

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

Behavioral Health Region 6

**Fort Sill Apache Tribe | Grant County
Hidalgo County | Luna County**

April 15th, 2026

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University of New Mexico
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Recommended Citation: University of New Mexico Behavioral Health Technical Assistance Center. (2026). Enhanced Sequential Intercept Mapping (E-SIM) and Prioritization Workshop Report **Behavioral Health Region 6 Fort Sill Apache Tribe | Grant County | Hidalgo County | Luna County.** {Insert URL}



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 6th Behavioral Health Region (Fort Sill Apache Tribe, Grant County, Luna County and Hidalgo County).** Appendix A.2 contains a list of acronyms used throughout this report.

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

The E-SIM Mapping and Prioritization Workshops take a systems approach, using a specific orientation, to inform regional behavioral health planning. Appendix A.3 includes the E-SIM that was adapted for New Mexico from the original Sequential Intercept Model (Griffin, 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 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 6 (Fort Sill Apache Tribe, Grant County, Luna County and Hidalgo County) over the course of 3 days (March 24th-26th, 2026). A copy of the agenda is included in Appendix A.4.

One hundred and three unduplicated people attended the Workshop. Eighty-seven people attended the first day with an additional 9 from the UNM BHTAC for a total of 96 attendees. Sixty-six people attended the second day with 9 people from the UNM BHTAC for a total of 75 attendees. Fifty-nine people attended the third day with 9 people from the UNM BHTAC for a total of 68 attendees. Participants represented a diverse range of perspectives from the following seven groups:

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>



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 **Youth 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 **Adult 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, and NM Mortality data 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), and NM Mortality data (Appendix A.8).

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.9) to the large group. Throughout the presentation, participants were invited to ask clarifying questions.

Provisional Priority Buckets

- Priority Bucket A: Crisis Services and Stabilization
- Priority Bucket B: Care Coordination
- Priority Bucket C: Treatment and Recovery Service Access
- Priority Bucket D: Housing and Basic Needs
- Priority Bucket E: Employment and Life Skills
- Priority Bucket F: Justice Diversion and Re-Entry
- Priority Bucket G: Workforce Capacity and Development
- Priority Bucket H: Funding & Policy and Infrastructure
- Priority Bucket I: Systems Coordination and Infrastructure
- Priority Bucket J: School-Based Supports
- Priority Bucket K: Youth, Family and Parental Supports
- Priority Bucket L: Outreach, Stigma Reduction and Substance Use Reduction



“Growing a Connected Community”

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 Services and Stabilization
2. Housing and Basic Needs
3. Treatment and Recovery Service Access
4. Workforce Capacity and Development
5. Youth, Family and Parental Supports

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: Crisis Services and Stabilization	12	8	0	10	9	14	1	54
Priority Bucket B: Care Coordination	7	0	0	0	1	0	0	8
Priority Bucket C: Treatment and Recovery Service Access	9	8	0	7	4	9	1	38
Priority Bucket D: Housing and Basic Needs	12	7	0	9	6	9	1	44
Priority Bucket E: Employment and Life Skills	1	3	0	3	1	1	0	9
Priority Bucket F: Justice Diversion and Re-Entry	11	3	0	4	3	5	0	26
Priority Bucket G: Workforce Capacity and Development	14	3	0	5	5	10	1	38
Priority Bucket H: Funding & Policy and Infrastructure	3	4	0	0	0	0	0	7
Priority Bucket I: Systems Coordination and Infrastructure	7	1	0	0	2	0	0	10
Priority Bucket J: School-Based Supports	4	4	0	6	1	4	0	19
Priority Bucket K: Youth, Family and Parental Supports	15	4	0	9	1	8	1	38
Priority Bucket L: Outreach, Stigma Reduction and Substance Use Reduction	0	0	0	1	2	0	0	3
Total	95	45	0	54	35	60	5	

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 6 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.

Priority 1: Crisis Services and Stabilization**Table 2: Summary of Priority 1 Discussion**

Action Items from the Intercept Mapping Sessions	• Establish a mobile crisis program, informed in de-escalation and trauma-informed care, and trained to make appropriate referrals. • Build a 23-hour crisis triage center in each county and one region-wide 14-day facility • Open up a part of each hospital for a crisis response unit • Establish and train CIT teams in each county, to be on call 24/7 • Clarify the liability around co-response teams • Implement co-response teams that have funding, equipment, training, and time to respond together • Connect treatment providers to prevention programs to provide support and share information when crises or suicidality come up • Recruit and retain volunteer first responders (including considering stipends) • Provide regular MHFA Training for First Responders
Top Priorities to Work on Now and Additional Considerations	Establish a regional Crisis Triage / Crisis Stabilization system • 23-hour crisis triage centers and/or 14-day stabilization facilities • Mobile crisis response available 24/7 • Ideally one center per county, with shared regional resources when feasible • Use existing assets where possible (e.g., Tu Casa building, hospital-leased rooms) Develop crisis response alternatives to law enforcement and ERs • Peer-based and multidisciplinary crisis response teams • Crisis Response Teams with CIT-trained first responders • Staggered response models based on level of crisis and population (youth, adults, geriatric) Expand workforce capacity • Recruit and retain clinicians, peers, social workers, RNs, and on-call medical providers • Develop a shared regional clinician pool / locum model • Increase bilingual (English/Spanish) providers • Improve pay and incentives, especially for rural/frontier work Improve coordination across counties and agencies • Strengthen communication between counties, hospitals, law enforcement, courts, CYFD, EMS • Create shared assessment tools and referral criteria across facilities • Establish regular clinician and stakeholder networks Expand detox and SUD-related crisis capacity

	- Identify regional detox options (possibly one site serving all three counties) - Integrate MAT and medical staffing where required - Coordinate with existing providers (e.g., Mesilla Valley, Las Cruces Recovery) Improve data collection and system planning - Collect and use crisis data (988, 911, ERs, law enforcement) - Conduct needs assessments, especially for Hidalgo and Luna - Track utilization and outcomes over time
Implementation Issues	Staffing and workforce challenges - Difficulty recruiting clinicians, RNs, and physicians (especially on-call) - Burnout risk → need flexible schedules, day/night teams, equitable pay across roles - Training needs: CIT, crisis response, youth-specific approaches, dementia care - Requirement for licensed clinicians for diagnostics and billing Facility and infrastructure limitations - Limited hospital space (e.g., Gila Regional capacity constraints) - Some counties lack hospitals altogether (Hidalgo) - Need to consider leasing hospital rooms, refurbishing existing buildings, or interim solutions 23-hour crisis centers cannot house detox; detox requires separate planning Geographic and county-level differences - Each county requires its own model due to population size, land mass, and resources - Large distances require reliable transportation and EMS coordination - Hidalgo currently has a single-person crisis response team with nowhere to transport individuals Legal, policy, and operational barriers - Patient rights and involuntary holds (72-hour holds, treatment guardianship) - CYFD requirements for youth services - Inconsistent assessment criteria across facilities - Security concerns and safety for healthcare workers - CMS/MCO requirements often misaligned with clinical or justice needs Coordination and hand-offs - Timely hand-offs from law enforcement, EMS, hospitals, and self-referrals - Need for warm hand-offs, shared EHR coordination, and clear pathways after crisis - Jail-based medical services considered as interim or supplemental options Transportation and access - Ambulance availability and EMS reimbursement - Transport logistics between counties - Cell/internet connectivity issues affecting telehealth and coordination
Sustainability Issues	Long-term funding and reimbursement - Sustainability through billing and reimbursement, not grant-only funding - Need high utilization rates to remain financially viable - Behavioral health reimbursement rates are lower than other medical specialties - Some services (e.g., MAT, detox) require costly additional staffing

