LFC RESULTS FIRST
Evidence-Based Options To Improve Outcomes

Report Issued:
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New Mexico
Legislative Finance Committee

Results First Approach

The Results First Approach uses a nationally recognized, peer reviewed model with a three-step process (see Appendix A for more details).

- **Use the best national research to analyze all available studies of similar programs across the country to identify what works, what doesn't, and how effective various programs are in achieving policy goals.**
- **Apply state-specific data to the national results to project the effect that different program and policy approaches would have in the state.**
- **Compare the cost of each program to its projected benefits and produce a report that ranks programs by the relative value they would generate with taxpayers.**

Research Report
Evidence-Based Behavioral Health Programs to Improve Outcomes for Adults

Overview. New Mexico continues to lead the nation in damaging substance abuse and mental health (behavioral health) outcomes despite four transformations of the behavioral health system in the past 20 years and substantial financial investments, including over half a billion dollars in FY15. For adults, New Mexico leads the nation in alcohol-death rates and is ranked among the worst in the nation in drug overdose death rates, suicide rates, and serious mental illness rates. These persistent challenges in behavioral health outcomes, along with gaps in services, have substantial consequences in costs to consumers and taxpayers including increased criminal activity, increased use of the health care system, property loss, decreased labor market earnings, and preventable deaths.

The purpose of this report is to identify strategies to address these outcomes and to identify what programs are potentially good investments for the state in light of Medicaid expansion and the potential for more New Mexicans to receive needed services.

Research provides evidence that many behavioral health services and programs are effective, and that many have benefits that will outweigh the costs of implementation. Some expensive and effective programs, though likely not cost-beneficial under today's system of helping people with serious mental illness, should still be considered for funding. However, the state does not have a comprehensive grasp on how it spends the estimated $209 million on adult behavioral health; whether its funding effective services, whether services are located in high need areas, or whether services are producing expected results. This report estimates the state only spends 11 percent of its limited funding on proven and effective programs for adults, even though past studies have recommended greater spending on these services. Further complicating efforts to improve outcomes, the state has implemented multiple large scale changes to how it organizes oversight and finances behavioral health since the late 1990s.

While the expansion of Medicaid to more New Mexicans, particularly childless adults, holds great promise for combating behavioral health problems, the state needs to spend its resources more strategically. This analysis promotes resource allocation, and reallocation, to prioritize spending on evidence-based practices that have been proven to improve outcomes, and targeting of efforts to high-risk high-needs areas of the state.

Adult Behavioral Health Outcomes in New Mexico. About one in ten New Mexico adults have a substance dependence or abuse issue and two in ten suffer from mental illness. Behavioral health outcomes in New Mexico continue to rank among the worst in the nation. For example, New Mexico historically has serious negative outcomes for adults including:

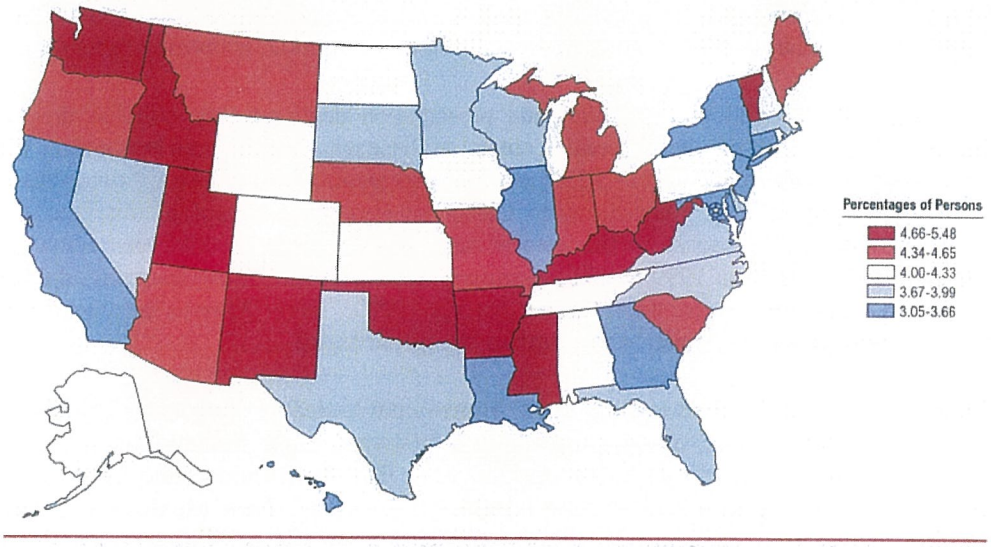
- Eight of the ten leading causes of death are at least partially caused by substance abuse;
- The alcohol-related death rate has been the highest in the country since 1997;
- The drug overdose death rate remains the second highest in the country, though the number of drug overdose deaths has decreased over the past two years;
- The percentage of New Mexicans with a mental illness is higher than most states and the percentage with a serious mental illness is among the highest in the nation;
- From 2008-2012, about 63,000 adults or 4.3 percent of the adult population in New Mexico, had serious thoughts of suicide in the previous year prior to being surveyed; and
- The suicide rate has consistently been among the highest in the nation.

These adult behavioral health issues also affect children. For example, 63 percent of victims of child abuse in New Mexico have a parent (or caregiver) who abuses drugs, ranking New Mexico worst in the nation on this measure. In comparison, nationally 20 percent of child abuse victims face this issue. Similarly, maternal depression can have a multi-generational impact and research consistently shows adult depression detrimental for children. Studies in New Mexico find 11 percent to 23 percent of women are at-risk for postpartum depression, with most covered through Medicaid. Children of depressed mothers may act out more, have problems learning, have difficulty forming friendships, have difficulty getting along with peers, and have lower cognitive development. These children are also less likely to receive regular well-child visits and more likely to use expensive emergency rooms for usual care.

With the recent expansion of Medicaid through Centennial Care and the implementation of the federal Affordable Care Act, more New Mexicans are eligible for Medicaid funded services, providing the state with an opportunity to improve behavioral health outcomes. Historically, childless adults' access to behavioral health services has been limited to smaller state and federal grant funding, and to a limited array of services. An unfortunate byproduct has been that local jails and state prisons end up with large numbers of individuals with behavioral health problems, which is extremely costly to taxpayers.

Mental Health. Adult mental health issues range from stress, anxiety, depression to more serious functional impairment and life-threatening situations such as serious mental illness and suicide. New Mexico has higher rates of mental illness, serious mental illness and suicide than national averages. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports 19.6 percent (300,000) of New Mexicans 18 or older have a mental illness. This figure is above the national percentage of 18.2 percent. SAMHSA also reports 4.72 percent (72,000) of New Mexicans 18 or older have had a serious mental illness in the past year, up from 3.4 percent in 2008. This figure is well above the national percentage of 3.97 percent and ranks among the highest in the nation.

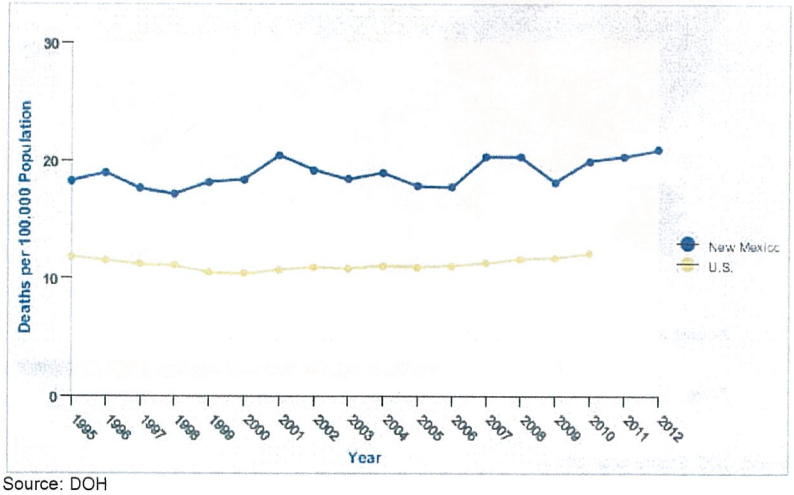
Figure 1. Percentage of Adult Population with a Serious Mental Illness



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2011 (revised October 2013) and 2012.

Around 90 percent of suicide victims have a diagnosable mental health condition, either a mood or substance abuse disorder. According to the Department of Health (DOH), New Mexico's suicide rate has consistently been among the highest in the country at 1.5 to 1.9 times the national rate. Male suicide rates are more than three times female rates, and in 2012, six counties (Taos, Sierra, Grant, Rio Arriba, Torrance, and Otero) had suicide rates that were more than twice the national rate.

Figure 2. Suicide Death Rates New Mexico and United States (1995-2012)



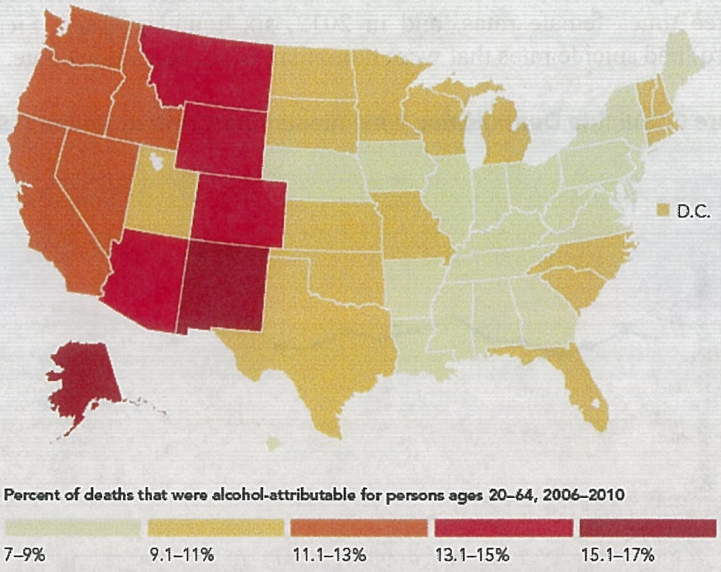
Source: DOH

Substance Abuse. Eight of the ten leading causes of death in New Mexico are at least partially caused by substance abuse. According to DOH, New Mexico has the highest alcohol-related death rate and the second highest drug-induced death rate in the nation. New Mexico's rates of dependence or abuse of illicit drugs and alcohol have remained above national rates since 2002, according to federal data.

