

**ENHANCED SEQUENTIAL INTERCEPT MAPPING (E-SIM)
AND PRIORITIZATION WORKSHOP REPORT**

Behavioral Health Region 13

Cibola County | Sandoval County | Valencia County

Pueblo of Acoma | Pueblo of Cochiti | Pueblo of Jemez

Pueblo of Laguna | Pueblo of San Felipe | Pueblo of Santa Ana

Pueblo of Zia | Santo Domingo Pueblo

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I. Background

The New Mexico (NM) Behavioral Health Reform and Investment Act (BHRIA) 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 the BHRIA 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.

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 the 13th Behavioral Health Region (Cibola County, Sandoval County, Valencia County, Pueblo of Acoma, Pueblo of Cochiti, Pueblo of Jemez, Pueblo of Laguna, Pueblo of San Felipe, Pueblo of Santa Ana, Pueblo of Zia, Santo Domingo Pueblo).** 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 E-SIM that was adapted for New Mexico from the original Sequential Intercept Model (Griffen, Helbrun, Mulvey, DeMattero & Schubert, 2015¹), modified in the following three ways:

- **The Addition of the 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, including those 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.

2. Overview of E-SIM Mapping and Prioritization Workshop

The UNM BHTAC facilitated the E-SIM Mapping and Prioritization Workshop in Behavioral Health Region 13 (Cibola County, Sandoval County, Valencia County, Pueblo of Acoma, Pueblo of Cochiti, Pueblo of Jemez, Pueblo of Laguna, Pueblo of San Felipe, Pueblo of Santa Ana, Pueblo of Zia, Santo Domingo Pueblo) over the course of 3 days (April 8th-10th, 2026). A copy of the agenda is included in Appendix A.4.

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-five unduplicated people attended the Workshop. Fifty-eight people attended the first day with an additional 10 from the UNM BHTAC for a total of 68 attendees. Forty-seven people attended the second day with 10 people from the UNM BHTAC for a total of 57 attendees. Forty-two people attended the third day with 10 people from the UNM BHTAC for a total of 52 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, Peer Support Workers, and Family Members/Loved Ones
7. Community & Local Organizations

The E-SIM Mapping process and discussion regarding priorities took place in three breakout groups, with roughly equal representation from the seven stakeholder groups. Breakout groups also included UNM BHTAC facilitators, note-takers and scribes.

During the first day of the workshop, the breakout groups focused on mapping resources, gaps and opportunities at each intercept of the **Adult E-SIM**. A summary of the discussion of resources, gaps, and action items identified across all three breakout groups, is included in Appendix A.5.

During the second day of the workshop, the breakout groups focused on mapping resources, gaps and opportunities at each intercept of the **Youth E-SIM**. A summary of the discussion of resources, gaps, and action items identified across all breakout groups, is included in Appendix A.6.

The third day of the workshop focused on the **identification of priorities**. The process used to determine the five priorities, along with the summary of the discussion of the top five priorities across all three breakout groups is described below.

During the morning of the first day, several additional materials were presented to the full group, including Region Specific Medicaid Snapshot data, NM Mortality data, and a summary of notes from the listening sessions that took place prior to the workshop across the Region, before participants dispersed into breakout sessions. Copies of these materials were included in participant packets and are also included as a separate appendix in this report: Region Specific Medicaid Snapshot data (Appendix A.7), NM Mortality data (Appendix A.8), and a snapshot of listening sessions data (Appendix A.9).

II. The Prioritization Process and Results from the Voting

Under the New Mexico Behavioral Health Reform and Investment Act (BHRIA), each Region 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 these 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 12 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.10) to the large group. Throughout the presentation, participants were invited to ask clarifying questions.

Provisional Priority Buckets

- Priority Bucket A: Community Resource Access & Engagement
- Priority Bucket B: Crisis Response, Mobile Services & 988 Coordination
- Priority Bucket C: Law Enforcement and First Responder Training and Coordination
- Priority Bucket D: Clinical Treatment, Recovery and Service Capacity
- Priority Bucket E: Care Coordination, Navigation and Continuity of Care
- Priority Bucket F: Justice Diversion, Courts and Detention-Based Services

- Priority Bucket G: Re-entry, Discharge Planning and Community Reintegration
- Priority Bucket H: Family Support and Engagement
- Priority Bucket I: School-Based Prevention, Youth Community Services and Supports
- Priority Bucket J: Housing, Transportation and Basic Needs
- Priority Bucket K: Workforce Development, Training and Provider Support
- Priority Bucket L: Systems Planning and Infrastructure Support

The 12 provisional 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 top five priorities are listed below and the results of the voting by group are summarized in Table 1.

Top Five Priorities

- 1. Crisis Response, Mobile Services and 988 Coordination**
- 2. Clinical Treatment, Recovery and Service Capacity**
- 3. Care Coordination, Navigation and Continuity of Care**
- 4. Housing, Transportation and Basic Needs**
- 5. Workforce Development, Training and Provider Support**

Table 1: Results of Priority Voting by Group

	Health System	Legal System	First Responders	Government	People with Lived Experience	Community Organizations	Tribal Representatives	Total
Priority Bucket A: Community Resource Access and Engagement	4	4	1	0	1	2	3	15
Priority Bucket B: Crisis Response, Mobile Services and 988 Coordination	10	3	3	2	1	2	8	29
Priority Bucket C: Law Enforcement and First Responder Training and Coordination	2	0	0	2	1	2	5	12
Priority Bucket D: Clinical Treatment, Recovery and Service Capacity	8	4	2	2	1	1	8	26
Priority Bucket E: Care Coordination, Navigation and Continuity of Care	6	2	1	2	0	5	6	22
Priority Bucket F: Justice Diversion, Courts and Detention-Based Services	0	4	0	2	0	2	0	8
Priority Bucket G: Re-entry, Discharge Planning and Community Reintegration	0	0	1	1	0	1	5	8
Priority Bucket H: Family Support and Engagement	2	0	1	0	0	3	2	8
Priority Bucket I:	1	1	1	2	0	2	2	9

School-Based Prevention, Youth Community Services and Supports								
Priority Bucket J: Housing, Transportation and Basic Needs	5	1	3	1	1	6	4	21
Priority Bucket K: Workforce Development, Training and Provider Support	7	1	1	1	0	3	8	21
Priority Bucket L: Systems Planning and Infrastructure Support	0	0	1	0	0	1	3	5
Total (duplicated)	45	20	15	15	5	30	54	

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

After the voting process was completed, participants once again convened into three breakout groups, with roughly equal representation from the seven stakeholder groups, to discuss the following guiding questions:

1. What are the most important action items related to each of the five priority buckets that Behavioral Health Region 13 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 breakout 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.

1. Priority 1: Crisis Response, Mobile Services and 988 Coordination

Table 2: Summary of Priority 1 Discussion

Action Items from the Intercept Mapping Sessions	• Increase coordination between 988 and tribal governments to encourage access to 988 and crisis response. • Coordinate mobile crisis response with tribes and non-tribal organizations. • Expand the SRMC crisis mobile team (with satellite teams across the Region), the Kewa crisis mobile team, and new teams (that work across jurisdictions). • Designate an mobile crisis team (MCT) hub for the region with localized community crisis response teams. • Consider implementing ABQ Community Safety Program, which sends peers to crises rather than law enforcement. • Link paramedics who handle a lot of behavioral health needs with MCTs to increase volume and continuity of care. • Build interoperability between 988 and 911, consider placing both in the same dispatch. • Educate communities on the difference between 988 and 911. • Develop co-response for behavioral health/law enforcement for crisis response in Cibola and Valencia Counties. • Develop “crisis support centers” or drop-in centers that include youth and adult services and are embedded in existing spaces, such as hospitals. • Have communities identify local contacts to coordinate with 988.
Top Priorities to Work on Now and Additional Considerations	Expand Mobile Crisis Response Capacity Across the Region • Develop localized mobile crisis response teams in all counties, with flexibility for: ○ Behavioral-health-led models ○ Co-response models with law enforcement ○ Tribal-led or culturally-based crisis response models

	• Expand existing teams (e.g., SRMC, Kewa) to cover larger geographic areas and move toward 24/7 coverage • Decide and operationalize a clear regional focus (mobile behavioral health units vs. crisis teams vs. co-response), acknowledging community differences Strengthen 988 and 911 Integration • Improve interoperability between 988 and 911, including: ◦ Soft handoffs from 911 to 988 ◦ Reducing unnecessary law-enforcement dispatch for behavioral health calls • Increase coordination between 988 and Tribal governments to improve access and trust • Conduct widespread public education on when and how to use 988 versus 911 Formalize Cross-Jurisdictional Collaboration • Develop MOUs/MOAs between: ◦ Tribes and counties ◦ Behavioral health providers ◦ Law enforcement ◦ Regional hospitals • Address jurisdictional authority explicitly, including Tribal, county, and BIA considerations. • Use regional hospitals as crisis response hubs for deployment where feasible. Build Workforce and Training for Crisis Response • Expand training for: ◦ Law enforcement ◦ Dispatchers ◦ CPSWs, CCSS, and paraprofessionals ◦ Crisis clinicians and supervisors • Promote MHFA, QPR, de-escalation, cultural responsiveness, and trauma-informed crisis response. • Ensure crisis teams include behavioral health, medical, and community-based roles, as appropriate.
Implementation Issues	Operational Design and Logistics • Large rural geography requires: ◦ Multiple teams ◦ Strategic placement of hubs ◦ Reliable vehicles and safe transport protocols • Many crisis calls occur after hours, requiring on-call, after-hours staffing models. • Limited or inconsistent cell phone service in rural and Tribal areas complicates response and follow-up. • Need crisis vehicles, equipment, and protocols for safe transport post-crisis. Governance, Jurisdiction, and Coordination • Crisis response must work across: ◦ Tribal, county, and state jurisdictions ◦ Pueblo and Navajo communities • Need consistent language and agreement on: ◦ Authority during crisis response ◦ Certificates for Evaluation (C4E), especially in Tribal contexts. • Law enforcement, Tribes, and behavioral health agencies must co-design models to ensure buy-in. • MOUs must clearly define:

	○ Roles ○ Information sharing ○ Continuity of care after the immediate crisis Workforce and Training Constraints • Shortage of licensed clinicians willing to provide on-call crisis coverage. • Need trained supervisors to support clinicians. • Crisis teams require competitive wages to attract and retain staff. • High risk of burnout and vicarious trauma among crisis teams, first responders, and law enforcement. Data, Systems, and Standards • Need standardized data systems to track: ○ Demographics ○ Acuity ○ Disposition ○ Outcomes • Data should inform: ○ Service design ○ Resource allocation ○ Funding justification • State toolkits and behavioral health standards must be followed and adapted locally. Community Engagement and Equity • Need explicit inclusion of all Tribes in the Region (Pueblo, Navajo, and others). • Tribal leadership and official buy-in are essential. • Schools and youth-serving systems need to be part of planning and implementation. • Households may need physical materials (e.g., packets) explaining crisis resources.
Sustainability Issues	Stable, Long-Term Funding • Crisis response funding often ends after several years; plans must extend beyond initial grant periods. • Explore blended financing, including: ○ Medicaid billing ○ Third-party revenue ○ BHRIA funds ○ Rural health care funds ○ Federal transformation funds ○ Tribal appropriations • Ensure coverage for uninsured and under-insured individuals in crisis. Workforce Retention and Wellbeing • Sustaining crisis teams requires: ○ Competitive wages ○ Career pathways ○ Ongoing training ○ Support for vicarious trauma and burnout • Long-term success depends on building local workforce capacity, especially in Tribal and rural communities. Training and System Continuity • Ongoing, not one-time, training for:

	○ Law enforcement ○ Dispatch ○ Crisis teams • Continuous education for: ○ Communities ○ Tribal officials ○ IHS and hospital partners • Crisis response models and MOUs must be updated regularly as leadership and staff change. Regional Collaboration • A regional consortium or learning collaborative can: ○ Share lessons learned ○ Coordinate training ○ Reduce duplication ○ Support consistency across counties and Tribes • Entities such as UNM BHTAC or Health Councils could provide facilitation and technical assistance. Accountability and Outcomes • Sustainability depends on demonstrating: ○ Reduced law enforcement involvement ○ Improved crisis resolution ○ Strong handoffs to community services ○ Positive outcomes for Tribal and rural communities • Clear data and outcomes are critical for continued legislative and community support.
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2. Priority 2: Clinical Treatment, Recovery and Service Capacity

Table 3: Summary of Priority 2 Discussion

Action Items from the Intercept Mapping Sessions	• Increase day programming for PSR for the appropriate patient population. • Increase easy access to Narcan for non-providers, including education and use for family members (vending machines, boxes). • Increase harm reduction services (training, Narcan, overdose recognition, etc.). • Reestablish CPSWs in SRMC Emergency Department (ED) and fund CPSWs in all EDs. • Support Porchlight IOP development in Valencia County. • Expand CCBHCs to Tribal and rural communities. • Expand access to non-medical detox for youth and adults. • Develop peer-run services such as the UNM Peer Living Room. • Utilize the UNM FOCUS model for whole family MAT services. • Utilize the Shared Care Approach in rural communities to maximize utilization. • Build BH capacity in the new Valencia County hospital. • Increase access to MOUD services in jails and prisons. • Support IOP services inside and outside the jail in Valencia County. • Increase access to forensic ACT teams. • Provide CCSS wraparound services. • Increase Tribal culturally-relevant services (sweat lodges, drumming, talking circles etc.). • Promote on-call hours in health facilities. • Consider developing a mobile detox unit. • Include inpatient and detox services in the new hospital in Valencia County. • Bridge available modalities to include traditional practices.
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	• Increase coordination between SRMC, CCBHC, and small providers, • Increase access to same-day walk-in services through SRMC CCBHC. • Ensure specialized services for Asian American and Pacific Islander, LGBTQ, and other youth who have limited access to resources. • Increase access to IOP, FFT, MST, RTCs, partial hospitalization, and high-fidelity wraparound (especially for people without Medicaid). • Develop strategies to reduce the delay in getting youth BH evaluations. • Increase the number of outpatient providers who practice DBT, experiential therapies, and somatic therapies. • Explore Bernalillo County Young Adult Program 45-day inpatient model. • Have CCSS support medication adherence. • Promote education about medication and side effects. • Utilize technology to have a provider available through telehealth/virtual communication. • Increase mobile community-based services like immunizations, screening. • Create a Tribal-based prevention curriculum that can be used Tribe-wide (Pueblo-wide) that can be tested across time as an evidence-based model. • Increase training for law enforcement and public defenders on rights to treatment and related issues. • Increase training for Adult Probation and Parole Officers (APPOs on recognizing BH and cognitive disability issues. • Provide training for Tribal court for pre-trial services, risk and responsiveness.
Top Priorities to Work on Now	Expand Access to Core Clinical and Crisis Services • Expand CCBHC services from Sandoval County into Valencia and Cibola Counties, either through: ◦ UNM expansion, or ◦ New CCBHC development with shared regional planning • Increase detox options, including: ◦ Medical and non-medical detox ◦ Mobile detox units for youth and adults • Maximize Medicaid billing for crisis response, while identifying options to cover non-Medicaid individuals (e.g., BHRIA funds). • Reduce delays in behavioral health evaluations, especially for youth involved with courts. Strengthen Recovery-Oriented and Peer-Led Services • Develop peer-run recovery services, such as: ◦ Peer Living Rooms ◦ Peer-led safe spaces • Invest in wraparound services for uninsured and under-insured individuals. • Expand harm reduction services, including Naloxone (Narcan) access and training. Create Accessible “One-Stop” Service Hubs • Establish one-stop-shop hubs with: ◦ Same-day, walk-in access ◦ Multiple providers under one roof ◦ Integrated clinical, peer and social supports • Expand IOP services, including: ◦ Within detention ◦ In the community post-release ◦ Potential expansion into Cibola County Center Culture, Equity, and Community

	• Integrate culturally-based and traditional practices into clinical treatment. • Provide cultural liaisons to support clinicians with: ◦ Co-diagnosis ◦ Translation ◦ Cultural interpretation • Expand safe spaces for youth, including: ◦ School wellness rooms ◦ Community-based intergenerational spaces
Implementation Issues	Workforce and Capacity • Ongoing shortages of licensed clinicians, especially in rural and Tribal communities. • High turnover due to over-use of interns, contributing to distrust and lack of continuity. • Need for succession planning focused on: ◦ Recruitment ◦ Retention ◦ Training community-based providers from within local populations • Limited capacity of small Tribal communities to absorb new programs without added support. Training, Quality, and Consistency • Need for robust, standardized training for: ◦ Peers and CPSWs to conduct basic screenings and assessments ◦ Cultural responsiveness, including Tribal, LGBTQIA+, and undocumented populations ◦ Trauma-informed and family-centered engagement • Need to shift from “packet handoffs” to clinical interviews with families. • Need safer, family-engaged models for: ◦ Outpatient withdrawal monitoring ◦ Crisis response and stabilization Systems and Coordination • Implementation of mobile detox and crisis services requires: ◦ Transportation logistics ◦ Liability coverage ◦ Staffing models • Courts and behavioral health systems need stronger relationships to: ◦ Expedite evaluations ◦ Coordinate access to housing, food, transportation, and treatment • Expansion of services across counties and Tribes requires: ◦ MOUs ◦ Shared jurisdiction agreements ◦ Clear referral pipelines Infrastructure and Data • Identifying physical spaces for: ◦ Peer-run services ◦ Youth safe spaces ◦ Detox or stabilization services • Data systems needed to: ◦ Track outcomes ◦ Justify expansion ◦ Support billing and reimbursement
Sustainability Issues	Long-Term Funding Stability • Heavy reliance on short-term grants poses major sustainability risks.

	• Need to ensure services are: ◦ Billable under Medicaid where possible ◦ Supplemented with BHRIA or state funds for non-Medicaid individuals • Counties face budget constraints, requiring: ◦ Regional cost-sharing ◦ State advocacy ◦ Blended funding strategies Billing and Reimbursement • Expand sustainable billing for: ◦ Peer support ◦ Care coordination ◦ Crisis response ◦ Wraparound services • Address CPSW credentialing bottlenecks that limit billing capacity. • Clarify what services CCBHCs and hospitals (e.g., new Valencia County hospital) will provide long-term. Workforce Pipeline Sustainability • Build durable pipelines with: ◦ Universities and colleges ◦ Tribal colleges ◦ Contracted clinicians • Grow “community-to-workforce” models so staff are recruited from the communities they serve. • Support long-term retention through: ◦ Training ◦ Supervision ◦ Professional advancement opportunities Data, Outcomes, and Accountability • Need consistent data to: ◦ Demonstrate clinical outcomes ◦ Justify ongoing investment ◦ Support expansion requests • Without measurable outcomes, programs risk defunding even when needs remain high. Program Durability • Peer-run services, youth spaces, detox programs, and one-stop hubs all require: ◦ Permanent funding streams ◦ Stable staffing ◦ Integration into existing systems (not stand-alone projects)
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3. Priority 3: Care Coordination, Navigation and Continuity of Care

Table 4: Summary of Priority 3 Discussion

Action Items from the Intercept Mapping Sessions	• Hire someone to monitor available services, open beds, polices, etc., to keep providers up to date. • Increase coordination between CYFD and BH to support parents rather than criminalizing abuse and neglect. • Increase the number of Tribal clinical liaisons/cultural brokers who help community members navigate western medical systems.
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	• Develop MOUs between BH agencies and police departments to respond to crises on Tribal lands. • Improve communication with Tribes about people being released from long-term detention and inpatient care. • Improve coordinated release (e.g., release with meds, appointment set up, practical hours of release). • Increase services in detention facilities and continuity of care upon release. • Increase access to insurance for adults. • House CPSWs and CHWs in community centers and libraries to help enroll people in Medicaid and access online health resources. • Increase awareness of services that MCOs provide (reinstate Medicaid upon release; access BH; Tribal liaisons). • Gain access to funding to hire navigators to increase awareness of existing resources. • Increase telehealth to reduce the need for transportation. • Develop community hubs for patients to connect with providers, CHWs, and CPSWs. • Increase understanding of cultural context and unique Tribal needs for Tribes and counties to share resources. • Develop MOUs across counties and Tribes to work across jurisdictions and coordinate limited services. • Create MOUs with organizations that are already doing work to bring to other communities. • Increase access to multilingual navigational support to educate families about resources. • Support navigators to help parents connect youth and families to BH services and supports, and to navigate the legal system.
Top Priorities to Work on Now	Regional Care Coordination Infrastructure • Establish a region-wide care coordination framework that spans Tribes, counties, detention facilities, inpatient settings, and community providers. • Develop standardized, sustained MOUs/MOAs among behavioral health agencies, courts, law enforcement, detention facilities, hospitals, and Tribes. • Advocate for technical assistance and templates to support Tribes and local partners in developing MOUs efficiently and consistently. Dedicated Care Coordination & Navigation Roles • Hire navigators / care coordinators (regional, county, or Tribal-based) to: ○ Help individuals and families understand and access existing services ○ Coordinate care during crisis, detention, discharge, and re-entry ○ Monitor service availability, open beds, eligibility requirements, and policy changes • Expand the use of CHWs and CPSWs as trusted navigators embedded in: ○ Community centers ○ Libraries ○ Detention and re-entry settings • Create a regional role responsible for maintaining and responding to resource information and care coordination inquiries. Continuity of Care Across Justice and Health Systems • Ensure care coordination begins in detention or inpatient care and continues post-release, including: ○ Behavioral health services ○ Case management ○ Medicaid reenrollment

	○ Warm handoffs to community providers • Strengthen coordination among Tribes, counties, CYFD, courts, and inpatient facilities, especially for youth and justice-involved individuals. Shared Information & Visibility • Develop a regional hub to coordinate: ○ MOUs and MOAs ○ Contacts ○ Training ○ Resource availability (beds, programs, eligibility) ○ Maintain online resource platform • Improve and maintain existing resource platforms (e.g., ShareNM, 211) with real-time updates and multilingual access or develop new platform. • Convene a regional justice and behavioral health “summit” to align partners and accelerate coordination efforts.
Implementation Issues	Governance, Ownership, and Structure • Clarify who serves as the regional hub for care coordination (e.g., Health Councils, regional entity, or designated lead agency). • Define clear workflows for how care coordination operates across: ○ Detention ○ Inpatient care ○ Community re-entry ○ Tribal and county systems • Determine placement and supervision of navigators (Tribal, county, or regional). Legal, Policy, and Compliance Barriers • Medicaid coverage is paused during detention, limiting access and continuity of behavioral health services. • HIPAA and FERPA considerations require: ○ Clear Release of Information (ROI) processes ○ MOUs that explicitly address information sharing at discharge • Some detention facilities do not allow behavioral health providers onsite, requiring negotiation and agreements. • Some Tribes face challenges navigating and negotiating MOUs one-by-one without standardized support. Operational Challenges • Lack of shared language and understanding across systems (detention, BH, courts, Tribes) complicates coordination. • Agencies often do not consistently update resource directories, leading to outdated or inaccurate information. • Navigators’ physical location (community centers, libraries, clinics) affects billing eligibility and sustainability. • Need for regional training for probation, justice partners, and providers on care coordination roles and expectations. Equity and Access Considerations • Care coordination must be culturally responsive and support Tribal sovereignty. • Navigation must support individuals who: ○ Lose Medicaid eligibility ○ Are uninsured or underinsured ○ Are justice-involved or transitioning between systems

Sustainability Issues	Funding and Financing • Heavy reliance on short-term grants threatens long-term viability. • Need to ensure navigators, CHWs and CPSWs, are in billable roles, including: ◦ Medicaid billing where allowable ◦ Care coordination reimbursement mechanisms • Explore blended funding models, including: ◦ County contributions ◦ State allocations (e.g., BHRIA) ◦ Stable local funding ◦ Philanthropy and private donations • Consider advocacy and lobbying strategies to secure long-term funding. Workforce Sustainability • Embed care coordination duties into existing positions rather than standalone grant-funded roles. • Build capacity within Health Councils, CYFD, Tribal health departments, and providers to absorb coordination functions. • Address workforce burnout by: ◦ Clarifying roles ◦ Reducing duplication ◦ Providing regional support structures Systems and Tools • Maintain and fund resource directories (e.g., ShareNM, 211), which are often underfunded and vulnerable. • Ensure ongoing staffing to: ◦ Monitor services and open beds ◦ Respond to inquiries ◦ Push regular updates to providers and communities • Use data and outcomes to justify continued investment: ◦ Reduced recidivism ◦ Improved continuity of care ◦ Increased service utilization ◦ Reduced duplication and system gaps Regional Collaboration • Sustained collaboration across Tribes, counties, and the state is more cost-effective than siloed efforts. • Formalizing coordination through MOUs, dashboards, and summits reduces dependency on individual relationships. • Align care coordination with existing regional infrastructure (Health Councils, CYFD, UNMH navigators) rather than creating parallel systems.
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4. Priority 4: Housing, Transportation and Basic Needs

Table 5: Summary of Priority 4 Discussion

Action Items from the Intercept Mapping Sessions	• Expand transportation across the Region. • Increase access to transportation upon release to access resources (e.g., shuttles, taxis, transport hubs in ABQ, sober driving). • Increase transportation for families to visit people in faraway jails and prisons. • Work with local bus companies and invest in transportation in rural areas to ensure better transportation to and from after-school and summer programming. • Examine regulations for transportation to expand eligibility (e.g., age, distance, waivers for fare, more bus stops; same-day request for urgent appointments, discharge from higher level of care).
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	• Create dedicated safe walking/bike routes along roads. • Find funding solutions to help people stay housed that incorporate BH supports. • Increase second-chance housing (tiny houses, refurbished motels, and other buildings). • Create a regional center with transitional housing that can be accessible to Tribal communities. • Support the grant-funded Men's and Women's transition center building/program development (Santo Domingo). • Expand access to transitional housing and group homes for youth. • Refurbish existing spaces for housing. • Partner with Tribal Housing for second-chance housing opportunities. • Have youth shelters in each County. • Offer shower and laundry vouchers at aquatic centers and other places for people who have limited access to these supports. • Increase access to broadband in all communities (enables better use of telehealth; 988).
Top Priorities to Work on Now	Expand and Coordinate Transportation Options Region-Wide • Expand transportation access across Region 13 for behavioral health, re-entry and basic needs, including: ○ Appointments ○ Crisis services ○ Discharge from inpatient, residential treatment, jails and prisons ○ Family visitation • Maximize existing transportation resources, such as: ○ Medicaid transportation ○ Sandoval County Express ○ Rio Metro ○ Route 66 transport (with expanded limits) ○ EMS pilots (e.g., AMR/NM Swift Link) • Support community-based transportation models, including: ○ CHWs and CPSWs providing non-emergency transport ○ Innovative, non-traditional models (e.g., community or Tribal "ride" services) • Advocate for flexible transportation funding, including vouchers for: ○ Gas ○ Hotels ○ Food ○ Long-distance and out-of-state travel when necessary Increase Access to Housing Across the Continuum • Expand transitional living options, including: ○ Transitional housing without restrictive time limits ○ Local placements instead of out-of-region placements • Advocate for second-chance housing for people with: ○ Justice involvement ○ Poor credit ○ Criminal histories • Increase housing options for: ○ People with long-term behavioral health disabilities ○ Youth and LGBTQAI+ youth needing safe shelter ○ People reentering communities after incarceration • Explore creative housing models, including: ○ Repurposed buildings (hotels, unused facilities) ○ Tiny homes in Tribal communities

	○ Intergenerational housing (youth and seniors) • Support local housing planning, such as Cibola County's effort to adopt a housing ordinance. Address Immediate Basic Needs • Expand use of waivers and flexible supports for: ○ Showers ○ Phones and cell service ○ Food and gift cards ○ Transportation • Provide intentional, culturally responsive re-entry care packages, tailored to individual needs (basic items and traditional items such as cultural materials). • Advocate for safe youth spaces and shelters, including culturally affirming and LGBTQAI+-inclusive environments.
Implementation Issues	Transportation Barriers and Logistics • Transportation gaps within Tribal communities and across county boundaries. • Long distances, rural geography, and limited fleets complicate timely access. • Current policies require advance notice (e.g., Route 66) and restrict service areas. • Rising fuel costs affect transportation feasibility. • EMS-based and pilot transportation programs are limited to institution-to-institution trips and do not meet community-based needs. • Need case managers/navigators to coordinate and educate people about available transportation options. • Long-distance and out-of-state transport remains difficult to access. Housing Development and System Barriers • Zoning laws are a major barrier to affordable, transitional, and supportive housing. • Landlord stigma limits second-chance housing opportunities. • Housing eligibility exclusions (e.g., sex-offense history) restrict access and need review. • Permanent supportive housing requirements (e.g., HUD's one-year homelessness rule) exclude many people in need. • Insufficient shelters in many communities and overly restrictive criteria for access. • Staffing, property maintenance, and operational capacity needed for any housing expansion. • Need for housing skill-building, especially for people experiencing chronic homelessness. Infrastructure and Access Challenges • Limited broadband and internet access affects housing stability and service navigation. • Transport is often needed within communities, not just between institutions. • People who are re-entering from corrections or inpatient services may be placed far from home with no return transportation. • Youth, seniors, and populations involved with re-entry face unique housing constraints that require tailored solutions.
Sustainability Issues	Long-Term Funding and Cost Management • Pilot transportation programs (e.g., AMR / EMS transport) are not sustainable without ongoing funding. • Transportation expansion requires: ○ Stable funding for drivers, fleets, coordinators ○ Ongoing voucher pools

	• Housing expansion requires: ◦ Capital investment (renovations, construction) ◦ Long-term operating funds ◦ Staffing and maintenance resources • Need to address rising operational costs (fuel, utilities, upkeep). Workforce and Capacity • Sustained workforce needed for: ◦ Drivers ◦ Coordinators ◦ Case managers/navigators • Explore dual-role models (e.g., CPSWs serving as drivers) where appropriate and safe. • Workforce shortages and burnout could limit scale if not addressed. System Integration and Policy Alignment • Sustainability depends on: ◦ Collaboration with city planners, housing authorities, and Tribal housing departments ◦ Alignment with local ordinances and zoning reform • Programs must be embedded into existing systems, not stand-alone pilots. Long-Term Stability for Individuals • Housing and transportation solutions must support long-term stability, not just crisis response. • Holistic approaches are needed to address collateral consequences of justice involvement, such as: ◦ Driver's license reinstatement ◦ Employment access ◦ Documentation • Continuous quality improvement using data is essential to: ◦ Demonstrate outcomes ◦ Justify continued investment ◦ Adjust programs over time
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5. Priority 5: Workforce Development, Training and Provider Support

Table 6: Summary of Priority 5 Discussion

Action Items from the Intercept Mapping Sessions	• Establish provider and staff incentives to work in rural and underserved areas (e.g., student loan repayment, housing, bonuses). • Increase awareness of existing student loan repayment programs (e.g., National Health Service Corps). • Increase CPSW training to build the workforce (especially for Tribal CPSWs). • Make salaries competitive for therapists working in Tribes and rural areas. • Increase access to supervision toward licensure for BH providers in rural areas and develop opportunities for clinical supervisors to receive mentorship. • Develop an education pipeline in middle and high schools for legal, law enforcement, and BH jobs and provide opportunities to see how these jobs work. • Create partnerships with colleges and universities for internships and other training opportunities. • Have employers build the capacity of lower-level or pre-licensed staff to increase their training and education (e.g., paying for tuition; flexible schedules for education; state incentives for these opportunities).
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	• Remove red tape for licensing residential treatment, accessing insurance, DD waiver, credentialing for providers and service types, clinical licenses, and other services. • Increase cultural education opportunities for providers. • Improve training for hospital staff on how to deliver SBIRT. • Promote training for and/or recruit clinicians for night/crisis work. • Provide cultural training on BH, local Tribes, Tribal sovereignty, and history. • Provide training for judges, lawyers, and staff on BH issues, diversion, and treatment. • Communicate with Tribal leadership about BH issues. • Provide mentorship for new Tribal leaders, especially on crisis response. • Increase the number of peer support workers with lived experience of BH and incarceration. • Find sustainable options to ensure the CPSW credentialing board certifies youth and family peer support. • Support flexible work schedules for BH providers for work-life balance. • Train youth to step into roles as CHWs, case managers, RBTs doing ABA, CPSWs, etc., to get into BH fields. • Encourage satellite campuses and Tribal colleges to develop BH curriculum and certification programs. • Encourage Tribal colleges to certify CHWs, CPSWs, and other paraprofessionals. • Increase training for BH service providers, schools, and community members on ICWA and IFPA, trauma-informed care, LGBTQ BH, foster care best practices, etc. • Conduct cross-training between community agencies, • Cross-train BH staff and law enforcement in jurisdictions, etc.
Top Priorities to Work on Now	Build and Retain a Local Behavioral Health Workforce (“Grow Our Own”) • Advocate for loan repayment and service-agreement programs to incentivize local community members to pursue behavioral health careers and commit to serving Region 13. • Support pipeline development that moves individuals from: ○ High school to paraprofessional roles (BMS, CCSS, case aides) ○ CHW/CPSW roles to licensed behavioral health providers • Invest in youth and early-career pathways, including internships, mentoring, and vocational/trade training tied to behavioral health and support services. • Encourage Tribal colleges and local/community colleges to offer behavioral health coursework, certifications, and training locally. Improve Recruitment and Compensation • Advocate for competitive salaries and incentives to recruit and retain staff in rural and Tribal communities. • Support creative compensation strategies, including: ○ Loan repayment ○ Rural stipends ○ Paid drive time ○ Flexible time off ○ Advancement opportunities • Promote funding for housing and transportation supports for workforce, such as: ○ Use of RVs or temporary housing ○ Company vehicles for long-distance travel Expand and Coordinate Training

	• Increase access to specialized clinical trainings (e.g., MST, EMDR, DBT, trauma-informed care). • Expand cross-training between behavioral health providers and law enforcement on: ○ Mental health ○ Trauma ○ Crisis response ○ Care coordination ○ Cultural humility • Streamline and expand training and certification for CPSWs and other paraprofessionals. • Create a regional training clearinghouse/one-stop shop for workforce training opportunities.
Implementation Issues	Recruitment and Attraction Challenges • Rural and Tribal areas are less attractive without enhanced incentives and intentional recruitment. • Current recruitment efforts are insufficient and need: ○ Stronger marketing ○ Clear career pathways ○ Active outreach beyond the region • Market-rate salary studies often underestimate the true cost of rural recruitment, requiring advocacy with HR and funders. Workforce Pipeline and Training Barriers • High vacancy rates and long waitlists mean filling immediate hiring needs alongside long-term pipeline development. • Limited access to local training programs forces people to leave the region for education. • Need structured succession planning and mentoring to prevent workforce collapse when staff leave. • Transitioning staff to licensed roles requires: ○ Supervision ○ Education support ○ Flexible schedules • Behavioral health exposure and training should begin earlier (high school level) to build interest. Training Logistics and Coordination • Training requires: ○ Dedicated staff time ○ Space and trainers ○ Funding for national and local experts • Law enforcement participation is limited by staffing shortages and generational/cultural resistance. • Cross-training works best when: ○ Law enforcement helps lead trainings ○ Relationships between BH and LE are actively cultivated (e.g., regular meetings) • Need a regional needs assessment to identify training gaps and prioritize offerings. Infrastructure and Coordination • A central training platform or portal is needed to onboard new staff and reduce duplication.

