Division, COSIG Implementation Team and ValueOptions to identify and fund an evidence based COD model for treatment of SED/NBD youth. A pilot site has been selected and is actively engaged in training provided by COSIG. In addition ongoing measurement of model fidelity will be done along with tracking of outcomes. The goal is to implement a statewide system for treatment of COD amongst SED/NBD youth. The following steps and actions are needed toward this end: 1. Develop collaborations among a variety of agencies such as juvenile justice, substance abuse, mental health, primary health care, education, employment, youth development, faith communities, recreation, and others. 2. Use effective screening techniques to identify at-risk youth. 3. Conduct a comprehensive assessment that evaluates the youth's risks, needs, strengths, and motivation. 4. Based on the assessment, develop an individualized service/treatment plan that considers the youth's age, culture, and gender. 5. Use treatment methods that have been found effective, based on research and evaluation, with substance-abusing juvenile offenders. 6. Involve family in all aspects of the youth's treatment, including participation in assessment and treatment planning, and offering services for families. 7. Provide comprehensive case management across systems and over time. 8. Structure a system of care that encompasses a youth's transition from institutions to the community. 9. Implement a management information system that can be used to share information across programs and systems, thus reducing redundant data collection and improving screening and assessment capabilities.
CHILD - GOALS TARGETS AND ACTION PLANS
Provide Co-occurring Disorders Treatment

Foot Notes

Transformation Notes: Mental Health Transformation Services- Track and provide co-occurring services.
**Name of Performance Indicator:** Reduce Out-of-Home Treatment for SED/NBD Population

<table>
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<th>(2) FY 2007 Actual</th>
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**Table Descriptors:**

**Goal:** Provide increased evidence and best practice community based services to more effectively serve the target population. New Freedom Goals: 2.3, 2.4, 2.5.

**Target:** Reduce the use of out-of-home placement for those in the target population who would be better served with evidence/best practice based community services.

**Population:** Severly emotionally/neurobiologically disturbed youth, 18 and under in age.

**Criterion:** 1: Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Numerator: In FY05 number of SED youth in out-of-home placement reported by Medicaid. Denominator: Not available from Medicaid for FY05.

**Measure:** The number of SED youth placed out of the home for behavioral health treatment as reported by Medicaid. CYFD acknowledges that members of the target population will experience multiple out-of-home placements in a given year and over the course of treatment. Measure includes Treatment Foster Care, Residential Treatment and Group Home.

**Sources of Information:** New Mexico Medical Assistance Division (Medicaid) services and reimbursement as managed and reported by ValueOptions.

**Special Issues:** Reducing out-of-home placement of SED/NBD youth is a behavioral health system transformation goal for New Mexico. It is also linked to the state's Comprehensive Behavioral Health State Plan. There were almost 5,380 youth in therapeutic out-of-home placements in New Mexico during FY05. Forty-five percent (45%) of these youth were placed in Accredited Residential Treatment Centers (ARTCs), 23% were in non-accredited residential treatment centers (RTC) or group homes (GH), and 22% were in therapeutic foster care (TFC). Total expenditures for these out of home placements were approximately $55.8 million. Of this $55.8 million (M), $26.1M was for ARTCs and 11.3M was for non-ARTC group homes. $18.3M was for youth in therapeutic foster care settings.* New Mexico recognizes that it relies heavily on placement and multiple placements in out-of-home settings. In addition there is no clear measurement for the affectiveness of this use. CYFD maintains the following goals based on the consideration of this data. · To develop more options for intensive community based treatment for children and adolescents. · To have a continuum of care to prevent multiple placements out of the home. · To develop clear definitions for non-accredited residential treatment and group homes to ensure better distinction of target populations, admission criteria, services and staffing requirement. · To treat co-occurring disorders during out-of-home placement and after discharge. · To standardize rates of payment for distinct levels of service. · To work in the context of the New Mexico Behavioral Health Collaborative for oversight, coordination and payment of out-of-home services. The New Mexico Children, Youth and Families Department is undertaking the measurement of a new State Performance Indicator in the FY07 CMH Block Grant Application. The indicator has two parts to its measurement: 1. Reduce youth out-of-home behavioral health treatment placement and. 2. Increase number of youth accessing effective community based services. The indicator is a key element in the New Mexico Behavioral Health system transformation effort. It is central to the goals of CYFD, the
State Comprehensive Behavioral Health Plan and the New Mexico Behavioral Health Collaborative. Measuring progress toward this goal requires an increase in evidence and best practice based community services as well as an increase in the number and accessibility of all community based mental health services for youth and their families. In a cross agency collaborative effort, CYFD is participating in the introduction of Comprehensive Community Support Services (CCSS: Described below), as an additional means of addressing the needs of youth at risk for out-of-home placement as well as returning from such placement. In cooperation with the HSD Medical Assistance Division (Medicaid) CYFD is working to introduce CCSS to staff and provider agencies throughout the state for a SFY07 second quarter start date.

