



Policy Brief
September 2016

Healing Minds, Helping Taxpayers **Reforming Behavioral Healthcare in New Mexico**

By D. Dowd Muska and Christopher Abbott

Introduction

New Mexico's behavioral-health crisis is daunting. A 2014 report by the Legislative Finance Committee listed several grim statistics about the Land of Enchantment:

- 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.¹

Reforming the public system charged with enhancing behavioral health in the Land of Enchantment will not be easy. The depth of the problem, partisan politics, and bureaucratic sclerosis and inertia pose substantial obstacles to reform.

¹ "Results First: Adult Behavioral Health Programs," Program Evaluation Unit, Legislative Finance Committee, New Mexico Legislature, September 24, 2014.

But given the enormity of the challenge, broad and meaningful changes must be made to New Mexico's behavioral-healthcare system -- alterations that do not impose a greater burden on the state's beleaguered taxpayers. Herewith, the Rio Grande Foundation presents three *principles* that should shape reform, as well as four *policies* that promise lasting results.

What Is Behavioral Healthcare?

As defined by the National Association of State Mental Health Program Directors, behavioral healthcare "encompasses a broad array of services for people with mental health or substance abuse problems (or both). These problems range in severity: at one end of the spectrum, individuals face situational problems that disrupt their everyday lives but are short-term while at the other end, individuals have chronic, sometimes disabling behavioral health disorders (e.g., major depression, schizophrenia, bipolar disorder, or drug dependence)."²

Hundreds of millions of dollars are spent annually on New Mexico's public system of behavioral healthcare, with the Human Services Department (HSD) accounting for the largest portion of expenditures. (Other bureaucracies with significant involvement include the Department of Health and the Department of Children, Youth, and Families.) But compiling state spending on behavioral healthcare fails to account for the total impact of substance abuse and mental illness in the Land of Enchantment. The "costs to business, government, and society of dysfunctional adults and families" include "children who do not learn and are therefore unprepared for adulthood, lost taxes, lost workdays, and reduced productivity."³ These burdens cannot be precisely calculated, but there is little doubt that they run into the billions of dollars.

A History of Failure

In the last decade and a half, behavioral healthcare in New Mexico has undergone sweeping shifts in policy, as well as a major scandal -- conditions that have not been conducive to boosting the quality and lowering the cost of services.

In 2002, "Behavioral Health Needs and Gaps in New Mexico," an investigation commissioned by the Legislature, conducted a "comprehensive cross system analysis of behavioral health care for both children and adults. All New Mexico state agencies with behavioral health service budgets and responsibilities were included."⁴

The report found that there was "no identifiable behavioral health system leader with responsibility or authority across the behavioral healthcare systems in the state." In addition, the "benefit packages of the various behavioral health systems within New Mexico" were "not organized to maximize available resources or to provide incentives to providing care that has been proven to be effective (evidence-based or promising clinical practices)." Data regarding "all New Mexico behavioral health provider agencies do not exist in any consistent fashion or in any

² Joel E. Miller, "Too Significant To Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, for Their Families, and for Their Communities," National Association of State Mental Health Program Directors, 2012.

³ "Behavioral Health Needs & Gaps in New Mexico," Technical Assistance Collaborative, Inc., 2002.

⁴ *Ibid.*

single place,” and each system maintained “information about its provider agencies in different ways, sometimes even within the same system of care.” Finally, there was “no identified state level statewide human resource development leadership planning, strategy or focus to address the need for developing, training, recruiting, mainlining, and on-going learning of qualified behavioral healthcare practitioners.”⁵

“Behavioral Health Needs and Gaps in New Mexico” concluded that in “order to be a ‘good’ and effective system of care, there must be a *system* of care, not just a collection of services. The system must be planned and designed coherently, managed and led effectively, and owned and guided by those who benefit and contribute to the system’s existence and success.”⁶

In response, legislators and then-Governor Bill Richardson created the Interagency Behavioral Health Purchasing Collaborative. The entity’s job was to “identify behavioral health needs; inventory all expenditures; plan, design and direct a behavioral health system; and, contract with one or more behavioral health entities to provide statewide services.”⁷ Hopes ran high that the new organization, overseen by the HSD, would bring leadership, focus, and accountability to the state’s public system of behavioral healthcare.

But the years that followed would prove to be disappointing, as the Collaborative underperformed, and a series of radical policy changes brought chaos and uncertainty. In 2005, a year after the Collaborative’s creation, “consumers and providers adjusted to a ‘carved out’ behavioral health model by which the statewide entity, ValueOptions New Mexico, was contracted to manage Medicaid and non-Medicaid mental health and substance abuse programs and funding from six state agencies. In 2009, the statewide entity contract was awarded to OptumHealth.”⁸ In 2014, in yet another shift, four managed-care organizations contracted with the HSD to “carve in” behavioral health for their Medicaid recipients. OptumHealth remained as the statewide entity for non-Medicaid programs.

