

Senate Joint Memorial 4 Task Force Recommendations

December 2015

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Table of Contents

Introduction.....	1
Characteristics of the Target Population.....	2
Recommendations.....	3
1. Identify the relevant inmate population and assess their risks and needs.....	3
2. Inventory available community resources and gaps in needed resources.....	5
3. Provide for release from detention supported by wrap around services.....	6
4. Provide for release from detention with services that include housing.....	8
5. Create secure clinical facilities to serve “gap” population.....	10
6. Educate stakeholders regarding benefits of supportive treatment for individuals living with serious mental illness and available tools for release.....	12
Appendices.....	14
Number of Seriously Mentally Ill in NM Facilities.....	14
Criterial Checklist - Serious Mentally Ill.....	15
Core Service Agency Sites.....	17
Psychiatric Beds by City.....	19
Housing Chart Showing Chronic Homelessness.....	20
List of Members.....	21
Memorial.....	23

Senate Joint Memorial 4

The challenge for this task force is to study and make recommendations for clinically appropriate housing options for individuals with serious mental illness who are in custody in county detention facilities.

Senator Sander Rue,
SJM 4 Sponsor

Introduction

Protracted length of stay in detention for people with serious mental illness comes at substantial human as well as financial cost. Senate Joint Memorial 4, sponsored by Sander Rue in the 2015 regular legislative session, created this task force (Task Force) charged with recommending clinically appropriate housing options for individuals with serious mental illness who are in custody in county detention facilities¹.



Jails are used for holding because we don't know what else to do with some defendants.

Angela "Spence" Pacheco,
1st Judicial District Attorney

As elsewhere in the country, jails have become the *de facto* mental health hospitals for the state. The state hospital, the New Mexico Behavioral Health Institute, houses on average 80 individuals in its adult psychiatric unit and 50 in its forensic unit². In addition, there are a combined total of 491 psychiatric beds in 14 hospitals statewide. Using statistics from the Metropolitan Detention Center in Bernalillo County³, it can be estimated that approximately 35% of our county jail population (2,557 statewide on any given day) are on prescribed psychotropic medication and even more have a mental health diagnosis that isn't treated with medication. According to a study performed by the New Mexico Sentencing Commission in 2012, simply having a mental illness increases length of stay by 36 days and having a very serious mental health diagnosis such as a psychotic disorder increases median length of stay by 121 days when compared with inmates charged with the same crime who are the same age and gender.⁴ When competency is challenged, length of stay increases even more dramatically.⁵ The medium length of stay for someone whose competency is challenged but who is found competent (72.6% of the inmates evaluated) is 332 days (11 months). The median length of stay for someone who is found incompetent is 537 days (18 months).⁶

The Task Force and a smaller steering committee met throughout the summer to consider and vet recommendations. The final recommendations identify and assess the needs of the target inmates, match those needs with identified community resources through individualized plans providing for wrap around services and prompt release. The Task Force also recommends creating regional secure clinical facilities for identified individuals who are not released and who do not meet the criteria for commitment to state hospital as part of the criminal competency process and cannot be committed involuntarily in a civil commitment proceeding because of the pending criminal proceedings.

The appendix of this report assembles information that can be used to further develop and implement these recommendations.

Grace Philips, SJM4 Task Force Chair
New Mexico Association of Counties General Counsel



Recommendations The Task Force reached consensus on 6 interrelated recommendations ⁷	Page
Identify the relevant inmate population and assess their risks and needs.	4
Inventory available community resources and gaps in needed resources.	5
Provide for release from detention supported by wrap around services.	7
Provide for release from detention with services that include housing	8
Create secure clinical facilities to serve “gap” population (as defined)	10
Educate stakeholders regarding benefits of supportive treatment for individuals living with serious mental illness and available tools for release	13

¹ New Mexico is one of only two states in the country where there are more people held in jails than in prison. A one-day comparison from June 2013 showed that there were nearly 1,000 more men (7,030 versus 6,043) and more than twice as many women (1,405 versus 652) in New Mexico county jails than held by the New Mexico Corrections Department. This is despite the fact that jails are designed for short-term stay and rapid high turnover. The median length of stay is 147 days, but a majority of individuals booked into county detention facilities are released within 48 hours and ¾ are released within 14 days. The volume of people who pass through county jails is staggering. Although the average daily county jail population for fiscal year 2015 was approximately 7,305, there were more almost 100,000 individuals booked into county jails during the same period.

² The New Mexico state hospital has 116 licensed forensic beds 64 of which are currently operational and 121 adult psychiatric beds of which 96 are currently operational.

³ MDC, the largest county detention facility in the state, averaged 473 inmates per day on its mental health caseload during the first 6 months of this year. Of these inmates, an average of 110 were housing in the facility’s psychiatric unit.

⁴ <http://nmsc.unm.edu/reports/2013/effect-of-mental-health-diagnoses-on-length-of-stay-in-two-new-mexico-detention-facilities.pdf>

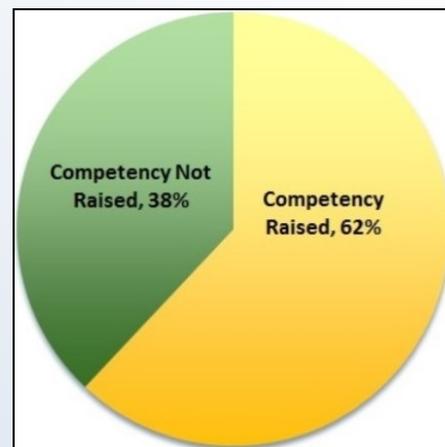
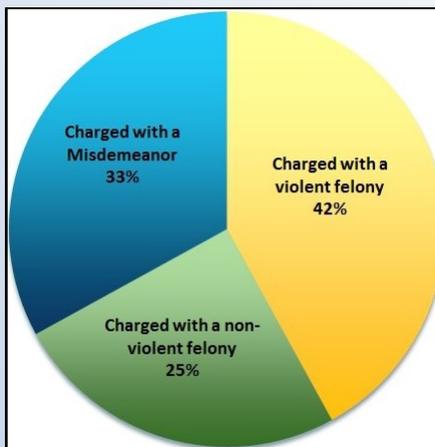
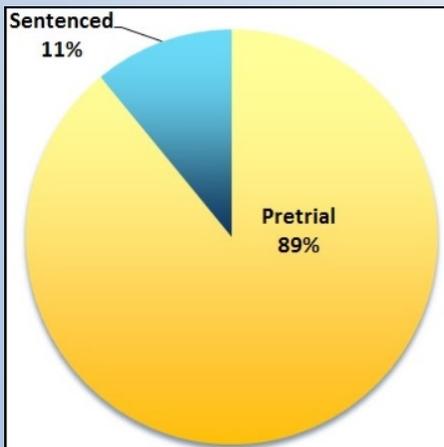
⁵ <http://nmsc.unm.edu/reports/2012/final-update-length-of-stay.pdf>

⁶ <http://nmsc.unm.edu/reports/2013/effect-of-competency-and-diagnostic-evaluation-on-length-of-stay-in-a-sample-of-new-mexico-detention-facilities.pdf>

⁷ The Task Force decided to limit its recommendations to adult inmates because the greater problem exists with adult detention and the recommendations discussed were not readily transferable.