	• Workforce housing, transportation, and travel logistics must be addressed as part of implementation. • A clearinghouse for training and workforce resources will require dedicated personnel to manage.
Sustainability Issues	Long-Term Funding Stability • Competitive salaries, incentives, and loan repayment programs require ongoing funding, not short-term grants. • Training and workforce development must be supported by: ◦ Stable regional or state funding ◦ Blended funding models (county, Tribal, state) • Workforce housing and transportation supports add recurring costs that must be planned for. Retention and Workforce Continuity • Sustainability depends on retaining staff, not just recruiting them. • Service agreements and contracts can help ensure staff remain with programs longer. • Turnover will continue without career advancement opportunities and ongoing training. • Burnout risk increases if workloads remain high due to persistent vacancies. Training System Durability • Training must be ongoing, not one-time events. • Regional education funds, shared trainers, and online portals can reduce costs over time. • Partnerships with Tribal colleges, universities, and training centers improve sustainability if embedded locally. System Integration • Workforce development must be integrated with: ◦ Care coordination efforts ◦ Crisis response systems ◦ Clinical service expansion • Sustained collaboration between behavioral health, education systems, Tribes, counties, and law enforcement is critical. • Data on vacancies, waitlists, and service demands are needed to justify continued investment and/or to strategy adaptation.

IV. Summary of Discussion Related to County or Tribe-Specific Priorities

1. Cibola County

Table 7: Cibola County Priorities Discussion

Action Items Most Relevant to Cibola County	Expand Transportation Access (Top Priority) • Increase access to transportation for behavioral health care, re-entry, crisis response, and basic needs. • Improve and expand Route 66 Express and related services to better meet community needs. • Develop flexible transportation options, including: ◦ Vouchers ◦ Emergency and non-emergency medical transport ◦ Expanded routes and hours • Advocate for better coordination at jail release, especially to avoid releasing people in the middle of the night without transportation. • Explore alternative transportation options, such as bikes for the Grants area. Build a Local Crisis Response System • Advocate for a locally appropriate crisis response model rather than defaulting to ER or law enforcement. • Build on existing responders already doing crisis work: ◦ First responders ◦ Chaplains ◦ Sheriff's Office • Emphasize training first, then gradually building a formal crisis response system. • Increase public awareness that police response to a mental health crisis does not mean criminal behavior or arrest. • Learn from existing regional models (e.g., Kewa, SRMC) to avoid duplicating efforts. • Advocate for a regional consortium approach to crisis response planning. Strengthen Workforce Skills and Retention • Advocate for specialized training for behavioral health providers to support recruitment and retention. • Support training models such as: ◦ CBT and DBT groups (especially for juvenile treatment court youth) • Advocate for Mental Health First Aid (MHFA) expansion for: ◦ Schools ◦ Youth ◦ Community members ◦ Churches • Promote Youth MHFA as a way to both build awareness and introduce youth to behavioral health careers. Build Community Connection and Quality of Life • Advocate for community spaces and events that support: ◦ Positive social activities ◦ Youth and family engagement ◦ Making Cibola County a more attractive place to live and work • Utilize existing venues, such as the Elks Lodge, for social and community-building activities.
Implementation Issues	Transportation Implementation Challenges • Route 66 Express requires 24-hour notice, limiting flexibility.

	• Routes are not specific, must be reserved, and are open to the general public, creating coordination challenges. • Funding and operations are split between Grants, Milan, and county sources. • Limited options for non-emergency medical transportation. • Need coordination with: ○ Route 66 Express ○ NM Swift Link ○ County and municipal partners • Rising liability concerns and operational logistics must be addressed. • Jail release practices (late-night releases) directly create transportation crises. Crisis Response Implementation Challenges • Need clarity on: ○ Who will staff crisis response ○ Who will fund it ○ How it will be organized • Law enforcement and first responders are already responding to crises but lack consistent behavioral health triage training. • Crisis calls currently result in transport to hospitals, regardless of acuity. • Buy-in is required from: ○ Police Department ○ Sheriff's Office • Data collection is needed early to justify funding and service expansion. • Need to coordinate across agencies and jurisdictions. Training and Workforce Barriers • Timing of youth services conflicts with school schedules. • Youth participation is difficult even when services are mandated. • Schools can be hard to engage due to governance and agenda access. • Getting MHFA into schools may require: ○ One-on-one engagement with school board members ○ Legislative advocacy (e.g., senator involvement) • Recruiting and retaining trained providers remains difficult in rural settings. Community Engagement Challenges • Need trusted, accessible spaces for activities. • Limited existing infrastructure for regular social programming.
Sustainability Issues	Sustainable Transportation Solutions • Liability concerns must be addressed for transportation services. • Long-term funding is required to move beyond pilots and limited service hours. • Transportation models must allow: ○ Same-day or emergency access ○ Vouchers for flexibility • Coordination across county, municipal, and state funds is necessary for durability. Sustainable Crisis Response Capacity • Start with training-based models (MHFA, QPR, CIT) to build capacity affordably. • Use Bachelor's-level staff supervised by licensed clinicians to reduce cost barriers. • Consider hiring behavioral health responders outside police departments initially to: ○ Avoid pulling PD resources

	○ Build community trust • Start small, collect data, and scale based on demonstrated need and outcomes. Workforce Sustainability • Specialized training must be recurring, not one-time. • Without consistent referrals (e.g., juvenile treatment court), programs risk being cut. • Retention depends on: ○ Meaningful training opportunities ○ Community support ○ Feasible workloads Community Sustainability • Ongoing community events and social spaces require: ○ Dedicated coordination ○ Shared ownership (nonprofits, community groups, churches). • These efforts support not only well-being but also long-term workforce recruitment and retention by improving community livability.
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2. Sandoval County

Table 8: Sandoval County Priorities Discussion

Action Items Most Relevant to Sandoval County	Establish a Unified, Countywide School-Centered Behavioral Health Framework • Advocate for countywide implementation of Narcan, substance misuse, and 988 education in all schools, including: ○ Discovery Education/Operation Engage (free program) ○ Student-appropriate prevention and crisis awareness education • Expand mobile crisis response capacity in schools, addressing gaps in: ○ Suicidal ideation (SI) response ○ On-site crisis stabilization • Advocate to the state for support in creating a standardized Sandoval County framework that: ○ Ensures consistent approval processes ○ Clarifies crisis response protocols ○ Strengthens coordination across schools, behavioral health, Tribal communities, justice systems and hospitals Strengthen Cross-System Partnerships • Formalize partnerships between SMRC and Tribal communities to address behavioral health needs by: ○ Creating a credentialed Tribal liaison position ○ Establishing release of information agreements and MOUs/MOAs ○ Developing consultation mechanisms • Advocate for school liaison and court liaison roles to improve coordination between: ○ Schools ○ Courts ○ Behavioral health providers • Improve understanding of behavioral health needs within the justice system to better engage providers. Address Transportation as a Barrier to Access • Advocate for solutions to transportation gaps between hospitals and homes, including:
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	○ Adding a bus line to and from the hospital ○ Providing Uber Health vouchers • Identify solutions for individuals who do not have cell phones, which limits use of ride-based services.
Implementation Issues	Permissions and School Engagement • Schools require: ○ Administrative approval ○ Parental consent ○ Clear policies for delivering Narcan, and raising awareness of substance misuse and 988 education • Inconsistent permissions create uneven access across schools. Crisis Response Capacity • Mobile crisis teams currently lack sufficient capacity for suicidal ideation response within school settings. • Clear supervision structures are needed for mobile crisis teams (MCTs). • Crisis response protocols must align across: ○ Schools ○ Behavioral health providers ○ Emergency services Partnership and Coordination Challenges • Building effective SMRC–Tribal partnerships requires: ○ Credentialed Tribal liaisons ○ Formal ROIs and MOUs/MOAs ○ Ongoing consultation models • Lack of coordination between behavioral health and the justice system limits provider engagement. • Liaison roles (school and court) are needed to reduce fragmentation. Transportation and Logistics • Hospital discharges are hindered by limited transportation options. • Ride-based solutions (e.g., Uber Health) require: ○ Cell phone access ○ Clear funding mechanisms • Public transit routes may need modification or expansion to meet behavioral health needs.
Sustainability Issues	Long-Term System Consistency • Sustainability depends on moving from pilot or ad-hoc efforts to a standardized, countywide approach supported by the state. • Without consistent approval and protocols, school-based services will remain fragmented. Workforce and Supervision • Ongoing supervision and support for mobile crisis teams is required to maintain service quality and prevent burnout. • Liaison positions (Tribal, school, court) must be permanent roles, not grant-dependent. Transportation Solutions • Transportation support must be sustainable beyond short-term fixes: ○ Stable funding for bus routes or vouchers ○ Solutions for individuals without phones • One-off transportation solutions will not meet long-term needs.

	Cross-System Partnerships • ROIs, MOUs, and MOAs require: ◦ Regular updates ◦ Maintenance as leadership changes • Long-term sustainability depends on institutionalized partnerships, not individual relationships.
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3. Valencia County

Table 9: Valencia County Priorities Discussion

Action Items Most Relevant to Valencia County	Develop a Continuum of Transitional Housing with Integrated Services • Develop transitional housing in Valencia County as a top priority to address gaps for: ◦ Justice-involved individuals ◦ Youth ◦ Men ◦ Women and families • Advocate to expand the existing domestic violence shelter (Valencia Shelter Services) to: ◦ Serve youth and men ◦ Expand options for women and families ◦ Include therapeutic and recovery-oriented spaces • Use DreamTree (Taos) as a model for developing a youth-focused shelter and supportive environment. Expand Community-Based Youth and Family Supports • Increase youth gathering places, such as: ◦ Community centers ◦ Gyms ◦ Safe, structured spaces for engagement • Advocate for mobile crisis response capacity by collaborating with: ◦ Existing outpatient providers ◦ The new hospital coming to Valencia County • Promote designs that integrate wraparound services into housing and community settings.
Implementation Issues	Housing and Shelter Expansion • Transitional housing and shelter expansion must include: ◦ On-site wraparound services (behavioral health, medical, education, employment support) ◦ Case management ◦ Therapeutic milieu spaces to support healing and recovery • Policies must be addressed, including: ◦ Pet policies, which can be a major barrier to shelter access • Expansion will require: ◦ Physical space planning ◦ Staffing models aligned to service intensity ◦ Learning from established models (e.g., DreamTree) Youth Engagement and Community Access • Youth gathering places require: ◦ Transportation to and from sites ◦ Funding to reduce cost barriers for existing youth programs (e.g., summer programs families currently must pay for) • Need care navigators or CPSWs on site or connected to these spaces to: ◦ Link youth and families to behavioral health and other resources

	- Explore intergenerational ride-share models, such as: - Elders who own vehicles partnered with young adults who can drive Crisis Response Development - Mobile Crisis Team (MCT) development requires: - Formal MOUs between outpatient programs, hospitals, and partners - Clear roles and responsibilities across agencies - Staffing plans that align with service hours and coverage needs
Sustainability Issues	Long-Term Housing and Service Stability - Transitional housing and shelter expansion must be supported by: - Sustained funding for wraparound services - Dedicated case management capacity - Reliance on part-time availability of community centers limits consistency; need permanent or reliably available locations. Workforce and Service Continuity - Sustainability depends on: - CPSWs and CHWs providing ongoing wraparound services and case management - Avoiding one-time or pilot staffing models that cannot be maintained - Promote family mentoring models, where families who successfully navigated services mentor new participants. Youth Engagement and Trust - Long-term success requires: - Building trust and rapport with youth - Consistent presence of support staff - Safe, welcoming spaces that encourage voluntary participation in behavioral health services Crisis Response Sustainability - Mobile Crisis Teams will require: - Cost-sharing agreements among partners to staff and operate teams - Integration with existing systems rather than standalone pilots - Sustainability depends on shared ownership between: - County - Providers - Hospital systems

4. Tribal Priorities

Table 10: Tribal Priorities Discussion

Action Items Most Relevant to Tribes in BHR 13	Establish a Regional, Tribal-Led Youth Treatment and Crisis Continuum - Advance the New Sunrise Treatment Center (Acoma) as a regional Tribal resource, with priority focus on youth: - Located on Acoma (ACL) property - Proposed as a joint program serving boys and girls - Include adolescent IOP services - Advocate for formal agreement and buy-in from all Tribes in Region 13 on: - Youth vs. adult focus (group consensus favored youth) - Regional access model - Ensure the project aligns with original legislative intent and allowable uses of funding. Expand Tribal-Connected Crisis Response
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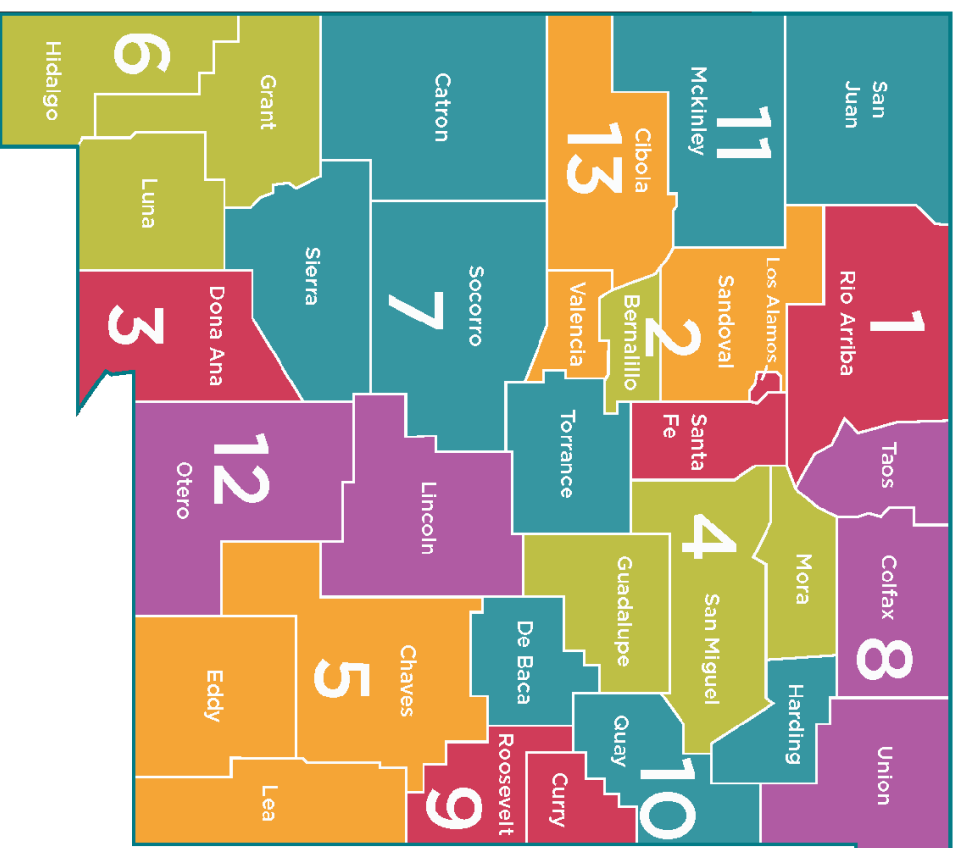
	• Advocate for a Tribal-inclusive mobile crisis unit, potentially by: ◦ Expanding Kewa or Sandoval mobile crisis response capacity • Ensure the crisis model: ◦ Meets state standards ◦ Collects and shares required data ◦ Partners with local counties where appropriate Standardize Tribal–State and Tribal–County Processes • Develop uniform MOUs Tribes can use when partnering with: ◦ Counties ◦ State agencies • Create a template for Tribal Courts to conduct uniform evaluations, improving consistency and equity across Tribes. Strengthen Cultural and Workforce Supports • Expand equine services for youth and adults as culturally-grounded treatment option. • Advocate for retention incentives for clinicians and staff serving Tribal communities, including: ◦ Gas ◦ Hotels ◦ Pay differentials Formalize Ongoing Tribal Collaboration • Advocate for a Tribal Summit to: ◦ Bring Tribal leadership together ◦ Continue planning ◦ Build shared vision and buy-in • Emphasize that some identified actions are low-or no-cost and can begin immediately.
Implementation Issues	Governance, Agreement, and Alignment • Need confirmation that all Tribes in Region 13 agree with: ◦ Using New Sunrise as a shared regional center ◦ A youth-focused model • Must clearly understand how funds can be spent and ensure compliance with legislation. • Indirect cost rate limitations (15%) may restrict program planning and staffing flexibility. Crisis Response Design and Coordination • Decisions needed on: ◦ Whether to expand Kewa or Sandoval mobile crisis teams ◦ How Tribal, county, and state systems will coordinate crisis response • Crisis services must: ◦ Follow state standards ◦ Collect required data ◦ Define how data will be shared with the state • Assessment of community needs is required to determine: ◦ Appropriate staffing ◦ Geographic coverage ◦ Partnerships with counties Tribal Planning and Readiness • Each Tribal community needs to complete an internal inventory of: ◦ Existing services

	○ Gaps ○ Capacity • This information is needed before next convening to support informed decisions. • Requests for a clear FAQ document outlining: ○ Process ○ Timeline ○ Decision points ○ Roles of partners • Acknowledgment that additional no-cost action items can move forward now. Technical Assistance and Coordination • Awareness that AOC and HCA already have technical assistance resources available, but: ○ Tribes need clarity on how and when to engage them ○ Coordination of TA will be important to reduce duplication
Sustainability Issues	Long-Term Viability of Regional Tribal Services • Shared regional services (e.g., New Sunrise, MCTs) require: ○ Long-term agreement among Tribes ○ Clear governance and cost-sharing structures • Sustainability depends on continued alignment with: ○ Legislative intent ○ Allowable funding uses Workforce Sustainability • Retention incentives (gas, lodging, pay differentials) must be: ○ Ongoing, not one-time ○ Budgeted as core operating costs • Rural and Tribal workforce challenges require predictable funding to prevent turnover. Crisis Response Sustainability • Mobile crisis services require: ○ Stable funding beyond startup ○ Ongoing data reporting to justify continuation ○ Integration with existing Tribal and county infrastructure • Indirect cost caps may limit administrative sustainability if not addressed early. Governance and Collaboration • Uniform MOUs and court evaluation templates must be: ○ Maintained and updated over time ○ Adaptable as leadership changes • Regular Tribal convenings (summits, gatherings) are essential for: ○ Maintaining alignment ○ Addressing emerging issues ○ Preventing fragmentation

V. List of Appendices

- A.1 Map of Behavioral Health Regions
- A.2 Acronym List
- A.3 New Mexico Enhanced Sequential Intercept Model (E-SIM)
- A.4 Workshop Agenda
- A.5 Adult E-SIM: Resources, Gaps, and Action Items Identified Across Breakout Groups
- A.6 Youth E-SIM: Resources, Gaps, and Action Items Identified Across Breakout Groups
- A.7 Region Specific Medicaid Snapshot Data
- A.8 New Mexico Mortality Data
- A.9 Summary of BHR 13 Listening Sessions
- A.10 PPT of Provision Priority Buckets

The NM Behavioral Health Reform Investment Act



- TRIBES/PUEBLOS INCLUDED IN EACH REGION

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

- Region 2**
- Pueblo of Isleta
 - Pueblo of Sandia

- Region 6**
- Fort Sill Apache Tribe

- Region 8**
- Taos Pueblo
 - Picuris Pueblo

- Region 11**
- Navajo Nation
 - Pueblo of Zuni

- Region 12**
- Mescalero Apache Tribe

- 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

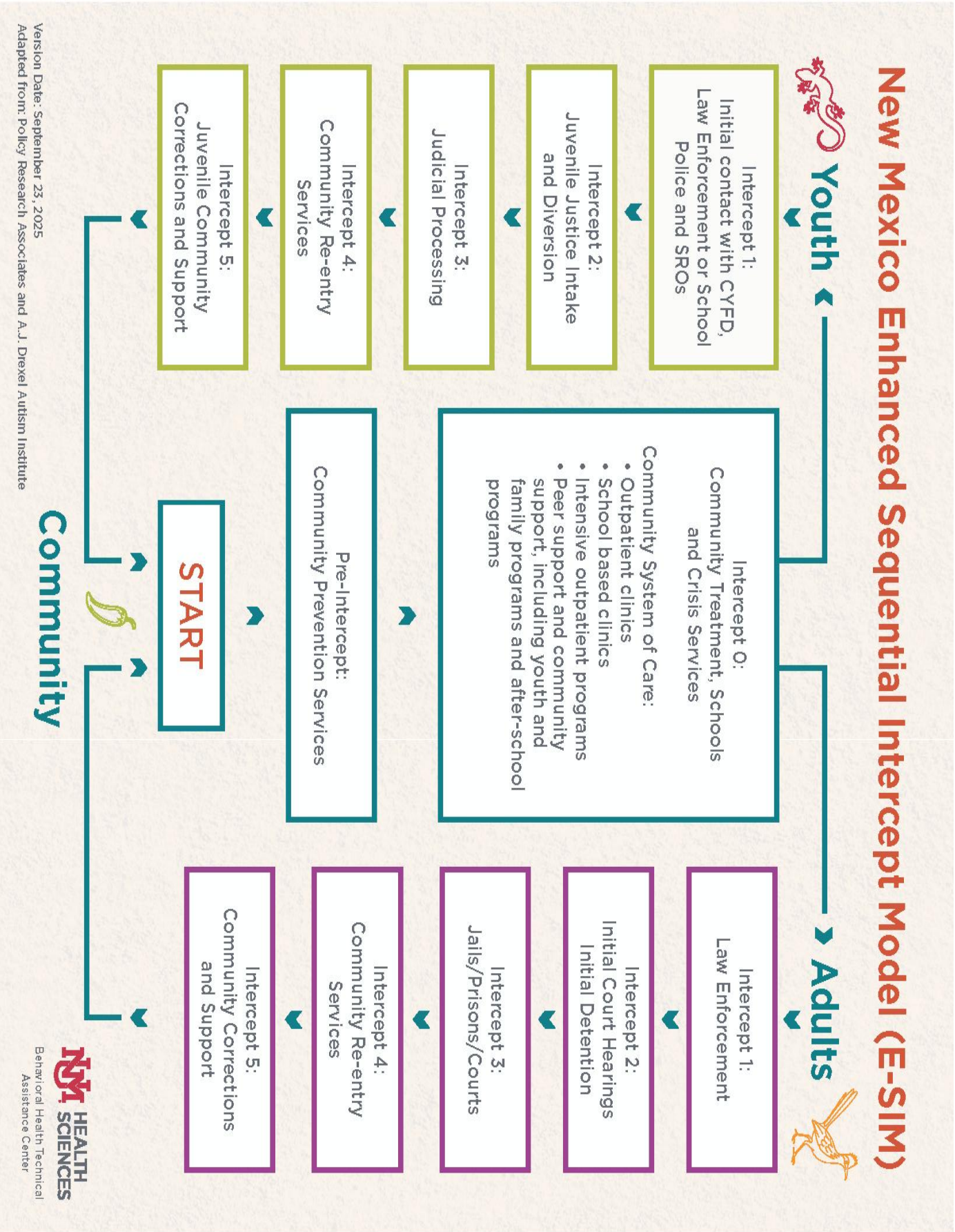
Appendix A.2 Acronym List

Acronyms

AA	Alcoholics Anonymous	DOH	Department of Health
ABA	Applied Behavior Analysis	DEA	Drug Enforcement Agency
ABQ	Albuquerque	DV	Domestic Violence
ACEs	Adverse Childhood Experiences	DVR	Department of Vocational Rehabilitation
ACL	Acoma-Canoncito-Laguna	DWI	Driving While Intoxicated
ACT	Assertive Community Treatment	E-SIM	Enhanced Sequential Intercept Model
AMR	American Medical Response	ED	Emergency Department
AOC	Administrative Office of the Courts	EHR	Electronic Health Record
APCG	All Pueblo Council of Governors	EMDR	Eye Movement Desensitization Reprocessing
APPO	Adult Probation and Parole Office	EMS	Emergency Medical Services
AWARE	Advancing Wellness and Resiliency in Education	ER	Emergency Room
BH	Behavioral Health	FACE	Family and Child Education
BHR	Behavioral Health Region	FACT	Forensic Assertive Community Treatment
BHRIA	Behavioral Health Reform and Investment Act (aka SB3)	FAQ	Frequently Asked Questions
BHSD	Behavioral Health Services Division	FERPA	Family Educational Rights and Privacy Act
BHTAC	Behavioral Health Technical Assistance Center (UNM)	FFT	Functional Family Therapy
BIA	Bureau of Indian Affairs	FINS	Family in Need of Services
BIE	Bureau of Indian Education	GED	General Educational Development
BMS	Behavioral Management Services	HCA	Health Care Authority
C4E	Certificates for Evaluation	HIPAA	Health Insurance Portability and Accountability Act
CBT	Cognitive Behavioral Therapy	HR	Human Resources
CCBHC	Certified Community Behavioral Health Center	HSC	Health Sciences Center (UNM)
CHIN	Children in Need of Services	HUD	Housing and Urban Development Department
CHR	Community Health Representative	ICWA	Indian Child Welfare Act
CHW	Community Health Worker	IEP	Individualized Education Program
CIT	Crisis Intervention Teams	IFPA	Indian Family Protection Act
CCSS	Comprehensive Community Support Services	IGA	Intergovernmental Agreements
CIRT	Community Intervention Response Team	IHS	Indian Health Service
COVID	Coronavirus Disease	IOP	Intensive Outpatient Program
CNM	Central New Mexico Community College	JCC	Juvenile Community Corrections
CPSW	Certified Peer Support Worker	JDAI	Juvenile Detention Alternative Initiatives
CQI	Continuous Quality Improvement	JJAC	Juvenile Justice Advisory Committee
CRAFT	Community Reinforcement and Family Training	JJCC	Juvenile Justice Coordinating Council
CYFD	Children, Youth and Families Department	JJS	Juvenile Justice Services
DA	District Attorney	JPO	Juvenile Probation Officer
DARE	Drug Abuse Resistance Education	KICKS	Katishtya Intergenerational Cultural Knowledge Sessions
DBT	Dialectical Behavior Therapy	LEAD	Law Enforcement Assisted Diversion
DD	Developmental Disability	LE	Law Enforcement

LGBTQIA2S Lesbian, Gay, Bi-Sexual,
 Transgender, Queer or Questioning,
 Intersex, Asexual, Two-Spirit
 MAT Medication-Assisted Treatment
 MCO Managed Care Organization
 MCT Mobile Crisis Team
 MDC Metropolitan Detention Center
 MFHA Mental Health First Aid
 MH Mental Health
 MI Mental Illness
 MI Motivational Interviewing
 MOA Memorandum of Agreement
 MOU Memorandum of Understanding
 MOUD Medication for Opioid Use Disorder
 MRT Moral Reconation Therapy
 MST Multisystemic Therapy
 NACA Native American Community Academy
 NAMI National Alliance on Mental Illness
 NHSC National Health Service Corps
 NMSU New Mexico State University
 OPRE Office of Peer Recovery and Support
 PD Police Department
 PMPM Per Member Per Month
 PMS Presbyterian Medical Services
 PSR Psychosocial Rehabilitation
 PTA Parent Teacher Association
 QPR Question, Persuade, Refer
 RAC Reception Assessment Center
 RBT Registered Behavior Technician
 RISE Reach, Intervene, Support and Engage
 ROI Release of Information
 RR Rio Rancho
 RRPD Rio Rancho Police Department
 RTC Residential Treatment Center
 RV Recreational Vehicle
 SAFE Students Achieving For Excellence
 SAMHSA Substance Abuse and Mental Health
 Services Administration
 SBHC School-Based Health Center
 SBIRT Screening, Brief Intervention, and Referral
 to Treatment
 SDOH Social Determinants of Health
 SEL Social and Emotional Learning
 SI Suicidal Ideation
 SMI Serious Mental Illness
 SPC Southern Pueblo Council

SRMC Sandoval Regional Medical Center
 SRO School Resource Officer
 SUD Substance Use Disorders
 SYSLE Sharing Your Story with Law Enforcement
 (NAMI)
 TA Technical Assistance
 TELI Tribal Early Learning Initiative
 TIC Trauma-Informed Care
 UNM University of New Mexico
 VCAN Valencia Community Action Network
 VINE Victim Information & Notification Everyday
 VMAT Valencia Medication Assisted Treatment
 WIOA Workforce Innovation and Opportunity Act
 YDC Youth Detention Center
 YDI Youth Development, Inc.



