

NEW MEXICO'S BEHAVIORAL HEALTH PLAN FOR CHILDREN, YOUTH AND THEIR FAMILIES

A Call for Action

March 29, 2007

INTRODUCTION

Drawing upon previous studies, in particular the Comprehensive Needs Assessment and Gap Analysis of New Mexico's Behavioral Health Services and Systems (2002), the Children's Behavioral Health Re-Design Committee Report (2003), the New Mexico Interagency Behavioral Health Purchasing Collaborative Concept Paper (2004), and the Out of Home Placement Study (2006) this plan outlines the steps to be taken to implement a community-based service system. Studies and recommendations have been made; it is time to complete the planning processes and implement the recommendations.

VISION AND PHILOSOPHY

The vision of the Collaborative serves as the foundation for all behavioral health work in the state. That vision is:

“A single behavioral health service delivery system in New Mexico in which available funds are managed effectively and efficiently; the support of recovery and development of resiliency are expected; mental health is promoted; the adverse effects of substance abuse and mental illness are prevented or reduced; and behavioral health customers are assisted in participating fully in the life of their communities.”

The Collaborative's philosophy for its work was developed by looking at the principles set forth in HB 271 and at the values and principles developed by various advisory and consumer/family groups in New Mexico and nationally. The following philosophy will guide the development of the children's service system.

- Services will be individually centered and family-focused based on principles of individual capacity for recovery and resiliency.
- Care must focus on increasing consumers' and families' abilities to successfully manage life challenges, on facilitating recovery and on building resiliency.
- Services will be delivered in a culturally responsive and respectful manner in the most appropriate, least restrictive mode (appropriate to

their legal status), including home- and community-based settings wherever possible.

- Service planning and management will utilize individual and family abilities and strengths and where appropriate, will be conducted in consultation with family, caregivers, and other persons critical to an individual's life and well-being.
- Services will be coordinated, accessible, accountable and of high quality.
- Each individual or family will direct his/her/their services to the extent possible.
- Services, where appropriate, will be individual/family-driven and – operated, and when operated or delivered by a consumer or family member, will be compensated equal to that of other professionals with similar experience and credentials.
- Services will include behavioral health promotion, prevention, early intervention, treatment, community support, and activities that further recovery and resiliency.
- The highest quality of care and information will be available to individuals, regardless of their race, gender, disability, sexual identity, ethnicity, language, literacy level, age, or place of residence.
- Mechanisms will be in place to ensure continuous quality improvement.
- Treatment and services will be based on effectiveness and individual preferences.

Following this philosophy the children's system will be built around community-based services and will include hospitalization and residential care as needed. The goal of the system is to assure that children and youth receive high quality care that supports recovery and resiliency. It is the responsibility of the Collaborative, its partners and the Statewide Entity to build a system that is appropriately balanced and driven by the needs of the

children, youth and their families.

THE PROPOSED SERVICE ARRAY

To move towards attainment of the Collaborative's goals, values and vision, it is necessary to establish a standard continuum of services that is available across the state and that defines what services will (and by exclusion, will not) be purchased. The continuum of services will provide guidance to providers, local collaboratives and the Statewide Entity about which services and providers will comprise the behavioral health service system. It will also support on-going and objective assessment of gaps in the current service continuum.

The Collaborative has identified a continuum that is comprised of seven domains, including:

- Entrance Services (e.g. screening, assessment, initial crisis services)
- Prevention/Early intervention services (school-based and infant mental health)
- Outpatient Services (traditional and evidenced based therapies, medication management)
- Community Supports and Services the Promote Resiliency (case management, behavior management, respite and other family supports)
- Intensive Support Services (intensive in-home services, multi-systemic therapy)
- Out of Home Residential Services (Residential and therapeutic foster care)
- Acute Intensive Services

The continuum is provided in Attachment A. As the New Mexico Children's Behavioral Health System matures, increased emphasis will be placed on evidence-based practices. It is believed that the increased use of evidence-based practices will help us build a more clinically effective and cost effective system of care.

HOW DOES THE CURRENT SERVICE ARRAY AND DOLLARS ALIGN WITH THE PRINCIPLES?

During FY 2006 approximately 68,859 unique individuals received at least one service paid by the Collaborative. The total expenditures for these individuals were \$220,534,236¹. Approximately 62 percent of all dollars are spent on inpatient and residential care, yet this represents approximately 10 percent of the (duplicated) people served. Intensive outpatient and recovery/maintenance, the two categories of service that most closely represent emerging best practices, account for less than 33 percent of the individuals served and about 20 percent of the dollars spent. The high expenditures on inpatient and residential care, plus the proportionately higher expenditures for outpatient versus recovery/maintenance services is an indicator of a relatively traditional behavioral health system. Attachment B provides more information regarding these expenditures.

