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## EXECUTIVE SUMMARY

### A. Introduction and Methods

This Project is a comprehensive assessment of behavioral health needs and gaps in New Mexico. The Project was supported by four state agencies<sup>1</sup> and three managed care organizations<sup>2</sup> in New Mexico. The Project purposes were to fulfill legislative directives about assessment of substance abuse needs in New Mexico (Senate Bill 628 and Senate Joint Memorial 14), to fulfill the conditions of a Medicaid waiver continuation, and to conduct a comprehensive assessment of the mental health and substance abuse (behavioral health) needs in New Mexico and the gaps between what currently exists and what is needed to meet those needs.

The Project Team assembled for this Project consisted of 18 professionals from around the country experienced in the development and delivery of mental health and substance abuse services, organizational and human resource development, and needs assessment/gap analysis processes. The team also included a consumer specialist, an economist, a statistician and American Indian and Hispanic/Mexican consultants.

A variety of methods were used to assure quantitative and qualitative analyses of information to determine the needs in New Mexico, the gaps in behavioral health services, and the system barriers to filling those gaps to meet the needs. These methods included data collection and analysis, document reviews, literature searches, key informant interviews, focus groups held around the state, consensus panels of clinicians, surveys of provider agencies and individual practitioners, and policy discussions with a Steering Committee developed specifically for this Project. Altogether, over 1,700 people participated in providing input for this Project. In some cases, because of the availability of data or reliable methods at the state or national levels, the methods utilized for determining the need for substance abuse services and for mental health services were different even though individuals often exhibit both types of service needs (Chapter III and IV).

While there were some limitations in both state and national data and materials or research available for this Project, the methods used were state of the art for a project of this kind. This Project and this report represent a snapshot or point-in-time analysis of New Mexico's systems and services. As positive system changes are made and available resources change over time, these changes should be taken into account to determine whether needs continue to be the same in New Mexico and whether the gaps and system barriers are better or worse. This report is a starting point for further and continuing analysis and planning.

It should be noted that a glossary of a few critical terms that may cause confusion if not defined and all the acronyms used in this report is included at the beginning of the Appendices.

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<sup>1</sup> The Behavioral Health Services Division (BHSD) of the Department of Health, the Medical Assistance Division (MAD) of the Human Services Department, the Prevention and Intervention Division of the Children, Youth and Families Department (CYFD), and the Developmental Disabilities Planning Council (DDPC).

<sup>2</sup> Cimarron, Lovelace and Presbyterian.

## B. Current Exemplary Efforts to Address Needs, Gaps and System Barriers in New Mexico

Throughout this report, New Mexico's behavioral health needs, gaps and system barriers are identified, as was requested of the Project Team. However, it is important at the outset to note that the Project Team found various systems, provider agencies, individual practitioners, and advocates responsible for or interested in behavioral healthcare in New Mexico currently hard at work on many of these needs, gaps and system barriers. Excellent services are being provided in many places and programs throughout New Mexico, often in spite of system barriers. System managers are approaching system barriers identified here with new and creative methods to resolve them, to the extent resources and their authority allow them to do so. Throughout this report, and in Chapter XIII in particular, some of these efforts are described.

During the focus groups, many individual programs were identified as being excellent or as worthy of replication (see Appendix I-4). Various state and local initiatives to address system barriers and service needs were also identified. The Project Team also saw evidence of areas of excellence or of promise during the course of the Project. At the state level, the Department of Corrections, Community Corrections Program is attempting to identify probationer and parolee behavioral health needs, help them transition to the community, and change its interface between prison and community programs. The Department of Finance and Administration's (DFA) DWI program is working with counties and the University of New Mexico to capture better information about persons sentenced to treatment and the treatment they receive. The Medicaid program is changing the way it contracts with managed care organizations and is requiring new accountability reporting. The Behavioral Health Services Division has undertaken statewide implementation of evidence-based practices in pharmacology (the New Mexico Pharmacotherapy Initiative or NMPI) and integrated services for adults with co-occurring substance use disorders and mental illness.

The Children Youth and Families Department has instituted the use of a common instrument to document client outcomes. This instrument was subsequently chosen by MAD for use by children's Medicaid providers, thereby standardizing outcome measures across the two systems. CYFD provides training for Medicaid and non-Medicaid providers in the use of this instrument. CYFD, MCOs and provider agency partners are jointly developing an evidence-based, cutting edge service technology program called multi-system therapy for behaviorally involved children in Santa Fe and Albuquerque. MCOs are working with CYFD and the Youth Diagnostic and Development Center on integration, authorization and payment for behavioral health and physical health services. The Bernalillo County Juvenile Detention Center, with assistance from CYFD, DOH and MAD, has opened a new program for juvenile offenders with mental health needs.

BHSD's Regional Care Coordinators are beginning to inventory their provider agencies' capacities to provide care and identify and quantify gaps in services at the regional level. The four-counties in southwestern New Mexico are working together to plan for their populations' behavioral healthcare needs. The University of New Mexico (UNM) has a rural psychiatry program that helps to provide psychiatric coverage for rural parts of New Mexico (Chapter VII).

UNM also has a special assessment team for individuals with mental retardation/developmental disabilities exhibiting mental health needs that can help to determine those needs and develop a plan for them (Chapter IV).

MCOs, DOH, MAD and various service provider agencies are holding coordination meetings to increase and improve services for those with concurrent developmental disabilities and mental illness. MCOs have initiated a behavior management services (BMS) focus group to engage providers and stakeholders in order to increase the availability of BMS services. MCOs are also working with MAD and providers/practitioners toward standardized clinical criteria and guidelines for assignment to levels of care (LOC); common and increased access to outpatient services without the need for prior authorization; and standardized utilization review forms. MAD also changed its contracts with MCOs beginning July 1, 2001 to reduce administrative layers and to introduce additional reporting and early warning system requirements to track managed care variables; behavioral health system authorization and denials; and complaints, grievances and appeals. MAD also recently began a behavioral health ombudsman program and convened a behavioral health advisory committee to provide guidance to MAD and MCOs on matters related to provision of behavioral health services. A care coordination system to assist Medicaid clients with multiple and complex special healthcare needs has been implemented to ensure that medical and behavioral health needs are identified and services coordinated with the individual and family.

School districts are piloting mental health programs both directly and in conjunction with provider agencies. The Healthcare for the Homeless Program in Albuquerque provides a well-respected array of services for individuals who are homeless and mentally ill or substance abusing. The Peanut Butter and Jelly program and the Crossroads program is providing excellent assistance to adults with addictions who are returning to the community from prison, and their families. Life Link in Santa Fe provides excellent services for persons who are homeless and who are in need of supported employment. The Heroin Project in Rio Arriba County has helped to reduce heroin related deaths substantially. The jail diversion program in Dona Ana County is helping mentally ill individuals engage in treatment rather than doing jail time. The Peer Bridger program and the Consumer Leadership Academy are helping adult service recipients become better self and system advocates.

The juvenile drug courts in Albuquerque and other areas of the state are helping adolescents arrested for drug related offenses obtain needed substance abuse services. The Sexual Assault Nurse Examiner (SANE) program in Santa Fe is helping address the mental health impacts of sexual assault. Therapeutic martial arts programs for abused and substance abusing children/adolescents is helping to prevent further trauma and increased substance abuse. "Double trouble" groups are providing peer counseling and support for persons who are mentally ill and substance abusing/dependent. The New Beginnings program in Silver City provides psychosocial rehabilitation and community support for persons with serious mental illness. Carlsbad Transitional Living program helps individuals with behavioral health needs move into permanent housing. Programs and efforts operated by Casa Milagro, St. Elizabeth's, St. Vincent's/Sangre de Christo collaboration, and UNM CASAA were identified by focus group participants as high quality programs. These are but a few of the programs and providers

working hard to address the needs and fill the gaps in New Mexico's behavioral health systems of care.

These efforts and others, while exemplary (especially given the lack of available resources) and while addressing many of the issues identified in this report, are not enough to completely remedy these system barriers. Substantial additional efforts and additional resources are needed to impact some of the system barriers identified by this Project. The findings and recommendations in this report should build on those efforts already underway and help remove existing barriers identified in Chapter XIII that prevent further improvements in New Mexico's behavioral healthcare services.

## C. Findings Regarding the Prevalence and Impacts of Substance Abuse and Mental Disorders in New Mexico

### 1. Prevalence of Substance Abuse/Dependence<sup>3</sup> and Mental Disorder

A large number of New Mexicans are affected by mental illness/emotional disturbance and/or substance abuse or dependence (Chapter III). Utilizing national data and weighting these data for New Mexico social indicators such as substance-related mortality rates, rates of hepatitis and HIV/AIDs and tuberculosis, it is estimated that 14,660 youth ages 12 through 17 and 82,235 adults are dependent on alcohol or drugs. This is a rate of 6.5 percent in New Mexico compared to 4.8 percent nationally. New Mexico's rate is higher than any other state except Alaska.

The rate varies by region (see map in Appendix II-1) with the Northwest (Region 1) having the highest rates of substance dependence across all age groups, followed closely by Region 5 (Bernalillo County) (see Table III-3). Substance abusers among the 15 through 17-year-old age group are estimated to equal 4,365 individuals and an additional 45,830 adults are estimated to be substance abusers. An additional 3,047 individuals in the state's jails and prisons are estimated to have substance use disorders (substance abuse or dependence). Adding all these numbers together, the total number of persons estimated to be directly affected by either substance abuse or dependence in New Mexico is 150,137.

Utilizing similar national data to estimate the prevalence of mental disorders in New Mexico results in a finding that 313,204 individuals have some kind of mental disorder. Of these, 70,766 adults have serious mental illness (SMI); 18,594 children/adolescents (ages 9 through 17) have severe emotional disturbance (SED); 242,438 adults have other mental disorders not considered to be SMI; and 36,923 children/adolescents have other mental disorders not considered to be SED.

For mental disorders, a proportion likely to need services from the public sector was calculated and compared with the numbers served. Only 19 percent of the adults needing public sector mental health services are currently being served, ranging from 23 percent served in Region 4

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<sup>3</sup> For purposes of prevalence estimates, the report distinguishes between substance abuse and substance dependence. For the rest of the report, the term substance abuse is used to incorporate both concepts and both populations.

(Southeast) to 15 percent served in Region 1 (Table III-8). For children/adolescents aged 9-17 with mental disorders, 52 percent are being served, ranging from 62 percent in Region 3 (Southwest) to 37 percent in Region 1 (Table III-9). Children ages 0 through 8 are being served in approximately the same proportions in each region as are older children and adolescents (Table III-10).