E-SIM Mapping and Prioritization Workshop Behavioral Health Region 13

Wednesday, April 8, 2026 – Friday, April 10, 2026

Wednesday, April 8th, 8:00 AM - 4:45 PM — Martinez Hall, NMSU-Grants, Grants, NM

Day 1: Mapping of Adult System

8:00 AM	Workshop Open for Registration, Networking and Continental Breakfast — Auditorium
8:30 AM	Welcome — Auditorium • Kate Fletcher, Cibola County Manager • Marcie Chavez, Cibola County Resource Leader • Senator Angel Charley, District 30 • Shannon Errickson, NAMI Speaker, In Partnership with the National Alliance on Mental Illness (NM) and Bristol Myers Squibb UNM Orientation and Overview of the Next 3 Days — Auditorium • Teresa Gomez, (emcee), UNM Department of Psychiatry and Behavioral Sciences
9:10 AM	Overview of Regional Medicaid Snapshot and State Epidemiological Data — Auditorium • Deborah Altschul, PhD, UNM Department of Psychiatry and Behavioral Sciences
9:30 AM	Pre-Intercept (Prevention): Mapping Existing Services, Gaps and Opportunities — Breakout Rooms
11:00 AM	Break
11:15 AM	Intercept 0: Mapping Existing Services, Gaps and Opportunities — Breakout Rooms
12:30 PM	Lunch — Auditorium
1:15 PM	Mapping Intercept 1 — Breakout Rooms
2:15 PM	Break
2:30 PM	Mapping Intercepts 2 and 3 — Breakout Rooms
3:30 PM	Break
3:45 PM	Mapping Intercepts 4 and 5 — Breakout Rooms
4:30 PM	Wrap-up and Overview of the Next Day — Auditorium • Deborah Altschul, PhD, UNM Department of Psychiatry and Behavioral Sciences

Breakout Room 1
Room 7

Breakout Room 2
Room 3

Breakout Room 3
Auditorium



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New Mexico



E-SIM Mapping and Prioritization Workshop Behavioral Health Region 13

Wednesday, April 8, 2026 – Friday, April 10, 2026

Thursday, April 9th, 8:00 AM - 4:30 PM — Martinez Hall, NMSU-Grants, Grants, NM

Day 2: Mapping of Youth System

8:00 AM	Workshop Open for Registration, Networking and Continental Breakfast — Auditorium
8:30 AM	Welcome — Auditorium • Marcie Chavez, Cibola County Resource Leader • Randy Gutierrez, Warden, Valencia County Detention Center Review of Previous Activities and Overview of the Day — Auditorium • Teresa Gomez, (emcee), UNM Department of Psychiatry and Behavioral Sciences
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 — Auditorium
1:00 PM	Mapping Intercept 1 — Breakout Rooms
2:00 PM	Break
2:15 PM	Mapping Intercepts 2 and 3 — Breakout Rooms
3:15 PM	Break
3:30 PM	Mapping Intercepts 4 and 5 — Breakout Rooms
4:15 PM	Wrap-up and Overview of the Next Day — Auditorium • Deborah Altschul, PhD, UNM Department of Psychiatry and Behavioral Sciences

Breakout Room 1
Room 7
Breakout Room 2
Room 3
Breakout Room 3
Auditorium



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New Mexico



E-SIM Mapping and Prioritization Workshop Behavioral Health Region 13

Wednesday, April 8, 2026 – Friday, April 10, 2026

Friday, April 10th, 8:00 AM - 4:00 PM — Martinez Hall, NMSU-Grants, Grants, NM

Day 3: Prioritization

- 8:00 AM** — **Workshop Open for Registration, Networking and Continental Breakfast**
— Auditorium
- 8:30 AM** — **Welcome**
— Auditorium
- **Marcie Chavez**, Cibola County Resource Manager
 - **Amanda Sanchez Villalobos**, 13th District Court Judge
- Overview of Goals for the Day**
Review of Discussion from Previous Day with Suggested List of Priorities
— Auditorium
- **Teresa Gomez, (emcee)**, UNM Department of Psychiatry and Behavioral Sciences
 - **Deborah Altschul, PhD**, UNM Department of Psychiatry and Behavioral Sciences
- 10:00 AM** — **Silent Ranking Using Dots for Final Priority List**
— Auditorium
- 10:15 AM** — **Break**
- 10:30 AM** — **Review Top 5 Priorities Based on Voting**
— Auditorium
- 11:00 AM** — **Small Group Discussion of Priority 1**
— Breakout Rooms
- 12:00 PM** — **Working Lunch/ Evaluation**
— Auditorium
- 1:00 PM** — **Small Group Discussion of Priorities 2 & 3**
— Breakout Rooms
- 2:00 PM** — **Break**
- 2:15 PM** — **Small Group Discussion of Priorities 4 & 5**
— Breakout Rooms
- 3:00 PM** — **Break**
- 3:15 PM** — **Small Group Discussion of Other Priorities**
— Breakout Rooms

Breakout Room 1
Room 7

Breakout Room 2
Room 3

Breakout Room 3
Auditorium



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Appendix A.5 Adult E-SIM: Resources, Gaps, and Action Items Identified Across Breakout Groups

On the first day of the workshop, participants were divided into three breakout groups, with roughly equal representation from the seven stakeholder groups, to identify resources, gaps and opportunities at each intercept of the Adult E-SIM. 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. Adult System Pre-Intercept: Community Prevention Services

Overview: The Pre-Intercept includes initiatives designed to address the root causes of social issues such as 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 1: Adult System Pre-Intercept: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Community Centers and Libraries	- Laguna Rainbow elderly center - Acoma Senior Center	- No adult focused community center in Grants - Community buildings abandoned or unusable - Ramah—Not a lot of activities for young adults after high school - Lack of social activities that aren't tied to drinking alcohol - There are community centers not open to the public that are very old and not being used - Lack of recurring staff funding for after-hours and weekend services	- Establish community hubs (libraries, community centers) for: -In person resource navigation -BH education -Social and cultural activities - Refurbish unused buildings using BH Trust Funds and federal/state dollars - Extend hours of operation (evenings/weekends) - Develop alcohol-free social and recreational programming for adults and young adults - Expand access to free and low-cost fun and healthy activities - Increase hours of operation for community centers - House CPSWs and CHWs in community centers and libraries to help enroll in Medicaid and access online health resources - More funding to increase services at Ramah Family Service Center
Vocational Education Programs	- Workforce programs (WIAO) - NMSU (telehealth, adult education, early college) - UNM Valencia counseling and resource center - CNM Rio Rancho programs (veterans, immigration, LGBTQ+, health careers) - RR Public Schools psychoeducation workshops		Bring in higher education to do intertribal/ intergovernmental agreements for job training

Family and Parenting Supports	• School based social emotional learning, counselors, and BH awareness education (adults indirectly supported through students and families) • State funded childcare • Home visiting programs for caregivers • San Felipe Tribal Home Visiting program with SUD and MH screening, infant MH and parenting classes	• Hard to sustain Home Visiting services	
Mental Health and Substance Use	• Primary care clinics (UNM Rio Rancho) with universal screening • CPSW in San Felipe have been successful in growing BH programming • CCBHCs in Sandoval: Can get pre-screening for substance misuse and additional services • Sandoval: Billboards across the County • Statewide Opioid Summit (Tribal focused, culturally adapted) • UNM Valencia has counseling and resource center	• Severe provider shortages statewide, especially on Tribal lands • Difficulty recruiting and retaining therapists (noncompetitive salaries, lack of supervisors, retirements) • High cost of malpractice insurance • Limited access to therapists willing to work in tribal settings • Waitlists, intake burdens, and lack of referral sources • Strong stigma, shame, and cultural barriers around seeking BH care • Lack of recurring staff funding for evenings/weekends • Telehealth is available but rural communities often prefer in-person services • Language barriers for elders from Tribal and Hispanic communities; rely on youth to translate • Providers who have a sliding scale system	• Increase competitive salaries for therapists on tribal lands • Expand CPSW and CHW training (especially Tribal workforce) • Develop supports for clinical supervisors • Expand access to insurance and non-Medicaid CPSW services • Expand psychoeducation and stigma reduction campaigns • Educate tribal leaders, judges, and legislators on BH and SDOH • Increase culturally-grounded prevention and traditional healing programs • Increase environmental prevention policies (e.g., alcohol, opioids) • Develop and provide mental health stigma reduction
Housing and Basic needs	• Food distribution programs (Roadrunner Food Bank partnerships, food boxes, food delivery) • Diaper, formula, period closets • Housing vouchers • Route 66 Van (low-cost rides) • SafeRide (Medicaid) • Assure Wireless phones	• Major transportation challenges across all of BHR 13 • Large geographic areas with limited or inaccessible bus systems • Lack of identified pickup/drop off sites • Transportation barriers for transition-age adults (18–25)	• Expand regional transportation options and coordination • Identify and publicize pick up/drop off sites • Use mobile services and in-home BH supports • Address data and phone limitations for rural residents • Link telehealth with transportation services • Expand broadband and Starlink

	• County transportation options (limited but exist) • Women's shelters and housing supports: Roberta's Place, Haven House, Valencia Shelter Services • Permanent and transitional housing (limited but exist) • NMSU food pantry • Tribal refurbishing of housing/buildings • Laguna Community Care Team • San Felipe Housing has worked to refurbish and use previously abandoned buildings • Sandoval CYFD: Food box distribution, diapers, formula, etc. first Friday of the month	• Limited internet and unreliable data access • Lack of transitional housing (ages 18–25)	• Offer shower and laundry vouchers • Increase transitional housing • Find funding solutions to help people stay housed that incorporates BH education
Other Community Resources	• Community outreach and prevention activities across all counties • County, Tribal, and Regional Health Councils coordinating prevention education • Certified Prevention Specialists • Annual Red Ribbon Relay (Tribal participation) • Tribal wellness programs (fitness, biking, walking, hiking, yoga, Zumba, cooking) • Cultural reintegration, storytelling, traditional gatherings, intergenerational knowledge sharing (e.g., Intergenerational Knowledge Sharing, ancestral planting, language) • Traditional healing perspectives integrated into prevention • Tribal calendars used as engagement tools • CHRs and CPSWs providing in-home prevention and outreach	• Lack of alignment between Western BH systems and Tribal needs • Punitive attitudes toward BH among some Tribal leadership • Limited understanding of BH and SDOH among leadership and legislators • Language barriers for elders and Hispanic community members • People unaware of services in neighboring communities • Social media not accessible or effective for elders • Difficulty coordinating overlapping events • Challenges distributing information in large rural areas • Limited data availability to show needs or apply for funding • Lack of services specifically designed for transition age adults • Few alcohol-free social activities for adults and young adults	• Develop, fund, and regularly update regional and county specific resource directories • Create a regional/state resource map and public BH chat/forum • Improve cross community awareness of available services • Fund a dedicated role to maintain resource information • Provide grant writing and grant management training • Increase number of Tribal clinical liaisons/cultural brokers who help community members navigate western medical systems • Expand free and low-cost community activities • Increase senior focused social events • Use maker markets, health fairs, fitness classes, and cultural gatherings as outreach • Improve data sharing mechanisms for grants and planning • Inform legislators of regional gaps and needs • Use county representatives as state liaisons • Provide small grants directly to communities for prevention

	• All Pueblo Councils of Governors (APCG), Southern Pueblo Council (SPC), 8 Northern Pueblo Council • Community newsletters • County and regional resource directories (Valencia, Cibola, developing Core Health guide) • NM Connects App • Pamphlets and printed directories • Billboards and public awareness campaigns • Social media campaigns • Rio Rancho hosts events once a quarter to gather people for family activities • Valencia Community Action Network is a small agency that is self-funded • Sandoval & Valencia County resource navigation support	• Social isolation among seniors and rural residents • Intergenerational and historical trauma • Lack of sustained funding for navigators, hubs, and prevention staff • Legislators are not often informed of local issues – need to communicate so they are better informed and serve communities	• Gain access to funds through BH Trust Funds to refurbish buildings and other development • Promote the growth of the Sandoval Health Council • Expand communication opportunities: Revisit connection with Tribal radio stations to distribute information; develop flyers, news bulletins
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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 high acuity behavioral health service system into local care and crisis care services.

Table 2: Adult System Intercept 0: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Crisis Services	• UNMH Mobile/MI services for probation, parole, EMS, police; CIT trained officers; mobile response teams in emergency departments • 988 education and crisis awareness • SRMC Crisis Mobile Team (partial coverage) • Kewa Crisis Mobile Team (SAMHSA funded) • Laguna 24-hour crisis team • PMS has crisis services and crisis line in Cibola • Milan PD crisis team	• Limited crisis response capacity and training gaps • Mistrust of providers, EMS, and first responders in small/rural communities • No mobile crisis teams in Valencia and Cibola Counties • Limited hours or scope of existing crisis teams • Poor coordination between 988 and Tribes • Jurisdictional issues (Tribal, county, city) for crisis response and transport • Delays due to distance and staffing constraints	• Use traveling therapists and mobile crisis units to reduce access barriers • Expand crisis mobile teams (SRMC, Kewa and establish teams in Cibola and Valencia) • Improve coordination between 988 and Tribal governments • Develop satellite and cross jurisdictional crisis response sites • Expand social detox and living room models • Expand CIT and co-responder models across all counties • Build CCBHCs in Los Lunas and/or Grants with crisis beds

	• Sandoval EMS triage model (non-LE diversion) • Parole and Probation officers trained in CIT • Rio Rancho Police Department (RRPD) CIT with embedded UNM/SRMC clinician • Corrales and Bernalillo CIT teams • CIT training integrated into law enforcement academies (8-hour block) • Many Valencia County staff trained in CIT • San Felipe Tribal Officials receive annual MHFA training • Santo Domingo law enforcement trained in BH and de-escalation • Some Cibola police and NM State Police receive in house CIT training • Sandoval County/SRMC co-responder model responding to crises • Santo Domingo crisis teams coordinate with Tribal officials for safety • San Felipe Behavioral Health Program responds alongside officers • Domestic violence shelter in Valencia County • Haven House • Cibola hospital offers crisis services • Parole and Probation officers are trained in CIT (8 hours) in academy	• Lack of social detox and continuum detox services • No mobile crisis teams in Cibola County and many Tribal communities • Limited facilities in Valencia County for crisis stabilization • Mobile crisis teams are expensive, low volume, and difficult to staff • Medicaid billing limitations for mobile crisis services • Limited immediate access to higher levels of care or transport • No ACT programs in several counties • Weak coordination between 988 and 911 systems • Poor 911–988 handoffs and communication • Distance in counties makes crisis response difficult; staffing too • Lack of access to acute care for mobile crisis teams to refer to	• Expand hospital BH capacity and alternative response units in Valencia County • Develop social-service based or peer-led first responder models • Link EMS/paramedics directly to mobile crisis teams • Create satellite locations for mobile crisis response • Improve interoperability between 988 and 911; co-locate dispatch where possible • Educate communities on difference between 988 and 911 • Increase coordination between 988 and Tribal governments to increase access to 988 and crisis response • Consider how to brand services. When individuals are in crisis this is an opportunity to provide information about the full spectrum of services • Expand CCBHCs – Next levels of care that are centrally located (for Tribal and rural communities): Social Detox living room model • Utilize the UNM FOCUS model for whole family MAT services • Utilize the Shared Care Approach in rural communities to maximize utilization • Develop community centers for patients to connect with providers and be utilized for CHWs • Link telehealth and transportation services to reduce transportation issues • Consider implementing ABQ Community Safety Program which sends peers to crises rather than law enforcement
Family Support	• CYFD Family in Need of Services (FINS) and Family Services Division (early intervention) • Cibola County, family services	• CYFD Family Services Division didn't get fully funded and slow to get started	• Increase CYFD–BH coordination to prevent criminalization of families
Outpatient Mental Health	• Cibola General Hospital Behavioral Health program (med management, SBIRT)	• Severe shortage of licensed behavioral health providers and CPSWs	• Incentivize providers to work in rural/Tribal areas (housing, loan repayment, bonuses)

and/or Substance use	screening, community health workers, resource guides) • DWI Programs (Sandoval & Valencia Counties) with in-house treatment, IOPs, compliance education, Medicaid/indigent enrollment help • Valencia Medication Assisted Treatment (VMAT) • Narcan education, distribution, and vending machines (Sandoval Health Commons, HSC funding) • MHFA and QPR training for Tribal staff, law enforcement, first responders, CHRs, drivers, and community members • IOP programs: Heart and Soul of NM, Full Circle, Heron Solutions, Porchlight (developing) • Outpatient providers across counties: PMS, Meridian, Casa San Jose, Open Skies, GD Psych, Rasmussen Counseling, Team Builders, Serna Solutions, Ideal Options • MAT programs (Ideal Options, Meridian, DOH, Sandoval Health Commons) • Suboxone programs in Cibola County • Santo Domingo: IOP, outpatient, equine therapy, grant funded crisis team • San Felipe: CPSWs, equine therapy, specialized MH contractors, home visiting • Laguna, Acoma, Ramah Tribal outpatient BH and peer support programs • DOH public health offices (harm reduction, MAT, Narcan	• High provider turnover and difficulty recruiting in rural/Tribal areas • Lack of Spanish speaking providers • Housing shortages for providers, impacting recruitment • Credentialing barriers (MCOs, EHR systems, licensure) • Limited access to BH resources (wait lists, intake burden) • Lack of transportation from ER to services; to outpatient BH; lots of missed appointments • Affordability of services; need to find ways to cover rates not covered in IOPs • Acoma/Laguna with high waitlist for psych treatment - need for specialty clinics	• Support clinical supervision and reduce burnout • Increase awareness and use of NHSC and other repayment programs • Support CPSW expansion and reestablish CPSWs in EDs • Improve credentialing and licensing processes • Provide cultural training for providers on Tribes, sovereignty, and history • Expand Narcan access for families and community members • Increase harm reduction education and overdose prevention • Increase wellness activities reimbursed by MCOs (e.g., yoga, Zumba) • Increase day programming for PSR for the appropriate patient population • Remove red tape for licensing residential treatment, accessing insurance, DD waiver, credentialing for providers and service types, clinical licenses and other services • Support Porchlight IOP development in Valencia • Develop ways to cover rates not covered in all IOPs • Expand mobile units to meet higher levels of care • Reduce stigma among families to accept services
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	distribution, suicide prevention programs, nurse advice/text line) • Wellbriety programs (Laguna, San Felipe, NMSU Grants) • Narcan education and vending machines (Sandoval County) • AA / Al Anon groups • CPSWs and peer support through Tribes, MCOs, CYFD, and probation/parole • Sandoval Health Commons • PMS has walk-in services (including crises) in Rio Rancho, Cuba and Grants and afterhours hotline • Sandoval (Rio Rancho) – New Awakening		
Hospitals and Inpatient Care	• Cibola Hospital crisis services and behavioral health programming • Emergency Departments conducting crisis assessments and referrals • UNM Care Campus (out of region) for higher level services • DOH has residential treatment and detox facilities	• Limited specialty and acute psychiatric services; people sent out of state or incarcerated • Unstable environments for people returning from inpatient care	• Improved training for hospital staff on how to deliver SBIRT screening • Reestablish CPSWs in SRMC ED and fund CPSWs in all EDs • Build a hospital in Valencia County with an extension of BH capacity and alternative response units
Care Coordination & Policy	• MCO care coordination and peer support services	• Little to no aftercare following hospitalization or residential treatment • Lack of wraparound services (housing, follow up, recovery supports) • Fragmented systems and silos; poor data sharing • Clients experience repeat intakes; medication info not shared • Limited awareness of MCO care coordination services • Burdensome requirements to access care coordination • Affordability gaps in IOPs and outpatient care • Medicare gaps and copays that patients cannot afford	• Develop strong aftercare and recovery support programs • Improve care coordination outside of MCOs; delegate to CCBHCs and local agencies • Hire a regional services monitor for bed availability, policies, and referrals • Develop shared data systems and CQI processes • Streamline intake and reduce duplication • Develop MOUs/MOAs across Tribes, counties, hospitals, and BH providers • Create statewide general counsel to standardize MOUs/MOAs • Increase access to insurance for adults

		• Many uninsured adults lack assistance enrolling • MCO PMPM payments insufficient for non-engaged clients • Lack of EHR compatibility and support for Tribes • Limited coordination between BH systems, law enforcement, CYFD, and hospitals • Many people are uninsured and don't know how to sign up	• Develop mechanism for data sharing for grant proposals and accessing resources • Increase awareness of services that MCOs provide (Medicaid enrollment; access BH; Tribal liaisons) • Work with HCA to revise MCO policies/contracts to better fit needs to engage people into care coordination services, aftercare, and other services • Consider ways to provide care coordination outside of MCOs and have more outpatient agencies receive PMPM to provide care coordination locally • Improve/streamline MCO credentialing process, help smaller organizations with process
Other	• Project ECHO	• Limited recovery-oriented community supports • Criminalization of behavioral health issues • Lack of cultural understanding and training related to Tribal sovereignty • Annual turnover in Tribal leadership disrupts continuity and agreements • San Felipe: Jurisdiction issues of transport between Tribal, city, county	• Utilize Pueblo infrastructure for service delivery • Expand family-based MAT models (e.g., UNM FOCUS Model) • Use shared care approaches in rural settings • Reduce stigma among families and communities • Train local "train the trainer" cultural educators • Expand transitional housing tied to BH services • Fund housing supports that integrate BH education • Invest in transition centers (e.g., Santo Domingo Men's & Women's programs) • Orient and educate new Tribal leadership on BH resources and systems • Hire someone to monitor available services, open beds, polices, etc. to keep providers up to date • Increased health literacy • Create options to access verbal information on health services and agency policies (e.g., video files and in-person assistance)

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

Category	Resources	Gaps	Opportunities/Action Items
Diversion and Early Intervention	• RRPD diverts individuals to behavioral health response teams • Valencia County “Ax Team” provides assessment prior to arrest • Cibola Hospital evaluates individuals with BH concerns before criminal charges • EMS triage model in Sandoval County (non-law enforcement diversion) • Tribal sheriffs serve as first responders with diversion authority • Jemez traditional/customary practices emphasizing family accountability • Dual law enforcement systems (Tribal and western) used by many Pueblos • Motivational Interviewing (MI) training through SRMC • Law enforcement training provided by BH providers • State red flag laws allowing temporary firearm removal • NAMI SYSLE (Sharing Your Story with Law Enforcement) • Municipal League and International Association of Chiefs of Police leadership resources • Los Lunas law enforcement noted for effective crisis response • Jemez has victim advocate in LE to refer to BH and other services • BH providers can provide training at LE academy	• Individuals with BH needs are jailed due to lack of alternatives • Lack of diversion programs (e.g., LEAD) in most counties • Insufficient staffing to form functional mobile crisis teams • Law enforcement burnout related to frequent crisis response • Small and rural departments struggle to release staff for training • Lack of trauma informed care (TIC) and adverse childhood events (ACEs) training • Limited ACT programs • Inconsistent training across agencies and jurisdictions • Tribal law enforcement leadership turnover and understaffing • Tribal officials often lack jurisdiction to detain or assess BH needs • Complex jurisdictional issues between Tribal, county, state, and BIA authorities • BIA law enforcement not always available • Lack of cross deputization agreements • No dedicated caseworkers supporting diversion at intercept 1 • Criminalization of behavioral health crises • Difficulty meeting criteria for involuntary BH holds • Time intensive red flag law process • Inconsistency and lack of follow through on new LE–BH initiatives	• Expand MHFA, CIT, TIC, MI, and ACEs training (including in academies) • Train traditional sheriffs and tribal officials and officers in BH diversion • Develop curriculum supplementing academy training on BH, SMI, SUD, trauma, and culture • Develop local law enforcement pipeline from high school • Increase incentives for advanced training in crisis response for law enforcement • Establish wellness and debriefing plans for law enforcement (including cultural/spiritual supports) • Build BH workforce pipeline aligned with law enforcement needs • Ensure APCG supports consistent BH training standards across Tribal law enforcement • Create mechanisms for consistent, authentic engagement with law enforcement • Implement LEAD diversion programs in Tribal and rural communities • Consider peer-ed models (e.g., Albuquerque Community Safety Program) • Reduce reliance on incarceration for BH crises • Increase access to ACT-style outreach where absent • Mentorship for new Tribal leaders, especially for crisis response • Explore existing mentorship programs for LE • Develop MOUs across counties and Tribes to work across jurisdictions and coordinate limited services

	• Sandoval County has Assertive Community Treatment (ACT) that goes into the community to meet with people with SMI • Acoma Law enforcement is called for diversion intervention	• Certificate for Evaluation implementation needs to consider Tribal sovereignty • Lack of clarity on who assumes responsibility for individuals during transport • Lack of communication and coordination between 988 and 911 • Lack of intercept 1 services in Cibola County • Lack of Tribal LE participation in multidisciplinary teams • Some police departments are so small that it's hard to take officers off duty for training • Lack of training of law enforcement on BH response • Some Tribal responders have more power than others	• Increase buy-in or incentives for LE to get extra training for working with SMI, crisis response etc. • Increased collaboration between various law enforcement agencies—reduce competitiveness, poaching, share resources, etc. • Need authentic, consistent engagement with LE • Conduct state summit for LE and BH • Citizen's police academy • Look at policies to cross-deputize/commission law enforcement across all police (Tribal and non-Tribal) • Implement evidence-based practices for diversion
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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 4: Adult System Intercept 2: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Intake and Initial Process	• Pretrial services in Cibola County (1–4 service levels) • Good pretrial services in all three counties (county courts only) • Judges refer individuals to treatment based on risk/need • Courts help connect participants to Medicaid, education, and services • Some Tribal courts refer to BH through wellness courts • Pre-prosecution and 90-day program (Cibola County)	• Lack of providers for competency evaluations and competency restoration • Long wait times and complex competency evaluation processes • No District Attorney's Office in District 13 (contracted from Albuquerque, delaying cases) • Tribal courts largely lack: -Pretrial services -Clinicians conducting BH assessments • Pretrial timeframes vary greatly (2 days to months), limiting consistent service delivery • Many services are voluntary, reducing engagement	• Create early intervention and pretrial diversion pathways • Improve access to competency evaluations using telehealth • Increase quick access to counseling post arrest and pre adjudication • Develop pre adjudication housing with wraparound services (jobs, housing, treatment) • Revisit relationship between Sandoval County BH Coalition and police department re MH competency

		• Sandoval County BH Coalition was working with police department to create an easier process for MH evaluations- not sure where that is now • Dealing with civil competency issues; difficult to establish guardianship for family members in Tribes • Often when found incompetent, magistrate courts discharge and there's a revolving door • Challenge to get people placed in state MH hospital; lack of providers to treat to restore to competence • Lack of transportation to treatment, court, and other services • Transportation barriers for people diverted back to the community	
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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 5: Adult System Intercept 3: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Specialty Courts	• Sandoval County Mental Health Court (1 year program including stabilization, medication management, benefits, employment, and housing support) • Adult Treatment Courts in all three counties • Substance Use Treatment Courts and DWI Compliance Programs in all counties • Veterans Court (Los Lunas Magistrate Court) • Healing to Wellness Courts: Acoma, Laguna, San Felipe, Santa Ana • Santo Domingo traditional court • Ramah Peacemaking Court • Family Healing to Wellness Court (Acoma)	• Severe workforce shortages across treatment courts, jails, probation, and diversion programs • Need for consistent providers, especially in Sandoval • Lack of RTCs for Tribal judges to refer individuals • Jurisdiction and transport challenges when individuals move between court and community • Municipal and magistrate judges not required to have law degrees • Acoma Family Healing to Wellness has few participants and staff; also, transportation issues; It is too complex of a process to enroll them	• Implement evidence-based diversion practices across courts • Expand diversion programs in magistrate and municipal courts • Implement risk responsivity screening tools universally (courts and detention) • Increase BH workforce capacity for courts and detention referrals • BH challenges with violent crimes due to lack of access to the treatment court • Train judges, prosecutors, defense attorneys, and court staff on: -Behavioral health -Diversion -Rights to treatment • Increase law enforcement and public defender training on BH and civil rights • Build education pipelines (middle/high school) for legal, LE, and BH careers

	– youth focused but relevant to adults/ families) • Acoma developing a Family Treatment Court • San Felipe Court coordinates with providers and reduces punishment when treatment engagement occurs		• Expand culturally relevant services: -Sweat lodges -Talking circles -Drumming -Traditional healing • Increase understanding of Tribal needs to support county–Tribal collaboration • Strengthen Peacemaking and Wellness Court models • Increase CPSWs in courtrooms to engage individuals in services • Increase advocacy supports for victims and families • Improve family assistance navigating courts and collateral consequences • Implement virtual courts to address transportation barriers • Expand rural broadband and tele-behavioral health • Improve funding sustainability for Valencia and Santo Domingo programs • Collect longitudinal data to support reauthorization and funding • Implement treatment and family courts in Cibola County and increase BH workforce for referrals • Implement DAs and public defender's office in BHR 13
Treatment and/or Education while in Detention, Jails or Prisons (e.g., MOUD, MAT, other groups)	• IOP providers enter jails to build rapport and initiate treatment • CorrHealth provides medical and behavioral health screening in Sandoval County detention • In depth BH assessments if detention exceeds 14 days • Sandoval County DWI Program: -In house and contracted counselors -Mandated assessments and counseling -Contract with San Juan 28-day program (day treatment, cultural components, CRAFT for families)	• Grant-funded jail programs lack sustainability • Pushback on harm reduction among some providers due to limited training • Families unable to visit incarcerated loved ones due to distance • Rural challenges affect medication delivery • No adult detention facilities in Tribal communities • Limited or no BH services in some local jails • People detained far from home cannot receive local clinical services • Lack of MOUD and methadone treatment in jails and prisons • No RISE program available region-wide	• Increase MOUD and methadone availability in jails and prisons • Create regional mobile BH teams to serve detention facilities • Increase services in detention facilities and continuity of care upon release • Increase access to BH assessments (including competency) in custody • Expand RISE type programs region-wide • Increase transportation supports for families visiting incarcerated individuals • Reassess systems to improve medication delivery • Support IOP services inside and outside jail in Valencia County

	• Full Circle Recovery provides court contracted assessments and treatment (partnered with Heart & Soul) • Sandoval County Mill Levy funding supports jail -based BH services (subject to reauthorization) • OPRE provides peer support training for incarcerated individuals • Serna Solutions provides CRAFT • Valencia County - Succeed Program (13-week course for substance use and mental health) and RISE program (from Health Care Authority)– Provides housing vouchers, backpacks at release, clothing, resume building, case management, MAT, therapy, etc.; all grant-funded	• Privately run facilities may prioritize profit over County or court goals • Misdiagnosis due to lack of screening and assessment • Low mental health literacy among defendants • Limited family supports to navigate the legal system • Limited advocacy and services for victims and children of incarcerated parents • Challenges for defense attorneys to access clients in detention, especially MDC • Difficulty getting MCOs to go into jails and prisons and link people to services • Some MCO care coordinators do not take training for working in detention so cannot enter	• Improve funding sustainability for Valencia County and Santo Domingo services • Continue to collect data over the years to support for sustainability efforts
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6. Adult System Intercept 4: Community Re-Entry Services