New Mexico has the second highest illicit and prescription drug mortality rate in the United States, according to a 2010 report by the federal Centers of Disease Control and Prevention (CDC). New Mexico's overdose death rate for 2010 (23.8 per 100,000 population) is almost twice the national rate (12.4 per 100,000 population). According to CDC, the sharp rise in opioid overdose deaths closely parallels an equally sharp increase in the prescribing of these drugs. Opioid pain reliever sales in the United States quadrupled from 1999 to 2010. Similarly, the substance abuse treatment admission rate for opioid abuse in 2010 was seven times higher than in 1999. New Mexico has been recognized for implementing many promising practices for combating opioid abuse.

Excessive alcohol use is the third leading cause of preventable death. Nationally excessive alcohol use leads to one in ten deaths among working-age adults (20-64 years old). In New Mexico, one in six deaths is caused by excessive alcohol use (1,200 deaths in 2012). The New Mexico rate for exessive drinking is 25 percent higher than the next ranked state Alaska. Additionaly, New Mexico's total alcohol-related death rate has increased 17 percent over the last two decades while the U.S. rate has decreased by 10 percent over the same time period.

Figure 3. Percent of Alcohol-Attributable Deaths (Ages 20-64)



Source: CDC, Stahre et al (2014)

New Mexico's Behavioral Health System. Undesirable behavioral health outcomes are not new to New Mexico. The state has taken a number of approaches to organize public agencies and resources to get

better outcomes. As a result, the behavioral health system has gone through a number of large scale changes since the late 1990s (See Appendix B for more detail). In 2002, the legislature and administration called for a comprehensive behavioral health needs and gaps analysis. The purpose of the 2002 study was to identify service needs and system barriers, as well to identify current efforts to overcome the barriers.

The 2002 analysis was important because it "identified a system that was fragmented, *lacked evidenced-based practices*, did not emphasize the principles of recovery and resiliency as the foundations of a transformed system, had varying degrees of accessibility, uneven quality of care, and lacked sufficient consumer and family participation in the planning and implementation processes." The analysis also emphasized "the need for a system of care which is 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."

The report recommended that the state:

- develop and use of common reporting system requirements;
- develop a common set of core services across funding streams;
- require or provide incentives for adherence to evidence-based practices; and
- create statewide behavioral health research and development capacity.

In 2004, the Legislature responded to the report and created the Interagency Behavioral Health Purchasing Collaborative (Collaborative) to develop and coordinate a single statewide behavioral health care system. The legislation was consistent with Executive direction that all agencies involved in the delivery, funding, or oversight of behavioral health care services in New Mexico collaborate in the creation of this new system.

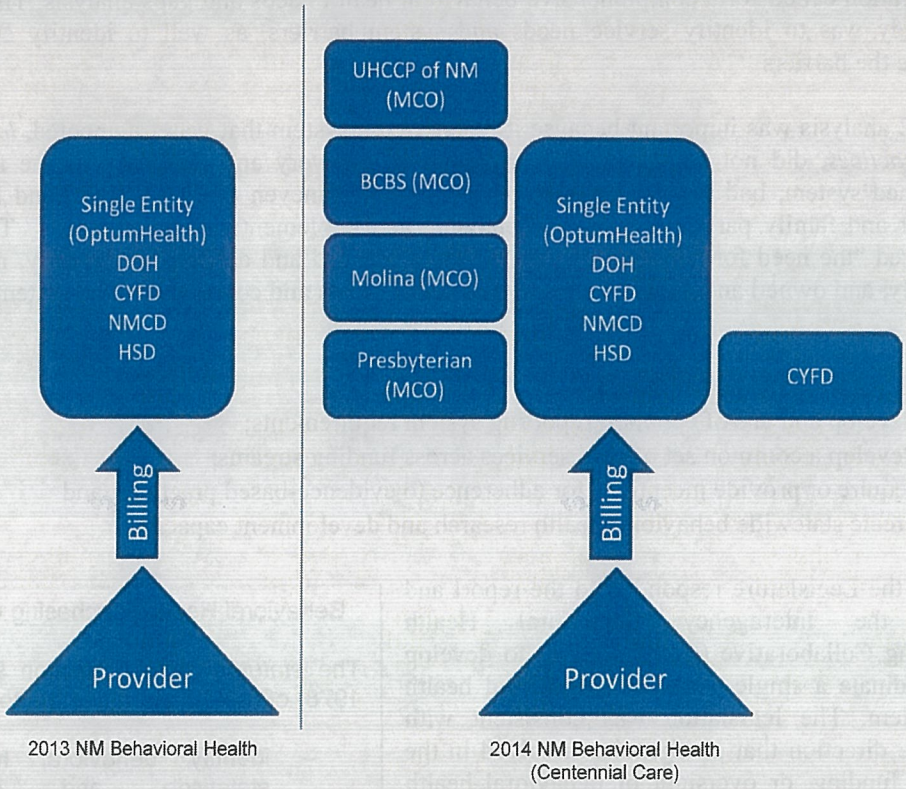
The Collaborative combined almost all behavioral health funding into a single entity (OptumHealth) to administer funding, contract for services and help create an integrated system up until 2014, when the state took yet another direction. Under the state's new Medicaid Centennial Care, funding for providers comes from multiple sources similar to before creation of the single entity and Collaborative, as shown in Figure 4. The transformation to Centennial Care brings the behavioral system nearly full circle from the approach to paying for services used before 2000.

Behavioral Health Purchasing Collaborative

The *statutory duties* (Section 9-1-7.6 NMSA 1978) of the Collaborative are to:

- identify behavioral health needs statewide and develop a comprehensive statewide behavioral health plan; and
- give special attention to regional differences, including cultural, rural, frontier, urban and border issues;
- inventory all expenditures for mental health and substance abuse services;
- plan, design and direct a statewide behavioral health system, and
- contract with one or more behavioral health entities to ensure availability of services throughout the state.

Figure 4. Behavioral Health Billing System Comparison FY13 to FY14



What Works. While New Mexico has taken a number of approaches to organize state agencies to address behavioral health, research shows what services work to improve outcomes. Thousands of high quality research studies on hundreds of programs addressing behavioral health have proven which treatments are effective at addressing substance abuse and mental health issues. The New Mexico Results First approach incorporates New Mexico specific statistics for costs, consequences, diagnosis rates, and treatment rates for incidence of mental illness and substance abuse in the state. The results of this approach provide consumer reports lists with potential return on investment and likelihood of positive return on investments reflecting improved outcomes. Results indicate that New Mexico can obtain improved mental health and substance abuse related outcomes if evidence-based programs are successfully implemented.

Evidence-based program or practice
A program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from a systemic review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication and, when possible, is determined to be cost-beneficial.

The New Mexico Results First approach provides estimates of potential return on investment and likelihood of a positive return on investment. These estimates are constructed conservatively to reflect the difficulty that can be encountered when implementing programs at scale. Some of these programs are currently implemented in New Mexico and the results of this report present the outcomes these programs should be producing assuming they are delivered as intended. However, previous program evaluations have found poor implementation can result in poor outcomes. Note that a number of promising programs are not included in the analysis in this report and some of these are programs that have been developed in New Mexico. Future directions should include incorporating rigorous outcome evaluations conducted on such programs to determine potential cost savings from program implementation.

Adult Mental Health Services. Rigorous research has shown the therapies, service strategies and comprehensive programs shown in Table 1 are effective at improving outcomes. However, many of these interventions do not appear to produce benefits that are likely to outweigh their costs, but are effective and should be considered for funding. For example, programs for difficult populations including the chronically homeless appear to deliver low or no return on investment and have a low likelihood of being cost-beneficial. However, these may be the best programs currently available to address potential negative outcomes faced by populations targeted by these interventions such as Assertive Community Treatment (ACT) and supported housing. As a result, there may not always be an economic reason to invest based on available research, but there are clear beneficial outcomes for individuals and society that policy makers should consider. These community based programs are likely cost-effective when compared to historical practices of long-term institutionalization of people with serious mental illness.

Table 1. Consumer Reports List for Adult Mental Health Services

Policy Area	Program/Intervention	Return On Investment (for every $1 invested)	Likelihood of Being Cost Beneficial	Available in New Mexico
Mental Health	**Service Strategies**			
	Collaborative primary care for depression	$11.61	99%	Unknown
	Collaborative primary care for anxiety	$32.81	95%	Unknown
	Collaborative primary care for comorbid depression and chronic health conditions	$6.30	99%	Unknown
	Illness Management and Recovery (IMR)	$0.17	23%	Yes
	Individual Placement and Support (IPS)	$2.57	75%	Yes
	Mobile crisis response	$0.46	14%	Unknown
	Primary care in behavioral health settings	$3.26	57%	Unknown
	Primary care in integrated settings (Veteran's Administration, Kaiser Permanente)	$6.16	60%	Unknown
	Primary care in community-based addiction centers	($1.67)	22%	Unknown
	Programs			
	Assertive Community Treatment (ACT)	($0.24)	20%	Yes
	Mental health courts*	$2.55	98%	Yes
	Peer specialist added to the mental health treatment team	$0.67	8%	Unknown
	Supported Housing for Chronically Homeless Adults	$0.07	0.01%	Yes
	Therapy			
	Cognitive-Behavioral Therapy for anxiety	$114.51	99%	Yes
	Cognitive-Behavioral Therapy for depression	$11.61	99%	Yes
	Cognitive-Behavioral Therapy for posttraumatic stress disorder (PTSD)	$ 101.26	99%	Yes
	PTSD Prevention following trauma-Adults	$6.12	99%	Yes

Source: NM Results First Approach
* Indicates cost-benefit analysis are for a unique population (adult supervision)

Individual placement and support for individuals with serious mental illness. This strategy focuses on vocational services for individuals with serious mental illness, considering client interests, competitive employment, rapid placement, and on-going support. In New Mexico, individual placement services and support is provided through state funding and is available at sites throughout the state. New Mexico spent around $100 thousand on individual placement and served 287 clients in FY13.

Assertive Community Treatment (ACT). Assertive Community Treatment (ACT) is a treatment and case management approach. Nationally, the most rigorous research suggests ACT reductions to social costs such as jail and healthcare do not offset the high cost of this service strategy. But there are few other options for serving this population of New Mexicans that have proven as effective. The program is likely much less expensive than long-term hospitalization or prison and should be considered for funding by policy makers. New Mexico has implemented five ACT programs: three in Albuquerque and one each in Las Cruces and Santa Fe. State specific research has shown positive outcomes for these programs in New Mexico. One program in Albuquerque showed a reduction of inpatient hospitalizations by approximately 1,000 patient days for 360 participants over a 5 year period. Visits to emergency rooms also decreased by 50 percent over the same time frame. According to BHSD, $3.7 million was dedicated to ACT serving 320 clients in FY13.