No examination of New Mexico’s behavioral-healthcare system would be complete without a summary of a highly publicized imbroglio that continues to this day. In June, 2013 Governor Susana Martinez’s administration froze Medicaid payments to 15 nonprofit providers of behavioral-health and substance-abuse services. The group comprised “roughly 85 percent of the state’s ... spending for more than 30,000 of the most vulnerable and difficult to treat consumers.”⁹

The funding suspensions were warranted, the administration argued, because an external audit “identified more than \$36 million in overpayments to the nonprofit operations from 2009 to 2012 – nearly 15 percent of all payments made to those providers – and turned up questionable business practices.”¹⁰ Specifically, the investigation found

⁵ *Ibid.*

⁶ *Ibid.*

⁷ “Fiscal Impact Report: HB 271/aHGUAC/aHAFC/aHFI#1/aSPAC,” Legislative Finance Committee, New Mexico Legislature, February 16, 2004.

⁸ “Cost and Outcomes of Selected Behavioral Health Grants and Spending,” Report #13-04, Legislative Finance Committee, New Mexico Legislature, May 16, 2013.

⁹ “Behavioral Health Provider Audit Results,” New Mexico Human Services Department, June 24, 2013.

¹⁰ Deborah Baker, “Treatment dollars mishandled, audit finds,” *Albuquerque Journal*, June 25, 2013.

a pattern of serious concerns that were identified by the Behavioral Health Collaborative during the first eight months of 2012, which point to the presence of endemic and egregious mismanagement throughout the State that undermines patient care, waste of state and federal Medicaid dollars, and in some cases, potential fraud that is being reported to the proper state and federal authorities. These deficiencies appear to have persisted for several years, and were identified as the result of a new software system designed to better detect errors and potential abuse, as part of ongoing quality control efforts.¹¹

Sadly, in short order, the administration's action devolved into a bitter partisan feud -- one that persists to this day. Less than two weeks after the payment suspensions, at a legislative hearing, "Human Services Department Secretary Sidonie Squier, after three hours of answering questions, reportedly stormed out angrily. Meanwhile, state Sen. Jerry Ortiz y Pino, D-Albuquerque, who had been grilling Squier, literally ruptured blood vessels in his brain and ended up in the hospital."¹²

For more than three years, the partisan rancor has raged. Democrats, closely aligned with the community of nonprofit providers, accuse the GOP governor of overreacting to what amounted to nothing more than innocent errors, and pursuing a "plan to replace New Mexico providers so that large, out-of-state corporations can be brought in to run the behavioral health system."¹³ Republicans and administration officials defend the governor's action as necessary, due to credible allegations of fraud, including "fake billing, potential shell companies, and CEOs improperly getting rich off Medicaid funds."¹⁴

Eventually, two Democratic attorneys general declined to prosecute any of the nonprofit organizations for fraud. Well over three years after the battle began, it remains intense, with the providers pursuing legal action to recover the funding that was denied to them, and the Democratic members of the state's congressional delegation pushing for a federal investigation of the Martinez administration's payment freeze, as well as legislation to protect "Medicaid patients by establishing clear guidelines that ensure that state agencies investigating allegations of fraud do so in a manner that both protects health care consumers and affords due process of law to the health care provider."¹⁵

Many officials and advocates in New Mexico's behavioral-healthcare community seem content to continue fighting over the past. But it's clear that there is plenty of blame to go around for the mistakes of the last few decades. Executive-branch managers utterly failed to build an efficient, accountable system. Legislators did not provide adequate oversight. And it's clear that while their actions may not have risen to the level of illegality, many of the state's behavioral-healthcare providers used taxpayer dollars in irresponsible, and even selfish, ways.

¹¹ "Behavioral Health Provider Audit Results," New Mexico Human Services Department, June 24, 2013.

¹² Steve Terrell, "State official storms out amid grilling on provider audit," *Santa Fe New Mexican*, July 6, 2013.

¹³ Steve Terrell, "Lawmaker: Plan to squeeze out local providers predates audit," *Santa Fe New Mexican*, July 31, 2013.

¹⁴ Sidonie Squier, "We must protect behavioral health services," *Santa Fe New Mexican*, July 27, 2013.

¹⁵ "Members of NM Delegation Introduce Bill to Prevent Suspension of Medicaid Services Without Thorough Investigation," press release, U.S. Sens. Tom Udall and Martin Heinrich, U.S. Reps. Ben Ray Lujan and Michelle Lujan Grisham, Apr 4, 2016.

But dwelling on the past accomplishes nothing. The focus now needs to be on moving forward. Three principles, and four policies, should shape a new era of behavioral healthcare in the Land of Enchantment.