Overview: Intercept 4 focuses on supported re-entry back into the community after jail or prison to reduce further justice involvement of people with behavioral health issues. 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 6: Adult System Intercept 4: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Community Re-entry services	• Valencia County Succeed & RISE Programs (grant-funded): -Housing vouchers -Clothing, food, backpacks at release -Resume building, case management • Outpatient and Intensive Outpatient Programs (IOP), including DBT and CBT • Medication for Opioid Use Disorder (MOUD/ MAT), including post release access	• Lack of transitional housing, reintegration centers, and family-focused services • Long waiting lists, limited bed space, land limitations, and landlord stigma • Restrictions on eligibility (e.g., must be sentenced) • Some Tribes restrict re-entry after incarceration • Poor communication between prisons/jails and Tribes about release and re-entry plans • Re-entry plans often not shared with Tribal communities • Court orders do not reliably result in treatment access	• Develop regional reintegration centers as hubs for services and resources • Expand women's and men's transitional housing, including: -Tiny homes -Mobile housing units -Refurbished motels or existing buildings • Create Intertribal and Tribal partnerships for transitional and second chance housing • Partner with Tribal housing authorities for re-entry housing • Expand forensic ACT teams and wraparound services

	supported by Department of Health • Nurse hotlines to schedule MOUD appointments after release • ACT (Assertive Community Treatment) services and need for forensic ACT • Desert Mountain Healing, New Mexico Solutions, and CCSS/CCBHC wraparound services • Moral Reconciliation Therapy (MRT) • CPSWs, including peer training in jails • Education for families about MAT/MOUD • Community Corrections Officers supporting re-entry in Valencia and Sandoval counties • Ankle monitoring as an alternative to incarceration • NM VINE for release notifications • Cibola Adult Treatment Court assistance with basic needs upon release • Just Health and managed care organization (MCO) programs linking people to services • Cultural accountability practices and Tribal justice approaches • Project ECHO (including CIT ECHO) • Transitional housing programs (men's and women's) • Tribal social services providing food, clothing, hygiene items • Some Pueblo-based men's and women's re-entry support groups • Equine-assisted therapy for women (San Felipe)	• Jurisdictional barriers between counties, Tribes, and state systems • Limited access to IOP and forensic ACT services • Unfunded or underfunded MAT/MOUD mandates in jails • Insurance/Medicaid activation delays upon release • Limited training for probation/parole officers on BH, SUD, DD, and cognitive disabilities • Background check requirements limiting use of peer support in jails • Limited engagement of families during incarceration • Lack of whole-family or intergenerational approaches • Historical trauma impacts (e.g., boarding school experiences) • Stigma and lack of behavioral health education in communities • Revocations driven by technical violations rather than new crimes • Employment barriers for justice-involved individuals • Transportation barriers after release • Federal grant restrictions that limit flexibility • Risk to victims when individuals do not follow through with programs • Need for FACT - Forensic Assertive Community Treatment – Multidisciplinary team of BH health professional and CPSW, team led by a prescribing doctor – Somewhat like a wraparound service	• Increase access to IOP, MAT/MOUD, and continuity of care pre-and post-release • Consider mobile detox units • Implement MRT more broadly • Improve coordinated release practices (meds, appointments, timing of release) • Expand training, certification, and employment of peer support workers • Use peers with lived experience in detention and re-entry settings • Mandate or strongly encourage family therapy during incarceration • Increase psychoeducation and behavioral health education for families • Shift focus from individual-only services to whole family and community approaches • Improve communication with Tribes regarding release and re-entry planning • Ensure Tribes receive advance notification and can prepare supports • Expand RISE and similar programs into more counties and Tribal communities • Strengthen intertribal collaboration for housing and re-entry services • Expand GED access and awareness across UNM campuses and Tribal education systems • Provide community education about re-entry • Increase job training and education before and after release • Promote second-chance employment and incentivize employers • Work with Tribal HR and leadership to reduce employment barriers • Increase access to transportation upon release (shuttles, transport hubs, coordinated rides) • Implement incentives-based supervision and graduated sanctions
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	• GED programs through colleges and Tribal education departments • DVR programs in Jemez, Acoma, and Laguna • WIOA employment benefits • Tribal ceremonies that support reintegration into the community • CorrHealth developing resource guide for re-entry • MH Court Aftercare program • NM Men's Recovery Program, 6-month program for men; Pavilions and Maya's place for women (6 and 12 month programs) • Acoma is developing reentry plan for people returning to the community • Heron Solution sober living		• Use data-driven supervision models focused on higher-risk individuals • Embed service providers in probation offices • Develop day reporting or community resource centers • Ensure MCOs are accountable for pre-release (90 day) care coordination and aftercare • Increase community education about re-entry and restorative/indigenous justice • Improve coordinated release (e.g., release with meds, appointment set up, practical hours of release) • Provide CCSS/CCBHC wraparound services
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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 7: Adult System Intercept 5: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Community Based Probation and parole	• Adult probation and parole specialized units (including sex offender parole programs)	• High probation/parole caseloads • Limited probation and parole services in Tribes	• Increase BH, SUD, DD, and cognitive disability training for probation/parole officers

Appendix A.6 Youth E-SIM: Resources, Gaps, and Action Items Identified Across Breakout Groups

On the second day of the workshop participants were divided into three breakout groups, with roughly equal representation from the seven stakeholder groups, to identify resources, gaps and opportunities at each intercept of the Youth E-SIM. 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 1: Youth System Pre-Intercept: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Community Centers & After-School Programs	- Afterschool, summer, sports, fitness, and wellness programming - Robotics, swimming, agriculture (4 H), and experiential learning programs - Valencia County We Can (VCAN) using rural community centers that have been underused; brings youth together, provides transportation, activities, food distribution, community gardens - Rio Rancho has SAFE before and after school programming for elementary schools - Cibola has programming for youth and families at Elk's Lodge - Valencia County Recreation Center		- Expand after school and extended hour programming for youth and families - Increase gathering places for youth like community centers, gyms, etc. - Expand VCAN activities to include activities outside of Valencia County - Promote non-profit status of Cibola Elks lodge to provide more services for youth and families - Utilize Valencia and Grants recreation centers to develop and host programs
School-Based Supports	- Head Start and Early Head Start programs, including language based and immersion programs - School embedded behavioral health providers, CPSWs, mental health counselors, and peer specialists - Prenatal care for first-time parents - Teen Health Centers in some high schools (e.g., Laguna/Acoma)	- Lack of school-based health centers across much of BHR 13 - Limited screening and early identification in schools, especially in Tribal communities - School counseling prioritizes academics over behavioral health - Limited advocacy capacity for students and families in school systems	- Expand school-based behavioral health and CPSW presence - Create wellness rooms and safe spaces within schools - Improve trauma-informed and culturally-responsive practices in school - Improve IEP/504 continuity and family-centered advocacy supports - Reintroduce and expand DWI and substance use prevention programs in schools

	• Community Health Workers (CHWs) delivering prevention and substance use education in schools • DWI and substance use prevention programs in schools (Health Rocks, DARE, DEA curriculum) • Social Emotional Learning (SEL) programs in schools • Native American Community Academy (NACA) charter school • Kewa does prevention presentation at schools • Sandoval County schools are more open to cultural wellness, trades and government structures; hire teachers from the community; speaking the language at school • H2 Academic program for truancy prevention • Valencia County school events—student presentations, high school bands, traditional dancers, drama • Cibola County: developing a survey/assessment of student needs and interests • Cibola: “I Love You Guys” training for teachers on mental health and suicide prevention	• IEP/504 plans do not consistently follow students who transfer schools • Bullying and school climate concerns • Misconceptions about school-based health centers among administrators and communities • Administrative turnover in schools prevents long-term continuity of services and supports • Engaging schools in taking part with student interest/need survey • Peer support networks in schools are lacking	• Increase access to SEL, MHFA, QPR, and suicide prevention training for educators • Use schools as hubs for youth engagement, leadership, and feedback • Increase presence of CPSWs and BH providers in schools to screen and refer to BH services • Ensure that schools have MOUs with BH programs to embed services in schools and ensure continuity • Develop school-based programs that use culture as a resource • Engage schools to participate in BH program development for students • Explore opportunities to increase success of SBHCs e.g., gain trust of administrators and community members by demystifying what SBHCs provide
Family & Parenting Supports	• Home visiting and prenatal programs for first time parents (e.g., San Felipe's Project AWARE and Project KEVA) • San Felipe Tribal Early Learning Initiative (TELI) coordinating early learning systems • San Felipe 0–3 Collaborative • FACE programs supporting parents and children learning together • Circle of Security and family-based programs	• Absence of teen parenting supports in many areas • Lack of CYFD mentoring programs and long wait lists in BHR 13 • Lack of parenting education: Parents do not know how to discipline, leaving youth to make decisions	• Develop parenting education and support programs for parents, young parents, and grandparents • Create more opportunities for families to participate together in programming

Youth Development & Vocational Supports	• Youth leadership programs (San Felipe's KYLI, Youth Councils, Leadership Institutes) • GED programs and dual credit/dual enrollment opportunities • Career enrichment, internships, work placements, and youth employment pipelines • Internship programs tied to health, victim services, and community programs • Santa Fe Indian School Leadership Institute • Valencia internship youth employment pipeline • UNM West Nursing program/Cuba: Saturday's dual credit program with high schoolers to engage in medical careers		• Expand GED, dual enrollment, and experiential learning opportunities • Increase career exposure and youth employment pipelines • Partner with organizations that already have trusted access to youth • Expand programming (e.g., help with employment) for young men in Acoma to foster independence and confidence • Develop regional youth coalitions for opportunities for ideas and feedback from youth • Use Tribal colleges to certify CHWs and CPSWs and other paraprofessionals
Mental Health & Substance Use	• Suicide prevention programs (San Felipe's KICKS, Yellow Ribbon, Project Venture, "Stop It," Red Ribbon Run) • San Felipe's Project AWARE mental health awareness and support school based program • QPR, MHFA, and similar prevention training courses • Valencia County boys and girls groups—vaping prevention; DARE program • DEA has a Discovery Education curriculum for substance use awareness and prevention; Has a specific Native American curriculum • Cibola General Hospital – suicide prevention and awareness	• Long waitlists for behavioral health, occupational therapy, physical therapy, and mentoring • Gaps in mental health and substance use services in some Tribal communities • Limited staffing, funding, and sustainability due to reliance on grants • Loss of key prevention programs (e.g., substance use education, juvenile community corrections) • Lack of awareness of available behavioral health resources for youth and families • Some leaders deny the substance abuse problems for youth in the community • Legalization of marijuana has created many challenges for youth; increased justice involvement; gateway to more substance use • Cibola County: lost substance misuse	• Expand evidence-based and cultural prevention programs (such as San Felipe's KICKS, Project Venture, Stop It) • Increase substance use prevention messaging tailored to youth and families • Conduct cross training between agencies and improve warm handoffs • Programs to help youth understand the realities of being in detention • Invest in BH stigma reduction campaigns

		education programming 2 years ago	
Housing & Basic Needs	• Summer lunch and food distribution programs • McKinney Vento supports for homeless youth • Youth shelter in Santo Domingo • Transportation supports such as shuttle systems (e.g., Grants) • Reception Assessment Center—helps families access clothes, food, etc. • Farmer's Market	• Transportation challenges to attend school, prevention, and enrichment programs • Limited broadband and internet access in rural areas	• Expand transportation options for youth (buses, transit systems, safe walking/biking routes) • Work with local bus companies and invest in transportation in rural areas to ensure better transportation to and from afterschool and summer programming • Improve broadband access to support telehealth, crisis services, and outreach • Utilize underused community buildings, recreation centers, and shared spaces
Other Community Resources	• Faith-based organizations providing counseling, prevention, and youth programming • Cultural systems of accountability and peacemaking programs • Culture-based education and language immersion programs • Cultural immersion, ancestral lands, land-based education, and traditional arts programs • Tribal traditional practices and intergenerational learning with elders • Farmers markets and community events that engage youth and families • Text-based communication systems used to share youth and family resources • Acoma—Ancestral lands program—schools, libraries—how to identify plants, seeds, land-based education, spiritual aspect of land; utilizing the hoop house, intergenerational planting • Unity Program—youth cultural exchange • Valencia Juvenile Justice Coordinating Council (JJCC) brings youth	• Community needs not always reflected in grant-driven programming decisions • Outreach methods not well matched to how youth and families actually access information • Limited youth motivation or buy-in for some programs • Juvenile Community Corrections (JCC) no longer in Cibola County; needs to be revived • Staffing and funding for programs; JJCC is grant funding • Programs are often deficit focused instead of strengths and health based; not always in touch with what the community actually wants or needs • Social media blasts and outreach aren't really being accessed • Housing development/ changes limit access to cultural teachings • Tribal communities need permission from leadership to formalize programming; cost-benefit analysis of current programs is lacking; lack	• Center cultural strengths, language, land-based learning, and elders' roles in programming • Reduce stigma through reframed behavioral health messaging and education campaigns • Increase community education about youth behavioral health and prevention resources • Conduct strategic planning for sustainability beyond grant cycles • Use data and evaluation to assess what programs are working • Share evaluation results with communities and leadership • Align funding strategies with community identified needs and cultural strengths • Create centralized, youth friendly ways to share information about services • Develop an evaluation process for implemented programs in Tribal communities • Expand BH messaging and programming to families and youth who need them most • Create a list of local resources that can translate documents and ensure that translators do not have to be certified • Tribes need to be the ones who certify their interpreters and

	together, outreach; broad involvement—warden, county managers, • JJ Advisory Council—brings stakeholders together; active in Jemez, Valencia County • Kewa has partnered to do a community health survey—interviewed 700+ households; shared results with community; #1 concern was substance use • Acoma: Community Health Office and Health & Recreation - Grants that help support traditional craft and cultural/linguistic building with youth to work with older family members	of data sharing, lack of coordination across communities • State documents that are translated into Spanish are not New Mexico Spanish, similarly Navajo translations are not accurate	translators to ensure cultural appropriateness
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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 behavioral health services, intensive outpatient programs, inpatient and residential services, crisis services, and a recovery system of care.

Table 2: Youth System Intercept 0: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Youth Crisis Services	• 988 crisis line (calls, chat, magnets distributed by EMS) • County and Tribal crisis lines and response teams (Laguna, PMS protocol line, Kewa CIRT, Health Care Authority numbers) • UNM SMRC youth crisis response • Flow charts and protocols for school responses to youth behavioral health crises • Santo Domingo youth shelter • Sandoval EMS hand out 988 magnets	• Limited or no mobile crisis teams (MCTs) in several counties • Long wait times for 988 responses in rural areas • Confusion between 988, protocol, and local crisis numbers • Lack of crisis response options for youth under the influence • No youth drop-in crisis centers • Low utilization of crisis services • Youth and families needing more parental and caregiver support during crises	• Expand and promote 988 use with targeted youth and family education • Clarify roles of 988, Pro-to-Call lines, and local crisis numbers • Develop mobile crisis teams in all counties and establish MOUs with Tribes or have Tribal MCTs • Create a regional crisis hub with localized response teams • Establish youth-inclusive crisis support or triage centers embedded in existing facilities • Develop youth drop-in centers and expand youth shelters statewide
Child & Family Support / Child Welfare	• Monthly psychoeducation nights for families	• Inadequate workforce capacity for family-	• Find ways to support youth who do not meet criteria for mandated reporting with CYFD

	- Juvenile Probation “Family in Need of Services” diversion and referral programs - Tribal communities have CHIN (Children in Need of Services) provides support for youth facing truancy, running away, or behavioral issues, often offering prevention and counseling to avoid juvenile justice involvement	centered meetings with fidelity	(e.g., when family is involved with police and youth are running away)
Hospitals & Inpatient Care	Emergency Departments (e.g., Cibola General Hospital) performing youth mental health and behavioral health assessments, safety planning, and referrals	- Limited inpatient, residential, detox, and RTC options for youth (especially girls) - Extremely limited crisis and residential capacity (e.g., only one youth bed serving multiple counties)	- Expand youth crisis, detox (inpatient and outpatient), residential, and RTC capacity—prioritizing girls’ RTCs - Include detox and inpatient youth services in new Valencia County hospital planning
Mental Health & Substance Use Services	- SRMC UNM outpatient clinic providing therapy, medication management, wraparound, and mobile outreach - CCSS, psychosocial rehabilitation, individual/family/group therapy, and medication management (PMS, Team Builders, private/group practices) - Multisystemic Therapy (MST) programs across counties - Youth and family peer support workers - Bloom Haven MST and early intervention programs - Behavioral Change Institute providing ABA for youth with neurodevelopmental disabilities - Community members serving as CPSWs and school supports (including language specific supports) - Regional outpatient and mobile BH providers serving youth across counties	- Long waitlists for outpatient BH and wraparound services - Shortage of licensed BH providers; recruitment and retention difficulties - Slow expansion of BH programs due to workforce pipeline issues - Limited supervision toward licensure in rural areas - Declining enrollment in BH educational programs - Same day walk-in services not available - Staff turnover disrupting continuity - Medication adherence challenges - Legal and clinical perspectives on treatment not aligned - Limited access to services in Native languages - Inaccurate or culturally inappropriate translations - Lack of specialized services (IOP, FFT, MST, partial hospitalization) - Shortage of licensed providers with crisis and youth specialization	- Increase outpatient, wraparound, detox, residential, and RTC capacity (with emphasis on girls’ RTCs) - Expand CCSS support for medication adherence and education - Improve continuity from crisis to outpatient care - Standardize and scale evidence-based programs across communities - Create directories of evidence-based practices and local BH services - Build youth to workforce pipelines (CHWs, CPSWs, case managers, RBTs, ABA, peer roles) - Increase access to supervision toward licensure in rural areas - Partner with colleges, universities, Tribal colleges, and satellite campuses for BH training - Increase access to IOP, FFT, MST, partial hospitalization, and high-fidelity wraparound (including for youth without Medicaid) - Increase mobile and community based behavioral health services

	• San Felipe's partnership with UNM to develop programs and place BH trainees in the community • San Felipe outpatient BH services	• Insufficient specialized staff to address youth in crisis • Fewer students are enrolling in social work and other BH fields • Bottleneck in certification of family and peer support workers • Sandoval County does not have specialized youth and family outpatient BH • Limited ABA services and they only serve people with Medicaid • Telehealth is not a great solution for all youth because it is hard to connect via telehealth and youth do not always sign on	• Support internships, flexible schedules, tuition assistance, and incentives for rural service • Incentivize providers to work in rural and Tribal communities • Establish and certify youth and family peer support credentialing pathways • State could model programming similar to SAMHSA AWARE model which places BH in schools • Provide funding to understand impact of ACEs; understand long-term impact of trauma • Ensure specialized services for Asian American and Pacific Islander, LGBTQ and other youth who have limited access to resources
School Health Centers & Systems	• San Felipe Project AWARE program embedding clinical teams, BH providers, CPSWs, and peer specialists in schools • School-based screening, safety planning, and discharge planning through Project AWARE • School-based telehealth counseling services • Tribal liaisons embedded in schools • School-based health centers (Valencia County, San Felipe, Cuba) • Alternative and specialized schools (e.g., Century High, Independence High with supports for teen parents) • Tribal partnerships in schools to support culturally-responsive BH services • Ramah-Navajo BIE schools have McKinney-Vento to assist youth who are homeless • Baca Community school has grandparents who serve as supports in school	• Inconsistent school-based health center availability • Lack of student resource officers and coordination with CYFD in some schools • Barriers to providing contracted services in schools (credentialing, background checks) • Remote learning leads to significant isolation	• Increase collaboration between SRMC CCBHC (including mobile outreach) and schools • Develop strategies to streamline credentialing for contracted or MOU BH providers to work in schools • Build off of the Jemez Valley schools and Waltowa Charter School model and develop similar programs in other Tribal schools

Care Coordination & Policy	No resources noted	- Fragmentation and silos across counties, Tribes, schools, and agencies - Poor continuity of services due to school administrative turnover - Data sharing, evaluation, and feedback loops are limited or underutilized - Private insurance does not cover all Medicaid available services - Limited MOUs between counties and Tribes - Jurisdictional complexity across Tribal, county, and state systems - Communication gaps between BH agencies, schools, juvenile justice, and communities - Not enough youth-focused services like wraparound - Data sharing limitations between Tribes, schools, and juvenile justice	- Strengthen collaboration between BH providers, mobile outreach teams, and schools - Streamline credentialing and MOUs for contracted providers in schools - Improve care navigation and multilingual supports for families - Coordinate implementation of Yazzie Martinez across BIE, counties, and Tribes - Improve cross-agency communication and data sharing - Build regional quality assurance and evaluation processes - Use data to guide funding, sustainability, and program scaling - Designate a regional entity to manage and communicate BH resource information - Maintain accurate, culturally relevant translations and locally certified interpreters - Train the APCG on the need and process for intergovernmental agreements between the state and Tribes
Other / Overarching Themes	Telehealth access points hosted onsite in Tribal communities	- Lack of standards for youth transitional housing - Continued impacts of COVID (isolation, DV, disengagement from in person services)	- Establish regional or county taskforces to assess youth behavioral health and justice needs - Tie BHRHA and other funding sources to workforce training and system improvements - Finalize and implement Yazzie-Martinez - Tribes need to enact their own laws to implement Yazzie-Martinez - Increase access to multilingual navigational support for educating families about current resources

3. Youth System Intercept 1: Initial Contact with Children, Youth and Families Department (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 3: Youth System Intercept 1: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Law Enforcement & SROs	• Law enforcement interactions that allow for diversion instead of formal charges • Police reports triggering access to juvenile justice resources • Police transporting youth to ERs or behavioral health providers during crises • School Resource Officers (SROs) in many high schools (capacity varies by county)	• Stigma, fear, and hesitance related to police • Inconsistent notification and referral practices by SROs and law enforcement • Disparities between schools, juvenile probation, Tribes, and CYFD • Requirement of a police report before juvenile justice can intervene • Lack of coordination and shared understanding across Tribal, state, and county systems • Jurisdictional complexity and difficulties formalizing intergovernmental agreements (IGAs) • Limited SROs in public and Tribal schools • SROs in the schools or officers in the schools do not notify entities who can divert, instead youth is referred back to the parents with limited access to services	• Increase cross training between behavioral health staff and law enforcement (jurisdiction, ICWA/IFPA, trauma informed response, de-escalation) • Use telehealth to extend provider availability during law enforcement encounters when appropriate • Fund and expand SRO positions with clear diversion and referral roles • Develop resources and training for SROs and officers to connect youth to services instead of defaulting to parental return with no treatment • Improve coordination between schools, juvenile probation, CYFD, and Tribes • Support development and implementation of intergovernmental agreements (IGAs) between Tribes and the state • Provide training to state and regional leaders on the IGA process and importance • Increase training across systems on ICWA, IFPA, culturally competent care, LGBTQ youth needs, and trauma informed practices
CYFD Initial Contact	• ICWA and IFPA mandated notification timelines ensuring Tribes are informed of youth involvement in protective systems • CYFD Office of Tribal Affairs partnerships, funding, and convening support • Dedicated Tribal points of contact and liaisons for CYFD coordination • CYFD JPOs, FINS have Tribal collaboration approach to immediately contact Tribes when a Native youth gets involved in the system • Kewa has a point person to work with CYFD	• Gaps in communication between state and Tribes, especially in foster care placements • Lack of culturally-relevant providers knowledgeable in ICWA and IFPA • Insufficient support for parents with youth in protective custody • Foster care workforce shortages and lack of families willing to provide treatment foster care • Kinship foster families receive less financial support than non-kin placements • Inconsistent foster parent training and enforcement of best practices	• Develop programs specifically supporting families with youth involved in juvenile justice or child welfare • Increase navigator roles to help families access behavioral health services and navigate legal systems • Expand foster parent recruitment, training, and public awareness campaigns • Increase support and equitable funding for kinship foster care placements • Reinstitute and operationalize intergovernmental agreements (IGAs) between Tribes and CYFD • Facilitate IGAs through the state Tribal Liaison Office

		• Stigma for CYFD involvement • CYFD often lack information about Tribal law or where Native youth are receiving services	• Create mechanisms for joint Tribal–state jurisdiction and co-heard cases • Develop services that keep Tribal youth in their home communities • Work with CYFD to increase follow-up and accountability with families and caregivers • Improve collaboration between CYFD and Tribes
School Police & Threat Assessment	• Student support centers in schools, including learning labs for detention		
Diversion & Early Intervention	• Valencia Juvenile Justice Coordinating Council (JJCC) and Juvenile Justice Advisory Committees • Pre-prosecution and diversion programs for youth • Tribal courts and officials engaging in diversion and systems of care approaches • CYFD Juvenile Justice Services (JJS) and Family in Need of Services (FINS) programs providing informal, voluntary, and diversion focused responses • Tribal CHINS (Children in Need of Services) programs addressing truancy, running away, and behavioral concerns to avoid deeper justice involvement • Collaboration between law enforcement, probation, and CYFD with opt-in diversion pathways • Reception Assessment Center (RAC) in Valencia and Sandoval Counties (H2 Academic) • Juvenile Detention Alternative Initiative (JDAI) focusing on reducing detention through alternatives	• Transportation limitations for diversion, treatment, and discharge from higher levels of care • Youth remaining hospitalized longer than clinically necessary due to no safe discharge options • Youth receiving higher levels of care than needed—or falling through gaps—due to lack of alternatives • Lack of diversion programs in Tribal communities	• Invest in youth prevention and diversion programs to reduce justice involvement • Develop programs that help youth understand the real-world impacts of detention • Create formal agreements and MOUs between law enforcement, schools, Tribes, and behavioral health providers • Develop clear referral pathways for diversion opportunities at first contact with law enforcement • Expand peer support services for non-crisis diversion situations • Expand transportation options, including same day and discharge transportation • Review and adjust transportation regulations to reduce access barriers • Expand diversion programs that include behavioral health referrals • Rebuild and strengthen Juvenile Justice Advisory Committees • Place SROs in all high schools with a clear diversion and referral role • Youth social detox—inpatient and outpatient; central facility that is accessible to the Tribes; all the Tribes contribute

	- Juvenile Justice Coordinating Councils and advisory structures (though some need rebuilding) - Community-based diversion programs linked to behavioral health services - H2 Academics “one stop shop” model offering: Wraparound, groups, boys’ and girls’ circles, respite and food and clothing drives		
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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 4: Youth System Intercept 2: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Juvenile Justice Intake & Initial Processing	- Consent decrees and pre-agreement decrees allowing dismissal if youth comply and avoid further trouble - Pre-prosecution and 90-day program to avoid court (Cibola County) - Juvenile Detention Alternative Initiatives (JDAI) focus on reducing recidivism by providing therapeutic interventions prior to incarceration	- Lack of competency evaluators and treatment placements - Providers are overworked and cannot be assigned to every case - Limited clinician capacity to support high volume juvenile cases - JDAI is not currently working due to recent increase in juvenile offenses that results in CYFD using more automatic holds - Juvenile community corrections – Cibola County is at risk of losing funding	- Include Tribal affiliation on arrest records and court forms to improve coordination - Develop strategies to reduce the delay in getting youth BH evaluations completed in a timely manner

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 mental health needs when imposing sanctions. The goal of these programs is to divert youth from detention and commitment.

Table 5: Youth System Intercept 3: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Courts	- Juvenile treatment courts in Valencia, Sandoval, and Cibola Counties - Cibola Youth Drug Court with: -Pre prosecution track requiring treatment compliance -Prosecution track with probation supervision and higher levels of care if needed - Navajo Nation Peace Making Program - Tribal Healing-to-Wellness courts - Tribal involvement in diversion and alternative court processes	- No youth courts in Sandoval County - Teen Courts eliminated in Valencia County and limited statewide - Contradictions between Tribal courts, traditional systems, and state juvenile systems - Intergovernmental agreements (IGAs) between Tribes and the state not functioning as designed - Lack of transportation for youth and families to attend court and visitation - Families not consistently engaged or involved throughout the process - Courts sometimes recommend services that do not exist locally	- Rebuild Teen Courts in Valencia County and expand youth courts statewide - Improve transportation access for court appearances, detention visits, and services - Improve education for courts on what services are realistically available in each county - Increase quality oversight of programs to reduce competition and system fragmentation - Consider implementing evidence-based models such as the Bernalillo County Young Adult inpatient program - Merge Cibola County juvenile treatment court with Laguna and Acoma - Develop mechanism for Tribal-state joint jurisdiction where Tribal and county judges hear cases together for joint disposition
Detention & Commitment	- Juvenile commitments to state facilities (YDC in Albuquerque, John Paul Taylor in Las Cruces) - High fidelity wraparound services available in some communities and detention settings - Comprehensive behavioral health assessments in detention (e.g., Meridian) - Parenting classes, basic needs support, and transportation provided through juvenile justice councils - Traditional and cultural practices supporting youth accountability and healing - Detention facilities have case	- Lack of Residential Treatment Centers (RTCs) for youth—especially for females - Native youth often sent out of state due to lack of in-state or local options - Limited or no MST, FFT, DBT, experiential, or somatic therapy providers - Tribal youth denied access to state or county facilities without IGAs - BIA oversight can place youth in detention or treatment without hearings or due process - Tribes not always notified when youth are detained - Lack of care coordination when youth lose Medicaid eligibility in detention - No payment mechanisms for assessments or wraparound once Medicaid is suspended	- Create RTCs for youth, with a strong emphasis on in-state facilities for girls - Explore reopening or funding facilities such as the New Sunrise Facility - Examine ACEs and trauma impacts among justice-involved youth - Provide traditional and cultural services to Native youth in detention and RTCs - Increase number of clinicians serving juvenile detention centers - Expand hours of services to allow family participation - Bridge western clinical services with traditional and cultural practices - Use BHRIA or other funding to cover service gaps when youth lose Medicaid in detention - Collect and analyze CYFD data on youth who lose coverage while detained - Reinstitute and/or implement intergovernmental agreements between all Tribes and CYFD

	management and navigation • JPOs meet with youth 3 months prior to release • Youth are put back on Medicaid 30 days prior to release and reconnected with MCOs		for youth evaluation and detention (CYFD Tribal Liaison could facilitate) • Increase access to transportation for families to visit youth in detention centers • Consider Bernalillo County Young Adult Program 45-day inpatient program • Explore with federal government why the New Sunrise Facility is not in operation or funded
Programs for guardianship/kinship	• Jemez Family Gatherings supporting wraparound and family engagement • Cibola JCC - Provide parenting classes for families with a justice-involved youth, transport, basic needs	• Limited family support services, especially culturally-responsive ones	• Expand family support services such as: -Family success coaches -Parent support groups -Family navigators • Increase involvement of parents throughout the juvenile justice process

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

Overview: Intercept 4 involves supported re-entry 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 6: Youth System Intercept 4: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Community Re-Entry Services	• Individual, family, and group therapy services • CCSS supports, including housing, employment, and educational assistance • Behavioral health clinics providing medication management, group sessions, navigators, and case management • Team Builders outpatient and supportive services • Licensed clinical social workers embedded in some schools • Youth placed back on Medicaid prior to release and reconnected with MCOs • Youth Development Inc. (YDI) educational and reentry programming	• Lack of transitional housing for youth who cannot safely return home • Youth are sometimes not allowed back into school upon return, leading to system hopping • Lack of continuity between detention, behavioral health, schools, and community services • Schools lack staffing and capacity to supervise and support returning youth • Limited referrals from schools to JPOs, treatment courts, or diversion programs • FERPA and other data sharing restrictions limit coordination	• Develop transitional housing options for youth who cannot return to an unsafe home • Develop standardized reentry assessments and designate responsible staff • Create liaison roles bridging detention, behavioral health, schools, and CYFD • Establish MOUs between detention facilities and schools to support smooth school reentry • Improve continuity of care from detention through reintegration • Advocate for stronger follow through and accountability within CYFD • Develop and expand intergovernmental agreements (IGAs) to formalize Tribal-state collaboration on reentry and discharge planning

	• CYFD coordination to restart or continue services upon release, including school reentry and follow up • Release to family homes or reintegration centers • Juvenile treatment courts statewide (limited availability locally) • Sandoval County Juvenile Community Corrections assists with housing and reentry supports • GED programs for youth unable to return to traditional schools • School-based and community-based educational referrals • Laguna Connections and similar workforce programs (WIOA like) • National Guard Youth Challenge Academy (5-month residential education, training, and leadership program) • Vocational and job readiness supports through community programs • Transitional housing options in Rio Rancho • Safe Homes in Jemez • Potential emergency housing pods connected to Tribal behavioral health clinics	• Youth returning to unsafe, unsupportive, or substance involved family environments • Lack of parental involvement or parents contributing to harmful behaviors • Return to same peer groups and environments that contributed to justice involvement • Limited kinship and foster supports in Tribal communities • Lack of mentors for youth exiting detention or residential treatment • Cultural and linguistic barriers between school staff and families • Limited recognition of neglect and emotional abuse by mandated reporters • Tribal behavioral health provider burnout • Limited understanding of rural challenges, including transportation burdens • Bureaucratic obstacles and Medicaid enrollment/red tape limiting provider participation • No female specific youth reintegration centers • Tribes lack formal reentry programs and are often excluded from discharge planning • No consistent sharing of reentry plans, especially with Tribes • Challenges serving youth aging out of CYFD eligibility • Growth of online learning increases isolation and reduces positive interpersonal engagement • Reduction or loss of grant funded prevention initiatives	• Use Tribal State Judicial Consortium and APCG to advance shared reentry planning • Develop Tribal clinical liaison roles to connect Tribes with inpatient BH and juvenile justice systems • Increase education on Children's Code and Tribal specific legal processes • Provide parenting education and support for parents, teen parents, and grandparents raising grandchildren • Create kinship care supports in Tribal communities • Facilitate peer mentoring using youth who have successfully navigated reentry • Increase opportunities for parent-to-parent support (e.g., PTAs, support groups) • Incorporate youth and family voice into service design and regional planning • Integrate behavioral health more deeply into child welfare programming • Expand high fidelity wraparound services for repeat offenders and high acuity youth • Increase access to experiential services (e.g., art, music, theater, land -based activities) • Expand family counseling, potentially making it mandatory in select cases • Provide training for providers, schools, and communities on welcoming and supporting returning youth • Expand transitional housing and group homes, including options for female youth • Support development of YDI and other youth transitional living services • Develop vocational pipelines and education to employment pathways • Increase job training and educational opportunities for reintegrating youth
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			• Create monitored community spaces to support online learning and reduce isolation • Train coaches, mentors, and community members as positive adult supports • Increase awareness and utilization of existing programs (e.g., JCCs, treatment courts, FINS) • Create centralized, youth friendly reentry resource websites and toolkits
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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 7: Youth System Intercept 5: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Juvenile Community Corrections	• Juvenile Community Corrections programs available in Sandoval, Valencia, and Cibola Counties • Some Tribes have Juvenile Probation Officers (JPOs)	• Juvenile probation officers not trained in Tribal codes or laws • JPOs underpaid and overburdened • Limited response capacity from some Juvenile Community Corrections programs	• Provide training for JPOs on Tribal laws, codes, and practices • Create pathways for Tribal JPOs to participate in state CYFD training

Appendix A.7 Region Specific Medicaid Snapshot Data

Highlights from the Region's Medicaid Snapshot Data

Data presented during the workshop includes all available Medicaid utilization data for the counties located within this region. The Medicaid data includes American Indian/Tribal individuals accessing services at public health facilities, private providers, as well as Indian Health Service agencies or Tribal 638 facilities. The data is not broken down (disaggregated) by Tribe or tribal affiliation. It is at the Tribe's discretion to request Medicaid data for their respective facilities and programs that fall within the service area and tribal boundaries of each Tribe. We respect Tribal sovereignty, including Tribal data sovereignty, therefore the data presented here is Medicaid data by county/state, not by Tribe.

