APPROVED

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Region 9
Curry / Roosevelt County
Behavioral Health Reform and Investment Act

Region Represented (1-13) : Region 9

Counties, Nations, Pueblos, and Tribes represented within region: Curry & Roosevelt Counties

Accountable Entity: Curry County

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SECTION 1: PROGRAM OVERVIEW

Region 9, encompassing Curry and Roosevelt Counties, serves a geographically large and predominantly rural population with significant behavioral health needs and limited behavioral health service capacity. Challenges within the Region include workforce shortages, limited access to appropriate levels of care, transportation barriers, and overreliance on emergency departments and law enforcement response for individuals experiencing behavioral health crises.

Behavioral health providers operate across the two counties with varying levels of infrastructure, resulting in inconsistent access to services and fragmented care coordination. Transportation barriers, workforce limitations, and insufficient local crisis care infrastructure further contribute to delays in accessing timely behavioral health treatment and support.

Medicaid utilization data identified system challenges across Region 9's behavioral health systems:

- Elevated emergency department utilization (20.32%) for behavioral health conditions, indicating overreliance on acute care
- Significantly low utilization of intensive outpatient services (2.28% vs. 7.23% statewide), reflecting insufficient access to appropriate levels of care
- High prevalence of behavioral health conditions, including:
    - Anxiety disorders (61.97% adults; 38.74% youth)
    - Mood disorders and ADHD
    - Substance use disorders, including stimulant, alcohol, and opioid use

While the Extended Sequential Intercept Mapping (E-SIM) and Prioritization Workshop Report [December 2025] from the University of New Mexico identified the following gaps:

- Workforce shortages across licensed providers, substance use specialists, and peer support roles
- Limited access to:
    - Detox and stabilization services
    - Crisis response infrastructure
    - Recovery and transitional housing
    - Youth prevention and early intervention programs
- Behavioral health services for youth are primarily crisis-driven rather than preventive

These findings demonstrate a system that is reactive rather than proactive, with insufficient capacity at the community level to prevent escalation to medical and mental health crises.

Regional Priorities

This plan reflects a coordinated regional strategy to address the most significant behavioral health infrastructure gap identified through stakeholder engagement, regional data analysis, and the Expanded Sequential Intercept Mapping (E-SIM) process. While multiple behavioral health needs were identified throughout the planning process, Region 9 elected to concentrate available Behavioral Health Reform and Investment Act (BHRIA) funding on a single transformational investment: implementation of the Horizon Behavioral Health Center, a Crisis Triage Center (CTC). This targeted investment is intended to strengthen crisis response capacity, improve continuity of care, reduce reliance on emergency departments and law enforcement, and establish sustainable behavioral health infrastructure for Curry and Roosevelt Counties.

Primary Priority: Crisis, Acute, and Higher-Level Care Infrastructure

The Region currently lacks sufficient local crisis stabilization and medication-based withdrawal management capacity. Individuals experiencing behavioral health crises frequently rely on emergency departments, law enforcement involvement, or out-of-region services due to limited local alternatives. Geographic barriers, workforce shortages, and insufficient behavioral health infrastructure further contribute to delays in accessing appropriate care.

The CTC is intended to address these gaps by creating a centralized behavioral health crisis resource that expands access to crisis stabilization services, medication-based withdrawal management, care coordination, and connections to ongoing treatment and recovery services.

Proposed Services & Outcomes

Proposed services include:

- Crisis stabilization services
- Medication-based withdrawal management services
- Peer support services
- Care coordination and referral management
- Behavioral health assessment and triage
- Coordination with healthcare, behavioral health, and justice system partners

Implementation of the CTC is expected to result in:

- Increased access to crisis stabilization and acute behavioral health services
- Reduced reliance on emergency departments for behavioral health crises
- Reduced law enforcement involvement in behavioral health crisis response
- Improved continuity of care and care transitions
- Increased treatment engagement and recovery support
- Expanded behavioral health system capacity across Region 9

Supporting System Investments

In addition to direct investment in crisis infrastructure, implementation will include workforce development, regional oversight, evaluation, and care coordination activities necessary to ensure successful implementation, performance monitoring, and long-term sustainability of the CTC.

These supporting activities are intended to strengthen the broader behavioral health system while maximizing the impact of the region's primary infrastructure investment.

Governance of Regional Planning Structure

Region 9 utilizes a collaborative governance structure designed to support implementation, oversight, accountability, and long-term sustainability of the CTC. Governance responsibilities are shared among Curry County as the Accountable Entity, Community Bridges as the proposed operating partner, and regional stakeholders representing healthcare, behavioral health, emergency response, justice system, and community-based organizations.

The governance structure is intended to support coordinated decision-making, implementation oversight, performance monitoring, and alignment with BHRIA requirements.

Major implementation, funding, and strategic decisions will be reviewed through the regional governance structure, with Curry County serving as the Accountable Entity responsible for fiscal oversight, contractual compliance, and final approval of regional funding decisions.

Governance responsibilities include:

- Strategic oversight and regional planning coordination
- Fiscal management and contract administration
- Implementation monitoring and performance reporting
- Stakeholder engagement and partner coordination
- Continuous quality improvement and evaluation activities

Coordination mechanisms include:

- Regular implementation and stakeholder coordination meetings
- Ongoing collaboration among healthcare, behavioral health, emergency response, and community partners
- Performance review and evaluation activities
- Annual review of implementation progress, outcomes, and sustainability planning

This governance structure promotes accountability, transparency, and coordinated implementation while ensuring the regional investment remains aligned with identified behavioral health needs and long-term system goals.

Accountable Entity

Curry County will serve as the designated Accountable Entity for this regional plan and will serve as the fiscal agent and primary coordinating body for the regional plan.

Roles and Responsibilities:

- Fiscal and administrative oversight.
- Coordination of regional partners.
- Monitoring implementation and performance.
- Ensuring compliance with BHRIA requirements.

The Accountable Entity will maintain clear governance structures and decision-making processes to ensure effective implementation of the regional plan's identified priorities and action items.

Stakeholder Engagement

Stakeholder engagement has been conducted through a variety of methods to ensure inclusive and representative input.

Participating groups include:

- Counties and local governments.
- Behavioral health providers.
- Healthcare systems.
- Community organizations.
- Individuals with lived experience.

Engagement methods include:

- Community meetings, listening sessions and workshops
- Structured feedback processes
- Collaboration with healthcare providers and social service organizations

Stakeholders will continue to participate throughout implementation through regular coordination meetings, performance reviews, evaluation activities, and ongoing feedback processes designed to support continuous quality improvement and regional accountability.

Continuity of Care & Longevity

The CTC is designed to serve as a critical component of the regional behavioral health continuum, providing stabilization, assessment, referral, and care transition services that connect individuals to appropriate levels of care.

The CTC will support continuity of care through coordinated referral pathways involving healthcare providers, behavioral health providers, community-based organizations, emergency departments, law enforcement agencies, emergency medical services, and other regional partners.

Individuals receiving services through the CTC will be connected to ongoing treatment and recovery support based on their identified needs. Discharge planning will begin at intake and will focus on coordinating appropriate follow-up care, engaging natural supports when appropriate, scheduling aftercare appointments, and connecting individuals with community-based behavioral health, substance use treatment, Medication-Assisted Treatment (MAT), primary care, peer support, housing resources, and other recovery services available throughout the Region. Care transitions will emphasize returning individuals to services within their home communities whenever clinically appropriate.

The regional plan emphasizes coordinated transitions between levels of care, ensuring that individuals are connected to appropriate services following crisis stabilization or withdrawal management services. Care coordination activities will focus on reducing service fragmentation, improving treatment engagement, and strengthening long-term recovery outcomes.

Long-term sustainability will be supported through alignment with Medicaid reimbursement models, integration with existing provider networks, ongoing evaluation and performance monitoring, and continued collaboration among regional partners. This approach promotes a sustainable crisis care continuum while improving access to behavioral health services throughout Region 9.

SECTION II: DEMONSTRATION OF NEED

While multiple behavioral health needs were identified through the regional planning process, stakeholders consistently identified crisis stabilization, withdrawal management, and acute behavioral health services as the most significant infrastructure gaps affecting the region. As a result, Region 9 elected to focus on the implementation of the CTC. This investment is intended to address the region's most pressing behavioral health service gap while strengthening continuity of care, crisis response capacity, and access to appropriate levels of treatment throughout Curry and Roosevelt Counties.

Population Needs

As reported by the Expanded Sequential Intercept Mapping (E-SIM) and Prioritization Workshop Report [December 2025] from the University of New Mexico, Region 9 serves an estimated population of approximately 65,000 residents. Regional demographics outlined in the report:

- Higher proportion of Non-Hispanic White residents (48.15%) compared to state average (45.22%)
- Lower proportion of Hispanic residents (36.53%) compared to state average (45.15%)
- Majority adult population (73.66%)

The E-SIM final report also included the following diagnoses and service utilization data indicators based upon the population covered by Medicaid in Region 9:

Youth (under 18):

- Anxiety disorders (38.74%) are the most prevalent diagnosis.
- Followed by ADHD (29.68%) and mood disorders (26.10%).

Adults (18+):

- Anxiety disorders (61.97%) are the most common.
- Followed by mood disorders (40.78%) and substance use disorders.
- Service utilization indicators:
    - Outpatient utilization is high (88.06%).
    - Intensive outpatient utilization is significantly lower than the state average (2.28% vs 7.23%).
    - Crisis service utilization is slightly elevated (25.33%).

Underscoring the need for substance use disorder treatment services in the Region, the New Mexico Department of Health reported the following non-fatal and fatal overdose counts from 2025 (provisional data) for adults in Region 9:

- 43 Non-Fatal Overdoses with 39 of those due to opioids.
    - In Curry County, the number of non-fatal overdoses have more than doubled as compared to 2024.
- 20 Fatal Overdoses (including suspected) with 13 of those due to opioids.

Additional youth behavioral health risk indicators further underscore the need for timely access to behavioral health assessment, crisis intervention, stabilization services, and coordinated referral pathways for youth experiencing behavioral health emergencies.

In Roosevelt County, 38.4% of high school students reported feeling sad or hopeless, compared to 36.7% statewide. Additionally, 20.8% reported seriously considering suicide and 10.4% reported attempting suicide—both higher than statewide averages (14.8% and 8.4%, respectively).

In Curry County, while reported rates of sadness and suicidal ideation are closer to or slightly below statewide averages, suicide attempt rates remain elevated (9.1% vs. 8.4% statewide).

These findings highlight significant behavioral health needs among youth in Region 9 and underscore the importance of timely access to behavioral health assessment, crisis intervention, stabilization services, and coordinated referral pathways across the continuum of care. While the regional investment strategy focuses on crisis and acute behavioral health infrastructure, improved crisis response capacity is expected to benefit youth and adults experiencing behavioral health emergencies throughout the region.

System pressure indicators:

- Behavioral health-related ER visits are higher than the state average (20.32% vs 18.80%)
- Workforce shortages are evident, particularly among substance use disorder specialists

This data demonstrates a system with high demand for outpatient services, limited access to higher levels of care, and insufficient behavioral health workforce capacity to meet regional needs.

Service Gaps & Challenges

The E-SIM workshop identified system-wide gaps across youth and adult behavioral health systems, with particular emphasis on prevention, crisis response, workforce capacity, and system coordination.

The E-SIM process identified multiple behavioral health service gaps across the continuum of care. The following findings informed regional planning and prioritization activities; however, available BHRIA funding will be concentrated on implementation of the CTC as the region's highest-priority infrastructure investment.

Key System Gaps

1. Workforce Shortages
    - Significant shortage of behavioral health providers across both counties
    - Limited availability of substance use disorder treatment specialists
    - Long wait times for services
2. Limited Crisis Infrastructure
    - Insufficient mobile crisis response utilization
    - Lack of co-responder models
    - Limited local medication-based withdrawal and crisis stabilization services
3. Housing and Reentry Gaps
    - Lack of transitional and supportive housing
    - No reintegration centers for youth or adults
    - Limited recovery housing options
4. Youth Prevention and Early Intervention Gaps
    - Limited prevention programming outside of schools
    - Lack of structured youth activities and safe spaces
    - Limited parental engagement and support services

5. System Fragmentation and Coordination Issues
    - Underutilization of care coordination programs
    - Limited communication between providers
    - Gaps in referral pathways and system navigation

The regional planning process identified multiple behavioral health service gaps across the continuum of care. While each of these needs remains important, available BHRIA funding is insufficient to fully address all identified challenges. Regional stakeholders therefore evaluated opportunities based on system impact, implementation readiness, sustainability, and ability to address multiple service gaps through a single investment strategy.

While the E-SIM process identified multiple behavioral health system challenges, regional stakeholders determined that crisis stabilization and acute behavioral health infrastructure represented the most immediate and consequential service gap. The absence of local crisis stabilization and withdrawal management capacity contributes to increased emergency department utilization, law enforcement involvement, delayed access to treatment, and reliance on out-of-region services. These findings directly informed the Region's decision to prioritize implementation of the CTC as its primary BHRIA investment strategy.

Impact

Implementation of the identified priority is expected to result in measurable system improvements. Key System Level Outcomes are:

System Level	Outcome
Access to Care	• Increase access to crisis stabilization services within Region 9 and reduce reliance on out-of-region placements • Increase access to medication-based withdrawal management services • Improve timely access to behavioral health assessment, triage, and stabilization services • Increase successful connection and referral to ongoing behavioral health treatment and recovery supports
Crisis Response	• Reduce behavioral health related emergency department utilization rate from 20.32% toward parity of statewide benchmark • Reduce reliance on law enforcement for behavioral health crisis response • Increase utilization of local crisis stabilization services and diversion opportunities • Strengthen coordination between healthcare, behavioral health, emergency response, and justice system partners • Increase diversion of individuals experiencing behavioral health crises from emergency departments and law enforcement response to appropriate behavioral health services

Workforce Capacity	• Increase behavioral health workforce capacity to support crisis stabilization, withdrawal management, care coordination, and recovery services associated with implementation of the CTC. • Reduce wait times for behavioral health screening, assessment, stabilization, and referral to treatment services
Continuity of Care & Recovery	• Improve successful transitions from crisis services to ongoing treatment and recovery supports • Increase treatment engagement and retention at 90 days and 180 days • Improve care coordination and continuity of care across the behavioral health continuum
System Sustainability	• Establish sustainable local crisis care infrastructure within Region 9 • Increase regional behavioral health service capacity through implementation of the CTC. • Support long-term sustainability through Medicaid reimbursement, non-Medicaid revenue sources, regional partnerships, and continuous quality improvement activities

SECTION III: IMPLEMENTATION

Readiness & Capacity

Region 9 demonstrates strong readiness to implement the proposed CTC through completed regional planning activities, established governance structures, identified implementation partners, and ongoing coordination among behavioral health, healthcare, and community stakeholders.

Over the past year, Region 9 has completed the Expanded Sequential Intercept Mapping (E-SIM) process, stakeholder engagement activities, regional needs assessment, service gap analysis, and prioritization process required to identify the highest-impact behavioral health investment opportunities. These efforts consistently identified crisis stabilization and acute behavioral health services as the region's most significant infrastructure gap.

Implementation planning is actively underway. Construction of the Horizon Behavioral Health Center CTC is progressing on schedule, with facility completion anticipated in October 2026 and service launch targeted for January 2027. Community Bridges, the proposed operator, has initiated key pre-operational activities including submission of a Letter of Intent to the state licensing agency, architectural plan review, licensing activities, Medicaid enrollment preparation, reimbursement rate discussions with the New Mexico Health Care Authority, and preliminary contracting discussions with Medicaid Managed Care Organizations, commercial payors, and TRICARE. These implementation activities position the Region to transition efficiently from planning into operational readiness following award of BHRIA funding.

The City of Clovis, the fiscal agent for the CTC, has identified Community Bridges Inc. as the proposed operating partner for development and operation of CTC. Preliminary implementation planning, financial modeling, sustainability planning, and service design activities have been initiated to support successful implementation and long-term sustainability.

Organizational readiness is further supported through:

- Designation of Curry County as the Accountable Entity responsible for fiscal oversight, contract administration, compliance monitoring, and regional coordination.
- Planned recruitment and onboarding of a Regional Behavioral Health Administrator to support implementation oversight, stakeholder coordination, performance monitoring, reporting, and compliance activities.
- Existing partnerships with behavioral health providers, healthcare organizations, emergency departments, local government agencies, justice system stakeholders, community-based organizations, and educational institutions throughout Curry and Roosevelt Counties that support workforce development, referral coordination, and continuity of care.
- Ongoing facility development, licensing, operational planning, workforce preparation, and implementation activities led by Community Bridges to support successful startup, service delivery, care coordination, and long-term integration of the CTC within the regional behavioral health continuum.
- Established regional commitment to improving crisis response capacity, continuity of care, and access to behavioral health services across the continuum of care.

The Region's planning efforts, governance structure, implementation partnerships, and identified funding strategy position Region 9 to move from planning into implementation and establish a sustainable CTC that addresses critical behavioral health service gaps throughout the region.

Approach

Region 9 will implement a phased, multi-year approach focused on establishing the CTC and supporting development of a sustainable regional crisis care continuum.

Phase 1 (FY26): Regional Planning & Project Development

Activities will focus on regional planning, stakeholder engagement, needs assessment, data analysis, and identification of priority behavioral health investments. Curry and Roosevelt County completed the Expanded Sequential Intercept Mapping (E-SIM) process, evaluated behavioral health service gaps, engaged regional stakeholders, identified the CTC as the region's primary infrastructure investment, and developed the Regional Behavioral Health Plan.

Additional activities included preliminary implementation planning, development of funding strategies, sustainability planning, and coordination with key partners to support future implementation efforts.

Phase 2 (FY27): Startup, Infrastructure Development, and Service Launch

Activities will focus on completion of facility construction, licensing and regulatory approvals, workforce recruitment and onboarding, staff training, equipment procurement and installation, operational startup, and launch of CTC services. Community Bridges will continue Medicaid enrollment activities, reimbursement rate development, and contracting with Medicaid Managed Care Organizations and other payors while establishing care coordination, referral management, and operational workflows. Funding during this phase will support startup costs, infrastructure investments, and initial implementation activities necessary to establish sustainable CTC operations.

Phase 3 (FY28): Service Expansion and System Integration

Activities will focus on strengthening referral pathways, improving coordination across healthcare, behavioral health, emergency response, and justice system partners, expanding service utilization, and optimizing operational performance. Evaluation activities will be utilized to identify opportunities for quality improvement and system enhancement.

Phase 4 (FY29): Sustainability and Performance Optimization

Activities will focus on long-term sustainability, performance monitoring, reimbursement optimization, and continuous quality improvement. Regional partners will utilize evaluation findings to strengthen system performance, improve outcomes, and ensure ongoing access to crisis stabilization and acute behavioral health services throughout Region 9.

This phased approach supports establishment of sustainable behavioral health infrastructure while ensuring implementation activities remain aligned with regional needs, available resources, and long-term system sustainability goals.

Structure & Governance of Implementation

Curry County as the accountable entity will oversee implementation through:

- Centralized program management, through recruitment and hiring of the Regional Behavioral Health Administrator position in Curry County.
- Fiscal oversight and compliance monitoring
- Performance tracking and reporting
- Contract administration and oversight of BHRIA-funded activities.
- Coordinator across providers and stakeholders.

Implementation will be carried out in coordination with Community Bridges, the proposed operating partner for the CTC, regional behavioral health providers, healthcare organizations, and justice system stakeholders. Additional partners that will be supporting this area include:

- Hospital systems and emergency departments
- Behavioral health and healthcare providers
- Emergency medical services and first responders
- Community-based organizations
- Peer support and recovery service providers
- Local government stakeholders
- Justice system partners

Coordination will occur through regularly scheduled meetings, quarterly performance reviews and annual strategic adjustments.

SECTION IV: SERVICE ALIGNMENT & ACCESS

Alignment to Regional Needs

The CTC was selected through the regional planning process as the single highest-priority investment to address the most significant behavioral health infrastructure gap identified within Region 9. Regional data, stakeholder engagement, and findings from the E-SIM process consistently demonstrated a lack of local crisis stabilization and medication-based withdrawal management services, resulting in increased reliance on emergency departments, law enforcement involvement, delayed access to treatment, and utilization of out-of-region services.

Implementation of the CTC will strengthen the regional behavioral health continuum by providing local access to crisis stabilization, withdrawal management, behavioral health assessment, care coordination, and referral services. The CTC is designed to serve as a centralized access point for individuals experiencing behavioral health crises while supporting timely connection to ongoing treatment and recovery services.

The proposed investment aligns with the Enhanced Sequential Intercept Model (E-SIM) through:

Intercept 0–1 (Community Services & Crisis Response)

- Expanded access to local crisis stabilization and behavioral health assessment services
- Increased diversion opportunities from emergency departments and law enforcement response
- Improved coordination with healthcare providers, emergency medical services, and community partners
-

Intercepts 2–3 (Treatment & Diversion)

- Medication-based withdrawal management services
- Care coordination and referral pathways to outpatient behavioral health treatment, substance use treatment, Medication-Assisted Treatment (MAT), primary care, peer support, and recovery services
- Improved access to appropriate levels of behavioral health care within the region

Intercepts 4–5 (Reentry & Community Integration)

- Coordinated transitions from crisis services to ongoing treatment and recovery supports
- Strengthened referral pathways that support long-term recovery and community integration

Provider Network & Capacity

The implementation strategy leverages existing healthcare, behavioral health, emergency response, and community-based service networks while expanding local crisis care infrastructure through development of the CTC.

The CTC will operate 24 hours per day, seven days per week, providing a centralized regional crisis response resource. Initial service capacity is anticipated to include approximately 12 to 14 crisis stabilization chairs for immediate behavioral health assessment, triage, stabilization, and care coordination, along with approximately 16 crisis residential beds supporting short-term stabilization and medication-based withdrawal management services for individuals requiring a higher level of care. Crisis residential services are anticipated to provide stays of up to approximately fourteen days, based upon clinical need and medical necessity.

Community Bridges will operate the CTC utilizing a trauma-informed, recovery-oriented model that integrates behavioral health assessment, peer support, care coordination, discharge planning, and referral management to connect individuals with ongoing treatment and community-based recovery resources.

Some of the key implementation and referral partners include:

- Community Bridges, the proposed operator of the CTC
- Local Hospitals and Emergency Departments
- Behavioral Health and Healthcare Providers throughout the region
- Local justice system partners
- Community-based organizations, peer support programs, and recovery service providers.

Community Bridges will coordinate care transitions with regional healthcare providers, behavioral health organizations, emergency departments, law enforcement, emergency medical services, and other community partners. Anticipated referral partners include Plains Regional Medical Center, Roosevelt General Hospital, Mental Health Resources, Psychiatric Care Center, Renew Health Addiction & Recovery, Clarity Mental Health & Wellness, and other regional providers to promote coordinated access to ongoing behavioral health treatment and recovery services.

The CTC is intended to function as a regional crisis care hub that complements existing behavioral health services rather than duplicating them. Through coordinated referral pathways and ongoing stakeholder collaboration, the CTC will strengthen continuity of care and improve access to appropriate services throughout the behavioral health continuum.

Responsiveness

The CTC is designed to improve access to behavioral health crisis services for residents across Curry and Roosevelt Counties, including individuals living in rural and underserved communities. Service design considerations include geographic access challenges, workforce limitations, transportation barriers, and the need for coordinated behavioral health and substance use treatment services.

Implementation will prioritize equitable access for individuals experiencing behavioral health crises, individuals with co-occurring mental health and substance use disorders, justice-involved populations, and other high-need community members. Services will be delivered through a trauma-informed, person-centered approach that emphasizes accessibility, timely intervention, coordinated care transitions, and connection to ongoing treatment and recovery support.

Partnerships with healthcare providers, behavioral health organizations, emergency response agencies, and community-based service providers will help ensure services remain responsive to local needs while strengthening regional behavioral health system capacity.

Compliance, Medicaid Coordination & System Alignment

All services will comply with New Mexico Behavioral Health Service Standards. Services are designed to integrate with existing behavioral health and healthcare systems.

Services are aligned with Medicaid-reimbursable models where applicable, including:

- Crisis stabilization services

- Medication-based withdrawal management services
- Peer support services
- Care coordination and referral management
- Behavioral health assessment and triage services

The CTC is intended to operate in alignment with New Mexico Medicaid behavioral health service requirements and applicable state behavioral health standards. The proposed service model is designed to support reimbursable crisis stabilization, behavioral health assessment, withdrawal management, care coordination, and referral services consistent with allowable Medicaid service structures and regulatory requirements.

Coordinated implementation activities between Community Bridges, state agencies, managed care organizations, healthcare providers, and behavioral health partners to support enrollment, credentialing, billing readiness, reporting compliance, and ongoing service integration. Alignment with Medicaid reimbursement pathways is a critical component of the project's long-term sustainability strategy and supports continuation of services beyond the initial BHRIA investment period.

Implementation activities will prioritize integration with existing regional behavioral health services, healthcare systems, emergency departments, emergency medical services, and community-based providers to strengthen continuity of care and improve coordination across the behavioral health continuum.

The regional plan also aligns with the Enhanced Sequential Intercept Model (E-SIM), ensuring that services are delivered across key intercept points.

SECTION V: FUNDING & STABILITY

Financial Alignment

Region 9's funding strategy is centered on establishment of the CTC, identified through regional data analysis, stakeholder engagement, and the Expanded Sequential Intercept Mapping (E-SIM) process as the region's highest-priority behavioral health infrastructure need.

The proposed investment supports startup, implementation, workforce development, infrastructure, service launch, and reimbursement stabilization activities necessary to establish a sustainable crisis care continuum serving Curry and Roosevelt Counties. Funding is designed to address critical gaps in crisis stabilization, medication-based withdrawal management, care coordination, and access to timely behavioral health intervention.

The majority of requested funding will support direct implementation of the CTC, including workforce recruitment and training, facility readiness, technology and equipment, service launch activities, and initial operational support during the reimbursement stabilization period. Additional funding supports regional administration, performance monitoring, evaluation activities, and oversight necessary to ensure successful implementation and compliance with BHRIA requirements.

This funding strategy reflects a targeted investment approach that prioritizes long-term system impact, regional service capacity, and sustainability. By focusing available resources on a single transformational infrastructure project, Region 9 aims to create lasting improvements in behavioral health access, continuity of care, crisis response capacity, and treatment engagement across the region.

Detailed budget allocations are included in the Appendix.

Sustainability Strategy

The CTC is intended to serve as a long-term component of the Region 9 behavioral health continuum. BHRIA funding will support startup, implementation, workforce development, infrastructure investments, service launch activities, and the initial reimbursement stabilization period required to establish sustainable operations.

Community Bridges, the identified operating partner for CTC, has developed financial projections demonstrating a pathway toward operational sustainability through a combination of Medicaid reimbursement, non-Medicaid payer sources, and other eligible state and federal revenue streams. BHRIA funding is intended to reduce implementation barriers and bridge the period between service launch and full realization of reimbursement revenue.

Long-term sustainability will be supported through:

- Medicaid reimbursement for eligible crisis stabilization and behavioral health services
- Non-Medicaid payer reimbursement and other allowable funding sources
- Integration within the regional behavioral health continuum and referral network
- Ongoing coordination with healthcare providers, behavioral health providers, emergency departments, justice system partners, and community-based organizations
- Continuous quality improvement, performance monitoring, and evaluation activities
- Workforce recruitment, retention, and professional development strategies

In addition to financial sustainability, the project is designed to strengthen regional behavioral health infrastructure by establishing local crisis stabilization capacity, reducing reliance on emergency departments and out-of-region placements, and improving continuity of care for individuals experiencing behavioral health crises.

Beyond the initial BHRIA investment period, long-term sustainability will be supported through a blended financing model that includes Medicaid reimbursement, commercial reimbursement, state and federal grant opportunities, local investment, and ongoing regional partnerships to maintain service capacity.

Curry County will utilize ongoing performance monitoring and evaluation activities to assess utilization, outcomes, financial performance, and service demand, allowing stakeholders to make adjustments that support long-term sustainability and system effectiveness.

Funding Coordination

As the accountable entity, Curry County will provide fiscal oversight and coordination of all BHRIA-funded activities. Responsibilities include:

- Budget management and allocation of funds
- Contracting with service providers and partners
- Monitoring expenditures and ensuring compliance with funding requirements
- Coordinating across regional partners, including Roosevelt County, behavioral health providers, healthcare systems, and justice system stakeholders

Administrative and evaluation expenditures will remain aligned with BHRIA funding limitations and will prioritize direct service implementation whenever possible. Regular financial and programmatic reporting will ensure accountability, transparency, and alignment with performance goals.

SECTION VI: RISK MITIGATION

Potential risks that may impact implementation and long-term sustainability of CTC have been identified. Proactive mitigation strategies have been incorporated into the regional plan to mitigate these risks to reduce implementation barriers, strengthen system coordination, and support successful project execution.

Key Risks & Mitigation Strategies

Workforce Recruitment and Retention

Recruitment and retention of qualified behavioral health professionals may impact startup timelines, service capacity, and long-term operations of the CTC.

Mitigation Strategy:

- Implement phased workforce recruitment and onboarding aligned with implementation milestones
- Utilize Community Bridges' existing recruitment, training, and workforce development infrastructure
- Incorporate peer support and recovery-oriented workforce roles where appropriate
- Implement retention strategies that support workforce stability and continuity of care

Rural Access and Service Utilization

Geographic distance, transportation barriers, and limited awareness of available services may impact utilization of the CTC, particularly among rural populations.

Mitigation Strategy:

- Develop coordinated referral pathways with hospitals, healthcare providers, emergency medical services, law enforcement agencies, and behavioral health providers
- Conduct community outreach and stakeholder engagement activities to increase awareness of available services
- Strengthen care coordination and transition planning processes to improve access and engagement

Implementation and Operational Readiness

Delays related to facility readiness, licensing, staffing, procurement, technology implementation, or operational startup activities may impact service launch timelines.

Mitigation Strategy:

- Utilize a phased implementation approach with clearly defined milestones and accountability measures
- Conduct ongoing implementation monitoring and project oversight through Curry County as the Accountable Entity
- Coordinate regularly with Community Bridges and implementation partners to address barriers and maintain project timelines
- Prioritize critical startup activities necessary to support operational readiness

Financial Sustainability and Reimbursement Risk

Delays in reimbursement revenue, changes in payer requirements, or lower-than-anticipated service utilization may impact long-term financial sustainability.

Mitigation Strategy:

- Align services with Medicaid reimbursement requirements and allowable billing structures
- Utilize BHRIA funding to support startup, implementation, and reimbursement stabilization activities
- Monitor service utilization, financial performance, and reimbursement trends through ongoing evaluation activities
- Identify additional funding opportunities and sustainability strategies as needed

Cross-System Coordination

Successful operation of the CTC requires coordination across healthcare, behavioral health, emergency response, justice system, and community-based service providers.

Mitigation Strategy:

- Establish clear roles, responsibilities, and referral pathways among regional partners
- Utilize Curry County as the Accountable Entity responsible for oversight, coordination, and performance monitoring
- Maintain regular communication with implementation partners and stakeholders
- Incorporate continuous quality improvement processes to identify and address coordination challenges

Performance Monitoring and Accountability

Failure to effectively monitor outcomes and implementation progress may limit the Region's ability to evaluate project success and demonstrate impact.

Mitigation Strategy:

- Implement a comprehensive performance monitoring and evaluation framework
- Conduct regular reporting and outcome reviews
- Utilize evaluation findings to support continuous quality improvement and operational adjustments
- Maintain compliance with BHRIA reporting, oversight, and accountability requirements

SECTION VII: FEASIBILITY

The feasibility of the proposed regional plan is supported by completed planning activities, established governance structures, identified implementation partners, and strong alignment between the proposed investment and documented regional behavioral health needs.

The CTC represents a targeted investment designed to address multiple system challenges through a single implementation strategy. By expanding access to crisis stabilization, medication-based withdrawal management, behavioral health assessment, care coordination, and referral services, the CTC is expected to strengthen continuity of care while reducing reliance on emergency departments, law enforcement involvement, and out-of-region service utilization.

Feasibility is further supported through identification of Community Bridges as the proposed operating partner, designation of Curry County as the Accountable Entity, and development of a phased implementation approach that supports project readiness, service launch, operational stabilization, and long-term sustainability. This approach allows the region to build capacity over time while maintaining accountability, performance monitoring, and alignment with BHRIA requirements.

Performance

The Regional Behavioral Health Administrator within Curry County, will utilize a performance management framework designed to monitor implementation progress, service utilization, continuity of care outcomes, and overall system impact associated with the CTC.

In addition to the regional performance measures identified within this plan, Community Bridges will monitor operational performance indicators associated with CTC implementation. Measures are expected to include referral sources, service utilization, capacity management, length of stay, provider encounters, follow-up appointment

Key performance indicators will include:

Access & Utilization	• Number of individuals served through CTC services • Number of crisis stabilization encounters • Number of medication-based withdrawal management encounters • Average time from referral to service engagement • Percentage of individuals successfully connected to ongoing treatment services
Continuity of Care	• Completion of discharge and transition plans • Successful referrals to outpatient behavioral health services, substance use treatment, primary care, and recovery supports • Treatment engagement following discharge • Follow-up service utilization rates
System Impact	• Reduction in behavioral health-related emergency department utilization

	• Reduction in law enforcement involvement related to behavioral health crises • Reduction in out-of-region placements for crisis stabilization services • Increased utilization of local behavioral health services • Number and percentage of individuals diverted from emergency departments and law enforcement response to appropriate behavioral health services.
Workforce & Operations	• Workforce recruitment and retention metrics • Staff training and credentialing completion rates • Service capacity utilization • Implementation milestone completion

Performance data will be reviewed regularly by the Accountable Entity, Community Bridges, Horizon Behavioral Health Center CTC leadership, and regional stakeholders to support continuous quality improvement, accountability, and long-term system sustainability.

Logic Model

A structured logic model framework will be utilized to guide implementation, measure performance, and demonstrate the relationship between project investments, implementation activities, and anticipated outcomes associated with the CTC.

Inputs include BHRIA funding, the CTC facility, Community Bridges as the proposed operating partner, regional provider networks, workforce resources, governance structures, and partnerships across healthcare, behavioral health, emergency response, justice system, and community-based organizations.