Reform Principles

1. More ‘Public Investment’ ≠ Better Results

New Mexico has faced budget strain for years, and there is little evidence that a strong economic turnaround will soon produce a substantial amount of revenue that could be made available for behavioral-healthcare programs. But even if more money were available, there is ample reason to be skeptical about the value of additional “public investment” as a tool to address substance abuse and mental illnesses.

A 2008 analysis by the John Locke Foundation explored states’ spending on mental health in relation to their grades by the National Alliance for the Mentally Ill. In the Southwest region, Arizona spent \$132.91, yet received a grade of D+. Texas (\$37.51) and New Mexico (dead last, at \$31.84) ranked near the bottom, but achieved grades of C and C-.¹⁶

That finding tracks with a comparison of the latest expenditure data from the National Association of State Mental Health Program Directors Research Institute and states’ rankings on Mental Health America’s survey of “mental health needs, access to care, and outcomes.” In the Southwest region, Arizona again spent the most, yet ranked close to the national bottom. At \$56.22 per capita, Oklahoma appeared to return much better value to taxpayers.

Table 1: The Relationship Between Spending and Behavioral-Health Outcomes

	Per Capita Mental Health Spending	MHA Rank
AZ	\$209.44	49
NM	\$131.34	35
CO	\$95.01	18
UT	\$64.39	45
OK	\$56.22	25
TX	\$38.05	32

Sources: National Association of State Mental Health Program Directors Research Institute, Mental Health America

Even revenue streams *earmarked* for behavioral healthcare are no guarantee of successful outcomes. In 2011, a devastating exposé by the *San Jose Mercury News* explored the results of Proposition 63, a ballot initiative approved by California voters in 2004. The measure increased taxes on high incomes, and by the time of the newspaper’s investigation, had raised more than \$7.4 billion to “fund expanded health services for mentally ill children, adults, [and] seniors.” But problems were “evident statewide, despite years of warnings from a high-level whistle-

¹⁶ Joseph Coletti, “Mental Health Reform: Steps Toward Improvement,” John Locke Foundation, October 2008.

blower and other mental health authorities.” The bulk of the funding had “gone to a cottage industry of consultants earning up to \$200 an hour, as well as a host of new programs that in many cases are only loosely linked to prevention, treatment and recovery.”¹⁷

Five years later, California’s Little Hoover Commission, an independent oversight agency, examined Proposition 63. The commission’s chairman concluded that after a decade,

the state cannot provide basic answers to basic questions: Has homelessness declined? Are programs helping Californians stay at work or in school? Who is being served and who is falling through the cracks? The state cannot adequately quantify an anecdotal sense that the act has made California a better place for the estimated 2.2 million adults with a mental health need and their families.¹⁸

The Land of Enchantment has its own example of a behavioral-health tax hike that has yet to deliver results. In February 2015, the Bernalillo County Commission “approved a one-eighth percent gross receipts tax increase to fund new behavioral and mental health services on a 3-2 vote. County leaders will invest this funding in proven ways to better manage the high cost of addiction, homelessness and mental health problems. These issues impact families throughout the community and drive up the cost of public services, especially at the Metropolitan Detention Center.”¹⁹

At the time of the vote, a skeptical county commissioner warned that it was “important that the county seek collaboration from the city, state, University of New Mexico Hospital, nonprofit and private sectors before throwing \$20 million of your hard-earned tax dollars at a problem and effectively striking out alone.”²⁰ A colleague agreed, lamenting that there was “no plan for how that money would be spent, managed and leveraged with other government and private resources. No plan for how we use the money set aside for mental health services to create positive and lasting results in our community.”²¹

Over a year after the tax increase took effect, the *Albuquerque Journal* editorialized that the county was “still working on that plan for new services to spend it on,” but had shifted “a small part of that new revenue to backfill a county budget shortfall,” and devoted “\$1.3 million from the new tax revenue to pick up the cost of an existing housing program that helps inmates coming out of jail, freeing up \$1.3 million for basic county operational costs.” In addition, “new program proposals are not even in the pilot phase because staffers are still working with other agencies on how to carry them out.”²²

¹⁷ Karen de Sá, “Mental Health Spending Creating Haves and Have-Nots,” *San Jose Mercury News*, June 26, 2011.

¹⁸ “Promises Still to Keep: A Decade of the Mental Health Services Act,” Report #225, Little Hoover Commission, January 2015.

¹⁹ “Commission Approves Mental Health Measure,” press release, Bernalillo County, New Mexico, February 26, 2015.

²⁰ Wayne Johnson, “Sales tax increase: We don’t need it -- county can get spending under control and help mentally ill,” *Albuquerque Journal*, February 16, 2015.

²¹ Lonnie Talbert, “Come up with plans for tax before raising it,” *Albuquerque Journal*, February 26, 2015.

²² “County must pay up on its mental health promise,” editorial, *Albuquerque Journal*, July 21, 2016.