Supported Housing. This strategy for adults with serious mental illness and chronic homelessness has somewhat mixed research results. Most research studies focused on cost-benefit evaluated the Housing First model of supported housing, but the majority of research found the programs' costs outweigh the benefits. The research in the Results First Approach has not yet monetized the benefits of reduced homelessness, which means the return on investment likely understates the benefits of the intervention. Again, when compared to historic practice of long-term hospitalization or prison and the lack of other evidence-based interventions for this social problem means this strategy should be considered by policy makers for funding.

In Albuquerque, the Housing First model for supportive housing program model is being used. The Heading Home model provides independent apartments with no specific requirements for abstinence or treatment. The model targets chronically-homeless, medically- vulnerable individuals. An independent cost study by the UNM Institute for Social Research found positive cost benefit from the program. The evaluation compared the same study group pre- and post-housing:

- One year post Heading Home study group member costs were 31.6 percent less than the pre-Heading Home study group member costs.
- Emergency costs decreased 36.2 percent.
- Jail costs decreased by over $18 thousand. Prior to housing study group members spent 766 days in jail and 281 days post housing.
- Hospital and outpatient treatment costs decreased by 64 percent.
- Social service cost increased by $469 percent.

Cognitive Behavioral Therapies. Some of the therapies' benefits far outweigh their costs, particularly cognitive behavioral therapy (CBT) for posttraumatic stress disorder. CBT is a form of treatment that focuses on examining the relationships between thoughts, feelings, and behaviors. By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, people with

mental illness can modify their patterns of thinking to improve coping. These are low cost interventions that have a high likelihood of being successful and cost-beneficial.

Adult Substance Abuse Services. Table 2 shows potential return on investment, likelihood of being cost beneficial, and whether these programs are offered in New Mexico for adult substance abuse services. Best bets for substance abuse treatment include brief intervention, contingency management, and medication treatments such as Buprenorphine and Methadone. These programs have a high return on investment and have a high likelihood of being cost-beneficial.

Table 2. Consumer Reports List for Adult Substance Abuse Services

Policy Area	Program/Intervention	Return On Investment (for every $1 invested)	Likelihood of Being Cost Beneficial	Available in New Mexico
Substance Abuse	Brief Alcohol Screening and Intervention for College Students (BASICS): A Harm Reduction Approach	$50.67	76%	Yes
	Brief Intervention in primary care	$31.14	94%	Yes
	Brief Intervention in emergency department	$14.58	80%	Yes
	Brief Intervention in medical hospital	$42.74	72%	Yes
	12-Step Facilitation Therapy	No Estimate	69%	Yes
	Behavioral Self-Control Training (BSCT)	($142.97)	23%	Unknown
	Brief Cognitive Behavioral Intervention for Amphetamine users	$90.82	70%	Unknown
	Brief Marijuana Dependence Counseling	$13.72	90%	Unknown
	Cognitive Behavioral Coping Skills Therapy	$264.92	99%	Unknown
	Community Reinforcement Approach (CRA) with Vouchers	$14.36	78%	Yes
	Contingency management (higher-cost) for substance abuse	$62.77	80%	Unknown
	Contingency management (higher-cost) for marijuana abuse	$16.03	81%	Unknown
	Contingency management (lower-cost) for substance abuse	$24.85	66%	Unknown
	Contingency management (lower-cost) for marijuana abuse	$0.23	49%	Unknown
	Day Treatment with Abstinence Contingencies and Vouchers	$1.37	53%	Unknown
	Family Behavior Therapy (FBT)	$14.57	74%	Yes
	Holistic Harm Reduction Program (HHRP+)	$13.17	62%	Unknown
	Individual Drug Counseling Approach for the Treatment of Cocaine Addiction	$2.80	55%	Unknown
	Matrix Intensive Outpatient Program (IOP) for the Treatment of Stimulant Abuse	$15.72	65%	Yes
	Motivational Enhancement Therapy (MET)	$32.69	63%	Yes
	Node-Link Mapping	No Estimate	55%	Unknown
	Peer support for substance abuse	$4.32	60%	Unknown
	Relapse Prevention Therapy	No Estimate	56%	Unknown
	Seeking Safety: Effect on substance abuse	$53.38	73%	Yes
	Supportive-Expressive Psychotherapy for substance abuse	($1.75)	45%	Unknown
	Buprenorphine/Buprenorphine-Naloxone (Suboxone and Subutex)	$2.75	97%	Yes
	Methadone Maintenance Treatment	$6.14	99%	Yes

Source: NM Results First Approach
* Indicates cost-benefit analysis are for a unique population (adult supervision)

Screening, Brief Intervention, and Referral to Treatment (SBIRT). This service strategy, performed in a number of settings including primary care or emergency department settings, is an evidenced-based model which provides opportunities for early intervention with at-risk substance users before more severe consequences occur. Screening quickly assesses the severity of substance use and identifies the

appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change, and referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

SBIRT was available through community- based primary health clinics, school-based health centers, and public health offices in New Mexico from 2004 to 2008 through federal grant funding. However, New Mexico did not have a sustainability plan for continuing the SBIRT program after funding expired in 2008. The loss of federal funding resulted in a severe limitation of available services. An independent evaluation of the New Mexico SBIRT program did demonstrate improved outcomes for those served.

Table 3. New Mexico SBIRT Patient Rate of Change as a Result of Receiving Services, 2003-2008

Government Performance and Results Act Measures	Percent at Intake	Percent at 6-Month Follow-Up	Rate of Change
Abstinence: did not use alcohol or illegal drugs	29%	46%	58%
Crime and Criminal Justice: had no past 30 day arrests	91%	95%	5%
Employment/Education: were currently employed or attending school	54%	83%	42%
Health/Behavioral/Social Consequences: experienced no alcohol or illegal drug related health, behavioral, social consequences	59%	83%	42%
Social Connectedness: were socially connected	72%	66%	-8%
Stability in Housing: had a permanent place to live in the community	62%	64%	2%

Source: CSAT Database 9/30/2008

In August 2013, SAMHSA awarded New Mexico a five year, $10 million grant for SBIRT programs. The grant was written in collaboration with the University of New Mexico, who will provide program evaluation and a portion of the training. Sangre de Cristo Community Health, which had been the primary administrator for the previous SBIRT program, will oversee service delivery and portions of the training. The Behavioral Health Services Division (BHSD) of the Human Services Department has hired a program administrator to oversee the other involved entities and be the primary contact with SAMHSA. Currently the program has been implemented at First Nations Community Healthsource in Albuquerque, Jemez Pueblo, and the Santa Fe Indian Health Services. Upcoming implementations include Laguna-Acoma Indian Health Services and Taos Pueblo Indian Health Services. Discussions are underway to include the program in the UNM Trauma Center. BHSD is working with the Medical Assistance Division to designate SBIRT an allowable Medicaid service. This action could provide sustainability for this evidenced-based service.

Matrix Model Intensive Outpatient (IOP). This service is defined by the Behavioral Health Services Division as a time-limited, multi-faceted approach to treatment services for individuals who require support and structure to achieve and sustain recovery. The service is aimed at individuals with substance abuse or co-occurring disorders. The core services include discharge and transition services planning, individual and group therapy, and psycho-education for the client and family. In FY13, $2.4 million was spent on Matrix Model IOP and served 1,493 clients, according to BHSD.

Methadone and Burprenorphine or Buprenorphine-Naloxone maintenance programs. These drug maintenance programs are substitute treatments for opioid addictions. Both drugs are opioids while Naloxone, a rescue drug, reduces respiratory depression associated with toxic exposure to opioids. If the Buprenorphine-Naloxone mixture is crushed and used intravenously rather than orally, the Naloxone causes serious withdrawal symptoms. This discourages the inappropriate use of Buprenorphine.

Substitution treatment with methadone or buprenorphine has been shown effective in numerous randomized trials, meta-analyses, and large-scale longitudinal studies. The less costly Methadone has shown to be more effective in retaining consumers in treatment, while buprenorphine has been reported to have a lower risk of abuse and diversion for nonprescription use. Although Methadone has proven to be more effective in maintenance treatment than buprenorphine, both drugs are superior to non-medication treatment. In 2013, HSD removed the requirement that Buprenophine have a prior authorization from the Medicaid managed care organizations before reimbursement to the provider. This improves access to the drug and potentially reduces harm from heroin and other opioids overdoses.

New Mexico, also, became the first state in the nation allowing pharmacists to prescribe Naloxone. Sixty pharmacists have completed the mandatory training and have been certified to prescribe Naloxone (Narcan). The state epidemiologist estimated that in 2013 there were as many as 500 statewide overdose reversals due to Naloxone administration. In such a rural state, pharmacists may be the only healthcare providers in a community. In FY13, the state spent $4.2 million on these programs and served 1,864 clients, according to BHSD.

Spending on Adult Behavioral Health. In FY15, New Mexico allocated almost $538 million for behavioral health services, with about $209 million, or 39 percent, targeting the adult population (ages 18 and over). Medicaid is the largest finance source for behavioral health, accounting for 84 percent of all funding and 73 percent of estimated funding targeting adults, as shown in Table 4. Most adult behavioral health claims based spending is dedicated to outpatient services, as shown in Figure 5.