Characteristics of the Target Population

When New Mexico detention administrators were asked to identify those individuals with the most serious mental illness who could not be appropriately managed in their detention facilities during the first six months of 2015, they identified 260 individuals. (appendix 1) The majority were nonviolent offenders held in pretrial detention. 28% were charged with battery on a peace officer, household member or healthcare worker. (13% Battery on a peace officer 11% Battery on a household member 4% Battery on a healthcare worker)



Recommendations

1. Identify the Population and Assess Their Risks and Needs

All individuals booked in county jails are screened for signs and symptoms of mental illness by booking staff. Individuals who are identified as having a possible mental health condition should be flagged for additional screening and release with services as appropriate.

What to Assess:

The Task Force is charged with recommending housing and services alternatives for individuals with serious mental illness (SMI) who are in custody. A definition for SMI has been agreed upon⁸ (appendix 2) and would also qualify the inmate for Medicaid services. Such a clinical diagnosis must be performed by a licensed mental health counselor, professional clinical counselor or other higher level clinician, and a clinical diagnosis alone is inadequate to determine the necessary services needed to support release from detention.

Jails have become the psychiatric crisis centers of first and last resort.

Matthew Elwell, CJM,
Luna County
Detention Administrator

The Task Force found that for appropriate linkages to resources to be achieved, a full spectrum of the inmate's needs must be identified. Assessments should include psychosocial, medical, and behavioral needs and strengths. Individuals with co-occurring disorders such as substance addiction must be included in the population served. Children of inmates who are affected by their incarceration must be identified so that their needs may also be addressed by the release plan. Information from law enforcement, detention facilities, health providers, the inmate and the

inmate's family must also be included in both the screening and release program planning. The inmate in particular can share what has and what has not worked for them in the past and consultation with the inmate will improve compliance with the plan that is developed.

How to Assess:

A specific person or team should be responsible for collecting and using all relevant information to create a fully informed release plan to support the inmate outside of detention. The Task Force felt that Core Service Agencies (CSAs) were well positioned to perform such enhanced assessments if adequate funding is provided. It is critical that assessment and planning occur promptly. Unfortunately, not every county will have health care providers qualified to perform the clinical diagnosis. Telemedicine may be useful for this purpose. However it is accomplished, the various screening and diagnostic information must be centralized and shared as appropriate to inform creation of the release plan.

Assessments should employ uniform methods for screening and identification of people with behavioral disorders in order to facilitate data collection as well as evaluation of programming. Mental health screening can be followed by an in depth psychosocial diagnosis as needed. Inmates often have prior medical documentation, including psychiatric evaluations that can expedite the process. Tools that are being successfully used in other jurisdictions include the ORAS (Ohio Risk Assessment System) <http://www.drc.ohio.gov/web/oras.htm>, which screens for criminogenic factors and the TCU (Texas Christian University) <http://ibr.tcu.edu/forms/tcu-drug-screen/>, which is a screening tool for substance use disorder. Both can be effective tools for mental health practitioners to screen individuals identified as having a mental illness for psychosocial needs, housing, employment, and amenability to treatment. Cultural sensitivity should be incorporated as well as attention to gender and age. The assessment process should engage inmates and their families (when appropriate and feasible) in assessing his or her own needs and should incorporate addressing those needs into the plan. Consultation with family members will add further insight and assist in producing the most beneficial individualized plan. The inmate's expressed clinical and social needs should then be balanced against public safety risks and criminogenic factors.

Funding Possibilities:

State and county indigent funds, Medicaid (for individuals no longer in custody)

Role for Legislature:

Validated assessment tools are essential but also cost money to perform and interpret. Some states have moved to state funding of screening tools to support uniformity and the sharing of information. <http://uacnet.org/legislation/key-issue-justice-reinvestment/>. A funding stream should be established to enable existing community providers to perform assessments and create and oversee release plans.

⁸ Definition of Serious Mental Illness:

The Task Force agreed that the definition of serious mental illness (SMI) adopted by the NM Behavioral Health Collaborative earlier this year is appropriate to apply to the population within the scope of this report. It includes schizophrenia and other psychotic disorders, major depressive and bipolar disorder and other mood disorders, anxiety disorders, obsessive compulsive and related disorders, trauma and stressor-related disorders, eating disorders, somatic symptom and related disorders and dissociative disorders. It does not include brain injury or mental retardation. Although the Task Force was charged with addressing the needs of individuals with the most serious mental illness, it quickly realized that these recommendations could also serve a broader population that may not meet the clinical definition of SMI (appendix 2) but who are still vulnerable and not appropriate for incarceration.

2. Inventory Available Resources and Gaps

It is critical to inventory and assess community programs and other resources available to provide post-release services. Health and community provider systems must be clearly identified. There are existing lists that inventory available behavioral health resources throughout the state; however, they are not sufficiently comprehensive. The process of inventorying resources should also serve to assess available programs and identify gaps in needed services.

Individuals living with serious mental illness who are involved with the criminal justice system require a wide range of supports in order to be successful in the community. These include not only electronic monitoring, behavioral health treatment, medication management, chronic medical care and sometime treatment guardians, but also housing, skills based education, vocational training, transportation, food support, benefits management, social activities, and employment. While a lot of good work has been done in the area of inventorying behavioral health treatment services, the state lacks a truly comprehensive and current accounting of the spectrum of services available on a community by community basis that are needed along with identification of gaps in services that need to be addressed.

Resources to Include in Inventory:

All **housing resources** including a range of housing options that meet the particular needs of the individual such as permanent supportive housing, recovery/sober living, mental health transitional living services, residential treatment, group homes, assisted living, transitional living options, and family homes; **Intensive case management** including wrap around services that include support with taking medication, getting groceries, getting to doctor appointments, peer activities, as well as activities of daily living such as hygiene and paying bills; **Employment services** such as job training, coaching, and placement; The full spectrum of **mental health services** including individual and group counseling, supportive therapy, skills development, medication, assertive community based treatment for recovery and resiliency, drop-in centers, recreation, peer specialists, and crisis triage; **Peer groups** to serve as the glue between weekly sessions with clinicians; **Substance abuse services** that will work with a population that has mental illness, including those taking medication; **Transportation resources** including public transportation, transportation vans, transport staff for work, shopping, treatment and non-treatment appointments; **Benefits support** for enrollment in Medicaid, SSI/SSDI, health care insurance exchange, SNAP, Medicare, VA, and tribal benefits as appropriate; **Subsidized childcare** and other parenting support and family services; **Public health services** to address infectious disease, nutritional screenings, needle exchange; **Education & Training** to support return to school, certification and skill development; **Treatment guardian**; and **Criminal justice supports** such as electronic monitoring and community custody.

Prosecutors will use services to release defendants who can be safely managed in the community if those services exist and we know about them.

Angela "Spence" Pacheco,
First Judicial
District Attorney

Needed Services:

Housing
Job training/placement
Education
Transportation
Benefits
Medication Management
Medical Health Care
Public Health Care
Childcare
Parenting support
Treatment Guardians
Electronic Monitoring
Mental Health Services
Substance Abuse Services
Peer services

The Task Force endorses a state-funded, user friendly, continuously updated, 24/7 accessible, comprehensive website that incorporates the good work that has been done but expands the scope and includes real time updating so that information is always current and includes detailed information about the scope of services provided, including eligibility, cost, insurance, and contact information. The inventory should also be accompanied by an analysis of the gaps in services in each community so that work can be done to develop missing supports. Peer specialists, for example, have long been recognized as affordable and effective resources but they are not widely available. A gap analysis could identify where and how such services are needed and recommend funding, for example, for one on one peer interventions in addition to groups.