The fact that over 62 percent of the reported behavioral health resources are allocated to inpatient and residential treatment suggests a need for greater attention to services that foster resiliency and services that can be effective alternatives to inpatient and residential care. In a mature behavioral health system with well-developed community services and supports as well as effective crisis response and hospital and residential diversion resources, one would expect these expenditures not to exceed 15 percent to 20 percent of total behavioral health resources. This will require New Mexico to re-deploy resources to develop evidence-based and promising service modalities that have been proven to reduce over-utilization of inpatient and residential services.

Identifying and targeting resources to high-risk children and youth is another successful strategy typically used by behavioral health authorities to assure most effective use of scarce public resources. In New Mexico, it appears that the 80 – 20 rule cuts both ways. That is, there are a small number of individuals using a very high amount of service resources at one end of the service spectrum, and at the same time there is a large group of individuals at the other end of the spectrum that receive very limited amounts of services. Over 75 percent of individuals served in 2006 received outpatient

¹ This analysis includes services provided to both adults and children.

services that supported resiliency. These individuals command less than 35 percent of the total behavioral health resources reported. More telling is the average expenditure per person within these service domains. The average of \$617 per user for outpatient and \$875 for services that support resiliency suggests that average individuals within these domains receive relatively few services. This would indicate that individuals receive fewer than ten to fifteen hours of service per year. These two service domains include many services and supports essential for recovery and resiliency and for reducing reliance on inpatient and residential treatment (e.g., case management, behavior management services), yet they seem to be relatively underutilized both on a per person basis and on a system wide basis.

WHAT STEPS CAN BE TAKEN TO REBALANCE NEW MEXICO'S SYSTEM OF CARE FOR CHILDREN?

There are several immediate next steps that the Behavioral Health Purchasing Collaborative will take to begin to shift resources from more resource intensive services to evidenced based and promising practices that support children in their homes and communities. These include:

- Implementing Clinical Home Pilot Project
- Evaluating Clinical Home Pilot Project
- Expansion of Clinical Home Pilot Project
- Organizing and Supporting Child and Family Networks and Initiatives
- Developing and Implementing Statewide and Local Children's Behavioral Health Services Delivery System Plans

The remainder of this document sets forth five specific strategies that will serve as the foundation for the New Mexico Children and Families Behavioral Health Plan. Each of these strategies provides an overview of the activities and implementation timeframes.

Action Step #1: Clinical Home Pilot Project

The BHPC is seeking to develop a pilot project for youth who are legally involved with the juvenile court and are in out-of-home placements or at risk of such placements. These youth represent the majority of referrals to residential treatment centers and group homes. The Collaborative is undertaking a nine month pilot project that will focus on these youth.

Funding and resources from the transformation grant for behavioral health system transformation will be used to support these efforts and if successful, role the pilot project out to children and families statewide.

The BHPC has identified the following goals for the pilot:

- To develop an alternative pathway for youth who are referred to Accredited Residential Treatment Centers (ARTCs) and group homes;
- To develop provider competencies in assessing a youth's needs, constructing service plans and coordinating services, including the use of the Child and Adolescent Functional Assessment Scale (CAFAS);
- To determine the right mix, amount, duration and costs of treatment services and natural supports needed by the target population;
- To empower families and providers to seek and/or create new treatment, interventions and informal supports for the target populations;
- To identify and achieve key outcomes for the target populations
- To offer incentives to providers by paying for performance; and
- To develop a learning community among consumers/families, providers, the Collaborative and the Statewide Entity regarding successful approaches to serving the target population as well as the program and system barriers that impede success.

The pilot project will begin on April 15th, 2007 in the Albuquerque, Santa Fe and Las Cruces areas with the following providers:

- **Albuquerque:** YDI, NM Solutions, Children's Treatment Center, Hogares, All Faiths;
- **Santa Fe:** Teambuilders, PMS, Hope Springs, Su Vida;
- **Las Cruces:** FYI.

These locations were selected due to the current availability of service alternatives to residential treatment centers (RTCs) in these areas, as well as the numbers of Juvenile Justice System (JJS) involved youth currently residing in these communities. The initial selection of providers to participate in this pilot was based upon the providers' locations, as well as their current resources, infrastructure, and flexibility to move with the system.

Youth participating in the pilot will be referred by Collaborative agencies or the Statewide Entity. The clinical home will be the single point of accountability to coordinate behavioral health treatment and supports for these youth and their families. Clinical homes will be multi-service agencies (or clusters of agencies) that will provide essential community-based services to participants in the pilot project including access to or provision of both substance abuse and mental health services.