Activities focus on implementation and operation of the CTC, including crisis stabilization services, medication-based withdrawal management services, behavioral health assessment, care coordination, referral management, workforce recruitment and training, performance monitoring, and regional coordination activities.

These activities are expected to produce measurable outputs, including increased crisis service capacity, increased utilization of local behavioral health services, expanded access to crisis stabilization and withdrawal management services, successful referrals to ongoing treatment, and strengthened coordination across regional systems.

Short-term outcomes include improved access to crisis services, increased treatment engagement, improved coordination across providers, increased utilization of local behavioral health resources, and stronger coordination among healthcare, behavioral health, and community partners.

Intermediate outcomes include reduced behavioral health-related emergency department utilization, reduced reliance on law enforcement response during behavioral health crises, reduced out-of-region placements, and improved treatment retention following crisis intervention.

Long-term outcomes focus on sustainable system-level improvements, including expanded regional behavioral health capacity, improved behavioral health outcomes, increased access to appropriate levels of care, strengthened crisis response infrastructure, and establishment of a sustainable regional crisis care continuum.

Evaluation and performance monitoring activities are integrated throughout implementation to ensure accountability, support continuous quality improvement, and demonstrate progress toward regional behavioral health system goals.

SECTION VIII: APPENDIX

Appendix A: Regional Priority

Priority #1: Crisis, Acute and Higher-level Care.

Priority and Primary Services:	Crisis, Acute and Higher-level Care. Implementation of the Horizon Behavioral Health Center (CTC), including crisis stabilization services, medication-based withdrawal management services, behavioral health assessment and triage, peer support services, care coordination, referral management, and coordinated transitions to ongoing treatment and recovery services.
Problem Statement:	The region lacks sufficient local crisis stabilization and withdrawal management capacity. Individuals experiencing behavioral health crises frequently rely on emergency departments, law enforcement involvement, or out-of-region services due to limited local alternatives. Workforce shortages, transportation barriers, and insufficient crisis infrastructure contribute to delays in accessing appropriate behavioral health care. Regional stakeholders determined that implementation of the CTC represented the single investment most capable of addressing multiple documented system gaps through a sustainable, evidence-based behavioral health infrastructure solution.
Overarching Goals	Establish a sustainable regional crisis care continuum supported through implementation of the CTC, regional oversight and coordination, ongoing evaluation, reimbursement revenue, and cross-sector partnerships. 1. Establish a sustainable regional crisis care continuum through implementation of the CTC, regional oversight, ongoing evaluation, reimbursement revenue, and cross-sector partnerships. 2. Increase access to crisis stabilization and medication-based withdrawal management services within Region 9. 3. Reduce reliance on emergency departments, law enforcement involvement, and out-of-region placements for individuals experiencing behavioral health crises. 4. Improve continuity of care through coordinated assessment, referral, care transitions, and engagement in ongoing treatment and recovery services. 5. Increase regional behavioral health system capacity through implementation of sustainable crisis care infrastructure and supporting workforce resources.
Budget for each service.	1. Horizon Behavioral Health Center (CTC) Startup, Infrastructure Development, Service Launch, and Reimbursement Stabilization: $5,731,437 2. Regional Behavioral Health Administration, Oversight, and Compliance: $650,000 3. Evaluation, Performance Monitoring, and Continuous Quality Improvement: $225,000 ***Total: $6,606,437***

Underlying Assumptions and Research Base: Why do you think this program will work?	The CTC was identified through the Region 9 planning process as the highest-priority behavioral health infrastructure investment to address the documented lack of local crisis stabilization and medication-based withdrawal management services. Evidence demonstrates that crisis stabilization services and Crisis Triage Centers improve access to appropriate levels of care, reduce unnecessary emergency department utilization, decrease reliance on law enforcement response during behavioral health crises, and improve continuity of care through coordinated assessment, stabilization, and referral services. Medication-based withdrawal management services are recognized best practices for supporting individuals experiencing substance use crises and reducing barriers to ongoing treatment engagement. When combined with care coordination, peer support, and structured referral pathways, these services strengthen the behavioral health continuum and improve transitions to ongoing treatment and recovery support. The proposed service model aligns with New Mexico Behavioral Health Service Standards and prioritizes services that are Medicaid reimbursable when appropriate. The project leverages established partnerships, existing regional provider networks, and Community Bridges' operational expertise to support successful implementation and long-term sustainability. This approach is classified as evidence-based and evidence-informed, as crisis stabilization services, withdrawal management services, care coordination, and peer support models have demonstrated effectiveness in improving access to care, reducing acute care utilization, increasing treatment engagement, and improving behavioral health outcomes. BHRIA funding will support startup, implementation, infrastructure development, workforce preparation, and reimbursement stabilization activities necessary to establish the CTC and bridge the period prior to long-term operational sustainability through Medicaid reimbursement, non-Medicaid revenue sources, and other funding opportunities.

Appendix B: Logic Model

Inputs	Actors	Activities	Outputs	Outcomes
• BHRIA Funding • Governance Structure	Curry County (Accountable Entity)	Fiscal oversight, contract administration, compliance monitoring, performance reporting	• # of contracts executed • # of reports submitted • # of oversight meetings conducted	• ST: Improved system coordination and oversight • LT: Sustained accountable crisis system performance
• Regional Coordination	Roosevelt County	Coordinate crisis service access and local response pathways for Roosevelt county residents	• # accessing crisis services • Average response time • # of referrals	• ST: Improved access and response • LT: Reduced ER and law enforcement reliance
• BHRIA Funding • Facility infrastructure • Workforce Resources	Horizon Behavioral Health Center via Community Bridges	Facility startup, workforce recruitment, licensing, service implementation, operational management	• # of facility staff hired • # of beds operational • Average length of stay • • # of services launched	• ST: Increased access to local stabilization services • Long-term: Reduced ER utilization
• Regional partnership	Local Hospitals and Emergency Departments	Referral coordination, discharge planning, diversion pathways	• # of coordination meetings • # of referrals • # of discharge connections	• ST: Reduced repeat ED visits • LT: Improved continuity of care
• Regional partnership	Local Law Enforcement & EMS	Crisis diversion, referral coordination, alternative response pathways	• # of diversions • % of referral activities to the CTC	• ST: Increased diversion to CTC • LT: Reduced

				law enforcement involvement
• Regional partnerships	Healthcare & Behavioral Health Providers	Referral acceptance, treatment engagement, care transitions	• # of referrals completed from CTC • % of treatment enrollments from CTC	• ST: Increased treatment engagement & retention • LT: Reduced repeat crisis episodes

Appendix C: Evaluation Guidelines

Target Population	Individuals experiencing behavioral health crises, substance use crises, and co-occurring behavioral health conditions residing within Curry and Roosevelt Counties. Eligibility: Individuals experiencing behavioral health crisis and individuals requiring crisis stabilization, medicated-based withdrawal management, or emergency behavioral health intervention Estimated annual service capacity will be refined during implementation based on final operational planning and projected utilization. Initial estimates indicate approximately 300–500 unduplicated individuals may be served annually through crisis stabilization, withdrawal management, assessment, and referral services.
Sampling	• Adults (18+) eligible to receive CTC services during initial implementation. • Youth will be included as additional crisis services become available in the future • Individuals experiencing acute substance use or behavioral health crisis • Individuals presenting to healthcare, emergency response, or justice system partners with behavioral health stabilization needs • Individuals requiring crisis stabilization, withdrawal management, assessment, referral, or care coordination services
Evaluation Approach and Methods	Evaluation will focus on implementation of the CTC, access to crisis stabilization and withdrawal management services, continuity of care outcomes, service utilization, and system-level impacts associated with reducing reliance on emergency departments, law enforcement response, and out-of-region placements. Evaluation activities will utilize implementation monitoring, milestone tracking, service utilization analysis, outcome measurement, and continuous quality improvement processes. Baseline measures will be established during implementation and compared against annual performance targets. Findings will be reviewed by Curry County, Community Bridges Inc. (CBI), Horizon Behavioral Health Center (CTC) leadership, and regional stakeholders to identify opportunities for system improvement and support required reporting under BHRIA. Outcomes are analyzed by subpopulation (i.e. youth vs adult; first-time crisis encounters vs prior crisis encounters) Methods: • Pre/post analysis of behavioral health-related emergency department utilization • Analysis of Crisis Triage Center utilization, service capacity, and referral patterns • Tracking successful diversion from emergency departments and law enforcement to the CTC • Analysis of continuity of care outcomes, including referral completion and treatment engagement • Comparison of utilization patterns among individuals with prior high behavioral health system utilization • Record reviews and case reviews

	• Participant, provider, and stakeholder feedback surveys
Data Collection	• Medicaid claims data (service utilization, emergency department utilization, behavioral health services) • CTC operational and service utilization records • Hospital and emergency department utilization data • Referral and care coordination records • Law enforcement and emergency response data, where available • Program performance reports • Participant, provider, and stakeholder surveys Data collection responsibilities will be shared among Curry County, Community Bridges, Horizon Behavioral Health Center leadership, participating healthcare partners, and other implementation partners as appropriate.
Implementation Timeline Outline a proposed timeline for activities across the appropriation period:	**Year One (FY 2026):** Regional planning, stakeholder engagement, E-SIM activities, service gap analysis, prioritization, implementation planning, and development of the Regional Behavioral Health Plan. **Year Two (FY 2027):** Complete facility readiness for the CTC, including: workforce recruitment and onboarding, licensing and operational startup activities, implementation of crisis stabilization and medication-based withdrawal management services, and establishment of referral and care coordination processes. Community Bridges Inc. (CBI) will continue Medicaid enrollment activities, reimbursement rate development, and contracting with Medicaid Managed Care Organizations and other payors while establishing operational workflows and coordinated referral pathways across the regional behavioral health system. **Year Three (FY 2028):** Operational stabilization of the CTC, expansion of service utilization, strengthening referral pathways, performance monitoring, reimbursement optimization, and implementation of continuous quality improvement activities to improve access, continuity of care, and overall system performance. **Year Four (FY 2029):** Long-term sustainability planning, evaluation of system-level outcomes, ongoing performance monitoring, reimbursement optimization, and continuous quality improvement activities to strengthen regional coordination and ensure continued access to crisis stabilization, medication-based withdrawal management, and acute behavioral health services throughout Region 9.
Contacts for Annual Progress Updates	The Regional Behavioral Health Administrator, through Curry County (Accountable Entity) will serve as the point of contact for annual progress reporting, evaluation coordination, performance monitoring, and BHRIA compliance activities.

Appendix D: Budget Justification

The proposed budget reflects a strategic and data-informed investment in crisis, acute, and higher-level behavioral health care infrastructure within Region 9. Funding is focused on establishment of the Horizon Behavioral Health Center (CTC), identified through regional planning, stakeholder engagement, and system analysis as the region's highest priority behavioral health infrastructure need.

The budget is designed to support startup, implementation, workforce development, infrastructure, service launch, and operational readiness activities necessary to establish a sustainable crisis care continuum serving Curry and Roosevelt Counties. Investments are intended to address existing gaps in crisis stabilization, medication-based withdrawal management, care coordination, and timely access to behavioral health intervention while strengthening continuity of care across the region.

Consistent with BHRIA guidance, requested funds will support startup, implementation, workforce ramp-up, infrastructure development, and the initial service delivery period necessary to establish the CTC and associated regional coordination infrastructure. Funding is intended to bridge the implementation and reimbursement stabilization period while the facility reaches operational capacity. Long-term sustainability is anticipated through Medicaid reimbursement, non-Medicaid payer sources, and other funding opportunities identified within the project's sustainability strategy.

Funding allocations are directly tied to measurable implementation goals and anticipated outcomes, including increased access to crisis stabilization services, reduced reliance on emergency departments and law enforcement, strengthened care transitions, increased treatment engagement, expanded regional behavioral health capacity, and improved behavioral health outcomes across Region 9.

Budget Category	Total Cost ($)	Purpose & Justification (Brief Narrative)
Personnel & Administrative Costs	$650,000.00	Supports project leadership, implementation oversight, fiscal management, reporting, compliance monitoring, contract administration, and regional coordination activities necessary to establish the CTC. In addition to the Regional Behavioral Health Administrator and other implementation functions required to ensure successful project execution, stakeholder coordination, performance monitoring, and compliance with BHRIA requirements. Administrative expenditures are structured to remain within BHRIA overhead limitations.
Direct Services	$2,000,000.00	Supports implementation and initial delivery of crisis stabilization, medication-based withdrawal management, peer support, care coordination, and related behavioral health services through the Horizon Crisis Triage Center. Funding will support the service launch and reimbursement stabilization period while increasing access to crisis intervention services, reducing reliance on emergency departments and law enforcement response, and improving connections to ongoing treatment and recovery support.

Budget Category	Total Cost ($)	Purpose & Justification (Brief Narrative)
Training & Workforce Development	$700,000.00	Supports workforce recruitment, onboarding, credentialing, training, and professional development activities necessary to establish and sustain a qualified behavioral health workforce. Funding will strengthen staffing capacity required to support crisis stabilization, withdrawal management, care coordination, and recovery-oriented service delivery while addressing regional workforce shortages.
Infrastructure & Equipment	$1,600,000.00	Supports facility readiness, clinical equipment, technology systems, EHR implementation, telehealth capacity, information technology infrastructure, furnishings, and other startup investments necessary to establish and operate the Horizon Behavioral Health Center. Infrastructure investments will improve access to behavioral health services, support service delivery, and create long-term regional capacity for crisis and acute behavioral health care.
Operational Costs	$1,431,437.00	Supports startup and implementation-related operational expenses necessary to launch Horizon Behavioral Health Center (CTC) services, including communications, supplies, technology maintenance, service coordination, referral management, operational support systems, and other costs directly associated with implementation and service delivery during the startup, launch, and reimbursement stabilization period. Funding is intended to bridge the period between facility launch and full realization of reimbursement revenue
Evaluation & Performance Tracking	$225,000.00	Supports evaluation, data collection, outcome monitoring, performance measurement, reporting activities, and continuous quality improvement efforts. Evaluation activities will assess implementation progress, service utilization, continuity of care outcomes, workforce development outcomes, and overall impact on regional behavioral health access, crisis system performance, and long-term sustainability.

Total Requested: $ 6,606,437.00

Appendix E: Provider List

Provider Name	County	Provider Category	Program Area
ABIGAIL LEGLER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ABIGAIL H DENNIS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ADRIANNA P WYCUFF	CURRY	Practitioner (Outpatient Services)	MEDICAID
AGAPE COUNSELING LLC	CURRY	Practitioner (Outpatient Services)	MEDICAID
AGAPE COUNSELING LLC	CURRY	Agencies (Outpatient Services)	MEDICAID
AHSHA VIGIL	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ALETRA T STEWART	CURRY	Practitioner (Outpatient Services)	MEDICAID
ALEXANDRA N JOHNSON	CURRY	Practitioner (Outpatient Services)	MEDICAID
ALEXIS HAMMER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ALEXIS OSTRANDER LBSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
ALI MAY TERRY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ALICIA MONTANO CSW	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ALYSSA J MARTINEZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ALYSSA RAMIREZ LMHC	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
AMANDA RODRIGUEZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
AMY MARTINEZ	CURRY	Practitioner (Outpatient Services)	MEDICAID
AMY M BRITTON LMHC	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
ANDREA MARGARITA MARTIN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ANDREA MARGARITA MARTIN	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
ANDRES SOLIZCHAVEZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ANGEL CLARK	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ANGELA M MARTINEZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ANGELA N LUTZ SCHOOL PSY	CURRY	Practitioner (Outpatient Services)	MEDICAID
ANGELINA A LOPEZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ANITA SOLVESON CSW	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
APRIL GARCIA	CURRY	Practitioner (Outpatient Services)	MEDICAID
ASHLEY COINER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ASHLEY EMMONS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ASHLEY B EMMONS	CURRY	Practitioner (Outpatient Services)	MEDICAID
ASHLEY FALCON BCBA	CURRY	Practitioner (Outpatient Services)	MEDICAID
ASHLEY LUBERA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
AURELIA R EDWARDS	CURRY	Practitioner (Outpatient Services)	MEDICAID
BAILLIE M JORTH	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
BE WELL COUNSELING PC	CURRY	Practitioner (Outpatient Services)	MEDICAID
BE WELL COUNSELING SERVICES	ROOSEVELT	Agencies (Outpatient Services)	MEDICAID
BERNADINE CORDOVA	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
BERNADINE G CORDOVA	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
BIATRIZ LAREZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
BJORN GENTY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
BONIFACE GITAU	CURRY	Practitioner (Outpatient Services)	MEDICAID
BONNIE M THOMAS	CURRY	Practitioner (Outpatient Services)	MEDICAID
BRADLEY H RIKEL	CURRY	Practitioner (Outpatient Services)	MEDICAID
BRANDI GOMEZ	CURRY	Practitioner (Outpatient Services)	MEDICAID
BRANDI L WATKINS	CURRY	Practitioner (Outpatient Services)	MEDICAID
BRANDI THOMAS CSW	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
BRENDA L ALVARADO LPCC	CURRY	Practitioner (Outpatient Services)	MEDICAID
BRENDA MOLINA CSW	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
BRENT L CLAY	CURRY	Practitioner (Outpatient Services)	MEDICAID
BRIANNA NETTLES BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
BRITTANY FREY	CURRY	Practitioner (Outpatient Services)	MEDICAID
BRITTNEY WHITE	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
BROOKE A BOWMAN	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
BRYCE BROWN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
CARLTON D LEWIS	CURRY	Practitioner (Outpatient Services)	MEDICAID
CASEY WINSLOW	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
CASEY L TURNBOUGH	CURRY	Practitioner (Outpatient Services)	MEDICAID
CATHY GRAY BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
CHARITY A BAGBY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
CHASE POE	CURRY	Practitioner (Outpatient Services)	MEDICAID
CHERI K JACKSON	CURRY	Practitioner (Outpatient Services)	MEDICAID

Provider Name	County	Provider Category	Program Area
CHRISTIAN GARCIA	CURRY	Practitioner (Outpatient Services)	MEDICAID
CHRISTINE MARTINEZ-GUAJARDO LCSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
CHRISTINE SANTARRELLI-HARRIS BCBA	CURRY	Practitioner (Outpatient Services)	MEDICAID
CHYANNE LEE PACHECO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
CLARISSA RENEE QUINTANA	CURRY	Practitioner (Outpatient Services)	MEDICAID
CLARITY MENTAL HEALTH AND WELLNESS	CURRY	Practitioner (Outpatient Services)	MEDICAID
CLAUDIA CORDOVA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
CLAY ENDEREZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
CLAY ENDEREZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
CONSULTING PSYCHOLOGICAL SERVICES PA	CURRY	Agencies (Outpatient Services)	MEDICAID
CORRINE CASAREZTURNER	CURRY	Practitioner (Outpatient Services)	MEDICAID
COUNTY OF ROOSEVELT DBA ROOSEVELT COUNTY	ROOSEVELT	Non-Medicaid	NON-MEDICAID
COURTNEY GUTIERREZ	CURRY	Practitioner (Outpatient Services)	MEDICAID
COURTNEY SPENCER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
CURRY COUNTY	CURRY	Non-Medicaid	NON-MEDICAID
CYNTHIA CICERO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
CYNTHIA SENA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
D ANNA PLEASANT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
DANIELLE I NEWMAN LPCC	CURRY	Practitioner (Outpatient Services)	MEDICAID
DANIELRAY M BLEA SMITH	CURRY	Practitioner (Outpatient Services)	MEDICAID
DAVID MCDOWELL	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
DAVID L ROSSEN	CURRY	Practitioner (Outpatient Services)	MEDICAID
DAYSHAUN M MOORE	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
DEBORAH L CHAVEZ LMSW	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
DEE A KREUTZER	CURRY	Practitioner (Outpatient Services)	MEDICAID
DERIC D FORD	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
DESIRAE M ROMERO MONTOYA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
DESTRY S HERNANDEZ	CURRY	Practitioner (Outpatient Services)	MEDICAID
DIANE T BERGIN LMHC	CURRY	Practitioner (Outpatient Services)	MEDICAID
DIANNA M HERRERA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
DIEDRA VARGAS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
DIOR LOWRY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
DOMINIC MARQUEZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
DOMINIC L WOODS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
EARTHA HODGE	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
EDITH A MORENO LBSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
ELICIA J ALEXANDER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ELIZABETH L KASBOHM	CURRY	Practitioner (Outpatient Services)	MEDICAID
ELIZABETH R FREDERICK	CURRY	Practitioner (Outpatient Services)	MEDICAID
ENMRSH INC	CURRY	Agencies (Outpatient Services)	MEDICAID
ENMRSH INC	CURRY	Practitioner (Outpatient Services)	MEDICAID
ENMRSH INC	CURRY	Practitioner (Outpatient Services)	MEDICAID
ENRIQUE F URIOSTE LBSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
ERIC M BANAGAY	CURRY	Practitioner (Outpatient Services)	MEDICAID
ERIKA P GRUSSENDORF LCSW	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
ERIN N MOSS	CURRY	Practitioner (Outpatient Services)	MEDICAID
ERNESTINE A TENNEFOS	CURRY	Practitioner (Outpatient Services)	MEDICAID
ESPERANSA G WELLS	CURRY	Practitioner (Outpatient Services)	MEDICAID
FRANCESCA M SALAZARGILLESPIE	CURRY	Practitioner (Outpatient Services)	MEDICAID
GABRIEL MONTOYA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
GABRIELLA PEREZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
GARDEN OF HOPE PSYCHIATRY LLC	CURRY	Practitioner (Outpatient Services)	MEDICAID
GARY N COX LMHC	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
GEMA VILLANUEVA	CURRY	Practitioner (Outpatient Services)	MEDICAID
GENEVA GONZALEZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
GERRIANE D ONTIVEROS LMHC	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
GLORIA ZOLMAN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
GUY MASSENA	CURRY	Practitioner (Outpatient Services)	MEDICAID
HALEY B HANCOCK	CURRY	Practitioner (Outpatient Services)	MEDICAID

Provider Name	County	Provider Category	Program Area
HANNAH B GRAVES	CURRY	Practitioner (Outpatient Services)	MEDICAID
HANNAH L BROOKS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
HANNAH R HAKOBIAN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
HAYLEE BILDILLI	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
HAYLEY KIDD BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
HAZEL RODRIGUEZ BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
HEATHER BEGLEY	CURRY	Practitioner (Outpatient Services)	MEDICAID
HEATHER K MIRANDA	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
IVONNE GONZALEZ-REYES BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JADE SMITH	CURRY	Practitioner (Outpatient Services)	MEDICAID
JAMES ANTONIO ABELAR	CURRY	Practitioner (Outpatient Services)	MEDICAID
JAMES C COLLINS	CURRY	Practitioner (Outpatient Services)	MEDICAID
JAMES J PADILLA	CURRY	Practitioner (Outpatient Services)	MEDICAID
JAMES JOSEPH PADILLA	CURRY	Practitioner (Outpatient Services)	MEDICAID
JANICE MARTINEZ	CURRY	Practitioner (Outpatient Services)	MEDICAID
JANINE E KINNISON	CURRY	Practitioner (Outpatient Services)	MEDICAID
JASMINE L ALDAY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JAZMIN COLMENERO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JAZMIN DAVILA TRUJILLO	CURRY	Practitioner (Outpatient Services)	MEDICAID
JENNIFER CONTRERAS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JENNIFER MACHADO	CURRY	Practitioner (Outpatient Services)	MEDICAID
JENNIFER ROBERTS	CURRY	Practitioner (Outpatient Services)	MEDICAID
JENNIFER LOUISE HARMON	CURRY	Practitioner (Outpatient Services)	MEDICAID
JEREMIAH QUINTON BILLIE	CURRY	Practitioner (Outpatient Services)	MEDICAID
JESSICA OROZCO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JESSICA L CALDERA	CURRY	Practitioner (Outpatient Services)	MEDICAID
JESSICA TERRY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JESUS TIRADO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JIMMI JONES CSW	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JOANNE S CLINTON	CURRY	Practitioner (Outpatient Services)	MEDICAID
JOHN E BIRKEY	CURRY	Practitioner (Outpatient Services)	MEDICAID
JOHNNIE SANTOS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JOHNNY SAIZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JOHNNY G CASADY	CURRY	Practitioner (Outpatient Services)	MEDICAID
JONATHAN P BRUNK	CURRY	Practitioner (Outpatient Services)	MEDICAID
JORDYN HAMMETT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JOSE DE LA ROSA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JOSE MENDEZ TARANGO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JOSHUA LAWSON BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JOSHUA M BEARE	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JUDY L MITCHELL	CURRY	Practitioner (Outpatient Services)	MEDICAID
JULIE STROUD	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
JUSTIN D NUTT	CURRY	Practitioner (Outpatient Services)	MEDICAID
KARA R BIBLE	CURRY	Practitioner (Outpatient Services)	MEDICAID
KATHERINE N HALL	CURRY	Practitioner (Outpatient Services)	MEDICAID
KATHERINE WILSON LMSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
KATHLEEN M DANIEL	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
KAYLAMARIE GUTHALS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
KAYLEE WILDER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
KELLI HAYDEN	CURRY	Practitioner (Outpatient Services)	MEDICAID
KELLY J PARKEY LCSW	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
KELLY WILLOUGHBY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
KELLYANN ROMERO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
KELSEY J PENIX LPCC	CURRY	Practitioner (Outpatient Services)	MEDICAID
KELSEY MONTIEL BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
KENDRA ELLIOTT P-LMSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
KERRI L BOLLINGER	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
KERRI R SELF CNP	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
KERSTYN IRENE ROSS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID

Provider Name	County	Provider Category	Program Area
KHIARA LOERA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
KIM COX	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
KIMBERLY WYMAN BRYANT	CURRY	Practitioner (Outpatient Services)	MEDICAID
KRYSTALLYNNE SHANIELLE MIKLE	CURRY	Practitioner (Outpatient Services)	MEDICAID
KYNDIE ANDREWS CSW	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
LA CASA DE BUENA SALUD INC	ROOSEVELT	FQHC (Outpatient Services)	MEDICAID
LACY SENA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
LACY A KEITH	CURRY	Practitioner (Outpatient Services)	MEDICAID
LAKASEY MONDRAGON	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
LAURA L VO	CURRY	Practitioner (Outpatient Services)	MEDICAID
LAUREN VITA SCHOOL PSY	CURRY	Practitioner (Outpatient Services)	MEDICAID
LEON CAVAZOS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
LESLIE MCKAY	CURRY	Practitioner (Outpatient Services)	MEDICAID
LIBRETTE E TYE	CURRY	Practitioner (Outpatient Services)	MEDICAID
LIFE CHANGES COUNSELING CONSULTING	CURRY	Agencies (Outpatient Services)	MEDICAID
LIFE SKILLS LEARNING CENTER	CURRY	Agencies (Outpatient Services)	MEDICAID
LIFE SKILLS LEARNING CENTER dba Matt 25 Inc	CURRY	Agencies (Outpatient Services)	MEDICAID
LINDA ROSE ROLDAN	CURRY	Practitioner (Outpatient Services)	MEDICAID
LINDSAY E OSBORN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
LISA OLSEN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
LISA K AGAN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
LORRI MURRAY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
LOTUS ASCENT	CURRY	Practitioner (Outpatient Services)	MEDICAID
LULA M BROWN	CURRY	Practitioner (Outpatient Services)	MEDICAID
LUZVEYA VAZQUEZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
LYNN P FRONK LISW LCSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
MADELINE CHURCHMAN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MANUEL BLEA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MANUEL A LOPEZ FAM HEALTH CTR	CURRY	FQHC (Outpatient Services)	MEDICAID
MARCIE MORRIS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MARCUS SMITH LPCC	CURRY	Practitioner (Outpatient Services)	MEDICAID
MARIA SCHMITT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MARIAH MORENO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MARILYN TRUELOCK	CURRY	Practitioner (Outpatient Services)	MEDICAID
MARIO CABRAL CSW	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MARIO M CHAVEZ	CURRY	Practitioner (Outpatient Services)	MEDICAID
MARK A MAESTAS	CURRY	Practitioner (Outpatient Services)	MEDICAID
MARK A SILLA	CURRY	Practitioner (Outpatient Services)	MEDICAID
MARTHA WESTON	CURRY	Practitioner (Outpatient Services)	MEDICAID
MARVIN D COX SR LCSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
MATTHEW KING	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MATTHEW S ALVARADO LPCC	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
MAYIM C ENHOLM	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MAYRA C PEREZ LMSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
MEAGAN RUSSELL	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MEAGAN RUSSELL	CURRY	Practitioner (Outpatient Services)	MEDICAID
MEAGAN A SEEKINS	CURRY	Practitioner (Outpatient Services)	MEDICAID
MELANIE M JIMENEZ LCSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
MELISSA GRIFFITH	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MELISSA TELLEZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MELISSA GALVAN BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MENTAL HEALTH RESOURCES	CURRY	Non-Medicaid	NON-MEDICAID
MENTAL HEALTH RESOURCES INC	CURRY	Agencies (Outpatient Services)	MEDICAID
MENTAL HEALTH RESOURCES INC	CURRY	Agencies (Outpatient Services)	MEDICAID
MICHAEL A GARCIA	CURRY	Practitioner (Outpatient Services)	MEDICAID
MICHAEL O GILCHREST LMHC	CURRY	Practitioner (Outpatient Services)	MEDICAID
MICHAYLA COOK	CURRY	Practitioner (Outpatient Services)	MEDICAID
MICHELLE BARGAS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MICHELLE M ONTIVEROS	CURRY	Practitioner (Outpatient Services)	MEDICAID

Provider Name	County	Provider Category	Program Area
MICHELLE N ERWIN	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
MIKO BIRDSONG PBSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
MINDY SENA LCSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
MIRIAM E DLOUHY	CURRY	Practitioner (Outpatient Services)	MEDICAID
MISTY BELANGER BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
MONICA BANUELOS	CURRY	Practitioner (Outpatient Services)	MEDICAID
MONICA PANDO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
NAOMI MARSHALL	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
NATHAN SNOW	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
NATHANIA PIERRE	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
NEXT STEP PSYCHIATRY LLC	CURRY	Practitioner (Outpatient Services)	MEDICAID
NICHOLE A OLGUIN	CURRY	Practitioner (Outpatient Services)	MEDICAID
NICOLE CORONADO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
NICOLE MARTINEZROMERO	CURRY	Practitioner (Outpatient Services)	MEDICAID
NICOLE RYAN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
NIKKI FLEMING	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
NORMA GALLEGOS	CURRY	Practitioner (Outpatient Services)	MEDICAID
NURSTEAD CONSULTING SERVICES LLC	CURRY	Agencies (Outpatient Services)	MEDICAID
NURSTEAD CONSULTING SERVICES LLC	CURRY	Non-Medicaid	NON-MEDICAID
NURSTEAD CONSULTING SERVICES LLC dba Nurstead Mental Health	CURRY	Crisis Services	MEDICAID
OLIVA GRANILLO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
OLIVER MANCILLA BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
OLIVIA GARCIA	CURRY	Practitioner (Outpatient Services)	MEDICAID
PATRICIA A CROOK	CURRY	Practitioner (Outpatient Services)	MEDICAID
PATRICIA A OHARE LMHC	CURRY	Practitioner (Outpatient Services)	MEDICAID
PRACTICAL SOLUTIONS ENTERPRISES LLC DBA CONNE	CURRY	Practitioner (Outpatient Services)	MEDICAID
PRECIOUS YARBOROUGH	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
REBBECCA J GOSSETT LPCC	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
REDA ALLISON	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
REFUGIA D BUSTAMANTE	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
RELINDIS A NDOFOR	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
RHONDA R GALLEGOS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
RHONDA R SHIELDS	CURRY	Practitioner (Outpatient Services)	MEDICAID
RICHARD LUCERO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
RILEY A EVERSON	CURRY	Practitioner (Outpatient Services)	MEDICAID
RIOVIDA COUNSELING LLC	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
ROBERTA CALDERON	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
RONALD D REID	CURRY	Practitioner (Outpatient Services)	MEDICAID
ROSWITHA H HURST	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
ROXIE A JOYNER	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
ROZALYN N COX	CURRY	Practitioner (Outpatient Services)	MEDICAID
RYAN K WOOD	CURRY	Practitioner (Outpatient Services)	MEDICAID
RYLEE ALLEN BT	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SABRINA ARANDA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SABRINA ARANDA	CURRY	Practitioner (Outpatient Services)	MEDICAID
SABRINA AVILA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SABRINA GASKILL	CURRY	Practitioner (Outpatient Services)	MEDICAID
SAMANTHA PAULISON	CURRY	Practitioner (Outpatient Services)	MEDICAID
SAMUEL BASIAKA ITIE	CURRY	Practitioner (Outpatient Services)	MEDICAID
SAMWEL RORYA APRN-CNP	CURRY	Practitioner (Outpatient Services)	MEDICAID
SANDRA L SHUYA	CURRY	Practitioner (Outpatient Services)	MEDICAID
SANDRA L WHITING LMHC	CURRY	Practitioner (Outpatient Services)	MEDICAID
SANDRA M TURNER	CURRY	Practitioner (Outpatient Services)	MEDICAID
SARA HODSON LPCC	CURRY	Practitioner (Outpatient Services)	MEDICAID
SASHA E SUTTON	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SETH BAKER LCSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
SHARON HENRY KWARULA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID

Provider Name	County	Provider Category	Program Area
SHASTA S RAEL	CURRY	Practitioner (Outpatient Services)	MEDICAID
SHAWNA OLIVAREZ	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SHEILA A STEPHENSON LISW	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
SHEREL E WHITED LISW	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
SIDNEY A BAKER LMSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
SIMON CARIAN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SOLITAIRE APODACA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SONIA GAYTAN MENDOZA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SONIA M GARCIA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SORINA R FLORES	CURRY	Practitioner (Outpatient Services)	MEDICAID
SOUTHEASTERN BEHAVIORAL ASSOCIATES LLC	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
STACY KEENER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
STEPHANIE L CROSSER	CURRY	Practitioner (Outpatient Services)	MEDICAID
SUSAN FOGARTY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
SUSAN L CHAMBLISS	CURRY	Practitioner (Outpatient Services)	MEDICAID
SYLVIA BALTAZAR	CURRY	Practitioner (Outpatient Services)	MEDICAID
TAMMY M AGUILAR LMHC	CURRY	Practitioner (Outpatient Services)	MEDICAID
TAMMY M FELLOWS	CURRY	Practitioner (Outpatient Services)	MEDICAID
TAWNA SHAY SPEER	CURRY	Practitioner (Outpatient Services)	MEDICAID
TAYLOR FERGUSON	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
TAYLOR J FAVER	CURRY	Practitioner (Outpatient Services)	MEDICAID
TAYLOR N MOORE LMSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
TERRY TUCKER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
THE HARBOR COUNSELING SERVICES PC	CURRY	Practitioner (Outpatient Services)	MEDICAID
THE PSYCHIATRIC CARE CENTER LLC	ROOSEVELT	Agencies (Outpatient Services)	MEDICAID
THOMAS PULLMAN	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
TIFFANIE MONDRAGON	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
TIFFANIE MONDRAGON	CURRY	Practitioner (Outpatient Services)	MEDICAID
TIFFANY A LITTLE LMSW	CURRY	Practitioner (Outpatient Services)	MEDICAID
TONI RIVERA	CURRY	Practitioner (Outpatient Services)	MEDICAID
TORI LYNN PEYCHICH	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
TRACY OUSLEY	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
TRICIA M GOBBER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
TUDY ROMERO	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
TYLER BOCK	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
VALENCIA OWENS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
VALENTINA HARPER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
VALERIE MESTAS	CURRY	Practitioner (Outpatient Services)	MEDICAID
VALERIE PACINI dba. PORTALES PROFESSIONAL SOCIAL WORK SERVICES	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
VERONICA RICHARDSON	CURRY	Practitioner (Outpatient Services)	MEDICAID
VICKIE MARIE HOBBS	CURRY	Practitioner (Outpatient Services)	MEDICAID
VIOLETA S NICOLASGUERRA	CURRY	Practitioner (Outpatient Services)	MEDICAID
WADE CARTER	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
WENDY CANTOS	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
WHITE OAKS COUNSELING LLC	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID
YUMI WELLNESS SUPPORT	CURRY	Agencies (Outpatient Services)	MEDICAID
YVONNE MATA	CURRY	Paraprofessional (Outpatient Services)	MEDICAID
ZACHARY MARTINEZ	CURRY	Practitioner (Outpatient Services)	MEDICAID
ZOE K RODRIGUEZ	ROOSEVELT	Practitioner (Outpatient Services)	MEDICAID

MEMORANDUM OF UNDERSTANDING
BETWEEN CURRY COUNTY and
ROOSEVELT COUNTY

This Memorandum of Understanding (this "MOU") is made and entered into by and among the Counties of Curry and Roosevelt, herein after referred to as "the parties," for collaborative work in furtherance of the implementation of the Behavioral Health Reform and Investment Act, NMSA 1978, § 24A-10-1 et seq. ("BHRIA"), enacted in 2025 in Chapter 3, Sections 1 through 11, inclusive, Session Laws 2025.