Many individuals who live with serious mental illness have dual diagnosis for substance use disorder. For wrap around services to be meaningful, they must serve dual diagnosis including accepting individuals with addiction and providing medication as prescribed. Certified peer counselors offer unique and effective support to individuals seeking recovery and employment of peers provides an incentive for sustained engagement with treatment. Family psycho-educational interventions may also be appropriate when family members can be incorporated into an ex-inmate's recovery.

Role for Legislature:

The Aging and Long Term Services, NM Crisis and Access Line, the UNM Center for Development and Disability, and Networks of Care Data System all maintain resource lists. Consider consolidating additional funding in an existing behavioral health resource entity to expand the scope of their resource lists, make them available on a user friendly continuously maintained state funded website, and support communities in identifying gaps in needed.

3. Provide for Release from Detention Supported by Wrap Around Services

Individuals with serious mental illness are more likely to be held and to be held for longer than similarly charged individuals who do not have a diagnosis. These recommendations propose that they be prioritized for release.

Grace Philips,
New Mexico
Association of Counties
General Counsel

Reducing the number of people with mental illness in jail is the first step in addressing the problem. The purpose of this recommendation is to provide for release under circumstances that will support sustained success in the community, reduce recidivism and protect public safety.

Once the individual is identified and a comprehensive list of available community resources compiled, a plan needs to be developed that offers eligible arrestees an opportunity to get out of jail and go into treatment. There are a number of ways such release programs can be managed. Mental Health courts exist in four of the larger communities statewide (Santa Fe, San Juan, and Sandoval counties and the city of Albuquerque, providing coverage for 63% of New Mexico residents according to: http://www.treatmentadvocacycenter.org/index.php?option=com_content&view=article&id=227&Itemid=162), and could be expanded to include pretrial supervision. In other communities, Core Service Agencies could contract to provide assessment, release planning, and oversight. There are Core Service Agencies (CSAs) in every county in the state (appendix 3) that are charged with providing

behavioral health services to the community. Interested CSAs are well situated to reach into their local detention facilities to identify and serve inmates with serious mental illness. Their scope of services could be crafted to provide services to individuals who are identified on booking in order to

County detention centers should partner with Core Service Agencies to divert people from jail instead of mandating CSAs to do it.

Chris Tokarski,
Executive Director
Mental Health
Resources Inc.

Diversion isn't a big deal but we need a place to divert in order to divert.

Angela "Spence" Pacheco,
1st Judicial District
Attorney

A release plan tied to available resources and benefits with evidence of treatment compliance could assist a Court considering conditional release for non-violent offenders who should be prioritized for supported release – even where there is a history of repeated criminal involvement or other court non-compliance.

Judge James Hudson,
5th Judicial District Judge

assess them using uniform tools and then connect them with services, using an individualized treatment/support plan for release. In communities where CSAs are not capable or willing, intensive care coordinators could be funded to go into the jails to perform these services. Identified services could also be accessed to enhance existing pretrial diversion programs. Court intervention is not required where the prosecutor agrees to drop charges in order to facilitate release into programming. Jail diversion programs should be expanded to address those held in custody where community resources are available.

The population of individuals with serious mental illness in jail can be reduced by increasing the availability of community mental health resources that will serve individuals with criminal histories and pending charges. Individualized plans for the treatment and services required to address an inmate's needs are a critical component of this recommendation. Connecting individuals with benefits is also essential in order for there to be sufficient resources to pay for the services. Medicaid expansion in New Mexico creates the opportunity for greater numbers of individuals to access medical and behavioral healthcare. Social security, SNAP, veterans' and other benefits can provide necessary resources to pay for services as well as food and shelter. Medicaid, SSI/SSDI, veteran, food stamp, and TANF benefit applications as appropriate should be initiated immediately.

Insufficient community based voluntary outpatient and residential treatment programs combined with aggressive policing of minor crimes and the absence of programs to divert people with mental health conditions who commit minor offenses from the criminal justice system only increase jail populations. Inadequate numbers of psychiatric beds in area hospitals exacerbates the problem.⁹ (appendix 4)

Inadequate transition planning compromises public safety and increases the incidence of psychiatric symptoms, hospitalization, relapse to substance abuse, suicide, homelessness and re-arrest. The level of treatment is key—more intervention is not necessarily better and can do harm for someone who does not need it. The most important task of the transition planner is to listen to the inmate to learn what has worked or not worked in the past and to plan accordingly. Collecting comprehensive information about and from the individual inmate and his or her family will make an appropriately individualized release plan possible.

Effective release planning can demonstrate to judges on both a case-by-case and system-wide level, how treatment programs that fail to meet the multiple needs of inmates with co-occurring disorders significantly reduce the likelihood of successful re-entry.

⁹ http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf

Medical adherence is critical to successful community integration and mechanisms should be developed to encourage and monitor medication compliance. Ideally medical stabilization would be initiated on booking with discharge medications provided through community services using a warm hand-off from the jail. Program participation is voluntary, and release into services as recommended by the Task Force is different from probation, parole, or other traditional supervised release.

Successful programs recognize that relapse is often part of recovery. Relapses should be expected and result in adjustments to the plan as opposed to termination from the program.

The Task Force discussed limiting participation to misdemeanants but decided that the specific circumstances of offenses involved as well as attributes of the individual inmate should be the determining factors for eligibility.

Role for Legislature and Other Policy Makers:

Some programs have restrictions on who they will serve and exclude the population addressed by this report. Funding should prioritize programs that accept individuals with mental illness, co-occurring disorders, criminal histories, and pending charges. Capacity can be built within existing Core Service Agencies or other local providers willing to serve the incarcerated population through a combination of state and local dollars. Medicaid expansion and SB 42, sponsored

by Senator Ortiz y Pino in 2015, will increase Medicaid enrollment and therefore access to critical funding to pay for medical and mental health care. Medicaid could also reinstate payment for targeted case management for people with serious mental illness.

Having services pick and choose who they are serving with state dollars limits their treatment outcome.

Rick Miera, Former State Representative

...the single most important thing a transition planner can do...is learn from the inmate what has worked or...not worked during past transitions and plan accordingly.

The APIC Model Report
National GAINS Center,
September 2002

We don't want to incarcerate this population but we are ill-equipped to effectively manage this population in the community.

Chief Sgambellone,
Los Alamos County
Police Department

4. Provide for Housing in Conjunction with Other Services

Housing for persons with serious mental illness should be available using a variety of models ranging from highly structured, professionally staffed to more autonomous arrangements. Housing instability disproportionately affects people leaving institutional stays. Individuals suffering from serious mental illness, alcohol dependency or past drug addiction are often denied housing based on criminal history or bad rental references; such individuals can often experience very significant barriers to housing.

Individuals entering or exiting the justice system encounter barriers to housing and services that negatively affect health outcomes and limit full integration into their communities.