From these data it is estimated that over 400,000<sup>4</sup> individuals in New Mexico have substance abuse/dependence or mental disorders. Each of these individuals has family members that are affected directly or indirectly by their abuse/dependence or disorder. A significant number of these individuals and families is affected by or have co-occurring mental illness/emotional disturbance and/or substance abuse/dependence (Chapter IV).

Not all of these individuals will need or request services for mental illness or substance abuse/dependence from publicly funded systems of care. Based on national experience and literature, this report assumes approximately 25-35 percent of those New Mexicans with disorders will need services from the publicly funded system of care (see Chapter XI), and that the publicly funded systems should be prepared to serve this proportion of those in need in order to have a comprehensive system that addresses the needs and provides for “services on demand” as required by the Senate Joint Memorial requesting portions of this needs assessment.

## 2. The Behavioral Health<sup>5</sup> Needs of Special Populations

The need for behavioral health services has an impact on and is impacted by poverty, homelessness, incarceration, family relations, and worker productivity. These impacts are often greater for persons who are American Indian and/or Hispanic/Mexican, who have been incarcerated, or who are homeless, have multiple disorders or are transitioning from one system to another (Chapter IV). Impacts due to poverty, lack of insurance, lack of available provider agencies and individual practitioners with cultural capacity to serve these populations, complexity of addressing multiple needs, and/or cultural issues mean that publicly funded systems of care are even more critical for special populations (Chapter III).

### Persons with co-occurring disorders of mental illness and substance abuse

Approximately 15 percent of all adults who have any severity and type of mental disorder also experience a co-occurring substance use disorder. This represents about 55,000 persons in New Mexico, at some point in their lives. According to the Surgeon General, about half of persons with serious mental illness have a co-occurring substance abuse disorder and approximately 40 to 50 percent of those who are in substance abuse treatment have co-occurring mental health needs at some point in their lives, and 25 to 35 percent has a current substance use disorder. For individuals with a prior year substance use disorder, 42 percent also have a mental disorder.

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<sup>4</sup> While this number may seem high, it represents about 22 percent of the state’s total population. The Surgeon General indicates that as many as 30 percent of the nation’s population could benefit from treatment for mental health needs alone, not counting substance abuse/dependence disorders. This figure for New Mexico is a refinement of prevalence estimates based on the best scientific data and studies available at this time (see Chapter III).

<sup>5</sup> Throughout the report, the term behavioral health is used to mean both substance abuse and mental illness for adults and children/adolescents.

Persons in jails and prisons have an even higher prevalence of co-occurring disorders. As many as one-half of female and one-third of male drivers in New Mexico with driving while intoxicated (DWI) offenses may have at least one additional psychiatric disorder, especially post traumatic stress disorder or major depression. DWI offenders also have a high prevalence of multiple drug and alcohol use. High rates of co-occurring disorders in children and adolescents, American Indians and Mexican/Hispanics have also been found in studies of these populations (Chapter IV).

Persons with co-occurring disorders have a higher likelihood of suicide, incarceration, family conflict, high service use and costs, as well as violence, and HIV infection. They are more likely to relapse and are at greater risk for hospitalizations and homelessness.

Services for persons with co-occurring disorders should be integrated and provided at the same time rather than provided separately or sequentially for one disorder and then the other. Yet, funding streams, provider agency histories and capacities, and practitioner licensure rules often serve to keep the services for these disorders separate (Chapter IV and VII). New Mexico has undertaken significant efforts to begin building co-occurring capable services throughout the various service delivery systems. The Behavioral Health Services Division (BHSD) is implementing a statewide systems development initiative to create integrated services in accordance with the national systems change evidence-based practice for comprehensive, continuous, integrated systems of care model (Chapter IV).<sup>6</sup> More needs to be done to meet the needs of this population.

#### *Persons with mental illness and mental retardation/developmental disabilities*

Individuals with mental illness and mental retardation/developmental disabilities (MI/MRDD) have difficulty receiving services for both disabilities since the systems, funding and provider agencies that serve mentally disordered or substance abusing/dependent individuals are separate from the systems, funding and provider agencies that serve persons with MRDD. The estimate of the number of such adults in New Mexico ranges from 1,500 to 3,500, while the estimated number of children/adolescents with MI/MRDD ranges from 2,300 to 2,700 individuals. Utilizing poverty as a factor, the number of MI/MRDD adults and children/adolescents needing publicly funded services in New Mexico is between 1,800 and 3,000 individuals (adults and children/adolescents). According to New Mexico key informants, it is estimated that about 70 percent of the MRDD individuals in jails are also mentally ill with severe behavioral problems.

Individuals with these dual diagnoses find themselves unable to secure appropriate services in New Mexico due to lack of service capacity, lack of an identified single system responsible for planning for and meeting their needs, and lack of skilled professionals to adequately meet their needs. While many provider agencies (including some residential treatment centers) and practitioners responding to surveys sent by the Project Team (Chapter V, VI and VII) indicated that they serve some individuals with both diagnoses, there were no provider agencies identified to the Project Team other than state-operated facilities that have specialized programs

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<sup>6</sup> This initiative has gained national recognition as an effective approach to systems change for state level planning, policy and implementation.

specifically designed for treating these individuals.<sup>7</sup> There are only a handful of practitioners (psychiatrists, psychologists, social workers and counselors<sup>8</sup>) that specialize in addressing the needs of this group. According to system, provider, family and service recipient stakeholder input, direct care staff working with these individuals are generally inadequately trained to address their unique and multiple needs.

Both the mental health and the MRDD systems in New Mexico currently have limitations about diagnoses, funding eligibility and service approaches that are adapted as best they can be when individuals with dual diagnoses meet some of these criteria. Neither system has specific responsibility for developing targeted programs and services for this population, especially if their situations prevent them from being clearly eligible for a program funded within the various systems of care. Education, corrections, and other service systems also have few specific options to address the specialized needs of these individuals. However, there is currently an interagency committee working on addressing the issues of this population in New Mexico.

*Adults and juveniles in corrections or detention*

New Mexico has more adult jail detainees in local jails per 100,000 than the national average. As many as 6 percent of adult jail inmates have a serious mental illness (360 per night in New Mexico) and almost two-thirds have been reported to have other mental or substance abuse disorders (3,780 per night in New Mexico). Women jail detainees have higher rates of serious mental illness and substance abuse than do male detainees. Among jail detainees with a serious mental illness, almost 72 percent have a co-occurring substance use disorder (Chapter IV).

There are few jail diversion programs in New Mexico, only a few drug courts, and only two currently operating mental health courts. These kinds of programs have shown success nationally and in New Mexico to keep mentally ill and substance abusing adults out of jail and in treatment that helps to reduce future offenses. These diversion programs and specialized courts have few community treatment alternatives to utilize for potential jail detainees. Services in jails consist mostly of assessments and limited medications.

The incarceration rate in state prisons in New Mexico is lower than the national average. The number of Hispanic and American Indian inmates is disproportionately high compared to their rates in the state's population. Approximately 18 percent of the total population in New Mexico's prisons has some form of mental health needs, compared to 16 percent nationally. About half of the 800 inmates receiving mental health services have co-occurring disorders of substance abuse and mental illness, although services for these needs are separated rather than integrated. Eighty to ninety (80 to 90) percent of state prisoners in New Mexico are assessed as having substance abuse or dependence, compared to 75 percent nationally.

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<sup>7</sup> There is a special assessment team for such individuals at UNM, but this team does not provide on-going treatment.

<sup>8</sup> Some practitioners, especially social workers and counselors, work with individuals who are MRDD and mentally ill in the context of the Medicaid waiver for developmentally disabled individuals. However, access to this program is limited by resource availability with a significant waiting list and by type and level of developmental disability.

The number of probationers and parolees in New Mexico is increasing about 5 percent per year, compared to a national growth rate of 3.6 percent. Service needs of these groups are difficult to meet due in part to the inadequate transition process from jail or prison to supervisee status, and to the lack of services designed for the unique needs of individuals with legal constraints, family reunification issues, and specialized housing and employment needs. According to DOC, the coordination between parole or probation officers and behavioral health workers is also often inadequate due to system and resource constraints. In the specialized Community Corrections program designed to address the needs of high risk/high need supervisees, case loads are too high, training is too limited, and resources are insufficient to address the housing, services, and safety needs of these individuals.

Driving while intoxicated is the second largest category of offenses resulting in jail time. Almost one-fourth of all jail detainees have DWI offenses. There are 5,000 second and subsequent DWI offenses committed in New Mexico each year. Only 58 percent of persons sentenced for DWI are sent for screening for services. According to stakeholders and key informants serving or analyzing the DWI population, many do not keep appointments or complete services (Chapter II and Appendix I-4). Data about the populations served and the services they receive is not currently consistently available across the 31 county programs. There are no programs available specifically designed for DWI offenders with co-occurring disorders. The services provided for DWI offenders lack state standards and are not consistently reported. While the state agency responsible for funding these programs estimates that it would take \$7.5 million to serve DWI offenders across the state, these estimates are not based on a fully developed system of care or a common agreement about what the array of services should be.

Children/adolescents in the juvenile justice system are a significantly underserved group in New Mexico. Juveniles in New Mexico are a larger percentage of the total population than is their percentage of the nation as a whole, with American Indian and Hispanic youth representing even higher proportions of the juvenile population in New Mexico than their proportions in the nation as a whole. The rate of poverty among New Mexican youth is 27.5 percent, which is substantially higher than youth in the nation as a whole (19.9 percent) and than the whole population in New Mexico (19.3 percent). Poor children in the juvenile justice system experience higher rates of mental, emotional and behavioral health problems than do other children. The rate of incarceration of juveniles in New Mexico is consistent with the national average.

The prevalence of serious mental disorders among juveniles in custody (20 percent) is higher than for other juveniles (5 to 9 percent). For American Indian youth in custody, the rate is estimated to be as high as 50 percent. CYFD estimates that 60-70 percent of juveniles in detention have some form of mental health need and the Child Welfare League of America suggests this number may be as high as 75 percent. This means that approximately 500 or more of New Mexico's incarcerated youth have mental health service needs. In one study, as much as 80 percent of juveniles arrested reported daily use of alcohol and other drugs just prior to arrest. Adolescents who commit violent crimes tend to have serious substance use histories, and involvement in substance abuse tends to lengthen the delinquent career of juveniles. In New Mexico, it has been reported in the Albuquerque journal, citing a Congressional study, that youth

are held extra days or even months in county detention facilities because needed mental health care is not available.<sup>9</sup>

Services needed for these juveniles include treatment for sex offenders, intensive outpatient substance abuse services, residential treatment services and in-home behavior management and family support services (including therapeutic foster care). Prevention, early intervention and diversion services to keep children/adolescents with substance abuse and mental disorders out of juvenile detention settings in the first place are critically needed in New Mexico.