1. **Purpose**

The BHRIA became effective on June 18, 2025. On November 7, 2025 Curry County executed an MOU with Administrative Office of the Courts to serve Region 9 as the Accountable Entity for purposes of 1) Establishing a Regional Stakeholder Planning Committee, herein after referred to as The Committee, 2) Conduct a Regional Planning Workshop within the Southeast Region of NM and 3) Assist The Committee in the development and submission of the Regional Plan.

The purpose of this MOU is to formalize the relationship between Behavioral Health Region 9's Counties.

2. **Definitions**

Accountable Entity: Is a government or quasi-government organization designated by the AOC to work with all counties and tribes within a behavioral health region.

Behavioral Health Reform and Investment Act (BHRIA): See Section 24A-10-1, NMSA 1978.

Behavioral Health Region: a geographic area of the state designated by the Executive Committee that encompasses one or more counties or judicial districts. In July of 2025 the Executive Committee adopted the judicial districts as the behavioral health regions.

Executive Committee: the committee designated by the BHRIA to review and approve behavioral health regional plans.

Regional Plan: means a plan that is developed collaboratively by behavioral health stakeholders to provide behavioral health services to each behavioral health region.

Regional Planning Workshops: a 2–3-day event in a behavioral health region convening all interested behavioral health stakeholders to conduct an E-SIM mapping of the services within the region and set state-funded behavioral health service priorities.

3. **Term of MOU**

This MOU is effective from April 21, 2026 through June 30, 2027, once signed and executed by the duly authorized representatives of the parties to this MOU. This MOU may be amended at any time by written agreement of the parties signed by duly authorized officers or officials of each of the parties.

4. **Roles and Responsibilities of Curry County**
   - Plan and implement E-SIM Workshop for Region 9
   - Draft and submit Early Access Funding grant application on behalf of Region 9
   - Plan and coordinate quarterly meetings for the Regional Stakeholder Committee
   - Hire and employ Regional Behavioral Health Administrator to manage all SB3 funds and grant contracts
   - Serve as the Accountable Entity and Fiscal agent for Region 9 SB3 funding

5. **Roles and Responsibilities of Roosevelt County**
   - Assist with the planning and implementation of the E-SIM Workshop for Region 9
   - Assist with the Early Access Funding grant application
   - Assist with coordination of quarterly Regional Stakeholder Committee meetings
   - Provide guidance and support in regards to the Regional Behavioral Health Plan
   - Provide articles, data, and photos for the Quarterly Behavioral Health Newsletter
   - Provide regular updates to Curry County detailing SB3 fund status and expenditures

6. **Funding, Compensation and Method of Payment**

   a. Delivery of services and budget table is included as Exhibit A.
   b. An invoice template is attached as Exhibit B.
   c. Curry County will reimburse Roosevelt County up to the amount of $375,000. Such total amount shall constitute full and complete compensation for the County's services under the Agreement, including all expenditures made and expenses incurred by Roosevelt County in delivering services.
   d. Roosevelt County agrees to prepare a monthly invoice documenting actual expenditures for services and operational costs. Invoices shall include backup documentation describing expenses incurred by Roosevelt County.
   e. Any changes or revisions to the budget must be pre-approved by Curry County.

7. **Changing Circumstances**

Parties agree to continually assess the provisions of this MOU and to communicate regularly regarding its sufficiency, and to amend this MOU to incorporate changed circumstances and current needs.

BY THE SIGNATURES below of the authorized officers, the parties do agree to this Memorandum of Understanding.

APPROVED BY:

Curry County

4/21/2026
Date

Roosevelt County

4/21/2026
Date

Exhibit A

Budget Table/Delivery of Services

Category	Description	Amount
Medication Assisted Treatment (MAT)	Medication Assisted Treatment (MAT) provided to detainees in the Roosevelt Detention Center who qualify for MAT services and have a substance use disorder. Expenditures include; medication and pharmaceutical expenses, clinical staffing, intake services, case management, screening, and treatment coordination.	$250,000
Re-Entry Services	Care coordination and case management support; Service navigation and referrals (behavioral health, housing, employment, etc), Coordination between detention and community providers; Programmatic supplies for participants - Program will follow the RISE Program format established by BHSD and will serve non-RISE participants on a volunteer basis	$100,000
Youth Treatment	Clinical staffing/intake, screening, treatment coordination for Teen Court participants	$25,000
	Total	**$375,000**

June 26, 2026

Health Care Authority - Behavioral Health Services Division
Attn: Behavioral Health Executive Committee
PO Box 2348
Santa Fe, NM. 87504

Re: Judicial District 9 Regional Behavioral Health Plan

Dear Members of the Committee,

On behalf of Community Bridges, Inc. (CBI), we strongly support the Regional Behavioral Health Plan for Judicial District 9. As a dedicated community provider, we recognize the critical need for a coordinated, robust, and accessible behavioral health continuum of care in our region. We believe this collaborative regional plan represents a vital step toward bridging service gaps, reducing systemic barriers, and improving outcomes for the individuals and families we collectively serve.

By signing this letter, Community Bridges, Inc. commits to actively partnering in the implementation and ongoing success of the Regional Plan in the following ways:

- **Collaboration & Integration:** We will actively participate in regional behavioral health committee meetings and workgroups to align our services with the plan's overarching goals.
- **Information & Resource Sharing:** Within the bounds of privacy regulations, we will share relevant data, best practices, and resources to help track regional progress and identify emerging needs.
- **Crisis Continuum Coordination:** We will lead coordinated service delivery across crisis, acute, and community-based settings to reduce care fragmentation and promote successful recovery and stabilization outcomes.
- **Care Coordination:** We commit to improving warm-handoff procedures and referral pathways with peer organizations to ensure patients experience a seamless continuum of care.
- **Stigma Reduction & Advocacy:** We will champion the initiatives of this Regional Plan within our own network and the broader community to promote mental health and substance use awareness.

We are eager and prepared to stand alongside our fellow regional stakeholders in this effort. Together, we can build a more resilient, equitable, and effective behavioral health system for our region.

Sincerely,

John Hogeboom
President and CEO

June 26, 2026

Health Care Authority - Behavioral Health Services Division
Attn: Behavioral Health Executive Committee
PO Box 2348
Santa Fe, NM. 87504

Re: Request for Standup Operational Funding Support for the Horizon Behavioral Health Facility

Dear Members of the Committee,

On behalf of the regional consortium consisting of **Curry County, De Baca County, Quay County, Roosevelt County, Union County, the City of Clovis, the City of Portales, and the Village of Fort Sumner**, we respectfully request your consideration in approving the standup operational funding for the Horizon Behavioral Health Center. These entities are located within the Eighth, Ninth, and Tenth Judicial Districts.

Recognizing the significant behavioral health needs throughout Eastern New Mexico, our local governments formed a regional consortium in 2021 to explore collaborative solutions to address the lack of accessible crisis stabilization, mental health, and substance use treatment services. The consortium undertook a regional needs assessment, including community surveys, stakeholder engagement, and planning efforts to evaluate existing service gaps and determine the most effective path forward. These efforts ultimately confirmed the need for a centralized regional behavioral health facility that would serve residents across our multi-county region.

As a result of this collaborative effort and the demonstrated regional need, Governor Michelle Lujan Grisham provided **$10 million in capital funding** for the acquisition of land and construction of the Horizon Behavioral Health Center in Clovis. This significant investment reflects the State of New Mexico's commitment to improving access to behavioral health services in rural communities and reducing the need for patients to travel hundreds of miles to receive appropriate care.

The Horizon Behavioral Health Center will provide comprehensive crisis stabilization, behavioral health, and substance use treatment services to residents throughout Eastern New Mexico. Once operational, the facility will significantly improve access to timely care, reduce burdens on hospitals, law enforcement, and emergency medical services, and provide individuals and families with treatment options much closer to home.

Construction of the facility is underway and will continue through the fall of this year. As we move from construction to implementation, our greatest challenge is securing stand up operational funding to ensure the facility can open fully staffed to provide high quality services.

....cont./..

While the State's investment has made construction possible, and the consortium has committed opioid settlement, indigent and other funding for the facility, initial standup operational support is essential to recruit and retain qualified clinical staff, provide 24-hour crisis services, maintain evidence-based treatment programs, and ensure long-term financial sustainability. Without this initial funding, the region risks having a state-of-the-art facility that cannot achieve its intended purpose of delivering life-saving behavioral health services to the communities it was built to serve.

We respectfully request your partnership in allocating requested funding through the behavioral health plans for regions 9, 10 and 8 for the Horizon Behavioral Health Center. The funding allocated for the Ninth Judicial District, if received in one tranche as soon as possible, will ensure that this regional collaboration fulfills its promise of expanding access to behavioral healthcare, improving health outcomes, strengthening public safety, and enhancing the quality of life for thousands of New Mexicans.

Thank you for your consideration and your continued commitment to improving behavioral healthcare across our state. We welcome the opportunity to discuss this request further and provide any additional information you may require.

For additional information about the Horizon Behavioral Health Center, please visit the website listed below.

Sincerely,

Mayor Pro Tem
City of Clovis

June 26, 2026

Health Care Authority - Behavioral Health Services Division
Attn: Behavioral Health Executive Committee
PO Box 2348
Santa Fe, NM. 87504

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....cont./..

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Thank you for your consideration and your continued commitment to improving behavioral healthcare across our state. We welcome the opportunity to discuss this request further and provide any additional information you may require.

For additional information about the Horizon Behavioral Health Center, please visit the website listed below.

Sincerely,

Meadow Forget

Meadow Forget
Roosevelt County Manager

June 26, 2026

Health Care Authority - Behavioral Health Services Division
Attn: Behavioral Health Executive Committee
PO Box 2348
Santa Fe, NM. 87504

Re: Request for Standup Operational Funding Support for the Horizon Behavioral Health Facility

Dear Members of the Committee,

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Recognizing the significant behavioral health needs throughout Eastern New Mexico, our local governments formed a regional consortium in 2021 to explore collaborative solutions to address the lack of accessible crisis stabilization, mental health, and substance use treatment services. The consortium undertook a regional needs assessment, including community surveys, stakeholder engagement, and planning efforts to evaluate existing service gaps and determine the most effective path forward. These efforts ultimately confirmed the need for a centralized regional behavioral health facility that would serve residents across our multi-county region.

As a result of this collaborative effort and the demonstrated regional need, Governor Michelle Lujan Grisham provided **$10 million in capital funding** for the acquisition of land and construction of the Horizon Behavioral Health Center in Clovis. This significant investment reflects the State of New Mexico's commitment to improving access to behavioral health services in rural communities and reducing the need for patients to travel hundreds of miles to receive appropriate care.

The Horizon Behavioral Health Center will provide comprehensive crisis stabilization, behavioral health, and substance use treatment services to residents throughout Eastern New Mexico. Once operational, the facility will significantly improve access to timely care, reduce burdens on hospitals, law enforcement, and emergency medical services, and provide individuals and families with treatment options much closer to home.

Construction of the facility is underway and will continue through the fall of this year. As we move from construction to implementation, our greatest challenge is securing stand up operational funding to ensure the facility can open fully staffed to provide high quality services.

....cont./..

While the State's investment has made construction possible, and the consortium has committed opioid settlement, indigent and other funding for the facility, initial standup operational support is essential to recruit and retain qualified clinical staff, provide 24-hour crisis services, maintain evidence-based treatment programs, and ensure long-term financial sustainability. Without this initial funding, the region risks having a state-of-the-art facility that cannot achieve its intended purpose of delivering life-saving behavioral health services to the communities it was built to serve.

We respectfully request your partnership in allocating requested funding through the behavioral health plans for regions 9, 10 and 8 for the Horizon Behavioral Health Center. The funding allocated for the Ninth Judicial District, if received in one tranche as soon as possible, will ensure that this regional collaboration fulfills its promise of expanding access to behavioral healthcare, improving health outcomes, strengthening public safety, and enhancing the quality of life for thousands of New Mexicans.

Thank you for your consideration and your continued commitment to improving behavioral healthcare across our state. We welcome the opportunity to discuss this request further and provide any additional information you may require.

For additional information about the Horizon Behavioral Health Center, please visit the website listed below.

Sincerely,

Scott Mitten
City Manager
City of Portales NM

June 26, 2026

Health Care Authority - Behavioral Health Services Division
Attn: Behavioral Health Executive Committee
PO Box 2348
Santa Fe, NM. 87504

Re: Request for Standup Operational Funding Support for the Horizon Behavioral Health Facility

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Brad Bender, Curry County Commission Chairman

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Sincerely,

J. De Gonzales
Quay County MGR
June 29 2026

Enhanced Sequential Intercept Mapping (E-SIM) and Prioritization Workshop Report

Behavioral Health Region #9
Curry County | Roosevelt County

December 20th 2025



Prepared by:
University of New Mexico
Behavioral Health Technical Assistance Center

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I. Background

The New Mexico (NM) Behavioral Health Reform and Investment Act (BHRIA) also known as Senate Bill 3 (SB3) was signed into law on February 27, 2025. This new law takes major steps to strengthen and rebuild NM's behavioral health system, including significant changes to how behavioral health and substance use treatment programs are managed statewide. The NM BHRIA is unique in that it focuses on building capacity and regional infrastructure to ensure that community voice and need inform regional behavioral health care. This new structure incorporates all three branches of government and brings stakeholders to the table – in a variety of ways – to strengthen the state's behavioral health care service system. The NM BHRIA Executive Committee oversees the implementation of SB3 and is responsible for approving regional behavioral health plans, directing and monitoring funding for those plans, establishing the behavioral health regions, and ensuring accountability throughout the implementation process. Two state agencies are leading the day-to-day efforts for this legislation: The NM Administrative Office of the Courts (AOC) and the NM Health Care Authority (HCA), Behavioral Health Services Division. The University of New Mexico (UNM) Behavioral Health Technical Assistance Center (BHTAC) assists these agencies with the operationalization and implementation of certain portions of the BHRIA.

During the first year of the legislation, one of the BHTAC's primary responsibilities is to facilitate Enhanced Sequential Intercept Model (E-SIM) Mapping and Prioritization Workshops in each of the 13 Behavioral Health Regions (Appendix A.1) and to produce a report summarizing the findings from each workshop. This report presents the findings from the E-SIM Mapping and Prioritization Workshop conducted in Behavioral Health Region 9 (Curry County and Roosevelt County). Appendix A.2 contains a list of acronyms used throughout this report.

1. Overview of the New Mexico Enhanced Sequential Intercept Model (E-SIM)

The E-SIM Mapping and Prioritization Workshops take a systems approach, using a specific orientation, to inform regional behavioral health planning. Appendix A.3 includes the NM E-SIM that was adapted for New Mexico from the original Sequential Intercept Model (Griffen, Helbrun, Mulvey, DeMattero & Schubert, 2015[1]), modified in the following three ways:

- **The Addition of a Pre-Intercept: Community Prevention Services:** Not all individuals with mental illness (MI) and/or substance use disorders (SUD) encounter the justice system. Therefore, when mapping services within the community, it is important to assess the resources and gaps in Community Prevention Services that aim to support all individuals who may never have justice system involvement.
- **The Addition of a Process to Support Mapping of the Youth System:** It is essential to understand the resources and gaps in services for youth who are at risk or living with MI and/or SUDs. Mapping these services helps ensure early identification and support.
- **The Focus on Prevention and Early Intervention:** Using a public health framework, the E-SIM identifies intervention opportunities and gaps to prevent New Mexicans from entering or moving deeper into the healthcare or justice systems.

II. Overview of E-SIM Mapping and Prioritization Workshop

The UNM BHTAC facilitated the E-SIM Mapping and Prioritization Workshop in Region 9 (Curry County and Roosevelt County) over the course of 3 days (December 2nd - 4th, 2025). A copy of the agenda is included in Appendix A.4. The first day of the workshop focused on mapping existing resources and opportunities in the youth system, the second day of the workshop focused on mapping existing resources and opportunities in the adult system, and the third day focused on the prioritization process.

[1] Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.). (2015). *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness.* Oxford University Press. https://doi.org/10.1093/med:psych/9780199826759.001.0001

Sixty-nine people attended the first day with an additional 9 from the UNM BHTAC for a total of 78 attendees. Fifty-six people attended the second day with 9 people from the UNM BHTAC for a total of 65 attendees. Fifty-two people attended the third day with 9 people from the UNM BHTAC for a total of 61 attendees. Participants represented a diverse range of perspectives from the following seven groups:

1. Health System
2. Legal System
3. First Responders
4. Tribal Representatives
5. Government
6. People with Lived Experience including Peer Support Workers, and Family Members/Loved Ones
7. Community & Local Organizations

During the morning of the first day, the Accountable Entity provided an overview of youth data in Behavioral Health Region 9. At the end of the first day, the BHTCA provided an overview of the Behavioral Health Region 9 Medicaid Snapshot Data (Appendix A.5). These data presentations were provided to help inform decisions regarding resource allocation (Day 3). The Medicaid Snapshot Data and additional NM Mortality Data were included in participants' packets (Appendix A.6). Highlights from the Medicaid Snapshot Data for Behavioral Health Region 9 are provided below.

III. Highlights from the Region's Medicaid Snapshot Data

Adult and youth data were compiled for Behavioral Health Region 9 (BHR9), which includes Curry County and Roosevelt County, with an estimated population of 47,156 and 18,7139, respectively (Census.Gov Quick Facts Population Estimates, July 1, 2024).

Demographics

- **Race/ethnicity:** Region 9 has a higher proportion of Non-Hispanic White (48.15%) individuals compared to the state (45.22%) and a lower proportion of Hispanic (36.53%) individuals than the state average (45.15%).
- **Age:** Region 9 has 73.66% adults (18+), slightly lower than the state (77.94%)

Behavioral Health Diagnoses

- **Under 18**:
  - Top diagnoses: Anxiety Disorder (Region 9: 38.74%, NM: 50.62%), Attention Deficit Disorders, and Mood Disorders were the most prevalent diagnoses for individuals under age 18.
- **18+**:
  - Anxiety Disorder was the most common disorder identified (Region 9: 61.97%, NM: 59.56%), followed by Mood Disorder and Alcohol Use Disorder.

Table 1: Top 10 Mental Health Diagnoses <18 years old

Diagnoses	% BHR9	% State
Anxiety Disorder	38.74%	50.62%
Attention Deficit Disorders	29.68%	26.03%
Mood Disorders	26.10%	21.89%
Developmental Disorders	13.32%	11.71%
Conduct Disorders	12.94%	10.06%
Intentional Self Harm & Suicidal Ideation	8.68%	7.13%
Cannabis Use Disorder	6.54%	5.30%
Emotional Disorders Childhood Onset	4.03%	4.63%
Psychotic Disorder	2.97%	3.23%
Alcohol Use Disorder	1.60%	2.00%

Table 2: Top 10 Mental Health Diagnoses 18+ years old

Diagnoses	% BHR9	% State
Anxiety Disorder	61.97%	59.56%
Mood Disorder	40.78%	37.12%
Stimulant Use Disorder	11.05	10.68%
Alcohol Use Disorder	10.75%	17.90%
Cannabis Use Disorder	10.48%	8.30%
Psychotic Disorder	8.87%	7.86%
Opioid Use Disorder	5.91%	12.67%
Hallucinogen/Inhalant/Other SUD	5.81%	5.84%
Attention Deficit Disorders	5.71%	6.81%
Intentional Self Harm & Suicidal Ideation	4.91%	5.29%

Adult and youth utilization data regarding services, infrastructure and crisis and emergency room visits are provided below.

Service Utilization

- Outpatient services are the most utilized service type in Region 9, 88.06% (NM rate = 86.82%).
- Crisis services utilization is slightly higher in Region 9 (25.33%) than the statewide rate (23.80%).
- Intensive outpatient service utilization is substantially lower in Region 9 (2.28%) compared to the statewide rate (7.23%).

Provider Utilization

- Utilization of Behavioral Health Prescribers is higher in Region 9 (18.70%) compared to the statewide rate (14.73%)
- Utilization of psychotherapy practitioners (BHR9 5.37%; NM 5.43%) and substance use specialists (BHR9 0.03%; NM 0.68%) is lower in Region 9 compared to statewide rates.

Crisis Calls & ER Utilization

- Crisis call rates decreased from 2023 to 2024 in Region 9, consistent with statewide trends:
  - NM: 1.42% → 1.32%
  - Region 9: 0.83% → 0.69%
- ER visit rates for behavioral health conditions are slightly higher in Region 9 (20.32%) than in NM overall (18.80%).

IV. Resources and Opportunities at Each Intercept of the E-SIM

During the E-SIM and Prioritization Workshop, participants were divided into two breakout groups with roughly equal representation from the seven stakeholder groups to identify resources, gaps and opportunities at each intercept. Each group also included UNM BHTAC facilitators, note-takers and scribes. The summary below reflects resources, gaps, and action items identified across all breakout groups. It is not intended to be an exhaustive inventory of regional resources, but rather those identified during the Workshop.

1. Youth System Pre-Intercept: Community Prevention Services

Overview: The Pre-Intercept includes proactive initiatives designed to address the root causes of social issues such as substance misuse, crime, and mental health difficulties, ideally before these issues escalate and require more intensive interventions such as contact with the justice or healthcare systems. The goal of these programs is to strengthen protective factors and sense of belonging while reducing risk factors that contribute to negative outcomes.

Table 3: Youth System Pre-Intercept: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Community Centers & After-School Programs	• After-school art and athletic programs (Clovis) • Fort Sumner recreation center (DWI prevention funded)	• Lack of business investment in youth facilities (pools, roller rinks, youth centers) • Limited economic development to support community programs	• Strengthen mentorship programs like Trust Mentorship to build skills and confidence • Create recreational centers supported by the community that provide free service
School-Based Supports	• HOUSE system in Curry County schools • School Resource Officers (Roosevelt & Curry) • Family support services in elementary schools • Sasquatch Program • United Way School Pulse Program • Maze of Life • Reality Check- United Way	• Youth have limited safe recreational spaces; lack of structured activities • Truancy policies leave students without alternatives after absences or suspensions • Juvenile probation officers intervene only at higher truancy levels • Law enforcement has lost authority to intervene with truant youth • Truancy consequences leave youth unsupervised	• Expand DOH Maze of Life mini-courses to more schools • Develop programs to reduce youth truancy
Family & Parenting Supports	• CMS home visiting program • 2 Drop-in Family Resource Centers	• Need more parent support programs beyond elementary level • Few programs offering early, home-based interventions • Grandparents raising grandchildren need support • Family engagement is challenging and often intergenerational • Low community trust in CYFD	• Develop more home-based programs for early intervention • More programs to support parents, grandparents, and other caregivers with youth in middle and high school
Youth Development & Vocational Supports	• Early childhood development center • ENMRSH Early New Mexico (youth & adult) • Head Start programs (Roosevelt, Eastern Plains Community Action)		• Increase access to vocational job training (Clovis Community College)
Mental Health & Substance Use	• Substance use classes, (Curry County) • Substance use and MH promotion and prevention in all the schools in Curry County • Prevention and promotion programming (Roosevelt) • Texaco random drug screening in schools	• Limited Medicaid acceptance • Lack of coordination among providers • Medicaid care coordinators and CCBHC services are underutilized • Significant shortage of mental health providers; long waiting lists • Some providers do not accept Medicaid	• Improve provider communication and coordination for better referrals • Expand workforce to support and grow existing services • Incentivize recent graduates (e.g., social workers, counselors) to stay in the region through loan repayment or higher wages • Collaborate with Cannon Air Force Base for student training opportunities

		• Limited access to resources and insufficient staffing • Gap in primary care services • Services for youth are mostly crisis-focused; lack of preventive options • Marijuana and substance use prevention programs are inadequate • Structural gaps in addressing behavioral health stigma and engagement	• Create more local services to increase access • Launch programs to raise awareness about marijuana risks for youth and families
Housing & Basic Needs	• No resources noted	• Limited access to affordable housing	• Develop programs to increase access to affordable housing
Other Community Resources	• Military & family consultants (Cannon AFB) • Faith-based supports • La Casita program for Hispanic families • Community success coaches for truancy • 4H programs • Multi-faith youth groups • Girls Circle • Positive Action • Boys Council • Picture This program • After party event at church in Portales after football games • Clovis Community College-kids college and Eastern NM University has summer programming • State parks and zoo • United Way 211 • Wild Cat Summer Program	• Limited community awareness of services	• Build on faith-based supports • Update and promote Share New Mexico resource database; educate schools and families about resources • Youth-led councils for events • Fund sports and other programs to reduce cost barriers • Organize safe, structured use of existing resources (e.g., skate parks, zoo) through peer-to-peer programs • Revive previously successful programs (Big Brothers Big Sisters, CASA, YMCA) • Collect youth data (e.g., YRRS) to secure funding • Create dedicated programs employing local youth for summer activities • Secure business buy-in for youth facilities (pools, roller rinks, youth centers) to support programming and economic development

2. Youth System Intercept 0: Community Treatment, Schools, and Crisis Services

Overview: Intercept 0 includes school systems and related student support systems that can provide connection to services rather than promoting exclusionary discipline or arrest. It also includes community and school-based programs for behavioral health that focus on prevention and early intervention to avoid crises and reduce risk for justice involvement. The goal of these programs is to connect youth with treatment, services, or other supports prior to any system involvement or exclusionary discipline within the schools. A comprehensive approach at this intercept includes community-based intensive programs, inpatient and residential services, crisis services, and a recovery system of care and outpatient services.

Table 4: Youth System Intercept 0: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Youth Crisis Services	• Mental Health Resources in Clovis and Roosevelt- outpatient therapy for MH and SA- IOP, MST, High Fidelity Wraparound, CCSS, psychiatry services, MAT, risk assessment • Curry County has a CCBHC starting 1/1/2026 • BH Collaborative (Horizon Crisis Triage Center) • Mobile crisis teams (MHR & Nurstead) • Life Changes counseling (evening hours) • 988 hotline • BeWell equine assisted therapy • In Clovis Schools MHR has MOU with school district to do assessments via zoom for youth in crisis • Nurstead Wellness Drop-in Center	• Not enough resources for youth; most services only available during crisis • Mobile crisis team (Nurstead) does not always respond; law enforcement ends up arresting individuals • Lack of co-response models for crisis calls • EMS transportation challenges in rural areas (e.g., Fort Sumner) • Shortage of mental health providers for youth in both counties	• Develop a full spectrum of care, including prevention, crisis response, and long-term treatment • Increase behavioral health workforce • Increase access to telehealth behavioral health services • Expand workforce capacity for crisis response and ongoing care • Implement cool-down centers and crisis stabilization facilities like Horizon • Expand Horizon to youth • Adopt a co-responder model for mobile crisis teams to improve collaboration between behavioral health and law enforcement
Child & Family Support / Child Welfare	• Family service providers (transportation, clothing, meals)	• Lack of parental engagement • CYFD regulations have led to closure of group homes and juvenile detention centers • Parents lack education on available resources and strategies for support. • Need more parental involvement and parenting classes (emotion regulation) • Grandparents raising grandchildren need support • Parent support groups to avoid CYFD involvement due to stigma • Need early intervention programs at home before crisis occurs	• Create treatment foster care homes for specialized support. • Teach families parenting skills and strategies to be more involved with youth • Offer parenting classes and emotional regulation programs • Explore ways to hold parents accountable for youth behavior while providing supportive resources
Hospitals & Inpatient Care	• Roosevelt General Hospital Children's Alliance (forensic interviews, in-home counseling) • Programs administered through the hospital	• No residential treatment locally; nearest facilities are far and do not serve females • No treatment foster care homes; no resources for homeless youth • Lack of certified peer support workers in emergency rooms	• Establish residential treatment centers for youth, including facilities for females • Introduce peer support in emergency rooms • Educate primary care providers on behavioral health referral pathways

		• Primary care providers need education on behavioral health referral pathways	
Substance Use Services	• DARE program coming back • Substance use class for youth 12-18	• Limited crisis response for substance-involved youth	
School Health Centers & Systems	• Social workers & LPCs in schools • Law enforcement info-sharing with schools • In Focus SEL program in schools • Employing student council to identify kids at risk in schools • IEPs	• Educators lack awareness of signs and symptoms of mental illness and substance misuse; breakdowns in existing systems	• Expand social emotional learning programs daily in schools • Provide additional training for School Resource Officers (SROs)
Care Coordination & Policy	• Law enforcement provides information immediately to schools when there is a loss, enabling schools to mobilize • CareLink NM Care Coordination program	• Managed Care Coordinators not fully utilized	
Other / Overarching Themes	• MHFA training (English & Spanish) • Postings everywhere- signs and symptoms of MH issues and how to get help • The county works with Clovis Area Transportation to help youth who may not have access to transportation attend the groups offered by the County • Free anger management classes at the Baptist Children's Home- Bridge to Hope	• Youth disconnected socially • Transportation barriers for youth, especially after hours and due to cost • No clear foundation for addressing youth suicide; social media and bullying exacerbate issues	• State-level social media campaigns for MH awareness • Develop strategies to engage disconnected youth, especially those not involved in school • Address youth impacted by EMS calls for parents with targeted interventions

3. Youth System Intercept 1: Initial Contact with Children, Family and Youth Division (CYFD), Law Enforcement, or School Police and School Resource Officers (SROs)

Overview: Intercept 1 includes law enforcement, including school-based police departments and School Resource Officers (SROs), municipal police departments, and the Children, Youth, and Families Department (CYFD) who have discretion to decide whether a case continues into the juvenile justice system. The goal of these programs is to divert youth into treatment instead of being referred into the juvenile justice system.

Table 5: Youth System Intercept 1: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Law Enforcement & SROs	• Strong school-law enforcement relationship • School Resource Officers & Public Safety Aids	• Limited collaboration between juvenile probation officers (CYFD), law enforcement, and schools	• Adopt successful models such as Alamogordo's CIT program to improve crisis intervention

	• Police receive crisis intervention and de-escalation training • Police can take youth to hospitals	• Dispatch transfers to 988, but calls often bounce back to police, creating confusion and delays • No dedicated Crisis Intervention Teams (CIT) in Clovis PD; only partial training for officers due to workforce shortages • Public Safety Aides (PSAs) lack de-escalation training • Law enforcement ends up handling crises without adequate behavioral health support • Low staffing in law enforcement leads to slow response times and reduced coverage	and law enforcement collaboration
CYFD Initial Contact	• Family in Need of Services (FINS) program	• CYFD discontinued family intervention specialists, removing a key early intervention resource	
School Police & Threat Assessment	• Schools can go direct to CYFD, PD or school counselors		
Diversion & Early Intervention	• Substance use classes (Safety First) • Consequence classes • Catch My Breath program • Healthy Futures • Curry County CYFD JJAC grant to create after school social and emotional learning classes and Trust Mentor program for youth being paired with trusted adults • Mental Health Resources has programs for youth near adjudication of after adjudication. MST and High-Fidelity Wraparound • Portales Junior High has a 4 week- emotion regulation group • Alternative Schools	• Limited diversion options • No local acute care facilities; nearest option is Amarillo across state lines • Limited resources for immediate behavioral health stabilization	• Implement Youth Challenge Program (modeled after National Guard) for at-risk youth to provide structure, education, and life skills • Offer programs that intervene early for youth struggling in school or at risk of justice involvement • Better integration of services across counties • Develop alternative pathways for youth with behavioral health needs beyond citations • Strengthen coordination between agencies for smoother referrals and shared resources

4. Youth System Intercept 2: Juvenile Justice Intake and Initial Processing

Overview: Intercept 2 involves initial case processing by juvenile probation in CYFD. After conducting a preliminary inquiry, juvenile probation may handle cases informally outside the court system, such as through diversion or other community-based programs, or formally by referring cases to the Children's Court Attorney (CCA). By statute, some youth shall be referred directly to the CCA by juvenile probation; they can choose to refer other youth to the CCA. CCAs can dismiss charges, divert youth into community-based programs, or refer

youth back to CYFD with informal recommendations for services. The goal of these programs is to divert youth into community-based programs.