The clinical homes participating in the pilot will:

- Accept all referrals from Collaborative agencies or the Statewide Entity. There will be a no reject policy.
- Perform an initial face-to-face assessment within 24 hours (or sooner if the youth is in crisis). This will require the pilot organizations to have 24/7 capacity to respond to requests immediately.
- Administer the CAFAS functioning assessment tool to all youth in the pilot project. (The Collaborative will provide training on the administration and interpretation of the functioning scale.)
- Develop and implement an initial service plan within 72 hours after the referral.
- Provide youth and families with a community support worker that will be responsible for assisting the youth and family through the assessment process and in developing the service plan.
- Have immediate access to crisis stabilization services that may include in-home respite, pharmacological evaluation and treatment, development of a crisis plan and comprehensive community support services.

Action Step #2: Evaluating Clinical Home Pilot Project

The pilot project fundamentally seeks to change the system's response to youth at risk of an out of home placement. More importantly, the project seeks to improve the quality of life for youth and families who have significant mental health needs and who are at most at risk of placement. Therefore the pilot project will track specific outcomes that indicate youth and families are improving and are satisfied with the quality of the services provided. We will also evaluate the functioning and outcomes of the systems' function. The outcomes identified for the pilot project are:

- Successful engagement - youth that are referred to clinical homes receive a timely assessment and are actively engaged in services during the first six months.
- Reduced Recidivism—youth who are transitioned from out-of-home placements remain in their home (natural, adoptive or kinship families or independent or supervised living arrangement) and/or have fewer and shorter out-of-home placements.
- Enhanced functioning in key areas as indicated by changes in the CAFAS scores in critical areas (school, others)
- Overall satisfaction of families, judges, JJS workers and local collaboratives

By September 2007 (after about 4.5 months of practice), a full review of “lessons learned to date” from the pilot project will be completed. Based on that review, a plan for implementing clinical homes in each area of the state will be developed and reviewed with each local collaborative. Based on all of the information gathered from the Pilot Project, the regulations and certification processes for clinical homes will then be developed, with the goal of having a completed mechanism for licensing or certifying clinical homes by July 1, 2008.

As the clinical homes are developed in this pilot, learning from this experience will be shared with broader groups of stakeholders, such as a consumers, families, judges ,JJS case workers, and providers who serve adults and children, for their input and assistance developing the final regulations and certification processes. The ultimate goal of the clinical home pilot is to move toward have a Core Services Agency model that will work for all children, youth and adults, not just youth involved in JJS.

Action Step #3: Expansion of Clinical Home Project

Additional populations that are at risk of out-of-home placement will be added in early summer. These will include youth in protective custody, youth who did not meet the medical necessity criteria for residential treatment and youth in out-of state placements. This will require additional capacity. Therefore, the number of providers and geographic locations will also be expanded within the first year of implementation.

Action Step: #4: Organizing and Supporting Child and Family

Networks and Initiatives

In all of the previously cited studies and in the philosophy articulated by the Collaborative the voice of consumers and families is paramount. Their voices should be heard in individual service planning, in developing programs, policies, and standards, as well as in evaluation of outcomes for individuals and for the system.

Together with the BHPC, the Collaborative will establish a work group, made up of youth consumers and families, to define formal mechanisms to assure consumer and family participation in service planning, policy development and evaluation and outcome measurement at local and state levels. The work group will also be asked to identify how the Collaborative can assist in strengthening youth and family networks, activities and initiatives across the state. The work group will be established in May, 2007; the work and recommendations of the work group will be presented to the BHPC and the Collaborative in September, 2007 for inclusion in the consumer and family engagement plan which will be available in October, 2007.

The clinical home pilot project will involve youth and their families in service planning, as well as asking for feedback from youth and families on how clinical homes can best support youth and families. Learning from the pilot will be shared with the work group.

Transformation grant funding and technical assistance will be available to the work group as it puts together recommendations for action.

Action Step #5: Develop and Implement Statewide and Local Children's Behavioral Health Services Delivery System Plans

The 2002 New Mexico Behavioral Health Gaps Analysis identified that over 17,000 children and families statewide need but do not receive mental health services. In addition, another \$35 million is needed to serve youth that need substance abuse services. The BHPC will develop a children's capacity plan for behavioral health services. The following goals will guide the plan for behavioral health services to children and their families:

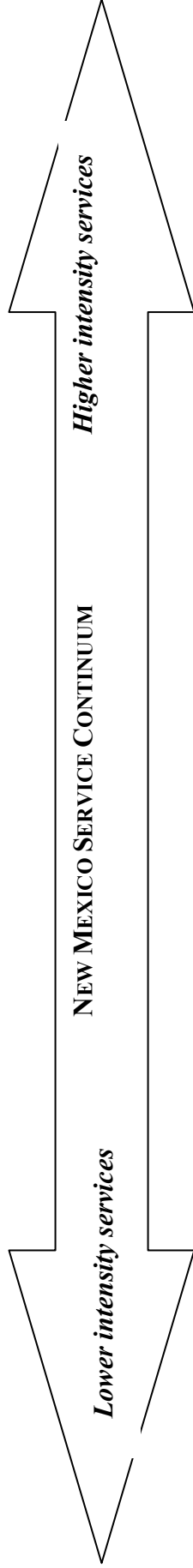
- Increase access and remove barriers to new and current mental health services and services for youth who are alcohol and drug dependent;
- Maximize mental health and substance abuse resources with more creativity, flexibility, and collaboration; and
- Identify priorities for funding children's behavioral health services.

The following information will be included in the BHPC statewide plan:

- The number of children that are currently served and the services they receive;
- The number of children in need of behavioral health services, including children in school and children receiving services through CYFD;
- The array of services that are available for children and families and how these services compare to the proposed continuum of services identified by the Collaborative;
- The recommended service priorities for children and families currently served as well as undeserved and underserved youth;
- The current funding available for behavioral health services for children and families; and
- A proposed purchasing plan based on the current funding available and the priorities identified by each local collaborative.

In addition, this plan will identify how children and families can better access services, including quick access to screening assessment, service planning and service coordination. The plan will identify how funding for existing services can be coordinated to create more flexibility in meeting children's needs. Finally, the plan will identify how culturally relevant and acceptable services can be developed, to ensure that services are linguistically accessible.

This plan will be completed by July, 2007 and will be provided to the Behavioral Health Planning Council, and through the Council to local collaboratives, judges, other children and youth stakeholders, and providers for review and input with the goal being a final action plan by October, 2007. This plan will have specific recommendations regarding the scope and amount of services that will be purchased for FY 2009 by the Collaborative.



| Entrance Services | Prevention and Early Intervention Services | Outpatient and Medication/Somatic Services | On-going Supports and Rehabilitation Services | Intensive Support Services | Out-of-Home Residential Services | Acute Intensive Services |
|--|---|--|--|--|--|--|
| <ul style="list-style-type: none"> Initial Screening and referral (may occur during initial crisis response) Initial crisis response/triage and referral Assessment (diagnostic, psychosocial) Physician assessment Other medical/physical assessment (RN, OT, PT) Psychological testing Neurological testing | <ul style="list-style-type: none"> Community Education Relapse Prevention Programs Environmental Strategies Newborn Visiting Parent Support Early Childhood Mental Health Intervention School-based Health Centers | <ul style="list-style-type: none"> Individual counseling Group counseling Family counseling Multi-family counseling Medication management and other medical/somatic services Pharmacy services School-based counseling Methadone Laboratory services Individual service plan development and review Specialized consultation Patient education | <ul style="list-style-type: none"> Peer supports Community Supports Aftercare Behavioral management skills development Psychosocial clubhouse/other day service programs Supported employment Supportive housing Recovery housing In-home respite services Traditional healing interventions | <ul style="list-style-type: none"> Substance abuse intensive outpatient services Psychiatric intensive outpatient services Partial hospital Assertive community treatment Community Support Teams Intensive home based treatment/family intervention Multi-systemic therapy Ambulatory detoxification services Crisis response and stabilization for enrolled consumers | <ul style="list-style-type: none"> Therapeutic foster care – levels I and II Crisis residential/stabilization Alcohol and drug rehabilitation (long and short term) 24 hour residential services Residential treatment facility services (child/adolescent) Out-of-home respite services | <ul style="list-style-type: none"> Mobile crisis services 23 hour crisis stabilization service Psychiatric inpatient services Alcohol and drug non-medical detoxification Alcohol and drug medical detoxification |

Attachment B: Behavioral Health Services Expenditures– FY 2006

| Service Category | Number of People Served | Dollars Paid for The Services | Average Dollars Paid Person | Percent of All Dollars Spent |
|--------------------------------------|--------------------------------|--------------------------------------|------------------------------------|-------------------------------------|
| IP Residential Detoxification | 7,877 | 21,062,214 | \$ 2,673.89 | 10% |
| Residential | 5,602 | 115,421,157 | \$ 20,603.56 | 52% |
| Intensive Outpatient | 5,828 | 10,987,152 | \$ 1,885.24 | 5% |
| Outpatient | 61,001 | 37,638,562 | \$ 617.02 | 17% |
| Recovery/Maintenance | 36,823 | 32,232,326 | \$ 875.33 | 15% |
| Other | 9,722 | 3,192,824 | \$ 328.41 | 1% |
| Total | 126,853 | \$ 220,534,236 | | 100% |