#### *Ethnic populations – American Indians and Hispanic/Mexican Population*

The Surgeon General of the United States has recently reported that ethnicity, “culture and race matter” when it comes to access to and effectiveness of behavioral healthcare. In New Mexico, American Indians represent 9.5 percent of the population (10 times the national average). Hispanic/Mexicans represent 42.1 percent of the population (almost 2 ½ times the national average). Studies to date of the prevalence of disorders among American Indians have been few and are not as scientifically valid as other prevalence studies, making it difficult to estimate prevalence in this population. However, it is known that suicide and homicide are the second and third leading causes of death among American Indians, with over 50 percent of the deaths from alcohol-related causes, and suicide rates 1 ½ times the national rate (2 – 3 times the national rate for American Indian youth ages 15 to 24).

American Indian adolescent exposure to violence can result in a 50 percent greater likelihood of becoming problem drug users as adults. American Indian veterans have a higher rate of post-traumatic stress disorder than do non-Indians. Some Indian youth have been found to have fewer anxiety disorders, the same rate of depression, and a greater amount of substance abuse and dependence disorders than their non-Indian counterparts. American Indians have been found to report less alcohol use and more illicit drug use than their non-Indian counterparts. Because American Indian youth have higher rates of substance abuse, American Indians are at increased risk for fetal alcohol syndrome, the leading known cause of mental retardation that results in maladaptive behaviors in adulthood creating functional mental disabilities. American Indians tend to use outpatient mental health and substance abuse services less than their prevalence of disorders would suggest they should, whereas their rate of inpatient hospitalization is higher than whites.

American Indians are diverse and have unique attributes associated with their belonging to sovereign nations within another country. Their beliefs about illness and about treatments make it critical that services for American Indians incorporate cultural traditions and native indigenous healers. Their disproportionate locations in rural areas makes development of service capacity more challenging. The Indian Health Service (IHS) offers limited prevention and outpatient mental health and substance abuse services for American Indians. The limited array of services offered through the IHS system frequently requires individuals to seek additional services through other state funded or controlled programs such as BHSD or Medicaid. The limited

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<sup>9</sup> It is not clear from this report whether this lack of needed services is truly a lack of mental health services at all or a lack of the specific type of service setting desired by juvenile detention centers before they are willing to release youth they feel need a residential setting after release.

coordination in planning and funding between state systems and IHS creates significant barriers for American Indians as they attempt to access appropriate behavioral health services.

The rate of prevalence of mental disorders among Hispanic/Mexican Americans<sup>10</sup> is generally comparable to those of Anglos, especially when these Americans are born in the United States or have lived here more than 13 years. Hispanic/Mexican youth tend to have higher levels of mental health problems than do Anglos, with more anxiety and depression. Mexican American men are more likely to abuse alcohol and illegal drugs than white men and their patterns of alcohol/drug use are different from white men. Mexican American women are less likely to report alcohol or drug use than their Anglo counterparts.<sup>11</sup> Substance abuse among Hispanic youth is especially high, leading to more dependence in adulthood.

New Hispanic/Mexican immigrants tend to have lower rates of mental disorders than do Anglos. However, the high rates of poverty, unemployment, and lack of insurance among the Hispanic/Mexican population and especially among new immigrants increases the need for publicly funded behavioral health services for this group.

Hispanic/Mexican populations have unique cultural attributes and strengths affecting their service needs and the treatment they receive. The proportion of these groups that are monolingual has a direct impact on the services they receive and the practitioners available to serve them. Their use of services is substantially lower than the prevalence in the population would suggest it should be. System complexities make it especially difficult for this population to access the care they need.

#### Adolescents in transition to adulthood

The child and adult behavioral health systems and funding criteria are different in New Mexico as well as in other states throughout the country. There are also differences between criteria for emotional disturbance as a youth in school in need of an Individualized Education Plan and the criteria for severe emotional disturbance for behavioral health care for children/adolescents. Eligibility criteria for these purposes and for purposes of receiving services in adult systems of care are different and service provider agencies and practitioners are also often different (Chapter III and VI). When an adolescent with behavioral health needs is being served in one of the children's behavioral healthcare systems and reaches age 18 (or age 21 for some programs), their legal status, eligibility and access to services changes. Many youth in the transitioning (16 to 24-year-old) age group have co-occurring or multiple disorders necessitating services from multiple systems of care (Chapter IV). Members of this age group need assistance with moving into independence, finding housing and employment, and completing school at the same time they are changing provider agencies or systems of care for their substance abuse or mental health needs (Chapter IV).

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<sup>10</sup> The full report notes differences among various Hispanic and Mexican groups. Some studies cited combine these groups and some discuss their needs separately.

<sup>11</sup> Some experts believe this has more to do with cultural issues and underreporting than with lower use of substances.

Youth with serious emotional disturbances tend to drop out of services and out of school during this transition period. At least one-third of adolescents receiving behavioral health services as children will need continuing services as adults. This means in New Mexico that at least 800 youth each year (based on data in Chapter IV regarding numbers of youth provided behavioral health services in New Mexico in FY 2001) need special transition planning to assure that their services continue uninterrupted. Service models are available nationally to help with this transition, but few programs in New Mexico are specifically designed to help these young people through this critical time.

#### Persons who are homeless

Over 11,000 individuals are homeless on any given night in New Mexico. Of these, about two-thirds have mental or substance abuse disorders. Eleven (11) percent of homeless individuals are families with children of which 84 percent are women with children. American Indians are over-represented in the homeless population compared to their numbers in the general population. Hispanic/Mexicans are under-represented even though their rates of poverty are high.

High poverty, unaffordable housing and entitlement-dependent disability are the three primary reasons for chronic or consistent homelessness. In New Mexico, it takes 2/3 to 4/5 of a disability payment check to rent an apartment. Fifty (50) percent of those who are consistently homeless have co-occurring disorders making treatment more difficult and outcomes less likely to be attained and sustained. Typically, homeless persons who are mentally ill have had prior contact with a service provider agency, often with experiences that were not always positive (Chapter IV). Mentally ill homeless individuals are twice as likely as other homeless persons to be arrested or jailed, mostly for misdemeanors. Most homeless mentally ill individuals can be engaged in treatment, housing and support services, but insufficient capacity exists in New Mexico to meet the needs of these individuals and families. Excellent programs exist in New Mexico, and planning for these populations is well-developed. However, resources are not sufficient to fulfill all the plans and meet the identified needs.

### **3. The Effects of Untreated Mental Illness and Substance Abuse Disorders**

Research documented by the Surgeon General and elsewhere in the federal government as well as experience in New Mexico and other states has shown that mental health and substance abuse services “work” (Chapter IV). For most conditions and populations, there are evidence-based or promising practices that have been shown to have clear results if provided in an appropriate manner with attention to the principles for providing that care, and with the range of behavioral health services in place that are needed to make each individual service effective (Chapter IV). Behavioral health services reduce the costs to business, government and society of dysfunctional adults and families, children who do not learn and therefore are unprepared for adulthood, lost taxes, lost workdays, and reduced productivity. Services reduce symptoms or use of substances, increase employment and school performance, improve family functioning and quality of life, and reduce crime, incarceration and homelessness.

Behavioral health services also decrease social service and child welfare costs, prison costs, costs for health and disability services, and costs of unemployment (Chapter IV). Out of every dollar spent by states on alcohol and other drug-related issues, 96 percent is used to address the results of substance abuse and only 4 percent is spent on treatment, prevention and research. In New Mexico, this ratio is 98 to 2 percent. The burden or effects of substance abuse on other publicly funded systems such as health, child welfare, public safety and justice accounts for 9.7 percent of the state budget, an average of \$265 for every person in the state. For every dollar spent on substance abuse prevention, treatment and research, \$41.43 is spent by the state of New Mexico on the consequences of substance abuse in these other programs.

Untreated mental health and substance abuse disorders<sup>12</sup> in New Mexico are estimated to cost the state's businesses, taxpayers and families more than \$3 billion annually. For every dollar spent on alcohol and other drug treatment, \$7.14 is saved by reductions in other social, governmental and economic costs. For every dollar invested in mental health services, there is as much as \$10 saved in other social, governmental and economic costs. Clearly, investing in behavioral health services is a cost-effective strategy for New Mexico to undertake.

#### **4. The Economic Climate Affecting Behavioral Healthcare in New Mexico**

All over the country, states are facing budget crises that are resulting in cuts to health and human services programs. New Mexico's recent debates over Medicaid funding are a reflection of this national trend. The economic climate is even worse for New Mexicans because the state had the third highest unemployment rate in the United States even before the events of September 11, 2001. New Mexico also has 49<sup>th</sup> lowest per capita income in the nation as well as having one of the highest proportions of people who are uninsured and who are living in poverty. In part because of these realities, New Mexico has a higher proportion of its total population eligible for Medicaid (18 percent compared to a national average of 11 percent).

At the same time, employer-sponsored healthcare costs in the nation as a whole are rising at double-digit rates after several years of relative stability. Nationally, Medicaid healthcare expenditures are expected to rise by over 7 percent per year for the next several years. Changes in Medicaid eligibility and services in New Mexico would likely have a higher impact on persons with behavioral health needs since these persons often have a disproportionate need for healthcare as well. They also are often disproportionately poor and uninsured (Chapters IV and X). Medicare also has restrictions on funding for behavioral health services (e.g., partial hospitalization, day services, medications) that are affecting New Mexicans in need of care and the provider agencies and practitioners that serve them.

#### **5. The Role of Insurance in Funding Behavioral Healthcare in New Mexico**

Compared to other Mountain states, New Mexico has the highest percentage of uninsured citizens below 100 percent of the Federal Poverty Level (FPL); the highest percentage of

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<sup>12</sup> These figures include the cost of tobacco use and addiction.

uninsured individuals below 200 percent of the FPL; and the lowest percentage of citizens covered by private employer health insurance. New Mexico also has among the highest percentage of non-elderly uninsured, with 27 percent uninsured as compared to the national average of 16 percent. Twenty-four percent of New Mexico's children and adolescents is uninsured compared to 15 percent in other Mountain states and 12 percent in the nation as a whole. New Mexico also has a lower percentage of individuals participating in employer-sponsored and individual/family private insurance (51 percent) than the nation as a whole (65 percent), as well as a lower average employer contribution to family insurance costs (67 percent compared to 76 percent nationally) and individual insurance costs (80 percent compared to 82 percent nationally).