	Workforce retention - Continued difficulty retaining providers in rural/frontier areas - Need competitive pay, incentives, contract bonuses, and work-life balance supports - Ongoing training and professional support Inter-county cost sharing and ownership - Clarify who owns and operates services (county vs. hospital vs. contracted entity) - Shared liability and cost-sharing models across counties - Counties already pay indirectly through law enforcement, jails, and hospitals when crisis services are absent System utilization and visibility - Past closures due to underutilization highlight the need for: - Broad eligibility criteria - Strong marketing to law enforcement, hospitals, courts, and the public - Position crisis services as an attractive alternative to incarceration or ER use Ongoing governance and collaboration - Establish local subcommittees or Community Advisory Boards - Maintain engagement across agencies, elected officials, and community partners - Strengthen communication across counties and reduce silos Data, reporting, and continuous improvement - Consistent reporting on outcomes, utilization, and cost avoidance - Use data to advocate at the state level for appropriate rates and policy changes
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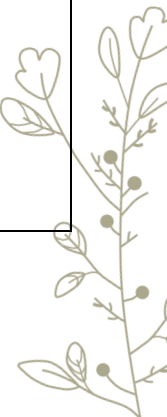
Priority 2: Housing and Basic Needs

Table 3: Summary of Priority 2 Discussion

Action Items from the Intercept Mapping Sessions	- Create a women’s transitional home - Build and maintain outhouses or porta-potties for people who don’t have homes - Create more group homes for people with significant impairment - Address safe housing for young children and youth - Prioritize funding for transportation to access services and programs - Develop a self-sustainable tiny-home village with on-site workshops and resources for employment, food/gardening, emotional healing, access to a general store - Create a Silver Lining Home in Luna County - Expand recovery housing - Allocate funding to support youth who are unhoused with clothing and the provision of transportation
Top Priorities to Work on Now	Expand housing across the full spectrum of need - Permanent supportive housing (especially in Lordsburg) - Transitional housing (including post-Tu Casa step-downs and re-entry housing) - Group homes - Housing for elders and people with disabilities (accessible units) - Housing for women (including pregnant people and those with children) - Housing for people re-entering the community after incarceration - Housing inclusive of LGBTQIA+ community members



	- Youth-specific housing and shelters (up to age 17) Increase affordable housing supply - New affordable family housing - Refurbishment of abandoned homes, motels, and other existing structures - Exploration of tiny home villages - Use of underutilized affordable housing units (e.g., Hidalgo County) Develop transitional and recovery-oriented housing models - Oxford House–style transitional living across all three counties - Recovery and transitional housing near services (healthcare, food, retail) - Transitional housing tied to employment and community stability Strengthen youth-focused housing and systems - Youth shelters - More foster homes - A tri-county youth-focused interagency council - Focused attention on youth aging out of systems Improve basic needs infrastructure - Transportation solutions (especially in Hidalgo County) - Mobile shower units - Porta potties, showers, and hygiene access - Emergency funds for utilities, food, and basic needs Increase coordination, leadership, and advocacy - Local government buy-in and cross-county collaboration - Housing asset mapping to understand land, capacity, and unit quality - Education and awareness of housing funds and resources (SB3, opioid settlement, Housing NM, etc.) - ACT teams integrated with housing stability efforts
Implementation Issues	Leadership and coordination gaps - Lack of a clear lead entity to manage projects and coordinate stakeholders - Rural communities have limited awareness of available funding and programs - Need stronger collaboration among counties, municipalities, nonprofits, health councils, developers, and legislators - Health councils may need expanded capacity and funding to take on coordination roles Housing supply and infrastructure challenges - Severe housing shortages across counties - High cost of refurbishing older properties (e.g., motels, buildings with asbestos) - Buildings are often out of code or unsafe due to disuse or squatting - Power and utility constraints (e.g., long timelines for PNM distribution and transformers) - Many communities lack accurate land and housing maps Regulatory and administrative barriers - Red tape for youth shelters (staffing requirements, background checks) - State housing requirements that limit usable stock - Utility fees, DMV fees, and other costs that create barriers for tenants





	• Medicaid and Medicare transportation limits (distance caps, advance scheduling) Community resistance and stigma • Neighborhood opposition to supportive or transitional housing • Need for proactive community engagement, town halls, and education • Stigma related to mental health, substance use, and homelessness Workforce and management needs • Staffing for property management and housing operations • Need for incentives for landlords to repair and rent to higher-need populations • Shortage of professionals to help rural residents navigate complex housing systems Population-specific challenges • Youth housing needs differ from adult housing and require dedicated focus • Youth aging out of foster or shelter systems lack step-down options • Border counties face family separation and transportation challenges • In-migration driven by housing voucher portability impacts local availability
Sustainability Issues	Long-term funding and financial viability • Many prior housing initiatives failed when grant funding ended • Housing rehabilitation and maintenance require ongoing investment • Need sustained funding for emergency utility and food assistance • Weatherization waitlists are long; expanding resources is necessary Ownership, maintenance, and management • Clear entity needed to own, manage, and maintain housing stock • Ongoing upkeep costs for refurbished or shared facilities • Ensuring housing does not deteriorate back into substandard conditions Workforce and leadership continuity • Retaining local leadership rather than relying on outside regions • Fully funding health councils or a central convener for long-term advocacy • Providing stipends to support participation in regional councils (e.g., youth council) Community buy-in and utilization • Sustained community engagement to reduce stigma and opposition • Open houses, community gardens, and neighborhood activities to build trust • Broad awareness so housing resources are actually used System navigation and information sharing • Ongoing need for an up-to-date housing and resource directory • Rural residents often lack guidance to navigate state and federal programs • Continued education on available housing, funding, and supportive services Equitable and regional approaches • Shared responsibility across counties for specialized housing models • Ensuring solutions serve residents while managing external demand pressures • Aligning housing investments with behavioral health, re-entry, and recovery systems





Priority 3: Treatment and Recovery Service Access

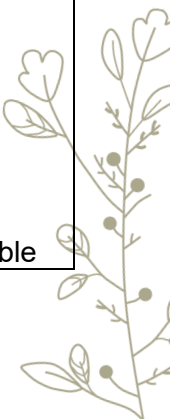
Table 4: Summary of Priority 3 Discussion