Table 6: Youth System Intercept 2: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Juvenile Justice Intake	• Informal intake diversion programs • Anger management programs • MST & high-fidelity wraparound services • Anger management program offered by MATT25	• No juvenile detention center locally • Limited anger management options for youth • Lack of parental engagement in treatment • Anger management program costs and is also combined with adults • More youth with guns results in violent crimes • Youth who fail to go to court result in more resources being used to track them down by law enforcement	• Youth Intensive Outpatient Program • Incentivize parental participation • Develop youth-specific anger management programs • MOUD for youth • Increase behavioral health workforce • Encourage law enforcement to report low level crimes • JPO should be encouraged to divert to community interventions • JPOs need teeth to ensure youth are referred and attend treatment • Need access to TFCs, RTCs and Acute Care
Initial Processing	• No resources noted		

5. Youth System Intercept 3: Courts, Detention, and Commitment

Overview: Intercept 3 involves case processing in Children's Court, which can result in juvenile commitment or community-based placements or referrals. Juveniles may be detained prior to adjudication or placed in an alternative community-based setting. The court also has discretion to invoke either an adult sentence or juvenile sanctions on those adjudicated as youthful offenders. The court may also divert juveniles, mandate treatment, or otherwise consider juveniles' mental health needs when imposing sanctions. The goal of these programs is to divert youth from detention and commitment.

Table 7: Youth System Intercept 3: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Courts	• Teen Court (Curry & Portales) • Children's Court		• Expand Teen Court • Develop IOP/Treatment Court
Detention & Commitment	• Trust Mentor Program (restarting Jan 2026) • Temporary Detention • While in detention youth have access to behavioral health, education and physical health services	• Only two commitment facilities statewide • No structured programs at this level • Drastic drop in referrals from JPOs to MST and High-Fidelity Wraparound • No programs to treat youth to competency • Juvenile treatment has not been standardized and are not evidence based	• Expand Trust Mentor Program • Big Brothers/ Big Sisters • Increase access to juvenile treatment to competency
Programs for guardianship/ kinship	• No resources noted		• Need to figure out strategies to incentivize ways to encourage parents to participate in treatment – otherwise youth are not engaged.

6. Youth System Intercept 4: Community Re-entry Services

Overview: Intercept 4 involves supported reentry back into the community after leaving juvenile correctional facilities. The goal of these programs is to link youth and individuals who have come of age to various services, including behavioral health services, to reduce further legal system involvement.

Table 8: Youth System Intercept 4: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Community Re-Entry Services	• CYFD transition services (housing, employment, GED, food)	• No transitional living facilities • No reintegration centers for females • Lack of services for young mothers • Limited transportation • No access to medication post-release • For one year commitment supervised release is only 3 months • No specialized care for youth sex offenders (Current MST services do not cover this population) • Lack of family engagement- especially hard when youth are receiving services outside of the county • Federal resources are going away due to Department of Education and related funding going away • Youth going back to the same friend group • Transition age youth do not have access to services	• Big Brothers Big Sisters • Transitional living facility • Reintegration center • Workforce investment in community health workers • Job skills & GED programs • Ensure medication continuity post-release • Life skills training programs • Have reentry programs inside youth detention such as the RISE (Reach, Intervene, Support and Engage) program for adults

7. Youth System Intercept 5: Juvenile Community Corrections

Overview: Intercept 5 involves mandated youth supervision and connection to services by juvenile probation and Juvenile Community Corrections (JJC) to further reduce justice involvement of youth. The goal of these programs is to provide individualized supports for youth to prevent violations or offenses that may extend connection to the juvenile correctional system.

Table 9: Youth System Intercept 5: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Juvenile Community Corrections	• Supervised release (JPO assigned) • Teen MHFA & Youth MHFA • Outpatient treatment programs	• There used to be a Juvenile Corrections Center program – these closed down during the pandemic • JPO is 8-5 job- need people monitoring after hours or on the weekend • Lack of transportation to get youth to attend classes	• Extend supervised release period • Develop JCC program

V. Resources and Opportunities at the Each Intercept of the Adult System E-SIM

1. Adult System Pre-Intercept: Community Prevention Services

Overview: The Pre-Intercept includes initiatives designed to address the root causes of social problems like substance misuse, crime, and mental health challenges within a community, ideally before they escalate and require more intensive interventions such as contact with the justice or healthcare systems. The goal of these programs is to strengthen protective factors and reduce risk factors that contribute to negative outcomes.

Table 10: Adult System Pre-Intercept: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Community Centers and Libraries	• Libraries		
Vocational Education Programs	• Clovis Community College vocational training • Workforce Solutions • Snelling Staffing (temp agency) • Department of Vocational Rehabilitation	• Workforce entry challenges • Limited vocational training for adults	• Expand vocational training • Clovis Community College trade training—fund students (e.g., CDL and other trades) to improve economic mobility • Expand Dept. of Vocational Rehabilitation to Roosevelt County
Family and Parenting Supports	• Pregnancy Resource Center • Christian Children's Home housing for single mothers	• Families need more support when loved ones have MH/SU difficulties.	• Family resources for early support; community navigators to help enroll in benefits/Medicaid.
Mental Health and Substance Use	• DWI prevention program (NARCAN training, campaigns) • SUBH program through Curry County • ENMU substance use awareness • NA and AA Meetings	• Lack of adult-specific substance use prevention programs • Need more MH therapists, NPs,SU providers (workforce gaps). • Limited detox services • Overuse of ER for behavioral health crises • Lack of primary care access • Peer Support Workers gap • Need education for postpartum women and primary care prescribers regarding pain meds and addiction risk.	• Improve family education on behavioral health • Increase CHWs/CPSWs in the community.
Housing and Basic needs	• Lighthouse Mission (homeless shelter) • Fraternal Order of Eagles (housing) • Free meals at Senior Centers • Meals on Wheels • MATT 25 (one-stop shop for food, clothing, classes) • Food Bank of Eastern NM • Churches providing food banks • Clovis Housing Authority	• Transportation barriers (CATs/PATS issues) • Affordable housing shortages • Strict HUD regulations constrain options; incomes too low to pay for housing. • Homeless shelter and transitional housing gaps, including for the working unhoused; no warming center.	• Expand transportation (CATs/PATS) • Increase housing funding • Develop supportive housing options • Transitional housing and homeless shelter expansion

Other community Resources	• Roosevelt County social media campaigns • Ministerial Alliance (Portales & Clovis) • 211 and United Way (resource hub) • Salvation Army • Calvary Care and Community Center • Angel Ministries • Point in Time Count • MHFA and YMHFA trainings • Find Help resource database • Catholic Church showers and hygiene support • Victim Services (ARISE) • Hartley House (domestic violence) • Girl Circle • Nurstead drop-in Center • La Casa Primary care • Peer to peer warmline • 988 to identify resources • Hospital has a clinic that helps people link to benefits • Department of Health Public Health Services • Charity Tracker in Portales • Community awareness outreach – prevention and harm reduction • Curry County is also working on resource database with the state called “find help”	• Women’s health services limited—more needed in Curry; none in Roosevelt.	• Restorative justice programming • Promote 988- smartphone notifications; social media/PeachJar/digital boards. • Build crisis triage center • Expand DV services • Warming center (inclusive, family-friendly, pets allowed) • Indigent health care dollars as bridge while people await Medicaid • Resource database awareness and community conversations among providers/churches to improve coordination • Hands-on outreach to people who are unhoused (showers, hygiene support)

2. Adult System Intercept 0: Community Treatment, Schools and Crisis Services

Overview: Intercept 0 includes intervention points for people utilizing behavioral health (including mental health and substance use disorders) systems of care. The focus is on supporting individuals in the community who are already showing signs of behavioral health need or in crisis before law enforcement or justice system involvement. The goal of these programs is to provide support to people with behavioral health symptoms and/or diagnoses and to divert people from the justice system and penetrating further into the behavioral health system into local care and crisis care services.

Table 11: Adult System Intercept 0: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Crisis Services	• Horizon Crisis Triage Center opening in 2026 • 988 hotline • Nurstead mobile crisis	• No psychiatric acute care • Horizon CTC initially adult-only, short stays, limited beds (14) across 5	• Develop psychiatric acute care locally

	• Co-responder model (law enforcement + ambulance) • Nurstead drop-in centers • Text 741 line national crisis line	counties—likely to hit capacity quickly; no transportation from Roosevelt • Nurstead MCT does not respond to calls involving substance use or weapons; rules of engagement are unclear to community/ providers	• CTC will enable longer stays than ER; plan transportation home from CTC at discharge • Co-responder mobile crisis model to address calls involving SU/weapons; add more Mobile Crisis Response Teams; clarify MCT rules for community/ providers • Train law enforcement on CTC use (procedures, certificates for evaluation)
Family Support	• Celebrate Recovery (family support) • Christian Children's Home	• Limited family support resources	
Outpatient Mental Health and/or Substance use	• BeWell counseling organization • Life Changes Counseling • Next Step psychiatric provider • Psychiatric Care Center • Faith-based rehab programs • Mission Rehab/Freedom Ranch (men only) • Lighthouse (limited women's support) • Outpatient behavioral health services (therapy, IOP for SU, CCSS, PSR, peers support, carelink for care coordination, MAT, med management, crisis line, walk in services) • Christian Believers counseling • Renew Health & Next Step Care (MAT) • Clarity Mental Health (ketamine treatments) • Southwest Behavioral Health Counseling • Agape provides Virtual Behavioral Health Counseling • Rio Vida	• No local detox center • Long waitlists for outpatient BH services • Marketing challenges for MH services • Not enough bilingual providers; broader workforce recruitment challenges in rural areas	• Increase bilingual services • MAT for postpartum women • Improve marketing and outreach • More providers, incentives and pathway programs; internships via CCC/ENMU • Increase CHWs & CPSWs; broaden CHW scope; leverage NM Rural Health Care tax credit; add workforce incentives/ bonuses and pathway programs • Detox facility locally; expand CTC/Residential bed capacity • Advocate Opportunity Scholarship revisions (work-in-NM requirement); blend federal/SB3/OUD settlement funds; CCC/ENMU apprenticeships for BH pipelines
Hospitals and Inpatient Care	• RTC provided by Community Bridges • Emergency room in both counties – Plains Regional in Curry and Roosevelt General in Portales	• No inpatient MH beds locally	• Add transportation for discharged clients • Inpatient BH treatment development
Care Coordination	• No resources listed		
Other	• VA helpline • ENMU social work program • United Way stipends for social work students	• Sober living options limited and largely men-only; faith-based models have exclusion criteria	• Sober living recovery housing—more units, especially for women

	• Overdose prevention – Narcan training • Sage House Sober Living		

3. Adult System Intercept 1: Law Enforcement

Overview: Intercept 1 includes law-enforcement led interventions aimed at de-escalating the situation and diverting individuals to treatment rather than arrest. The goal of these programs is to divert individuals to treatment instead of being arrested or booked into jail.

Table 12: Adult System Intercept 1: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Diversion and Early Intervention	• Officers trained in CIT and crisis negotiation • Law enforcement assisted diversion program • Nurstead collaboration for crisis diversion • QR code on PD business cards for resources • Certificate for Evaluation from behavioral health to enable law enforcement to pick up and bring to CTC • Officers will cross county lines to bring people to CTC in Clovis.	• Workforce shortages in law enforcement • Limited CIT-trained officers • Transportation gaps post-discharge • LEAD focus is drug possession/victimless crimes; broader diversion needs remain • Law enforcement sometimes must arrest due to lack of services (e.g., detox) • No detox center available to support diversion • Hard to hold people in ED; mobile crisis not always available.	• Expand CIT training • Develop mental health court/diversion programs • Expand mobile crisis team capacity • LEAD program expansion and formalization • Detox center to enable diversion • Transportation from CTC (and out-of-state facilities) back home after discharge • Co-responder model with police & BH • Increase number and experience of law enforcement officers • Grow 988 awareness to reduce 911 calls; formalize 988–911 agreements for diversion; study other counties' MOUs • Learn from Alamogordo co-responder model; clarify criteria for police/MCT joint response

4. Adult System Intercept 2: Initial Court Hearings Initial Detention

Overview: This intercept focuses on early diversion from the justice system after arrest but before formal charges are fully processed. The goal of these programs is to identify individuals with behavioral health symptoms and to use this information to inform decisions related to treatment needs in lieu of further justice processing.

Table 13: Adult System Intercept 2: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Intake and Initial Process	• Detention centers in both counties • Intake screening for MH and SU risk • MAT, parenting, and anger management classes in jail • Pre-trial services linking people to care	• No drug/alcohol rehab centers • Limited MAT services in jail • Delays in competency to stand trial evaluations • If non-violent and incompetent, individuals may be released to community without	• Add residential rehab facilities • Expand MAT funding and training • Increase case management in jails • Develop post-booking diversion programs • CAMS counselors in detention

	• Restorative justice coordinator • Pre-process diversion programs • PD has authority to divert before arrest • Competency to stand trial assessments • Public Defenders office refers people to residential treatment programs or sober living programs	mandated rehab (unlike Texas) • Restorative justice workforce constraints; coordinator positions for youth/adults; DWI dollars funding at risk of federal cuts	• Post-booking jail diversion programs • Restorative justice—community processing instead of judicial path; build buy-in & hire experienced staff • Locked residential rehab facility development • Expanded case management teams in jail (e.g., RISE-like model with case manager, NP, LISW) • Greater autonomy for pre-trial services; improved communication with probation/parole • Local sober housing and residential treatment programs growth • Family treatment court consideration

5. Adult System Intercept 3: Jails/Prisons/Courts

Overview: Intercept 3 focuses on individuals who are already involved with the formal justice system, being held in jail or on bail, and offers diversion opportunities through jail-based programming or specialized problem-solving courts. The goal of these programs is to address behavioral needs in lieu of punishment.

Table 14: Adult System Intercept 3: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Specialty Courts	• Specialty courts (treatment, exploring young adult and veterans' courts) • Curry County has Treatment Court program	• Lack of judges for criminal mediation • Limited restorative justice program funding	• Increase judges for mediation
Treatment and/or Education while in Detention, Jails or Prisons (e.g., MOUD, MAT, other groups)	• Curry County Jail screening occurs re: BH- offer medical detox and MOUD • Access to MH and SU treatment in jail • Services are provided for women who are pregnant. Work with CYFD if children are involved. • In the detention centers they offer MAT, Parenting classes, and anger management classes		• Expand trauma-specific treatment in jail • Develop rapid transition protocols from custody to treatment • Restorative justice program expansion and education/awareness • Coordination of services and curriculum through the judicial system to be offered in jail (e.g., trauma specific treatment etc.)

6. Adult System Intercept 4: Community Re-Entry Services

Overview: Intercept 4 focuses on supported reentry back into the community after jail or prison to reduce further justice involvement of people with behavioral health problems. The goal of these programs is to link individuals into community-based services to prevent further justice involvement and to increase the likelihood of successful re-entry into the community.

Table 15: Adult System Intercept 4: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Community Re-entry services	• RISE program (in-jail and post-release support) • Nurstead transitional housing • Freedom Ranch sober living • Fresh Start Rental Assistance Program • Move-in and Eviction Prevention Program • Linkages housing program • Probation can pay for temporary housing such as hotels for up to three months • Can transfer probation cases to every county (besides ABQ) so people can move if they chose to do so	• Because RISE is grant funded - eligibility criteria make it difficult (e.g., no disciplinary history), • Limited housing vouchers • No reintegration centers • Lack of family engagement in reentry planning • Limited peer support for reentry • RISE has a hard time connecting with providers, the wait lists are long • People coming out of prison have limited services • MAT providers are embedded in agencies that provide all types of services so there is a long waiting list • There is no BH planning with families when someone comes out of jail or prison • MHR has a linkages program but there are limited vouchers (only 19) resulting in a long wait list • People leave area to access reintegration services such as housing • Not many employers are willing to hire people with a criminal record • Sage House (Nurstead transitional living) has strict eligibility (Medicaid required; eviction for substance use)	• Expand transitional housing and halfway houses • Add peer support workers for reentry • Develop methadone and addiction treatment clinics • Create job training and employer incentive programs • Improve continuity of care post-release • Need for another reentry program • Job training programs, education programs • Family engagement mechanisms (agreements between P&P and families); ongoing anger management programs post-release • Additional reentry program with fewer eligibility criteria to include those not on probation

7. Adult System Intercept 5: Community Corrections

Overview: Intercept 5 focuses on community-based justice supervision with added support for people with behavioral health problems. The goal of these programs is to support individuals with a history of justice involvement to increase their likelihood of success in the community and decrease the likelihood of further justice involvement.

Table 16: Adult System Intercept 5: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Community Based Probation and parole	• MHR Community Corrections Program • Probation and parole discharge planning	• Lack of transportation to report to probation/parole • Half-way homes for individuals on parole have not been the best places to	• Need for a navigator who can help people on probation and parole • Reduce the time it takes to hire probation and parole officers –

	• Case management is available for treatment court participants if they are on probation and parole • Probation and parole officers • Half-way homes for individuals on parole • Specialized teams including sex offender team, high risk team	live. As a result, they haven't been that effective • No housing for those who leave the half-way house • Need for a remodel of the half-way house • No behavioral health team or trained therapist employed by probation/ parole team • Navigator support lacking for those on probation/parole; officers need awareness of community services	this is through the state - and incentivize probation and parole officers to work in rural communities • Collaborate with community college to offer vocational training opportunities (e.g., wielding classes) • Need for transportation for those who live in Roosevelt

VI. The Prioritization Process and Results from the Prioritization Voting

Under the New Mexico Behavioral Health Reform and Investment Act (BHRIA; SB3), each district is required to develop a Regional Plan identifying up to five grant or state-funded priorities. The prioritization process described below was designed to facilitate the identification of the five priorities.

At the end of the first and second day of the workshop, the UNM BHTAC reviewed the notes taken during the breakout sessions and identified themes (also referred to as Provisional Priority Buckets) that surfaced during the discussion of opportunities. A total of 13 Provisional Priority Buckets were identified and are listed below. During the first session of Day 3, UNM BHTAC presented a summary of the Provisional Priority Buckets and related action items (Appendix A.7). Throughout the PowerPoint presentation, participants were invited to ask clarifying questions.

1. Crisis, Acute, & Higher-Level Care Infrastructure
2. Agency Coordination
3. Community Communication
4. Community-Wide Prevention & Education
5. Youth Prevention Programs & Mentorship
6. Community-Based Programs for Youth and Adults
7. Family Engagement & Parenting Support
8. Workforce Development
9. Transportation Access
10. Housing & Homeless Services
11. Youth Diversion & Justice System Improvements
12. Services in the Adult Justice System
13. Reintegration Support

The 13 priority buckets were posted on chart paper around the room. Each participant received five dots to vote for their top five priorities. Each group (i.e., health system, legal system, first responders, tribal representatives, government, people with lived experience, and community organizations) was assigned a unique dot color. The final five priorities are listed below and the results of the voting by group are summarized in Table 17.

1. Priority Bucket 1: Crisis, Acute, & Higher-Level Care Infrastructure
2. Priority Bucket 2: Housing & Homeless Services
3. Priority Bucket 3: Community-Based Programs for Youth and Adults
4. Priority Bucket 4: Workforce Development
5. Priority Bucket 5: Youth Prevention Programs & Mentorship

Table 17: Results of Priority Voting by Group

	Health System	Legal System	First Responders	Government	People with Lived Experience	Community Organizations	Tribal Representatives	Total
Crisis, Acute and Higher-Level Care Infrastructure	7	19	3	8	0	3	0	40
Housing and Homeless Services	8	14	4	8	0	6	0	40
Community-Based Programs for Youth and Adult	3	12	4	7	0	4	0	30
Workforce Development	3	6	3	8	0	6	0	26
Youth Prevention Programs and Mentorship	1	7	4	7	0	6	0	25
Transportation Access	6	3	4	3	0	4	0	20
Youth Diversion and Justice System Improvements	0	4	6	4	0	2	0	16
Family Engagement and Parenting Support	0	1	2	7	0	2	0	12
Community-Wide Prevention and Education	1	5	4	0	0	0	0	10
Reintegration Support	1	3	1	1	0	3	0	9
Services in the Adult Justice System	0	5	0	2	0	1	0	8
Agency Coordination	0	1	0	0	0	2	0	3
Community Communication	0	0	0	0	0	1	0	1
Total	30	80	35	55	0	40	0	240

VII. Summary of the Discussion Related to the Top Five Priorities

After the voting process was completed, participants once again convened into two breakout groups to discuss the following guiding questions:

1. Is there anything else you would like to communicate to leadership about these specific priority buckets? More specifically, what is the most important action items related to each of the five priority buckets that Region 9 wants to advocate for at this time?
2. What are the implementation issues that need to be considered?
3. What are the sustainability issues that need to be considered?

The following section summarizes break-out session discussions related to each of the five top priority buckets. The action items aligned with the five final priority buckets are also presented below.

VII.A Priority Bucket 1: Crisis, Acute, & Higher-Level Care Infrastructure
Action Items from the Intercept Mapping Sessions

- Develop acute care options for all ages closer to the region
- Add peer supports in emergency rooms
- Increase opportunities for CIT training for law enforcement
- Train law enforcement on CTC services and policies
- Expand crisis triage center (e.g., longer stays, more beds, different levels of care, services for youth)
- Need local detox facility
- Create resources for residential services after CTC
- Need local substance use rehab services (SUD + co-occurring MH)
- Need inpatient and residential treatment for BH
- Increase collaboration and agreements between 988 and 911 for more opportunities for diversion
- Increase capacity of mobile crisis teams to serve all regions of the county
- Need co-responder crisis teams

1. Additional Programs, Best Practices, or Needs to Communicate to Leadership

- *Transportation Support:* Especially for returning individuals from the Crisis Triage Center (CTC).
- *Advanced CIT Training:* More specialized training for officers already CIT-trained.
- *Youth Crisis Triage Center:* Top priority; design for the build exists but funding for construction and operations is does not exist.
- *Extended Length of Stay (LOS):* For adult CTC and care coordination post-discharge.
- *Expand crisis services for youth in the current ER:* Explore options for expanding crisis services for youth in the current ER since adult ER demand will decrease after CTC opens.
- *Local Detox Facility:* For both youth and adults; reassess need after CTC opens.
- *Co-Responder Teams:* Behavioral health-led teams with law enforcement collaboration.
- *Residential Treatment Facilities:* For youth and adults, possibly integrated with transitional living and education.
- *Workforce Development:* Leverage ENMU MSW program and CCC nursing program; increase student placements.
- *Licensing Compact:* Faster licensing for professionals moving from other states.

2. Implementation Issues

- *Transportation Logistics:* No clear system for transporting individuals back from CTC.
- *Officer Training Burden:* Small communities lack staff to attend additional CIT training.
- *Funding Gaps:* Construction funded, but operational costs for CTC (adult and youth) remain unfunded.
- *Staffing Challenges:* Recruiting clinicians and law enforcement; need better pay and incentives.
- *Regulatory Barriers:* Co-responder teams face state funding restrictions and law enforcement staffing shortages.
- *Facility Design & Ordinances:* Residential treatment requires compliance with city/county regulations.
- *Licensing Delays:* No state compact; need expedited licensing for incoming professionals.
- *Security Needs:* For detox facilities accommodating different substance use cases.

3. Sustainability Issues

- *Ongoing Funding:* For CTC operations and potential detox facilities.
- *Workforce Retention:* Incentives to keep trained professionals in Region 9.
- *Medicare/Medicaid Billing Codes:* To pay for services like peer support to ensure reimbursement.
- *Training Continuity:* Maintain advanced CIT and co-responder training despite staffing shortages.
- *Integrated Care Models:* Combining residential treatment, transitional living, and education for long-term viability.

VII.B Priority Bucket 2: Housing & Homeless Services
Action Items from the Intercept Mapping Sessions

- Need affordable and low-income housing (not enough vouchers/units)
- Need emergency housing/homeless shelter
- Need transitional housing for youth and adults upon reentry such as halfway houses
- Need warming center inclusive to families and pets
- Need more sober living recovery housing for men and women
- Need independent living with intensive case management and/or supportive housing options for people with BH issues
- Need programs to support youth who are unhoused
- Need for someone who can help with benefits, such as Medicaid
- Use indigent health care dollars for people awaiting Medicaid coverage
- Need more hands-on outreach to people who are unhoused
- Work to impact housing policy, including regulations under grants
- Need local reintegration housing such as adequate halfway houses

1. Additional Programs, Best Practices, or Needs to Communicate to Leadership

- *Affordable and Low-Income Housing:* Clarify differences; advocate for more options and education for leadership.
- *Emergency Shelter + Warming Center:* Combine services with beds, showers, and staff to connect people to benefits.
- *Warming Shelters:* Accessible in each county, no eligibility criteria, staffed adequately, and linked to resources.
- *Permanent Supportive Housing & Supported Employment:* Begin planning for independent living with intensive case management.
- *Community Engagement:* Involve missed voices, including faith-based organizations, Cannon Air Force Base, city/county leaders, and alternate meeting locations.
- *Pilot Programs:* Start small-scale housing initiatives to build buy-in.
- *Resource Coordination:* Leverage NM Appleseed, Mortgage and Finance Authority, VA, and transit funding for housing and transportation.

2. Implementation Issues

- *HUD Waiting List:* Long delays; eligibility rules prevent use of available housing for permanent supportive housing.
- *Regulatory Barriers:* State and federal rules limit flexibility in housing programs.
- *Staffing Needs:* Warming centers and shelters require trained staff for resource navigation.
- *Location Challenges:* Shelter placement and community resistance (“Not in my backyard” concerns).
- *Education & Advocacy:* Leadership needs clarity on affordable vs. low-income housing; involve all local jurisdictions.
- *Coordination Across Counties:* Need to get support from all entities involved, city (i.e., Clovis and Portales) and county-level (i.e., Curry and Roosevelt).
- *Missed Stakeholders:* Need outreach to community leaders, faith-based groups, and military base.
- *Transit Connectivity:* Explore linking Clovis and Roosevelt for housing access.

3. Sustainability Issues

- *Funding Sources:* Medicaid for shelter operations; explore state vouchers for temporary housing.
- *Liability Concerns:* Hotel voucher programs risk property damage.
- *Workforce Retention:* Ensure adequate staffing for shelters and case management.
- *Community Buy-In:* Ongoing engagement with local leadership and stakeholders.
- *Long-Term Vision:* Independent living with intensive case management; permanent supportive housing models.

- *Resource Integration:* Maintain partnerships with state agencies, nonprofits, and local organizations for continued support.

VII.C Priority Bucket 3: Community-Based Programs for Youth and Adults
Action Items from the Intercept Mapping Sessions

- Need Residential Treatment Center for Youth
- Need Intensive Outpatient Treatment for Youth and Adults
- Need treatment foster care for youth
- Increase full spectrum of behavioral services across the lifespan, including telehealth services
- Need bridge to services for transition age youth to adult
- Increase substance use classes and connect to referral process
- Develop and fund medication assisted treatment programs for youth and adults
- Reduce waitlists for outpatient BH services
- Increase access to bilingual services and resources
- Need a methadone clinic
- Need a Clinic that just provides addiction treatment
- Increase screening for women's postpartum and expand Women's health services, including MAT treatment

1. Additional Programs, Best Practices, or Needs to Communicate to Leadership

- *Reduce Behavioral Health Waitlists:* Explore MSW students doing intakes; Medicare changes.
- *Maternal Health & Postpartum Support:* Increase screening for postpartum depression; add perinatal/postnatal SUD treatment; consider CHW follow-up and postcard care programs for pregnant mothers.
- *Telehealth Expansion:* Increase services across lifespan; ensure private spaces (e.g., library construction underway).
- *Adult SUD Rehab (30/60/90-day residential):* Add to action items; requires significant upfront funding and licensing.
- *Treatment Foster Care for Youth:* Train families and providers.
- *Residential Treatment for Youth:* Align with Crisis/Acute Care priorities.
- *Designated MAT & Methadone Clinics:* Address regulatory barriers, liability concerns, and stigma; leverage RHAPSODI (Reimaging Health and Public Safety Overdose Initiatives Project) grant for planning and implementation.
- D*ata Collection for Funding Justification:* Involve PED; incentivize schools; explore QR code on No Wrong Walls website.
- *Funding for Non-Medicaid Populations:* Expand access to CCSS, MST, High Fidelity Wraparound, Assertive Community Treatment, Treatment Foster Care, etc.

2. Implementation Issues

- *Workforce Shortages:* Need additional staff for outpatient services; retention strategies required.
- *Maternal Health Barriers:* Insurance limits early postpartum visits; need education and CHW follow-up.
- *Licensing Challenges for Rehab:* Two-year process; $2M cost before billing allowed; requires Joint Commission and state approval.
- *Regulatory Barriers for MAT Clinics:* Prescriber liability concerns; stigma; housing medication; lack of counseling.
- *Data Gaps:* No CDC Youth Risk Behavioral Surveillance System (YRBSS) data for Curry County; schools lack capacity for data collection; adult data tripled.
- *Funding Gaps:* Services for non-Medicaid populations currently unfunded; CYFD payment issues.
- *Infrastructure Needs:* Secure telehealth spaces; foster families trained in TFC.

3. Sustainability Issues

- *Workforce Retention:* Critical for reducing waitlists and maintaining service levels.

- *Maternal Health Follow-Up:* Postcard care programs for pregnant mothers can support ongoing engagement.
- *Medicaid Funding:* Rehab and treatment foster care sustainable once licensed; other services depend on Medicaid reimbursement.
- *Data-Driven Funding:* Need robust data to justify continued investment and demonstrate outcomes.
- *Diversified Funding Sources:* Grants (e.g., RHAPSODI) and alternative funding for non-Medicaid populations.
- *Community Awareness & Engagement:* Ongoing education about services and laws (e.g., CARA).

VII.D Priority Bucket 4: Workforce Development
Action Items from the Intercept Mapping Sessions

- Increase behavioral health workforce (e.g., counselors, social workers, therapists) and healthcare workforce in general (e.g., primary care providers, pediatricians)
- Retain providers through incentives (loan repayment, higher wages)
- Increase training for school resource officers
- Partner with universities for MSW students to provide acute care
- Expand Community Health Workers and Peer Support Workers
- Add more workforce to existing services (e.g. crisis-response, telehealth and in-person)
- Increase workforce for restorative justice programs
- Create pathway programs for high school students into BH fields
- Increase awareness and use of NM Rural Health Care tax credit for BH providers
- Advocate to revise Opportunity Scholarship to require NM work post-graduation
- Collaborate with Clovis Community College and ENMU for job training/apprenticeships/internship opportunities
- Incentivize new graduates to stay in NM
- Review statutes for licensure reciprocity for BH providers (Interstate Counseling Compact)
- Need more education on MAT among providers to adhere to best practices
- Develop role of community navigators to help people access and follow through with services
- Need to increase the number of law enforcement officers
- Increase the number of judges to increase the use of criminal mediation
- Reduce hiring time for probation and parole officers and incentivize probation and parole officers to work in rural communities

1. Additional Programs, Best Practices, or Needs to Communicate to Leadership

- *Behavioral Health Workforce Expansion:* Increase BH professionals and support staff (EMS, firefighters, law enforcement).
- *Opportunity Scholarship Expansion:* Include master's programs with payback requirements.
- *Loan Repayment Incentives:* Broaden to more careers.
- *Career Pathways for Youth:* Create mentorship programs starting in high school or earlier; partner with Cannon Air Force Base and local universities for marketing and outreach.
- *Positive Community Marketing:* Showcase Clovis' assets and positive law enforcement presence to attract professionals.
- *Reentry Workforce Programs:* Incentivize employers to hire individuals post-incarceration; integrate Workforce Innovation and Opportunity Act (WIOA); offer job training and certifications during detention.
- *Counseling Compact:* Promote adoption to increase access.
- *Community Amenities:* Investments like outdoor pools to attract residents.

2. Implementation Issues

- *Supervision Burden:* New graduates require supervision, reducing productivity for senior staff.
- *Malpractice Insurance Costs:* NM has high rates, creating barriers for providers.

- *Qualified Immunity Removal:* Legislative changes have reduced law enforcement recruitment and retention; Texas offers higher pay and immunity, drawing officers away.
- *Pay Disparities:* Need higher salaries for law enforcement and BH professionals.
- *Stigma & Culture:* Negative perceptions of law enforcement; need cultural shift and positive engagement.
- *Volunteer Recruitment:* Challenge for mentorship programs.
- *Employer Incentives for Reentry:* Need tax breaks and stigma reduction strategies.
- *Infrastructure for Training:* Partnerships for job training during incarceration; transition programs to community college.

3. Sustainability Issues

- *Retention Strategies:* Pathways for graduates to stay in the community; incentives for long-term commitment.
- *Liability Coverage:* Consider state liability pool or stipends for insurance costs.
- *Marketing & Community Engagement:* Ongoing campaigns to promote the area and law enforcement culture change.
- *Funding for Incentives:* Scholarships, loan repayment, and employer incentives require stable funding streams.
- *Integrated Workforce Development:* Collaboration across education, justice, and health sectors for continuity.

VII.E Priority Bucket 5: Youth Prevention Programs & Mentorship
Action Items from the Intercept Mapping Sessions

- Develop peer-to-peer mentoring programs (sports, 4H, United Way)
- Develop youth led councils/committees to organize events
- Reinvigorate Big Brothers Big Sisters and CASA (Court Appointed Special Advocate) programs
- Expand Trust Mentorship Program
- Create youth recreation and/or development center (YMCA-style) offering free programming
- Develop truancy programming to identify youth at risk for justice involvement
- Create programs for marijuana and vaping awareness and prevention
- Work with the National guard to bring the Youth Challenge Program
- Expand DOH Maze of Life mini-courses to more schools
- Build vocational educational programs for job skills, GED, higher ed
- Obtain business buy-in in Roosevelt County to support pools, roller rink, youth center, etc.
- Identify strategies for engaging youth who are not involved in school
- Expand social emotional learning in the schools (e.g., In-Focus)
- Organize structured activities with adult oversight in free and safe spaces, such as skate parks, zoos
- Identify and build on faith-based supports
- Identify opportunities to build support for positive cultural identity development for all youth
- Develop a youth mentorship program for people on probation to do community service
- Develop app “There is nothing to do here” to share community resources
- Collaborate with Cannon Airforce base and Clovis Community College for vocational training and mentoring

1. Additional Programs, Best Practices, or Needs to Communicate to Leadership

- *Truancy Program:* Develop enforceable truancy laws or ordinances to support school attendance.
- Vocational Education: Job skills, GED, and higher education programs for youth, including those not enrolled in school.
- *Reinvigorate CASA Program:* Court-appointed special advocates for youth.
- *Explorer Programs:* For law enforcement, EMS, and firefighting careers.
- *Parenting Classes:* For reintegration after detention/incarceration; include restorative justice groups.