Demographics

- BHR 13 has a similar proportion of Non-Hispanic White (36.28%) individuals compared to the state (36.53%).
- The Hispanic population is lower in BHR 13 (45.21%) vs. statewide (48.15%).
- The Non-Hispanic Black population is similar in BHR 13 (1.78%) compared to the state (1.81%).
- 12.2% of BHR 13 is American Indian and Alaskan Native, much higher than the state (8.6%).
- Age distribution: BHR 13 has 77.49% adults (18+), similar to the state (77.94%). BHR 13 has similar youth (<18) population (22.51%) vs. the state (22.51%).

Behavioral Health Diagnosis

- **Under 18:**
 - For youth under age 18, anxiety disorder is the most common diagnosis, with rates similar to the state average (BHR 13: 51.1%, NM: 50.6%).
 - All other diagnoses appear at rates similar to state averages.
- **18+:**
 - For adults over age 18, anxiety disorder remains the highest diagnosis with rates lower than the state average (BHR 13: 55.4%, NM: 59.6%)
 - All other diagnoses appear at rates similar to state averages.

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

Diagnoses	% BHR13	% State
Anxiety Disorder	51.1%	50.6%
Attention Deficit Disorders	25.4%	26.0%
Mood Disorders	20.2%	21.9%
Developmental Disorders	10.6%	11.7%
Conduct Disorders	9.8%	10.1%
Intentional Self Harm & Suicidal Ideation	6.6%	7.1%
Cannabis Use Disorder	5.5%	4.6%
Emotional Disorders Childhood Onset	5.3%	3.2%
Psychotic Disorder	2.5%	5.3%
Impulse Disorders	2.0%	1.5%

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

Diagnoses	% BHR13	% State
Anxiety Disorder	55.4%	59.6%
Mood Disorder	35.4%	37.1%
Alcohol Use Disorder	16.6%	17.9%

Opioid Use Disorder	11.0%	12.7%
Stimulant Use Disorder	8.1%	10.7%
Cannabis Use Disorder	7.6%	8.3%
Psychotic Disorder	6.0%	7.9%
Attention Deficit Disorders	5.9%	6.8%
Intentional Self Harm & Suicidal Ideation	4.3%	5.3%
Hallucinogen/Inhalant/Other SUD	3.9%	5.8%

Service Utilization

- Outpatient services are the most utilized service in BHR 13, similar to the state as a whole (BHR 13: 87.2%, NM: 86.8%).
- Crisis services are utilized slightly less in BHR 13 (20.6%) compared to across the state (23.8%).
- Intensive outpatient utilization is slightly lower compared to across the state (BHR 13: 6.8%, NM: 7.2%).
- Residential and Inpatient Service utilization is lower compared to the state (BHR 13: 3.4%, NM: 4.9%).

Provider Utilization

- Utilization of Behavioral Health Prescribers is lower in BHR 13 (12.3%) compared to NM (14.7%).
- Utilization of psychotherapy practitioners is lower compared to the state (BHR 13: 3.6%, NM: 5.4%).
- Utilization of substance use specialists is similar (BHR 13: 0.7%, NM: 0.7%) compared to the state.

Crisis Calls & ER Utilization

- Crisis call rates slightly decreased from 2023 to 2024 in BHR 13:
 - BHR 12: 0.83% → 0.81%
- ER visit rates for behavioral health conditions are slightly lower in BHR 13 as compared to the state (BHR 12: 16.6%, NM: 18.8%).

Behavioral Region 13 vs The State of New Mexico

Examining behavioral health disorder diagnoses, and utilization of services, facilities and infrastructure in Behavioral Region 13 compared to the state of New Mexico.

County in Behavioral Region 13: Cibola, Sandoval, Valencia

Objective

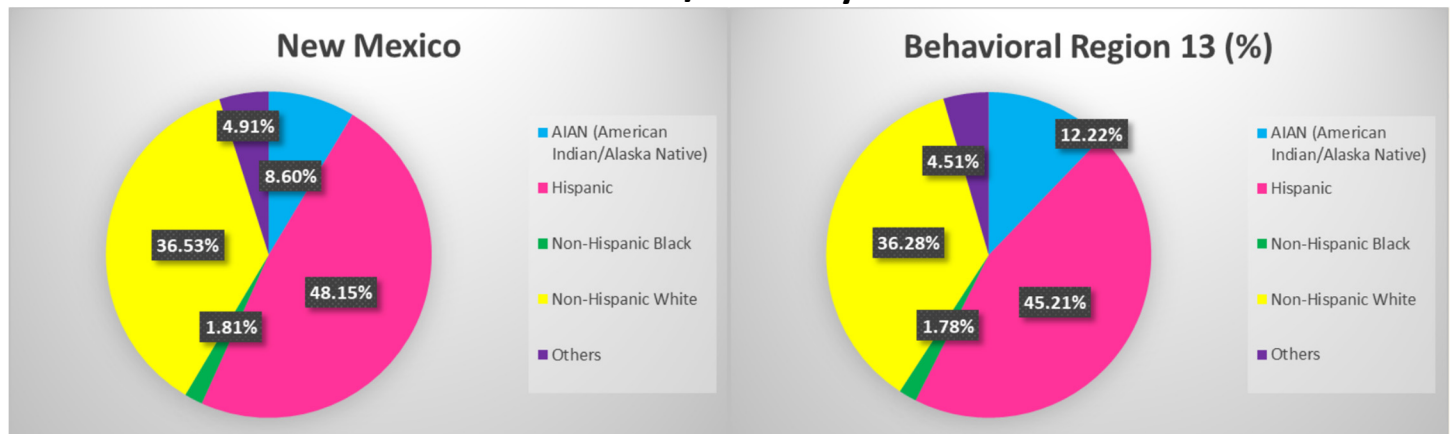
To compare Behavioral Region 13 (Cibola, Sandoval, Valencia) with the state on below characteristics

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

Demographic Comparison

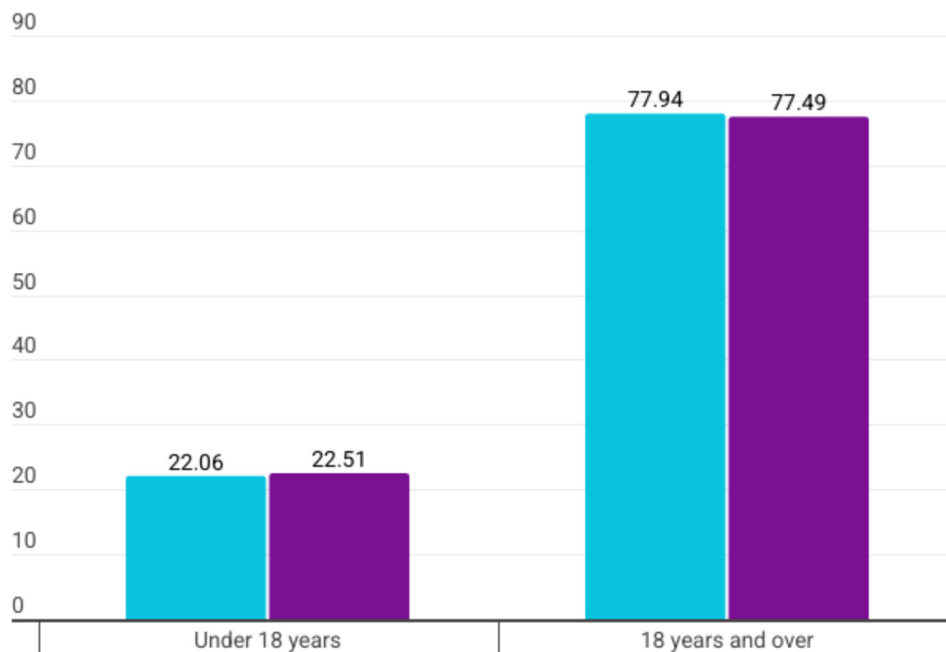
Key demographic factors reveal significant regional variations

Race/Ethnicity



Age Distribution – New Mexico vs. Behavioral Region 13

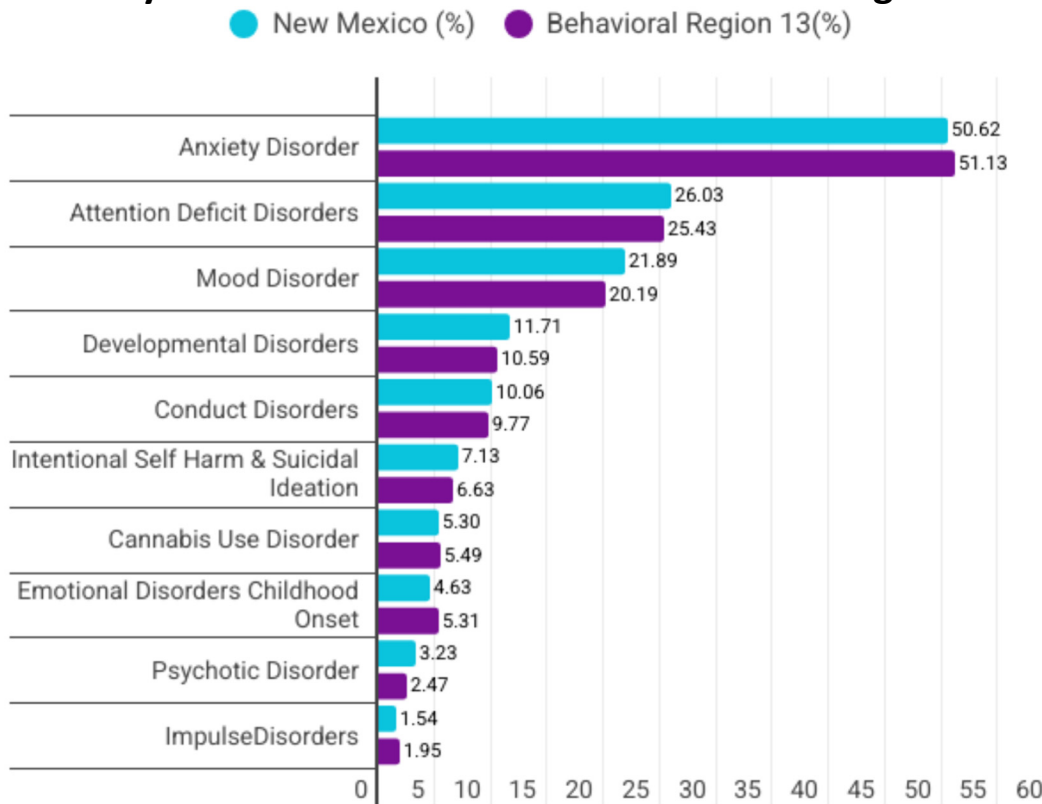
● New Mexico (%) ● Behavioral Region 13 (%)



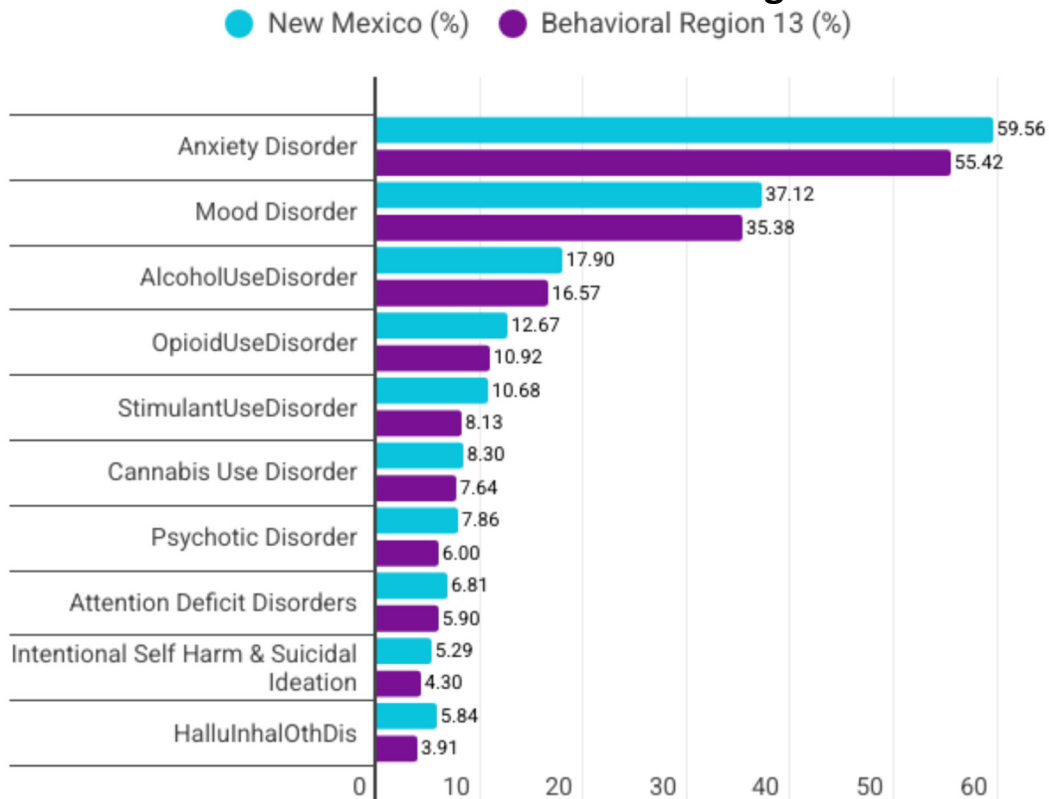
Top 10 behavioral health disorder diagnosis by age group

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

<18-year-olds – New Mexico vs. Behavioral Region 13



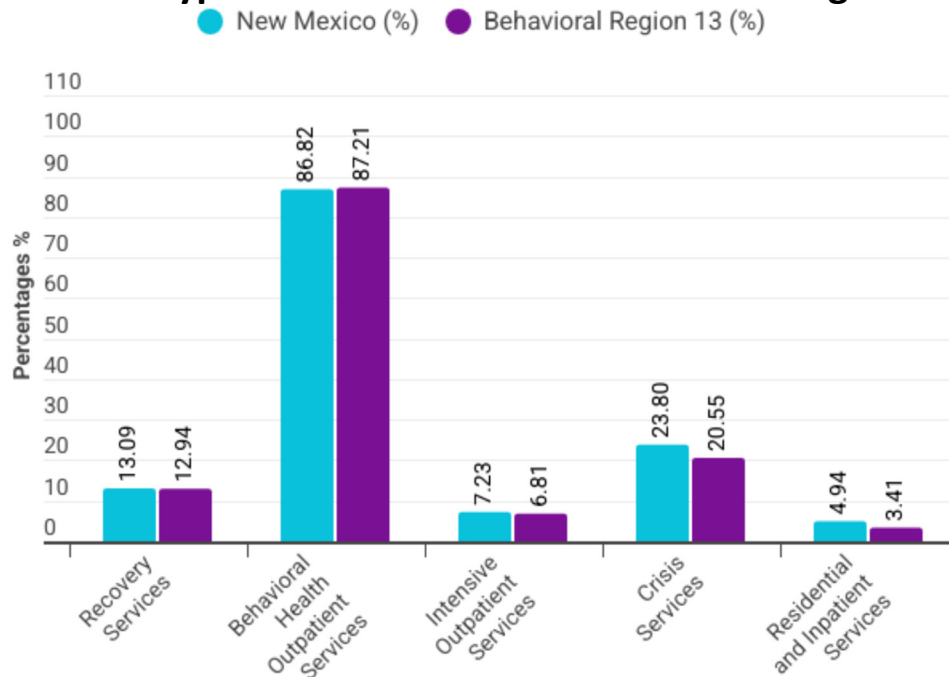
18+ New Mexico vs Behavioral Region 13



Service Utilization

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

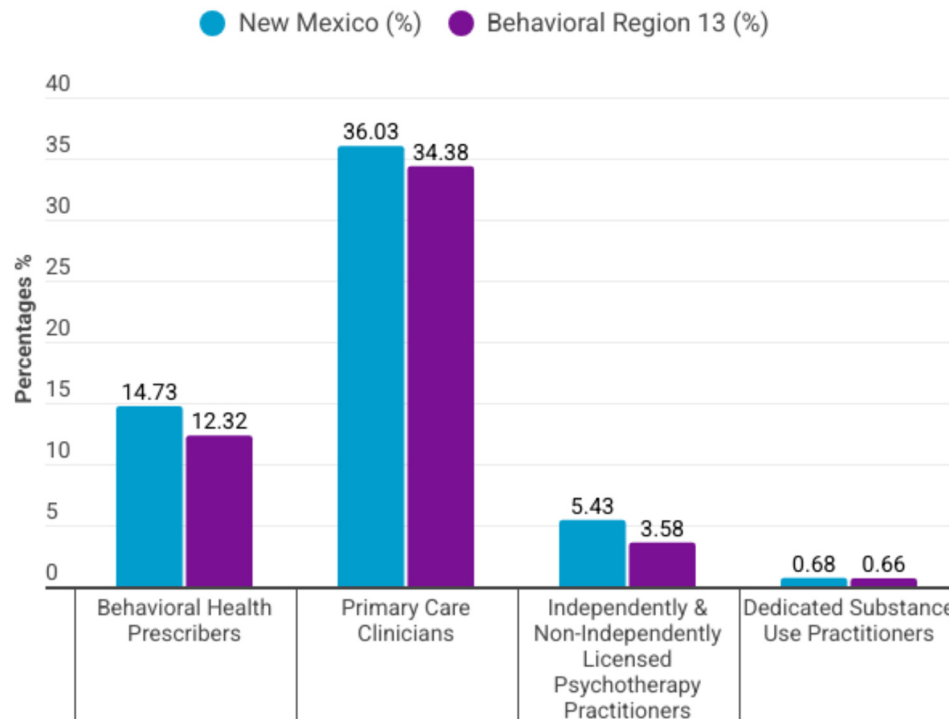
Service Types – New Mexico vs. Behavioral Region 13



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.

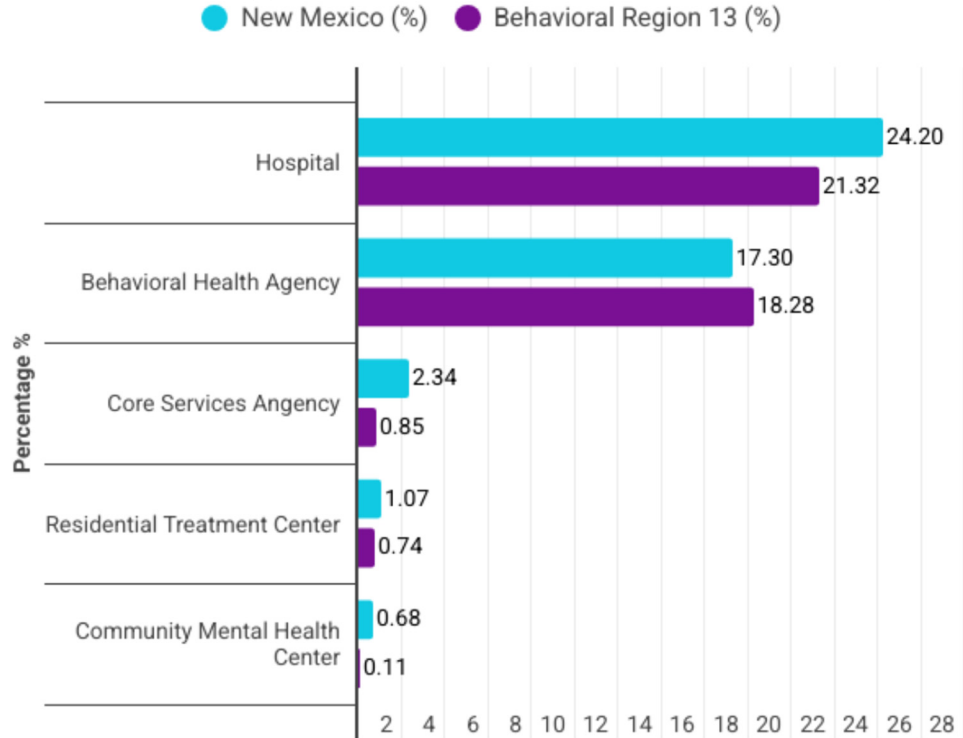
Individuals on Medicaid are more likely to have at least one contact with a prescriber than with a therapist in a calendar year.



Infrastructure Utilization

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

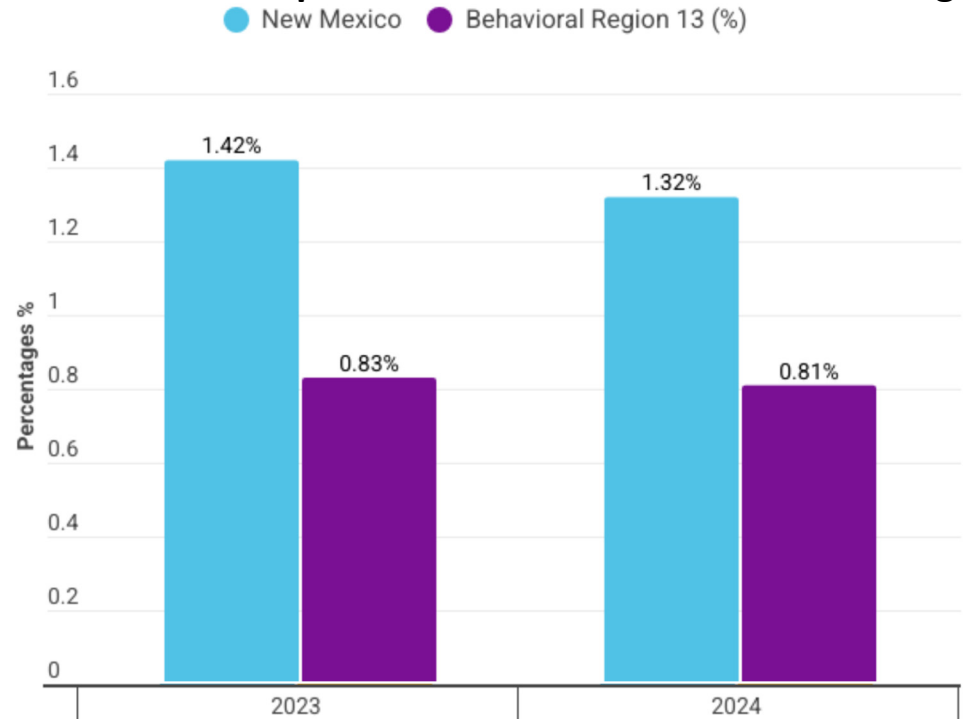
Infrastructure Type – New Mexico vs. Behavioral Region 13



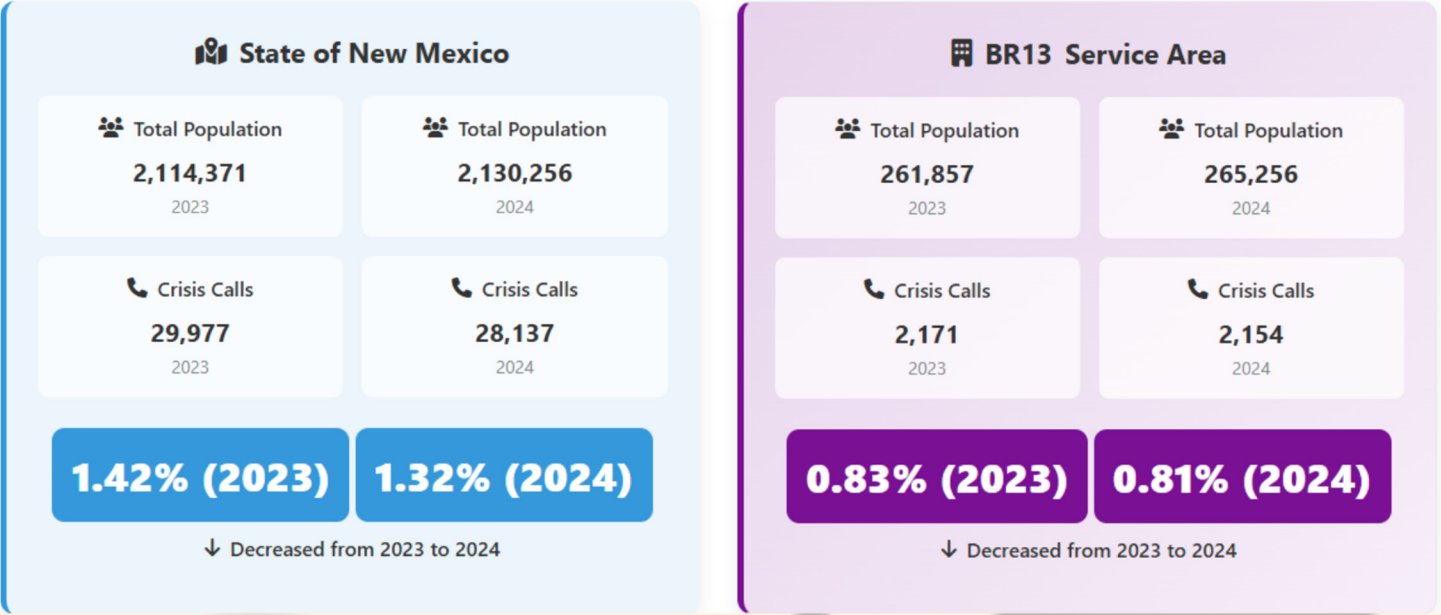
Crisis Call per Capita

Percentage of population who made a crisis call.

Crisis Call Rate Per Capita – New Mexico vs. Behavioral Region 13

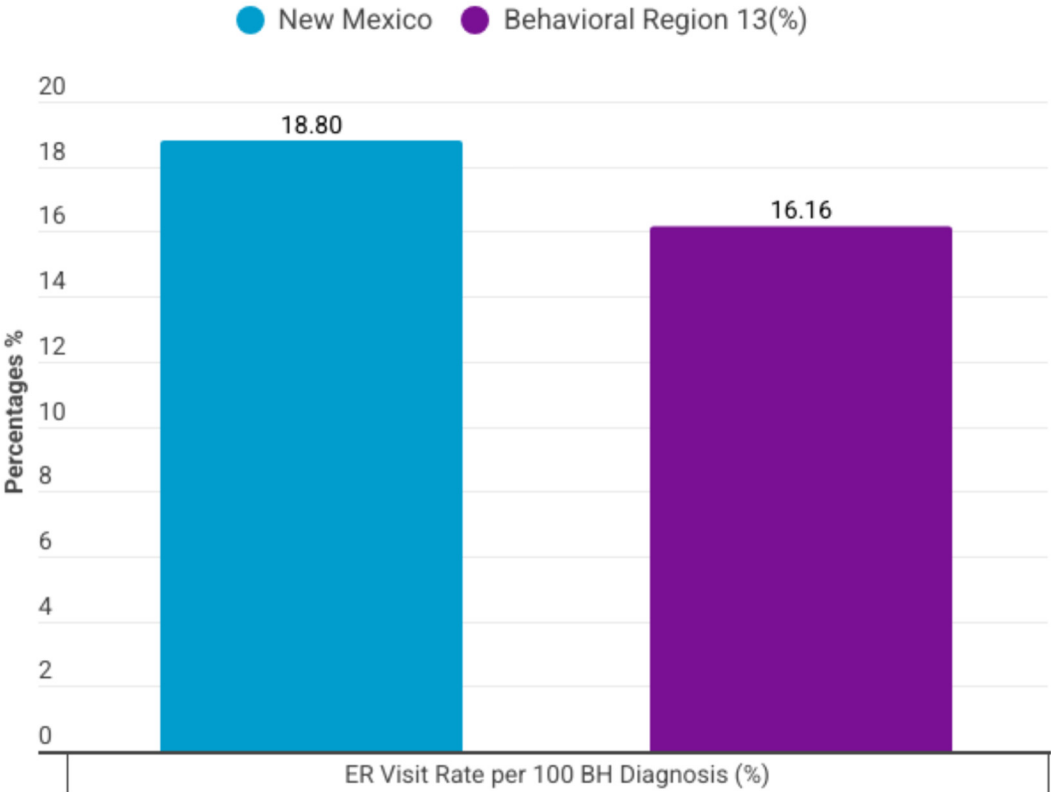


Crisis Call per Capita (cont.)