Action Items from the Intercept Mapping Sessions	• Implement MST services • Create a residential treatment center in the region to alleviate transportation barriers • Embed behavioral health providers in recreational centers to facilitate activities with families or children without calling it therapy • Intervene earlier (with younger children) for prevention and intervention services • Fund different tiers of intervention for youth: 24/7 crisis stabilization, 2-week inpatient, 6-month treatment • Develop evidence-based programming that fits with community culture • Ensure CPSWs are trained and familiar with addiction and mental health concerns to support and staff the hospitals • Expand training for peer support services for people who are local and provide more localized training • Expand peer support in the jails • Promote “back to basics” of on-site social workers for improved recovery • Peer support in every APO office • Place peer support workers hired by behavioral health agencies in the probation offices and provide oversight and clinical supervision with an MOU for the exchange of information and collaboration • Expand Recovery Management Center (RMC) program – across Luna and Grant counties • Create opportunities for positive social activities that support recovery • Increase parent support groups or peer-led groups for parents with youth with behavioral health conditions • Expand detox, both medical and social • Utilize evidence-based practices to instill hope (e.g. New Hope for People with... series)
Top Priorities to Work on Now	Improve access to treatment and recovery services across the region • Increase regional transportation funding to reach treatment, IOP, clinics, and recovery services • Develop mobile behavioral health units, including prescribers (in person or via telehealth) • Increase access to psychiatric hospitals closer to BHR 6 communities • Support development of residential treatment centers (including near-term openings in Hidalgo County) Expand treatment and recovery workforce • Incentivize providers to come to and remain in rural and frontier areas • Expand the definition of behavioral health providers to include CPSWs, CHWs, frontline staff • Support CPSW pipelines, certification, and CEUs • Advocate for affordable housing programs or incentives for providers Strengthen youth-focused prevention, treatment, and recovery • Intervene earlier with at-risk youth • Expand middle-school-focused programming • Increase youth-specific counseling, therapy, and intensive treatment options • Develop systems to refer youth from schools to therapy • Build awareness of existing youth and family resources • Expand youth-focused treatment courts or mandated treatment options





	Increase engagement in treatment and recovery • Address stigma and distrust of health systems • Improve trauma-informed care across providers • Identify ways to motivate people to engage and remain in treatment (e.g., incentives, peer support) • Build a pipeline from youth peer support to adult peer support Expand evidence-based and specialized services • Implement evidence-based practices (EBPs) • Expand medical and social detox capacity • Increase awareness and utilization of existing IOP capacity
Implementation Issues	Workforce shortages and constraints • Limited workforce makes EBPs and expanded services difficult to implement • Youth therapy requires specialized skills (play therapy, family therapy) • Counselors in schools and youth-focused providers are underpaid relative to demand • Long wait times and barriers for CPSW certification (sobriety documentation, CEUs, staffing capacity) Transportation barriers • Lack of transportation limits access before, during, and after treatment • Medicaid and Medicare distance limits restrict travel • Need for county-coordinated or centralized transportation systems • Consider linking transportation to crisis centers and treatment transitions Youth and family system challenges • Youth often disengage from therapy; telehealth is not effective for many • Limited after-school options for youth • Gaps between schools, JPOs, therapists, and CYFD referrals • Parents may not be held accountable or supported adequately • Guardians often lack clear guidance on where to seek help • Many families must send youth out of state for care Engagement and referral inefficiencies • No-show rates impact provider reimbursement • Current billing models do not allow flexible payment for missed appointments • Inconsistent awareness of current treatment capacity (e.g., IOP under-referral) • Communication gaps between courts, providers, schools, and families Infrastructure limitations • Gila Regional Medical Center limited to 25 beds and no longer has inpatient BH • Challenges in getting medication from pharmacies to client in mobile or rural settings
Sustainability Issues	Workforce recruitment and retention • Long-term sustainability depends on attracting and keeping providers • Use of interstate licensure compacts to support recruitment • Ongoing investment in CPSWs, peers, and youth-specialized clinicians Transportation funding • Continued funding required to maintain regional and cross-county transportation solutions • County-based or centralized transportation models may be more sustainable





	Youth-focused service continuity • Sustained investment in youth counseling, school-based therapy, and family engagement • Retaining therapists who specialize in youth and adolescents • Maintaining early-intervention and school-to-treatment referral systems Engagement and system performance • Need ongoing strategies to reduce no-shows and improve treatment adherence • Payment models currently limit financial sustainability of innovative approaches Community trust and stigma reduction • Continuous trauma-informed care training • Ongoing efforts to rebuild trust between clients and health systems Cross-system coordination • Sustained communication between courts, schools, providers, and behavioral health systems • Long-term commitment to shared ownership of recovery outcomes across agencies
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Priority 4: Workforce Capacity and Development

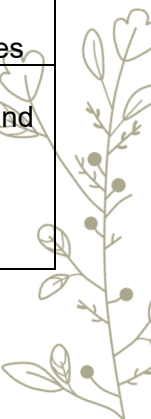
Table 5: Summary of Priority 4 Discussion

Action Items from the Intercept Mapping Sessions	• Develop a pipeline to support youth to train as peer support workers • Increase access to supports for providers to prevent burnout • Hire therapists as county employees to provide jobs with benefits • Develop incentives for interns and local youth to stay in the area • Provide SBIRT training • Expand requiring CIT and behavioral health training for law enforcement • Train local providers in MAT • Provide training in cultural competence and awareness for out-of-state contractors • Recruit more Spanish-speaking providers in Hidalgo and Luna counties • Provide CEUs locally for in-person and high-quality training • Advocate for restoring WNMU workforce programs in Hidalgo County
Top Priorities to Work on Now	Grow and sustain a local behavioral health workforce • Pipeline programming that starts with youth, encouraging interest in medical and behavioral health careers and return to BHR 6 after training • Internships and mentorships for high school students and early-career staff • Collaboration with local schools (e.g., CNA programs, career fairs) Improve workforce recruitment and retention • Incentives such as student loan repayment, scholarships, housing assistance, and tax breaks • Affordable and workforce-specific housing (including housing for trainees) • Incentives for spouses' employment • Expanded loan forgiveness and repayment beyond short-term contracts • Broaden recruitment to value local providers and lived experience, not only outside credentials Strengthen the behavioral health employment structure





	• Hire therapists as county employees to support: ▪ School-based therapy ▪ 23-hour crisis and 14-day stabilization services • Place therapists in schools via external agencies so they can focus on therapy (not guidance counseling) Increase training and professional development • Access to CME, MAT, SBIRT, CIT, cultural competence, and burnout prevention training • Region-wide CIT training for counselors and law enforcement • Open SBIRT billing eligibility for all providers to support early intervention Address workforce well-being • Burnout prevention supports and wellness incentives • Trauma-informed and culturally competent care training • Build positive, supportive team environments
Implementation Issues	Recruitment challenges in rural and frontier areas • Difficulty retaining nurses and therapists locally, especially in Western NM/Silver City • Lifestyle barriers (housing, transportation, poverty, limited amenities) • Recruiting older clinicians may be easier, but long-term sustainability requires younger workforce pipelines Incentive and funding complexity • State tuition reimbursement and tax incentive programs exist but can be administratively burdensome • Some programs (e.g., HRSA) have extensive paperwork that discourages participation • Need clear strategies to incentivize providers to stay beyond contract terms Workforce infrastructure barriers • Lack of affordable housing for workforce and trainees • Long licensing and credentialing timelines at both the state and MCO levels • Agencies often absorb internship costs without county or state support School-based workforce challenges • Parent consent and engagement can be difficult • Schools need space and coordination with external therapy providers • Payment requires contracts with MCOs to bill for in-school services Training access and relevance • Training must be region-wide to be financially feasible • Cultural competence training must account for differences between counties • Need centralized lists of available training and providers Leadership and management issues • Micromanagement and lack of accountability contribute to burnout • Local workforce (e.g., LSAAs) may be overlooked compared to external hires
Sustainability Issues	Retention beyond grant funding • Long-term sustainability depends on whether staff feel valued, supported, and heard • Incentives need to extend past initial contracts (loan forgiveness, housing stability, employment for spouses)