Melissa Marcoline,
Supportive Housing
Coordinator, Behavioral
Health Services Division
NM HSD

Homelessness and in particular chronic homelessness which is linked to mental illness is a statewide problem.¹⁰ (attachment 5) Permanent supportive housing (PSH) is an evidence-based model that provides subsidized community-based housing, as well as services and supports like health care, case management, and employment assistance to very low income or homeless individuals. Housing is “permanent” because there is no time limit on how long housing can be utilized. In most programs, whether or not a resident chooses to access services and supports is not a condition of housing. However, participants may be required to commit to regular home visits that focus on housing stabilization supports and eviction prevention.

Housing without stabilization support often leads to termination of tenancy and an individual’s subsequent eviction that can further limit access to quality housing. Permanent supportive housing is key. Transitional living may also play an important role in expediting release while permanent housing is arranged.

Supportive housing could be sufficient for many individuals leaving detention but some will need housing that offers even more services in order to be successful. Half way houses, transitional housing, health homes, or residential treatment may be needed for homeless mentally ill individuals who need time to rebuild social skills before they are found more permanent placement in the community.

Arrest and detention is often the only path available to law enforcement in situations where people are not sufficiently ill to gain admission to a hospital but too ill to be ignored. Where rates of homelessness are growing, it is increasingly difficult to avoid jail as a substitute for housing. The cost per night of Linkages beds, however, averages \$19.60 significantly less than the estimated \$61.00 to \$123.00 per night per diem estimated for county detention beds.

Inmates with co-occurring disorders who are homeless or at risk of homelessness should be prioritized for community low-income and supportive housing resources because the stability of these individuals is both a clinical and a public safety concern. The concept of behavioral health homes, residential treatment, and other models are extremely important as not all individuals will be able to manage successfully (at least initially) using supportive housing. Residential treatment that accepts individuals with addiction and provides medication management is key for the population.

Funding:

Federal Continuum of Care Homeless Assistance Programs, New Mexico Linkages, SSI/SSDI, grants, federal, state or local government funding including county indigent funds.

Housing is a health intervention not an amenity or add on and criminal convictions are barriers to housing.

Melissa Marcoline,
Supportive Housing
Coordinator, Behavioral
Health Services Division
NM HSD

¹⁰ SM 44 (2015) also sponsored by Senator Sander Rue recently resulted in recommendations regarding supportive housing and other solutions.

Role for Legislature and Other Policy Makers:

Increase or create funding for permanent supportive housing that targets individuals being released from custody and that will accept individuals living with both serious mental illness and substance addiction. Provide for Medicaid funding of adult residential care. Fund additional Linkages beds to meet the needs of mentally ill people who can live independently with support services. Create a unified message on the need for housing of all citizens and remove landlord incentives to exclude the population addressed by this report.

One thing that is happening is that at the same time local governments are trying to house this population, another arm of the same government is encouraging and incentivizing landlords to exclude this population... The government needs to send a single message on the need to provide housing for all of its citizens.

Lisa Simpson,
Technical Advisor to the Adult Detention Reform Coordinator

5. Create Secure Clinical Facilities to Serve “Gap” Population

Programs that provide for release or diversion with services will not serve all individuals who are in custody in county jails and who have serious mental illness. A secure alternative must be created to care for the individuals who are not released due to their charges, lack of community services, severity of their condition, and/or because of safety. Currently, there is no appropriate alternative for this “gap” population.

The rules and regimes that define corrections and detention are counter-therapeutic and potentially harmful to the mental as well as physical well-being of someone with a serious mental illness. Many inmates with mental disabilities deteriorate behind bars where their symptoms worsen. Mental health treatment is subordinate to custodial and security concerns and is provided to meet the constitutional requirement prohibiting deliberate indifference to an inmate’s serious mental health condition as well as to facilitate security.

Therapeutic detention should be provided to serve individuals with serious mental illness who are not released back into the community pending trial or following sentencing.

The gap population identified by the Task Force consists of individuals who are vulnerable and extremely high need but who are charged with a violent felony, still awaiting a competency determination, or are otherwise not appropriate for or likely to be released. These are the individuals who stay in detention the longest.

The effect of competency proceedings on length of stay cannot be overstated. According to a study performed by the NM Sentencing Commission in 2012, the competency process extends the median length of stay to 11—18 months. <http://nmsc.unm.edu/reports/2013/effect-of-competency-and-diagnostic-evaluation-on-length-of-stay-in-a-sample-of-new-mexico-detention-facilities.pdf>.

We have many seriously mentally ill who do not meet the criteria of being more likely than not in the near future (i.e. days) to be at serious risk of great bodily harm to themselves or others. However, these non-emergency people may be suffering terribly.

Dr. Merrit Ayad,
Santa Fe County
Adult Detention Center

The average duration of adult competency proceedings varies greatly throughout the state: from 41 days for closed cases in Bernalillo County Metropolitan Court to 318 days for FY15 cases still pending in Colfax County in the 8th Judicial District.

Judicial District	Days to Process
1st Judicial District	151 days
2nd Judicial District	130 days
3rd Judicial District	89 days
4th Judicial District	131 days
5th Judicial District	156 days
6th Judicial District	90 days
7th Judicial District	153 days
8th Judicial District	163 days
9th Judicial District	180 days
10th Judicial District	143 days
11th Judicial District	149 days
12th Judicial District	170 days
13th Judicial District	154 days
Metropolitan Court	49 days

Jails are not licensed healthcare providers. Consensus of the Task Force was that the proposed facility should be “treatment first” but also secure. It could not be a hospital because hospitals are restricted on who they can admit and under what circumstances. A therapeutic jail would hold individuals in custody against their will. Individuals in this population would not necessarily be at imminent risk to themselves or others and would also not be eligible for treatment to competency at the state hospital. The proposed facility also should not be a detention facility because of the incompatibility of detention with recovery.

This is a resource that does not exist in New Mexico and would therefore need to be clearly defined. The Task Force recommends that such facilities not be part of a detention facility, but operate under a chain of command that prioritizes treatment and therapeutic amenities. There was no consensus about whether such facilities should be operated by the state, local government or under regional authorities, but concern was voiced about housing them under corrections or another public safety department. A juvenile model considered by the steering committee is the Mendota Mental Health Institute Juvenile Treatment Center in Wisconsin in which high risk youth convicted of violent offenses serve their sentence in a program administered by the Wisconsin Department of Health Services/Division of Mental Health and Substance Abuse Services while in custody of the Division of Juvenile Corrections. Other ideas include making the facility a full spectrum behavioral health services facility with non-secure residential treatment areas, out-patient, crisis triage, day reporting activities, vocational services, and other community resources. Miami, Florida is currently renovating a former hospital to serve as such a facility. Other communities have built or renovated former detention facilities to provide secure therapeutic services for individuals with substance addiction serving time for related offenses. Operating procedures could reflect forensic unit operations at the state hospital but would not be able to be licensed as a hospital in order to serve the desired population.

Licensed hospitals need legal authority to house someone for treatment.

Dr. Grey Clark,
Behavioral Health
Medical Director,
Presbyterian Health
Plan

This new hybrid facility would meld detention with treatment holding treatment as the priority. The Task Force recommends an operation that looks a lot like the state hospital forensic unit: clinical teams, primary care doctors, detoxification protocols, psycho social rehabilitation, use of peer specialists, dental care, lessons in money management, vocational skills, intensive discharge planning and psychiatric technicians instead of correctional officers. Assignment to the facility would be a classification decision and individuals whose charges are resolved would no longer be eligible to stay. Although transportation and travel time to regional therapeutic facilities was raised

as a concern, the consensus was that the limited size and high need characteristics of this population required at least regional facilities.