New Mexico recently passed a parity law to require businesses over a specified size to offer equal coverage for major mental illnesses as for other health conditions, when major mental illnesses are covered. However, this law did not require coverage of mental illnesses and did not include parity for substance abuse disorders. A review of insurance benefits of major plans in New Mexico suggests that coverage of services for mental and addictive disorders is still very limited and that services covered tend to be traditional outpatient and inpatient care rather than services designed to assist individuals with these needs to regain community living capabilities.

Due to their lower rates of employment, higher levels of poverty and recent immigrant status, members of racial and ethnic minority groups such as American Indians or Hispanic/Mexican Americans generally have significantly higher uninsured rates. Since unemployment is rising among these groups as well as among other groups within New Mexico (6.1 percent in February 2002 and predictably reaching over 7 percent in 2003), the pressure on the public system to provide behavioral healthcare for New Mexicans will almost certainly grow in the years ahead.

## **6. Adequacy of Rates Paid to Provider Agencies and Individual Practitioners**

Multiple rates are paid to provider agencies and/or practitioners for the same or similar service due to the multiple systems and payers in New Mexico. A weighted average rate for each service was calculated for this Project to utilize for analysis and comparison purposes. Not all providers/practitioners receive this weighted average. Some may receive more and some less. Low rates resulting in low salaries and insufficient service capacity were identified repeatedly by focus group participants as a concern for New Mexico's ability to adequately serve persons with behavioral health needs.

A review of a few critical behavioral health rates revealed that mental health counseling, adult day treatment, mobile crisis intervention, and education and support groups are services (see Appendices V-1 and V-2 for service definitions) for which New Mexico's weighted average rate is less than comparison states. Adjusted rates for mobile crisis and education/support groups were adjusted for the substance abuse computer modeling process, since these are critical services for ideal systems of care (Chapter IV). Additionally, behavior management and intensive case management are critical services that are part of a good system of care (Chapter IV) and therefore rates should be adjusted upward. The costs of delivering those services is high

in communities and homes because travel and liability. These high costs may prohibit interested providers/practitioners from offering these services without additional reimbursement to cover their indirect costs. Adjusted rates based on this analysis were used to determine the expenditures necessary to meet New Mexico's behavioral healthcare needs (for an ideal system of care).

#### D. Characteristics of a Good System of Care

The common elements of a good public sector behavioral healthcare system include:

- Customer orientation;
- Commitment to recovery and resiliency;
- Clarity of system design;
- Clinical and service excellence;
- Sufficiency of resources;
- Attention to human resources;
- Equity of access and continuity;
- Integration of care across systems or provider agencies;
- Community-based solutions; and
- Stewardship of public funds.

Some of these elements are present to some degree in parts of New Mexico's systems of care. New Mexico has the potential to have all these elements in place with additional planning, resources and removal of system barriers (Chapters XII and XIII). New Mexico has multiple points of authority for various aspects of publicly funded behavioral health care. The Project Team found that many of these are disconnected from the others without common goals or directions, and sometimes without coordination among them.

In order to be a "good" and effective system of care, there must be *a system* of care, not just a collection of services. The system must be planned and designed coherently, managed and led effectively, and owned and guided by those who benefit from and contribute to the system's existence and success. This system of care can be created by design and organization (e.g., a single state agency and single local entity responsible for behavioral health services of all types for all ages) or by good processes in place to coordinate design and services across multiple agencies. In either case, the result should be enhancement of services for better outcomes while making the most of limited dollars available.

Organizational characteristics of this good system of care include the following:

- A single set of goals and expected outcomes;
- A single or consistent set of definitions, regulations and standards;
- A common, agreed upon set of performance and outcome indicators;
- A common data system or common data elements across systems;
- Seamless client transitions;
- Problem-resolution forums to address cross-system issues;
- Standards and processes for assuring culturally specific services;
- Time and distance standards for service access;
- Sufficient service capacity to meet access standards

- Common clients' rights and protections;
- Common messages about persons with behavioral health needs and services for stigma reduction and good public policy;
- A single plan of action with consistent priorities and benchmarks for success;
- A coordinated quality management and improvement process;
- A commitment to and action plan for developing human resources;
- A commitment to learning through research and evaluation;
- An adequate administrative and financial infrastructure and resources; and
- Widespread stakeholder involvement.

Service principles and approaches for children/adolescents and for adults with substance abuse and/or mental health needs are described in Chapter IV of the report.

### E. New Mexico's Current Systems and Services

New Mexico currently has multiple departments at the state level and different organizational structures under contract with those state departments to manage and deliver behavioral health services. The three primary systems of care include BHSD for non-Medicaid eligible adults, MAD for Medicaid eligible adults and children, and CYFD for children/adolescents and their families. In addition, the Department of Corrections, State Department of Education, Office of School Health, Department of Finance and Administration/DWI Program, Long Term Services Division, and Indian Health Service have responsibility for certain services, funds or populations. BHSD, MAD and CYFD have electronic data systems while the others have a variety of reporting mechanisms with a wide range of available data. BHSD's, MAD's and CYFD's data systems are all in different types of transitions and each currently has inadequate, incomplete or inaccurate data to some degree. However, these data were combined to create a common picture of the services currently delivered and populations currently served across these three major behavioral health fund sources (Chapter V).

Currently, multiple service definitions are utilized throughout the various state and regional systems of care making comparisons across systems difficult. A common service taxonomy and set of definitions is recommended and proposed (Appendix V-1 and V-2). This proposed taxonomy was used for the analysis of service utilization data in New Mexico.

51,608 unduplicated individuals received behavioral health (mental health and/or substance abuse) services in FY 2001 by BHSD, MAD and CYFD (Chapter V). Other individuals received behavioral health services from other aspects of New Mexico's various systems, although the number of additional individuals served is relatively small. Of these individuals served, 71 percent received mental health services only, 14 percent received substance abuse services only, and 8 percent received both mental health and substance abuse services. Services for almost eight (8) percent of the individuals served could not be classified as to type due to incomplete data in the three major data systems.

Children ages 0 to 17 represented 35 percent of those served (compared to their proportion in the total population of 28 percent). Young adults aged 18 to 20 represented just under 4 percent of

those served (compared to just over 4 percent in the population as a whole). Adults aged 21 to 64 represented 43 percent (compared to 56 percent in the population), and adults 65 and over represented slightly more than 1 percent of those served (compared to 12 percent in the population). In these data, over 17 percent of the individuals were of unknown age.

American Indians represented almost 12 percent of those served compared to their proportion in the population of almost 10 percent. Hispanic/Mexicans represented 36.5 percent (compared to 42 percent in the population), and Whites represented 30 percent (compared to 45 percent in the population). Almost 18 percent of those served were unable to be identified by race or ethnicity.

Over \$100,000,000 was spent on behavioral health services by these three state agencies. These funds include state and federal funds (including federal mental health and substance abuse block grant funds as well as the federal match portion of Medicaid). Of this amount, approximately 39 percent was spent on inpatient psychiatric and detoxification services and residential detoxification services (see Appendices V-2 for all service definitions used in this report). Twenty-four and one-half (24.5) percent was spent on other residential services; only 2 percent on intensive outpatient services; 27 percent was spent on outpatient services; and almost 8 percent was spent on recovery/maintenance services. Over 63 percent of all dollars was spent on inpatient and residential services for only 11 percent (duplicated count) of people served. A large number of individuals received very small amounts of low-intensity services. An average of between \$500 and \$600 was expended per user for outpatient and recovery/maintenance services. Evidence-based or emerging promising practices in the intensive outpatient and the recovery/maintenance categories represented only 25 percent of individuals served and only 10 percent of dollars spent. Greater expenditures in these categories are recommended and will likely help reduce the expenditure in the higher cost categories.

A review of Medicaid expenditures for psychiatric and substance abuse related medications by these three state agencies was conducted (Chapter V). About 90 percent of all Medicaid behavioral health service recipients were identified in the MAD database as having received at least one dose of some psychoactive medication. Anti-depressants had both the largest number of users and the highest dollar amount paid for class of medications. Anti-convulsants were next in total dollar expenditures, followed by traditional anti-psychotics and then atypical anti-psychotics. It should be noted that BHSD has begun to pay for some medications as part of its New Mexico Pharmacotherapy Initiative (NMPI) to implement evidence-based medication practices. However, these funds are not included in the data reported here.

Finally, a review of service expenditure by type of service pre- and post-managed care in New Mexico revealed that utilization of psychiatric inpatient services went up by almost 50 percent (from \$17 million in FY 1997 to just over \$38.2 in FY 2001) after having been reduced the year prior to implementation of managed care (from \$26.5 million in FY 1996). Residential treatment services expenditures went down more than 50 percent after managed care (from \$60.5 million in FY 1997 to \$20.8 million in FY 2001), after increasing slightly in the year before managed care was implemented (from \$56.0 million in FY 1996). Expenditures for all other services stayed about the same. This pattern is exactly the opposite of what one would expect or hope for from a managed care implementation, and suggests that benefit design and requirements of

service delivery are not aligned in ways that would encourage lower costs and more effective community-based services as alternatives to facility-based services (Chapter III). On the other hand, the amount of residential service capacity in New Mexico suggests that reduction in the use of this service, *if* combined with an increase in community-based and in-home services, would be appropriate (Chapter VI).

All in all, services currently provided tend to be high cost/high intensity or low cost/low intensity without necessary community supports to produce good outcomes. The benefit packages of the various behavioral health systems within New Mexico are not organized to maximize available resources or to provide incentives to providing care that has been proven to be effective (evidence-based or promising clinical practices). Few community supports, in-home services, and/or rehabilitative services are available for children, families or adults, therefore requiring use of high end/high cost services or services that are insufficient and therefore likely to be ineffective or less effective than they could be. Few crisis and diversion services are available or appropriately designed or reimbursed to prevent the need for high cost inpatient and residential services for children and adults, or jail/prison stays for juveniles or adults with mental health and/or substance abuse needs.

Transportation services, services that are community rather than clinic or facility-based, and services for persons in transition from prisons/jails, hospitals, institutions, and residential treatment facilities are among the most needed services identified by focus group participants. According to focus group participants, populations most in need of additional services are:

- children/adolescents (including infants to school age, adolescents (especially females) transitioning into adulthood);<sup>13</sup>
- persons with co-occurring disorders (mental illness and substance abuse or mental illness and developmental disabilities); and
- persons with special cultural needs (e.g., Spanish-speaking, immigrants, American Indians, etc.).<sup>14</sup>

It should be noted that there are a number of excellent service provider agencies and practitioners and system initiatives throughout New Mexico at state and local levels. The service capacity issues identified in this report should not be considered the fault of system actors so much as a reflection of system barriers discussed in Chapter XII of this report. Recommendations to overcome some of these system barriers are identified in Chapter XIII and summarized in this Executive Summary.