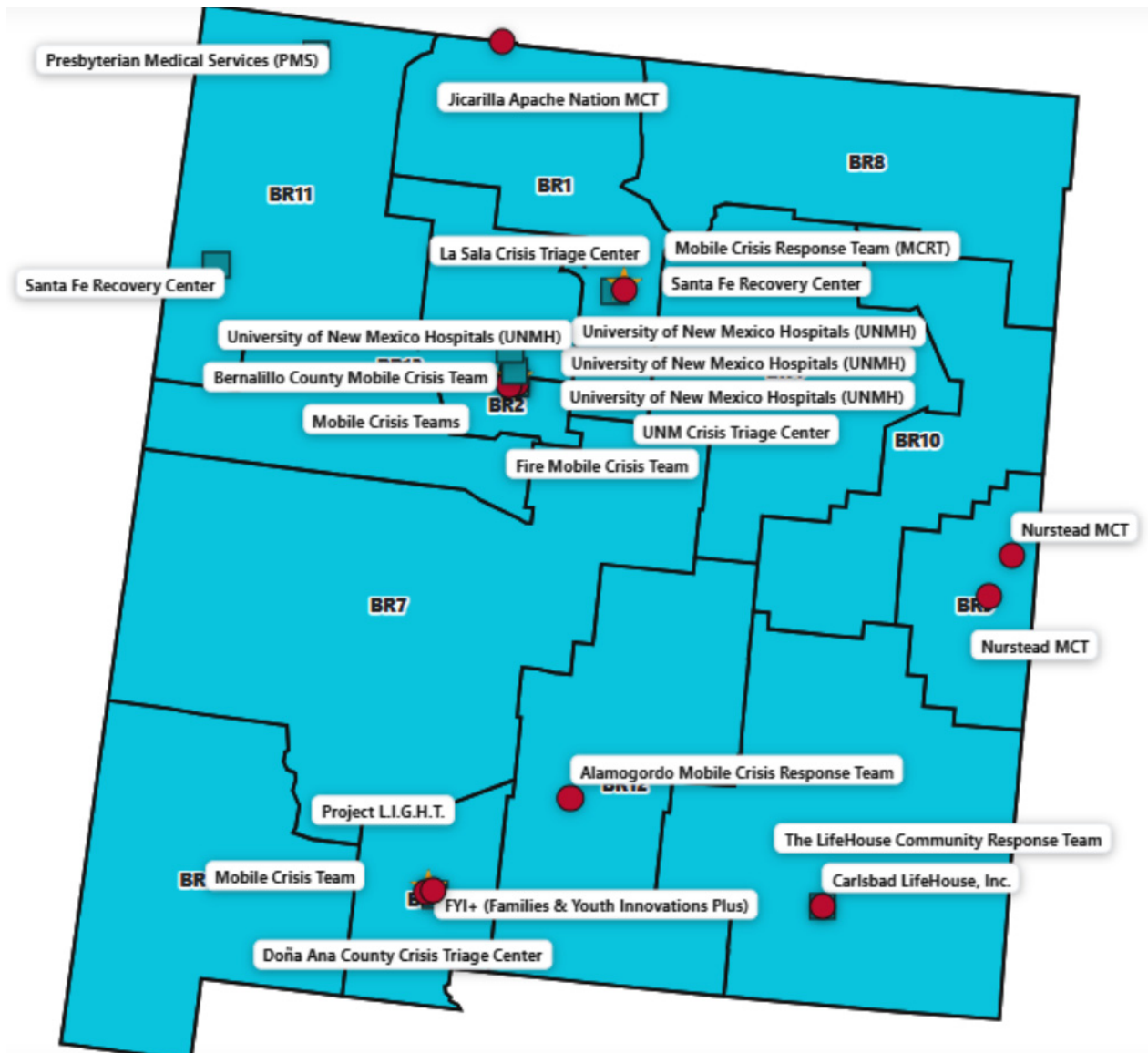
Emergency Room Utilization

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	87401	CCBHC
Santa Fe Recovery Center	McKinley	BR11	2028 E Aztec Ave, Gallup	87301	CCBHC
Santa Fe Recovery Center	Santa Fe	BR1	2504 Camino Entrada, Santa Fe	87507	CCBHC
La Sala Crisis Triage Center	Santa Fe	BR1	2052 Galisteo St, Santa Fe	87505	Crisis Triage Center
Mobile Crisis Response Team (MCRT)	Santa Fe	BR1	2052 Galisteo St, Santa Fe	87505	Mobile Crisis Team
UNM Hospital	Bernalillo	BR2	2600 Yale Blvd NE, Albuquerque	87106	CCBHC
UNM Hospital	Bernalillo	BR2	1031 Lambertson Pl NE, Albuquerque	87107	CCBHC
UNM Hospital	Bernalillo	BR2	2600 Marble Ave NE, Albuquerque	87106	CCBHC
UNM Crisis Triage Center	Bernalillo	BR2	2600 Marble Ave NE, Albuquerque	87106	Crisis Triage Center
Mobile Crisis Teams	Bernalillo	BR2	1210 San Mateo Blvd SE, Albuquerque	87108	Mobile Crisis Team

Bernalillo County Mobile Crisis Team	Bernalillo	BR2	415 Silver Ave SW, Albuquerque	87102	Mobile Crisis Team
Fire Mobile Crisis Team	Bernalillo	BR2	6840 2nd St NW Ste 301, Albuquerque	87107	Mobile Crisis Team
FYI+ (Families & Youth Innovations Plus)	Dona Ana	BR3	1320 S Solano Dr, Las Cruces	88001	CCBHC
Dona Ana County Crisis Triage Center	Dona Ana	BR3	1850 B Copper Loop, Las Cruces	88005	Crisis Triage Center
Mobile Crisis Team	Dona Ana	BR3	845 N Motel Blvd, Las Cruces	88005	Mobile Crisis Team
Project L.I.G.H.T.	Dona Ana	BR3	201 E Picacho Ave, Las Cruces	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, Rio Rancho	87144	CCBHC
Nurstead MCT	Roosevelt	BR9	604 E 2nd Street, Portales	88130	Mobile Crisis Team
Nurstead MCT	Curry	BR9	300 Commerce Way, Clovis	88101	Mobile Crisis Team
Alamogordo Mobile Crisis Response Team	Otero	BR12	700 Virginia Ave, Alamogordo	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	690 Mundo Rd, Dulce	87528	Mobile Crisis Team

Behavioral Region 13



● Mobile Crisis Team
 ■ CCBHC
 ★ Crisis Triage Center

Name	County	BR	Address	Zip Code	Type
University of New Mexico Hospitals (UNMH)	Sandoval	BR13	3200 Broadmoor Blvd NE	87144	CCBHC

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 (BR13)	
	Beneficiary N=217,656	%	Beneficiary N=24,152	%
Recovery Services	28,500	13.09%	3,126	12.94%
PSW	4,707	2.16%	258	1.07%
CCSS	20,270	9.31%	2,419	10.02%
PSR	362	0.17%	9	0.04%
CSW	7,215	3.31%	675	2.79%
FSW	155	0.07%	10	0.04%
CHW	0	0.00%	0	0.00%
BMS	1,113	0.51%	213	0.88%
BT	2,044	0.94%	204	0.84%
BHOP Services	188,968	86.82%	21,062	87.21%
BH Workforce	106,765	49.05%	10,839	44.88%
BH-Prescribers	32,061	14.73%	2,976	12.32%
Psychiatrist	10,700	4.92%	1,280	5.30%
PsyNursePract	20,228	9.29%	1,583	6.55%
PrescPsychologist	2,704	1.24%	277	1.15%
PrimaryCare	78,429	36.03%	8,303	34.38%
Independently and Non-Independently Licensed Psychotherapy Practitioners	11,814	5.43%	864	3.58%
Psychologist	861	0.40%	69	0.29%
LCSWLISW	4,824	2.22%	293	1.21%
LPCC	4,506	2.07%	341	1.41%
LPAT	27	0.01%	6	0.02%
LMFT	482	0.22%	53	0.22%
LMSW	1,225	0.56%	92	0.38%
LMHC	1,533	0.70%	145	0.60%
LAMFT	48	0.02%	3	0.01%
Dedicated Substance Use Practitioners	1,480	0.68%	160	0.66%
LADAC	629	0.29%	83	0.34%
LSAA	882	0.41%	80	0.33%
CADAC	0	0.00%	0	0.00%
Intensive Outpatient Services	15,741	7.23%	1,645	6.81%
IOP	12,049	5.54%	1,211	5.01%
PartialHosp	1,051	0.48%	12	0.05%
ACT	1,555	0.71%	313	1.30%
MST	1,455	0.67%	141	0.58%
FFT	11	0.01%	0	0.00%
HEDIS	1,073	0.49%	13	0.05%
Crisis Services	51,804	23.80%	4,964	20.55%
ED	41,094	18.88%	3,932	16.28%
UrgentCare	21,369	9.82%	2,093	8.67%
MobileCrisis CTC	1,854	0.85%	130	0.54%
Crisis Intervention	1,476	0.68%	127	0.53%

New Mexico Mortality Rates

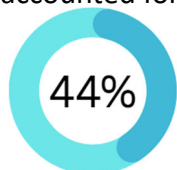
Examining Suicide Deaths, Alcohol-Related Deaths, and Drug Overdose Deaths in the state of New Mexico

Overview

Overall Crisis

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

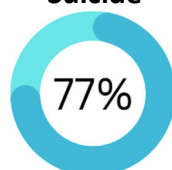
In 2021, these causes accounted for



of all deaths among residents aged 12–34

Rates far exceed national averages:

Suicide



higher than U.S. average

Drug-induced deaths:



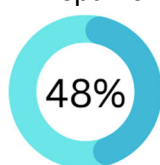
Demographics & Geography



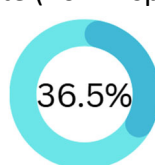
Population: 2.1 million

Race/Ethnicity:

Hispanic



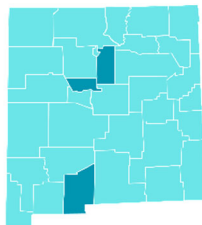
White (non-Hispanic)



Native American



Urban concentration:



50% of residents live in

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

(6% of land area)

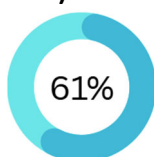
Rural/frontier context:



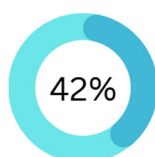
25 of 33 counties have <15 people per square mile, limiting access to care

Comorbidity of Mental Health and Substance Use

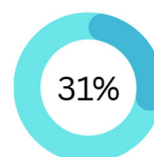
Youth (Grades 9–12):



report mental health concerns

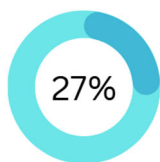


use ≥1 substance

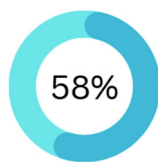


have both (co-occurring mental health + substance use disorder)

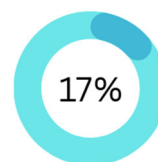
Adults:



report mental health concerns

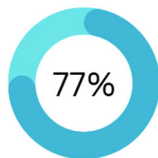


use ≥1 substance



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



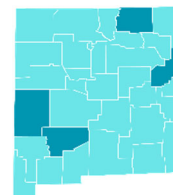
Substance use costs New Mexico about \$890 million annually (as of 2007)



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>

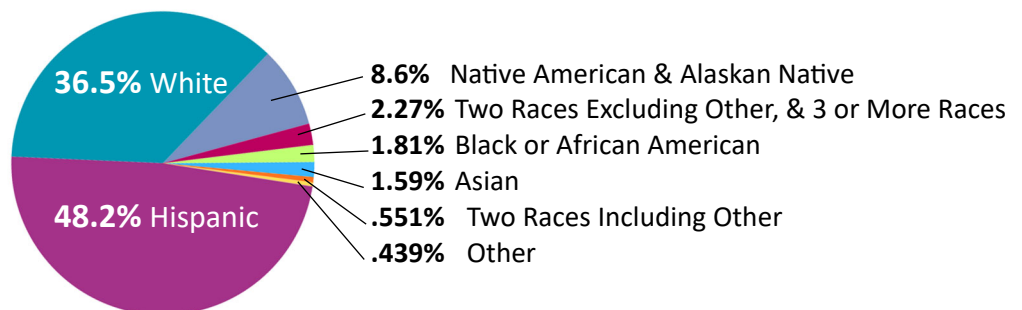
Population

Source: U.S. Census

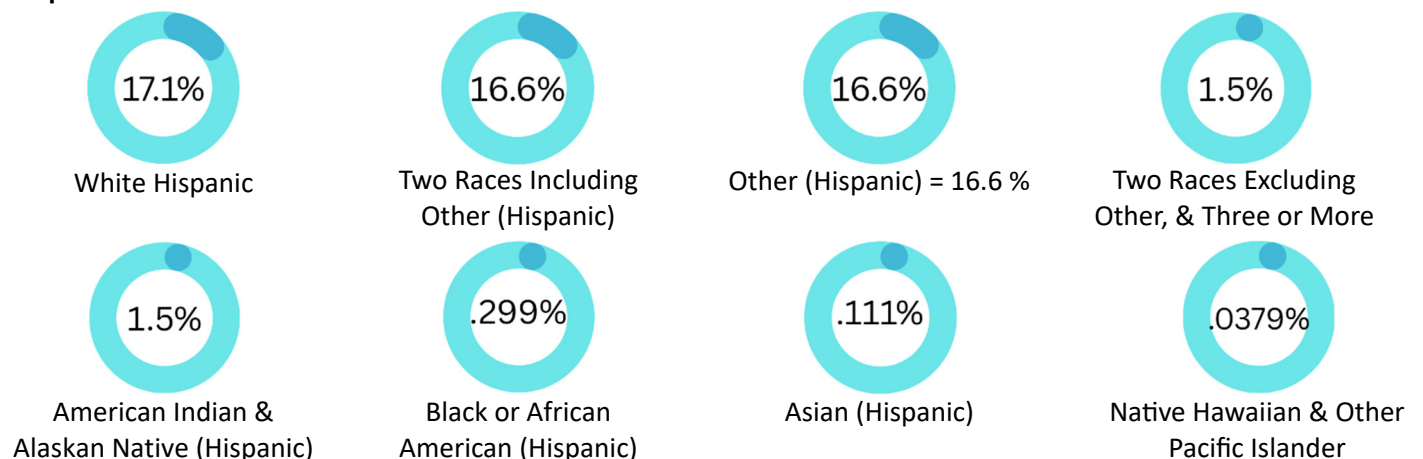


Population: 2,117,522

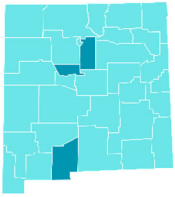
Race/Ethnicity



Hispanic breakdown:



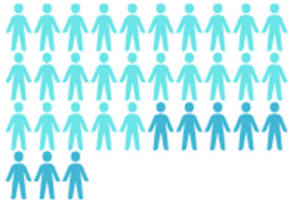
Rural/Frontier



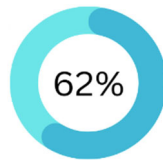
50% of residents live in

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

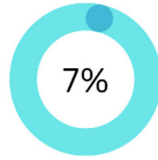
These 3 counties make up only 6% of the state's total land area



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

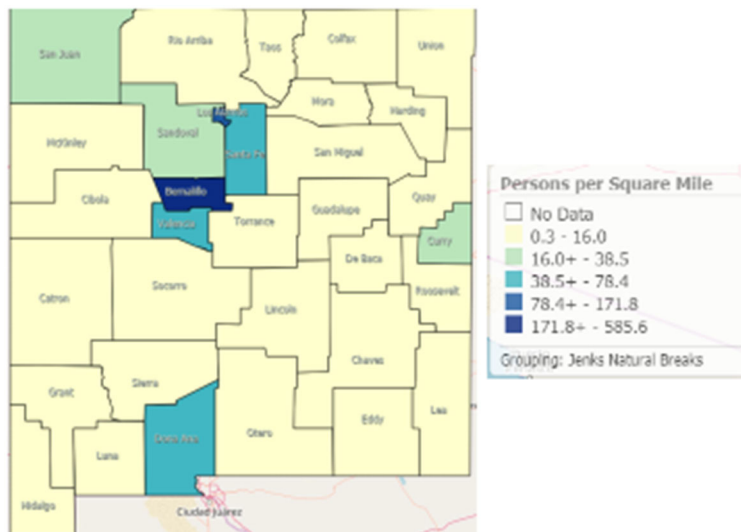


of the population resides in seven urban counties (including Bernalillo County, home to one-third of the state's residents)



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

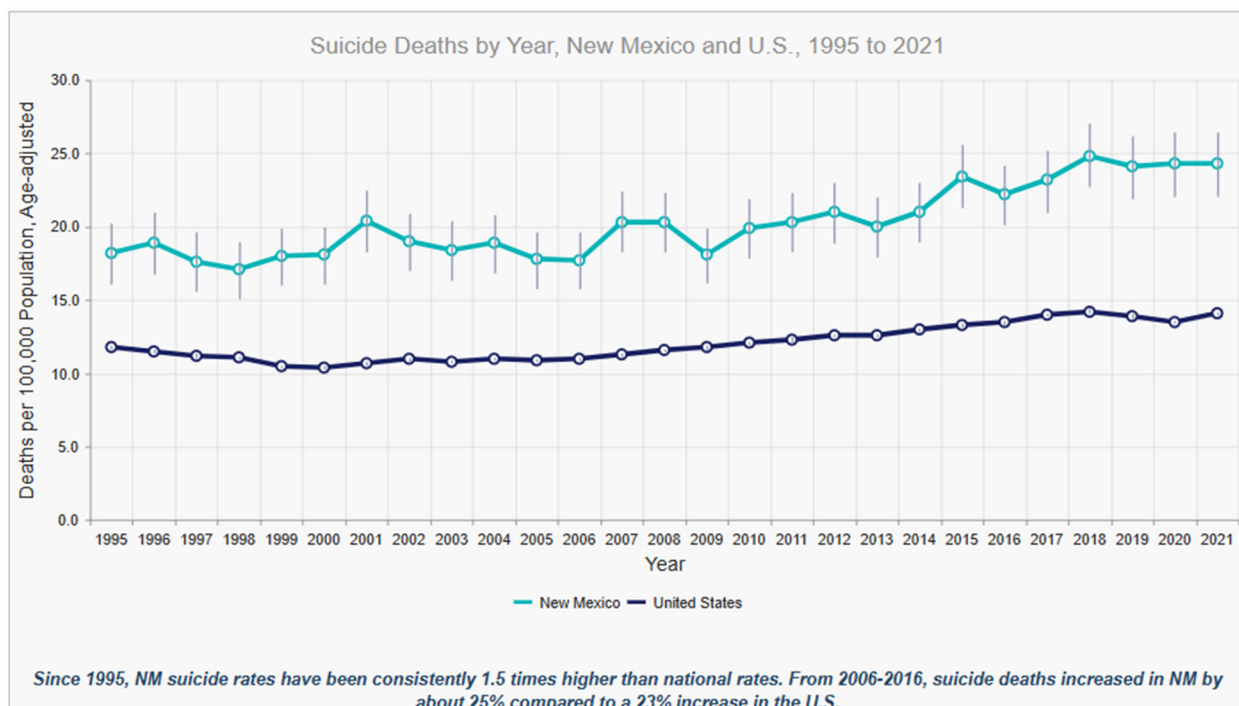
Source: New Mexico's Health Indicator Data & Statistics - <https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html>

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

Suicide & Self-Injury Related Deaths

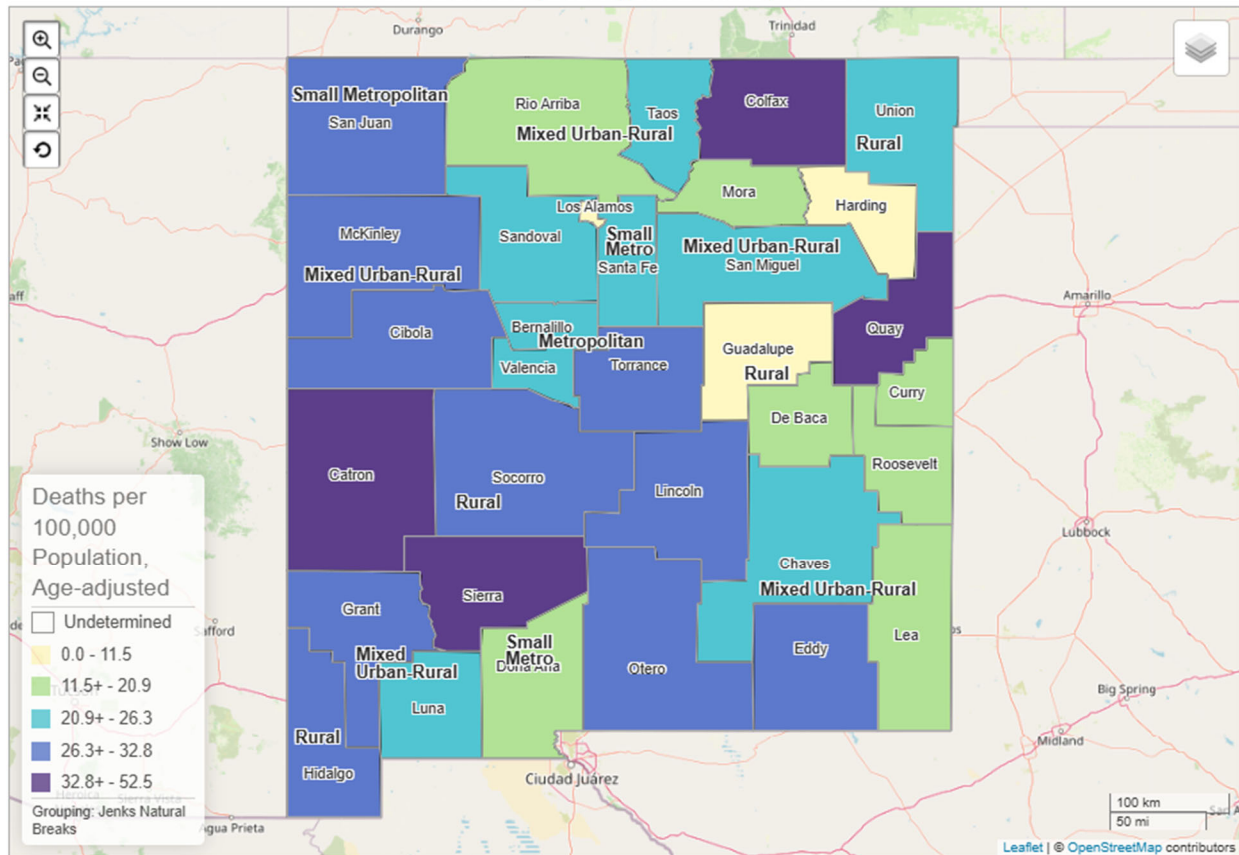
- Suicidal behaviors are a major public health concern and a leading cause of morbidity and mortality in New Mexico.
- In 2018:
 - Suicide was the 9th leading cause of death overall in New Mexico.
 - It was the 2nd leading cause of death among individuals aged 5–34 years.
 - It was the 4th leading cause 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



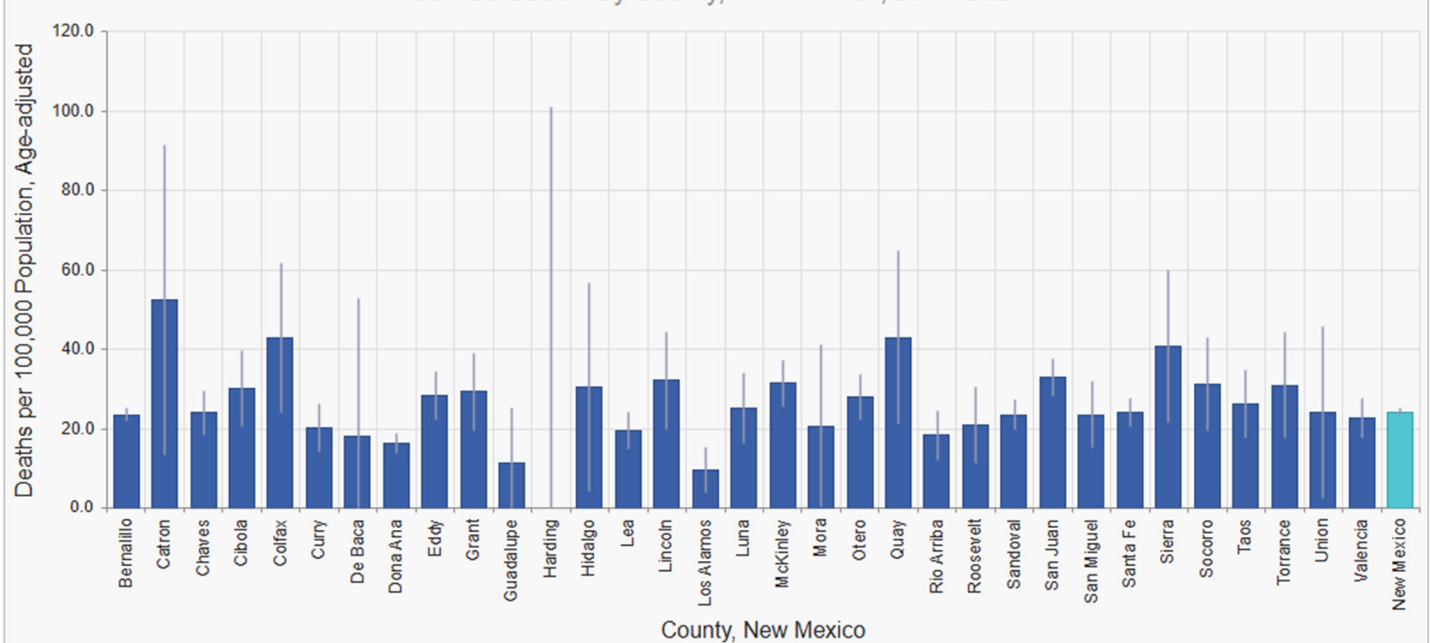
Suicide Deaths by Year, by County, NM

Suicide Deaths by County, New Mexico, 2017-2021



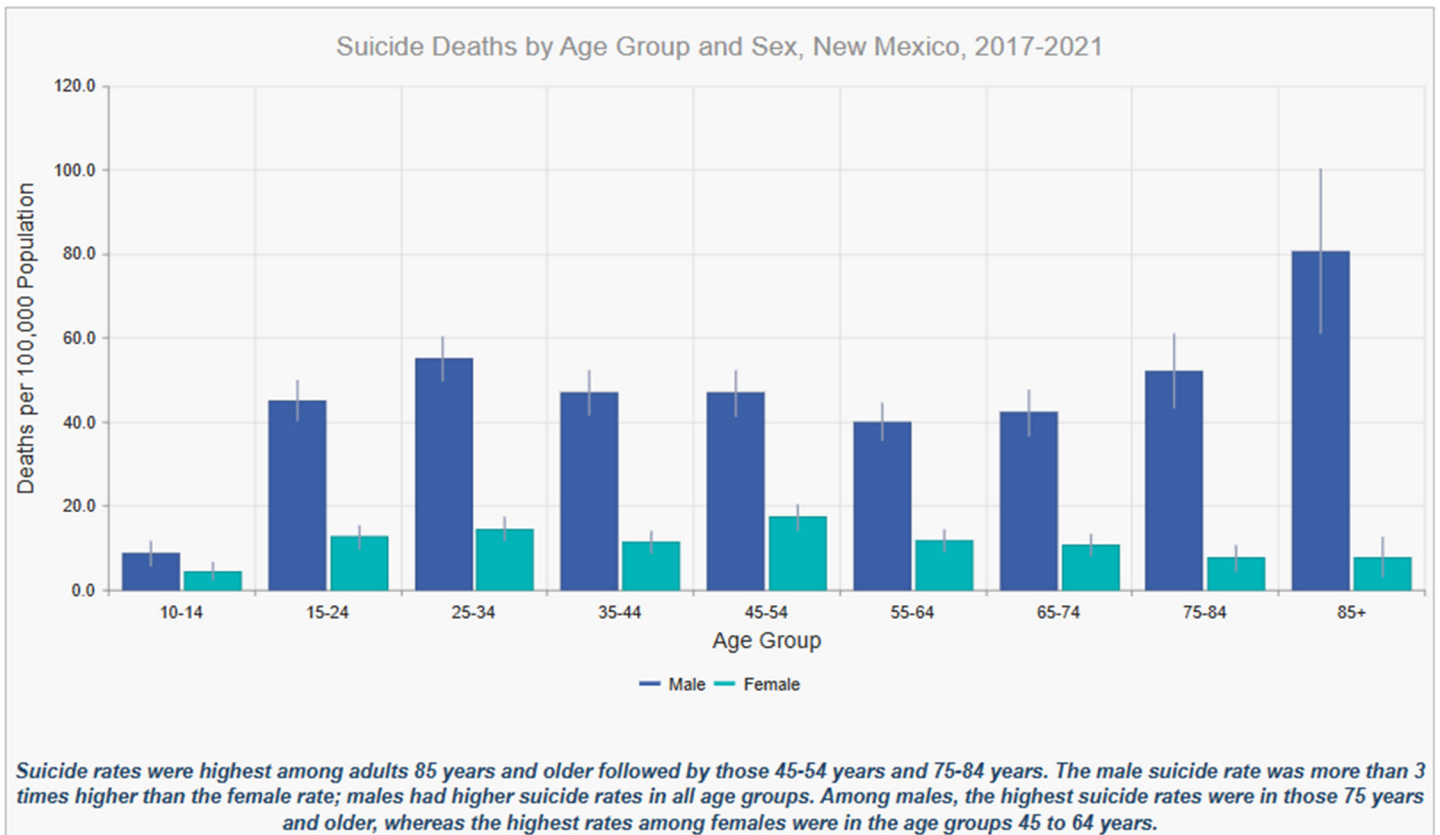
Suicide Deaths by County, NM

Suicide Deaths by County, New Mexico, 2017-2021

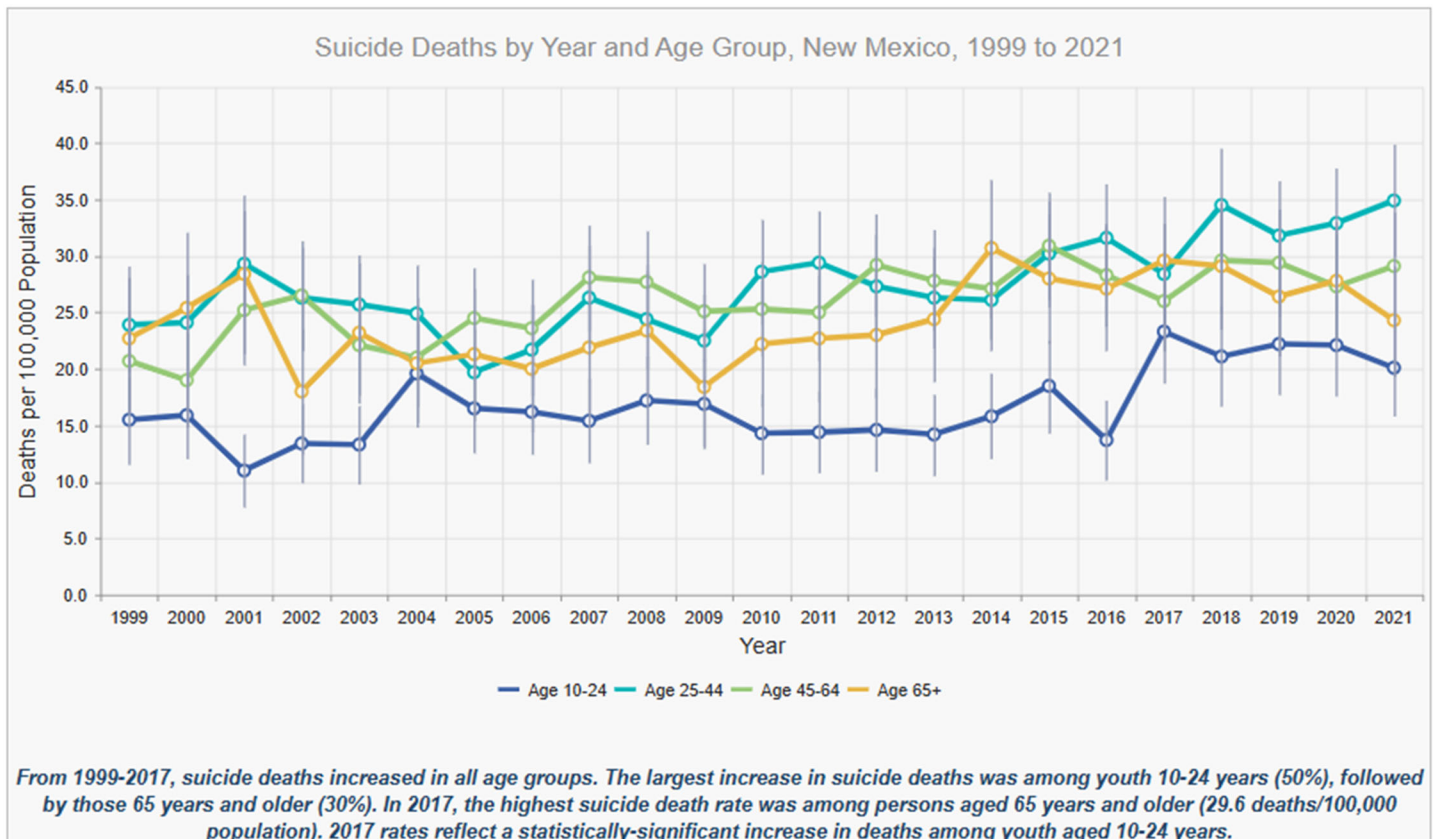


From 2013-2017, 20 NM counties had age-adjusted suicide rates that were significantly higher than the 2016 U.S. rate. NM counties with the highest suicide rates included Catron, Hidalgo, Grant and Sierra Counties in the Southwest; Quay County in the Southeast; and Taos, San Miguel and Torrance Counties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