The cost of operations for such a facility would be greater than the average per diem cost for detention. The average FY2014 operating cost per bed for the New Mexico Behavioral Health Institute forensic unit was \$365.72 per day, and the average daily cost per bed for the adult civil unit was \$516.12.

Role of Legislature:

To accomplish this recommendation, the legislature would need to create laws and redefine the laws that affect everything from building codes to admitting procedures and to licensing standards, in order to create a new facility model that currently does not exist, and which will accept inmate patients who need specific treatment in a specialized setting. Funding would not be available through Medicaid because the facility would be secure custodial and therefore not qualify as inpatient hospitalization under current regulations. However, the state could explore whether operation of such a facility could be a value added service from the Managed Care Organizations (MCOs). The Task Force recommends that a feasibility study be performed and that a pilot facility be established.

As long as persons who are seriously mentally ill continue to be placed in county jails, special management must continue to be utilized. Currently it is the ONLY option. Simply put... seriously mentally ill persons do not belong in county jails.

Mark Caldwell,
Santa Fe County
Detention Administrator

6. Educate Stakeholders Regarding Benefits of Supportive Treatment for Individuals Living with Serious Mental Illness and Available Tools for Release

Education is critical to increase the likelihood of early release and reduce unnecessary use of detention for people living with serious mental illness.

Education regarding mental illness, available resources, the benefits of diversion on public safety, and other aspects of these recommendations is essential in order for these recommendations to be successfully implemented. Stakeholders need to be informed regarding available alternatives to detention and how they can improve public safety. Legislators and the general public need information regarding the fiscal and human cost of what we are doing now so that policy initiatives can be aligned in a way that makes sense. Courts, attorneys and families need education on the use and limitations of treatment guardians. Law enforcement needs training on how to deal with individuals in mental health crisis and education regarding available community resources that might offer an alternative to arrest and detention.¹¹ Detention staff need ongoing training regarding best practices for management of this high need population and also the availability of treatment guardian appointments in certain cases.

NAMI's In Our Own Voice program more than many of the other education programs I have been exposed to, brought to me a better understanding of what a person with a mental illness goes through.

Jim Ogle,
NAMI Albuquerque

¹¹ Good work is being done to improve existing crisis intervention training for law enforcement through a consent decree between the City of Albuquerque and the US Department of Justice in *United States of America v. the City of Albuquerque*, 1:14-cv-01025, Section VI, Crisis Intervention, B. Behavioral Health Training.

On a more individual level, families of incarcerated people need information about how to support them when they are released back into the community. Education regarding available community resources is also critical for all stakeholders including inmates who should have information regarding their own mental illness, how to deescalate themselves and deal with their mental health challenges.

Some existing courses offered by the National Alliance on Mental Illness (NAMI)¹² include:

- ◆ Family to Family
- ◆ NAMI Basics
- ◆ In Our Own Voice
- ◆ Provider Education
- ◆ Peer to Peer

People with lived experience provide a perspective that no one else can.

Nancy Koenigsberg,
Senior Attorney,
Disability Rights New Mexico

Peers should be recognized as a hugely important and underutilized resource for educating the full spectrum of stakeholders identified in this report as well as for providing support to individuals. In addition, Mental Health First Aid (MHFA) training is widely available in New Mexico where there are 139 certified instructors who delivered training to over 1,600 adults and youth during the first 8 months of this year and who have trained approximately 8,000 individuals in New Mexico over the last four years.¹³

Who should receive education?

- ◆ Legislators
- ◆ Law Enforcement
- ◆ Detention staff
- ◆ The Judiciary
- ◆ Prosecutors
- ◆ Defense counsel
- ◆ Probation/parole staff
- ◆ Medical/mental health staff

What should the education cover?

- ◆ Mental Health generally, including recovery and resiliency, stigma, de-escalation techniques, and how to communicate with individuals living with serious mental illness who are in crisis
- ◆ Inmate population, length of stay, and recidivism
- ◆ Available resources in the community to support diversion
- ◆ Evidence based information on diversion

Who should provide the education?

- ◆ Peers
- ◆ NAMI
- ◆ Mental Health First Aid Trainers
- ◆ Crisis Intervention (CIT) trainers
- ◆ Colleagues from communities with successful diversion programs
- ◆ NMAC and NM Municipal League
- ◆ Trained providers such as psychiatrists and psychologists

How would the education be funded?

- ◆ Grants
- ◆ Free Services
- ◆ General Fund

There should also be an opportunity for inmate education about their illness as well as family education. The education should have an eye to instilling a sense of hope for recovery for both inmates and staff. Wellness Recovery Action Plan (WRAP) Training for example is an evidence based practice for self-help.

Role of Legislature:

The legislature should fund comprehensive education and make available information to key stakeholders that supports implementation of these recommendations

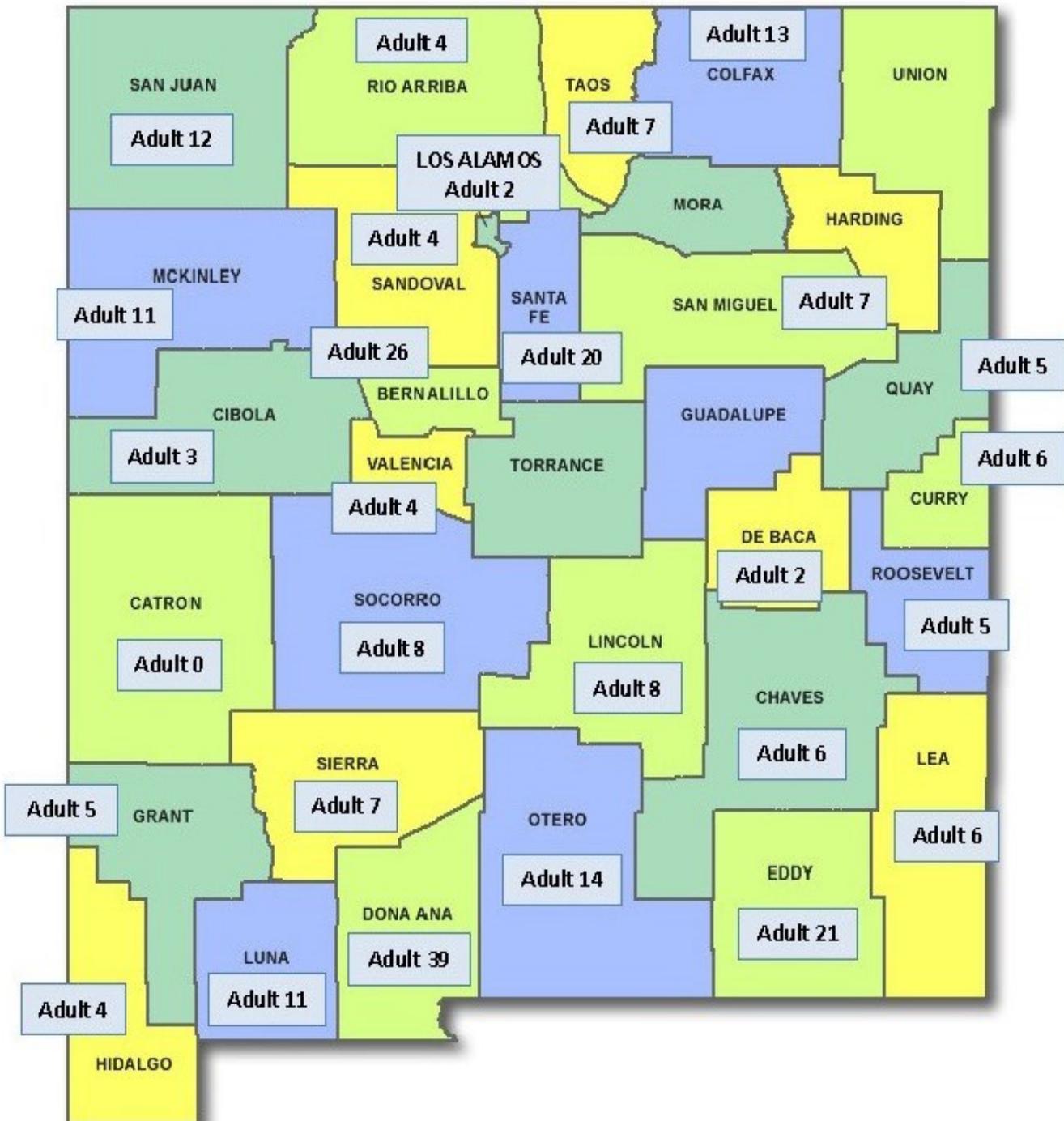
¹² For more information on NAMI programs go to: <https://www.nami.org/Find-Support/NAMI-Programs>