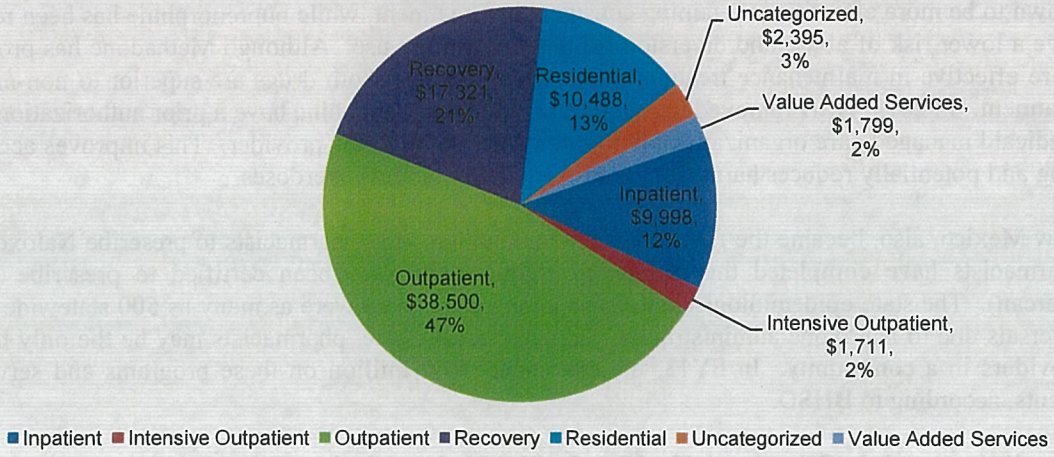
Table 4. FY15 New Mexico Behavioral Health Operating Budget By Agency
(in millions)

Agency	Descriptions of Budget Items (Uses)	Amount Dedicated to Adults[1]	Total Amount[2]
Human Services Department (HSD)	Medicaid Managed Care, Fee for Service, Affordable Care Act, Behavioral Health Services Division (BHSD) Substance Abuse and Community Mental Health	$153,742.02	$452,182.40
Department of Health (DOH)	Behavioral health institute, other centers	$36,107.90	$38,565.80
Administrative Offices of the Court (AOC) and Judicial Districts	Drug and mental health courts	$6,800.00	$13,184.30
Children, Youth and Families Department (CYFD)	Field and facility mental health	$0.00	$12,670.20
Department of Finance and Administration (DFA)	DWI Prevention and Treatment[3]	$3,539.00	$7,135.00
New Mexico Corrections Department (NMCD)	Community Corrections and Offender Management	$6,362.60	$6,362.60
Developmental Disabilities Planning Council (DDPC)	Office of Guardianship	$186.60	$4,168.60
Department of Transportation (DOT)	DWI Prevention and Treatment	$2,620.00	$3,539.10
Public Education Department (PED)	HSD Medicaid	$0.00	$36.00
Total	**All Items**	**$209,358.12**	**$537,844.00**

Source: Behavioral Health Compilation and AOC

Notes: 1. Estimates derived from program descriptions and claims data percentage splits.
2.. Total includes Other State Funds potentially duplicating transfers between agencies such as Medicaid. This amount is less than 5 percent of the total.
3. Of the $19 million available from DWI funds, the Behavioral Health Collaborative identifies $7.1 million being used for prevention and treatment.

Figure 5. FY13 Adult Behavioral Health Service Utilization
(in millions)

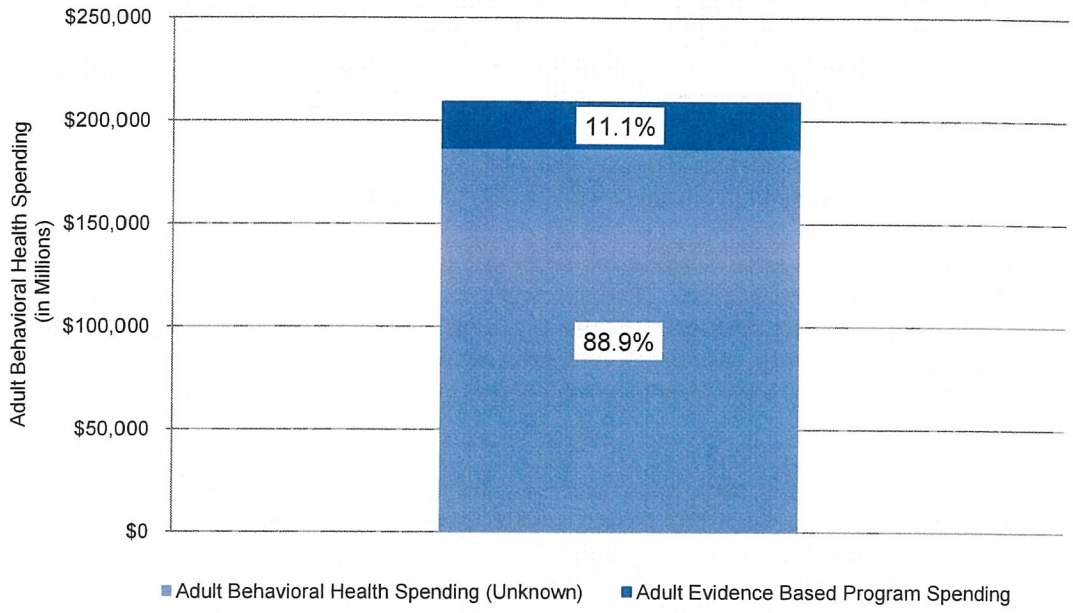


Source: OptumHealth CI-09 Report

LFC staff identified $23 million, or 11 percent, was spent on evidence-based adult behavioral health services and programs in 2013. These evidenced-based services and programs included drug courts, mental health courts, Assistive Community Therapy (ACT), Peer Support, Matrix Intensive Outpatient Treatment, and Medication Assisted Therapy (Methadone and Buprenorphine). LFC staff inventoried evidence-based programs included in the Results First database, which include the programs that underwent the highest and most rigorous research design and included information to derive cost-benefit analysis. Other evidence-based services and research not in the Results First database was considered in this analysis and a list of those programs is included in Appendix C. To date not all of this research meets the requirements for cost-benefit analysis but shows many other behavioral health strategies are effective.

Overall, the state and federal government have sought to prioritize investments in evidence-based services. One of the key findings of the 2002 behavioral health needs and gaps study was the lack of evidence-based services used in the state. State law requires the Behavioral Health Collaborative to inventory behavioral health funding and spending, but it has not developed a comprehensive system to identify spending on evidence-based services and programs. As a result, the system could be spending large amounts on services with unknown effectiveness. The Collaborative also does not have a comprehensive performance management system to regularly report performance. There is no current tracking of what evidence-based services are used and how much of these services are used. This is primarily due to data limitations.

Figure 6. Evidence-Based Spending on Adult Programs
(in millions)



Source: HSD, AOC, LFC Analysis

Policy Options. New Mexico would benefit from prioritizing future behavioral health investments in evidence-based programs, with attention on prioritizing the most cost-beneficial programs, when there are multiple investment options for a service or program. The state would also benefit from targeted investments in effective, but expensive, programs for people with serious mental illness such as supportive housing. The state needs a better inventory of how it currently spends its money on adult behavioral health and reprioritize spending, a process that should occur annually through the Behavioral Health Collaborative. Finally the state needs to target investments in what works to where the needs are in the state. Knowing to what extent evidence-based programs are currently being delivered and making better investments to high-risk high-need areas of the state would also be beneficial. Using existing resources for services that have been proven to work and targeting what works to areas of highest need is paramount for improving behavioral health outcomes.

Previous Policy Recommendations. Previous reports and recommendations have informed policy makers over the last fifteen years, and are still relevant given inconsistent implementation. The state needs a regular assessment of needs and gaps as contemplated in the Collaborative's statutory duties, with particular attention to evidence-based and cost-beneficial services and programs. An updated independent study similar to the 2002 needs and gaps analysis may well be warranted absent action from the Collaborative.

Recommendations from the 2002 Needs and Gaps Analysis have, for the most part, not been implemented, and would prove beneficial to the behavioral health system.

- Development and use of common reporting system requirements;
- Development of a common set of core services;
- Requirement and/or providing of incentives for adherence to evidence-based practices; and
- Creation of a statewide behavioral health research and development capacity.

Other reports have made recommendations which have not been implemented which could also be beneficial to the state and to consumers served are included in Appendix D.

Investment Zone Strategy. Challenges and risks facing the state in behavioral health are not equally distributed across New Mexico. The state serves a greater proportion of adults needing mental health services than the national average, but thousands of New Mexicans who could benefit are not receiving publicly funded services. Medicaid expansion to childless adults, in particular, creates the potential for large scale changes in behavioral health outcomes if the state spends its limited resources smarter and in targeted ways.

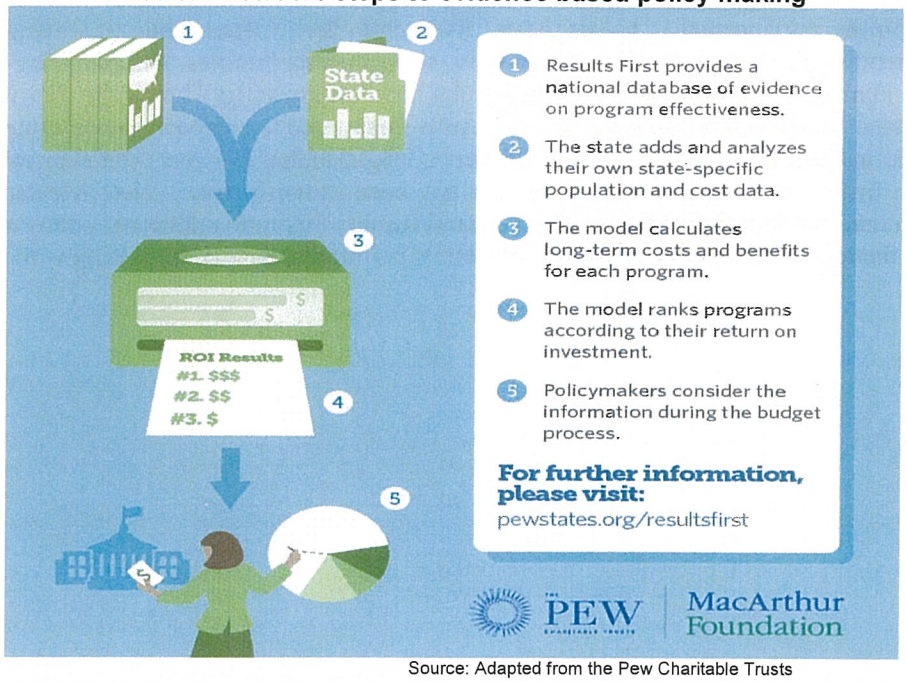
The early childhood system has used an investment zone strategy to identify geographic areas with poor outcomes or high risk, assessed service availability and targets resources accordingly. The state could develop a similar process for behavioral health, both in terms of combating poor outcomes but also addressing workforce needs to delivery evidence-based services and programs. Through the Department of Health, the state has the capability to carry out much of the mapping of outcomes, behavioral health risk factors, distribution of providers and methods to target sub-county level areas for investments. Appendix E shows some of this capability.