	Workforce well-being and burnout prevention • Ongoing access to wellness supports (gym memberships, self-care opportunities, burnout support groups) • Building strong support teams and healthy organizational cultures • Leadership accountability to reduce burnout and turnover Local economic development • Investing in housing, education, shopping, and community amenities to make counties livable for workers • Economic development tied directly to workforce retention Sustained training and credentialing capacity • Continued funding for CEUs, CPSW pathways, and certification supports • Streamlining credentialing and licensing processes where possible Long-term workforce pipeline stability • Recruiting and training local youth increases the likelihood of long-term retention • Ongoing investment in internships, mentorships, and school-to-career pathways • County and state participation needed to take internship costs off individual agencies
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Priority 5: Youth, Family and Parental Supports

Table 6: Summary of Priority 5 Discussion

Action Items from the Intercept Mapping Sessions	• Expand comprehensive support for basic needs for families, including social-emotional learning for families • Expand parenting support & engagement (e.g. through Parents as Teachers) to develop parent coaching to support youth with behavioral health conditions • Have CHWs or other health educators support parents with questions around medication management • Provide more behavioral health services for parents/caregivers • Develop wraparound programs for the siblings and families of court-involved youth • Strengthen mentoring programming for parental involvement and integration in their kids' lives • Develop greater outreach and home visitation for parents • Develop programming for pregnant women and post-partum support and education to continue through the child in elementary school • Expand childcare services, extended hours, and pick up services • Increase access to healthy lifestyle activities and opportunities for new peer groups • Partner with local businesses to provide resources to youth (e.g., gym memberships, sports equipment, and fees) • Fund the existing recreation center in Luna County in collaboration with SROs and counselors • Expand after-school programming (e.g., Big Sister Big Brother, life skills, Boys & Girls Club, YMCA) • Address the emerging generation gap that is heightened by new technology • Improve community connections by better utilizing spaces already existing for cooperative activities • Help youth access alternative school and GED options • Expand and support the Police Athletic League to promote positive role models and sports opportunities
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Top Priorities to Work on Now	• Develop a Family Community Center Strengthen youth social-emotional and behavioral health supports • Add Social Emotional Learning (SEL) to the core school curriculum (advocate at the state level) • Implement wraparound services with coordinated care teams • Expand youth peer support for at-risk youth • Improve early identification and referral of youth to behavioral health treatment • Consider mental health courts for youth (identified as an additional idea) Reduce stigma and increase access to services • Normalize behavioral health care and medication through family education • Reduce fear and stigma of behavioral health providers engaging families in homes • Use presumptive eligibility to allow youth and families to access services without requiring a diagnosis • Increase awareness of available programs and resources Enhance family and parental engagement • Increase parental involvement in schools • Provide parenting education and mentoring • Offer education to parents on children’s behavioral health needs and medication options • Support grandparents raising grandchildren • Promote family outreach programs to increase referrals Expand after-school, childcare, and community-based supports • Childcare with extended and non-traditional hours (nights, evenings, shift work) • After-school, summer, and school-break programs • Safe indoor spaces during extreme weather • Recreation and community centers accessible to all ages • Activities after school and work hours for families Improve youth engagement, activities, and life skills • Recreational and enrichment activities (sports, biking clubs, cooking classes) • Tutoring and academic support • Life skills education (financial literacy, job skills, basic car and civic skills) • Mentoring programs (e.g., Big Brothers Big Sisters, peer-led models) Improve system navigation and coordination • Increase care coordination, case management, and CHW support (including CHWs in schools) • Schools working with JPOs to address truancy • Strengthen connections between schools, behavioral health providers, and community supports
Implementation Issues	Access and eligibility barriers • Services often require a diagnosis to begin or continue care • Need prescreening processes for presumptive eligibility • Transitional housing and RTC options are limited for youth with high acuity needs Family and parental engagement challenges





	• Parents may be working, lack transportation, or unable to attend school events • Parental accountability structures are limited; schools and JPOs often fill the gap • Some families struggle to ask for help or engage consistently • Need culturally appropriate outreach in trusted community settings School and system coordination issues • Gaps between schools, JPOs, and behavioral health providers • Challenges securing parental consent for services • Lack of after-school options contribute to truancy and disengagement • State policy issues (e.g., unsafe school bus stop distances) Infrastructure and resource gaps • Limited or no recreation/community centers in Luna and Hidalgo counties • Existing centers have limited hours and staffing • Activities and programs are costly to operate • Shortage of volunteers and paid staff to supervise youth safely • Need facilities such as commercial kitchens for some programming Workforce and support needs • Need more mentors, screeners, and supervisors to ensure safety • Risk of secondary trauma for youth peer supporters and Natural Helpers • Need training and support for mentors, peers, and outreach staff
Sustainability Issues	Ongoing funding • Long-term funding required for childcare, before- and after-school care, and extended hours (ECECD funding noted) • Sustaining recreation centers, programs, staff, and supervision beyond initial funding • Continued funding for care coordination, CHWs, and youth peer supports Community buy-in and utilization • Sustained stigma-reduction efforts are needed to keep families engaged • Use familiar, trusted community members to maintain participation • County and city involvement essential for space, activities, and ordinances Workforce retention and support • Prevent burnout for mentors, peer supporters, and outreach workers • Ongoing training, screening, and supervision to maintain program quality and safety Cross-system collaboration • Continued coordination among schools, counties, behavioral health providers, JPOs, and community organizations • County-owned or shared spaces may help sustain outreach and family engagement activities Long-term prevention focus • Embedding SEL, life-skills education, and parenting education into schools supports lasting impact • Early intervention and family engagement reduce long-term system costs and crises



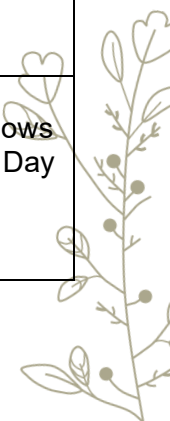


IV. Summary of Discussion Related to County or Tribe-Specific Priorities

1. Grant County

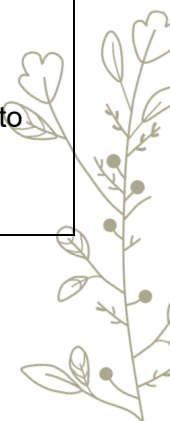
Table 7: Grant County Priorities Discussion