- *Youth Development Center:* Revamp previous successful models; include paid mentorship opportunities for high school students.
- *Positive Youth Programs:* Big Brother Big Sister, CASA, YMCA, and other mentorship initiatives.
- *After-School Programs:* Free, accessible programs with transportation solutions; avoid burdening school staff.
- *National Guard Youth Challenge Program:* Promote and incentivize participation in vocational and mentorship opportunities.
- *Sports and School Coordination:* Reduce stress by simplifying participation options and coordinating events so youth are not overburdened.
- *County Collaboration:* Curry and Roosevelt Counties share resources and offer different programs.
- *Grant Opportunities:* Leverage HRSA and other funding sources; explore creative grant writing for new programs.
- *Indigent Health Care Fund:* Utilize County funds for contracts supporting youth programs and safe transportation.

2. Implementation Issues

- *Legal Barriers:* Truancy enforcement requires laws or ordinances; current limitations due to ACLU rights.
- *Transportation Needs:* Free transport between CCC and high schools; after-school program logistics; collaboration with bus companies or CATs/PATs.
- *Awareness & Outreach:* Inform youth and families about available programs; secure parental permissions early.
- *Staffing Challenges:* Ensure adequate staff for after-school programs without burdening school personnel.
- *Program Revitalization:* Determine requirements to restart CASA and youth development centers.
- *Resource Coordination:* Counties must collaborate to share strengths and avoid duplication.
- *Funding & Incentives:* Identify grants, SB3 funding, and county indigent funds; incentivize participation in programs like Youth Challenge.
- *System Coordination:* Align schools, CYFD, and community organizations for truancy interventions and parenting classes.
- *Curriculum Development:* Create content for parenting classes and restorative justice programs.
- *Community Buy-In:* Engage local service providers and health councils to fill gaps.

3. Sustainability Issues

- No sustainability issues were discussed.

VIII. List of Appendices

A.1 Map of Behavioral Health Regions

A.2 Acronym List

A.3 The New Mexico Enhanced Sequential Intercept Model (E-SIM)

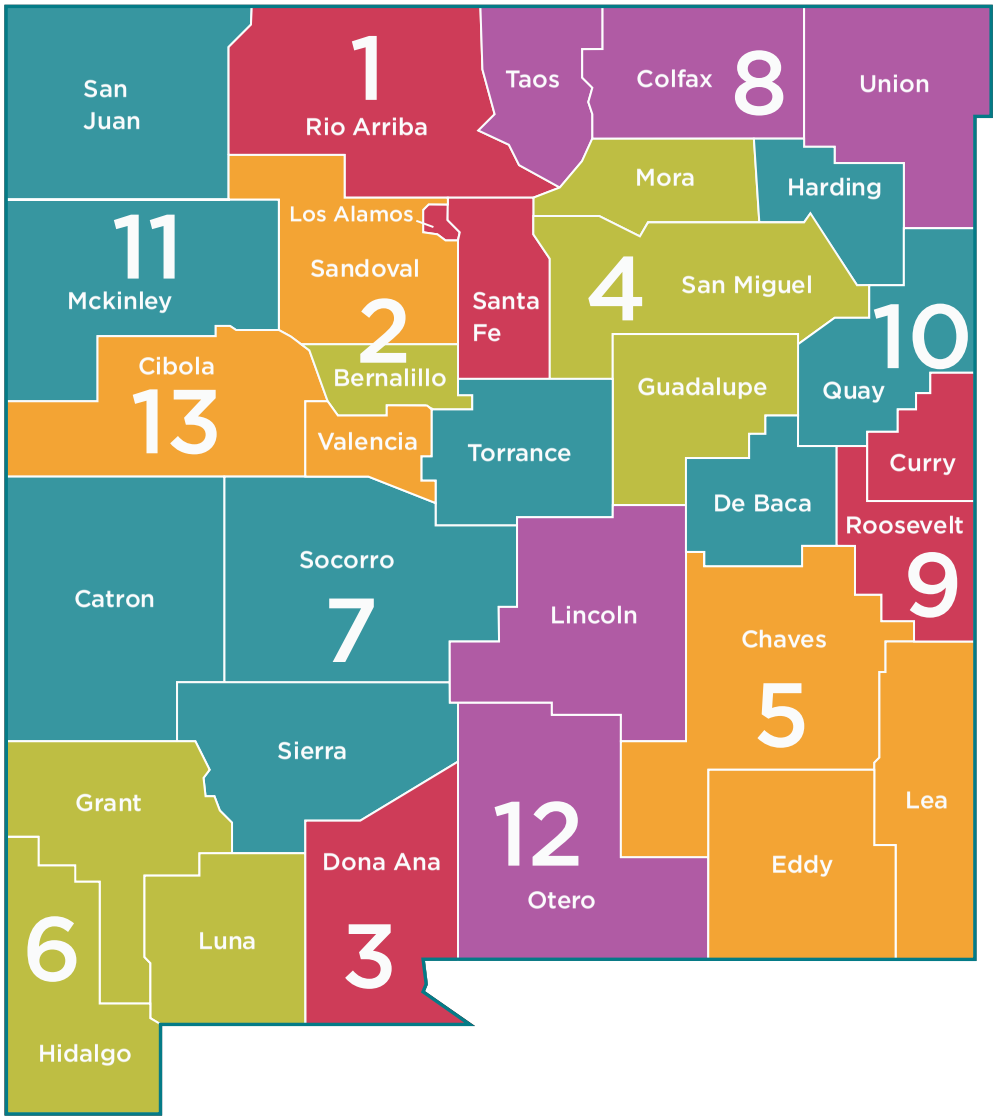
A.4 Workshop Agenda

A.5 Region Specific Medicaid Snapshot Data

A.6 New Mexico Mortality Data

A.7 PPT of Provision Priority Buckets

The NM Behavioral Health Reform Investment Act



Region 1
- Ohkay Owingeh
- Santa Clara Pueblo
- Pueblo of San Idelfonso
- Pueblo of Pojoaque
- Nambe Pueblo
- Pueblo of Tesuque
- Jicarilla Apache Nation

Region 2
- Pueblo of Isleta
- Pueblo of Sandia

Region 6
- Fort Still Apache Tribe

Region 8
- Taos Pueblo
- Picuris Pueblo

Region 13
- Pueblo of Laguna
- Pueblo of Acoma
- Pueblo of Cochiti
- Pueblo of Jemez
- Pueblo of Zia
- Pueblo of Santa Ana
- Santo Domingo Pueblo
- Pueblo of San Felipe

Region 11
- Navajo Nation
- Pueblo of Zuni

Region 12
- Mescalero Apache Tribe

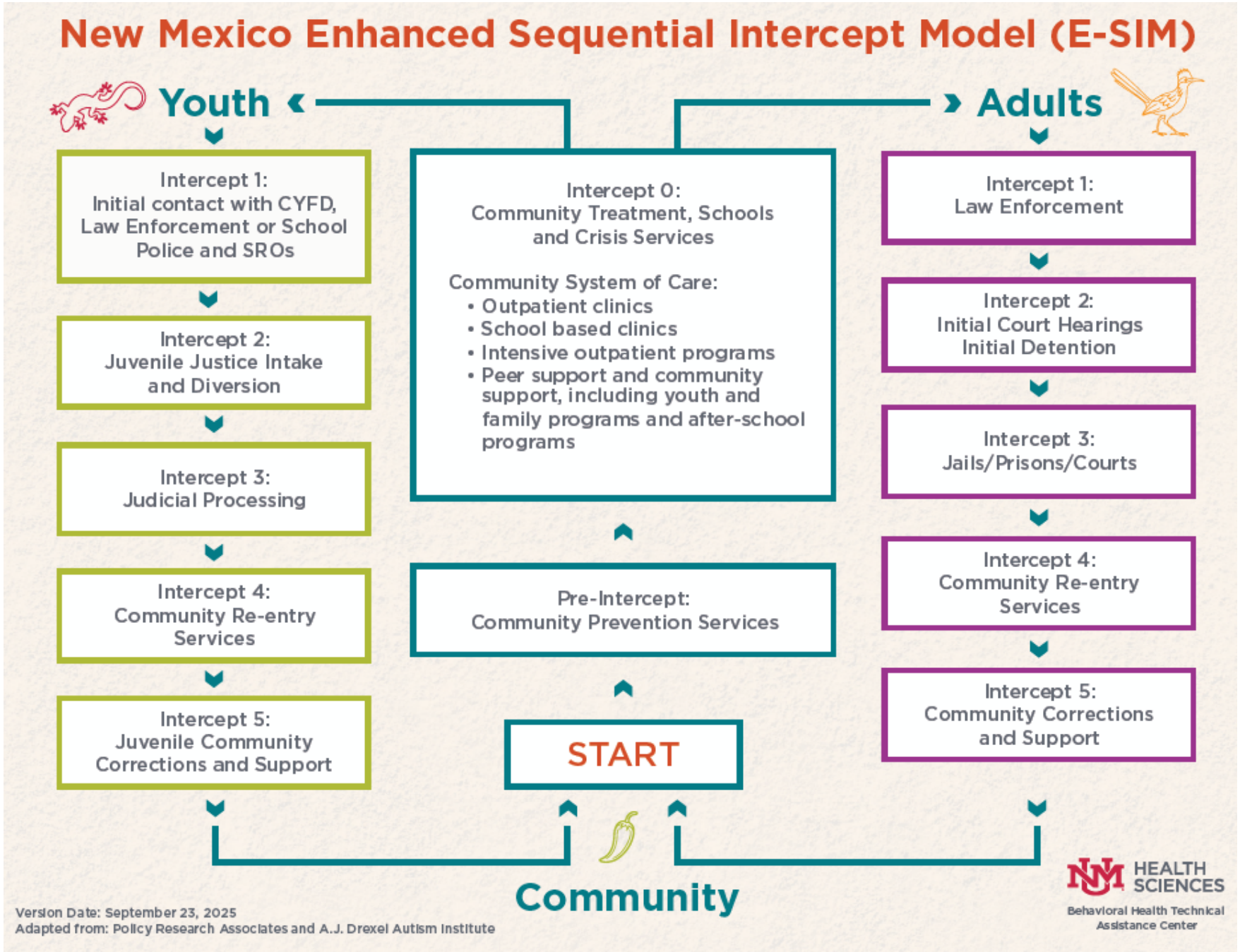
Appendix A.1: Map of Behavioral Health Regions

Appendix A.2: Acronym List

Acronyms

AA	Alcoholics Anonymous
AOC	Administrative Office of the Courts
AFB	Air Force Base
ARISE	Sexual Assault Services. and Child Advocacy Center
BH	Behavioral Health
BHRIA	Behavioral Health Reform and Investment Act (aka SB3)
CASA	Court Appointed Special Advocate
CATs	Clovis Area Transit System
CCBHC	Certified Community Behavioral Health Center
CHW	Community Health Worker
CIT	Crisis Intervention Teams
CMS	Centers for Medicare & Medicaid Services
CCSS	Comprehensive Community Support Services
CTC	Crisis Triage Center
CYFD	Children, Youth and Families Department
DARE	Diffuse, Allow, Run Toward, and Engage
DOH	Department of Health
DV	Domestic Violence
DWI	Driving While Intoxicated
E-SIM	Enhanced Sequential Intercept Model
EMS	Emergency Medical Services
ENMRSH	Early Childhood Services
ENMU	Eastern NM University
GED	General Educational Development
HCA	Health Care Authority
IEP	Individualized Education Program
IOP	Intensive Outpatient Program
JJAC	Juvenile Justice Advisory Committee
JCC	Juvenile Community Corrections
JPO	Juvenile Probation Officer
LPC	Licensed Professional Counselor
MAT	Medication-Assisted Treatment
MATT25	Matthew 25 Hope Center and Food Pantry
MCT	Mobile Crisis Team
MFHA	Mental Health First Aid
MI	Mental Illness
MH	Mental Health
MHR	Mental Health Resources
MOU	Memorandum of Understanding
MOUD	Medications for Opioid Use Disorder
MST	Multisystemic Therapy
NA	Narcotics Anonymous
PATS	Portales Area Transit System
PD	Police Department
PSA	Public Safety Aids
PSR	Psychosocial Rehabilitation
RISE	Reach, Intervene, Support and Engage
RTC	Residential Treatment Center
SA	Substance Abuse
SEL	Social and Emotional Learning
SRO	School Resource Officers
SUBH	Substance Use & Behavioral Health Program
SUD	Substance Use Disorders
TFC	Therapeutic Foster Care
YMCA	Young Mens Christian Association
YMHFA	Youth Mental Health First Aid
YRRS	Youth Risk and Resiliency Survey
UNM BHTAC	Behavioral Health Technical Assistance Center

Appendix A.3: The New Mexico Enhanced Sequential Intercept Model (E-SIM)



Appendix A.4: Workshop Agenda

E-SIM Mapping and Prioritization Workshop Curry, Roosevelt County/ Region 9

Tuesday, December 2 - Thursday, December 4, 2025

Theme - Breaking the Cycle: Integrating Behavioral Health and Justice Through Collaboration

Tuesday, December 2nd — Clovis Civic Center , Clovis, NM

Day 1: Mapping of Youth System

8:00 AM — ***Workshop open for Registration, Networking and Light Breakfast***
— Enchantment II

8:30 AM — **Welcome and Overview of the Day**
— Enchantment II
- **Deborah Altschul, PhD,** UNM Department of Psychiatry and Behavioral Sciences

8:50 AM — **Overview of Data on Youth Gaps and Needs**
— Enchantment II
- **Bethany Brzozowske, MPH, CHES**, Curry County Substance Use & Behavioral Health Program Manager
- **Shannon Morrison, PhD,** Morrison Associates Contracted Evaluator

9:15 AM — **Pre-Intercept (Prevention): Mapping Existing Services, Gaps and Opportunities**
— Breakout Rooms

10:45 AM — ***Break***

11:00 AM — **Intercept 0: Mapping Existing Services, Gaps and Opportunities**
— Breakout Rooms

12:15 PM — **Lunch**

1:00 PM — **Mapping Intercept 1**
— Breakout Rooms

2:00 PM — ***Break***

2:15 PM — **Mapping Intercept 2 and 3**
— Breakout Rooms

3:15 PM — ***Break***

3:30 PM — **Mapping Intercept 4 and 5**
— Breakout Rooms

4:15 PM — **Curry County Medicaid Snapshot, Wrap-up and Overview of the next day**
— Enchantment II
- **Deborah Altschul, PhD,** UNM Department of Psychiatry and Behavioral Sciences

Breakout Room 1
Esperanza I

Breakout Room 2
Esperanza II

E-SIM Mapping and Prioritization Workshop
Curry, Roosevelt County/ Region 9

Tuesday, December 2 - Thursday, December 4, 2025

Theme - Breaking the Cycle: Integrating Behavioral Health and Justice Through Collaboration

Wednesday, December 3rd — Clovis Civic Center , Clovis, NM

Day 2: Mapping of Adult System

8:00 AM ***Workshop open for Registration, Networking and Light Breakfast***
— Enchantment II

8:30 AM **Welcome and Overview of the Day**
Review of Discussion from Previous Day with Suggested List of Priorities
— Enchantment II
- **Deborah Altschul, PhD,** UNM Department of Psychiatry and Behavioral Sciences
- **The Honorable Donna Mowrer,** 9th Judicial District Court Presiding Judge
- **JD Jones**, In Partnership with the National Alliance on Mental Illness (NM) and Bristol Myers Squibb

9:00 AM **Pre-Intercept (Prevention): Mapping Existing Services, Gaps and Opportunities**
— Breakout Rooms

10:30 AM ***Break***

10:45 AM **Intercept 0: Mapping Existing Services, Gaps and Opportunities**
— Breakout Rooms

12:00 PM **Lunch**

1:00 PM **Mapping Intercept 1**
— Breakout Rooms

2:00 PM ***Break***

2:15 PM **Mapping Intercept 2 and 3**
— Breakout Rooms

3:15 PM ***Break***

3:30 PM **Mapping Intercept 4 and 5**
— Breakout Rooms

4:30 PM **Wrap-up and Overview of Goals for Prioritization Day**
— Enchantment II
- **Deborah Altschul, PhD,** UNM Department of Psychiatry and Behavioral Sciences

Breakout Room 1
Esperanza I

Breakout Room 2
Esperanza II

E-SIM Mapping and Prioritization Workshop
Curry, Roosevelt County/ Region 9

Tuesday, December 2 - Thursday, December 4, 2025

Theme - Breaking the Cycle: Integrating Behavioral Health and Justice Through Collaboration

Thursday, December 4th — Clovis Civic Center , Clovis, NM

Day 3: Prioritization

8:00 AM — ***Workshop open for Registration, Networking and Light Breakfast***
— Enchantment II

8:30 AM — **Welcome and Overview of the Day**
Review of Discussion from Previous Day with Suggested List of Priorities
— Enchantment II
- **Deborah Altschul, PhD,** UNM Department of Psychiatry and Behavioral Sciences
- **Annette Crisanti, PhD,** UNM Department of Psychiatry and Behavioral Sciences
- **Rachel Wiley, PhD,** ABPP, Lt Col, USAF, BSC, 27 Special Operations Medical Readiness Squadron

10:00 AM — **Silent Ranking Using Dots for Final Priority List**
— Enchantment II

10:15 AM — ***Break***

10:30 AM — **Review Top 5 Priorities Based on Voting**
— Enchantment II

11:00 PM — **Small Group Discussions of Priority 1**
— Breakout Rooms

12:00 PM — **Networking Lunch**

12:45 PM — **Small Group Discussions of Priority 2 & 3**
— Breakout Rooms

1:45 PM — **Small Group Discussions of Priority 4 & 5**
— Breakout Rooms

2:45 AM — ***Break***

3:00 PM — **Small Group Discussions of Other Priorities**
— Breakout Rooms

4:30 PM — **Evaluation and Provide Next Steps**
— Enchantment II
- **Lance Pyle,** Curry County Manager
- **Meadow Forget,** Roosevelt County Manager

Breakout Room 1
Esperanza I

Breakout Room 2
Esperanza II

Appendix A.5: Region Specific Medicaid Snapshot Data

Behavioral Region 9 vs The State of New Mexico

Examining behavioral health disorder diagnoses, and utilization of services, facilities and infrastructure in Behavioral Region 9 compared to the state of New Mexico.

County in Behavioral Region 9: Curry, Roosevelt

Objective

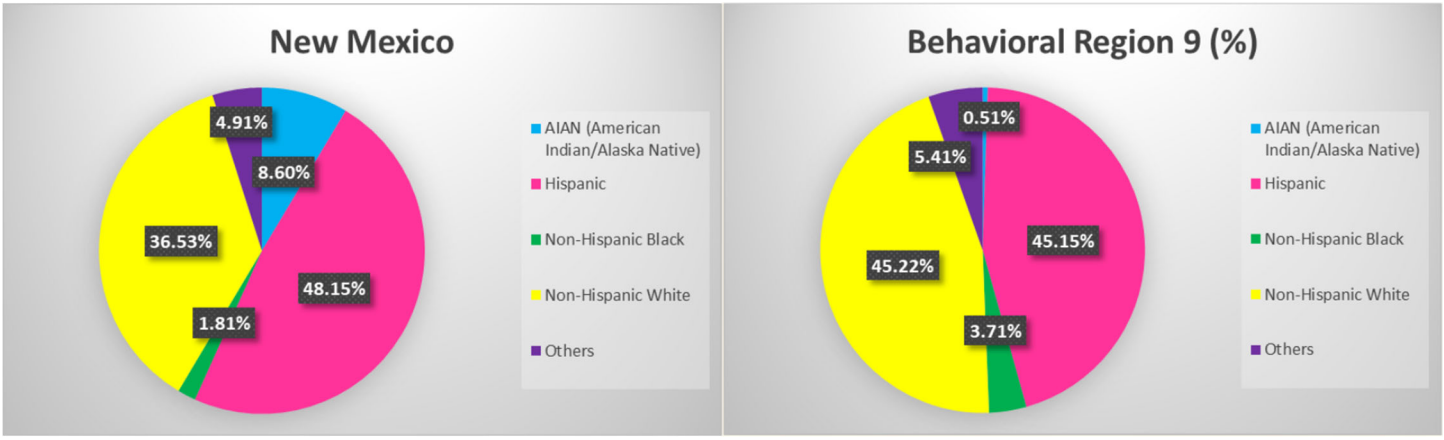
To compare Behavioral Region 9 (Curry and Roosevelt) with the state on below characteristics

- Demographic variations
- Differences in behavioral health diagnoses
- Services, facility and infrastructure utilization

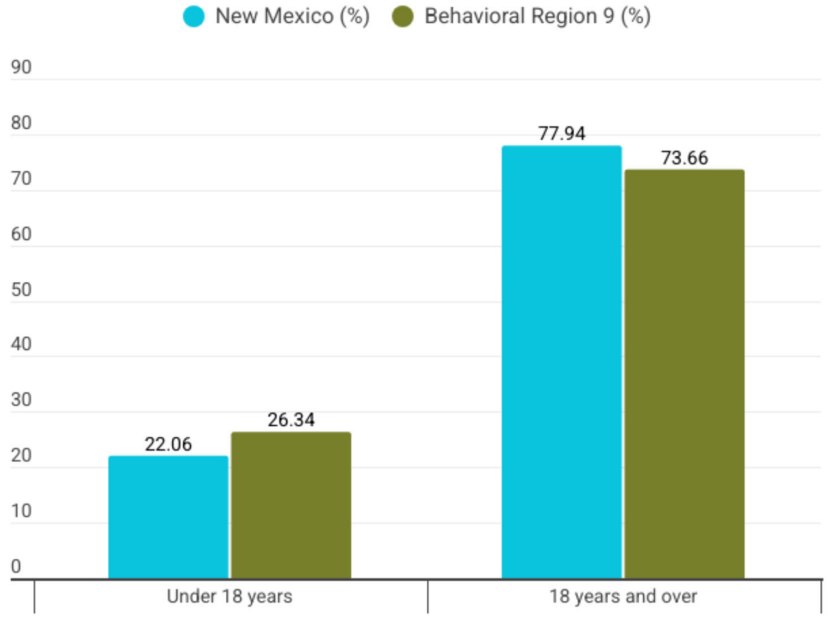
Demographic Comparison

Key demographic factors reveal significant regional variations

Race/Ethnicity



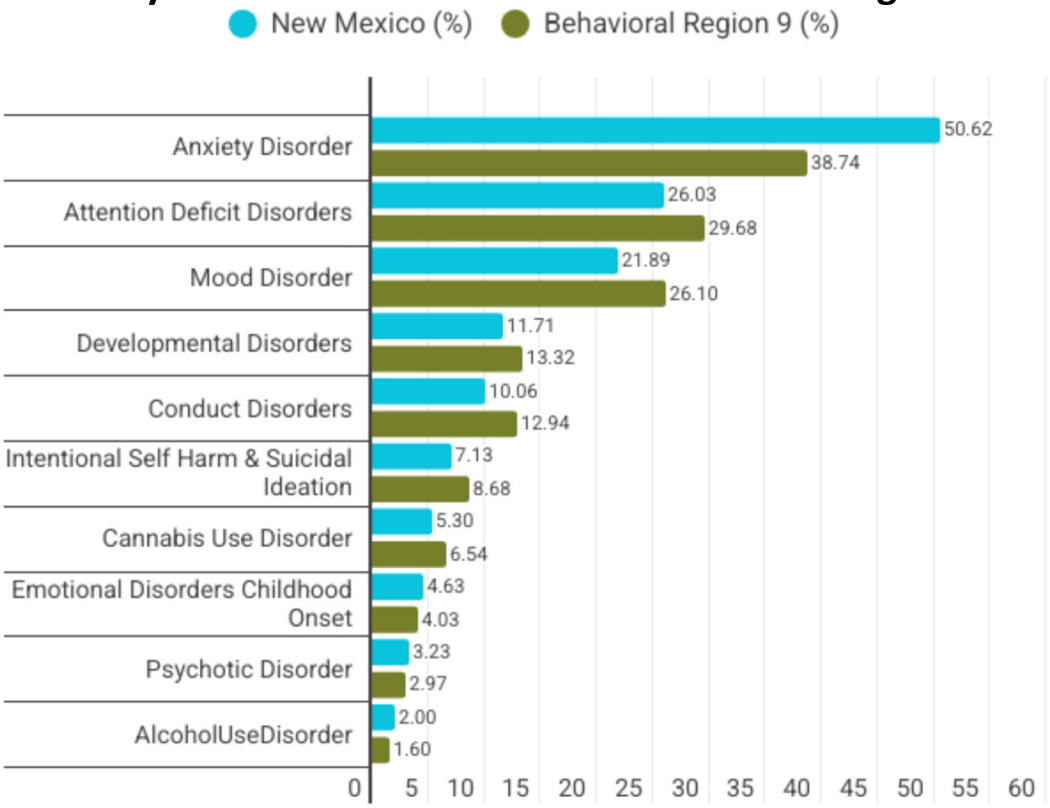
Age Distribution – New Mexico vs. Behavioral Region 9



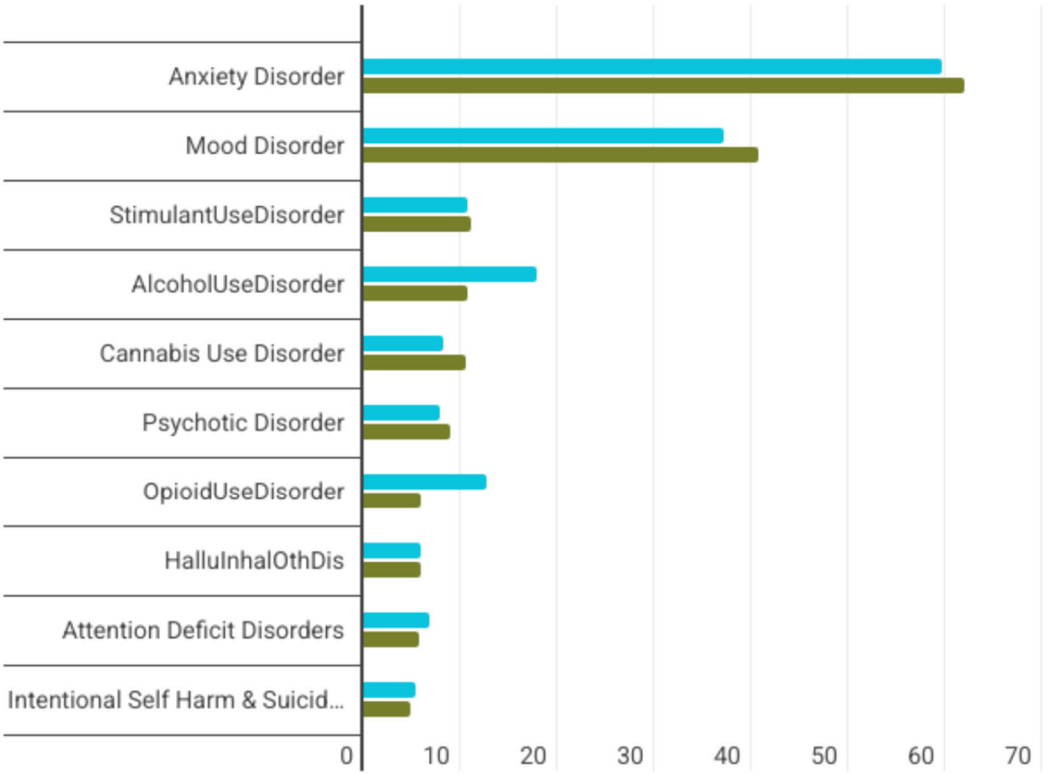
Top 10 behavioral health disorder diagnosis by age group

Percentage of Medicaid recipients who had a diagnosis of specific Behavioral Health (BH) disorder.

<18-year-olds – New Mexico vs. Behavioral Region 9

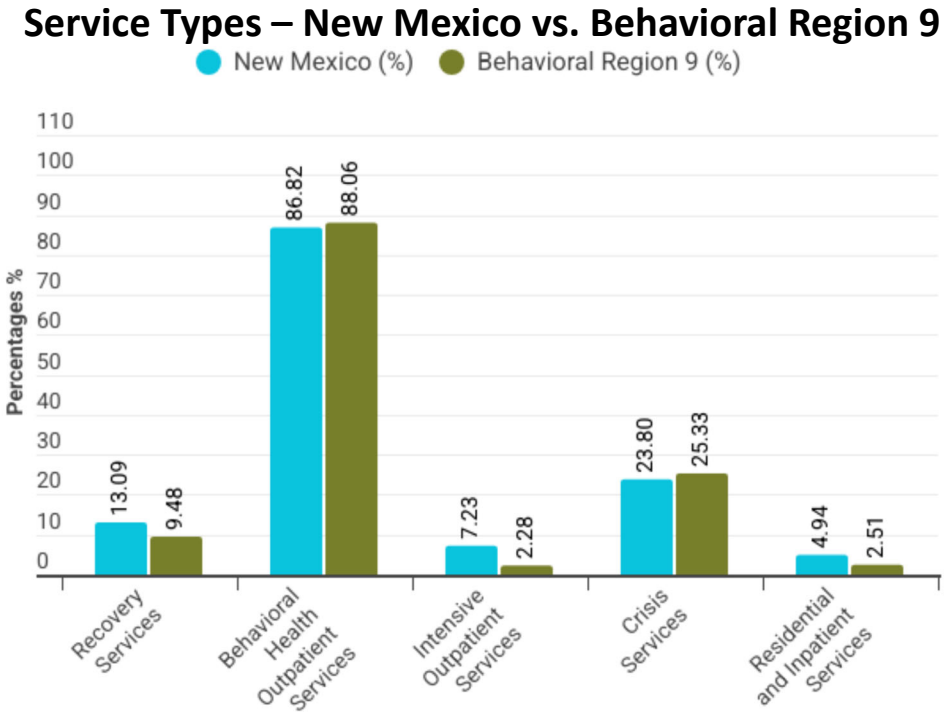


18+ New Mexico vs Behavioral Region 9



Service Utilization

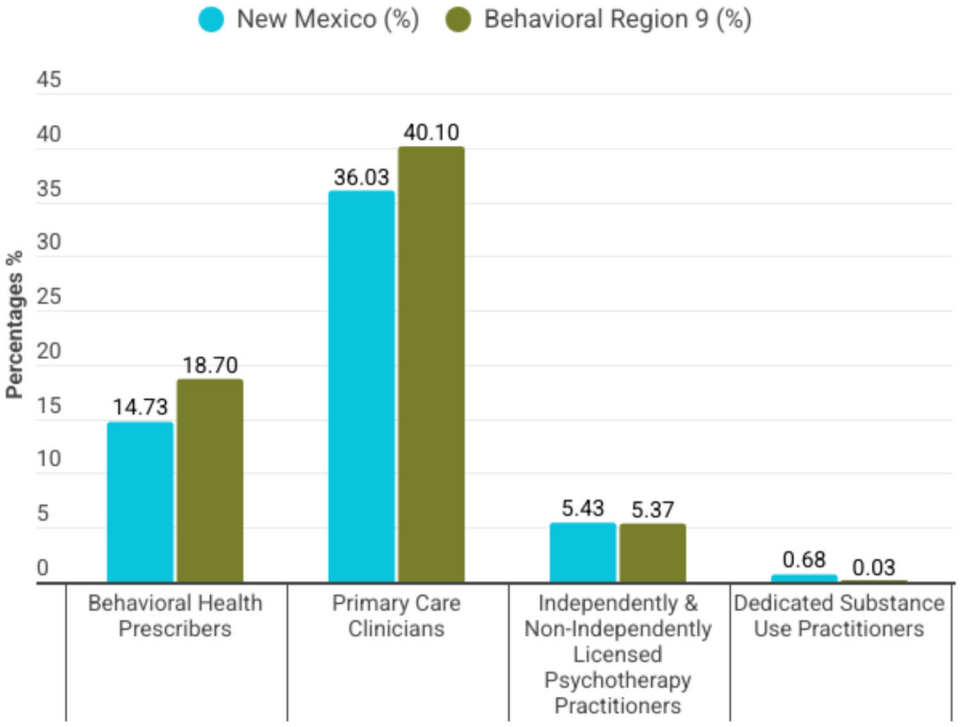
Percentage of Medicaid recipients with Behavioral Health (BH) conditions receiving different types of Behavioral Health services.



Behavioral Health Outpatient Utilization

Percentage of Medicaid recipients with Behavioral Health (BH) condition who had at least one outpatient visit and were seen by the different types of providers.