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<sup>13</sup> The need for specialized services for adolescent females, especially those who are perpetrators of sexual offenses, came up often in focus groups and interviews.

<sup>14</sup> While there is a growing number of Asian Americans and Asian immigrants in parts of New Mexico, a special analysis of the needs of this population was not part of the scope of this Project. This population is included in data analysis of service utilization and in prevalence estimates.

## F. Regional Comparisons

There are considerable regional variations in service access and utilization patterns in New Mexico (Chapter VIII). For example, Region I (Northwest) residents utilize more substance abuse and residential/inpatient services while Region III (Southwest) residents utilize more mental health services than other regions. Regional profiles were created to describe the demographics, service patterns and service delivery capacity of each Region in detail. These differing patterns could be a function of available services or could be a reflection of variable need. However, despite demographic and socioeconomic factors, there is no evident pattern or logic to the variations in service access and resource allocation, nor does there appear to be an explicit policy goal driving these variations. All regions have a high utilization of inpatient and residential care compared to the more desirable and effective community-based service modalities.

The proportion of persons who need behavioral health services that are served in each region ranges from 11 percent in Region 5 to 16 percent in Regions 1 and 3, with a statewide average of 14 percent (Table VIII-85).

All five regions in New Mexico have significant unmet needs. The needs of rural areas in Region 1 (Northwest), Region 3 (Southwest) and Region 4 (Southeast) as well as the far Northeast corner of Region 2 are significantly more pronounced than the needs of urban areas surrounding Santa Fe, Albuquerque, and Las Cruces, especially when capacity to meet needs is compared to the special demographic and socioeconomic factors of each region.

None of the rural regions or areas of the state can be said to be worse than any of the other rural/urban areas in terms of need for services. Region 3, especially the three counties bordering Mexico and a fourth county just north of these three counties (Catron, Grant, Hidalgo, Luna Counties), have significantly less provider agency and practitioner capacity than other parts of the state. Therefore, this area has an even wider gap in services than other parts of the state. A special review of these four counties was conducted and recommendations specific to this area of the state were developed (Chapter IX). These recommendations include special service development and sub-regional planning. The statewide recommendations (e.g., Recommendation 17 regarding development of regional human resource development plans) should take into account the particular needs of this sub-region of the state.

## G. Provider Agency Capacity to Meet New Mexico's Behavioral Health Needs

Provider<sup>15</sup> agency and practitioner capacity in New Mexico is uneven geographically. No part of New Mexico has all the provider agency or practitioner capacity it needs. Some parts of New Mexico have few if any provider agencies or private practitioners to meet the county or area's behavioral health needs.

### 1. Provider Agencies – Numbers and Services Provided

The provider agency configurations in different parts of New Mexico indicate that there is a significant number of provider agencies doing the same kinds of services (e.g., primarily outpatient or case management) and/or a small number of comprehensive provider agencies with a large number of small specialty provider agencies. This configuration may result in a large amount of choice for service recipients and/or significant inefficiency without a process to manage coordination among providers and practitioners serving the same clients or types of clients and difficulty managing continuity of care for a single individual or family across provider agencies and/or practitioners.

A total of 423 behavioral health provider agencies was identified statewide (0.23 provider agencies per 1,000 population) from 10 different lists of provider agencies submitted by organizations represented on the Project Steering Committee. In addition, another 35<sup>16</sup> provider/agencies not in the list of 423 provider agencies (Appendix VI-1) were determined to provide services for persons convicted of driving while intoxicated (DWI) and sentenced to or referred for specialized DWI services.

Data about all New Mexico behavioral health provider agencies do not exist in any consistent fashion or in any single place. Each system describes and keeps information about its provider agencies in different ways, sometimes even within the same system of care. Therefore, provider agency numbers and capacity reported here should be considered an educated estimate rather than precise actual amounts (Chapter VI).

Statewide, there are more provider agencies proportionately in Region 2 (North Central/Northwest) than in other parts of the state. All other regions have between 0.21 (Region 1) and 0.24 (Regions 4 and 5) per 1,000 population. Region 5 has the most provider agencies per square mile, with Regions 4 and 2 having the least provider agencies per square mile. Region 5 has the largest total number of provider agencies followed by Region 2. All these data are rough proxies for provider agency capacity. The further individuals and families have to travel to

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<sup>15</sup> Throughout the report, the term “provider” is used to mean agencies or organizations that provide publicly funded behavioral services in New Mexico, while the term “practitioner” is used to mean licensed, certified, or trained individuals delivering behavioral health services. Practitioners include psychiatrists, psychologists, social workers, counselors, nurses, case managers, and direct care staff. In this Executive Summary, the terms “provider agency” and “individual practitioner” are used in order to keep these concepts separate for the reader.

<sup>16</sup> There are a total of 71 DWI provider agencies identified to the Project Team. However, 36 of them are providers already in the larger provider agency list of 423.

receive services the more difficult the access. On the other hand, a provider agency that is close by but that does not have adequate services to offer does not allow for access any more than a provider agency a long distance away.

Of the 423 behavioral health provider agencies identified, 53 percent are reported to serve children/adolescents only; 34 percent serve adults only; and 27 percent serve both. 44 percent are reported to provide outpatient services; 37 percent provide multiple types of services; and 27 percent provide recovery/maintenance services. 21 percent are reported to provide crisis services. These services could be a crisis hotline or telephone triage capacity, or something more extensive. Few mobile crisis or crisis respite services were identified. A large number of providers deliver prevention services due in part to BHSD's strategy of funding county-based prevention providers plus a number of special prevention/early intervention initiatives. There seem to be no providers currently that deliver assertive community treatment services, although key informants indicated such services previously existed in New Mexico. The reason for the reduction or disappearance of this service is unclear. Assertive community treatment (ACT) and comprehensive crisis services are critical for persons with high-intensity or multiple needs and helps to avoid the need for hospitalization.

A high proportion of provider agencies seem to be single service provider agencies. One would expect fewer but more multi-service, multi-site provider agencies in a state with limited resources and many rural/frontier areas (Chapter II). However, this may be counterbalanced by a combination of highly diverse populations requiring specialized provider agencies, or it may be a reflection of multiple and varied administrative "silos" and funding mandates and priorities. The array and location of provider agencies appears to be more haphazard or historical than planned, again more reflective of disconnected and multiple systems than an inappropriate set of choices by any one system manager.

The results of the provider agency survey adds evidence to this data and to the service utilization data to suggest that provider agency capacity for community-based, in-home, crisis, diversion and intensive outpatient services is not sufficiently developed in New Mexico while traditional outpatient and residential/inpatient services are sometimes relied on to the exclusion of these more effective community services. These patterns are the result of benefit and system design more than a lack of willingness or ability on the part of provider agencies or of system managers.

In some areas and for some services, individual practitioners may provide services not identified as being provided by provider agencies, thereby increasing the capacity in a particular geographic area. However, for those services that are critical and sparsely available such as ACT, jail diversion, intensive case management, and comprehensive crisis services, it is unlikely that individual practitioners will fulfill such roles since they require team based approaches, organizational relationships, and 24 hour, seven day a week availability. Additionally, given the lack of individual practitioners in rural areas (Chapter VII), individual practitioners are not likely to fill these additional critical roles.

## 2. Residential Treatment Services

A specific analysis of residential treatment services was conducted. Residential treatment services (RTS) capacity in New Mexico began declining between 1994 and 1998, prior to the introduction of managed care. In 1998, New Mexico had the highest combined residential treatment center (RTC) and psychiatric admission rate west of Arkansas with higher admission rates than comparison Mountain states of Arizona, Nevada, Colorado, Montana and Utah. The numbers of RTS facilities dropped from 1998 to 2000 and increased slightly in 2001. This suggests a slight decrease post-managed care. However, given the admission rates, a decline in RTS and inpatient services together would have been appropriate. As indicated earlier, inpatient expenditures actually increased. Without the addition of other community- and family-based services, the decreased expenditures for RTS probably represent simply a reduction in available services. Increasing RTS is not the recommended solution. Increased community- and family-based services is a more appropriate and evidence-based approach to serving populations that may otherwise be identified as needing RTS.

## 3. Inpatient Capacity

Inpatient capacity (public and private) in New Mexico appears to be adequate statewide to meet identified needs (Chapter VI), but this resource is not evenly distributed, thereby creating access problems for parts of the state for certain types of inpatient care (e.g., the southern part of the state has few resources for inpatient services for adults without insurance or under involuntary commitment – Chapter IX). The number of psychiatric inpatient beds per 100,000 in New Mexico is in the 100-124 range, compared to 75-99 for Colorado, Utah and Montana, and under 75 for Arizona and Nevada. Only 10 states have a range of beds per 100,000 population higher than New Mexico.

Given these rates of beds per 100,000 combined with the lack of community-based alternatives, a better use of limited resources would be investment in crisis, diversion, ambulatory or social detoxification, and in-home services in those parts of the state without sufficient inpatient resources.

## 4. School-Based Behavioral Health Services

Schools provide a significant amount of behavioral health assessment and interventions for children and adolescents, through Individualized Education Plans for special education students and through school personnel who serve as school counselors, psychologists, and social workers. In addition, in New Mexico there are 17 school-based health centers that received over 21,000 visits in FY 2001. Of these, over 29 percent were for behavioral health issues. There are also five school-based mental health programs being piloted with additional behavioral health specialists in the school health centers. These programs provide opportunities for access to services for children/adolescents who can or will not or who have parents who can or will not seek services in other ways. These services should be expanded in each school district in each region of the state, with standards set for each school system regarding the behavioral health capacity necessary at each grade level.

## H. Individual Practitioner Capacity in New Mexico – Human Resource Needs

There is currently no identified state level statewide human resource development leadership, planning, strategy or focus to address the need for developing, training, recruiting, maintaining, and on-going learning of qualified behavioral healthcare practitioners in New Mexico. There are however, significant efforts being undertaken by groups of individuals or organizations at the local and university levels. The University of New Mexico's Rural Psychiatry Program is an example of one such effort (Chapter VII). A statewide human resource development focus and plan will be critical if New Mexico is to be able to meet its residents' behavioral healthcare needs.

### 1. Number of Licensed Practitioners in New Mexico

Across the nation, human resource needs are emerging as a critical issue for behavioral health administrators. The number of key practitioners in training is declining, and the number of available practitioners with the specialized skills necessary to work in changing public sector behavioral health environments and with populations with complex needs is increasingly limited. In New Mexico, the total number of healthcare workers is decreasing both in numbers and in terms of the industry's payroll as a proportion of total state payroll. The number of physicians per 100,000 population has begun to decrease and is only 77 percent of national rates. Nurses per 100,000 population represent only 89 percent of national rates. The number of medical school graduates in New Mexico has also declined, and the average age of physicians in New Mexico is increasing.