Action Items Most Relevant to Grant County	Implement a 23-hour crisis triage program • Viewed as a high-priority and immediately actionable need • Strong interest and potential support from Behavioral Health Services Division (BHSD) • Anticipated to be heavily utilized by law enforcement and save significant police time Adopt a systems-based approach to behavioral health • Move away from siloed, stand-alone programs toward coordinated systems of care • Ensure individuals in crisis are routed to the <i>most appropriate</i> level of care, not just the fastest or easiest option Address rural vs. urban differences explicitly • Advocate for state agencies and legislators to recognize that rural communities require different models and solutions • Ensure policy and funding decisions do not default to urban assumptions Increase family and parent engagement • Expand and strengthen parenting programs (building on effective models like RMC parenting groups) • Improve engagement strategies for families involved with behavioral health and youth systems Develop accessible, localized resource navigation • Improve or replace underperforming online referral tools • Create a comprehensive Grant County resource guide (food, housing, healthcare, insurance) • Position the Health Council to coordinate or maintain this resource Expand affordable housing • Recognized as a core unmet need that directly impacts behavioral health outcomes Increase supports for grandparents raising grandchildren • Address food insecurity, clothing needs, and caregiving supports Improve care coordination • Strengthen coordination across providers, systems, and services within the county Strengthen local capacity of nonprofit agencies • Advocate for greater state investment in nonprofit infrastructure, not just service delivery
Implementation Issues	Crisis system implementation • 23-hour crisis triage must integrate smoothly with law enforcement workflows • High anticipated utilization requires adequate staffing and protocols from Day 1 System coordination challenges





	• Many people in crisis currently enter care through the easiest path, not the most appropriate one • Need redesigned workflows and shared understanding across agencies Rural context barriers • Rural realities are often overlooked by state agencies and funding mechanisms • Solutions must account for distance, workforce shortages, culture, and limited infrastructure Parent and family engagement • Engagement is feasible and effective (e.g., RMC parenting groups) but requires intentional outreach • Some families face logistical and trust barriers Resource navigation limitations • Online guides and referral platforms are difficult for many residents to use • Need a trusted, locally tailored and maintained resource tool Housing constraints • Lack of affordable housing complicates treatment, recovery, and family stability • Housing solutions extend beyond behavioral health but are essential to outcomes Cultural mismatches in service delivery • Telehealth providers often lack understanding of local culture and community context • Impacts engagement, trust, and service effectiveness Nonprofit capacity • Many nonprofits struggle with infrastructure and operational support • Limited staffing and resources affect coordination and continuity of services
Sustainability Issues	Long-term funding for crisis and care coordination systems • Systems must be funded beyond initial pilots or grants • Sustainability requires alignment with law enforcement, healthcare, and state funding streams Infrastructure support for nonprofits • State grants that support operational infrastructure are essential to keep agencies functioning • Service expansion is not sustainable if agencies cannot keep doors open Ongoing care coordination • Sustaining improved coordination requires dedicated roles, shared tools, and accountability • Care coordination cannot be an “extra task” layered onto existing staff Affordable housing supply • Without long-term housing solutions, behavioral health gains are difficult to maintain Family and caregiver support



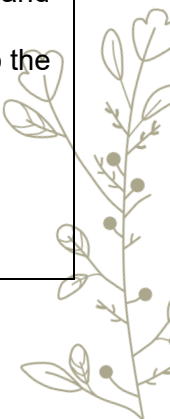


	- Continued investment needed for grandparents raising grandchildren and other informal caregivers - These households are critical to youth stability and prevention Rural-specific policy commitment - Sustainability depends on continued recognition that rural counties need different funding, staffing, and service models - One-size-fits-all approaches will not endure
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2. Hidalgo County

Table 8: Hidalgo County Priorities Discussion

Action Items Most Relevant to Hidalgo County	Housing and transportation are the most urgent and cross-cutting needs - Lack of housing affects crisis response, workforce retention, re-entry, and family stability - Transportation barriers prevent access to healthcare, food, education, and services (people cannot meet needs using bikes alone) - Elderly residents who are still working need transportation assistance - Advocacy should prioritize county-led housing and transportation solutions such as a county van that could help people get to dentist and doctor’s appointments. County would own the van, provide the gas and hire the driver. Can consider repairing current county owned vans that were used for senior care. - To connect with Patricia Lucero to leverage opportunities for weatherizing and upgrading current housing (e.g. The Projects) Integrated crisis services rather than siloed programs - Hidalgo County does <i>not</i> need separate 23-hour crisis, CIT, and mobile crisis programs - Advocate for a single, pooled, integrated crisis response model that combines: - CIT-trained law enforcement. Would need more than one CIT trained officer. - Co-responder team is likely best fit in Hidalgo(social worker + officer) - Crisis stabilization and follow-up. Could also include assertive outreach - Embedded LCSWs and home visits can reduce stigma and improve engagement School-based behavioral health services - Currently no behavioral health services in schools - Advocate for county-hired school-based therapists and crisis teams serving both school districts - Students often prefer being seen at school and it is more feasible than telehealth - Would like a marquee at each school with a list of current resources - Consider creating a newsletter for families about resources for parenting and support - Consider hiring a BH provider through Hidalgo County that has access to the schools and can also support the crisis system. Workforce development and retention - County-based hiring to provide jobs, benefits, and retention - Expand peer support specialists, CHWs, and CIT-trained staff - Incentivize people who want to stay and “love the work”
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	Education and outreach on existing resources • Many residents do not know what services exist in Hidalgo County • Current outreach (e.g., magnets) is outdated or youth-focused only • Need education targeted to adults as well as youth • Use local channels such as newspapers and in-person messaging, not only online listings • Purchase a digital marquee for each school to communicate resources
Implementation Issues	Uninsured population and billing limitations • Crisis services may be billable, but many residents are uninsured • Comparable models (e.g., Las Cruces CTC) require: ▪ ~\$1M budget ▪ ~70% billable services ▪ Minimum daily utilization (1–6 people/day) to be sustainable • Need to assess whether this utilization is realistic for Hidalgo Law enforcement staffing shortages • County is already short on officers • Hiring a full co-response team requires careful staffing and role definition • Co-responders may be more feasible than stand-alone crisis teams County administrative capacity • County would need to: ▪ Become a Medicaid provider ▪ Manage hiring, benefits, and supervision of behavioral health staff • County employment may reduce billing complexity but shifts long-term responsibility to local government School-based service logistics • Transportation remains a barrier for youth needing services outside school • Telehealth via Zoom has limitations (students disengage) • Family therapy and consistent on-site services may be billable • Questions remain about sustainability after initial funding periods (e.g., after 4 years) Transportation system design • Proposal for a county-run van system to transport residents for: ▪ Medical appointments ▪ Grocery shopping ▪ School and family needs • Requires drivers, scheduling, liability coverage, and ongoing funding Housing development complexity • No Section 8, but housing is still critically insufficient • Transitional housing models exist elsewhere (e.g., motel conversion) • Need a multi-year (4-year) action plan to improve housing stock • Community projects (e.g., “the projects”) need city-county collaboration to restart
Sustainability Issues	Long-term funding responsibility • Many solutions rely on county funding, not billing • Sustainability depends on: ▪ County budget commitments ▪ State support (especially as crisis calls become billable) ▪ Realistic assumptions about utilization and staffing