Taxpayer revenue must fund New Mexico's behavioral-healthcare system. But blindly hiking taxes and/or appropriating additional dollars is unwise. The goal should be to use existing financial resources in the most effective ways possible.

2. Don't Look to Washington

Repeated audits and investigations have revealed that the federal government's behavioral-healthcare system is a mess. As described by U.S. Rep. Tim Murphy (R-PA), a practicing psychologist: "We are spending \$130 billion a year over some 112 government programs and agencies that don't work together, have little accountability, and in many cases not very good results."²³ For example, a 2014 audit by the Government Accountability Office (GAO) found that the Federal Executive Steering Committee for Mental Health "has not met since 2009."²⁴

Perhaps most disturbingly, the "the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation"²⁵ has repeatedly demonstrated a lack of seriousness in dealing with the nation's behavioral-health challenges. *The Wall Street Journal* noted that the Substance Abuse and Mental Health Services Administration (SAMHSA) "uses its \$3.6 billion annual budget to undermine treatment for severe mental disorders":

For instance, SAMSHA's *Guide to Mental Illness Awareness Week* suggests schools invite as speakers such radical organizations as MindFreedom, which rejects the existence of mental illness and stages "human rights" campaigns against drug treatment and commitments. Or the National Coalition for Mental Health Recovery, which "holds that psychiatric labeling is a pseudoscientific practice of limited value in helping people recover." SAMSHA underwrites the Alternatives conference, which in 2013 included a session titled "Dance Your Way to Wellness and Recovery" and a presentation from the "Hearing Voices Network," which "believes that hearing voices is a part of human experience."²⁶

According to Mental Illness Policy Org., the bureaucracy suffers from grandiosity, and fails to focus on those with the greatest behavioral-health problems:

SAMHSA's strategic plan claims SAMHSA's goal is to create "a high-quality, self-directed, satisfying life integrated in a community for all Americans." A top SAMHSA official told *Time* magazine: "The behavioral health of the entire population is a priority for SAMSHA." Of SAMHSA's eight "strategic initiatives," only one involves getting treatment to adults with serious mental illness. Schizophrenia was not mentioned in the strategic plan. SAMHSA has not helped reduce homelessness, incarceration, violence, the lack of hospital beds and the lack of treatment for people with serious mental illness.²⁷

²³ E. Fuller Torrey & Sally Satel, "Fixing America's Mental-Health System," *National Review*, June 17, 2015.

²⁴ "Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness," GAO-15-113, Government Accountability Office, December 18, 2014.

²⁵ "About Us," Substance Abuse and Mental Health Services Administration website, n.d., accessed August 2, 2016.

²⁶ "The Definition of Insanity," editorial, *The Wall Street Journal*, April 2, 2014.

²⁷ "Problems at SAMSHA," Mental Illness Policy Org., February 10, 2015.

While the federal government does make grants to local and state governments for behavioral health programs, Washington's long-term liabilities all but guarantee that such largesse will not continue. The national debt is \$19.5 trillion.²⁸

But America's fiscal crisis is much greater. As Boston University's Lawrence J. Kotlikoff told the Senate Budget Committee in 2015: "Our country is broke. It's not broke in 75 years or 50 years or 25 years or 10 years. It's broke today. Indeed, it may well be in worse fiscal shape than any developed country, including Greece." The cause of the economist's concern is not the national debt, but the unfunded liabilities for entitlement programs such as Social Security, Medicare, and Medicaid. Estimates vary, but there is no question that the obligations are massive. At "58 percent of the present value of projected future taxes," Kotlikoff explained to senators, Washington is "in far worse fiscal shape than was Detroit before it went broke." His estimate of the nation's total bill for unfunded liabilities is \$210 trillion.²⁹

The federal government cannot keep its behavioral-health house in order, and its coffers are rapidly dwindling. New Mexico should not count on "help" from Washington. The state must design a system to address substance abuse and mental illness that relies on policies and funding generated within the Land of Enchantment.

3. Adopt Meaningful Assessments

Public administrators, at all levels of government, have become skilled at documenting inputs. But for taxpayers, such a focus is woefully incomplete. The real need is to gauge inputs against outputs -- i.e., determine whether tax dollars are being spent wisely.

For example, since the suspension of Medicaid funding to 15 nonprofit providers in the summer 2013, the HSD has repeatedly touted the increased number of New Mexicans obtaining treatment. In April, the department announced that in "fiscal year 2013, 87,373 New Mexicans received behavioral health services. In 2015, that number increased to 153,031. This represents a 75 percent increase from 2013, which means more New Mexicans are receiving behavioral health services than ever before."³⁰

But access to care is exactly that -- access to care. Metrics that catalogue actual *progress* in behavioral health would be far more useful. The Collaborative does publish more detailed quarterly "performance measures," but the statistics are of limited value. For example, the number "of adults diagnosed with major depression who received continuous treatment for 180 days with an antidepressant medication" is tracked, as is the percentage "of individuals discharged from inpatient facilities who receive follow-up services within thirty days." Again, the progress being made by such individuals is not measured. In addition, and rather oddly, the

²⁸ "The Debt to the Penny and Who Holds It," website, Bureau of the Fiscal Service, U.S. Department of the Treasury, accessed August 24, 2016.