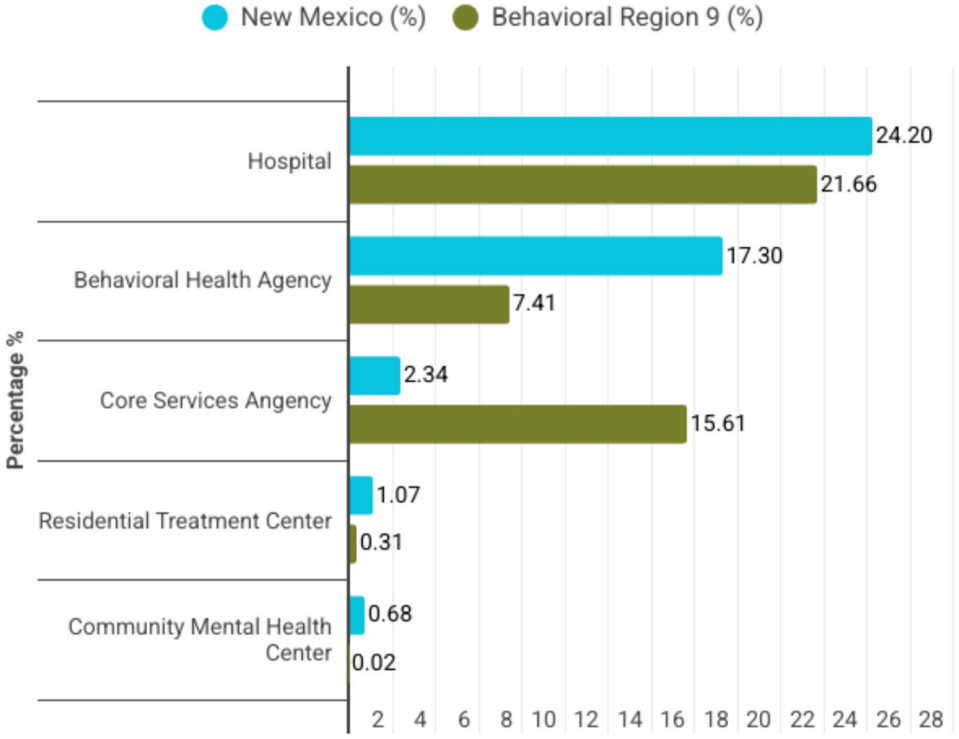
Individuals on Medicaid are more likely to have at least one contact with a prescriber than with a therapist in a calendar year.



Infrastructure Utilization

Percentage of Medicaid recipients with a Behavioral Health (BH) condition who had at least one visit to an eligible infrastructure type.

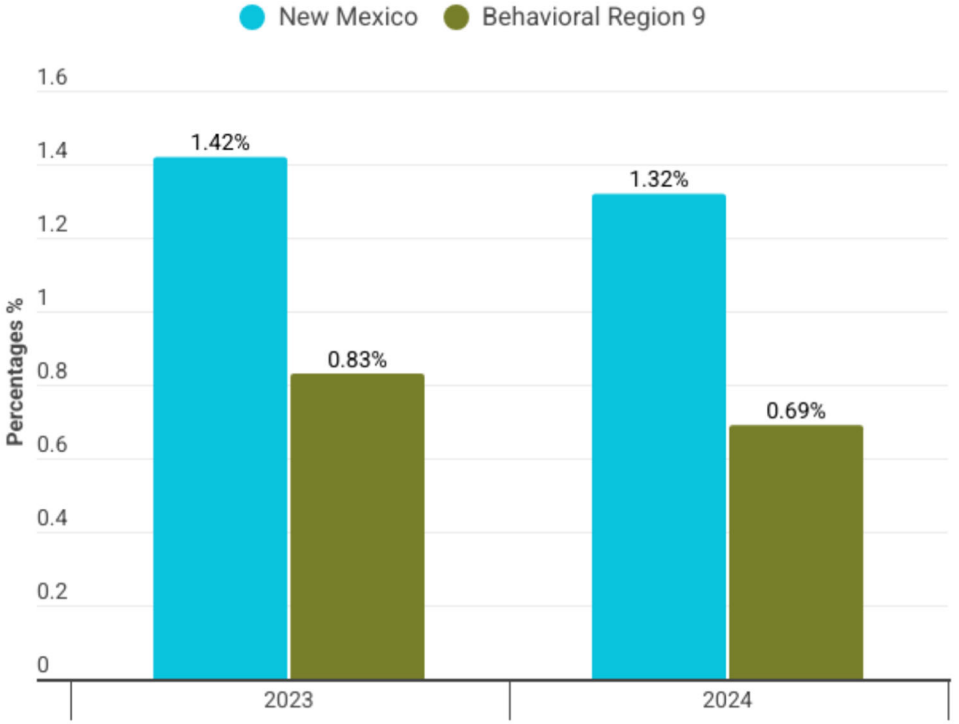
Infrastructure Type – New Mexico vs. Behavioral Region 9



Crisis Call per Capita

Percentage of population who made a crisis call.

Crisis Call Rate Per Capita – New Mexico vs. Behavioral Region 9



Crisis Call per Capita (cont.)

State of New Mexico

Total Population 2023	Total Population 2024
2,114,371	2,130,256
Crisis Calls 2023	**Crisis Calls 2024**
29,977	28,137
1.42% (2023)	**1.32% (2024)**

↓ Decreased from 2023 to 2024

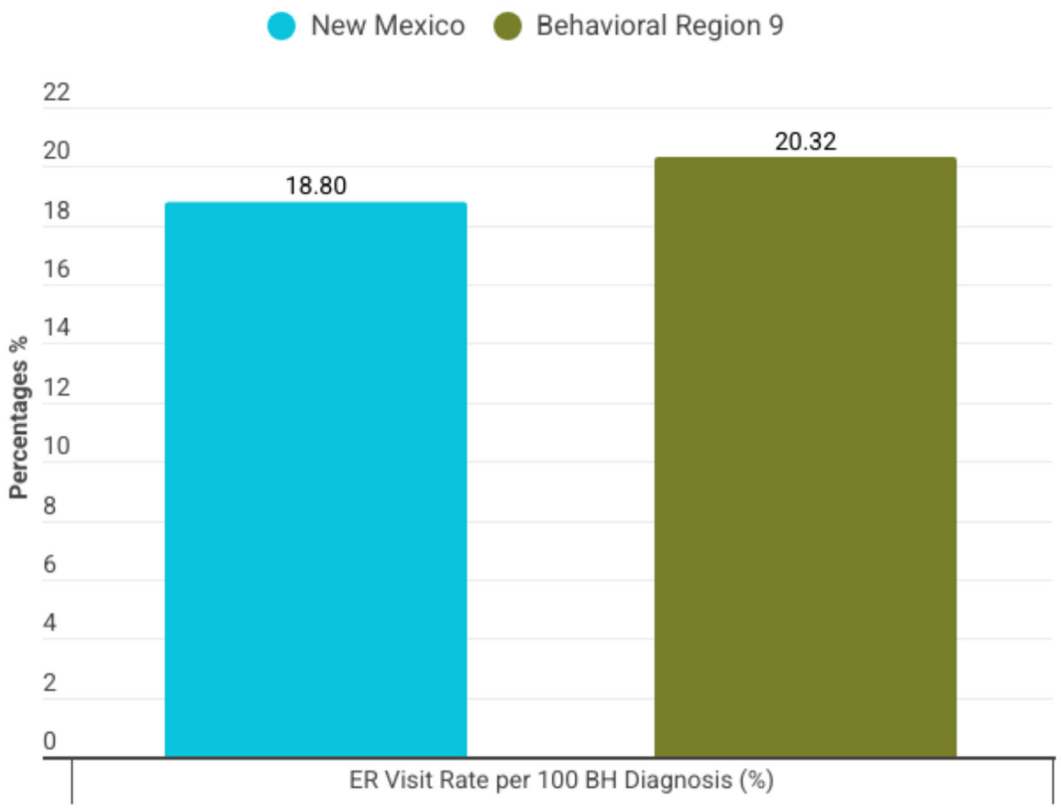
BR9 Service Area

Total Population 2023	Total Population 2024
66,009	65,869
Crisis Calls 2023	**Crisis Calls 2024**
549	452
0.83% (2023)	**0.69% (2024)**

↓ Decreased from 2023 to 2024

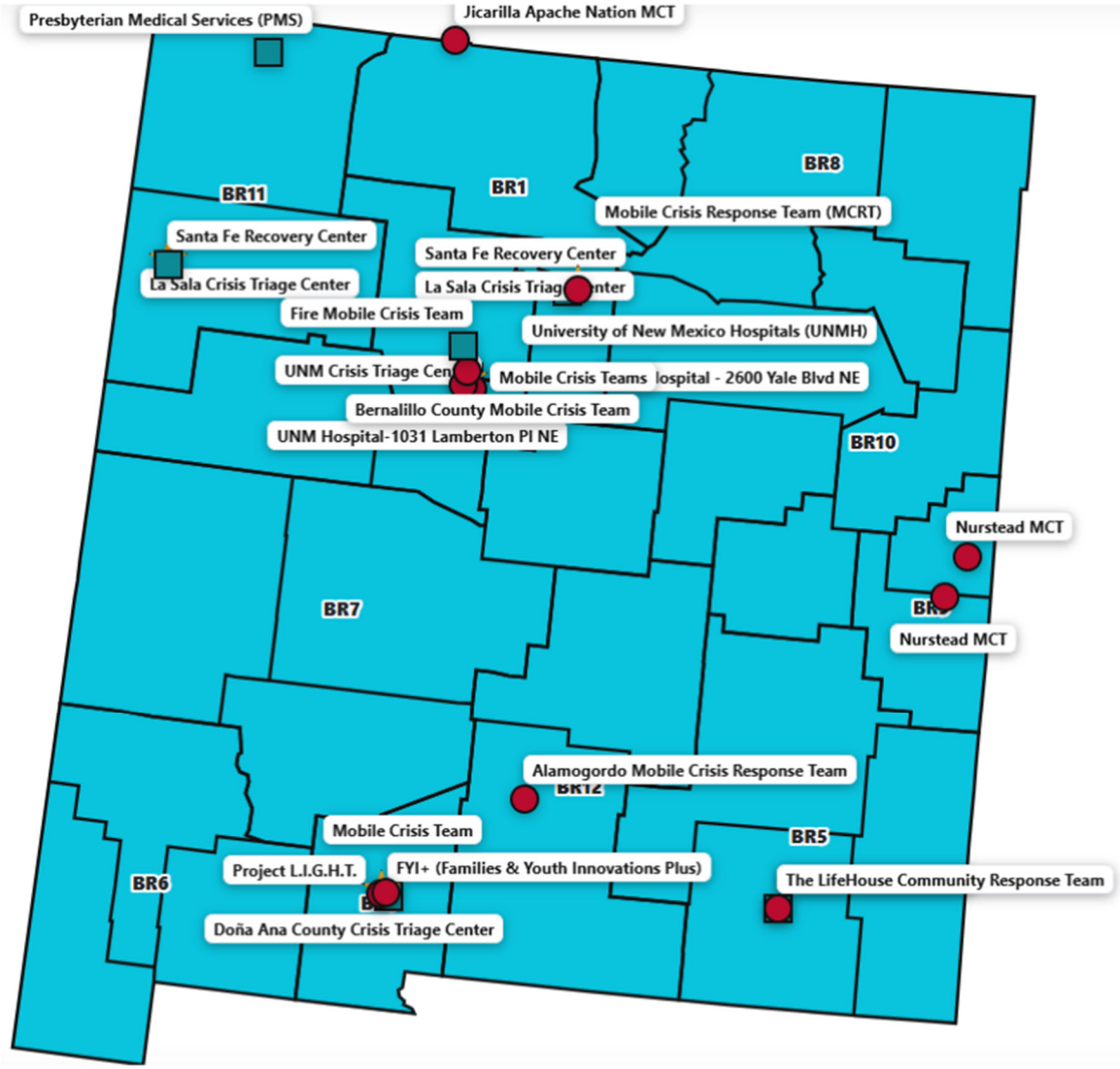
Emergency Room Utilization

Percentage of Medicaid recipients with Behavioral Health (BH) condition who had at least one emergency room (ER) visit.



CCBHC, CTC, Mobile Crisis

New Mexico

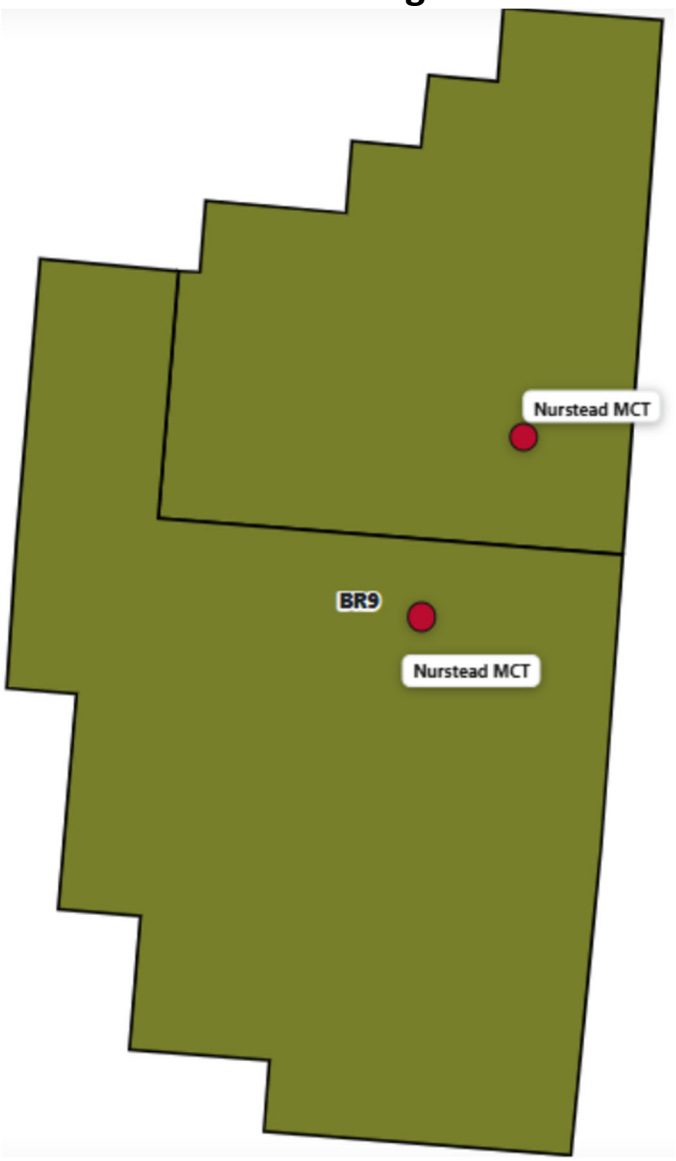


Mobile Crisis Team CCBHC Crisis Triage Center

Name	County	BR	Address	Zip Code	Type
Presbyterian Medical Services (PMS)	San Juan	BR11	1001 W Broadway Suite E & D, Farmington, NM 87401	87401	CCBHC
Santa Fe Recovery Center	McKinley	BR11	2028 E Aztec Ave	87301	CCBHC
Santa Fe Recovery Center	Santa Fe	BR1	2504 Camino Entrada	87507	CCBHC
La Sala Crisis Triage Center	Santa Fe	BR1	2052 Galisteo St	87505	Crisis Triage Center
Mobile Crisis Response Team (MCRT)	Santa Fe	BR1	2052 Galisteo St	87505	Mobile Crisis Team

UNM Hospital	Bernalillo	BR2	2600 Yale Blvd NE	87106	CCBHC
	Bernalillo	BR2	1031 Lamberton Pl NE	87107	CCBHC
	Bernalillo	BR2	2600 Marble Ave NE	87106	CCBHC
UNM Crisis Triage Center	Bernalillo	BR2	2600 Marble Ave NE	87106	Crisis Triage Center
Mobile Crisis Teams	Bernalillo	BR2	1210 San Mateo Blvd SE	87108	Mobile Crisis Team
Bernalillo County Mobile Crisis Team	Bernalillo	BR2	415 Silver Avenue SW, Albuquerque, NM 87102	87102	Mobile Crisis Team
Fire Mobile Crisis Team	Bernalillo	BR2	6840 2nd St NW Ste 301, Albuquerque, NM 87107	87107	Mobile Crisis Team
FYI+ (Families & Youth Innovations Plus)	Dona Ana	BR3	1320 S Solano Dr, Las Cruces, NM	88001	CCBHC
Doña Ana County Crisis Triage Center	Dona Ana	BR3	1850 B Copper Loop, Las Cruces, NM 88005	88005	Crisis Triage Center
Mobile Crisis Team	Dona Ana	BR3	845 N. Motel Blvd, Las Cruces, NM	88005	Mobile Crisis Team
Project L.I.G.H.T.	Dona Ana	BR3	201 E Picacho Ave	88005	Mobile Crisis Team
Carlsbad LifeHouse, Inc.	Eddy	BR5	1900 Westridge Rd, Carlsbad	88220	CCBHC
University of New Mexico Hospitals (UNMH)	Sandoval	BR13	3200 Broadmoor Blvd NE	87144	CCBHC
Nurstead MCT	Roosevelt	BR9	604 E 2nd Street, Portales, NM 88130	88130	Mobile Crisis Team
Nurstead MCT	Curry	BR9	300 Commerce Way, Clovis, NM 88101	88101	Mobile Crisis Team
Alamogordo Mobile Crisis Response Team	Otero	BR12	700 Virginia Ave, Alamogordo, NM 88310	88310	Mobile Crisis Team
The LifeHouse Community Response Team	Eddy	BR5	1900 Westridge Rd, Carlsbad	88220	Mobile Crisis Team
Jicarilla Apache Nation MCT	Rio Arriba	BR1	500 Mundo Rd, Dulce, NM 87528	87528	Mobile Crisis Team

Behavioral Region 9



Mobile Crisis Team CCBHC Crisis Triage Center

Name	County	BR	Address	Zip Code	Type
Nurstead MCT	Roosevelt	BR9	604 E 2nd Street Portales, NM 88130	88130	Mobile Crisis Team
Nurstead MCT	Curry	BR9	300 Commerce Way, Clovis, NM 88101	88101	Mobile Crisis Team

Appendix

Service Utilization Table

Percentage of Medicaid recipients with Behavioral Health (BH) conditions receiving Behavioral Health services by service type.

Service	STATEWIDE (NEW MEXICO)		BEHAVIORAL REGION (BR9)	
	Beneficiary N=217,656	%	Beneficiary N=6,182	%
Recovery Services	**28,500**	**13.09%**	**586**	**9.48%**
PSW	4,707	2.16%	97	1.57%
CCSS	20,270	9.31%	237	3.83%
PSR	362	0.17%	0	0.00%
CSW	7,215	3.31%	214	3.46%
FSW	155	0.07%	9	0.15%
CHW	0	0.00%	0	0.00%
BMS	1,113	0.51%	43	0.70%
BT	2,044	0.94%	66	1.07%
BHOP Services	**188,968**	**86.82%**	**5,444**	**88.06%**
BH Workforce	**106,765**	**49.05%**	**3,494**	**56.52%**
BH-Prescribers	**32,061**	**14.73%**	**1,156**	**18.70%**
Psychiatrist	10,700	4.92%	282	4.56%
PsyNursePract	20,228	9.29%	1,029	16.65%
PrescPsychologist	2,704	1.24%	9	0.15%
PrimaryCare	**78,429**	**36.03%**	**2,479**	**40.10%**
Independently and Non-Independently Licensed Psychotherapy Practitioners	**11,814**	**5.43%**	**332**	**5.37%**
Psychologist	861	0.40%	4	0.06%
LCSWLISW	4,824	2.22%	81	1.31%
LPCC	4,506	2.07%	211	3.41%
LPAT	27	0.01%	0	0.00%
LMFT	482	0.22%	0	0.00%
LMSW	1,225	0.56%	17	0.27%
LMHC	1,533	0.70%	63	1.02%
LAMFT	48	0.02%	1	0.02%
Dedicated Substance Use Practitioners	**1,480**	**0.68%**	**2**	**0.03%**
LADAC	629	0.29%	1	0.02%
LSAA	882	0.41%	1	0.02%
CADAC	0	0.00%	0	0.00%
Intensive Outpatient Services	**15,741**	**7.23%**	**141**	**2.28%**
IOP	12,049	5.54%	84	1.36%
PartialHosp	1,051	0.48%	7	0.11%
ACT	1,555	0.71%	5	0.08%
MST	1,455	0.67%	40	0.65%
FFT	11	0.01%	5	0.08%
Crisis Services	**51,804**	**23.80%**	**1,566**	**25.33%**
ED	41,094	18.88%	1,256	20.32%
UrgentCare	21,369	9.82%	474	7.67%
MobileCrisis CTC	1,854	0.85%	353	5.71%
Crisis Intervention	1,476	0.68%	350	5.66%

New Mexico Mortality Rates

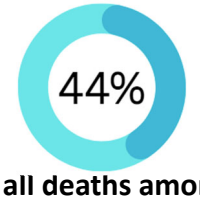
Examining Suicide Deaths, Alcohol-Related Deaths, and Drug Overdose Deaths in the state of New Mexico

Overview

Overall Crisis

- New Mexico faces some of the **highest "deaths of despair" rates** (suicide, alcohol, drug overdose) in the United States

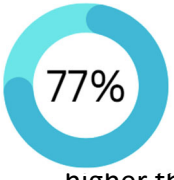
In 2021, these causes accounted for



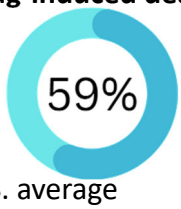
of all deaths among residents aged 12–34

Rates far exceed national averages:

Suicide



Drug-induced deaths:



higher than U.S. average

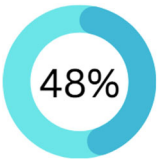
Demographics & Geography



Population: 2.1 million

Race/Ethnicity:

Hispanic



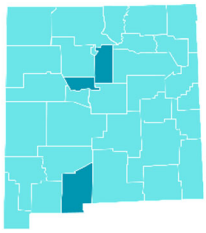
White (non-Hispanic)



Native American



Urban concentration:

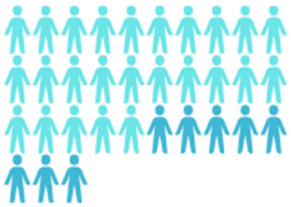


50% of residents live in

- **Bernalillo,**
- **Doña Ana, and**
- **Santa Fe Counties**

(6% of land area)

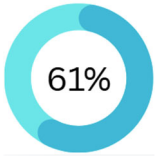
Rural/frontier context:



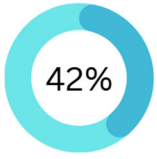
25 of 33 counties have <15 people per square mile, limiting access to care

Comorbidity of Mental Health and Substance Use

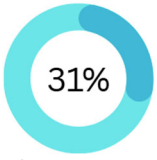
Youth (Grades 9–12):



report mental health concerns

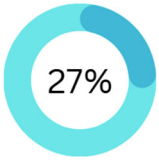


use ≥1 substance

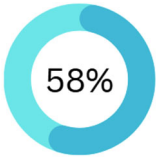


have both (co-occurring mental health + substance use disorder)

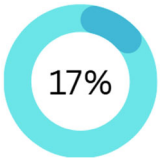
Adults:



report mental health concerns

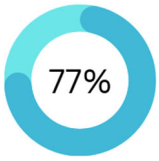


use ≥1 substance



have both (co-occurring mental health + substance use disorder)

Substance Use:



of youth suicide attempters used at least one substance

Youth using **4+ substances** were



more likely to be injured in a suicide attempt

Alcohol-Related Deaths

- **Highest alcohol-related death rate in the U.S. since 1997**

1 in 5 deaths among working-age adults

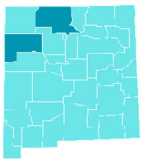


(ages 20–64) is alcohol-related — **twice the national rate**

Alcohol misuse linked to



- **domestic violence,**
- **chronic disease,**
- **poverty, and**
- **unemployment**



Highest Rates by NM County: McKinley, Rio Arriba

Drug Overdose Deaths

- **Overdose death rate has tripled since 1990**

Recent surges in



methamphetamine and fentanyl deaths



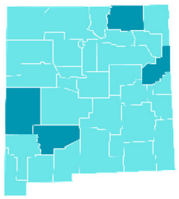
Substance use costs New Mexico about **$890 million annually (as of 2007)**



Highest Rates by NM County: Bernalillo, Rio Arriba

Suicide & Mental Health

- Suicide consistently ranks among the **top 10 causes of death** statewide
- **#1 cause of death for youth (ages 12–17)** between 2017–2021
- Over **15,000 Years of Potential Life Lost** annually to suicide
- Risk factors include
  - **mental illness**
  - **substance use**
  - **trauma**
  - **isolation**
  - **barriers to care**



Highest Rates by NM County: Catron, Colfax, Quay, Sierra

Populations at Highest Risk

- Female students
- LGBTQ+ students and adults
- Individuals with disabilities
- Low-income populations (<$15,000 annual income)
- People experiencing unstable housing or sexual assault

Equity and Systemic Context

Health disparities are amplified by



- **rural isolation**
- **economic**
- **inequality**
- **historical trauma**

Urgent need for prevention intervention efforts that are:



- **integrated**
- **culturally responsive**
- **equity-driven**

especially in **Hispanic, Indigenous, and rural communities**

Demographics: New Mexico

Source: https://datausa.io/profile/geo/new-mexico

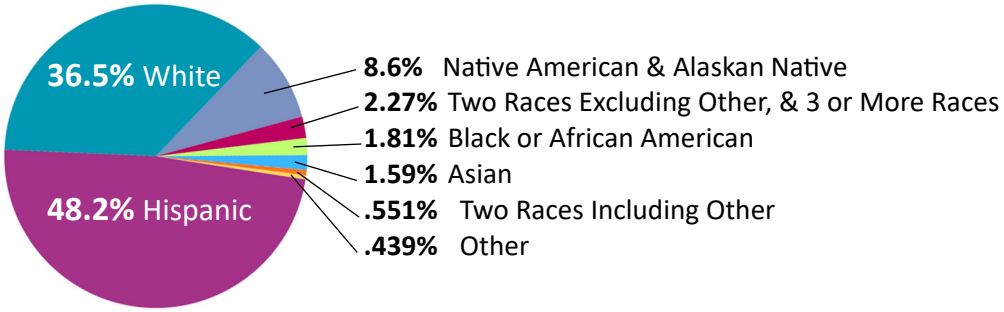
Population

Source: U.S. Census



Population: 2,117,522

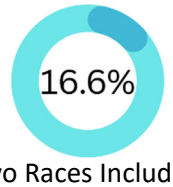
Race/Ethnicity



Hispanic breakdown:



White Hispanic



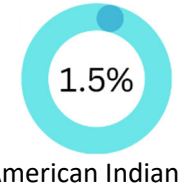
Two Races Including Other (Hispanic)



Other (Hispanic) = 16.6 %



Two Races Excluding Other, & Three or More



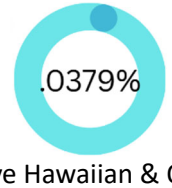
American Indian & Alaskan Native (Hispanic)



Black or African American (Hispanic)

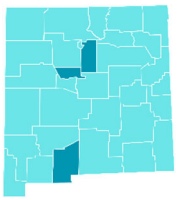


Asian (Hispanic)



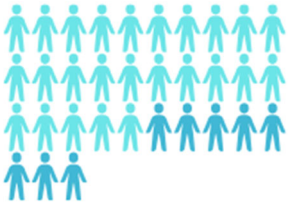
Native Hawaiian & Other Pacific Islander

Rural/Frontier

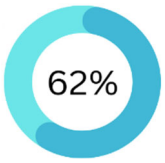


50% of residents live in
- **Bernalillo,**
- **Doña Ana, and**
- **Santa Fe Counties**

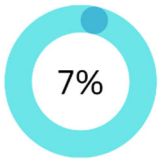
These 3 counties make up only 6% of the state's total land area



25 of 33 counties have a population density below 15 persons per square mile

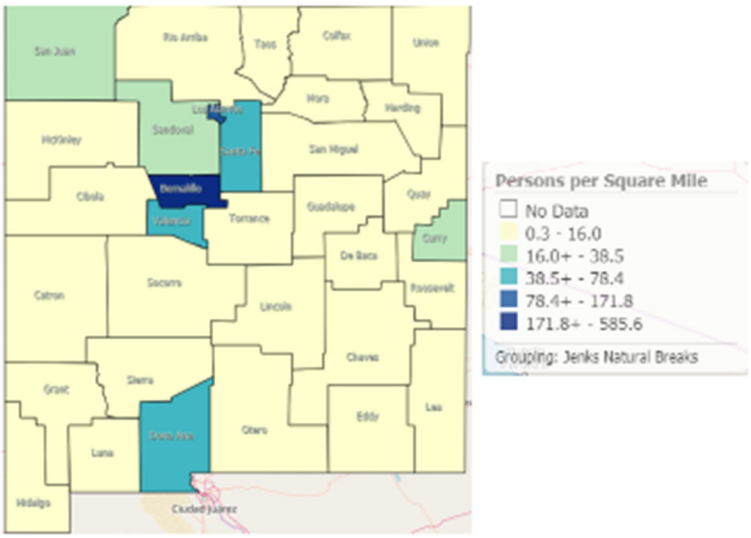


of the population resides in seven urban counties (including Bernalillo County, home to one-third of the state's residents)



of the population lives in frontier (Fewer than 7 persons per square mile) or sub-frontier areas (7–14 persons per square mile)

Estimated Population County by County - Population Density, 2017



NM Co-morbid "Deaths of Despair"

Source: NM Department of Health Report (2024). Injury and Behavioral Epidemiology Bureau Center For Health Protection New Mexico Department of Health

Suicide, Overdose, Alcohol-related *Deaths*

- Accounted for 44% of deaths among New Mexicans aged 12–34 in 2021.
- Tripled since 1999 (from 46.9 to 121.5 deaths per 100,000).
- Suicide rate: 77% higher than U.S. average.
- Drug-induced death rate: 59% higher than U.S. average.
- Suicide was #1 cause of death for youth ages 12–17 (2017–2021).

Estimated Population *Affected* (2021)

- Youth (Grades 9–12):
  - 61% (62,000+) had ≥1 mental health concern.
  - 42% (43,000+) used ≥1 substance.
  - 31% (31,000+) had both — co-morbid SUD + mental health concern.
- Adults:
  - 27% (≈448,000) had ≥1 mental health concern.
  - 58% (≈961,000) used ≥1 substance.
  - 17% (≈285,000) experienced both.

Substance *Use and Suicide*

- 77% of youth who attempted suicide also used at least one substance.
- 25% of binge drinkers reported a suicide attempt in the past year.
- 61% of heroin users reported a past-year suicide attempt.
- Youth using 4+ substances were 27× more likely to be injured in a suicide attempt.
- Among adult males, 52% of suicide-related ER visits involved substance use; 26% involved alcohol.

Disparities and Equity Findings

- Accounted for 44% of deaths among New Mexicans aged 12–34 in 2021.
- Female students
  - 2× more likely to experience sadness and use substances
  - 2.5× more likely to self-injure
  - 2× more likely to attempt suicide
- LGBTQ+ students
  - 3× higher risk of suicide attempts and substance use
  - 2–3× higher across all mental health–substance co-morbidity measures
- Gender nonconforming students:
  - 3× more likely to attempt suicide and use substances
- Students with disabilities
  - 3× more likely to attempt suicide and use substances
- Unstable housing
  - 3.5× more likely to attempt suicide and use substances
- Sexual assault survivors
  - 6.5× more likely to attempt suicide and use substances
  - 10× more likely to be injured in a suicide attempt
- Adults with disabilities
  - 3× more likely to have mental distress, depression, and suicidal thoughts with substance use
- Adults with income <$15,000
  - 2–3× higher co-morbidity rates

Suicide & Self-Injury

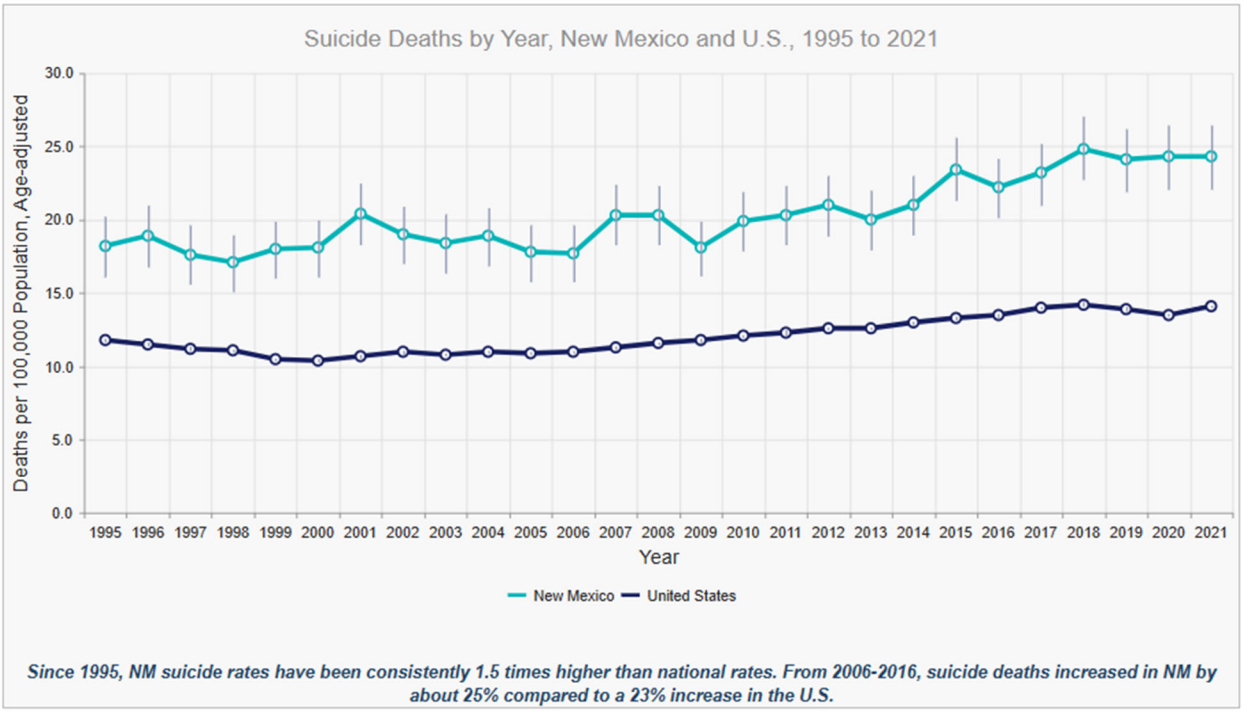
Source: New Mexico's Health Indicator Data & Statistics - https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html

The suicide death rate is defined as the number of deaths attributed to suicide per 100,000 population.