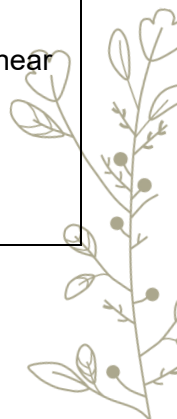


	Workforce retention • County jobs with benefits may improve retention, even if funding is uncertain • Ongoing incentives are needed for: ▪ Peer support specialists ▪ CHWs (more flexible criteria) ▪ CIT-trained officers and clinicians • Specialized training (youth, crisis, substance use) must be continuous Housing sustainability • Even if housing resources expand, there is still not enough supply • Transitional and re-entry housing must be paired with: ▪ Workforce support ▪ Transportation ▪ Activities and meal programs • Past assets (e.g., workforce centers, community spaces) should be revitalized rather than recreated Transportation continuity • Transportation systems must be reliable long-term, not pilot-only • Pandemic-era examples (e.g., meal delivery using school buses) show feasibility but require permanent funding Outreach and awareness • Resource education must be updated regularly • Materials need to be maintained, not one-time efforts • Sustainability requires ownership of messaging and community trust over time
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3. Luna County

Table 9: Luna County Priorities Discussion

	Develop a multipurpose, multigenerational community and recreation center • A free, alcohol-free community hub serving youth, families, adults, and elders • Extended hours to cover after-school, evenings, weekends, and school breaks • Programming beyond athletics, including: ▪ Cooking ▪ Chess and gaming ▪ Art ▪ General mechanics ▪ Seminars, workshops, and clubs ▪ Sports and physical activities • Integration of transportation (bus routes) to ensure access for all residents • Joint involvement and investment from city and county leadership Create a localized Community Needs & Volunteer Bulletin Board • Physical and/or digital bulletin board in central community spaces (e.g., near basketball courts) • Used to advertise: ▪ Volunteer opportunities ▪ Youth chaperones and mentors ▪ Community activities and needs
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	- Adapt and localize Share NM so it reflects Luna County–specific resources and opportunities Expand positive youth engagement and supervision - Provide safe, structured spaces for youth outside school hours - Increase adult engagement and mentoring to support youth development - Promote intergenerational activities and relationships
Implementation Issues	Facility development and coordination - Requires collaboration between city and county governments - Space planning must support diverse age groups and activities - Center must be accessible, welcoming, and safe Transportation logistics - Establish a bus route to and from the community center - Determine whether registration is: - Year-round, or - By semester - Need clear scheduling, supervision, and funding for transit Program design and staffing - Programs should intentionally integrate: - Social skills - Positive community relations - Common courtesy and respect - Need staff or facilitators to run and supervise activities - Alcohol-free policies must be enforced Volunteer recruitment and supervision - Volunteers needed to: - Chaperone youth - Mentor and guide activities - Background checks are required - Volunteer recruitment is challenging and requires ongoing outreach Resource coordination and information management - Share NM or a similar platform must be: - Localized - Regularly updated - Changes in agencies and services (openings, closings, relocations) create maintenance challenges - A dedicated staff person or coordinator is needed to update resources at least every 6 months Marketing and community engagement - Outreach through schools and community networks is essential - Continuous efforts needed to raise awareness and encourage participation Partnership development - Explore partnerships such as with VinTif Solutions to support intergenerational mentoring programs - Requires coordination, shared goals, and role clarity
Sustainability Issues	Long-term funding Operating a free, extended-hours community center requires stable, ongoing funding





	• Transportation costs (buses, drivers, maintenance) must be sustained beyond start-up • Staffing for programming, coordination, and supervision must be funded permanently Volunteer sustainability • Reliance on volunteers requires: ▪ Continuous recruitment ▪ Support and supervision ▪ Clear roles and expectations • Burnout and turnover are risks without adequate support Staff capacity and coordination • Maintaining a community bulletin board and localized resource directory requires dedicated staff • Sustainability depends on having clear ownership of: ▪ Resource updates ▪ Volunteer coordination ▪ Program oversight Community buy-in • Programs must remain relevant and well-used to justify continued investment • Ongoing engagement across generations supports long-term success • Community trust and participation are key to sustaining alcohol-free, safe spaces Partnership continuity • Long-term success depends on sustained collaboration among: ▪ City and county governments ▪ Schools ▪ Community organizations ▪ Volunteer networks • Partnerships must be maintained even as leadership or funding changes
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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 Youth E-SIM: Resources, Gaps, and Action Items Identified Across Breakout Groups

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

A.7 Region Specific Medicaid Snapshot Data

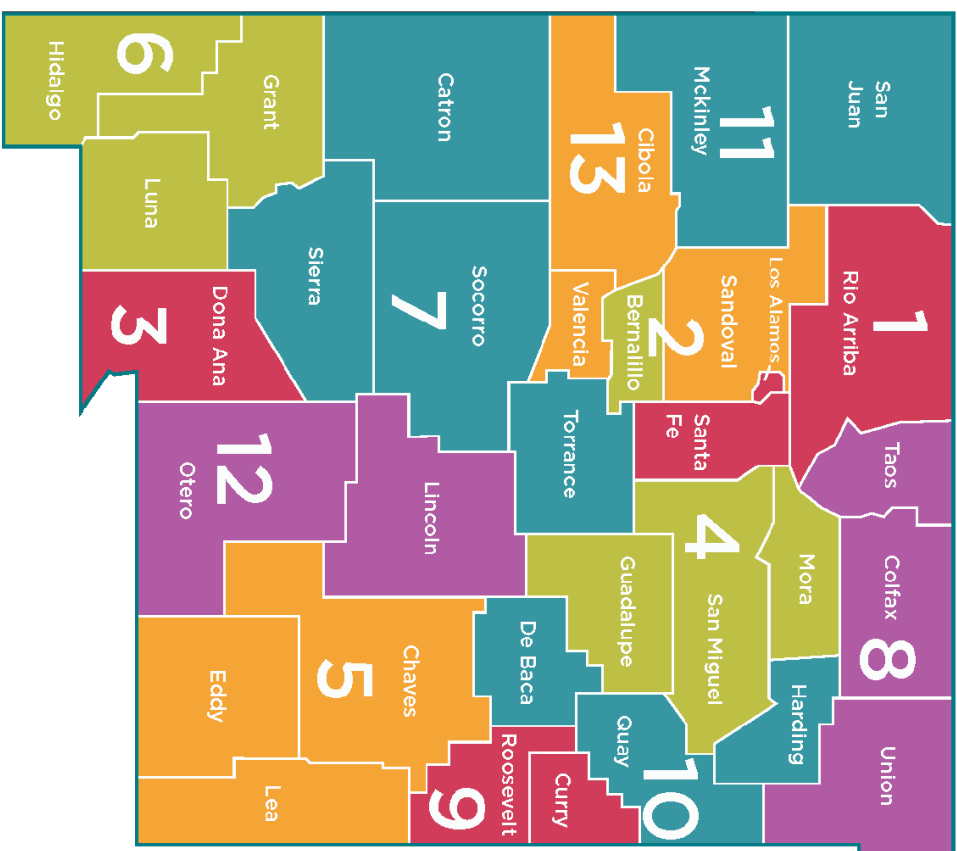
A.8 New Mexico Mortality Data

A.9 PPT of Provision Priority Buckets



Appendix A.1 Map of Behavioral Health Regions

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 11**
- Navajo Nation
 - Pueblo of Zuni