Conclusion. New Mexico faces considerable challenges with high rates of adult mental illness and substance abuse, and poor outcomes when national comparisons are made. Research provides evidence that many behavioral health services and programs are effective, and that many have benefits that will outweigh the costs of implementation. Some expensive and effective programs, though likely not cost-beneficial under today's system of helping people with serious mental illness, should still be considered for funding. However, the state does not have comprehensive grasp on how its spends the estimated $209 million on adult behavioral health; whether its funding effective services, whether services are located in high need areas, and whether services are producing expected results. While the expansion of Medicaid to more New Mexicans, particularly childless adults, holds great promise for combating behavioral health problems, the state needs to spend its resources more strategically. This analysis promotes resource allocation, and reallocation, to prioritize spending on evidence-based practices that have been proven to improve outcomes and then targeting of efforts to high-risk high-needs areas of the state.

Appendix A: History and Background of the New Mexico Results First Project

The Washington State Institute for Public Policy (WSIPP) has utilized a cost-benefit model to inform decisions of policy makers so they can invest in evidence-based programs that deliver the best results for the lowest cost. WSIPP has attributed a number of positive outcomes to the use of the approach on which Results First is based, including a savings of $1.3 billion per biennium and improved outcomes in the state of Washington.

Results First: Five steps to evidence based policy making



Source: Adapted from the Pew Charitable Trusts

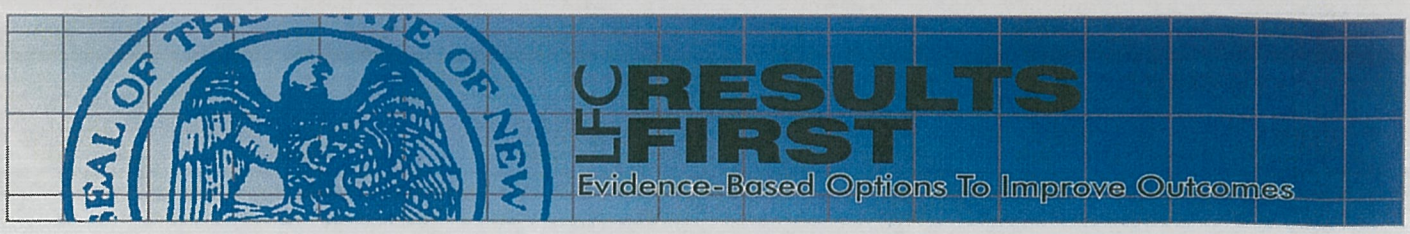
Cost-Benefit Analysis of Evidence-Based Programs. The result of the cost-benefit analysis conducted in this report indicates New Mexico could obtain favorable outcomes for behavioral health consumers, if the state successfully implements evidence-based programs. The cost-benefit estimates were constructed conservatively to reflect the difficulty that can be encountered when implementing programs at scale. Likewise, well-run behavioral health service programs can achieve reported or better results.. Poorly run programs will not. Some of these programs are currently implemented in New Mexico and the results of this study present the outcomes these programs should be producing based on rigorous research. Several factors need to be considered when interpreting findings. Our analysis is based on an extensive and comprehensive review of research on program outcomes as well as an economic analysis of the benefits and costs of investments in evidence-based programs. The results indicate that New Mexico can obtain favorable outcomes if it can substantially and successfully increase its use of several evidence-based programs. The predicted costs, benefits, and return on investment ratios for each program are calculated as accurately as possible but are, like all projections, subject to some level of uncertainty. Accordingly, it is more important to focus on the relative ranking of programs than small differences between them; some programs are predicted to produce large net benefits and represent 'best buys' for the state while others are predicted to generate small or even negative net benefits and represent neutral or poor investment opportunities.

Evidence-Based Program Implementation in Other States through Results First. States have made substantial progress in their implementation of Results First over the past year and their use of the process to inform and strengthen policy and budget decisions. These efforts have resulted in millions of dollars in targeted funding, cost-savings, and cost-avoidance that will improve long-term outcomes for citizens. States have identified many lessons learned that can help all teams maximize the value of their work, and Results First will use this feedback to develop new tools over the coming year to help states collaborate and share these best practices. Results First is also working to expand the scope of the cost-benefit analysis model and bring additional tools to states to support evidence-based policymaking. Collectively, this work can be instrumental in helping states live within their means while improving their ability to achieve critical goals, such as reducing recidivism, strengthening families, and preparing children for the future. The number of states participating in Results First has grown to 14 over the past year. Most states have completed initial implementation of the Results First model's criminal justice component. Oregon has used the analysis broadly to determine whether a long-standing (10-year) statutory mandate directing agencies to invest in evidence-based programs has been cost-effective. New Mexico, along with a number of other participating states, plans to expand Results First into additional policy areas along with integrating the results of the analysis within the state's performance-based budgeting work.

Appendix B: History of Major Events in New Mexico's Behavioral Health System

2000	Behavioral health services are administered through regional care coordination entities contracted by managed care companies.
2001	The New Mexico Medicaid Behavioral Health Advisory Committee issues report on managed behavioral health care options and improved cross-agency coordination of services. The Committee made system-wide proposals considered essential to the effective functioning of any behavioral health model for the state, including topics related to access, quality, financing, and treatment of consumers and interagency coordination.
2002	At the direction of the legislature and administration, the New Mexico Behavioral Health Needs Assessment and Gap Analysis Project was completed. The report was funded by state agencies and managed care organizations.
2003	Governor Richardson directed all agencies tasked with the delivery, funding or oversight of behavioral health care services including, mental health and substance abuse services and treatment to work collaboratively to create a single behavioral health service delivery system throughout the state.
2004	The New Mexico Legislature passes House Bill 271, establishing the Behavioral Health Purchasing Collaborative and Behavioral Health Planning Council.
2005	Behavioral health is separated from physical health. The Collaborative selects ValueOptions New Mexico, Inc. as the single statewide entity to manage mental health and substance abuse programs and funding from six separate state agencies.
2008	The Collaborative selects OptumHealth New Mexico to replace ValueOptions as the single statewide entity.
2009	After the go-live of the OptumHealth New Mexico system, significant issues arose. A Directed Corrective Action Plan was imposed on OptumHealth, with consultant, Alicia Smith and Associates to monitor.
2012	The HSD submits an 1115 Medicaid waiver application to the Centers for Medicare and Medicaid Services. The New Mexico plan is called Centennial Care. CYFD funding is no longer funneled through the Collaborative, but is administered by the agency.
2013	Federal government approves New Mexico's Medicaid Waiver proposal. Governor Martinez announces New Mexico will expand access to Medicaid for up to 170 thousand eligible New Mexicans under the Patient Protection and Affordable Care Act.
2014	Centennial Care integrates physical and behavioral health and selects four MCOS to manage Medicaid funding and providers and one third party administrator to manage state general and federal grant funds. This change coincided with Medicaid expansion and the establishment of the New Mexico Health Insurance Exchange.

Source: LFC Files



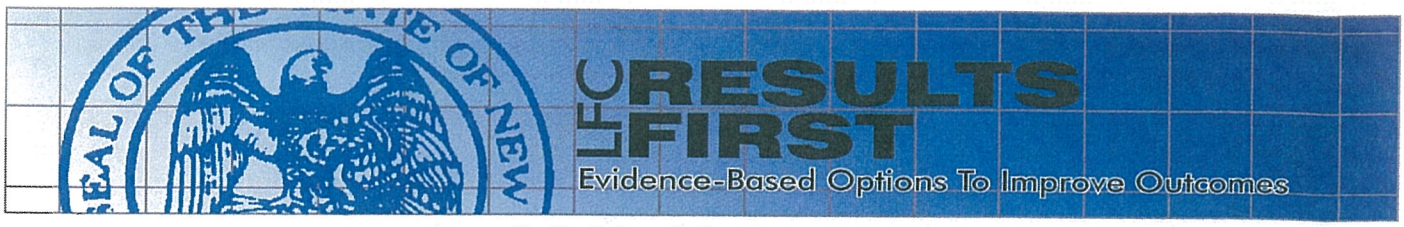
Appendix C: Evidence-Based Adult Behavioral Health Programs Identified in the Results First Clearinghouse Database

Program Area	Intervention	Level of Evidence (Green=Highest rated, top tier programs; Yellow=Promising, near top tier programs; Red=No Evidence of Effeciveness)
Mental health: adult	Acceptance and Commitment Therapy	Green
Mental health: adult	Acceptance-Based Behavioral Therapy for Generalized Anxiety Disorder	Yellow
Mental health: adult	Assisted outpatient treatment	Green
Mental health: adult	Behavioral Activation Treatment for Depression	Green
Mental health: adult	Brief Eclectic Psychotherapy for Posttraumatic Stress Disorder	Yellow
Mental health: adult	Brief Self-Directed Gambling Treatment	Yellow
Mental health: adult	Bringing Baby Home	Yellow
Mental health: adult	Clinician-based Cognitive Psychoeducational Intervention for Families (Family Talk)	Green
Mental health: adult	Cognitive Behavioral Analysis System of Psychotherapy	Yellow
Mental health: adult	Cognitive Behavioral Therapy for Acute Stress Disorder	Green
Mental health: adult	Cognitive Behavioral Therapy for Adults with Depression	Green
Mental health: adult	Cognitive Behavioral Therapy for Late-Life Depression	Green
Mental health: adult	Cognitive Enhancement Therapy	Green
Mental health: adult	Cognitive Processing Therapy	Green
Mental health: adult	Cognitive Therapy	Green
Mental health: adult	Computer-Based Cognitive Behavioral Therapy, Beating the Blues	Green
Mental health: adult	Coordinated Anxiety Learning and Management Tools for Living Program	Green
Mental health: adult	Coping With Work and Family Stress	Green
Mental health: adult	Depression Prevention (Managing Your Mood)	Green
Mental health: adult	Dialectical Behavior Therapy	Green
Mental health: adult	Dynamic Deconstructive Psychotherapy	Green
Mental health: adult	Functional Adaptation Skills Training	Green
Mental health: adult	ICCD (International Center for Clubhouse Development) Clubhouse Model	Yellow
Mental health: adult	IMPACT (Improving Mood—Promoting Access to Collaborative Treatment)	Green
Mental health: adult	Intensive Short-Term Dynamic Psychotherapy	Green
Mental health: adult	Interpersonal Psychotherapy	Green
Mental health: adult	JOBS Program	Green
Mental health: adult	Kognito At-Risk for College Students	Yellow
Mental health: adult	Kognito Family of Heroes	Yellow
Mental health: adult	Life Goals Collaborative Care	Green
Mental health: adult	Medicaid benefits for mental illness	Yellow
Mental health: adult	Mental Health First Aid	Green
Mental health: adult	Mindfulness-Based Cognitive Therapy	Green
Mental health: adult	MoodGYM	Green
Mental health: adult	Narrative Exposure Therapy	Green
Mental health: adult	National Alliance on Mental Illness Family-to-Family Education Program	Green
Mental health: adult	New York University Caregiver Intervention	Green
Mental health: adult	OQ-Analyst	Green
Mental health: adult	Panic Control Treatment	Yellow
Mental health: adult	Partners for Change Outcome Management System	Green
Mental health: adult	Partners in Care	Green
Mental health: adult	Penn Resilience Training for College Students	Green