¹³ For more information on MHFA in New Mexico go to: <http://www.nmsoc.org/mhfa.html>

Appendices

Number of Seriously Mentally Ill in New Mexico Facilities

Individuals Housed from January 1, 2015 thru June 30, 2015
Total: 260



Serious Mental Illness (SMI) CRITERIA CHECKLIST



SMI determination is based on the age of the individual, functional impairment, duration of the disorder and the diagnosis. Adults must meet all of the following four criteria:

- 1. **Age:** Must be an adult 18 years of age or older.
- 2. **Diagnoses:** Have one of the diagnoses specified in the list below as defined under the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*. The diagnosis would need to have been determined within the prior 12 months by an appropriately credentialed and licensed professional.
- 3. **Functional Impairment:** The disturbance is excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 4. **Duration:** Expected duration of the disorder is to be six months or longer.

List of Diagnoses for #3 Above

Schizophrenia – 295.90 diagnoses

- Schizophrenia 295.90

Other Psychotic Disorders

- Delusional Disorder 297.1
- Schizoaffective Disorder 295.70
- Other Specified Schizophrenia Spectrum and Other Psychotic Disorder 298.8
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder 298.9

Major Depression and Bipolar Disorder

- Major Depressive Disorder 296.XX
- Bi-Polar Disorders 296.XX (all except Unspecified Bi-Polar and Related Disorder 296.80)

Other mood Disorders

- Cyclothymic Disorder 301.13
- Persistent Depressive Disorder 300.4

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Criteria Checklist - Serious Mental Illness

Anxiety Disorders

- Panic Disorder 300.01
- Generalized Anxiety Disorder 300.02

Obsessive Compulsive & Related Disorders

- Obsessive Compulsive & Related Disorders 300.3

Trauma and Stressor-Related Disorders

- Posttraumatic Stress Disorder 309.81

Eating Disorders

- Anorexia Nervosa 307.1
- Bulimia Nervosa or Binge Eating Disorder 307.51

Somatic Symptom and Related Disorders

- Conversion Disorder 300.11
- Somatic symptom Disorder 300.82
- Factitious Disorder Imposed on Self 300.19
- Borderline Personality Disorder 301.83

Dissociative Disorders

- Dissociative Amnesia 300.12
- Dissociative Identify Disorder 300.14

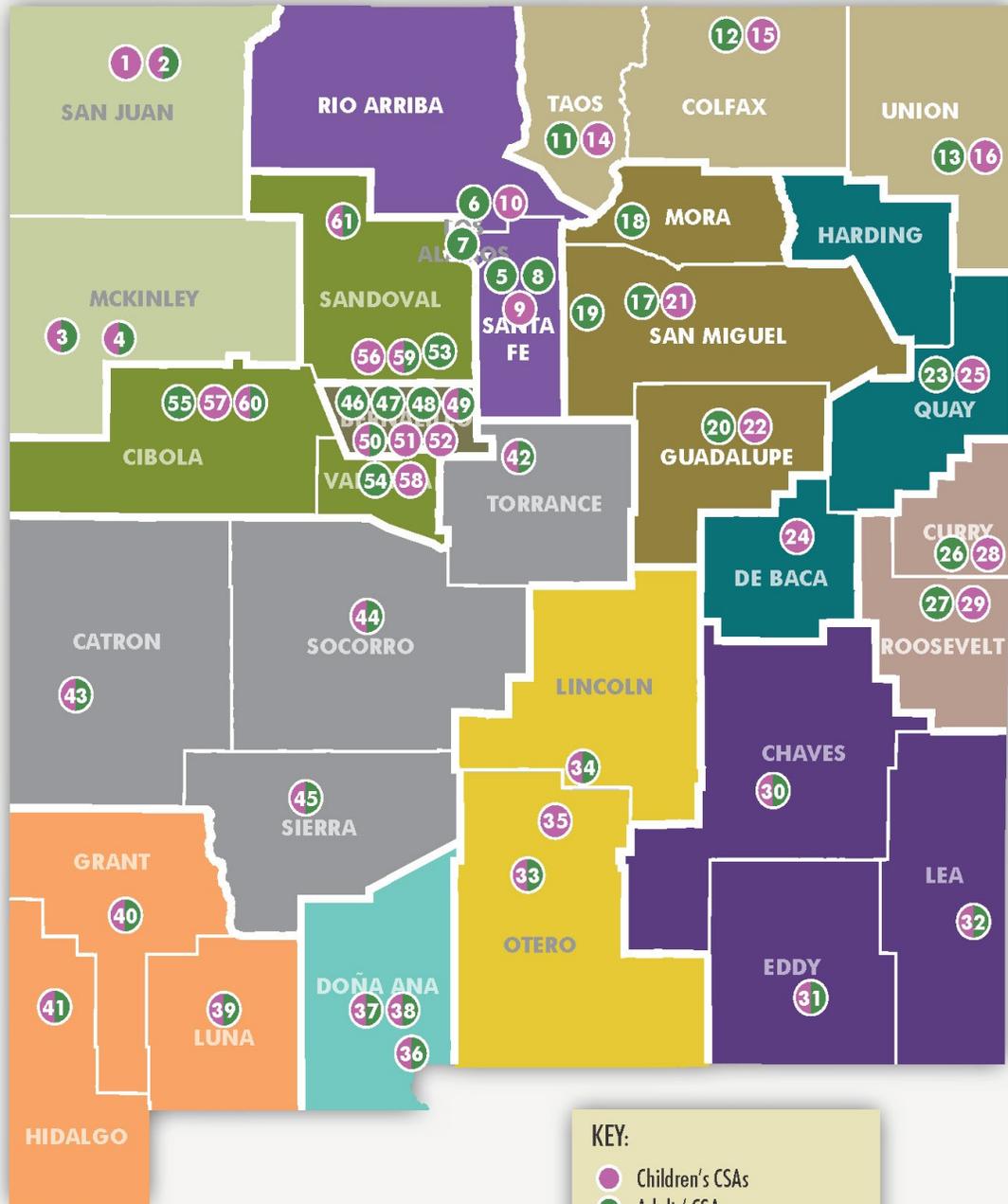
Personality Disorders [For which there is an evidence based clinical intervention available]