²⁹ Laurence J. Kotlikoff, "America's Fiscal Insolvency and Its Generational Consequences," testimony before the U.S. Senate Budget Committee, February 25, 2015.

³⁰ "New Mexico Behavioral Health Services Continue Increase in 2015," infographic, New Mexico Human Services Department, April 25, 2016.

Collaborative records the number “of suicides among youth served by the Behavioral Health Collaborative and Medicaid programs,” but not suicides among adults.³¹

Taxpayers and behavioral-healthcare managers need more and better metrics, in order to understand whether the state’s system of assistance to substance abusers and the mentally ill is working. Are drug and/or alcohol use declining? Is the suicide rate dropping? Are there fewer individuals with mental distress being arrested? What percent of patients are able to effectively manage their condition(s) and reintegrate into the community? How does New Mexico compare to its neighbors, and the nation? Data must be produced for these and other questions, in order to meaningfully judge the direction of behavioral healthcare in New Mexico.

Progress is likelier to be made if the state’s behavioral-healthcare system relies more on evidence-based services, which are programs or practices which have

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.³²

Unfortunately, a legislative analysis recently found that the state spends just “11 percent of its ... funding on proven and effective [behavioral-healthcare] programs for adults, even though past studies have recommended greater spending on these services.”³³

Making providers and managed-care organizations responsible for results would be an effective tool to expand evidence-based treatments in New Mexico. With inadequate measurements, and no performance incentives in place, the current system is focused almost solely on inputs. That must change.

Reform Policies

1. Fix, or Eliminate, the Collaborative

As previously discussed, the Interagency Behavioral Health Purchasing Collaborative was created in 2004. It consists of 15 state agencies, and is led by the HSD, which contributes 80 percent of the Collaborative’s budget. It coordinates services via six regions that represent the four quadrants of the state, as well as Bernalillo County and tribal lands. The regions are subdivided into 18 local collaboratives, which are designed to give communities ownership of their health issues and make recommendations.

³¹ “New Mexico Behavioral Health Collaborative Meeting,” New Mexico Human Services Department, April 14, 2016.

³² “Evidence-Based Programs to Reduce Recidivism and Improve Public Safety in Adult Corrections,” New Mexico Legislative Finance Committee, September 24, 2014.

³³ *Ibid.*

As the core entity for behavioral healthcare in New Mexico, the Collaborative performs several important roles, including setting service definitions, monitoring training, and conducting evaluations. The Collaborative was designed as a cooperative system – an alternative to agencies using their limited resources on behavioral healthcare on their own. For example, rather than having the Corrections Department manage psychological disorders, some of its resources could be redirected to help inmates with mental illnesses receive treatment to avoid incarceration in the first place. Likewise, the Children, Youth and Families Department and Public Education Department would be able to coordinate funding so students can access behavioral healthcare in school.

Unfortunately, the Collaborative has been a disappointment, almost from the start. In a highly critical report released less than a decade after its creation, the Legislative Finance Committee concluded that “the results of the Collaborative’s execution as the state’s behavioral health authority” were “mixed.” Reviewing previous analyses, researchers wrote that “financial management of the statewide entity needs improvement to better monitor utilization and cost of provider services, the effective oversight of access to care and sufficiency of the statewide entity’s network of providers is lacking, and the impact of publicly funded treatment efforts in New Mexico is virtually unnoticeable with the continuous trend of substance abuse by the population and the lack of sufficient data to determine treatment outcomes.”³⁴

The inability of the Collaborative to better coordinate services has led many providers to advocate for its termination. Opponents of the entity predict that eliminating HSD’s monopoly on the control of the behavioral-healthcare system would allow other agencies to operate more freely. Thus, rather than needing HSD’s representative on the Collaborative to approve partnerships, agencies such as Children, Youth, and Families Department and Public Education Department would be able to reach agreements independently to improve patient outcomes. Additionally, termination would eliminate an additional level of bureaucracy that lacks the support of even its own member agencies, many of whom have stopped attending Collaborative planning meetings.³⁵

If the Collaborative can’t be fixed, it should be terminated.

2. Expand Mental-Health Courts

Mental-health courts (MHCs,) which function similarly to drug courts, hear cases involving persons who have psychiatric disabilities and have been charged with a crime. However, MHCs address perpetrators’ mental-health needs, rather than focus on detention, as a way to prevent future misconduct. The courts bring offenders into the behavioral-healthcare system and ensure they are receiving the services they need by requiring and incentivizing treatment, medical care, and case management. This approach is particularly beneficial for people who would not be in the behavioral-healthcare system otherwise.