- Region 6**
- Fort Sill Apache Tribe

- Region 8**
- Taos Pueblo
 - Picuris Pueblo

- 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 (includes AL-A-Teen)	DMV	Department of Motor Vehicles
ABC	Airway, Breathing, Circulation	DOC	Department of Corrections
ACEs	Adverse Childhood Experiences	DOH	Department of Health
ACT	Assertive Community Treatment	DV	Domestic Violence
ADA	Americans with Disabilities Act	DWI	Driving While Impaired
AOC	Administrative Office of the Courts	E-SIM	Enhanced Sequential Intercept Model
AOT	Assisted Outpatient Treatment	EBP	Evidence-Based Practice
APO	Adult Probation Office	ECECD	Early Childhood Education and Care Department
BH	Behavioral Health	EHR	Electronic Health Records
BHR	Behavioral Health Region	EMDR	Eye Movement Desensitization and Reprocessing
BHRIA	Behavioral Health Reform & Investment Act	ER	Emergency Room
BHSD	Behavioral Health Services Division	EMS	Emergency Medical Services
BHTAC	Behavioral Health Technical Assistance Center	EMT	Emergency Medical Technician
Boot Heel	Boot Heel Youth Association	FERPA	Family Educational Rights and Privacy Act
CATS	Coalition Against Teens (using) Substances	FFT	Functional Family Therapy
CBPYR	Community-Based Prevention, Intervention & Reunification Program	FMCSA	Federal Motor Carrier Safety Administration
CBPIR	Community Based Prevention, Intervention, and Reunification	FQHC	Federally Qualified Health Center
CCA	Children's Court Attorney	GED	Generalized Education Development
CCSS	Comprehensive Community Support Services	GPS	Global Positioning System
CEU	Continuing Education Unit	HCA	Health Care Authority
CHI	Center for Health Innovation	HMS	Hidalgo Medical Services
CHW	Community Health Worker	HS	High School
CIT	Crisis Intervention Team	HRSA	Health Resources and Services Administration
CJ	Criminal Justice	ID	Identification/Identify
CME	Continuing Medical Education	IDA	Impaired Driving Assessment
CMS	Centers for Medicare & Medicaid Services	IOP	Intensive Outpatient Treatment
CNA	Certified Nursing Assistant	JCC	Juvenile Community Corrections
CPR	Cardiopulmonary Resuscitation	JJCS	Juvenile Justice Continuum of Services
CPSW	Certified Peer Support Worker	JJS	Juvenile Justice Services
CSW	Community Support Worker	JPO	Juvenile Probation Officer
CTC	Crisis Triage Center	LCSW	Licensed Clinical Social Worker
CYFD	Children, Youth, and Families Department	LEAD	Law Enforcement Assisted Diversion
DA	District Attorney	LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning/ Intersex, Asexual, and +
DARE	Drug Abuse Resistance Education	LSAA	Licensed Substance Abuse Associate
DBT	Dialectical Behavior Therapy	MAT	Medication Assisted Treatment
		MCO	Managed Care Organization
		MH	Mental Health