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Core Service Agency Sites



CORE SERVICE AGENCY SITES



KEY:

- Children's CSAs
- Adults' CSAs
- Child and Adult CSAs

Core Service Agency Sites



CORE SERVICE AGENCY SITES

KEY:

- Children's CSAs
- Adults' CSAs
- Child and Adult CSAs

Childhaven

1 Farmington (505) 325-5358

Presbyterian Medical Services

2 Farmington (505) 325-0238
3 Gallup (505) 863-3828
4 Thoreau (505) 862-7417

Presbyterian Medical Services

5 Santa Fe (505) 986-9633
6 Española (505) 747-7400
7 Los Alamos (505) 747-7400

The Life Link

8 Santa Fe (505) 438-0010

Agave Health

9 Española (505) 747-0081
10 Santa Fe (505) 471-5006

Tri-County Community Services

11 Taos (575) 758-5857
12 Raton (575) 445-2754
13 Clayton (575) 374-2032

Agave Health

14 Taos (575) 758-7263
15 Raton (575) 445-3557
16 Clayton (575) 374-8300

NM Behavioral Health Institute/CBS

17 Las Vegas (505) 454-5100
18 Mora (575) 387-2677
19 Pecos (505) 757-6112
20 Santa Rosa (575) 472-3068

Agave Health

21 Las Vegas (505) 454-8265
22 Santa Rosa (575) 472-0745

Mental Health Resources

23 Tucumcari (575) 461-3013

Turquoise Health & Wellness

24 Fort Sumner (575) 355-8326
25 Tucumcari (575) 461-4411

Mental Health Resources

26 Clovis (575) 769-2345
27 Portales (575) 359-1221

Turquoise Health & Wellness

28 Clovis (575) 742-2620
29 Portales (575) 356-2223

Turquoise Health & Wellness

30 Roswell (575) 623-1480
31 Carlsbad (575) 885-4836

Lea County Guidance Center

32 Hobbs (575) 393-3168

La Frontera NM

33 Alamogordo (575) 437-7404
34 Ruidoso (575) 630-0571
35 Mesalero (505) 464-0016

La Frontera NM

36 Anthony (800) 426-0997
37 Las Cruces - Griggs Ave. (575) 647-2800
38 Las Cruces - S. Solano Dr. (575) 527-7900

La Frontera NM

39 Deming (575) 546-2174
40 Silver City (575) 388-4412
41 Lordsburg (575) 542-3304

Presbyterian Medical Services

42 Torrance County (505) 384-2777
43 Catron County Medical Center (575) 533-6456
44 Socorro Mental Health (575) 835-2444
45 Sierra County (pending) n/a

Agave Health

46 Albuquerque - Coors Blvd. NW (505) 338-3320
47 Albuquerque - Central Ave. SE (505) 268-1125

Saint Martin's

48 Albuquerque (505) 764-8231

Open Skies

49 Albuquerque (505) 345-8471

YDI

50 Albuquerque (505) 873-1604

All Faiths Receiving Home

51 Albuquerque (505) 271-0329

University of New Mexico

52 Albuquerque (505) 272-2190

Valle del Sol of NM

53 Bernalillo (505) 867-2383
54 Los Lunas (505) 865-3350
55 Grants (505) 287-7985

Open Skies

56 Rio Rancho (505) 891-9797
57 Grants (505) 285-3672
58 Los Lunas (505) 565-1761

Presbyterian Medical Services

59 Rio Rancho (505) 896-0928
60 Grants (505) 287-2273
 Northern Sandoval Co. (Cuba) Check-board Area Health System
61 (575) 289-3291

Psychiatric Beds by City

Hospital	City	Total Beds	Psychiatric Beds
Gerald Champion Regional Medical Center	Alamogordo	99	17
Haven Behavioral Senior Care of ABQ	Albuquerque	34	34
HealthSouth Rehabilitation Hospital, Albuquerque	Albuquerque	87	
Kindred Hospital of Albuquerque	Albuquerque	61	
Lovelace Medical Center	Albuquerque	263	44
Lovelace Medical Center - Heart Hospital	Albuquerque	55	
Lovelace Rehabilitation Hospital	Albuquerque	62	
Lovelace Westside Hospital	Albuquerque	80	
Lovelace Women's Hospital	Albuquerque	120	
Presbyterian Hospital	Albuquerque	453	
Presbyterian Kaseman Hospital	Albuquerque	85	46
University of New Mexico Hospital	Albuquerque	527	91
Artesia General Hospital	Artesia	49	15
Carlsbad Medical Center	Carlsbad	115	
Union County General Hospital	Clayton	25	
Plains Regional Medical Center	Clovis	100	
Mimbres Memorial Hospital & Nursing Home	Deming	25	
Espanola Hospital	Espanola	70	
San Juan Regional Medical Center	Farmington	194	13
San Juan Regional Rehabilitation Hospital	Farmington	16	
Rehoboth McKinley Christian Health Care Services	Gallup	60	
Cibola General Hospital	Grants	25	
Lea Regional Medical Center	Hobbs	186	20
Advanced Care Hospital of Southern NM	Las Cruces	20	
Memorial Medical Center	Las Cruces	199	
Mesilla Valley Hospital	Las Cruces	88	88
Mountain View Regional Medical Center	Las Cruces	168	
Rehabilitation Hospital of Southern New Mexico	Las Cruces	40	
Alta Vista Regional Hospital	Las Vegas	54	
Los Alamos Medical Center	Los Alamos	47	
Nor-Lea General Hospital	Lovington	25	
Roosevelt General Hospital	Portales	24	
Miners' Colfax Medical Center	Raton	25	
Presbyterian Rust Medical Center	Rio Rancho	81	
UNM Sandoval Regional Medical Center	Rio Rancho	72	12
Eastern New Mexico Medical Center	Roswell	162	25
Lovelace Regional Hospital - Roswell	Roswell	26	
Lincoln County Medical Center	Ruidoso	25	
CHRISTUS St. Vincent Physicians Medical Center	Santa Fe	19	
CHRISTUS St. Vincent Regional Medical Center	Santa Fe	248	20
Guadalupe County Hospital	Santa Rosa	10	
Peak Behavioral Health Services, LLC	Santa Teresa	56	56
Gila Regional Medical Center	Silver City	68	10
Socorro General Hospital*	Socorro	24	
Holy Cross Hospital	Taos	29	
Sierra Vista Hospital	TorC	15	
Dr. Dan C. Trigg Memorial Hospital	Tucumcari	25	
TOTALS		4366	491

