OVERVIEW: BEHAVIORAL HEALTH LOCAL COLLABORATIVES

In 2004, The New Mexico State Legislature passed and the Governor signed into law a statute creating the state Interagency Behavioral Health Purchasing Collaborative (Collaborative), a body of the 15 State Agencies (17 members) that are responsible for mental health and substance abuse services that would collaborate to plan, design and direct a single statewide behavioral health system. This effort was designed to ensure both availability of services and efficient use of funding, taking into consideration funds appropriated to specific affected departments, and contract with a single behavioral health entity to ensure availability of services throughout the state.

Recognizing that this State collaboration would only be effective if local efforts at collaboration are successful in bringing to bear the variety of input and resources in local areas to solve local issues, the Collaborative provided for the organization of Local Collaboratives (LCs) throughout the state. Initially, 15 LCs were organized, which corresponded geographically to the 13 Judicial Districts, as well two additional Collaboratives to represent the Native American communities in the state. In 2008, recognizing that two LCs could not adequately represent the diverse interests and needs of all of the Native American communities of our state, the Collaborative approved an additional three Native American LCs. See the last section for a complete listing of the Local Collaboratives and the locality or constituency each covers.

SUMMARY: The original purpose of the Local Collaboratives was to develop strong local voices to guide behavioral health planning and services, a key consideration in the planning and design of the Collaborative's initiative. Local Collaboratives were identified or formed locally and recognized by the Collaborative to help create and sustain the partnerships among consumers, family members, advocates, local agency providers, and community stake holder groups. Through the years, LCs identified behavioral health services needs, made recommendations towards building local capacity to promote wellness and recovery, and developed a range of local resources to serve consumers and their families.

Basic Functions of Local Collaboratives:

- To create, enhance and sustain needed partnerships among local agencies, community groups, families, consumers, and advocates.
- To be the voice of local communities, help identify needs, develop a range of resources, and ensure the relevance and responsiveness of services and supports to improve the quality of life of those affected by behavioral health outcomes.
- To the extent possible, provide local input to the Collaborative on policy aspects of behavioral health services.

Specific functions will include:

- Participation in local area and community needs assessments and input for behavioral health-related and other Health and Human Services (HHS) planning, including interaction with the state Behavioral Health Planning Council and its subcommittees;
- Identification of service needs and gaps, including recommendations of priorities to the state Collaborative and the Statewide Entity (SE) for the geographic area or population represented;
- Help with capacity building and resource development planning for locally identified target groups in need of services, with a particular focus on informal or natural supports;
- Coordination across multiple health and human services systems to assure individuals are well-served, systems do not duplicate each other, and limited resources are maximized and well-utilized;

- Review and input to state Collaborative member agencies about funding provided to and programs developed for the geographic area or population represented;
- Review and response to data and information provided by the state HHS agencies and the SE about service needs, utilization and outcomes in the geographic area or population represented;
- Provision of input regarding quality and coordination of services and needs for training and technical assistance;
- Assistance and recommendations to the Collaborative and the SE regarding problem-solving that needs to occur or resolution of problems identified by the local collaborative, the state Collaborative, or the SE.

GOVERNOR'S PERFORMANCE MEASURE:

Goal 4. Improve Behavioral Health through an Interagency and Collaborative Model
Task 4.2 Improve access, quality, and value of mental health and substance abuse services
Task 4.4 Increase rural, frontier, and border access to behavioral health services

HSD STRATEGIC PLAN:

Goal 4: Improve Behavioral Health Services through an Interagency Collaborative Model
Goal 4.2: Reduce adverse impacts of substance abuse and mental illness on individuals, families and communities
Task 4.5: Develop New Mexico's behavioral health workforce

COMPREHENSIVE STRATEGIC PLAN:

Goal 1: Assist Consumers to Participate Fully in the Life of Their Communities

1. Adult consumers have housing, employment and/or supports to successfully manage life challenges; to live, work, learn and participate fully in the lives of their communities.
3. Consumers play an active and authentic role in Local Collaboratives' (LCs) membership and leadership.
5. Local service delivery systems are consumer driven and involve families appropriately.

Please refer to the 2010 BH Collaborative Strategic Plan located at:
http://www.bhc.state.nm.us/pdf/Strategic%20Plan%20PowerPoint%2010%2019%2010.pdf

OTHER PERFORMANCE MEASURE:

- *NM Strategic Priorities, Proposed Strategic Priorities for 2010-2011*
  BHPC Recommendations to the Collaborative
  Priorities: Crisis Response
  Suicide Prevention
  Transportation

- CLAS Standards 4, 5, 6 and 7 are mandated for all recipients of Federal funds.
  - Standard 4: Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
  - Standard 5: Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
  - Standard 6: Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff.

Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- Standard 7: Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

CURRENT FUNDING:
In previous years, each Local Collaborative received $21,000 for its annual operation expenses. In FY 12, LC budgets were reduced to $6,000. These expenses include meeting costs, stipends and travel costs for consumers and family members to participate in Local Collaborative meetings and activities, and the contracting of an Administrative Assistant to facilitate coordination of activities and dissemination of information. Fiscal management has shifted to reducing or eliminating meeting stipends, mileage reimbursement, and elimination of administrative assistant support. More meetings take place via teleconference.

CURRENT PROGRAM STATUS:
Link to the FY 10 Behavioral Health Planning Council Annual Report
(http://www.bhc.state.nm.us/pdf/Annual%20Rpt%209_15.pdf

FACTS/CHALLENGES:
The Local Collaboratives (LCs) have made considerable strides in increasing behavioral health awareness and engagement statewide, through creating mentorship groups, attendance and participation in beneficial conferences and trainings, increased community commitment, legislative successes, strengthening of valuable partnerships, and local development and input on statewide initiatives such as systems of care planning.

Local Collaboratives continue to be functional and active. Most of them meet monthly. Several have identified committees that address specific issues of concern or represent the various county or other geographical components of the organization. All of them have email lists that serve as a communication network on matters of behavioral health and several have active web sites. Most have contracted an administrative assistant that manages communications, keeps records and provides all necessary administrative support to the LC.

The 18 Local Collaboratives represent the following geographical areas or communities:

LC 1: Santa Fe, Rio Arriba, and Los Alamos Counties
LC 2 : Bernalillo County
LC 3 : Dona Ana County
LC 4 : San Miguel, Mora, and Guadalupe Counties
LC 5: Chaves, Lea, and Eddy Counties
LC 6: Grant, Hidalgo, and Luna Counties
LC 7: Catron, Sierra, Socorro, and Torrance Counties
LC 8: Taos, Union, and Colfax Counties
LC 9: Roosevelt and Curry Counties
LC 10: Harding, DeBaca, and Quay Counties
LC 11: McKinley and San Juan Counties
LC 12: Otero and Lincoln Counties
LC 13: Cibola, Sandoval, and Valencia Counties
LC 14: Mescalero, Jicarilla, Zuni, Laguna, Acoma, Isleta, and some Navajo Chapters.
LC 15: Navajo Nation
LC 16: Sandoval County Pueblos

LC 17: Off Reservation Native Americans LC 18: Eight Northern Pueblos