³⁴ “Cost and Outcomes of Selected Behavioral Health Grants and Spending,” Report #13-04, Legislative Finance Committee, New Mexico Legislature, May 16, 2013.

³⁵ *Ibid.*

Bernalillo County Metropolitan Court’s MHC “includes intensive treatment and supervision by a team of legal and mental health providers and regular trips before the judge rather than incarceration. For most misdemeanor offenders, it serves as a pre-prosecution diversion -- meaning that those who successfully complete the program, which can take three months to a year, serve no jail time and have their charges dismissed.”³⁶

Evidence is beginning to demonstrate the effectiveness of MHCs. According to Columbia University’s Paul S. Appelbaum:

After some early equivocal findings, most recent studies have confirmed that MHC participation is associated with reduced rates of re-arrest and re-incarceration compared with ordinary handling by the courts and correctional system. A newly published study of the District of Columbia MHC, for example, found that 25 percent of misdemeanor defendants with serious mental illnesses who “graduated” from the program were rearrested within two years, compared with 48 percent of defendants who were eligible for the program but didn’t enter it. . . . Similarly positive results come from Ramsey County, Minnesota, in which St. Paul is located: misdemeanants who went through the usual criminal process were two and a half times more likely to be convicted in their first year in the community and served almost five times as many days in jail in that period compared with MHC completers.³⁷

There have not been extensive studies of MHCs in New Mexico, but the data that are collected are encouraging. In the 2015 fiscal year, offenders who graduated from the state’s MHC programs had a recidivism rate of 19.3 percent. For all program participants, including those who did not graduate from their mental health court, the recidivism rate increases slightly to 23 percent, which is significantly lower than the state’s overall rate.³⁸

There is room to expand MHCs in New Mexico, as the five existing courts serve the Albuquerque-Santa Fe region, and only four of the state’s 13 judicial districts. Yet the remainder of the state accounts for over 750,000 people, which would yield a 60 percent increase in MHC participation if the new courts were utilized at the same rate as the existing courts. Interest in MHCs appears to be growing in the state. For example, Otero County officials, including Commissioner Susan Flores and District Judge Division IV Angie Schneider, recently “led a discussion on bringing a mental health court to Otero County.”³⁹

While the primary issues MHCs aim to address are public safety and offenders’ well-being, the financial benefits should not be overlooked. New Mexico’s up-front incarceration cost per

³⁶ Joline Gutierrez Krueger, “Mental Health Court provides help all around,” *Albuquerque Journal*, December 17, 2014.

³⁷ Paul S. Appelbaum, “Mental Health Courts: A workaround for a broken mental health system,” *Washington Monthly*, June/July/August 2016.

³⁸ “NM Mental Health Treatment Court Performance Measures Reporting Period: FY 15 Year-End,” New Mexico Corrections Department, n.d., accessed August 8, 2016.

³⁹ Wayne Neal II, “Twelfth Judicial District Proposes Mental Health Court,” *Alamogordo Daily News*, July 19, 2016.

prisoner per year is just over \$35,500, or \$97.25 per day.⁴⁰ That is more than seven times the cost of enrollment in a mental-health treatment court program, which costs \$3,700 per year, or \$10 per day.⁴¹

3. AOT Is Finally the Law – Use It

After many years of debate, in 2016, legislators passed and Governor Susana Martinez signed a bill aimed at “those individuals with a primary diagnosis of a mental disorder who have not complied with treatment and as a result have been hospitalized or incarcerated twice in the past four years, threatened or committed violence on others or themselves, or have been recently or will soon be released from treatment or prison.”⁴²

Modeled on legislation adopted in nearly every state, and often called “Kendra’s Law,” assisted outpatient treatment (AOT) was defined as “services ordered by a district court, including case management services, care coordination or assertive community treatment team services, prescribed to treat a patient’s mental disorder and to assist a patient in living and functioning in the community or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in harm to the patient or another or the need for hospitalization.”

AOT may require medication, blood tests or urinalysis, individual or group therapy, “day or partial-day programming activities,” “educational and vocational training or activities,” substance-abuse and counseling, “supervision of living arrangements,” and “any other services prescribed to treat the patient’s mental disorder and to assist the patient in living and functioning in the community, or to attempt to prevent a deterioration of the patient’s mental or physical condition.”⁴³

Relatives and healthcare officials can file a “petition for an order authorizing assisted outpatient treatment” for adults who have “demonstrated a history of lack of compliance with treatment for a mental disorder.” A treatment plan is then drafted, to include “case management services or an assertive community treatment team to provide care coordination and assisted outpatient treatment services.” At the conclusion of a hearing, “the court may order the respondent to receive assisted outpatient treatment if it finds by clear and convincing evidence that the respondent meets all criteria set forth in ... the Assisted Outpatient Treatment Act.” Appeals are allowed, and “a party or the respondent’s surrogate decision-maker may apply to the court to stay, vacate, modify or enforce the order.”⁴⁴

Supporters have assembled impressive, and voluminous, evidence that, in the words of the Treatment Advocacy Center’s Brian Stettin, AOT “leads to reduction of hospitalization and

⁴⁰ “Corrections Statistics by State: New Mexico,” National Institute of Corrections, United States Department of Justice, n.d., accessed August 10, 2016.