Housing Chart Showing Chronic Homelessness

Need for New Supportive Housing by New Mexico County

County	2014 Census Population	Poverty Rate	Total # of Homeless People Counted on 1/26/15*	Estimated Total Need for Supportive Housing**	Total # of Chronically Homeless People on 1/26/15***	Relative Priority
Dona Ana County	213,676	27	333	534	112	H
Sandoval County	137,608	17.7	35	344	0	H
Valencia County	75,817	23.4	20	190	0	H
Chaves County	65,878	21.2	28	165	4	H
McKinley County	74,098	40.3	108	185	51	H
Otero County	65,082	21.3	14	163	0	H
Lea County	69,999	14.8	12	175	0	H
Bernalillo County	675,551	18.7	1,378	1,689	265	H
San Juan County	123,785	22.7	207	309	27	H
Eddy County	56,395	15.1	86	141	29	H
Rio Arriba County	39,777	24.8	2	99	0	H
Cibola County	27,349	32.2	2	68	0	M
Luna County	24,673	31.2	15	62	2	M
San Miguel County	28,239	35.9	7	71	2	M
Taos County	33,084	26.2	21	83	2	M
Torrance County	15,611	27.8	0	39		M
Roosevelt County	19,536	24.6	0	49		M
Curry County	50,969	21.1	30	127	0	M
Sierra County	11,325	26.9	0	28		M
Grant County	29,096	22.4	8	73	0	M
Lincoln County	19,706	18.8	0	49		M
Quay County	8,501	25.8	0	21		M
Colfax County	12,680	20.1	0	32		L
Guadalupe County	4,468	25.8	0	11		L
Hidalgo County	4,560	25.7	0	11		L
Santa Fe + County	148,164	18.1	323	370	196	L
Socorro County	17,310	27.9	0	43	0	L
Mora County	4,592	23.8	0	11		L
Catron County	3,556	21.7	0	9		L
De Baca County	1,825	22	0	5		L
Union County	4,297	20.1	0	11		L
Los Alamos County	17,682	4	0	44		L
Harding County	683	15.2	0	2		L
New Mexico	2,085,572	21.4	2,629	5,214	690	

* Total number of homeless persons sheltered and unsheltered counted on January 26, 2015.

** Need for supportive housing based on state study showing need for 5,000 beds, divided up by county according to population.

*** Chronically homeless people are those with disabilities who have been homeless for a year or 4 times in 3 years and are the highest users of costly services including hospitals and jails.

Count and Analysis by the New Mexico Coalition to End Homelessness

Task Force Members and Participants

SJM 4 Sponsor & Chair

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District 23 (Bernalillo)

Grace Philips, Chair
New Mexico Association of Counties

SJM 4 Steering Committee

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National Alliance on Mental Illness
Taos County

Rick Miera
Former State Representative and
House Majority Leader

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Fifth Judicial District Court

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San Juan County Juvenile Detention Center

James Ogle, Co-Chair Legislative Committee
National Alliance on Mental Illness

Scott Pokorny
Aging & Long-Term Services Department

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Bernalillo County Metro Court

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Los Alamos Clerk

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Senate Joint Memorial 4 - Sponsored By Senator Sander Rue

Requesting the New Mexico Association of Counties to study housing and clinical service options for individuals with serious mental illness who are in custody awaiting trial.

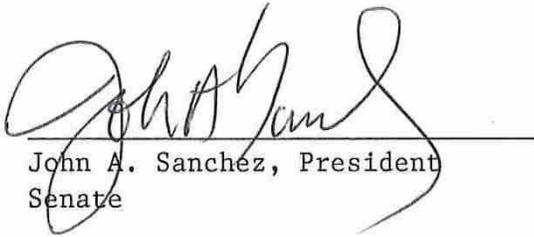
- WHEREAS, the state's county detention facilities have become de facto mental health facilities; and
- WHEREAS, according to a 2012 study conducted by the New Mexico sentencing commission, individuals receiving mental health services while in detention have a median length of stay that is twenty-five percent longer than the length of stay for all pretrial inmates; and
- WHEREAS, individuals diagnosed with the most serious mental illness, such as psychotic disorders, have a median length of stay that is eighty-two percent longer than individuals of the same gender and age who have been charged with the same crime; and
- WHEREAS, individuals whose competency to stand trial is in question have a median length of stay that is two hundred seventy-eight percent longer than other pretrial inmates; and
- WHEREAS, few detention centers are equipped to deal adequately with this population; and
- WHEREAS, the condition of individuals with serious mental health disorders can deteriorate when they are incarcerated; and
- WHEREAS, the current situation exposes the state and local governments to substantial liability; and
- WHEREAS, individual agencies and counties cannot provide the solution to this problem alone because it is a systemic problem that requires collaboration and the development of alternatives among state, county and municipal governments as well as health care providers and advocacy organizations;

Now, therefore, be it resolved by the legislature of the State of New Mexico that the New Mexico Association of Counties be requested to convene stakeholders to study and make recommendations for clinically appropriate housing options for individuals with serious mental illness who are in custody in county detention facilities; and

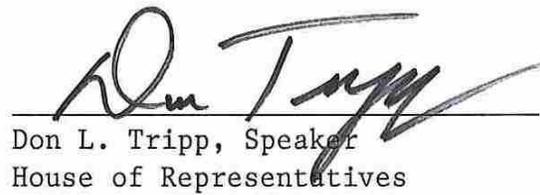
Be it further resolved that stakeholders include but not be limited to representatives from the New Mexico municipal league; the department of health; the aging and long-term services department; the corrections department; the veterans' services department; the behavioral health services division of the human services department; the department of finance and administration; the interagency behavioral health purchasing collaborative; the administrative office of the district attorneys; the administrative office of the courts; the public defender department; the New Mexico sheriffs and police associations; the New Mexico behavioral health institute at Las Vegas; the New Mexico hospital association; disability rights New Mexico; the national alliance on mental illness; mental health clinicians; and two individuals living with serious mental illness identified by the interagency behavioral health purchasing collaborative; and

Be it further resolved that the New Mexico association of counties be requested to report that the New Mexico association be requested to report its findings to the appropriate interim legislative committees by December 1, 2015; and

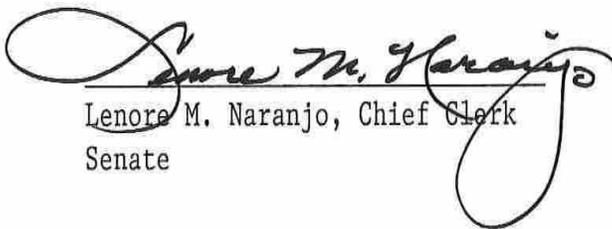
Be it further resolved that copies of this memorial be transmitted to the executive director of the New Mexico association of counties, the executive director of the New Mexico municipal league, the director of the New Mexico behavioral health institute at Las Vegas, the director of the administrative office of the district attorneys, the director of the administrative office of the courts, the chief public defender, the New Mexico hospital association, the director of the interagency behavioral health purchasing collaborative, the executive director of disability rights New Mexico, the executive director of the national alliance on mental illness and the secretaries of health, public safety, aging and long-term services and corrections.



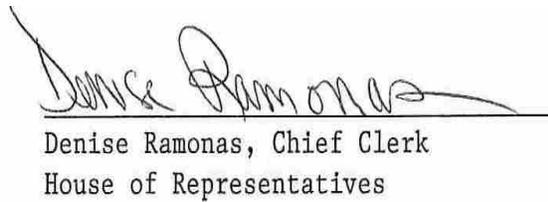
John A. Sanchez, President
Senate



Don L. Tripp, Speaker
House of Representatives



Lenore M. Naranjo, Chief Clerk
Senate



Denise Ramonas, Chief Clerk
House of Representatives