**Significance:**
A New Mexico children’s behavioral health system transformation goal: The New Mexico Children, Youth and Families Department is undertaking the measurement of a new State Performance Indicator in the FY07 CMH Block Grant Application. The indicator has two parts to its measurement: 1. Reduce youth out-of-home behavioral health treatment placement and, 2. Increase number of youth accessing effective community based services. This latter indicator will be reported as part of the “Increased Access to Services” National Outcome Measure. Reducing out-of-home placement is a key element in the New Mexico Behavioral Health children’s system transformation effort. It is central to the goals of CYFD, the State Comprehensive Behavioral Health Plan and the New Mexico Behavioral Health Collaborative. Making progress toward this goal requires an increase in evidence and best practice based community services as well as an increase in the number and accessibility of all community based mental health services for youth and their families. In a cross agency, collaborative effort, CYFD is participating in the introduction of Comprehensive Community Support Services (CCSS is Described below), as an additional means of addressing the needs of youth at risk for out-of-home placement as well for those returning from such placement. In cooperation with the HSD Medical Assistance Division (Medicaid) CYFD is working to introduce CCSS to state staff and provider agencies throughout the state for a SFY07 second quarter start date.

**Action Plan:**
STRATEGIES BEING INITIATED TO REDUCE RESIDENTIAL TREATMENT FOR YOUTH COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS): CCSS is a new service which was added to the Medicaid State Plan Amendment Application submitted in FY07 to the Federal Government. The outcome of this Application is still pending. CCSS or its unbundled components are community-based services based on the concepts of recovery and resiliency. It includes those services formerly included in case management but also includes psychosocial rehab, life skills and peer supports. CCSS is designed to be more consumer driven with an emphasis on delivering the services and supports necessary to maintain SDMI adults and SED/NBD children and adolescents in the community. It will replace case management on or around September 1. CORE SERVICE AGENCIES (CSAs) New Mexico has a network of Community Mental Health Centers (CMHC’s) but in many communities, particularly in the rural areas, services remain sparse. In addition, many of the CMHC’s do not offer comprehensive children’s services and many children’s providers do not offer a comprehensive array of services. To rectify this problem, The New Mexico Children, Youth and Families Department (CYFD) will promulgate regulation, in coordination with the Department of Health (DOH), to create Core Service Agencies (CSA’s). CSA’s will be comprehensive for either children, adults or both. The comprehensive model means that they offer all required services. Only CSA’s will be allowed to provide CCSS. CSA’s will be expected to serve as a clinical home for enrolled clients. REDEFINE RESIDENTIAL TREATMENT LEVELS OF CARE The Behavioral Health Purchasing Collaborative will re-define residential levels of care. This will include revision of service descriptions and criteria to utilize residential treatment services in a manner more consistent with need and philosophy. Specifically, non-accredited residential services will no longer be a defined level of care. Accredited residential treatment centers (ARTC’s), group homes and treatment foster care will be the only out-of-home placement levels of care. Group homes will provide crisis residential services, which is currently not a service in New Mexico, as well as specialty care for sex offenders and various co-occurring disorders. EXPAND NUMBER OF EVIDENCED BASED PRACTICES AND NUMBER OF CLIENTS SERVED In addition to the development of CCSS, community based evidenced based practice will be emphasized. Multi-Systemic Therapy is being added to the Medicaid
state plan and expanded as appropriate. Functional Family Therapy will be expanded and Multi-Dimensional Treatment Foster care will be developed. See the NOM on Evidence Based Practice in this application. *“Out-of-home placement Study; Performed for the State of New Mexico”. The Technical Assistance Collaborative. In draft, January 9, 2006.
CHILD - GOALS TARGETS AND ACTION PLANS
Reduce Out-of-Home Treatment for SED/NBD Population
Foot Notes
Transformation Notes: Mental Health Transformation Infrastructure Activity- Development or expansion of provider network. Utilize evidence based practices.
New Mexico

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan
New Mexico

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.