⁴¹ “NM Mental Health Treatment Court Performance Measures Reporting Period: FY 15 Year-End,” New Mexico Corrections Department, n.d., accessed August 8, 2016.

⁴² “Survivor helps deliver outpatient treatment law,” editorial, *Albuquerque Journal*, February 26, 2016.

⁴³ SB 113, New Mexico Legislature, Regular Session, 2016.

⁴⁴ *Ibid.*

criminal acts,” and reduces the number of “people ... getting treated in jails or prison for mental illness.”⁴⁵

It took New Mexico far too long to adopt AOT. But now that it is permitted in the state, the challenge is move forward with implementation. AOT is not mandatory. To initiate the treatment process, a municipality or county must sign a memorandum of understanding with “its respective district court with respect to the funding of such district court’s administrative expenses, including legal fees.”⁴⁶ With local governments facing significant fiscal challenges, it would be easy to ignore the opportunity AOT offers. But any up-front costs are likely to be repaid in the longer term.

Violent behavior “by individuals with untreated severe mental illness is a significant and increasing problem,” and accounts “for approximately 10 percent of all homicides.”⁴⁷ Studies have consistently shown that AOT “can reduce ... criminal justice system costs.”⁴⁸ New Mexico’s municipalities and counties should move rapidly to reallocate the financial resources necessary to implement AOT in their communities. Once begun, of course, AOT should be subjected to the same rigorous assessments that must be applied to all parts of the state’s behavioral-healthcare system.

4. Expand the Community of Caregivers

According to the New Mexico Health Care Workforce Committee 2015 Annual Report, between 2013 and 2014, the “estimated number of psychiatrists decreased by 32 practitioners, an alarming decline given the serious shortages of behavioral health professionals across the state.” To meet the national metric of 1 per 6,500 residents, state would need to add “an additional 109 psychiatrists.”⁴⁹ With “its vast rural landscape, access to a psychiatrist outside urban communities like Albuquerque, Santa Fe, and Las Cruces is challenging.”⁵⁰ Behavioral-healthcare providers also complain of a shortage of other professionals, including “prescribing psychologists and psychiatric nurse practitioners.”⁵¹

The problem of an insufficient number of behavioral-health workers was greatly exacerbated by the state’s expansion of Medicaid under Obamacare, which greatly expanded the number of people eligible for services.⁵² The result, oftentimes, has been long waiting lists and shorter or less frequent appointments.

⁴⁵ Brigitte Russell, “NM senator: Assisted outpatient treatment saves money, lives,” Watchdog.com, February 10, 2015.

⁴⁶ SB 113, New Mexico Legislature, Regular Session, 2016.

⁴⁷ “Does Assisted Outpatient Treatment (AOT) Decrease Violence?,” Backgrounder, Treatment Advocacy Center, June 2016.

⁴⁸ “Assisted Outpatient Treatment Saves Money,” Backgrounder, Treatment Advocacy Center, January 2013.

⁴⁹ 2015 Annual Report, New Mexico Health Care Workforce Committee, October 1, 2015.

⁵⁰ “Behavioral Health Business Plan,” Prepared for Bernalillo County Board of County Commissioners, Community Partners, Inc., December 1, 2015.

⁵¹ Diana Alba Soular, “Shortage plagues La Clinica mental health service,” *Las Cruces Sun-News*, December 8, 2015.

⁵² Dan Boyd, “State Medicaid costs called a ‘runaway train,’” *Albuquerque Journal*, October 28, 2015.

The behavioral-healthcare worker shortage has prompted some legislators to draft subsidization proposals. For example, in 2015, SB 154 unsuccessfully attempted to appropriate \$12 million “to the board of regents of the University of New Mexico for expenditure in fiscal years 2015 through 2020 to expand access to behavioral health and substance use disorder treatment through training and support of the primary care work force in twenty community clinics.”⁵³

But such efforts are flawed, since they do not require the behavioral-healthcare workers funded to remain in the state once their training is complete. The Land of Enchantment’s economic woes and social pathologies are substantial – e.g, high unemployment, low wages, poorly performing government schools, and a serious violent-crime rate.