Suicide & Self-Injury Related Deaths

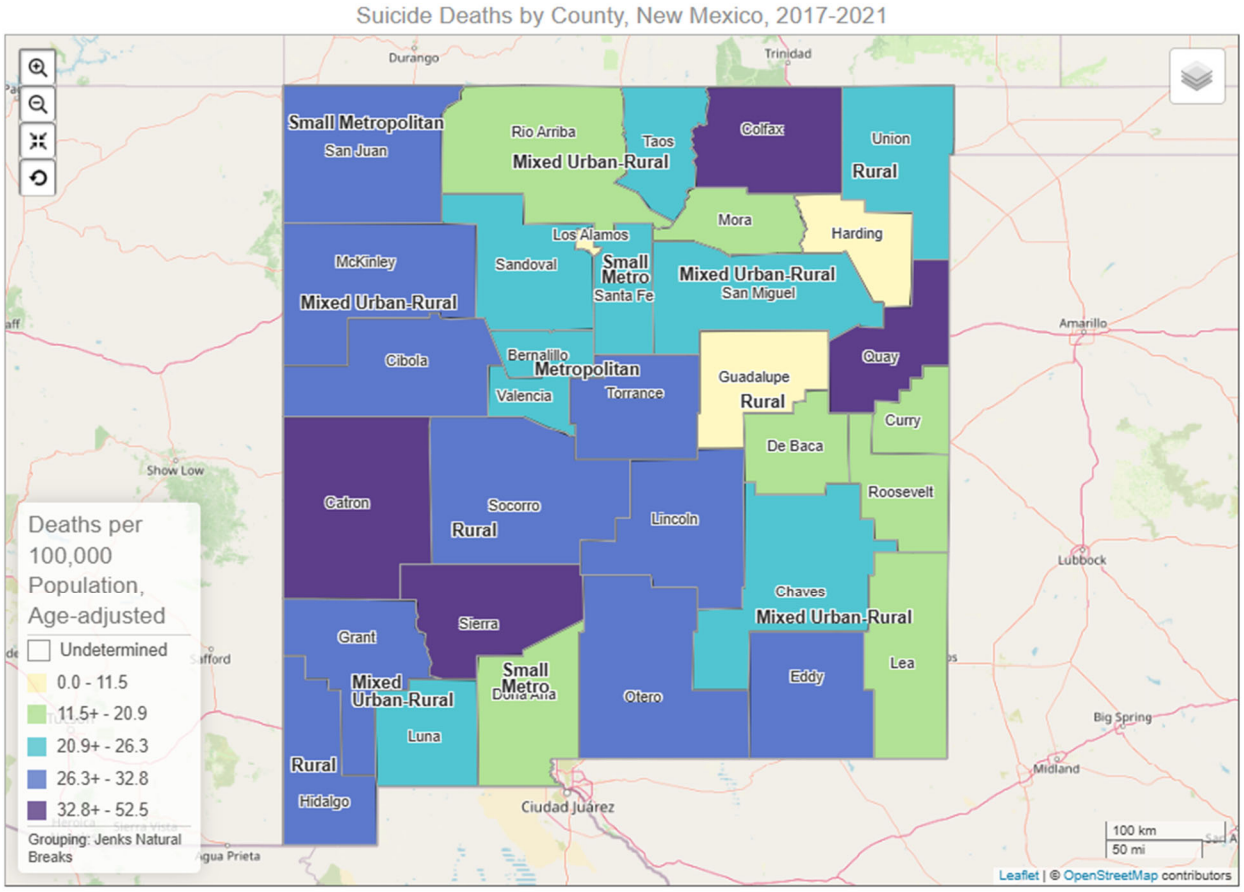
- Suicidal behaviors are a major public health concern and a leading cause of morbidity and mortality in New Mexico.
- In 2018:
  - Suicide was the 9th leading cause of death overall in New Mexico.
  - It was the 2nd leading cause of death among individuals aged 5–34 years.
  - It was the 4th leading cause of death among individuals aged 35–44 years.
- Suicide accounted for 15,048 Years of Potential Life Lost (YPLL: measures premature mortality) — ranking 4th after:
  - Unintentional injuries
  - Cancer
  - Heart disease
- Trends:
  - Suicide deaths have been increasing in both New Mexico and the U.S.
  - New Mexico's suicide death rates have been at least 50% higher than national rates for the past 20 years.
- Risk factors for suicide include:
  - Mental disorders, especially clinical depression
  - Previous suicide attempt
  - Alcohol and substance abuse
  - Family history of suicide
  - History of child maltreatment
  - Feelings of hopelessness or isolation
  - Barriers to mental health treatment
  - Loss (relationships, social connections, employment, finances)
  - Physical illness

Suicide Deaths by Year, NM and US

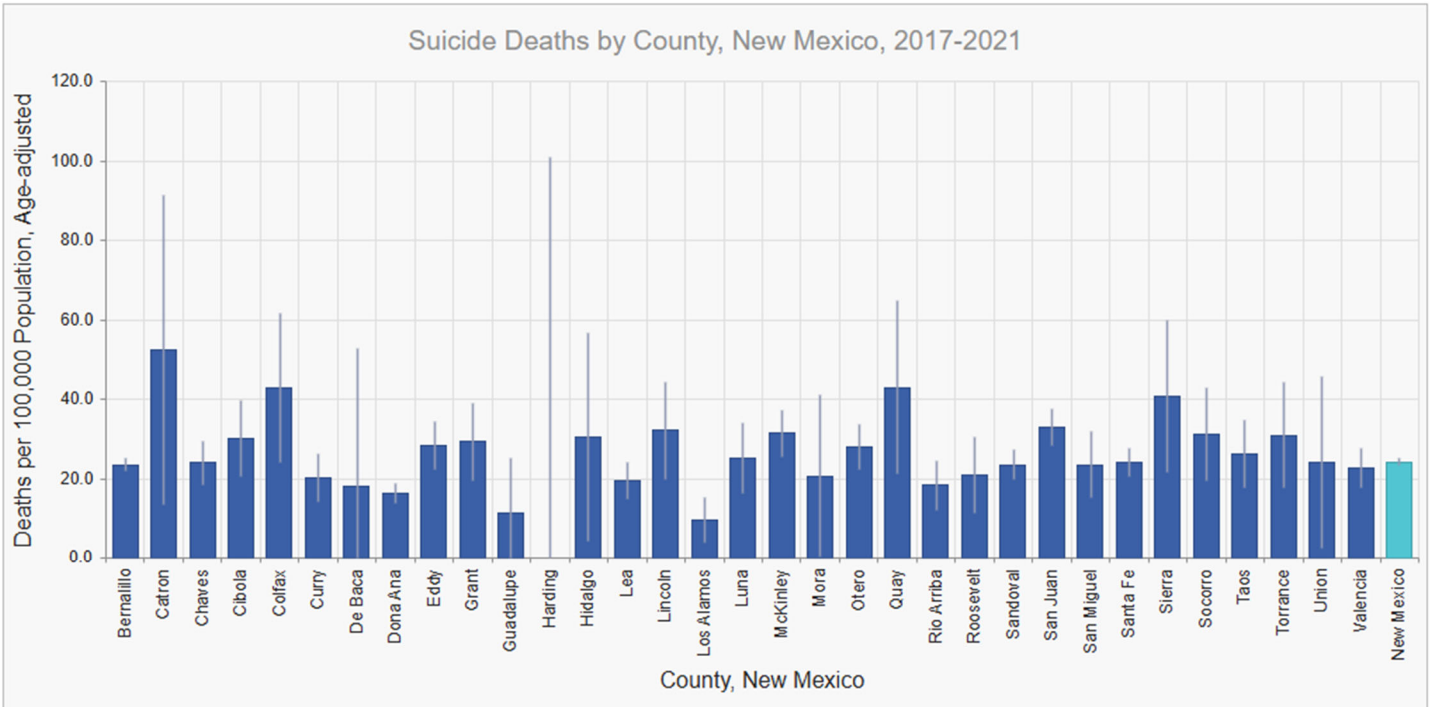


Since 1995, NM suicide rates have been consistently 1.5 times higher than national rates. From 2006-2016, suicide deaths increased in NM by about 25% compared to a 23% increase in the U.S.

Suicide Deaths by Year, by County, NM

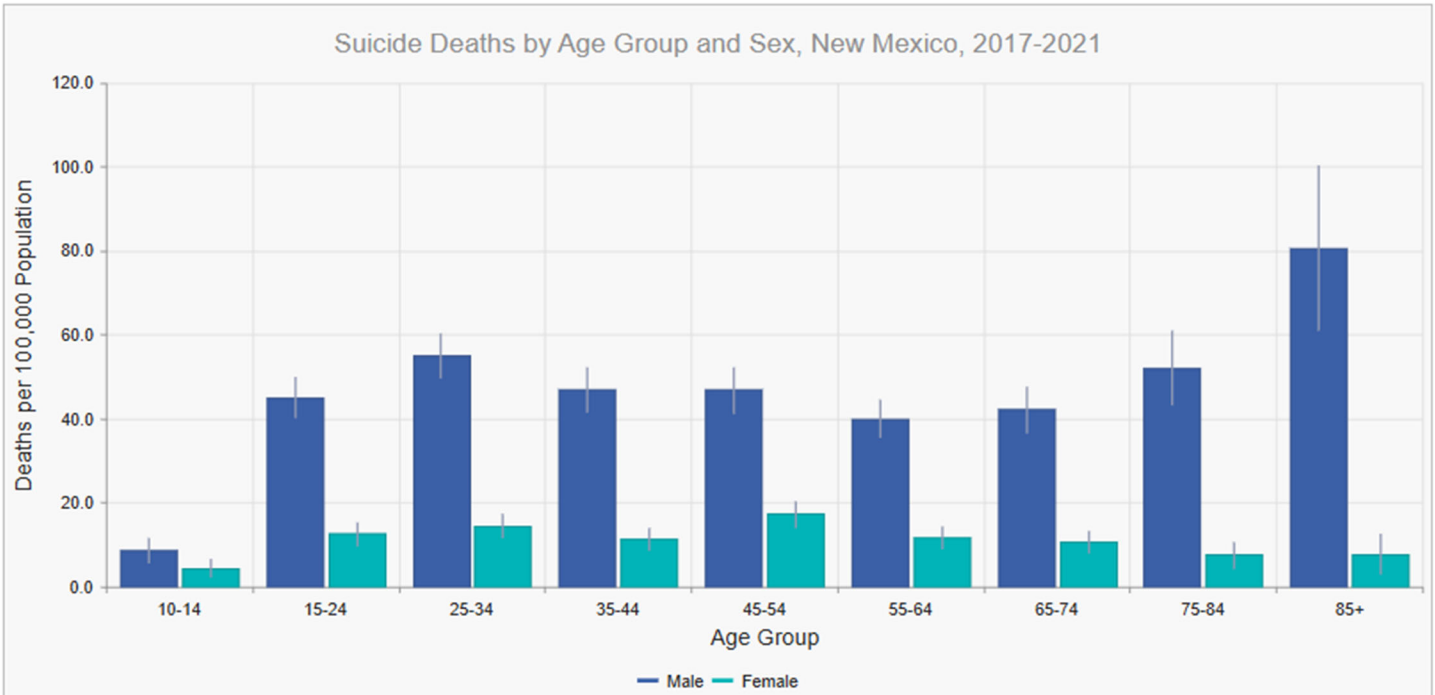


Suicide Deaths by County, NM



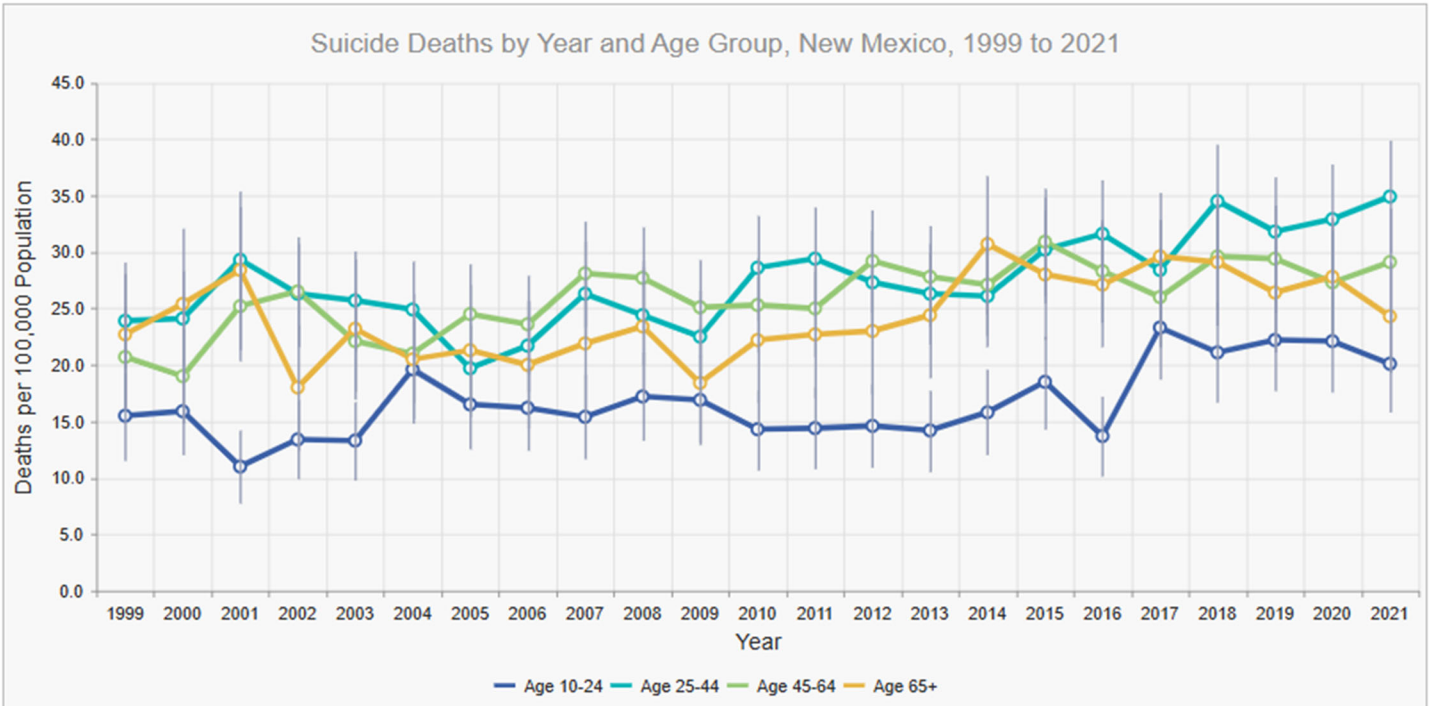
From 2013-2017, 20 NM counties had age-adjusted suicide rates that were significantly higher than the 2016 U.S. rate. NM counties with the highest suicide rates included Catron, Hidalgo, Grant and Sierra Counties in the Southwest; Quay County in the Southeast; and Taos, San Miguel and Torrance Counties in the Northeast.

Suicide Deaths by Age Group and Sex, NM



Suicide rates were highest among adults 85 years and older followed by those 45-54 years and 75-84 years. The male suicide rate was more than 3 times higher than the female rate; males had higher suicide rates in all age groups. Among males, the highest suicide rates were in those 75 years and older, whereas the highest rates among females were in the age groups 45 to 64 years.

Suicide Deaths by Year and Age Group, NM



From 1999-2017, suicide deaths increased in all age groups. The largest increase in suicide deaths was among youth 10-24 years (50%), followed by those 65 years and older (30%). In 2017, the highest suicide death rate was among persons aged 65 years and older (29.6 deaths/100,000 population). 2017 rates reflect a statistically-significant increase in deaths among youth aged 10-24 years.

Alcohol Related Deaths

Source: New Mexico's Health Indicator Data & Statistics - https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html

Alcohol-related death is defined as the total number of deaths attributed to alcohol per 100,000 population, age-adjusted to the U.S 2000 Standard Population.

Alcohol Related Deaths

- Alcohol is the fourth-leading preventable cause of death in the United States, following:
  - Tobacco
  - Poor diet and physical inactivity
  - Illegal drugs
- New Mexico has had the highest alcohol-related death rate in the United States since 1997.
- The consequences of excessive alcohol use in New Mexico extend beyond death and include:
  - Domestic violence
  - Crime
  - Poverty and unemployment
  - Chronic liver disease
  - Motor vehicle crashes and other injuries
  - Certain cancers
  - Other medical conditions

Nationally:

1 in 10 deaths among working-age adults



(ages 20–64) is attributable to alcohol

In New Mexico:

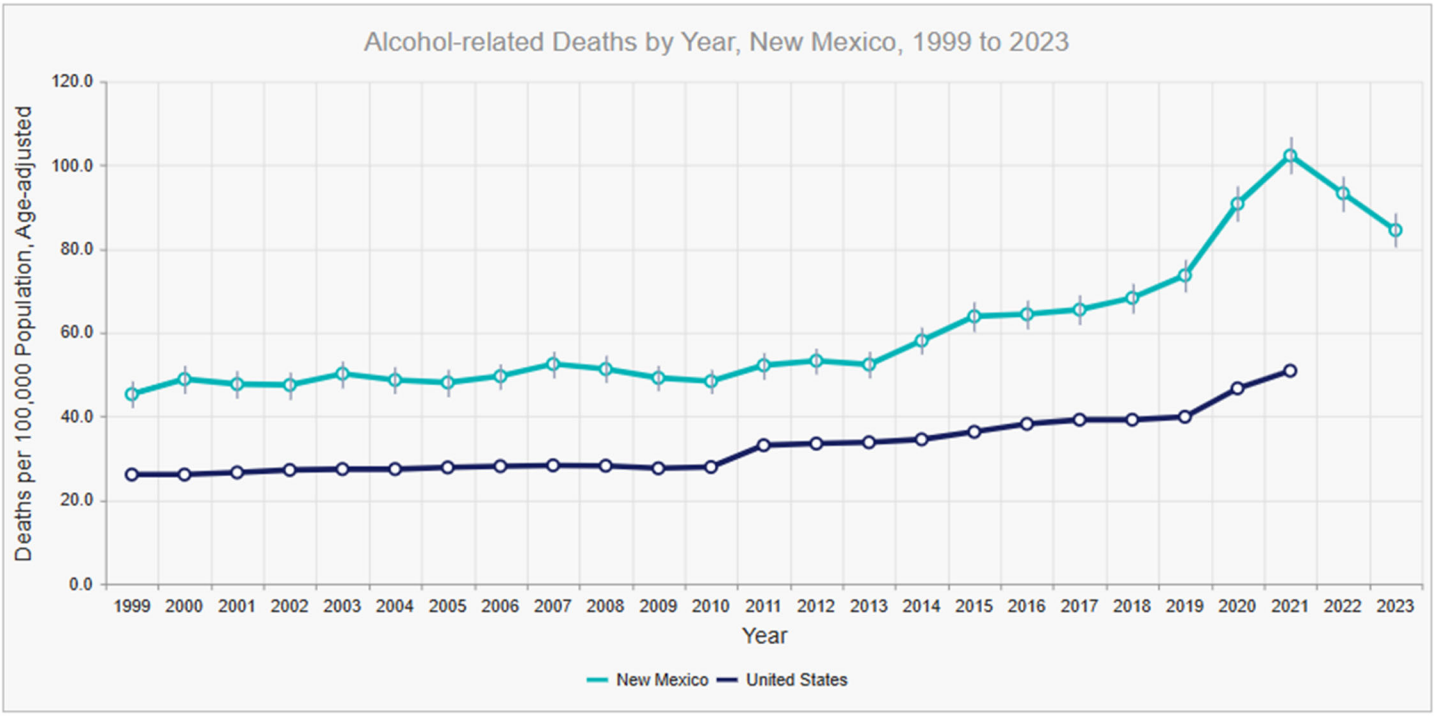
1 in 5 deaths among working-age adults



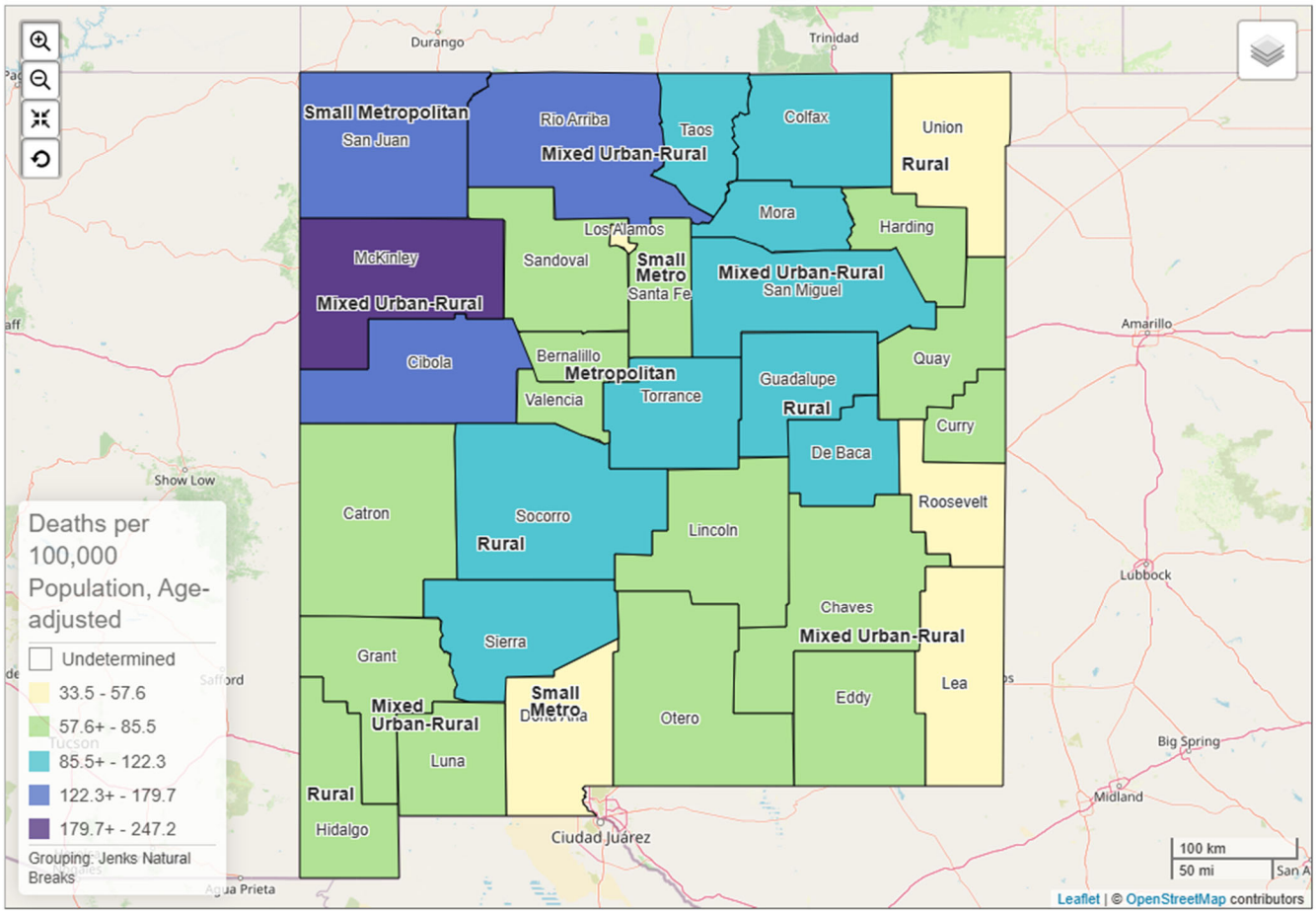
(ages 20–64) is alcohol-related

— **This is twice as high as the national rate**

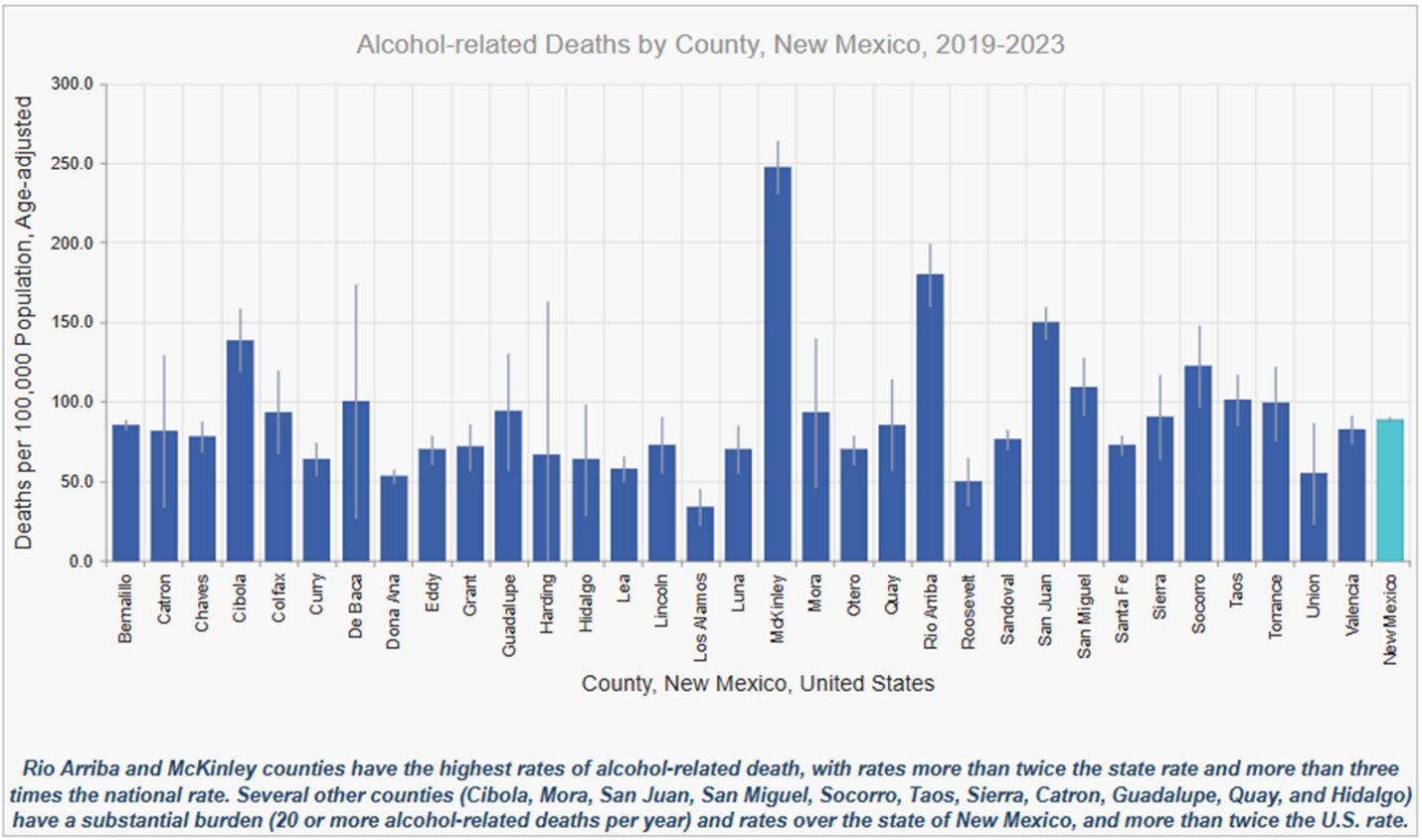
Alcohol-Related Deaths by Year, NM



Alcohol-related Deaths by County, NM, 2019-2023

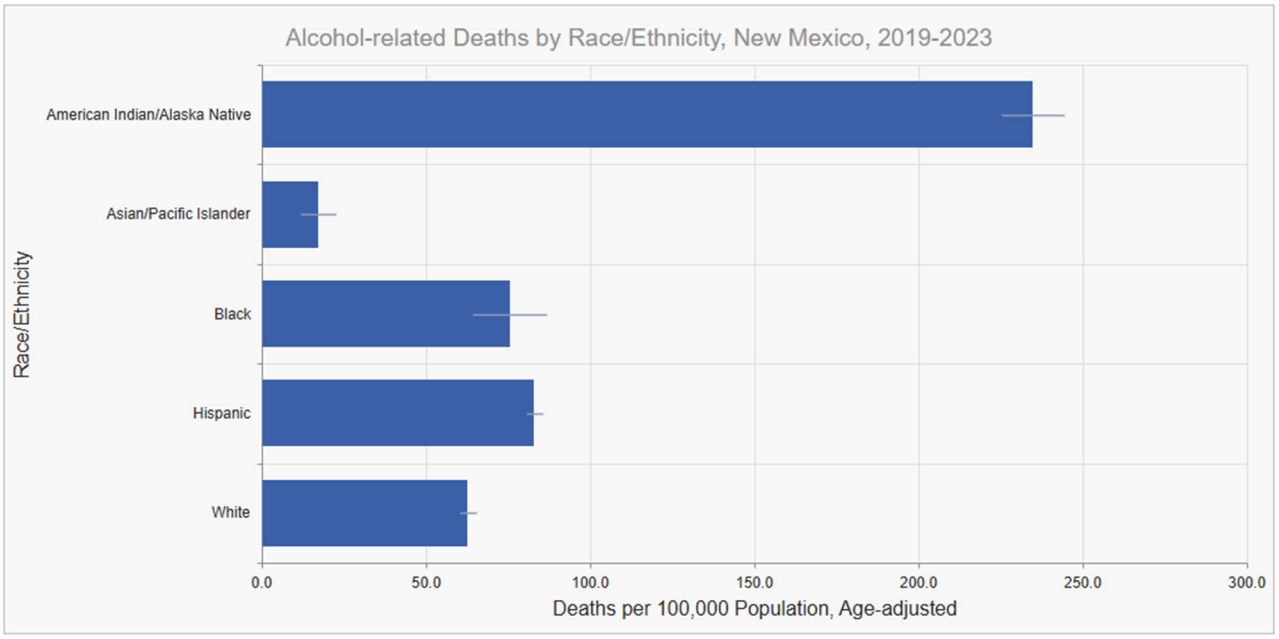


Alcohol-related Deaths by County, NM

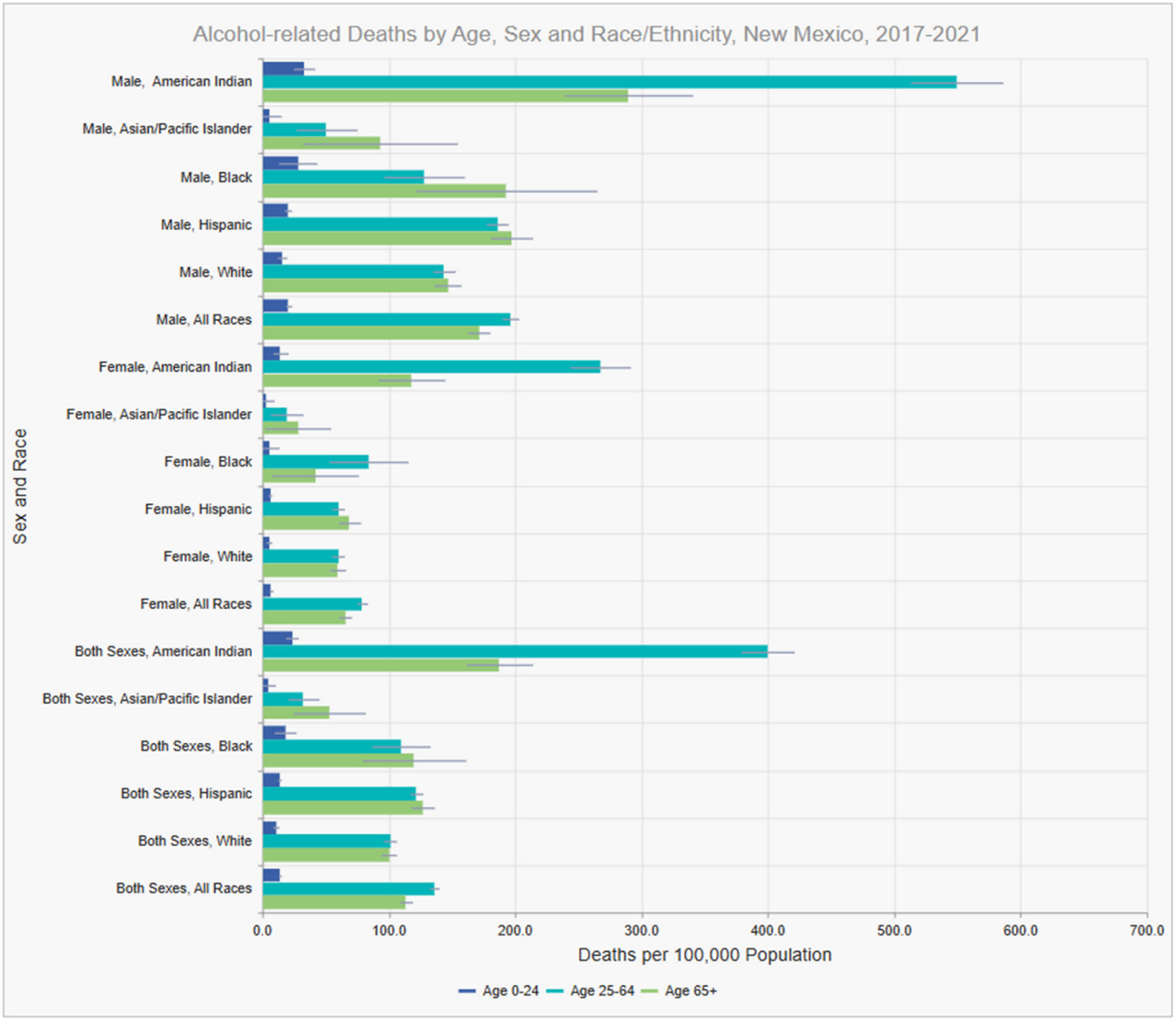


Rio Arriba and McKinley counties have the highest rates of alcohol-related death, with rates more than twice the state rate and more than three times the national rate. Several other counties (Cibola, Mora, San Juan, San Miguel, Socorro, Taos, Sierra, Catron, Guadalupe, Quay, and Hidalgo) have a substantial burden (20 or more alcohol-related deaths per year) and rates over the state of New Mexico, and more than twice the U.S. rate.