Suicide Deaths by Age Group and Sex, NM



Suicide Deaths by Year and Age Group, NM



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:

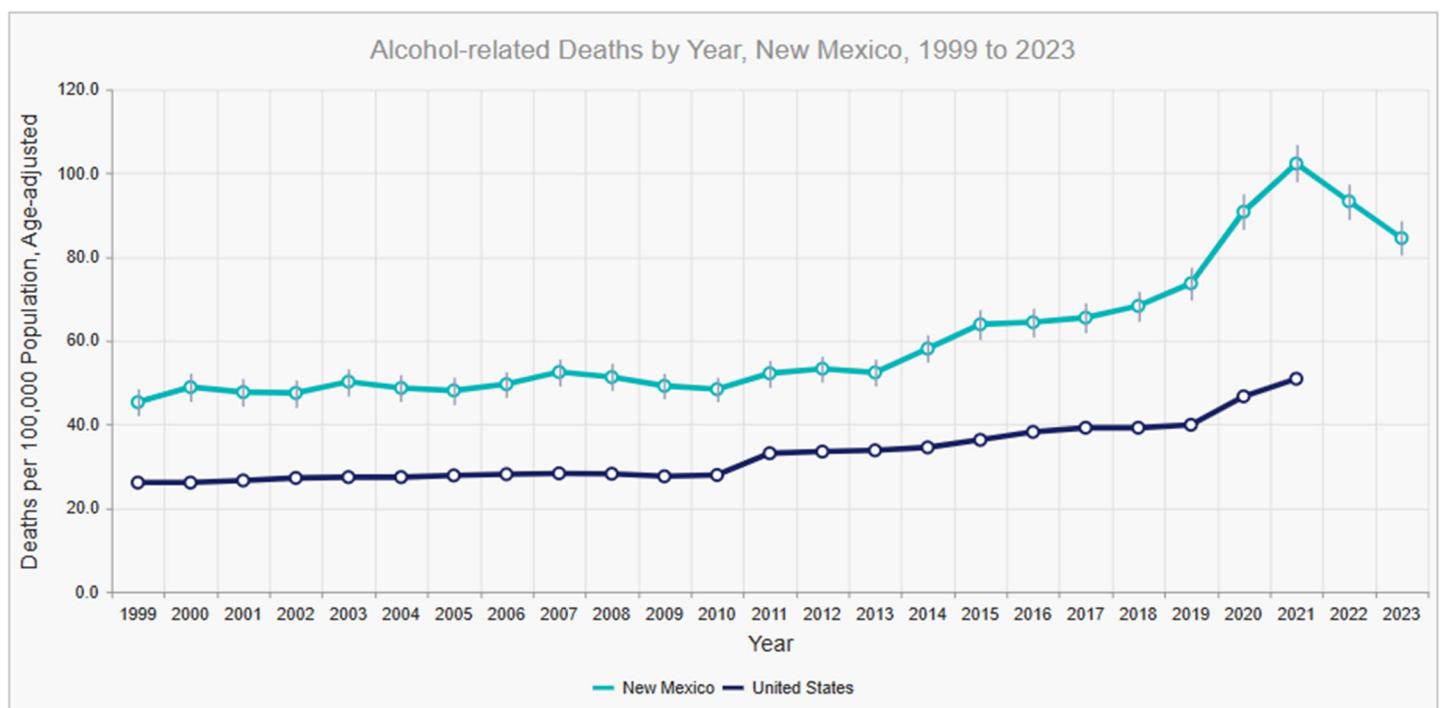
1 in 5 deaths among working-age adults



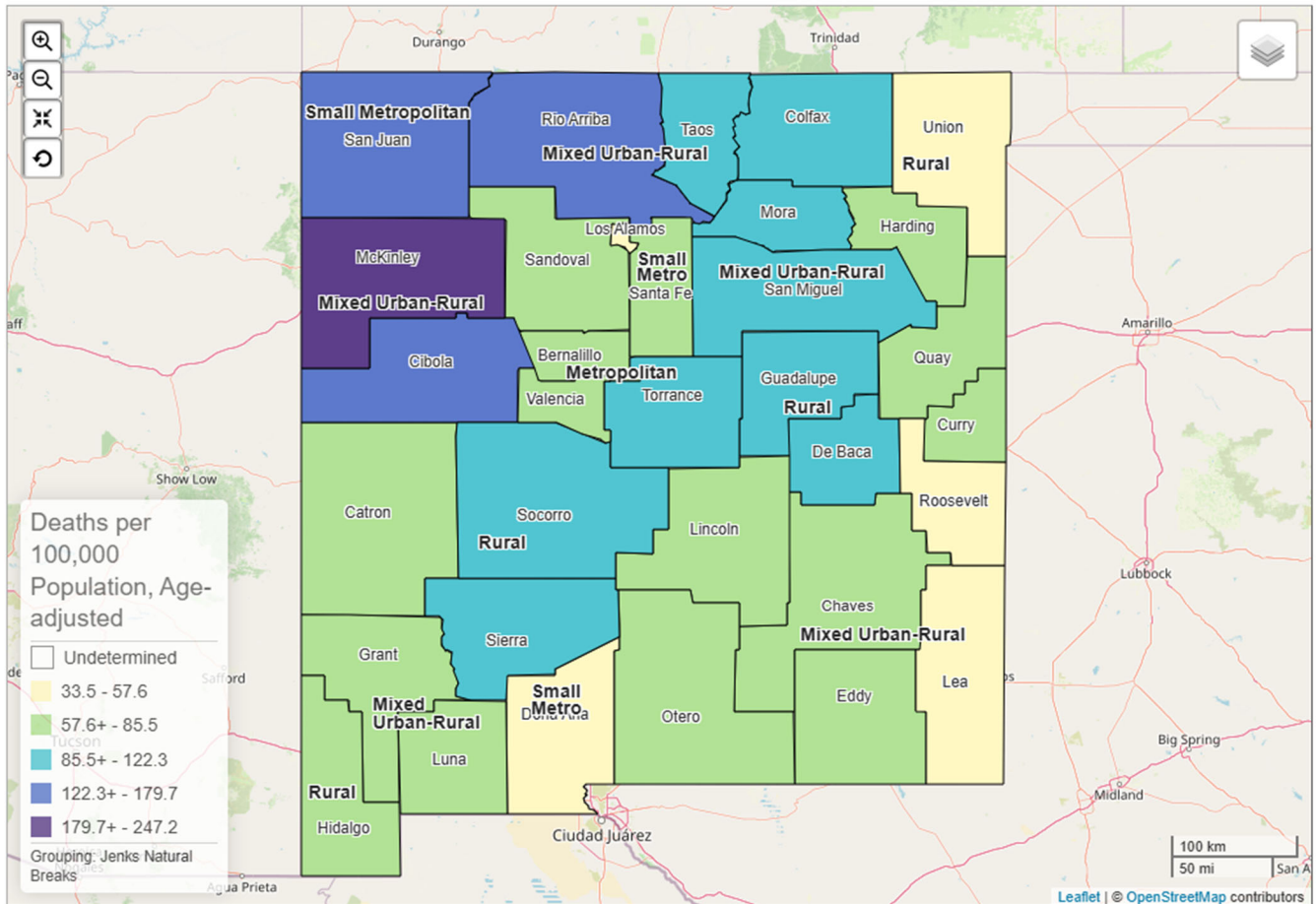
(ages 20–64) is alcohol-related

— This is twice as high as the national rate

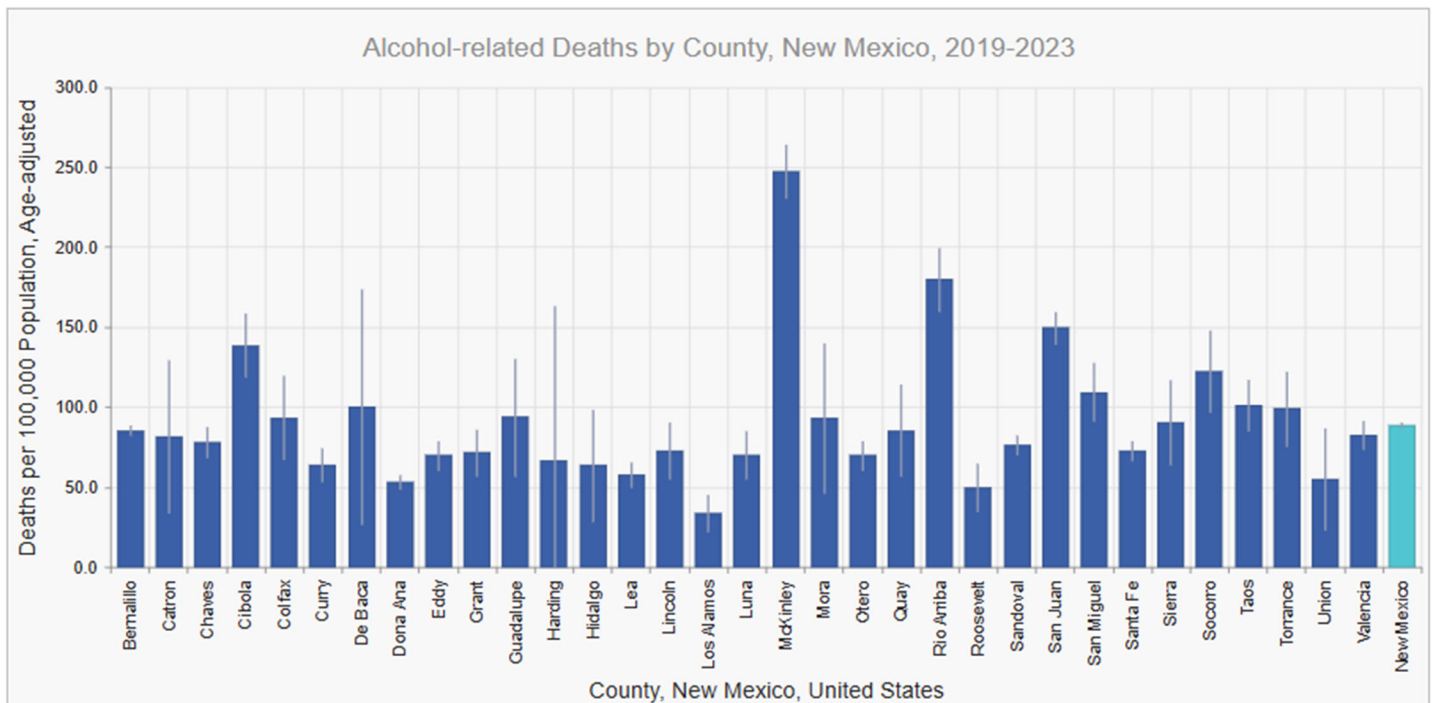
Alcohol-Related Deaths by Year, NM



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

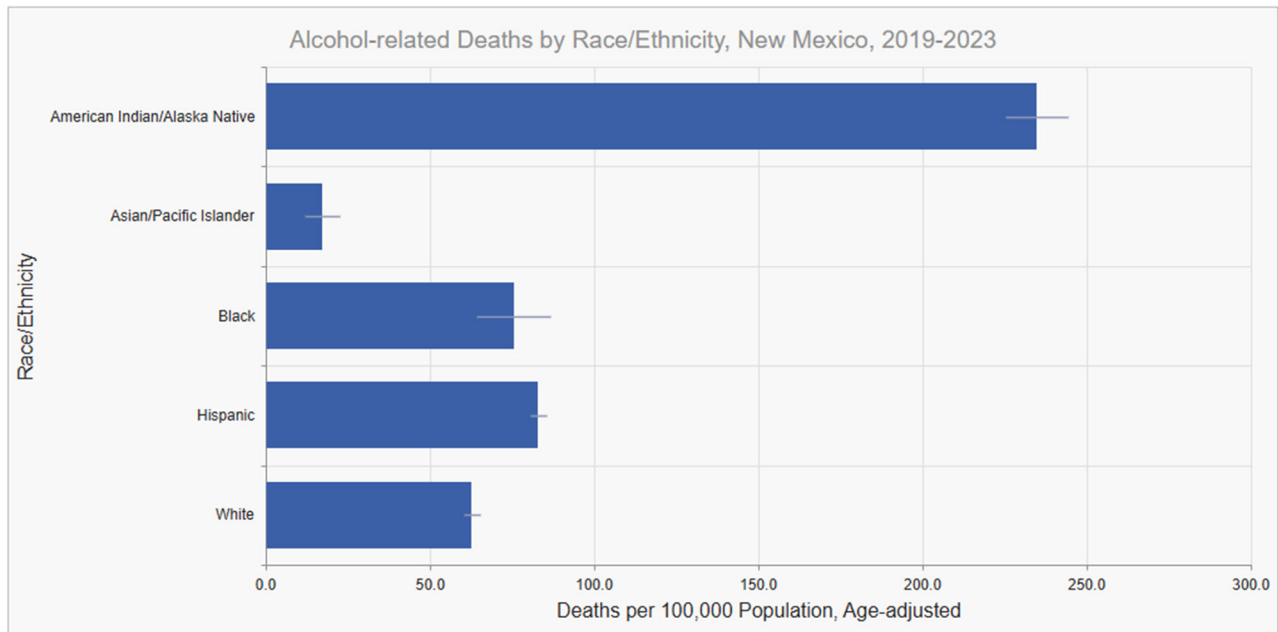


Alcohol-related Deaths by County, NM

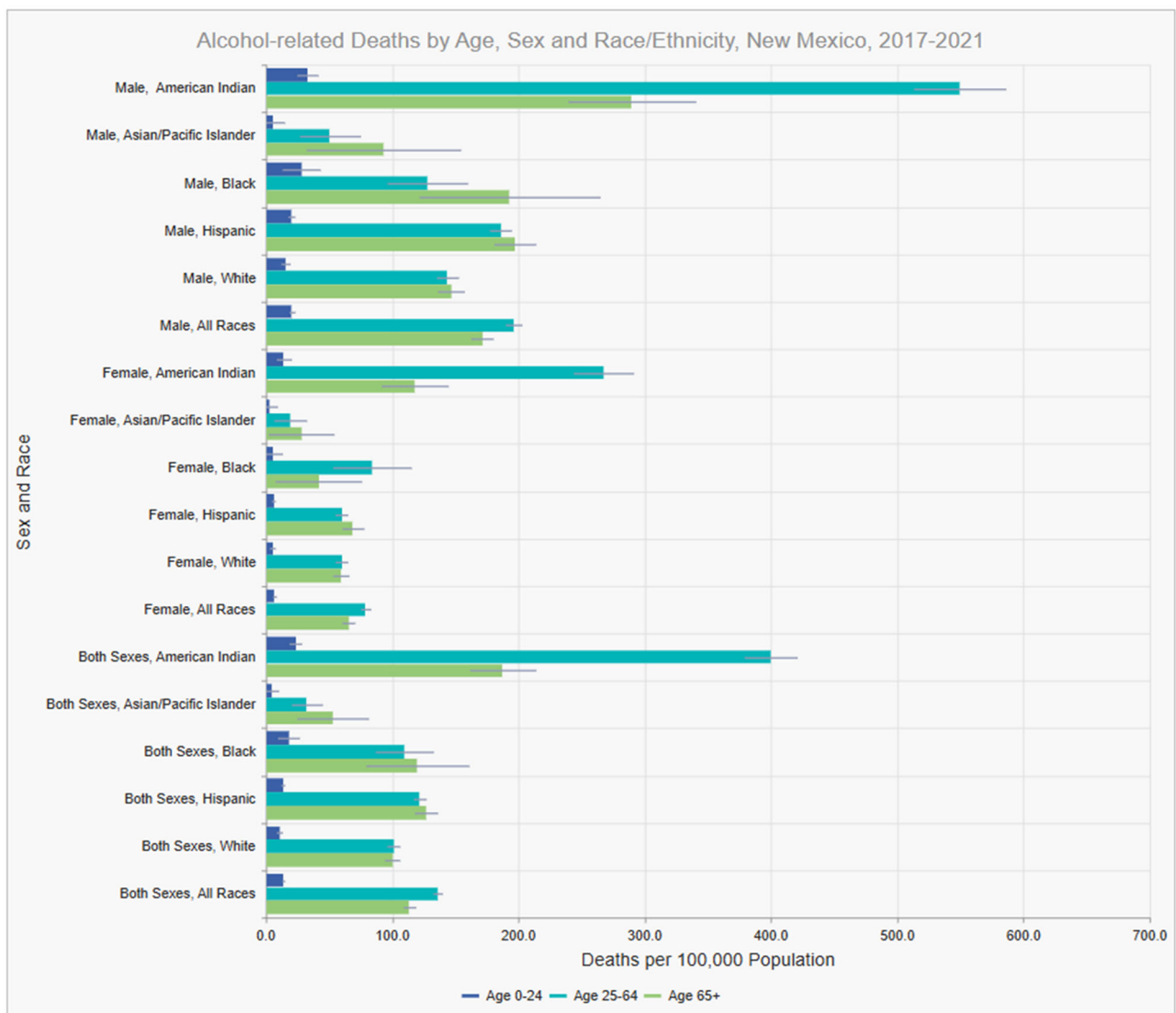


Rio Arriba and McKinley counties have the highest rates of alcohol-related death, with rates more than twice the state rate and more than three times the national rate. Several other counties (Cibola, Mora, San Juan, San Miguel, Socorro, Taos, Sierra, Catron, Guadalupe, Quay, and Hidalgo) have a substantial 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

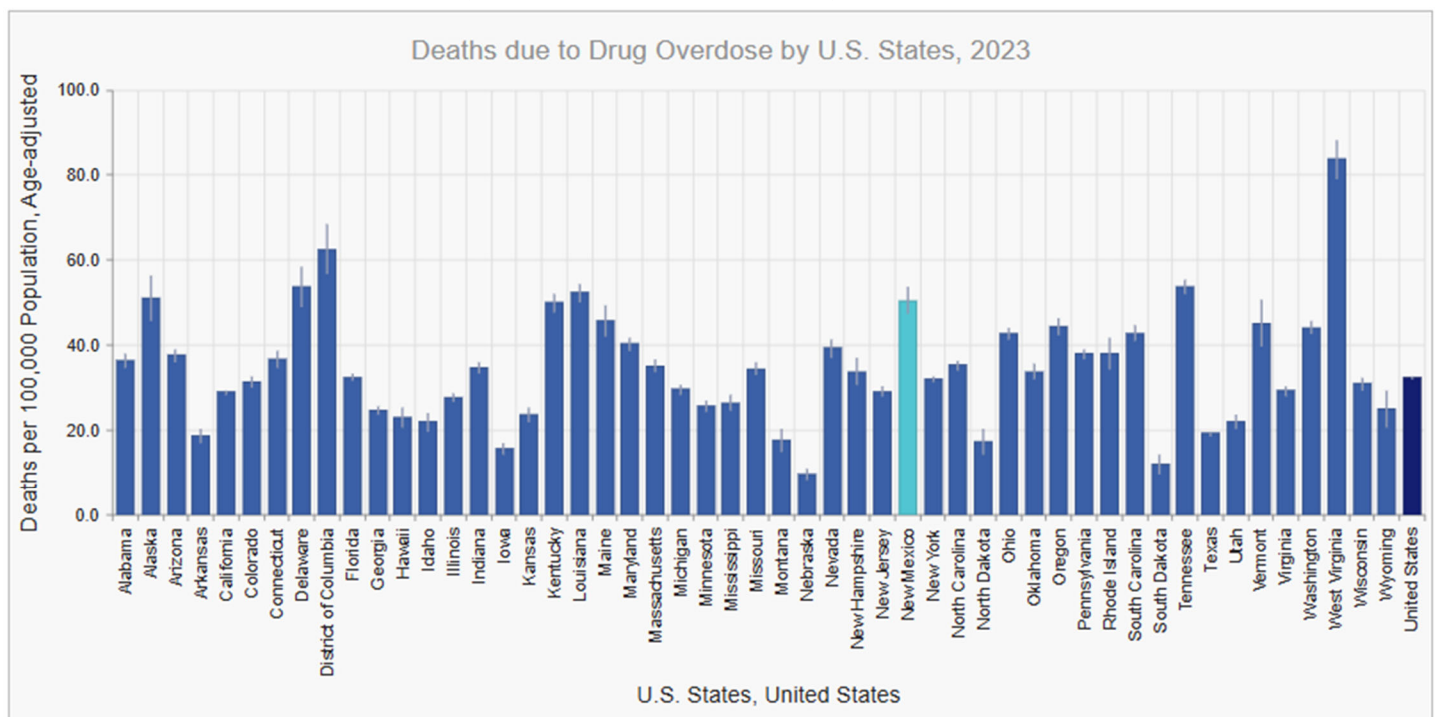
Source: New Mexico's Health Indicator Data & Statistics - <https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html>

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.