Compared to the nation as a whole, New Mexico has slightly fewer psychiatrists per 100,000 population (13.7 in New Mexico compared to 14.2 in the nation). Compared to the average of other Mountain states (10.9), New Mexico has more clinically active/trained psychiatrists than all other Mountain states except Colorado (15.5). New Mexico has fewer psychologists than the country as a whole (25.2 in New Mexico compared to 28.4) and about the same as the average of other Mountain states (25.1). New Mexico social workers per 100,000 are fewer than the nation as a whole (31.2 in New Mexico compared to 36.2) and fewer than other Mountain states (34.8). The proportion of counselors per 100,000 population in New Mexico (159.5) is higher than the nation as a whole (47.8) and than most other Mountain states (74.3). It should be noted that not all social workers and counselors are available to the behavioral health system. Many work in healthcare, schools, long term care, and commercial settings. The specific proportions that work in sectors other than public behavioral healthcare in New Mexico were not known by the Project Team, given the state of current data systems and information provided to the Team.

Many practitioners licensed in New Mexico have out-of-state practice addresses (Chapter VII). Only 58 percent of psychiatrists have New Mexico addresses while 88 percent of psychologists, 91 percent of social workers, 93 percent of substance abuse counselors, and 90 percent of mental health counselors have New Mexico addresses. Additionally, almost four out of five in-state New Mexico psychiatrists have practice addresses in Bernalillo and Santa Fe Counties. Approximately 70 percent of psychologists, 47 percent of social workers, and 53 percent of

counselors have practice addresses in these two Counties. Additionally, psychiatrists responding to the practitioner survey for this Project indicated that a smaller proportion of them spend time in direct client care (as opposed to administration, teaching, research, etc.) than do psychiatrists in the country as a whole.

These data indicate that even though the actual numbers of practitioners are comparable to, higher than or only slightly lower than other states, the actual numbers of these practitioners – especially psychiatrists and psychologists practicing in New Mexico combined with the numbers of all types of practitioners working in only two counties, *there are inadequate numbers of practitioners* in New Mexico as a whole, but particularly outside Albuquerque and Santa Fe. Practicing psychiatrists are especially in short supply anywhere other than these two cities. The number of child psychiatrists in New Mexico is even more concerning with a total of only 54 for the whole state, 15 of whom work for the University of New Mexico and only 12 of whom live outside of Albuquerque or Santa Fe. Despite these realities, there are no organized system-wide efforts in New Mexico to recruit, develop and/or distribute behavioral healthcare practitioners for the future, with the exception of the Rural Psychiatry Program at the University of New Mexico (UNM).

## 2. Practitioner Salaries<sup>17</sup>

Salaries of physicians and nurses generally in New Mexico are about 90 percent of their counterparts nationwide, but these data do not account for cost of living differences in New Mexico. Survey data indicate that physicians and nurses are more concerned about their satisfaction with the direction the healthcare industry is going than with salary levels (Chapter VII). According to the U.S. Department of Labor, psychiatrists' salaries in New Mexico are only slightly lower (\$122,820 average wage) than other Mountain states for which data is available, except Utah. This average salary in New Mexico is higher than the average psychiatrist salary in Texas, and higher than the nation as a whole (Chapter VII).<sup>18</sup>

The average substance abuse counselor salary is less than the national average and less than the average in Mountain states. The average salaries for mental health counselors and social workers in New Mexico are generally slightly higher than their counterparts in the nation and comparable to their counterparts in Mountain states. It should be noted that counselors and social workers sometimes work in settings other than behavioral health, e.g., health, school, long-term care, and social service settings. Salaries are often higher in these settings than in direct care positions in behavioral health. Therefore, the data for these practitioners may not reflect the true reality within the publicly funded behavioral health field in New Mexico (Chapter VII).

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<sup>17</sup> These data generally represent industry salaries. For those practitioners who earn their living through contracts or billable income, these data may not be comparable.

<sup>18</sup> It should be noted that the relative standard error for the data on psychiatrists' salaries in New Mexico is higher than other states' or the nation's data, so these disparities could be somewhat less.

### 3. Results of Provider Agency and Individual Practitioner Surveys

Results of a survey of provider agencies conducted by the Project Team indicate that provider agencies rely heavily on social workers and counselors as well as on non-licensed staff for direct care. The proportion of Spanish-speaking licensed practitioners working for or contracting with those provider agencies that responded to this survey<sup>19</sup> ranged from 10 to 25 percent with only 5 percent of nurses and over 27 percent of case managers (some of whom are non-licensed professionals) speaking Spanish in their practice. Few practitioners working or contracting for the provider agencies responding to the survey speak American Indian languages, other than substance abuse interns and licensed alcohol and drug addiction counselors (LADACs). Only 12 and 20 percent respectively of substance abuse interns and LADACs working for or contracting with responding provider agencies speak such languages.

These survey results indicated that salaries, licensing requirements and lack of qualified applicants, along with geographical location were the most significant barriers to recruitment of qualified staff. Those provider agencies responding felt that having a positive work environment, consistent quality of supervision and a flexible work schedule, as well as a stable organizational environment were key factors in retaining employees once hired. Training needs identified included effective supervision, crisis intervention techniques, co-occurring disorders, and documentation requirements.

The majority of practitioners surveyed<sup>20</sup> indicated that their experiences with the process of obtaining a license to practice in New Mexico was neither difficult nor easy with a substantial number reporting it was either difficult or easy. Over one-third of psychologists and almost 30 percent of counselors indicated that the process was difficult, while 21 percent and 17 percent of psychiatrists and social workers respectively indicated the process was difficult. Focus group participants indicated that nurses also experience difficulty at times, although this group of practitioners was not surveyed for this project (Chapter VII). Comments of those practitioners responding to the practitioner survey provide some insights about how the process might be streamlined or made easier to help in the recruitment of practitioners from other states.

A number of responding practitioners reported working in other states, especially Texas, California, Arizona, Colorado and New York. A number of practitioners report working in multiple counties with a only a few Bernalillo and Santa Fe County practitioners reporting work in other counties.

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<sup>19</sup> A total of 93 providers responded to the survey or almost 22 percent of the 423 providers listed in Appendix VI-1. However, the percentage of provider organizations responding could be higher since the list of 423 included multiple sites of the same organization and since some of the provider agencies responded for all their sites inclusively. The results of this survey are not large enough to be statistically valid, but do suggest trends and do tend to support other data and stakeholder input regarding services capacity in the state.

<sup>20</sup> A total of 1,173 practitioners responded to the practitioner survey out of 7,342 surveys sent (16.0 percent). Of these, 97 psychiatrists (20.6 percent), 122 psychologists (23.8 percent), 404 social workers (12.8 percent), and 486 counselors (15.4 percent) responded. As a consequence, these survey results can only suggest rather than scientifically find results that can be extrapolated to all licensed practitioners in New Mexico. However, they do suggest trends and do tend to support other data and stakeholder input to this Project.

Between 85 and 95 percent of each type of practitioner reported spending up to 20 hours per week on billing, documentation and paperwork. These results suggest opportunities for decreasing these paperwork hours through the use of other types of staff and freeing up time for direct care work with clients.

About one-third of psychiatrists say they spend less than 20 hours per week on direct client care, stemming from a number of reasons (e.g., working part-time, teaching, being in administrative positions, doing paperwork, etc.). Few practitioners responding to the practitioner survey speak Spanish in their practice and a very limited number speak American Indian languages. This is consistent with the results reported by provider agencies in response to the provider agency survey.

The types of clients served by the practitioners who responded to the survey indicate that a much higher percentage of all kinds of professionals serve adults rather than children and a higher percentage serve mental health clients than substance abuse clients. Significantly, all types of practitioners reported high percentages of individual practitioners serving adults and children with co-occurring substance abuse and mental illness with a substantial percentage reporting that they serve adults and children with both developmental disabilities and mental illness.

When practitioners who do not see Medicaid or other publicly funded clients in their practices were asked why they do not serve such clients, the responses consistently indicated that the amount of paperwork, the difficulty of requirements, and slow or low reimbursement are the critical reasons why they do not serve these clients.

Practitioner responses indicated a substantial number of practitioners expecting to leave practice in the next 5 years (27 percent of psychiatrists) and 40 to 50 percent of all practitioners (53 percent of psychiatrists) expect to leave within 10 years. This does not give the state much time to work to develop practitioners for the future, given the time it takes to train and place behavioral health practitioners, especially psychiatrists.

## I. Comparison of New Mexico to Other States

New Mexico is like rural western or Mountain states such as Arizona, Colorado, Montana, Nevada, and Utah. These states were utilized for comparison with New Mexico to the extent data from these states could be obtained. Occasionally, other states were used as comparisons where the content of the comparison or available data made these other states a better choice. These comparisons are discussed throughout the report.

In general, compared to these Mountain states, New Mexico is poorer, with higher unemployment (Chapter II), higher rates of uninsured persons and families (Chapter X), and lower expenditures per capita and per user for behavioral health services (Chapter II). New Mexico has a lower rate per 100,000 population of all types of behavioral health practitioners except counselors than the nation as a whole, and more of or comparable rates of each type of practitioner except social workers compared to Mountain states. New Mexico generally pays

practitioners comparably to these other states, except for substance abuse counselors (Chapter VII).

Compared to moderately wealthy states with mature behavioral health systems, New Mexico has a less well-developed service array (Chapter VI) and has significantly lower expenditures for behavioral healthcare. New Mexico's weighted average rates for services are significantly lower than the rates of these comparison states for crisis services and somewhat lower for mental health individual counseling and adult day treatment. These rates may be lower for educational and support groups, behavior management, and intensive case management. Other rates in New Mexico are generally comparable to those paid by other states (Chapter XI).

## J. Financial Resources Needed to Fill the Gaps

Funding provided for health and substance abuse services in New Mexico is inadequate to meet the behavioral health needs of New Mexico's residents (Chapter XI, see especially Table XI-24). New Mexico needs to spend at least \$169 million for a good system of substance abuse services and \$217 million for an ideal system of substance abuse services. These resources could come from additional federal, state, local or other resources. New Mexico currently spends only \$32 million for substance abuse services across all systems (BHSD, MAD, CYFD, Community Corrections Program in the Department of Corrections (DOC),<sup>21</sup> DWI, and School-Based Health). This represents just under 19 percent of a good system of care and just under 15 percent of an ideal system of care.