Alcohol-related Deaths by Race/Ethnicity, NM



Alcohol-related Deaths by Age, Sex, Race/Ethnicity, NM



Drug Overdose Deaths

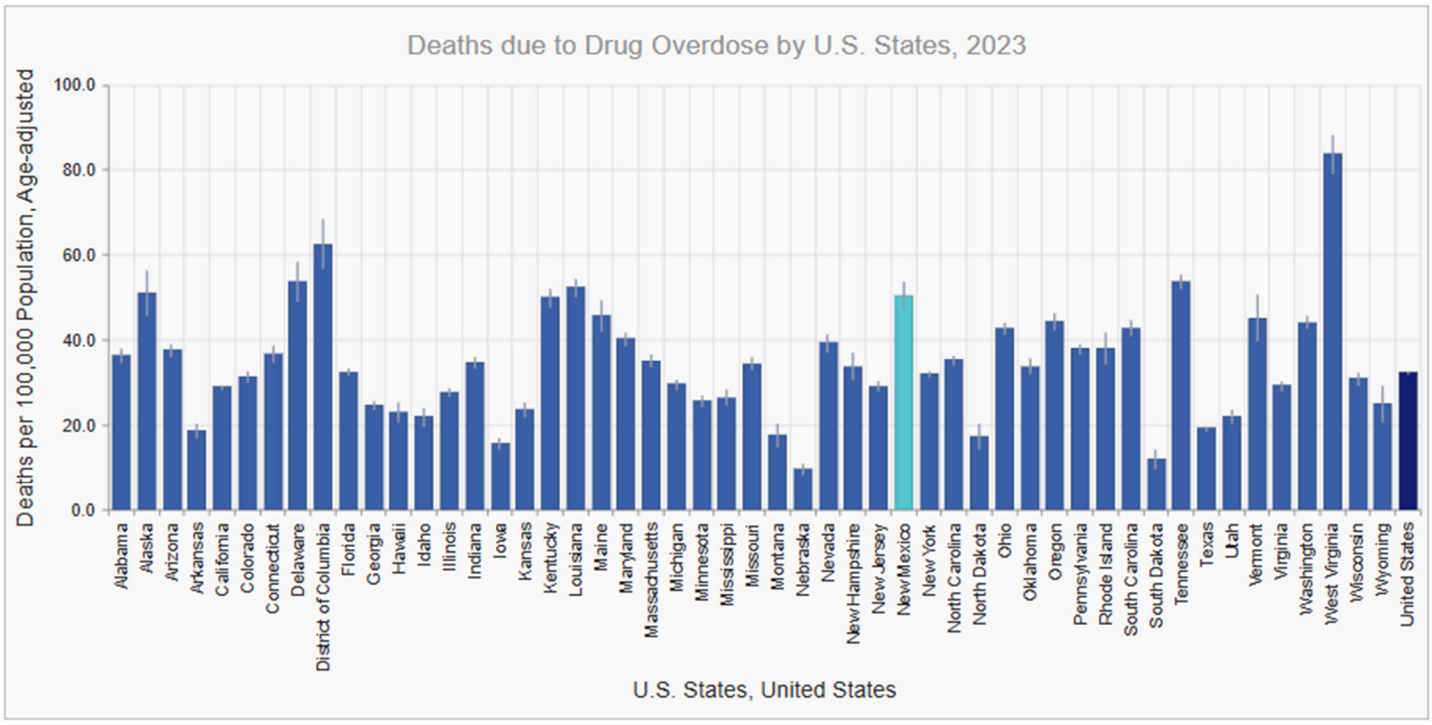
Source: New Mexico's Health Indicator Data & Statistics - https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html

Drug overdose death is defined as the number of deaths caused by drug overdose per 100,000 population, age-adjusted. Drug overdose deaths are those in which drug overdose is the primary cause, whether unintentional or intentional.

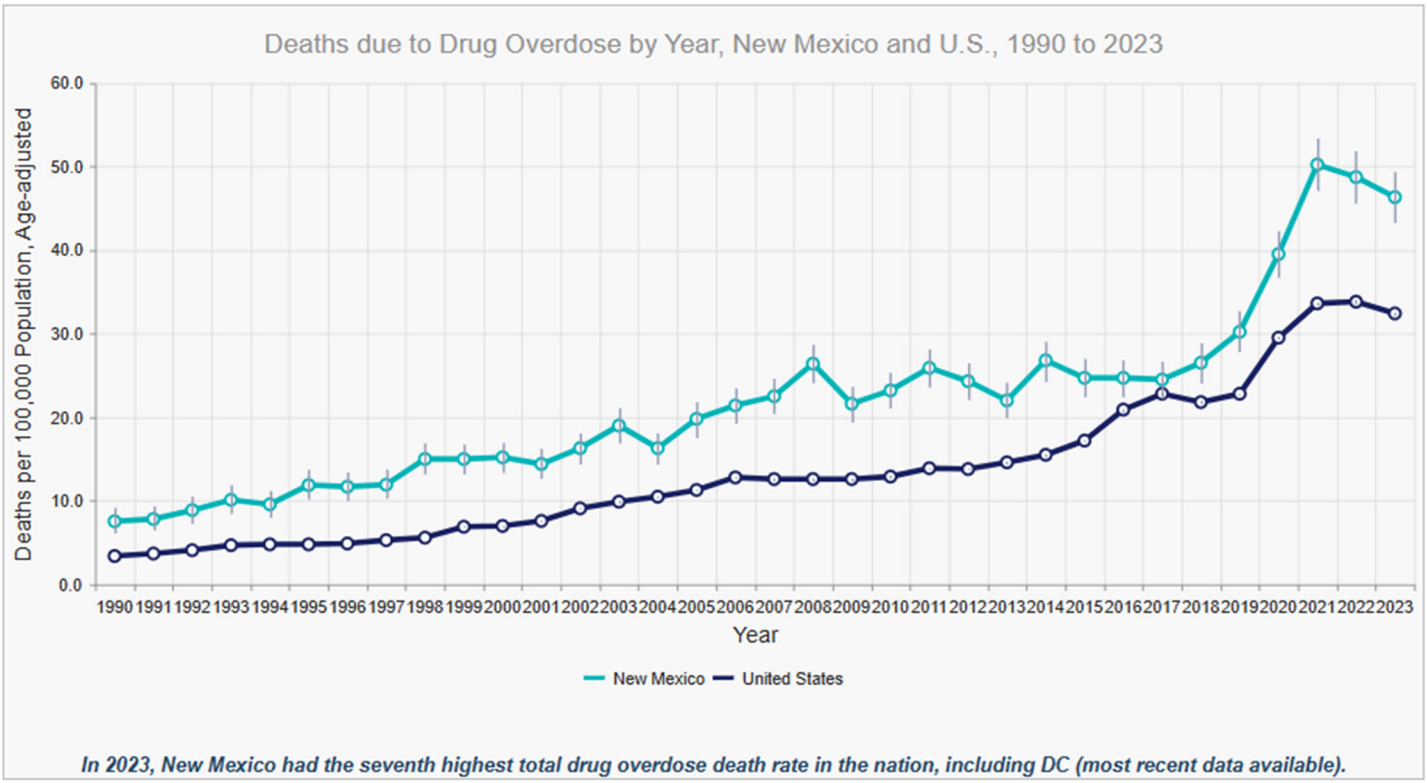
Drug Overdose Deaths

- **New Mexico** has had one of the **highest drug overdose death rates** in the nation for **most of the past two decades**.
- The **drug overdose death rate** in New Mexico has **more than tripled since 1990**.
- **Trends in drug-related deaths:**
    - Deaths from **illicit drugs** have remained **relatively steady** over the past decade.
    - Deaths related to **methamphetamine** and **fentanyl** have **increased dramatically**.
    - **Drug abuse** is among the **most costly health problems** in the United States.
- In **2007**, the estimated cost of **prescription opioid abuse, dependence, and misuse** in New Mexico was **$890 million**.

Drug Overdose Deaths by U.S. States



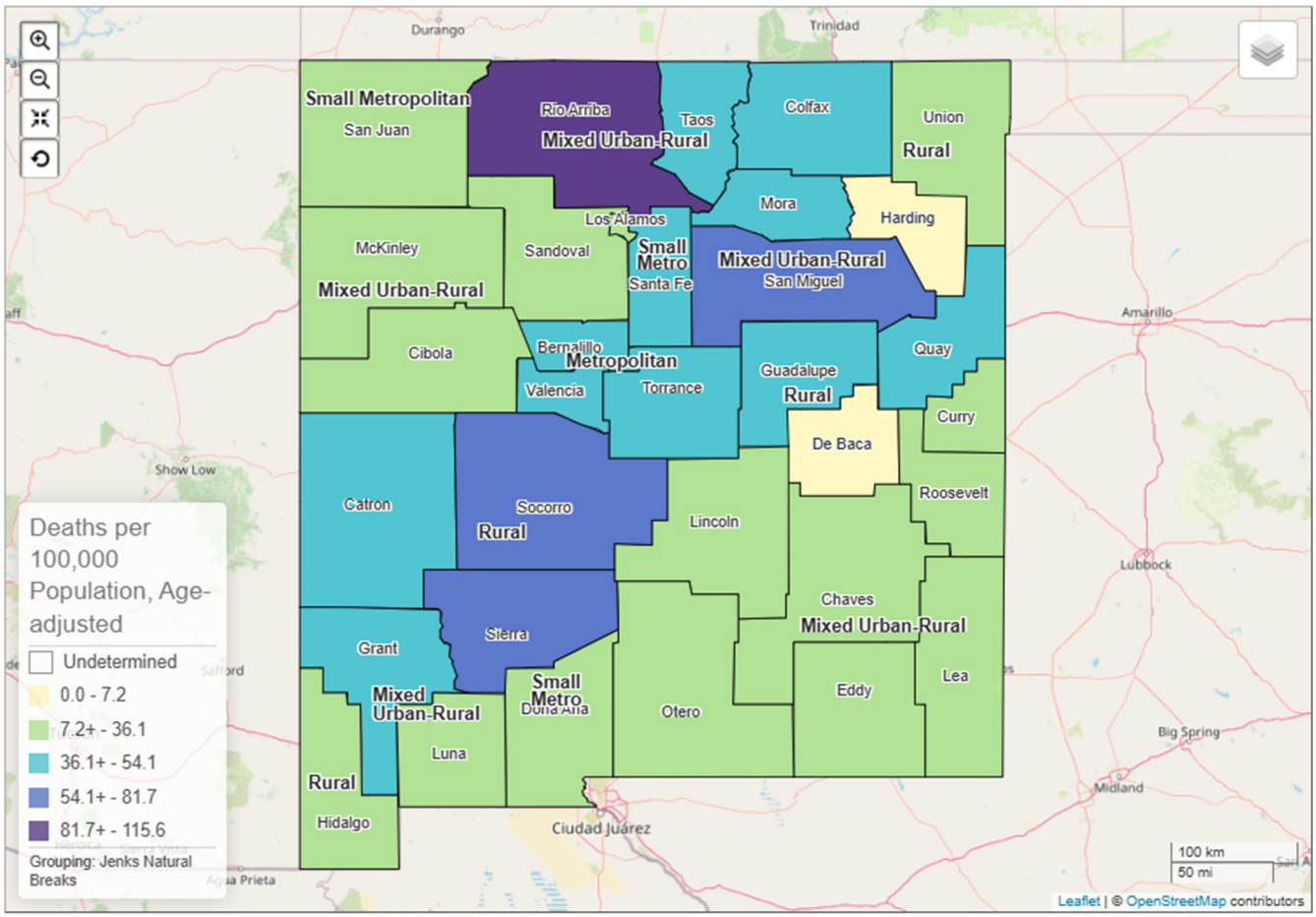
Drug Overdose Deaths by Year, NM and U.S



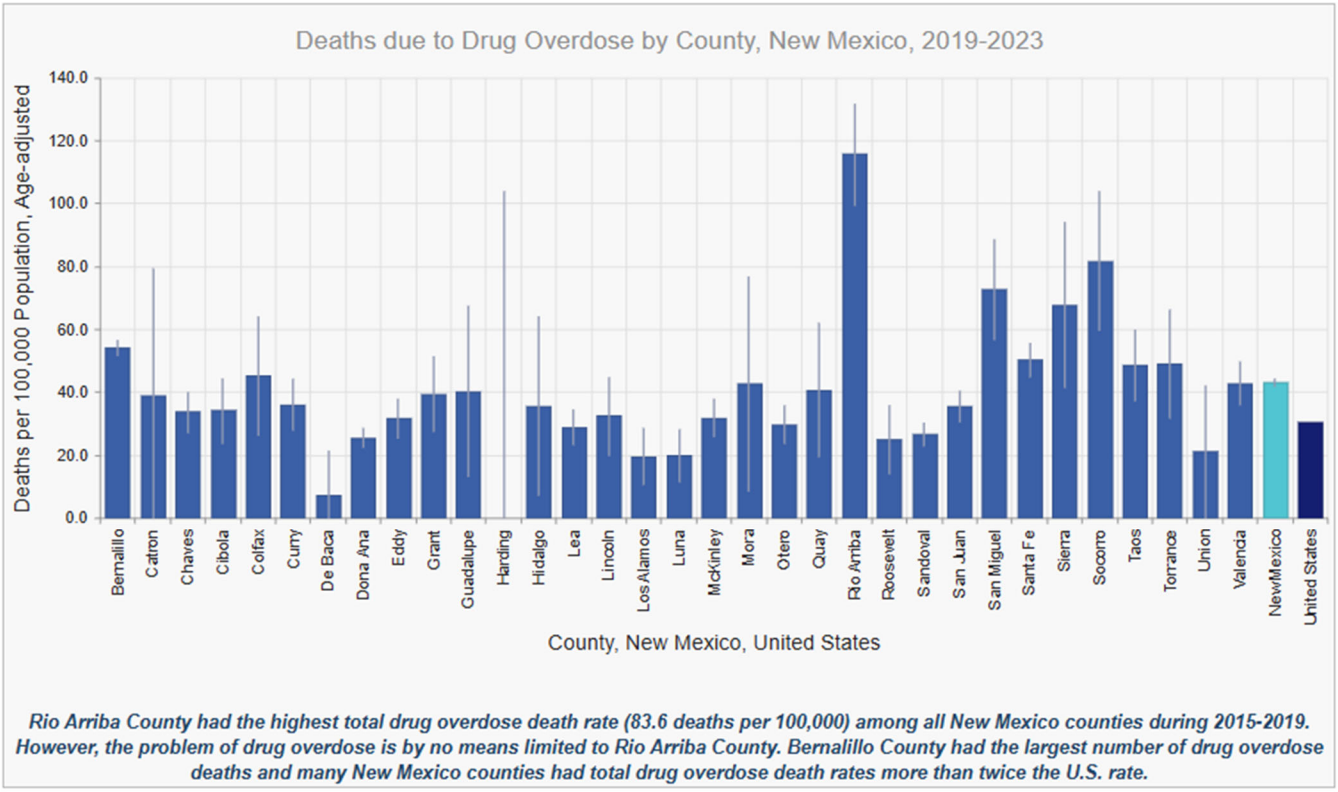
In 2023, New Mexico had the seventh highest total drug overdose death rate in the nation, including DC (most recent data available).

Drug Overdose Deaths by County, NM

Deaths due to Drug Overdose by County, New Mexico, 2019-2023

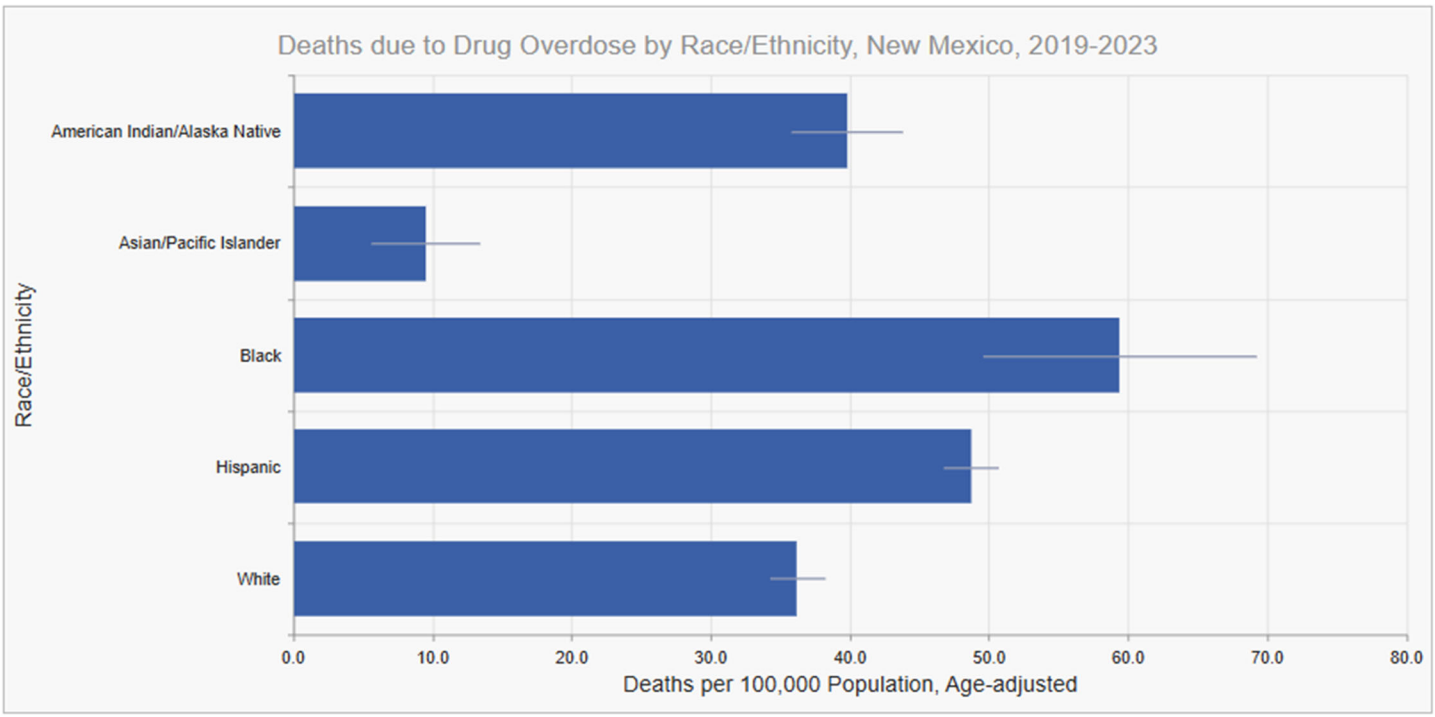


Drug Overdose Deaths by County, NM



Rio Arriba County had the highest total drug overdose death rate (83.6 deaths per 100,000) among all New Mexico counties during 2015-2019. However, the problem of drug overdose is by no means limited to Rio Arriba County. Bernalillo County had the largest number of drug overdose deaths and many New Mexico counties had total drug overdose death rates more than twice the U.S. rate.

Drug Overdose Deaths by Race/Ethnicity, NM

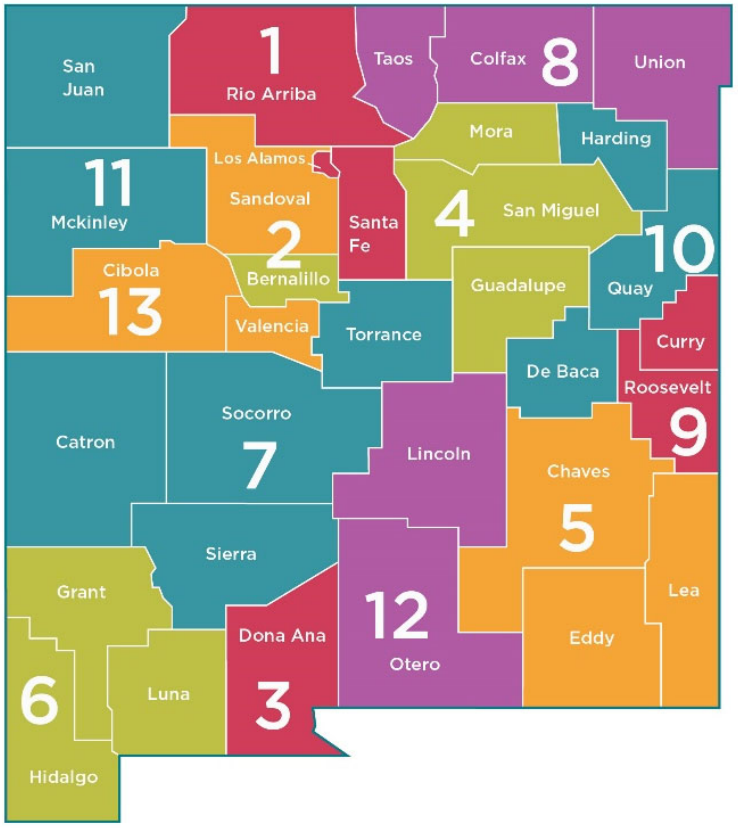


Region/ County

Source: New Mexico's Health Indicator Data & Statistics - https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html

Suicide Deaths, Alcohol Related Injury Deaths, and Deaths Due to Drug Overdose.

The NM Behavioral Health Reform Investment Act



Region 1
- Ohkay Owingeh
- Santa Clara Pueblo
- Pueblo of San Idelfonso
- Pueblo of Pojoaque
- Nambe Pueblo
- Pueblo of Tesuque
- Jicarilla Apache Nation

Region 2
- Pueblo of Isleta
- Pueblo of Sandia

Region 6
- Fort Still Apache Tribe

Region 8
- Taos Pueblo
- Picuris Pueblo

Region 13
- Pueblo of Laguna
- Pueblo of Acoma
- Pueblo of Cochiti
- Pueblo of Jemez
- Pueblo of Zia
- Pueblo of Santa Ana
- Santo Domingo Pueblo
- Pueblo of San Felipe

Region 11
- Navajo Nation
- Pueblo of Zuni

Region 12
- Mescalero Apache Tribe

Region 1

- Los Alamos, Rio Arriba, Santa Fe
- Ohkay Owingeh, Santa Clara Pueblo, Pueblo de San Idelfonso, Pueblo of Pojoaque, Nambe Pueblo, Pueblo of Tesuque, Jicarilla
    - Specific tribal community data is not available

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Los Alamos	9.6 ▼	33.5 ▼	19.6 ▼
Rio Arriba	18.3 ▼	179.7 ▲	115.6 ▲
Santa Fe	24.1 ▼	72.9 ▼	50.1 ▲
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9(2021)**	**32.4 (2023)**

Region 2

- Bernalillo
- Pueblo of Isleta, Pueblo of Sandia
    - Specific tribal community data is not available

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Bernalillo	23.4 ▼	85.3 ▲	54.1 ▲
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 3

- Doña Ana

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Dona Ana	16.3 ▼	53.1 ▼	25.4 ▼
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 4

- Guadalupe, Mora, San Miguel

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Guadalupe	11.5 ▼	93.6 ▲	40.1 ▼
Mora	20.6 ▼	93.2 ▲	42.7 ▼
San Miguel	23.5 ▼	109.3 ▲	72.7 ▲
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 5

- Chaves, Eddy, Lea

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Chaves	23.9 ▼	78.1 ▼	33.6 ▼
Eddy	28.3 ▲	69.9 ▼	31.7 ▼
Lea	19.5 ▼	57.6 ▼	28.9 ▼
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 6

- Grant, Hidalgo, Luna
- Fort Sill Apache Tribe
    - Specific tribal community data is not available

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Grant	29.3 ▲	71.6 ▼	39.4 ▼
Hidalgo	30.4 ▲	63.7 ▼	35.6 ▼
Luna	25.1 ▲	69.9 ▼	19.9 ▼
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 7

- Catron, Sierra, Socorro, Torrance

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Catron	52.5 ▲	81.4 ▼	38.8 ▼
Sierra	40.7 ▲	90.1 ▲	67.7 ▲
Socorro	31 ▲	122.3 ▲	81.7 ▲
Torrance	30.9 ▲	99.1 ▲	48.8 ▲
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 8

- Colfax, Taos, Union
- Taos Pueblo, Picuris Pueblo
    - Specific tribal community data is not available

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Colfax	42.8 ▲	93.5 ▲	45.2 ▼
Taos	26.3 ▲	100.8 ▲	48.6 ▲
Union	24.1 ▼	54.8 ▼	21.2 ▼
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 9

- Curry, Roosevelt

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Curry	20.2 ▼	63.7 ▼	36.1 ▼
Roosevelt	20.9 ▼	50.0 ▼	25 ▼
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 10

- De Baca, Harding, Quay

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
De Baca	17.9 ▼	100.1 ▲	7.2 ▼
Harding	0 ▼	66.4 ▼	0 ▼
Quay	43 ▲	85.5 ▲	40.6 ▼
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 11

- McKinley, San Juan
- Navajo Nation, Pueblo of Zuni

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
McKinley	31.4 ▲	247.2 ▲	31.8 ▼
San Juan	32.8 ▲	149.5 ▲	35.6 ▼
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 12

- Lincoln, Otero

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Lincoln	32.1 ▲	73.0 ▼	32.4 ▼
Otero	27.9 ▲	69.6 ▼	29.7 ▼
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

Region 13

- Cibola, Sandoval, Valencia

Per 100k, Age-Adjusted

County	Suicide Deaths	Alcohol-Related Deaths	Drug Overdose Deaths
Cibola	30.1 ▲	138.7 ▲	34.1 ▼
Sandoval	23.5 ▼	76.1 ▼	26.6 ▼
Valencia	22.6 ▼	82.4 ▼	42.8 ▼
New Mexico	**24.3 (2021)**	**84.5 (2023)**	**46.3 (2023)**
National	**14.1 (2021)**	**50.9 (2021)**	**32.4 (2023)**

BHR 9 Priority Buckets
Across Adult and Youth Systems

Priority Buckets

1. **Crisis, Acute, & Higher Level Care Infrastructure**
2. **Agency Coordination**
3. **Community Communication**
4. **Community-Wide Prevention & Education**
5. **Youth Prevention Programs & Mentorship**
6. **Community-Based Programs for Youth and Adults**
7. **Family Engagement & Parenting Support**
8. **Workforce Development**
9. **Transportation Access**
10. **Housing & Homeless Services**
11. **Youth Diversion & Justice System Improvements**
12. **Services in the Adult Justice System**
13. **Reintegration Support**

Priority #1: Crisis, Acute Care, and Higher Level Care Infrastructure

- Develop acute care options for all ages closer to the region
- Add peer supports in emergency rooms
- Increase opportunities for CIT training for law enforcement
- Train law enforcement on CTC services and policies
- Expand crisis triage center (e.g., longer stays, more beds, different levels of care, services for youth, etc.)
- Need local detox facility
- Create resources for residential services after CTC
- Need local substance use rehab services (SUD + co-occurring MH)
- Need inpatient and residential treatment for BH
- Increase collaboration and agreements between 988 and 911 for more opportunities for diversion.
- Increase capacity of mobile crisis teams to serve all regions of the county
- Need co-responder crisis teams

Priority #2: Agency Coordination

- Improve provider communication and coordination between agencies
- Connect hospital discharge planners with MHR for evaluations (8 AM–11 PM)
- Provide discharge planners with resource lists for after-hours support
- Community conversations among providers, churches, etc., for better coordination
- Coordinate transportation to get to services and classes
- Increase communication between pre-trial services and probation and parole
- Need continuity of care for BH services between release from jail and getting services in the community

Priority #3: Community Communication

- Update Share NM resource database regularly & increase community awareness
- Promote 211
- NM Alliance of Health Councils - need more education in schools and among families to learn about resources
- Increase awareness of services (e.g., public health offices, peer-to peer line)
- Increase marketing and ads through social media, TV, Peach Jar App, School digital boards and community newsletters

Priority #4: Community-Wide Prevention and Education

- Develop strategy for educating families about BH system and available support
- Promote 988 and expand awareness campaigns
- Use Smart Phone notifications to let community members know about 988 services
- Develop healthy options: walking trails/outdoor spaces
- Create entertainment options not around alcohol culture
- Increase community and provider awareness of current Mobile Crisis Team
- Need community buy-in and awareness of Restorative Justice Programs
- Provide ongoing anger management programs for youth and adults
- Increase community buy-in for data collection
- Expand prevention programming to adults (currently mostly youth-focused)
- Expand Domestic Violence Services
- Enhance community policing model
- Develop anti-Stigma Training for Community Members
- Fund Clovis Community College trade training
- Expand Department of Vocational Rehabilitation Services to Roosevelt County
- Pay for CDL training or other trades to bring jobs to the community

Priority #5: Youth Prevention Programs and Mentorship

- Develop peer-to-peer mentoring programs (sports, 4H, United Way)
- Develop youth led councils/committees to organize events
- Reinvigorate Big Brothers Big Sisters and CASA (Court Appointed Special Advocate) programs
- Expand Trust Mentorship Program
- Create youth recreation and/or development center (YMCA-style) offering free programming
- Develop truancy programming to identify youth at risk for justice involvement
- Create programs for marijuana and vaping awareness and prevention
- Work with the National guard to bring the Youth Challenge Program
- Expand DOH Maze of Life mini-courses to more schools
- Build vocational educational programs for job skills, GED, higher ed
- Obtain business buy-in in Roosevelt County to support pools, roller rink, youth center, etc.
- Identify strategies for engaging youth who are not involved in school
- Expand social emotional learning in the schools (e.g., In-Focus)
- Organize structured activities with adult oversight in free and safe spaces, such as skate parks, zoo, etc.
- Identify and build on faith-based supports
- Identify opportunities to build support for positive cultural identify development for all youth
- Develop a youth mentorship program for people on probation to do community service
- Develop app “There is nothing to do here” to share community resources
- Collaborate with Cannon Airforce base and Clovis Community College for vocational training and mentoring

Priority #6: Community-Based Programs for Youth and Adults

- Need Residential Treatment Center for Youth
- Need Intensive Outpatient Treatment for Youth and Adults
- Need treatment foster care for youth
- Increase behavioral services across the lifespan, including telehealth services
- Need a full spectrum of care and continuity of care across the lifespan
- Need bridge for services for transition age youth to adult
- Increase substance use classes and connect to referral process
- Develop and fund medication assisted treatment programs for youth and adults
- Reduce waitlists for outpatient BH services
- Increase access to bilingual services and resources
- Need a methadone clinic
- Need a Clinic that just provides addiction treatment
- Increase screening for women’s postpartum and expand Women’s health services, including MAT treatment

Priority #7: Family Engagement & Parenting Support

- Develop programs to promote parenting engagement in the life of the child (e.g., school attendance)
- Create parenting classes (especially for families reuniting after incarceration)
- Develop strategies to incentivize parent participation in treatment
- Coordinate school and sport scheduling to reduce parental stress
- Need more home-based programs
- Assist parents in becoming accountable for youth's behavior

Priority #8: Workforce Development

- Increase behavioral health workforce (e.g., counselors, social workers, therapists) and healthcare workforce in general (e.g., primary care providers, pediatricians)
- Retain providers through incentives (loan repayment, higher wages)
- Increase training for school resource officers
- Partner with universities for MSW students to provide acute care
- Expand Community Health Workers and Peer Support Workers
- Add more workforce to existing services (e.g. crisis-response, telehealth and in-person)
- Increase workforce for restorative justice programs
- Create pathway programs for high school students into BH fields
- Increase awareness and use of NM Rural Health Care tax credit for BH providers
- Advocate to revise Opportunity Scholarship to require NM work post-graduation
- Collaborate with Clovis Community College and ENMU for job training/apprenticeships/internship opportunities
- Incentivize new graduates to stay in NM
- Review statutes for licensure reciprocity for BH providers (Interstate Counseling Compact)
- Need more education on MAT among providers to adhere to best practices
- Develop role of community navigators to help people access and follow through with services
- Need to increase the number of law enforcement officers
- Increase the number of judges to increase the use of criminal mediation
- Reduce hiring time for probation and parole officers and incentivize probation and parole officers to work in rural communities

Priority #9: Transportation Access

- Expand public transportation (e.g., CATs and PATs); currently often need 24-hour advance scheduling
- Expand transportation access for more rural areas
- Need to identify transportation from the CTC or any treatment facility (out of state) back home

Priority #10: Housing and Homeless Services

- Need affordable and low-income housing (not enough vouchers/units)
- Need emergency housing/homeless shelter
- Need transitional housing for youth and adults upon reentry such as halfway houses
- Need warming center inclusive to families and pets
- Need more sober living recovery housing for men and women
- Need independent living with intensive case management and/or supportive housing options for people with BH issues
- Need programs to support youth who are unhoused
- Need for someone who can help with benefits, such as Medicaid
- Use indigent health care dollars for people awaiting Medicaid coverage
- Need more hands-on outreach to people who are unhoused
- Work to impact housing policy, including regulations under grants
- Need local reintegration housing such as adequate halfway houses

Priority #11: Youth Diversion & Justice System Improvements

- Encourage JPOs to divert youth to community interventions (e.g., MST)
- Develop steadier referral mechanisms from JPOs
- Assign behavioral health counselors to youth awaiting court
- Develop programs for youth to do community service and work
- Mandate youth into treatment (diversion approach)
- Address dual diagnosis in justice-involved youth
- Expand teen court and find permanent funding for it – currently grant funded
- Create juvenile treatment courts
- Restart Juvenile Community Correction Program
- Build a juvenile detention facility nearby
- Use a soft approach to mandate youth into treatment
- Create a juvenile reintegration center
- Develop plans to ensure safety and monitoring (more ankle bracelets)
- Create access to medication upon release from detention
- Develop reentry programs inside youth detention similar to the RISE program
- Increase supervised release period and intensify requirements

Priority #12: Services in the Adult Justice System

- Need to identify a revenue source for restorative justice programming as it is currently funded by DWI dollars but these dollars may be cut by federal government
- Develop Law Enforcement Assisted Diversion (LEAD) program and post-booking jail diversion program where people are diverted to treatment instead of the justice system
- Expand treatment courts for young adults and veterans and families
- Need greater case management for everyone in jail with medication- funding would support a team similar to RISE with a case manager, a NP, and an LISW
- Need more coordinated services and curriculum to be offered in jail (e.g., trauma specific treatment, MAT, etc.)
- Need referral document so you can move individuals from custody to treatment right away (Rocket Docket)

Priority #13: Reintegration Support

- Create written agreements between Probation/Parole and families for reintegration terms
- Need reentry program that has fewer eligibility criteria
- Utilize peer support workers to help with reentry
- Engage families whose loved one is reentering communities after jail or prison
- Promote education and incentives for employers to hire people with criminal record
- Need for a navigator who can help people on probation and parole
- Increase probation and parole officers' awareness of services in community
- Incentivize community colleges to offer vocational training programs for those released from incarceration
- Expand conditions of probation to include participation in vocational training programs
- Need behavioral health team or trained therapist employed by probation and parole team