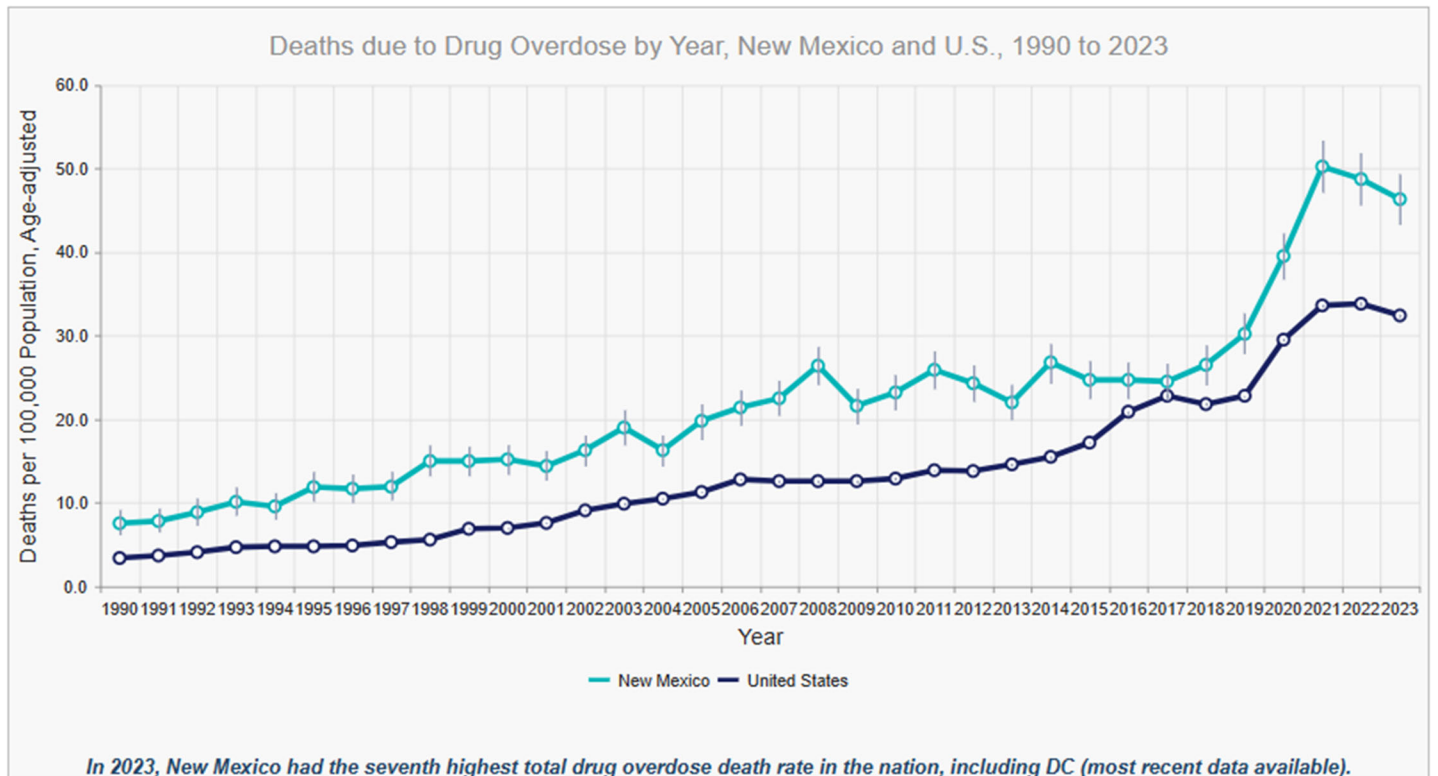
Drug Overdose Deaths

- **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

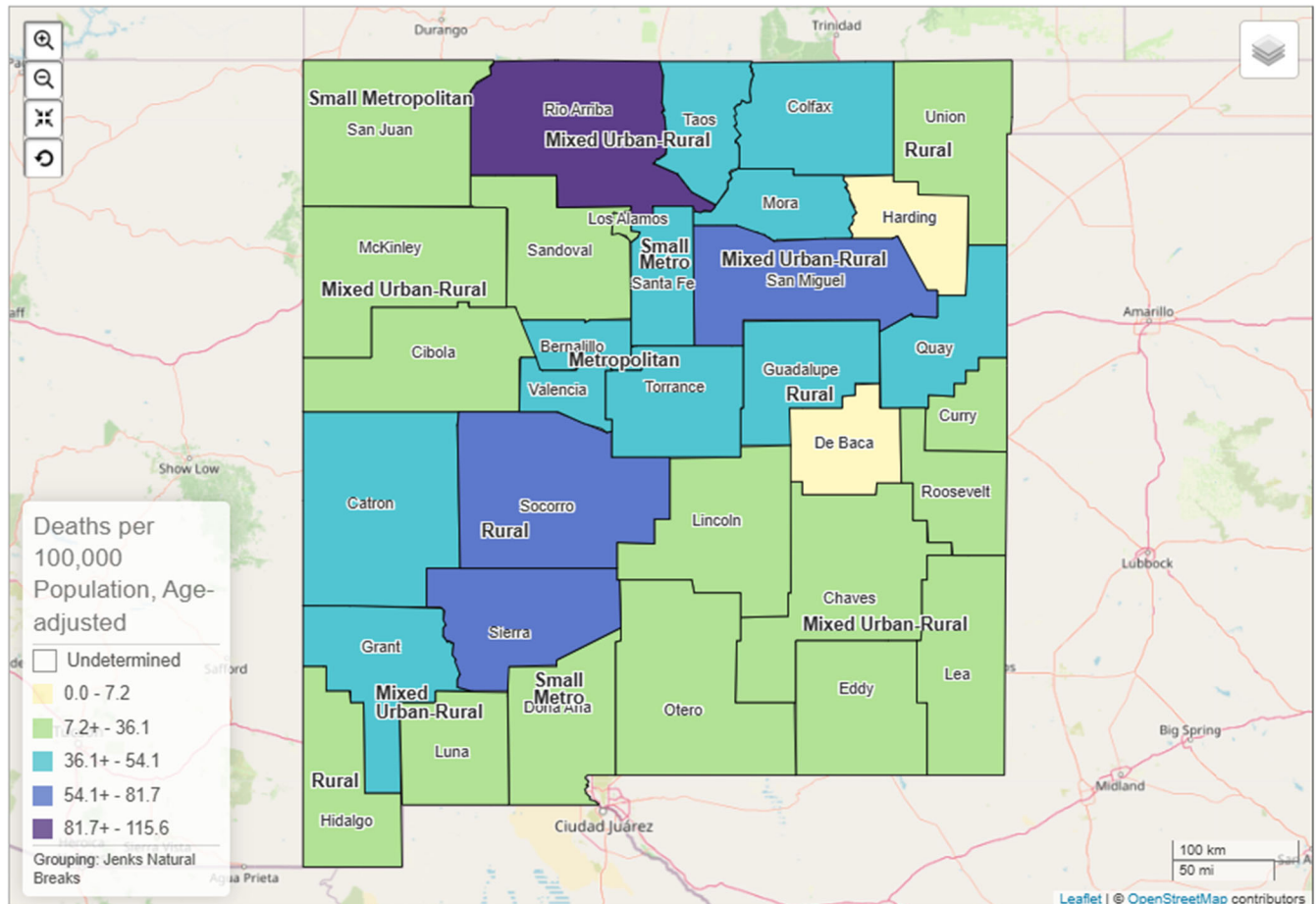


Drug Overdose Deaths by Year, NM and U.S

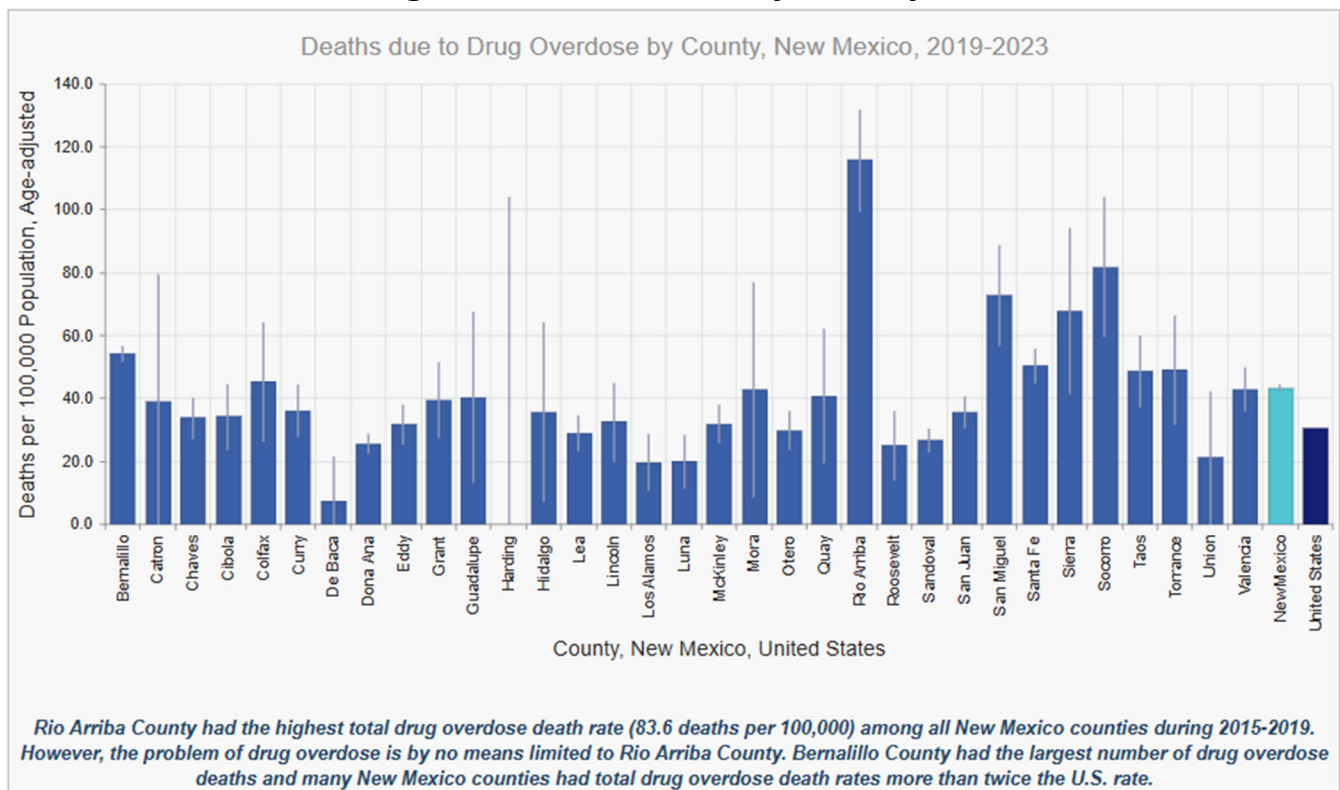


Drug Overdose Deaths by County, NM

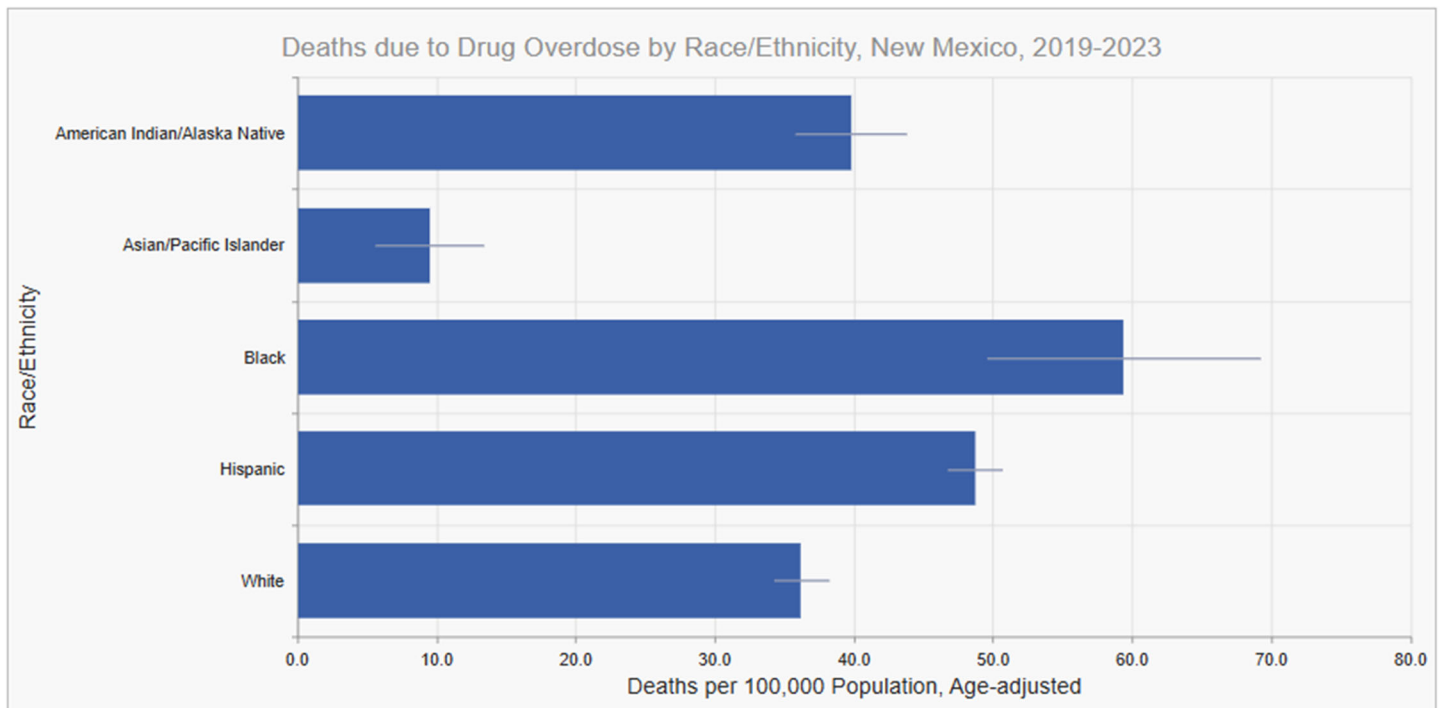
Deaths due to Drug Overdose by County, New Mexico, 2019-2023



Drug Overdose Deaths by County, NM



Drug Overdose Deaths by Race/Ethnicity, NM

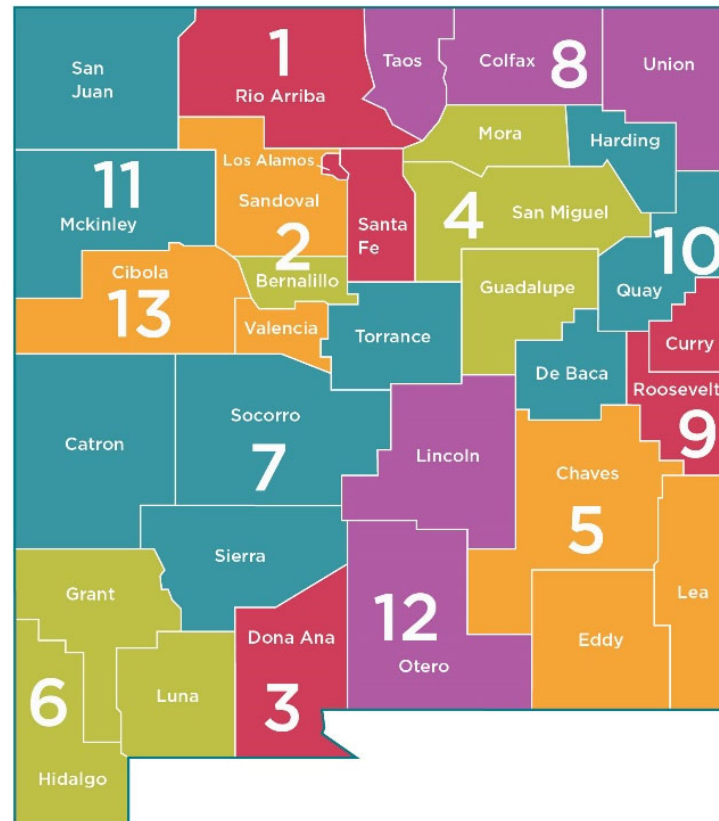


Region/ County

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



- TRIBES/PUEBLOS INCLUDED IN EACH REGION

Region 1

- Ohkay Owingeh
- Santa Clara Pueblo
- Pueblo of San Ildefonso
- Pueblo of Pojoaque
- Nambe Pueblo
- Pueblo of Tesuque
- Jicarilla Apache Nation

Region 2

- Pueblo of Isleta
- Pueblo of Sandia

Region 6

- Fort Sill 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

<i>Per 100k, Age-Adjusted</i>			
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

<i>Per 100k, Age-Adjusted</i>			
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

<i>Per 100k, Age-Adjusted</i>			
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

<i>Per 100k, Age-Adjusted</i>			
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

<i>Per 100k, Age-Adjusted</i>			
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

<i>Per 100k, Age-Adjusted</i>			
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

<i>Per 100k, Age-Adjusted</i>			
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

<i>Per 100k, Age-Adjusted</i>			
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

<i>Per 100k, Age-Adjusted</i>			
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)

Region 13 Listening Session Data Snapshot

Key Challenges Identified

- Length of MCO credentialing process causes delay in patient visits/long waitlists for psychiatric services
- People on Medicare are excluded from comprehensive community-based supports if they don't ALSO qualify for Medicaid
- When an individual in crisis is referred to another agency there is sometimes a lack of follow-up leaving the person without a clear path to care
- Programs requiring sobriety before admission prevent people from getting help when they are most willing
- Lack of sharing information across agencies can result in patients repeating histories multiple times
- Fixed-income seniors on Medicare cannot afford the out-of-pocket costs for regular treatment
- Travel times of 2-3 hours to Bernalillo County for specialized services reduces access to care
- Insufficient and unreliable public transit prevents people without vehicles to seek care or attend sessions
- Lack of reliable Wi-Fi limits access to alternate service delivery options such as telehealth
- Lack of cultural and linguistic integration in healthcare services
- Poverty and lack of economic opportunity lead to high rates of anxiety, depression, and untreated trauma
- Cultural and legal barriers re: immigration status prevents residents from accessing safety net supports
- Lack of support systems for families to navigate behavioral health needs before issues escalate to crises
- Workforce instability and a lack of culturally competent care negatively impact Tribal behavioral health
- Providers in Tribal communities face burnout due to required navigation of conflicting federal, state, and tribal regulations along with high caseloads (This is particularly prominent in IHS facilities)
- A distrust of services outside of the Tribal communities due to concerns of the cultural competency of providers and a history of lack of follow-through
- Absence of a Tribal clinical liaison in many Tribal settings
- Lack of family-centered traditional healing for Tribal communities
- Tribal providers are overburdened with Tribal wellness courts, managing disputes with CYFD, and navigating the IFPA within the context of state and federal regulations, which often conflict
- There are no facilities in the Region to house and treat youth who are incompetent to stand trial and pose danger to the community
- Lack of detox facilities
- Community centers closed to the public during usable hours limiting opportunities for local programming

Identified Strengths of the Region

- Multisystemic therapy helps prevent future incarceration or hospitalization
- The UNM FOCUS Model
- Multigenerational family networks and cultural resilience
- H2 Academic Solutions (Valencia County)
- Narcan distribution and educational training efforts, Narcan vending machine in Belen
- Mobile teams (available in limited areas)

Key Recommendations

- “No-Wrong-Door” approach where individuals are admitted to programs regardless of sobriety status
- Strengthen cross-system collaboration and shared responsibilities across all agencies
- Bridge the Medicare/Medicaid intersection to ensure affordability for the most vulnerable
- Implement localized health hubs and mobile units with reliable Wi-Fi for telehealth within Tribes
- Establish localized outpatient facilities within every community, eliminating 2-3 hour travel times
- 24/7 crisis response, ensuring individuals in crisis are rapidly connected to services
- Require state partners to visit and learn about communities before offering services to ensure cultural humility, commitment, and rebuild trust
- Increase the number of Tribal clinicians serving their own communities by addressing burnout, by providing reflective supervision, institutional support, and manageable caseloads
- Implement a streamlined MCO credentialing process, reducing administrative delay and waitlists

Region 13 Priority Buckets

Region 13 Priority Buckets

- Community Resource Access & Engagement
- Crisis Response, Mobile Services & 988 CoordinationLaw
- Law Enforcement & First Responder Training and Coordination
- Clinical Treatment, Recovery & Service Capacity
- Care Coordination, Navigation & Continuity of Care
- Justice Diversion, Courts & Detention-Based Services
- Reentry, Discharge Planning & Community Reintegration
- Family Support & Engagement
- School-Based Prevention, Youth Community Services & Supports
- Housing, Transportation, and Basic Needs
- Workforce Development, Training & Provider Support
- Systems Planning and Infrastructure Support

Community Resource Access & Engagement

- Establish community hubs for in-person resource sharing, services, and community activities
- Develop and provide mental health stigma reduction and BH psychoeducation activities
- Establish social and recreational activities for young adults that don't include alcohol
- Increase prosocial, low-cost community events that include awareness of health and related resources (e.g., Maker Markets; health fairs)
- Increase hours of operation for community centers
- Increase community education on what Counties do and how they provide resources
- Fund a dedicated person to create & continuously update a Regional resource directory with sections for each Tribe and County, and an inventory of EBP's
- Designate an entity to communicate with and inform providers and/or the public about BH services in the region
- Include language access in the regional directory by including locally certified interpreters and translators
- Increase utilization of community resources to ensure translated documents are locally accurate and relevant
- Increase health literacy
- Create options to access verbal information on health services and agency policies (e.g., video files, in-person assistance)
- Expand communication opportunities: connect with tribal radio stations; develop flyers, news bulletins, and websites to communicate; Use social media to share/learn about community events, notifications on trash cans
- Address stigma and lack of education about BH, substance misuse, etc.
- Increase awareness of GED programs at UNM campuses and in Tribal ed departments
- Increase access to interpretation and translation services
- Increase social events for seniors
- Host a statewide/regional chat forum for BH questions, publicize resources

Crisis Response, Mobile Services & 988 Coordination

- Increase coordination between 988 and tribal governments to encourage access to 988 and crisis response
- Coordinate mobile crisis response with tribes and non-tribal organizations
- Expand the SRMC crisis mobile team (with satellite teams across the Region), the KEWA crisis mobile team, and new teams (that work across jurisdictions)
- Designate an MCT hub for the region with localized community crisis response teams
- Consider implementing ABQ Community Safety Program, which sends peers to crises rather than law enforcement
- Link paramedics who handle a lot of BH needs with MCTs to increase volume and continuity of care
- Build interoperability between 988 and 911, consider placing both in the same dispatch
- Educate communities on the difference between 988 and 911
- Develop Co-response for BH LE for crisis response in Cibola and Valencia Counties
- Develop "crisis support centers" or drop-in centers that include youth and adult services and are embedded in existing spaces, such as hospitals
- Have communities identify local contacts to coordinate with 988

Law Enforcement & First Responder Training and Coordination

- Increase TIC, MI, and ACEs training, including at the law enforcement academy
- Train law enforcement on how to speak to EDs about risk to have successful admittance
- Increase training for law enforcement and Tribal Officials on response for youth in crisis
- Support trainings on culturally competent care for EMTs, crisis response teams, law enforcement, and other providers engaging with youth
- Explore existing mentorship programs for law enforcement
- Develop a curriculum to supplement law enforcement training around BH and cultures beyond the academy
- Increase buy-in or incentives for law enforcement to get extra training for working with people with SMI, crisis response, etc.
- Increase collaboration among various law enforcement agencies—reduce competition, poaching, and share resources, etc.
- Revisit the relationship between the Sandoval County BH Coalition and the police department regarding MH competency evaluations
- Create a mechanism for APCG to ensure that all law enforcement across Tribes receive training and implement best practices regarding BH
- Look at policies to cross-deputize/ commission law enforcement across all police (Tribal and non-Tribal)
- Expand Sandoval CIT teams, process, and access regions
- Expand MHFA training for Tribal law enforcement to use as a de-escalation tool
- Train Tribal traditional sheriffs on BH and diversion
- Training law enforcement on tools for working with individuals with SMI or SUDs to help with historical trauma
- Conduct a state summit for law enforcement and BH
- Promote use of wellness plans for law enforcement; debriefing, including cultural and spiritual components

Clinical Treatment, Recovery & Service Capacity

- Increase day programming for PSR for the appropriate patient population
- Increase easy access to Narcan for non-providers—education and use for family members (vending machines, boxes)
- Increase in harm reduction services (training, NARCAN, overdose recognition, etc.)
- Reestablish CPSWs in SRMC ED and fund CPSWs in all EDs
- Support Porchlight IOP development in Valencia County
- Expand CCBHCs to tribal and rural communities
- Expand access to non-medical detox for youth and adults
- Develop peer-run services such as the UNM Peer Living Room
- Utilize the UNM Focus model for whole family MAT services
- Utilize the Shared Care Approach in rural communities to maximize utilization
- Build a hospital in Valencia with BH capacity
- Increase access to MOUD services in jails and prisons
- Support IOP services inside and outside the jail in Valencia County
- Increase access to forensic ACT teams
- Provide CCSS wraparound services
- Increase tribal culturally relevant services (sweat lodges, drumming, talking circles etc.)
- Promote on-call hours in health facilities
- Consider developing a mobile detox unit
- Include inpatient and detox services in the new hospital in Valencia
- Bridge available modalities to include traditional practices

Clinical Treatment, Recovery & Service Capacity (Con't)

- Increase coordination between SRMC, CCBHC, and small providers
- Increase access to same-day walk-in services through SRMC CCBHC
- Ensure specialized services for Asian American and Pacific Islander, LGBTQ, and other youth who have limited access to resources
- Increase access to IOP, FFT, MST, RTCs, partial hospitalization, and high-fidelity wraparound (especially for people without Medicaid)
- Develop strategies to reduce the delay in getting youth BH evaluations
- Increase the number of outpatient providers who practice DBT, experiential therapies, and somatic therapies
- Explore the Bernalillo County Young Adult Program 45-day inpatient program model
- Have CCSS support medication adherence
- Promote education about medication and side effects
- Utilize technology to have a provider available through telehealth/virtual communication
- Increase mobile community-based services like immunizations, screening
- Create a tribal based prevention curriculum that can be used tribal wide (Pueblo-wide) that can be tested across time as an evidence-based model
- Increase training for law enforcement and public defenders on rights to treatment and related issues
- Increase training for APPOs on recognizing BH and cognitive disability issues
- Training for tribal court for pre-trial services, risk and responsiveness

Care Coordination, Navigation & Continuity of Care

- Hire someone to monitor available services, open beds, polices, etc., to keep providers up to date
- Increase coordination between CYFD & BH to support parents instead of criminalizing abuse and neglect
- Increase the number of Tribal clinical liaisons/cultural brokers who help community members navigate western medical systems
- Develop MOUs between BH agencies and police departments to respond to crises on Tribal lands
- Improve communication with tribes about people released from long-term detention and inpatient care
- Improve coordinated release (e.g., release with meds, appointment set up, practical hours of release)
- Increase services in detention facilities and continuity of care upon release
- Increase access to insurance for adults
- House CPSWs and CHWs in community centers and libraries to help enroll people in Medicaid and access online health resources
- Increase awareness of services that MCOs provide (Medicaid upon release; access BH; tribal liaisons)
- Gain access to funding to hire navigators to increase awareness of existing resources
- Increase telehealth to reduce the need for transportation
- Develop community hubs for patients to connect with providers, CHWs, and CPSWs
- Increase understanding of cultural context & unique needs for Tribes and Counties to share resources
- Develop MOUs across counties and tribes to work across jurisdictions and coordinate limited services
- Create MOUs with orgs that are already doing work to bring to other communities
- Increase access to multilingual navigational support to educate families about resources
- Support navigators to help parents connect youth and families to BH services and supports, and to

Justice Diversion, Courts & Detention-Based Services

- Increase access to the LEAD jail diversion program in Tribal communities
- Implement risk and responsiveness screening tools for detention centers and courts; universal screening
- Implement virtual courts to address transportation issues, and provide high-speed internet in rural areas
- Start diversion programs in the magistrate and municipal courts
- House DA and the public defender's offices in District 13
- Implement family courts in Cibola County
- Increase access to advocacy for victims
- Increase access to family supports to navigate the legal system and to handle collateral consequences
- Increase access to CPSWs in courtrooms to engage people in services
- Create regional mobile teams to provide BH services in detention facilities
- Increase access to BH assessments (including competency evaluations) in corrections
- Develop tele-behavioral health services for individuals who are in out-of-state facilities
- Create MH Court Aftercare program
- Use a data-driven approach to supervised release (focus resources on higher-risk individuals)
- Increase access to indigenous/restorative justice
- Implement the Moral Reconciliation Treatment model to increase moral reasoning
- Include tribal affiliation on arrest records and other court forms to help connect youth back to the community

Justice Diversion, Courts & Detention-Based Services (Con't)

- Increase access to education and training for courts on what services are available in each county, so they do not recommend services that do not exist
- Develop mechanism to pay for gap for when youth are in detention and no longer have Medicaid to ensure care coordination or BH services
- Develop a mechanism for Tribal-state joint jurisdiction where judges from the Tribal and county courts hear cases together for joint disposition
- Find ways to support youth whose family does not meet criteria for mandated reporting with CYFD, (when family is involved with police or youth are running away)
- Create agreements between the police, the school, and BH to share information on diversion opportunities
- Rebuild Teen Court in Valencia County
- Rebuild the juvenile justice advisory committee in Cibola
- Create long-term, high-fidelity wraparound services for repeat offenders and severe cases
- Provide education and awareness of existing programs (e.g., JCC)
- Provide education to communities on state and Tribal Children's Codes
- Increase the number of clinicians who provide services in the juvenile detention centers
- Provide traditional and cultural services to Native youth in detention or RTCs
- Increase access to training for JPOs related to Tribal rules and regulations
- Create a mechanism for Tribal JPOs to participate in state CYFD JPO training

Reentry, Discharge Planning & Community Reintegration

- Increase housing, training, jobs, and other services before and after release
- Develop a reintegration center as a hub of services and resources
- Work with Tribal HR, leadership, and other employers to allow for and incentivize second-chance employment opportunities
- Increase strategies to develop formal reentry programs for Tribes
- Expand RISE into other Counties and Tribes
- Increase access to CPSWs for people released from incarceration
- Provide community education about reentry
- Foster inter-tribal collaboration for transitional housing after release from detention
- Support the potential development of YDI transitional living services
- Ensure that faith-based orgs have access to information to support reintegration
- Embed service providers in probation offices
- Develop a standardized re-entry assessment and identify someone to conduct this
- Develop a liaison role between school, detention, and BH to streamline continuity of care
- Develop MOUs with detention and schools to ensure smooth reentry into schools
- Create a website with tips for re-entry resources and training
- Develop relationships between Tribes and State to increase connections for psychiatric discharge planning and reentry plans (role could be called Tribal Clinical Liaisons)
- Engage youth peers who have navigated the system to mentor youth coming out of detention and residential treatment
- Ensure provider and community training on how to engage youth and identify issues for those coming out of detention and psychiatric facilities

Family Support & Engagement

- Reduce stigma among families to accept services
- Increase family buy-in to engage in family counseling
- Provide psychoeducation to families with an incarcerated family member
- Shift service approach from the individual level to the family level
- Subsidize costs for home medical equipment
- Expand hours of services to increase family involvement
- Expand services for family support (e.g., family success coaches, parent support groups, family navigators)
- Increase access to opportunities to teach families about advocacy for youth in schools
- Develop programs to support families with youth involved in JJ or CPS
- Increase mandates for foster care family training on trauma-informed care and other related best practices
- Increase public awareness of the need for foster parents
- Develop parenting programs and support for parents, young parents, and grandparents across developmental stages
- Integrate BH into CPS for intensive support and therapy for youth and families
- Create opportunities (e.g., PTAs) for parents to support each other in their well-being
- Create kinship care support opportunities in Tribal communities for foster parents and grandparents

School-Based Prevention, Youth Community Services & Supports

- . Promote substance use prevention programs in schools
- . Increase access to MHFA and other supports for teachers and school guidance counselors to recognize and refer people to services
- . Increase the presence of CPSWs and BH providers in schools to screen and refer to BH services
- . Ensure that schools have MOUs with BH programs to embed services in schools and ensure continuity
- . Create wellness rooms in schools so youth have safe places
- . Develop school-based programs that use culture as a resource
- . Ensure that schools utilize trauma-informed approaches
- . Improve IEP practices to be more youth and family-centered
- . Increase collaboration between SRMC CCBHC (including mobile outreach) and schools
- . Build off of the Jemez Valley schools and Waltowa Charter School model and develop similar programs in other Tribal schools
- . Expand programming such as Project Venture and Kicks and train elders to be facilitators/mentors
- . Reinstate DWI programming in schools
- . Engage schools to participate in the BH program development for students
- . Explore opportunities to expand SBHCs

School-Based Prevention, Youth Community Services & Supports (Con't)

- . Increase awareness of youth programs like "Stop It" using communication through school systems
- . Partner with Head Start and schools for BH early prevention and intervention services
- . Place SROs in all high schools
- . Develop resources for SROs and law enforcement to make referrals for youth in need of services
- . Advocate with schools and PED to use existing programs (e.g., FINS, JPOs, Treatment courts)
- . Promote dual enrollment with colleges and experiential learning opportunities
- . Ensure PED-funded charter schools offer full array of services available in public schools
- . BIE and County schools need to coordinate and collaborate on Yazzie-Martinez
- . Promote programs to help youth understand the realities of being in detention
- . Increase the number of youth gathering places, such as community centers and gyms
- . Expand Valencia Community Action Network to include activities outside of Valencia
- . Utilize Valencia and Grants recreation centers to develop and host programs
- . Expand programming (e.g., help with employment) for young men in Acoma to foster independence and confidence
- . Expand activities like art, music, and theatre to engage youth in activities beyond sports
- . Create support and monitoring for online learning – possibly at community centers

Housing, Transportation & Basic Needs

- Expand transportation across the Region
- Increase access to transportation upon release to access resources (e.g., shuttles, taxis, transport hubs in ABQ, sober driving)
- Increase transportation for families to visit people in faraway jails and prisons
- Work with local bus companies and invest in transportation in rural areas to ensure better transportation to and from after-school and summer programming
- Examine regulations for transportation to expand qualifications (e.g., age, distance, waivers for fare, more bus stops; same-day request for urgent appointments, discharge from higher level of care)
- Create dedicated safe walking/bike routes along roads
- Find funding solutions to help people stay housed that incorporate BH supports
- Increase second chance housing (tiny houses, refurbished motels, and other buildings)
- Create a regional center with transitional housing that can be accessible to Tribal communities
- Support the grant-funded Men's and Women's transition center building/program development (SD)
- Expand access to transitional housing and group homes for youth
- Refurbish existing spaces for housing
- Partner with tribal housing for second-chance housing opportunities
- Have youth shelters in each County
- Offer shower and laundry vouchers at aquatic centers and other places for people who have limited access to these supports
- Increase access to broadband in all communities (enables better use of telehealth; 988)

Workforce Development, Training & Provider Support

- Establish provider and staff incentives to work in rural and underserved areas (e.g., student loan repayment, housing, bonuses)
- Increase awareness of existing student loan repayment programs (e.g., National Health Service Corps)
- Increase CPSW trainings to build the workforce (especially for Tribal CPSWs)
- Make salaries competitive for therapists working in Tribes and rural areas
- Increase access to supervision toward licensure for BH providers in rural areas and develop opportunities for clinical supervisors to receive mentorship
- Develop an education pipeline in middle and high schools for legal, law enforcement, and BH jobs and provide opportunities to see how these jobs work
- Create partnerships with colleges and universities for internships and other training opportunities
- Have employers build the capacity of lower-level or pre-licensed staff to increase their training and education (e.g., paying for tuition; flexible schedules for education; state incentives for these opportunities)
- Removing red tape for licensing residential treatment, accessing insurance, DD waiver, credentialing for providers and service types, clinical licenses, and other services
- Increase cultural education opportunities for providers
- Improved training for hospital staff on how to deliver SBIRT screening

Workforce Development, Training & Provider Support (Con't)

- . Promote training for and/or recruit clinicians for night/crisis work
- . Provide cultural training on BH, local tribes, tribal sovereignty, and history
- . Provide training for judges, lawyers, and staff on BH issues, diversion, and treatment
- . Educate and communicate with Tribal leadership about BH issues
- . Provide mentorship for new tribal leaders, especially on crisis response
- . Increase the number of peer support workers with lived experience of BH and incarceration
- . Find sustainable options to ensure the CPSW credentialing board certifies youth and family peer support
- . Support flexible work schedules for BH providers for work-life balance
- . Train youth to step into roles as CHWs, case managers, RBTs doing ABA, CPSWs, etc., to get into BH fields
- . Encourage satellite campuses and Tribal Colleges to develop BH curriculum and certification programs
- . Encourage Tribal colleges to certify CHWs, CPSWs, and other paraprofessionals
- . Increase training for BH service providers, schools, and community members on ICWA and IFPA, trauma-informed care, LGBTQ BH, foster care best practices, etc.
- . Conduct cross-training between community agencies
- . Cross-train BH staff and law enforcement in jurisdictions, etc.

Systems Planning and Infrastructure Support

- . Provide training programs for grant writing and grant management for local stakeholders
- . Provide small grants to get money into communities for prevention activities
- . Gain access to funds through the BH Trust Funds to refurbish buildings and for other development
- . Develop a mechanism for data sharing for grant proposals and accessing resources
- . Increase funding for environmental prevention policies and regulations
- . Develop strategies to collect and use local data for CQI and sustainability
- . Develop regional youth coalitions for opportunities for ideas and feedback from youth
- . Inform/educate legislators on gaps within communities
- . Use county representatives as liaisons to the state
- . Develop sustainable funding mechanisms for local initiatives
- . Develop ways to cover services not covered in all IOPs
- . Use regional health councils as a way to coordinate/collaborate efforts
- . Improve rural address systems to ensure location accuracy, especially for pharmacy medication delivery
- . Allocate funding to increase services at Ramah Family Service Center
- . Increase wellness activities (e.g., yoga, Zumba) reimbursed by MCOs
- . Use data and evaluation to understand what programs and activities are working

Systems Planning and Infrastructure Support (Con't)

- Share evaluation results with communities and leadership; explain the importance of data; use existing data
- Encourage communities to work together to share data and use a quality assurance process
- Create a Sandoval County task force to assess BH challenges and needs
- Gain youth and family voice on services that would be most helpful for the BHRIA Region 13 plan
- Train Tribes on IRB processes
- Partner with agencies that already have a captive audience with youth and families (e.g. Boys and Girls Clubs to survey youth about needs
- Strategic planning for the sustainability of services
- Match grant funding mechanisms with community needs and desires
- Provide funding to understand impact of ACEs; understand the long-term impact of trauma
- Train the All Pueblo Council of Governors (APCG) on the need and process for intergovernmental agreements between the state and Tribes (Could discuss this issue at a separate Tribal meeting for this Region)

OTHER CONSIDERATIONS

State Policy Development Opportunities

- Work with HCA to revise MCO policies/contracts to better fit the needs for engaging people into care coordination services, aftercare, and other services
- Need to review SB3 language to hold MCOs accountable for the 90 day period prior to release for care navigation and aftercare
- Work with HCA to revise MCO policies to expand to emails and text messages to engage people in care coordination services
- Develop a statewide policy to ensure people show up for court to prevent revictimization
- Allow competency evaluation via telehealth to decrease wait times
- Develop policies to increase access to CPSW services for people who are not Medicaid eligible
- Create a statewide general counsel to develop uniform documents for MOUs and MOAs
- Fund juvenile community corrections – Cibola is at risk of losing funding
- Maximize available services funded by Medicaid
- Consider ways to provide care coordination outside of MCOs and have more outpatient agencies receive PMPM to provide care coordination locally
- Develop RTCs for youth, prioritizing girls
- Explore with the federal government why the New Sunrise Facility is not in operation or funded
- Reinstitute and/or implement intergovernmental agreements between all tribes and CYFD for youth evaluation and detention (state tribal liaisons office could facilitate)

Region 13 Five Top Priorities

- 1) Crisis Response, Mobile Services and 988 Coordination
- 2) Clinical Treatment, Recovery, and Service Capacity
- 3) Care Coordination, Navigation, and Continuity of Care
- 4) Housing, Transportation, and Basic Needs
- 5) Workforce Development, Training and Provider Supports