New Mexico’s best option to attract behavioral-healthcare workers is to make the state a more attractive place to live. That means aggressively pursuing an economic-development strategy that includes deregulation, tax cuts/simplification, and a right-to-work law. It also means tackling social ills through welfare reform and school choice. When the state becomes richer and safer, all manner of professionals, including those who treat substance abuse and mental disorders, will be drawn to New Mexico.

In the meantime, there are a few measures policymakers can pursue to lighten the behavioral-healthcare workforce’s load. Mental health first aid, a concept originating in Australia a decade and a half ago, is

an 8-hour course that introduces participants to risk factors and warning signs of mental health concerns, builds understanding of their impact, and overviews common treatments. The course uses role-playing and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect persons to professional, peer and social supports as well as self-help resources.

Mental Health First Aid allows for early detection and intervention by teaching participants about the signs and symptoms of specific illnesses like anxiety, depression, schizophrenia, bipolar disorder, eating disorders, and addictions. The program offers concrete tools and answers key questions like “What can I do?” and “Where can someone find help?” Participants are introduced to local mental health resources, national organizations, support groups, and online tools for mental health and addictions treatment and support.⁵⁴

Government employees whose jobs involve daily interaction with the public – such as teachers, police officers, firefighters, and community-service workers – should be encouraged, if not required, to seek certification. While participation in the program hardly qualifies one as a behavioral-health professional, Mental Health First Aid’s impact is not in doubt. Research shows “that the program saves lives, improves the mental health of the individual administering care *and* the one receiving it, expands knowledge of mental illnesses and their treatments, increases

⁵³ SB 154, New Mexico Legislature, Regular Session, 2015.

⁵⁴ “Mental Health First Aid,” National Council for Behavioral Health website, n.d., accessed August 24, 2016.

the services provided, and reduces overall social distance toward individuals with mental illnesses by improving mental health literacy.”⁵⁵

Peer support is another way for non-professionals to compensate, to some degree, for New Mexico’s insufficient behavioral-healthcare workforce. Peers “are persons with mental health conditions who have completed specific training that enables them to enhance a person’s wellness and recovery.” They “work in a variety of locations, such as peer support centers, crisis stabilization units, respite programs, psychosocial rehabilitation programs, and in psychiatric hospitals.

Peer support can be a one-on-one experience or a group of people sharing together.”⁵⁶ The best-known example of a peer-support network is Alcoholics Anonymous. But peers have become more and more important in all aspects of behavioral health. They are “usually paid for their services and are often certified.”⁵⁷ But the broad services provided by peers come at a much lower cost than those supplied by the highest-earning behavioral-healthcare workers, such as psychiatrists and psychologists.

Peer support has its limits. But perhaps the only positive aspect of the widespread prevalence of behavioral-health problems in New Mexico is the existence of a large community of men and women who have been successfully treated for substance abuse and/or mental disorders. All efforts should be made to encourage this cohort to offer its knowledge and experience to those currently suffering from behavioral-health issues.

Conclusion

No one denies the desperate need to improve behavioral healthcare in the Land of Enchantment. The data are disturbing. Far too many New Mexicans abuse themselves with alcohol and/or drugs. Too many citizens fail to get treatment for depression, bipolar disorder, and schizophrenia. And the state’s suicide rate is unacceptably high.

Change will not come quickly, but improvement is possible. Policymakers must fundamentally rethink their current strategies. The limits of government spending must be acknowledged, and a closer “partnership” with Washington should be avoided. Assessments and accountability measures must improve. A final determination about the Collaborative is overdue. Mental-health courts should be expanded, and assisted outpatient treatment effectively employed. While the near-term likelihood of a surge in behavioral-healthcare workers is low, Mental Health First Aid and peer support can play important roles in enhancing the caregiving community.

The crisis is severe, but a reorientation toward sound principles and effective policies can greatly improve New Mexico’s behavioral-healthcare system.

⁵⁵ “Frequently Asked Questions,” Mental Health First Aid USA website, n.d., accessed August 24, 2016.

⁵⁶ “Peer Support: Why it Works,” National Coalition for Mental Health Recovery, April 2014.

⁵⁷ Paul Gionfriddo , “Peer Support Programs Offer A Golden Opportunity For Funders To Affect Delivery Of Behavioral Health Services,” *Health Affairs* Blog, October 30, 2013.

D. Dowd Muska (dmuska@riograndefoundation.org) is research director for and Christopher Abbott is a policy analyst with the Rio Grande Foundation, an independent, nonpartisan, tax-exempt research and educational organization dedicated to promoting prosperity for New Mexico based on principles of limited government, economic freedom and individual responsibility.

Rio Grande Foundation
P.O. Box 40336 • Albuquerque, NM 87196
Phone: (505) 264-6090 • Fax: (505) 213-0300
Info@RioGrandeFoundation.org • @RioGrandeFndn