Mental health: adult	Prevention of Suicide in Primary Care Elderly: Collaborative Trial	Green
Mental health: adult	PRIME for Life	Green
Mental health: adult	Program of All-Inclusive Care for the Elderly	Green
Mental health: adult	Program to Encourage Active, Rewarding Lives for Seniors	Green
Mental health: adult	Prolonged Exposure Therapy	Green
Mental health: adult	Psychiatric Rehabilitation Process Model	Green
Mental health: adult	Psychoeducational Multifamily Groups	Yellow
Mental health: adult	Psychotherapies for victims of sexual assault	Green
Mental health: adult	QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention	Yellow
Mental health: adult	Relationship-Based Care	Yellow
Mental health: adult	Resources for Enhancing Alzheimer's Caregiver Health II	Green
Mental health: adult	Senior Reach	Yellow
Mental health: adult	Skills Training in Affective and Interpersonal Regulation plus Modified Prolonged Exposure	Yellow
Mental health: adult	Systems Training for Emotional Predictability and Problem Solving	Yellow
Mental health: adult	TEAMcare	Green
Mental health: adult	Telemedicine-Based Collaborative Care	Green
Mental health: adult	Trauma Affect Regulation: Guide for Education and Therapy—Adults	Green
Mental health: adult	Trauma Recovery and Empowerment Model	Yellow
Mental health: adult	United States Air Force Suicide Prevention Program	Yellow
Mental health: adult	Wellness Recovery Action Plan	Green
Substance abuse: adult	A Woman's Path to Recovery (based on A Woman's Addiction Workbook)	Yellow
Substance abuse: adult	Alcohol Behavioral Couple Therapy	Green
Substance abuse: adult	Arkansas Center for Addictions Research, Education, and Services	Yellow
Substance abuse: adult	Behavioral Couples Therapy for Substance Abuse	Green
Substance abuse: adult	Behavioral Day Treatment and Contingency Managed Housing and Work Therapy	Yellow
Substance abuse: adult	Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women	Yellow
Substance abuse: adult	Brief Alcohol Screening and Intervention of College Students	Green
Substance abuse: adult	Brief Marijuana Dependence Counseling	Green
Substance abuse: adult	Brief Motivational Interviewing for Alcohol Use	Red
Substance abuse: adult	Brief Negotiation Interview for Harmful and Hazardous Drinkers	Green
Substance abuse: adult	Brief Strengths-Based Case Management for Substance Abuse	Green
Substance abuse: adult	Broad Spectrum Treatment and Naltrexone for Alcohol Dependence	Yellow
Substance abuse: adult	Buprenorphine maintenance treatment	Green
Substance abuse: adult	Celebrating Families!	Yellow
Substance abuse: adult	Challenging College Alcohol Abuse	Yellow
Substance abuse: adult	Checkpoint Tennessee	Green
Substance abuse: adult	Cocaine-Specific Coping Skills Training	Green
Substance abuse: adult	College Drinker's Check-up	Green
Substance abuse: adult	Community Reinforcement + Vouchers Approach	Green
Substance abuse: adult	Community Reinforcement Approach	Yellow
Substance abuse: adult	Computer-Assisted System for Patient Assessment and Referral	Green
Substance abuse: adult	Contracts, Prompts, and Reinforcement of Substance Use Disorder Continuing Care	Green
Substance abuse: adult	COPE: Collaborative Opioid Prescribing Education	Yellow
Substance abuse: adult	Creating Lasting Family Connections	Green
Substance abuse: adult	Customized Employment Supports	Yellow
Substance abuse: adult	Double Trouble in Recovery	Yellow
Substance abuse: adult	Drinker's Check-up	Yellow
Substance abuse: adult	Enough Snuff	Green
Substance abuse: adult	Healthy Living Project for People Living With HIV	Green
Substance abuse: adult	Healthy Workplace	Yellow

Substance abuse: adult	Helping Women Recover & Beyond Trauma	Green
Substance abuse: adult	InShape	Yellow
Substance abuse: adult	Interactive Journaling	Yellow
Substance abuse: adult	Interim Methadone Maintenance	Green
Substance abuse: adult	Living in Balance	Green
Substance abuse: adult	Matrix Model for Adults	Yellow
Substance abuse: adult	Methadone maintenance treatment	Green
Substance abuse: adult	Modelo de Intervención Psicomédica (Psycho-Medical Intervention Model)	Yellow
Substance abuse: adult	ModerateDrinking.com and Moderation Management	Green
Substance abuse: adult	Modified Therapeutic Community for Persons With Co-Occurring Disorders	Green
Substance abuse: adult	Motivational enhancement therapy	Green
Substance abuse: adult	Motivational interviewing	Green
Substance abuse: adult	MyStudentBody.com	Yellow
Substance abuse: adult	Naltrexone for federal probationers	Yellow
Substance abuse: adult	Network Support Treatment for Alcohol Dependence	Green
Substance abuse: adult	Network Therapy	Yellow
Substance abuse: adult	Oxford House Model	Yellow
Substance abuse: adult	Parent-Child Assistance Program	Yellow
Substance abuse: adult	Prize-based Incentive Contingency Management for Substance Abusers	Green
Substance abuse: adult	Project Link	Yellow
Substance abuse: adult	Reinforcement-Based Therapeutic Workplace	Green
Substance abuse: adult	Relapse Prevention Therapy	Green
Substance abuse: adult	Seeking Safety for Adults	Green
Substance abuse: adult	Service Outreach and Recovery	Yellow
Substance abuse: adult	Staying Free	Green
Substance abuse: adult	STEPS Comprehensive Alcohol Screening and Brief Intervention Program	Yellow
Substance abuse: adult	Supportive-Expressive Psychotherapy	Green
Substance abuse: adult	TCU Mapping—Enhanced Counseling for Substance Users	Green
Substance abuse: adult	Team Awareness	Green
Substance abuse: adult	Telephone Monitoring and Adaptive Counseling	Green
Substance abuse: adult	Training for Intervention ProcedureS for the University	Green
Substance abuse: adult	Twelve Step Facilitation Therapy	Green
Substance abuse: adult	Wellness Initiative for Senior Education	Green
Substance abuse: adult	Family Behavior Therapy for Adults	Green

Source: Results First Clearinghouse Database



Appendix D: Other Policy Recommendations

2011 New Mexico Drug Policy Task Force:

- The creation of a high level central office charged with developing and administering a comprehensive statewide addiction prevention, harm reduction, and treatment system;
- Need for a comprehensive inventory and map of behavioral health and substance abuse disorder services;
- Deployment of proven cost-savings strategies for prevention of alcohol abuse; and
- Making substance abuse treatment effective and available.

Previous LFC program evaluations:

- Strengthen oversight of the statewide entity's monitoring of program integrity;
- Direct the process by which information will be exchanged between the statewide entity and the MCOs to ensure BHSD has consistent data to administer the system and ensure consumer services are efficient and timely;
- Require the statewide entity and Centennial Care MCOs to provide more detailed analyses of financial, service utilization, and provider access information for monitoring of behavioral health system performance and to target resources appropriately;
- Establish performance measures in MCO contracts which would aid in monitoring the level of provider oversight for program integrity by MCOs;
- Develop a minimum provider outcome data set to present to the Legislature, to display on public websites, or to provide to the public on request; and
- Prioritize service funding to evidence-based practices.

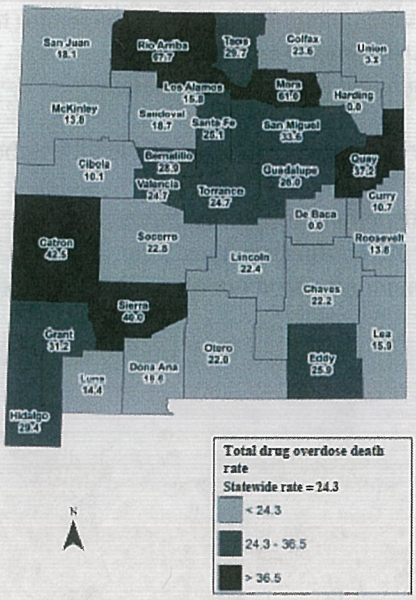
July 2014 State epidemiologist report to the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee

- Make use of data on deaths to target high risk areas;
- Promote evidence-based prevention strategies; and
- Assess and address treatment infrastructure gaps in New Mexico.

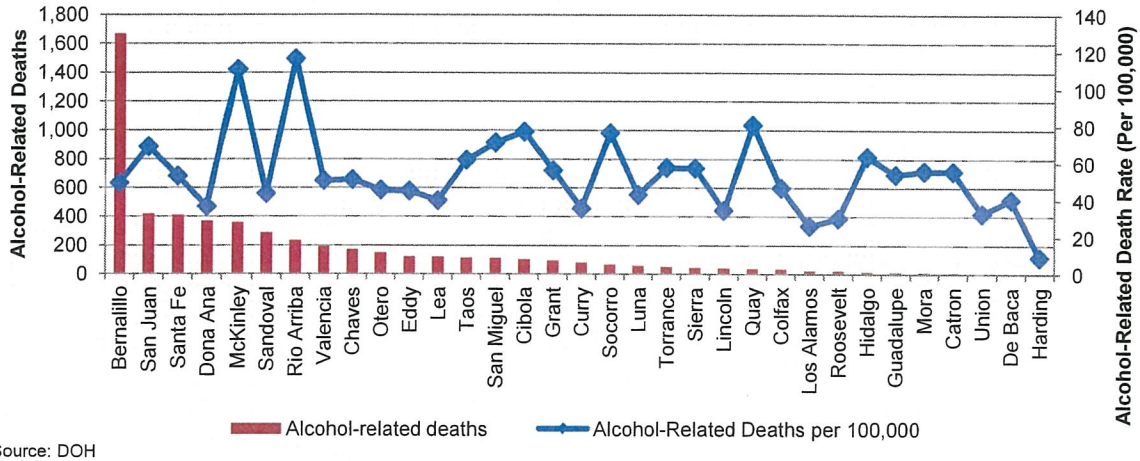
Appendix E: Investment Zone Examples

- Map Outcomes. Within the state, DOH has high quality data on the occurrence of mental health and substance abuse levels on a county level. For example, based on DOH data, we know that substance abuse varies throughout the state. According to DOH, the highest numbers of alcohol-related deaths are in Bernalillo County whereas the highest rates of alcohol-related deaths are in Rio Arriba County, a relatively rural area of the state. Attention should be placed on balancing high rates versus high numbers of bad outcomes. For example, Albuquerque overall may have lower rates of certain outcomes due to the size of the population when compared to less populated counties. But certain areas of Albuquerque may represent serious problems and have numbers that far outpace other areas of the state.
- Directing resources based on a location specific risk assessment. Through the behavioral health collaborative and its member agencies and contracts, the state should identify current resources allocated by geographic regions, the types of services and programs available in communities and whether they are evidence-based. Combined with the mapping of outcomes and risk, the state could assess whether investments are appropriately targeted. The same process can be used for addressing the workforce needed to deliver evidence-based services and programs.