New Mexico would need to spend \$197 million for a good mental health system of services and \$327 million for an ideal mental health system of care. It currently spends only \$90 million for mental health services in New Mexico (not quite 46 percent of a good system and 27.5 percent of an ideal system). These additional resources would allow investment in services for more individuals and families; different kinds of services than are currently available, including more services considered evidence-based and promising practices; higher reimbursement for providers to assure service capacity does not erode and that critical community, school and home-based services are available; and more service capacity in areas of the state currently facing serious gaps in service capacity.

For prevention services, New Mexico currently spends \$24 million and would need to spend \$73 million for a good system and \$109 million for an ideal system of mental health and substance abuse prevention services. At the state level only (not including RCC, MCO, or provider levels), New Mexico would need to spend about three times what it spends now (\$33-34 million compared to \$11 million) for administrative infrastructure to support a good or ideal system of care. However, the percentage of the total budget that would need to be expended for state level administration would decrease from 7.3 percent to 7 or even 5 percent of total expenditures, as the state moves from the current system to a good and then an ideal system of care. For this infrastructure, New Mexico needs to invest in data systems, human resource development,

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<sup>21</sup> Note: this amount does not include funding for behavioral health services in prisons or in jails.

research and evaluation, and financial and administrative accountability capacity, including quality management and improvement.

These estimated costs for a good and an ideal system of care were derived from a sophisticated computer-supported dynamic modeling system for substance abuse services and a comparison of New Mexico to other states with relatively good systems of care for mental health services.

## K. System Barriers and Recommendations to Address System Issues

Five critical system barriers were identified through this Project (Chapter XII). They are:

- Multiple disconnected systems;
- Lack of consistent, complete and reliable data for accountability and planning;
- Inadequate services and benefit design;
- Lack of provider agency and individual practitioner capacity and inadequate information to track that capacity; and
- Insufficient resources to meet the need.

These barriers prevent the delivery of high quality services for New Mexicans in need of substance abuse and mental health services. Some of these system issues in New Mexico are the same as those in some other states (e.g., lack of practitioner capacity). For other system barriers, the type of barrier (e.g., multiple disconnected systems) or the extent to which the barrier is impairing delivery of services for those in need (e.g., insufficient resources) is significantly more pronounced in New Mexico than in other parts of the country.

None of the identified system barriers is insurmountable, and none is the “fault” of current system actors. Rather, they are the result of the lack of overall system design with a common vision, leadership, administration, and expectations for behavioral healthcare for New Mexicans. The recommendations following each barrier take into account the characteristics of a good system of care (Chapter IV) and the findings throughout the report. A more complete explanation of each recommendation is found in Chapter XIII.

It should be noted that these recommendations add to many efforts already being taken by a number of the existing mental health and substance abuse provider agencies and system managers. Examples of these efforts are described in Section B of this Executive Summary and in Chapter XIII of the full report.

### 1. Multiple Disconnected Systems

New Mexico has multiple systems at the State and local levels with overlapping jurisdictions and requirements that are funding, managing, overseeing, authorizing and/or providing behavioral health services. These various systems operate in “silos” with each system having its own structure and organization; regional boundaries; goals and purposes; eligibility requirements; service definitions; payment rates; payment mechanisms; financial reporting system or systems; client eligibility and service utilization data tracking systems; standards; program requirements;

provider agency or individual practitioner registration and/or credentialing process; contract requirements; and criteria for quality or success. Because of the multiple systems, there is no identifiable behavioral health system leader with responsibility or authority across all the behavioral healthcare systems in the state.

This situation creates system inefficiencies; ineffective use of public resources; inability to account for overall system impacts on services, funding, and provider agency capacity; strains on provider agencies and individual practitioners trying to navigate the various systems and requirements; difficulty for clients and families trying to obtain access to services; and inability to plan for or meet New Mexico's behavioral healthcare needs in a coherent organized and coordinated fashion.

***Recommendation 1: Identify a single Behavioral Health Cabinet Cluster<sup>22</sup> at the State level to provide leadership, direction and planning for all the state's behavioral healthcare systems.***

***Recommendation 2: Develop and utilize common service system goals and expectations.***

***Recommendation 3: Develop and utilize common service definitions, utilizing the proposed service definitions in the final report or similar agreed upon taxonomy and definitions.***

***Recommendation 4: Select or develop common assessment and utilization management tools and protocols.***

***Recommendation 5: Require regional planning that utilizes common regional boundaries, encompasses all players and all services with identified gaps and action steps, focusing on core services that should be available in each region (see Recommendation 10).***

***Recommendation 6: Identify clearly who has the primary administrative responsibility for leadership, planning for, and serving persons with mental retardation/developmental disabilities (MRDD) and mental illness and/or substance abuse and for adolescents with substance abuse service needs.***

***Recommendation 7: Increase the support for consumer and family services and advocacy efforts at the state and regional levels.***

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<sup>22</sup> This term is used to distinguish this group from a stakeholder group such as the Governor's Mental Health Planning Council. While such groups are critical, they are generally advisory in nature. This Cabinet Cluster would include both Cabinet level and other state agencies responsible for various aspects of behavioral healthcare in New Mexico. There is no particular magic in this name. The important concept is who are members of the group and what their charge, responsibilities and authority are for creating a single system of behavioral health care in New Mexico.

## 2. Lack of Consistent, Complete and Reliable Data for Accountability and Planning

Each different system has its own management information system (MIS). Because of the multiple data systems, none of which are currently complete or totally accurate, there is no current way to count the number of unduplicated persons served or to identify all the services a unique individual or family has received.

Some data systems are currently designed to capture only minimal data. For example, MAD MCOs are required to report only service encounters but not unit costs of the services delivered and not administrative costs associated with delivering those services; enhanced behavioral health services are not reported at all other than in aggregate. Counties are encouraged but not required to utilize the common assessment and service reporting process for DWI services. CYFD provider agencies and practitioners are required to report outcomes and other data, but so far, the only penalty assessed is withholding of payment until the data submission is complete. (CYFD is moving towards funding based on outcome results.)

None of the management information systems (MIS) are designed to collaborate with other systems data sets. There is little system level or data system communication among the multiple departments' MIS. There is little connection between client and service information and financial management systems; therefore, there is no way to track accurately the exact amounts paid for exactly which services for exactly which clients with what results.

Some of these data systems are in transition and will ultimately be more complete and accurate, but only within the system or silo that the particular data system sits. For example, BHSD is working with RCCs to make the reported data more complete and more accurate. DFA is encouraging and is considering requiring counties to utilize a common data reporting tool. CYFD is revamping its MIS system to be easier to use and to receive direct data uploads from each provider agency site on a monthly basis.

Given the complexity and confusion among the different delivery systems, there is considerable cost shifting potential among and between BHSD, CYFD, MAD and potentially schools, juvenile justice, and corrections with no real way to track whether and the extent to which these shifts are occurring.

***Recommendation 8: Develop and utilize common reporting system requirements.***

***Recommendation 9: Create a single behavioral health provider agency and individual practitioner registry detailing services offered, capacity by service type, staffing patterns, service locations, and special programs or competencies.***

## 3. Inadequate Services and Benefit Design

Because there are multiple systems in New Mexico, each acting with its own goals, charge and direction, the design of services available and populations eligible for those services are not well-

conceived as a coherent whole. Funding streams are not adequately coordinated and utilized to assure the best outcomes for a client or family. Likewise, the ways in which the services available and the intended outcomes interact are not as effective as they should be, and the financial resources to pay for these services are not as efficiently utilized as they could be.

The benefit package for Medicaid managed care does not require the delivery of those community-based and in-home services that have been proven to work best and does require services that, without additional service frequencies, length or types, are not as likely to be effective. The Medicaid program (which utilizes 75 percent federal dollars) has not been designed to maximize the use of this resource.

The benefit package for non-Medicaid adult services is loosely designed to include those services necessary for persons with higher priorities, such as persons in crisis, persons with serious mental illness, and persons with co-occurring substance abuse and mental illness. However, the services required are in generalized levels of care such as outpatient, intensive outpatient, residential, and prevention. Specific services specifically designed for such priority individuals (e.g., supported employment and housing, assertive community treatment teams, mobile community treatment services available 24 hours per day 7 days per week, with crisis residential and crisis respite capacity, and jail diversion) are encouraged rather than required.

There are few incentives or system requirements for state facility services to be coordinated with community-based services and vice versa. Even though BHSD has made attempts to introduce such incentives and requirements, they are largely paper requirements and encouragements rather than actual fiscal or structural incentives.

Across the various systems in New Mexico, a large amount of resources is spent on inpatient and general outpatient services as opposed to alternative community-based, in-home and non-facility or clinic-based services. Without a greater investment in such services, New Mexico's systems are likely to find increasing expenditures for high intensity, high cost services rather than for services more likely to result in recovery for individuals and a return to resilience for youth and their families.

The Project Team could find no concept of a "clinical home" for individuals receiving care, that is, no single place or practitioner responsible for an individual or family's care across multiple systems or provider agencies. Therefore, there is a high degree of discontinuity of care, making it difficult for individuals and families to receive consistent care from hospitals to community to school to home to juvenile detention facilities, etc. Such inconsistent care is likely to result in inefficient use of resources and ultimately less than effective care.

State level policies attempting to introduce or require high quality services and service approaches that are known to be effective for publicly funded clients (e.g., integrated services for persons with co-occurring disorders; intensive case management or assertive community treatment for adults with serious mental illness; medication algorithms for specific mental illnesses; enhanced multi-systemic services for children with behavioral or conduct disorders; supported housing and employment techniques; wrap-around approaches for

children/adolescents; crisis and diversion services for MI/SA persons in courts or local jails; consumer-operated services; and intensive outpatient services or recovery/maintenance services for adult substance abusing clients) do not appear to be gaining momentum at the community and provider agency and practitioner levels except in small pilot projects or in limited geographic areas.

The Project Team could not find evidence that the introduction of managed care, carved into the Medicaid health care system, has yet produced changes in the types of services provided (Chapter II, V, and VIII) in the integration of health and behavioral healthcare at the clinical level or in access to community-based services. The Team also could not find that such changes were intended initially. There is some evidence from a recently reported study conducted by the University of New Mexico that access to care decreased and barriers increased for Medicaid eligible adults after the introduction of managed care (Chapter II and XII). Medicaid eligible children experienced somewhat greater access and use than children in other insurance categories or service systems (Chapter V). Inpatient expenditures increased while expenditures for intensive outpatient services decreased and all other services stayed the same (Chapter V). Therefore, the promise of managed care for behavioral health (as opposed to the cost-savings intention and promise of managed care overall) does not appear to have been achieved as of the time period covered by this report.