Total Drug Overdose Deaths per 100,000



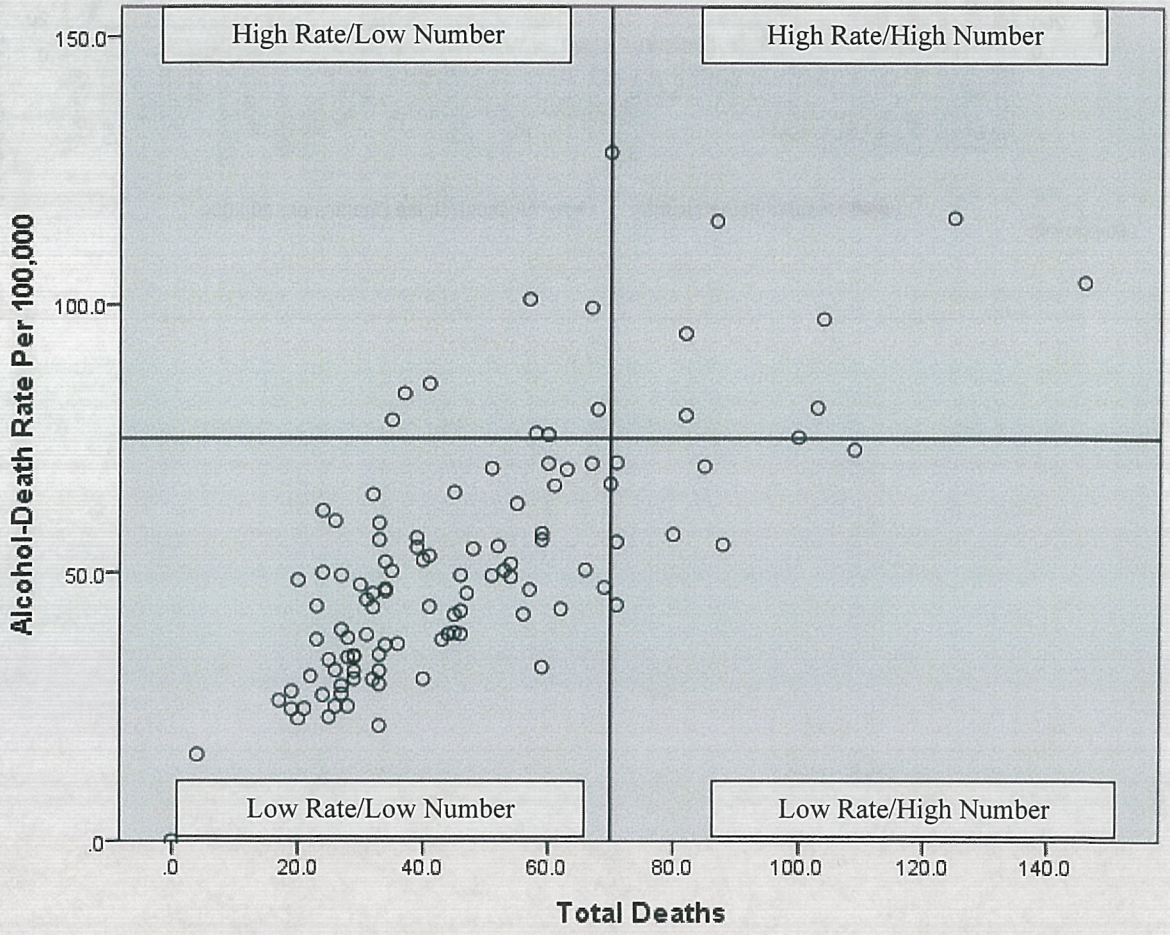
New Mexico Alcohol-Related Deaths and Alcohol-Related Death Rates 2008-2012
(rate per 100,000)



Source: DOH

DOH data is available for small areas of the state on a sub-county level. Sub-counties areas are somewhat similar in population but differ in geographic size. For example, data exist for the small areas, identifying alcohol-death rate and number of deaths. An analysis based on death rate and deaths could be beneficial in identifying the most problematic areas of the state. Plotting data based upon rate and number to identify areas with alcohol-death rate and number of deaths provides a better picture of high-risk, high-needs areas.

Scatterplot By Alcohol-Related Death Rate and Total Alcohol-Related Deaths By DOH Designated Small Area (2005-2009)



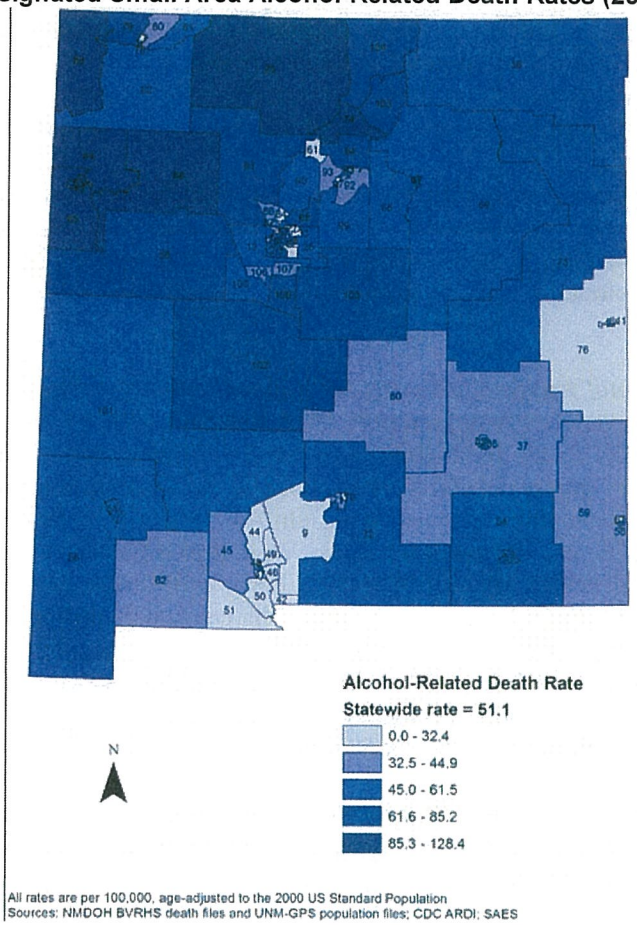
The small areas that fall into the high rate/high number category for alcohol-related deaths include (see corresponding Table and Map below for location in New Mexico):

DOH Designated Small Area Alcohol-Related Death Rates and Deaths 2005-2009

DOH Small Areas Number	DOH Small Area Name	Alcohol-Related Death Rate Per 100,000	Alcohol-Related Deaths
1	Bernalillo County, Central Penn	80.7	103
8	Bernalillo County, Lomas Broadway	97.3	104
15	Bernalillo County, Central Coors	79.3	82
38	Cibola County	75.2	100
63	McKinley County, Gallup	116.2	125
65	McKinley County, SW	94.6	82
66	McKinley County, SW	128.4	70
74	Rio Arriba, Espanola and Pueblos	104.2	146
83	San Juan County, West	115.6	87

Source: DOH

DOH Designated Small Area Alcohol-Related Death Rates (2005-2009)



Appendix F: Evidenced-Based Practices for Substance Abuse and Mental Health Disorders.
(* indicates program available in New Mexico)

Although some of the evidenced-based practices for the treatment of mental illness and substance abuse disorders identified by the Washington State Institute for Public Policy are available in New Mexico, access is limited and oversight of program fidelity is lax for many programs. Programs available in New Mexico are identified by an asterisk (*). Others may be available but are buried in generic individual therapy codes and specific treatment interventions cannot be identified.

Assertive Community Treatment (ACT). ACT is a treatment and case management approach that includes the following key elements: a multidisciplinary team that includes a medication prescriber, direct service provided by team members, caseloads that are shared between team members, services provided in locations convenient for the patient, and low patient-to-staff ratios.

Cognitive Behavioral Therapy (CBT). CBT is a form of treatment that focuses on examining the relationships between thoughts, feelings, and behaviors. By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, people with mental illness can modify their patterns of thinking to improve coping. CBT is a type of psychotherapy that is different from traditional psychodynamic psychotherapy in that the therapist and the patient will actively work together to help the patient recover from their mental illness. People who seek CBT can expect their therapist to be problem-focused and goal-directed in addressing the challenging symptoms of mental illnesses. Because CBT is an active intervention, one can also expect to do homework or practice outside of sessions.

Collaborative care management for depression and depression with co-morbid medical conditions is primarily provided by care coordinators within managed care organizations to ensure collaboration between physical and behavioral health consumer issues. This is not a service which is billed by the organization, but is a contractual obligation for the medical and behavioral health entities covered through administrative fees.

Illness Management and Recovery refers to those services which employ a broad range of strategies to help individuals with mental health or substance abuse disorders collaborate with professional caregivers, reduce their susceptibility to the illness, and cope effectively with their symptoms. Recovery support services are delivered by professionals or peers focusing on improvement of self-esteem and to foster skills that help people pursue their personal goals. In New Mexico, much of the focus for recovery and resiliency has been on the use of peer specialists. These individuals have self-identified themselves as consumers of behavioral health services. The state has a certification program for peer specialists for individuals working in a certified agency to interact with consumers having severe mental illness. Peers who are not certified can provide services in other venues such as drop-in centers, self-help groups, and other consumer operated activities. Peers are valued in the recovery system because they have experienced the same life obstacles as those they mentor and have mastered the ability to manage their symptoms and improve their overall life experiences.