However, it should be noted that new efforts began in 2001 (FY 2002) to reduce the distinctions between the management of health and behavioral health care by prohibiting health care managed care organizations (MCOs) from subcapitating behavioral health care management to specialty behavioral healthcare organizations (BHOs). At the same time, new efforts to standardized approaches among the MCOs and to increase attention to behavioral health care funded by Medicaid began. New contract requirements from MAD to the MCOs were also put into place to address some of these issues within the Medicaid funded behavioral health system, including additional reporting requirements and an early warning system to track key variables such as authorizations and denials, and complaints, grievances, and claims payments. A behavioral health ombudsman for Medicaid clients and a behavioral health advisory council to provide input to MAD on behavioral health matters have also been instituted in the last year. The outcomes of these new efforts remain to be seen since these efforts were too new to be reflected in the data available for this report.

***Recommendation 10: Develop a common set of core services across all systems as a goal for each region to plan for and strive toward meeting.***

***Recommendation 11: Develop standards for school-based mental health services and for DWI programs.***

***Recommendation 12: Require and/or provide incentives for adherence to evidence-based practices in each system of care.***

***Recommendation 13:*** Redesign Medicaid benefits to maximize attention to evidence-based practices, including mandating many of the current optional behavioral healthcare Medicaid benefits.

***Recommendation 14:*** Maximize housing, vocational rehabilitation and educational resources for persons with mental health and/or substance abuse service needs, including those with MRDD and mental illness and/or substance abuse.

***Recommendation 15:*** Create a statewide behavioral health research and development capacity.

#### **4. Lack of Provider Agency and Individual Practitioner Capacity and Inadequate Information to Track that Capacity**

In addition to the lack of provider agency and individual practitioner capacity described above (and in Chapters VI and VII), especially in rural areas of New Mexico, there is no identifiable statewide planning and focused commitment on the human resource needs for the future. Without sufficient numbers and types of provider agencies and individual practitioners, the behavioral health needs of New Mexicans cannot be met. Without adequate training and continuing education, staff cannot keep up with the latest advances in behavioral health service delivery technology. There are also licensing and regulatory barriers that could be removed to make it easier to recruit and retain practitioners to New Mexico and still maintain quality of the practitioner pool.

Additionally, there is no source of information for tracking and planning for human resource needs. No system manager was able to provide information about the capacity of its provider agencies and individual practitioners, that is, how many of a particular type of client or how many units of a particular type of service can be provided in a given time period. Even sources of information that are available are incomplete or inaccurate, therefore it is impossible to get a complete statewide count of provider agencies and individual practitioners available to the behavioral healthcare systems in New Mexico or of provider agency and individual practitioner capacity.

No single list of psychiatrists or psychiatric nurses is available without extensive and labor intensive surveys and information requests. Therefore, it is impossible to accurately determine the extent of these practitioners available in the state and whether this capacity is growing or declining. While lists of psychologists, counselors, and/or social workers are available from state licensing boards, there is no single source of data about the extent to which these practitioners are practicing in New Mexico, and what constitutes their practices in geographic areas or for what types of clients.

Multiple system processes (for example, credentialing) also sometimes create barriers or complexities that inhibit provider agencies and individual practitioners from easily increasing service capacity in needed areas.

***Recommendation 16:*** Create a New Mexico Behavioral Health Institute (NMBHI) to provide leadership and capacity building in human resource development planning, training, and distribution throughout the state and to provide leadership in research and development of evidence-based practices across all publicly funded systems of behavioral healthcare in New Mexico (see Recommendation 15).

***Recommendation 17:*** Develop a comprehensive statewide human resource development (HRD) plan for behavioral health, followed by the development of five regional HRD plans, addressing current and future behavioral healthcare human resource development needs and issues in New Mexico generally and specifically for each of the five regions.

***Recommendation 18:*** Reconsider and change licensure rules and regulations that do not allow reciprocity or that make receiving reciprocity from other states difficult, and that may serve as barriers to licensure of behavioral healthcare professionals in New Mexico.

***Recommendation 19:*** Require annual collection of a common core set of data from each licensed professional and from each behavioral health provider agency that will allow for tracking of trends and identification of needs and of progress toward meeting behavioral healthcare human resource development goals.

***Recommendation 20:*** Identify and implement incentives for recruiting and retaining practitioners in rural and underserved areas, giving special attention to practitioners from American Indian and Hispanic/Mexican cultures, to the use of rural health clinics, and to the training and use of alternative practitioners such as primary care physicians and nurse practitioners, especially in rural areas.

***Recommendation 21:*** Redesign credentialing processes so that one credentialing process is implemented for all major systems of care.

## 5. Insufficient Resources to Meet the Need

The resources necessary to meet the needs for publicly funded behavioral healthcare services in New Mexico are described in detail in Chapter XI of this report. The lack of such resources in New Mexico is described in general and in comparison to other states in Chapters II, V, VIII and IX. While New Mexico is not likely to be able to fund the total need in the near future, some additional resources are critical. Without a minimal investment in resources for behavioral health, additional costs in corrections, juvenile justice, child welfare and unemployment related services will be result. These costs are described in Chapter IV and X.

***Recommendation 22:*** *Develop and implement a plan to maximize Medicaid resources for behavioral health services.*

***Recommendation 23:*** *Set a common rate schedule for commonly defined services (see Recommendation 3) across all systems that allows negotiation between payers and provider agencies and individual practitioners, or in different geographic regions, but that requires a degree of consistency across all payers for the same service. Increase rates paid for behavior management, mobile crisis services, and education and support groups across all payers. Consider the extraordinary costs of transportation, liability insurance, and distance supervision for critical services in rural areas.*

***Recommendation 24:*** *Provide start-up funding to implement these recommendations, including funding for services and for infrastructure (see Chapter XI).*

***Recommendation 25:*** *Fund a single region to develop a comprehensive system or a pilot of a service type before funding additional services statewide.*

#### L. Priorities for Action and Funding (Recommendation 24)

The Project required that the Project Team recommend priorities for service system planning. Based on the data, the stakeholder input and the experience of the Project Team, the following recommended priorities should be addressed, in order of importance, as resources become available or as efforts can begin:

##### Services and Populations:

- Crisis services and jail/hospital alternatives;
- In-home and wrap-around services for children and their families, including therapeutic foster care where needed;
- Integrated services for persons with multiple or co-occurring needs, especially those with mental illness and MRDD, or mental illness and substance abuse;
- Mental health and substance abuse services for youth in state custody;
- Transition services for adults with behavioral health needs who are leaving prisons and jails;
- Transition services for adolescents moving to adulthood and in need of continuing behavioral health services;
- Consumer and family-operated services;
- Substance abuse services for adolescents;
- Intensive outpatient services for substance abusing adults;
- Assertive community treatment and/or intensive case management or community support services for adults with serious mental illness;
- Culturally specific services for American Indians, recent Mexican immigrants, and monolingual Hispanic individuals and families;
- School-based behavioral health clinics and services;
- Supported employment and housing for adults; and

- Other identified service needs (Chapters III, V, VIII and XII) based on regional plans, as funding is available.

### Planning and Infrastructure

- Development of a Behavioral Health Cabinet Cluster and related activities;
- Development of common service definitions;
- MIS enhancements or changes to collect and report common data elements;
- Revisions to the Medicaid benefit design to maximize resources;
- Human resource development planning and implementation (including creation of the New Mexico Behavioral Health Institute);
- Individual practitioner and provider agency data collection and registry;
- Licensure rules and regulation changes;
- Regional service planning efforts;
- Common credentialing process;
- Common utilization management criteria and protocols;
- Creation of research and development capacity; and
- Other identified administrative and infrastructure enhancements (Chapter XI), as funding and resources (including time) are available.

### M. Implications for Legislative Action

There is much in this report to provide direction and possibilities for Executive branch action to improve behavioral health services and systems in New Mexico in addition to the need for new funding. In fact, some of the recommendations in Chapter XIII should actually help make current resources go further, after initial investment in planning, changing rules and regulations, and decreasing administrative barriers.

There are implications in these recommendations for legislative action as well. To the extent that these recommendations can proceed without legislative action, they should. However, the legislature may need or want to provide direction or authority for some of these recommendations. Offered here are examples of actions the New Mexico Legislature can consider to implement these recommendations. These examples are not listed in order of priority or importance.

1. Create and charge the Behavioral Health Cabinet Cluster, or provide for the Governor to appoint and charge such a coordinating and directing body, to develop a comprehensive plan for behavioral health across systems at the state and local levels.
2. Require regional behavioral health planning, by common identified boundaries, including all system actors in a given region and authorize the Behavioral Health Cabinet Cluster to fund services and programs based on that plan.
3. Fund service and infrastructure priorities as identified in these recommendations, utilizing a pilot approach or another approach to concentrate enough new service dollars to make a real difference in a given geographic area or for a given service or population.

4. Fund comprehensive services based on a total plan for the region, not specific facilities or programs (e.g., not a detoxification facility for a specific county or group of counties, or a state hospital for a specific part of the state without addressing the range of treatment services necessary to make detoxification effective or without first trying hospital alternatives such as crisis respite and mobile crisis response that will enhance the entire service delivery system).
5. Require licensing boards to work with the Department of Health, the Human Services Department, the Children Youth and Families Department and other critical system managers and stakeholders (including representatives of licensed practitioners and provider agencies) to identify barriers and recommend solutions to inadequate supplies of licensed professionals.
6. Require licensing boards to collect common information each year and make this data available for planning purposes in a common location.
7. Authorize reciprocity for all behavioral health professionals, and request licensing boards to indicate how they currently or plan to make this possible while still assuring that New Mexico practitioners demonstrate adequate competencies to practice.
8. Require a study or analysis of Medicaid benefits design with the charge to determine how mental health and substance abuse services could be increased and different types of services made available within the limited currently available dollars or with identified increments of increases in funding.
9. Require/establish a single provider agency and individual practitioner registry as recommended in Recommendation 9.
10. Require the application process for Medicaid eligibility to be started for potentially eligible individuals 60 to 90 days prior to release from prison, and suspension rather than termination of Medicaid benefits for individuals with behavioral health needs in jails, to enhance service system transitions.
11. Create, charge, and provide initial funding for a New Mexico Behavioral Health Institute, to develop a comprehensive human resource development plan for behavioral health throughout New Mexico.
12. Require all school districts to plan for behavioral health services in schools, subject to available resources, and pursuant to standards established by the Department of Education in conjunction with the DOH Office of School Health and system stakeholders.
13. Require BHSD to establish standards for DWI programs, in consultation with DFA, counties and DWI providers/practitioners and service recipients.
14. Include substance abuse in insurance parity legislation.

Whether these actions proceed with Legislative direction or at the initiative of the Executive branch, they will serve to enhance the quantity and quality of behavioral health services available for New Mexicans.