Individual placement and support for individuals with serious mental illness focuses on vocational services for individuals with serious mental illness, considering client interests, competitive employment, rapid placement, and on-going support.

Mental Health Courts. Mental health courts, modeled after other therapeutic courts (e.g., drug courts, DUI courts), divert offenders with mental health issues from incarceration to treatment in the community or serve as a condition of release from incarceration. These courts utilize mental health assessments, individualized treatment plans, intensive case management, and judicial monitoring to provide participants with the resources needed to avoid criminal behavior while improving public safety. In some courts, charges are dropped with successful completion of the program. Programs can vary in length sometimes up to 24 months. New Mexico has five mental health courts, the design of which is determined by individual courts.

Mobile Crisis Response. Two types of mobile crisis interventions have been deemed evidenced based: an interdisciplinary team who was dispatched after consumers call a mental health hotline or a 911 mobile response team staffed by police and psychiatric nurses.

Peer Support for Serious Mental Illness. Peer Support is a component of a comprehensive service including a peer support specialist as a member of the treatment team. (See Illness and Recovery above).

Primary Care- behavioral health co-located in community-based and integrated care settings. Primary care services are co-located in behavioral health setting in support of comprehensive coordination of all health care.

Post-Traumatic Stress Disorder (PTSD) Prevention Following Trauma. CBT treatment to persons in the first weeks and months following trauma, before a diagnosis of PTSD can be made. Treatments involve five to ten hours of individual therapy combining education on effects of trauma, relaxation, and exposure.

Supported Housing for Chronically Homeless Adults. Supported housing includes programs which provide permanent supportive housing to chronically homeless single adults. Most research studies reviewed to determine cost-benefit used the Housing First model which provides independent apartments with no specific requirements for abstinence or treatment. Programs typically provide intensive case management and services. Housing is in independent apartments; participants hold the lease but receive subsidies to pay rent.

Brief Intervention. Brief Intervention is a comprehensive, integrated public health approach to the delivery of services for persons with substance abuse disorders or at risk of developing these disorders. Services are delivered in primary care settings, ERs, college campuses, and other community settings. Screening and assessment determines illness severity and identifies the appropriate level of intervention. Brief intervention or brief treatment is provided. The counselor motivates and refers those who need more intensive services.

12-Step Facilitation Program. A 12-step program is a standalone program such as Alcoholics and Narcotics Anonymous which encourages a client's active participation working through the 12 steps which serve as the guiding principle for the programs. The use of a sponsor to aid the consumer in abstinence mimics the peer support model.

Behavioral Self-Control Training. Behavioral self-control training is a standalone treatment used to pursue a goal of moderate or non-problematic drinking rather than complete abstinence.

Community Re-Enforcement with Vouchers. Known in New Mexico as Access to Recovery, the program provides clinical and recovery-support services to individuals with substance abuse issues. Individuals who are deemed eligible through an intake process are issued treatment and recovery support vouchers for services. The process allows clients to choose their provider, including such services as massage, pastoral counseling, and fitness programs.

High and Low Cost Contingency Management and Day Treatment for Abstinence Contingencies on Vouchers. The programs reward individuals for attending treatment or abstaining from drug use. The day treatment program combines day treatment with contingencies for negative urinanalysis which may include housing, minimum wage employment, subsidies for utilities, or personal hygiene items.

Dialectical Behavioral Therapy(DBT). DBT is a cognitive-behavioral treatment to treat those with severe mental disorders including chronically suicidal individuals often suffering from borderline personality disorder. DBT for substance abusers focuses on the following five main objectives: (1) motivating patients to change dysfunctional behaviors, (2) enhancing patient skills, (3) ensuring the new skills are used in daily life, (4) structuring the client's environment, and (5) training and consultation to improve the counselor's skills.

Family Behavioral Therapy. Family Behavior Therapy is a standalone behavioral treatment aimed at reducing substance use. Participants attend sessions with at least one family member, typically a cohabitating partner. The treatment consists of several parts including behavioral contracting, skills to reduce interaction with individuals and situations related to drug use, impulse and urge control, communication skills, and vocational or educational training.

Holistic Harm Reduction. The Holistic Harm Reduction Program is a treatment for those with drug abuse or dependence who are HIV positive. The primary goals are harm reduction, health promotion, and improving quality of life. These goals are achieved by providing the knowledge, motivation, and skills necessary to make choices that reduce harm to oneself and others. The treatment also addresses medical, emotional, social, and spiritual problems that can impede harm reduction. The treatment is generally provided in 12 group sessions.

Individual Drug Counseling Approach for the Treatment of Cocaine Addiction. The therapy is individual drug counseling for the treatment of cocaine addiction that can be provided as a component of comprehensive outpatient therapy or as a standalone treatment. The individual drug counseling approach follows a 12-step philosophy and addresses the physical, emotional, spiritual, and interpersonal needs of the client. The model is generally applied in 36 individual sessions over six months with booster sessions as needed.

Matrix IOP for Treatment of Stimulant Abuse (IOP). IOP is a multi-faceted approach to treatment services for individuals who require structure and support to achieve and sustain recovery. IOP targets specific behaviors with individualized interventions. Services should address both mental health and substance abuse disorders. Services are delivered in a multi-disciplinary approach. Duration is typically 3-6 months.

Node Link Mapping. Node-link mapping is a supplement or tool that can be used during counseling sessions. "Maps" are used as a means of visually representing a client's needs, problems, and solutions and act as a communication tool that provides an alternative way to facilitate discussion between client

and counselor. These maps can also directly illustrate cause-and-effect patterns of drug use to facilitate problem solving.

Seeking Safety. Seeking Safety is psychotherapy for trauma/PTSD and substance abuse. Seeking Safety is a standalone therapy designed to treat co-morbid trauma/PTSD and substance use disorders. Seeking Safety covers 25 topics, each independent of the others, and allows for flexible use (mixed thinking, behavior, and emotions; (2) treating trauma/PTSD and substance abuse at the same time; (3) a focus on ideals; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes (e.g. clinician self-care). Only a couple of programs in New Mexico identify Seeking Safety in their service array.

Supportive-Expressive Psychotherapy for Substance Abuse. Supportive-expressive psychotherapy is a time-limited therapy for use with individuals with heroin and cocaine addictions. The therapy is generally provided in an individual format and includes two components: supportive techniques to allow patients to feel comfortable discussing experiences and an expressive component to help patients understand problematic relationship patterns.

Relapse Prevention Therapy is an intervention approach to help patients anticipate and identity strategies to avoid using drugs and alcohol.

Buprenorphine and Buprenorphine with Naloxone Medication Assisted Therapy. Buprenorhpine or Buprenorphine-Naloxone is an opiate substitution treatment used to treat opioid dependence. It is generally provided in addition to counseling therapies. Buprenorhpine/Buprenorphine-Naloxone suppresses withdrawal symptoms and blocks the effects of opioids. The addition of Naloxone reduces the probability of overdose and reduces misuse by producing severe withdrawal effects if taken any way except sublingually. The drug is generally given during the maintenance phase. Buprenorphine and Buprenorphine/Naloxone are alternatives to methadone treatments.

Methadone Maintenance Treatment Medication Assisted Therapy. Methadone is an opiate substitution treatment used to treat opioid dependence. It is a synthetic opioid that blocks the effects of opiates, reduces withdrawal symptoms, and relieves cravings. Methadone is dispensed in outpatient clinics that specialize in methadone treatment and is often used in conjunction with behavioral counseling approaches.

Appendix G: NEW MEXICO Selected Drug Use, Perceptions of Great Risk, Average Annual Marijuana Initiates, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, and Past Year Mental Health Measures in *New Mexico*, by Age Group: Estimated Numbers (in Thousands), Annual Averages Based on 2011-2012 NSDUHs

Age	Ages 12 to 17	Age 18+
ILLICIT DRUGS	Number (in thousands)	Number (in thousands)
Past Month Illicit Drug Use[1]	23	169
Past Year Marijuana Use	33	213
Past Month Marijuana Use	17	139
Past Month Use of Illicit Drugs Other Than Marijuana[1]	9	56
Past Year Cocaine Use	2	33
Past Year Nonmedical Pain Reliever Use	14	78
Perception of Great Risk of Smoking Marijuana Once a Month	42	472
Average Annual Number of Marijuana Initiates[2]	11	9
ALCOHOL	Number (in thousands)	Number (in thousands)
Past Month Alcohol Use	21	775
Past Month Binge Alcohol Use[3]	13	351
Perception of Great Risk of Drinking Five or More Drinks Once or Twice a Week	65	718
TOBACCO PRODUCTS		
Past Month Tobacco Product Use[4]	19	424
Past Month Cigarette Use	14	363
Perception of Great Risk of Smoking One or More Packs of Cigarettes per Day	112	1,129
PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT[5]	Number (in thousands)	Number (in thousands)
Illicit Drug Dependence[1]	5	31
Illicit Drug Dependence or Abuse[1]	11	42
Alcohol Dependence	3	53
Alcohol Dependence or Abuse	8	116
Alcohol or Illicit Drug Dependence or Abuse[1]	16	146
Needing But Not Receiving Treatment for Illicit Drug Use[1,6]	10	37
Needing But Not Receiving Treatment for Alcohol Use[6]	7	111
PAST YEAR MENTAL HEALTH	Number (in thousands)	Number (in thousands)
Had at Least One Major Depressive Episode[7,8]	20	131
Serious Mental Illness[8,9]	--	72
Any Mental Illness[8,10]	--	300
Had Serious Thoughts of Suicide	--	61

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006. See Section B.4.8 in Appendix B of the *Results from the 2008 National Survey on Drug Use and Health: National Findings*.

[2] *Average annual number of marijuana initiates* = $X_1 \div 2$, where X_1 is the number of marijuana initiates in the past 24 months.

[3] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

[4] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.

[5] Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[6] Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs (or alcohol), but not receiving treatment for an illicit drug (or alcohol) problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

[7] Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which specifies a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from persons aged 18 or older to produce an estimate for those aged 12 or older.

[8] For details, see Section B of the "2011-2012 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at http://www.samhsa.gov/data/NSDUH/2k12State/NSDUHsae2012/Index.aspx.

[9] Serious mental illness (SMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and resulted in serious functional impairment.

[10] Any mental illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011 (SMI and AMI Estimates Revised October 2013) and 2012.