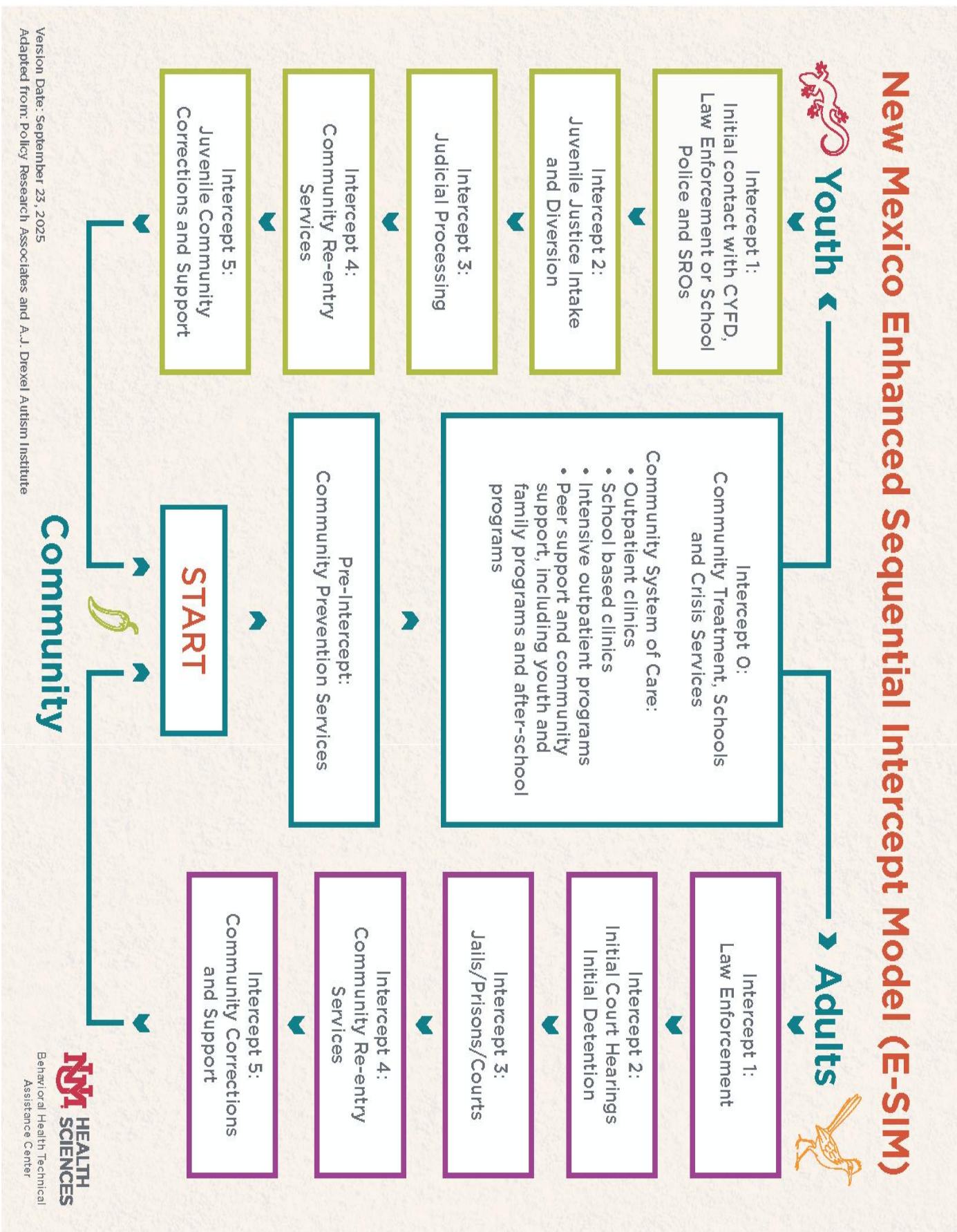




MHFA	Mental Health First Aid
MI	Mental Illness
MOU	Memorandum of Understanding
MST	Multisystemic Therapy
NUPAC	Nicotine Use Prevention and Control
OT	Occupational Therapy
PACES	Productive and Compensatory Experiences
PAX	Peace, Productivity, Health and Happiness
PC	Primary Care
PCP	Primary Care Provider
PD	Police Department
PSR	Psychosocial Rehabilitation
PT	Physical Therapy
QR	Quick Response
QPR	Question, Persuade, Refer
RBT	Registered Behavioral Technician
RISE	Reach, Intervene, Support, Engage
RMC	Recovery Management Center
RN	Registered Nurse
ROI	Release of Information
RTC	Residential Treatment Center
SA	Sexual Assault
SAS	Sexual Assault Support
SASS	Silver Regional Sexual Assault Support Services
SB3	Senate Bill 3
SBHC	School-Based Health Center
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SEL	Social Emotional Learning
SPIN	Supporting People In Need
SRO	School Resource Officer
SS	Social Security
STC	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
TLC	Transforming Luna County
VA	Veterans Administration
WOTC	Work Opportunity Tax Credit
WNMU	Western New Mexico University
YMCA	Young Men’s Christian Association



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



Appendix A.4 Workshop Agenda

E-SIM Mapping and Prioritization Workshop Behavioral Health Region 6

Tuesday, March 24, 2026 – Thursday, March 26, 2026

“Growing a Connected Community”

Tuesday, March 24th, 8:30 AM - 4:30 PM — Mimbres Valley Special Events Center, Deming, NM

Day 1: Mapping of Youth System

- 8:30 AM** — **Workshop Open for Registration, Networking and Continental Breakfast**
— Event Center Main Room
- 9:00 AM** — **Welcome**
— Event Center Main Room
- **Heather Edwards**, Behavioral Health Coordinator, Region 6
 - **Charlene Webb**, Grant County Manager
 - **Tisha Green**, Hidalgo County Manager
 - **Chris Brice**, Luna County Manager
 - **Steve Pierce**, CPSW, Recovery Management Center; 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**
Overview of Regional Medicaid Snapshot and State Epidemiological Data
— Event Center Main Room
- **Caroline Bonham, MD**, UNM Department of Psychiatry and Behavioral Sciences
- 9:50 AM** — **Pre-Intercept (Prevention): Mapping Existing Services, Gaps and Opportunities**
— Breakout Rooms
- 11:05 AM** — **Break**
- 11:15 AM** — **Intercept 0: Mapping Existing Services, Gaps and Opportunities**
— Breakout Rooms
- 12:30 PM** — **Lunch**
— Event Center Main Room
- 1:30 PM** — **Mapping Intercept 1**
— Breakout Rooms
- 2:30 PM** — **Break**
- 2:45 PM** — **Mapping Intercepts 2 and 3**
— Breakout Rooms
- 3:30 PM** — **Break**
- 3:45 PM** — **Mapping Intercepts 4 and 5**
— Breakout Rooms

Breakout Room 1
Room 114

Breakout Room 2
Room 116

Breakout Room 3
Room 120



Bristol Myers Squibb



NAMI New Mexico

NM HEALTH SCIENCES
Behavioral Health Technical Assistance Center

E-SIM Mapping and Prioritization Workshop Behavioral Health Region 6

Tuesday, March 24, 2026 – Thursday, March 26, 2026

“Growing a Connected Community”

Wednesday, March 25th, 8:30 AM - 4:30 PM — Mimbres Valley Special Events Center, Deming, NM

Day 2: Mapping of Adult System

- | | |
|----------|---|
| 8:30 AM | Workshop Open for Registration, Networking and Continental Breakfast
— Event Center Main Room |
| 9:00 AM | Welcome
— Event Center Main Room <ul style="list-style-type: none"> • Heather Edwards, Behavioral Health Coordinator, Region 6 • Lidia Vega Chavira, LMSW, LADAC; NAMI Speaker, In Partnership with the National Alliance on Mental Illness (NM) and Bristol Myers Squibb Review of Previous Activities and Overview of the Day
— Event Center Main Room <ul style="list-style-type: none"> • Caroline Bonham, MD, UNM Department of Psychiatry and Behavioral Sciences |
| 9:30 AM | Pre-Intercept (Prevention): Mapping Existing Services, Gaps and Opportunities
— Breakout Rooms |
| 10:45 AM | Break |
| 11:00 AM | Intercept 0: Mapping Existing Services, Gaps and Opportunities
— Breakout Rooms |
| 12:15 PM | Lunch
— Event Center Main Room |
| 1:15 PM | Mapping Intercept 1
— Breakout Rooms |
| 2:15 PM | Break |
| 2:30 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
— Event Center Main Room <ul style="list-style-type: none"> • Caroline Bonham, MD, UNM Department of Psychiatry and Behavioral Sciences |

Breakout Room 1
Room 114

Breakout Room 2
Room 116

Breakout Room 3
Room 120



E-SIM Mapping and Prioritization Workshop Behavioral Health Region 6

Tuesday, March 24, 2026 – Thursday, March 26, 2026

“Growing a Connected Community”

Thursday, March 26th, 8:30 AM - 4:30 PM — Mimbres Valley Special Events Center, Deming, NM

Day 3: Prioritization

- | | |
|----------|--|
| 8:30 AM | Workshop Open for Registration, Networking and Continental Breakfast
— Event Center Main Room |
| 9:00 AM | Welcome
— Event Center Main Room <ul style="list-style-type: none"> • The Honorable Judge James B. Foy, District Court, Grant County • Heather Edwards, Behavioral Health Coordinator, Region 6 Overview of Goals for the Day
Review of Discussion from Previous Day with Suggested List of Priorities
— Event Center Main Room <ul style="list-style-type: none"> • Caroline Bonham, MD, UNM Department of Psychiatry and Behavioral Sciences |
| 10:15 AM | Silent Ranking Using Dots for Final Priority List
— Event Center Main Room |
| 10:30 AM | Break |
| 10:45 AM | Review Top 5 Priorities Based on Voting
— Event Center Main Room |
| 11:15 AM | Small Group Discussion of Priority 1
— Breakout Rooms |
| 12:15 PM | Working Lunch/ Evaluation
— Event Center Main Room |
| 1:15 PM | Small Group Discussion of Priorities 2 & 3
— Breakout Rooms |
| 2:15 PM | Small Group Discussion of Priorities 4 & 5
— Breakout Rooms |
| 3:15 PM | Break |
| 3:30 PM | Small Group Discussion of Other Priorities and Identification of Top Priorities for Counties
— Breakout Rooms |

Breakout Room 1
Room 114

Breakout Room 2
Room 116

Breakout Room 3
Room 120





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

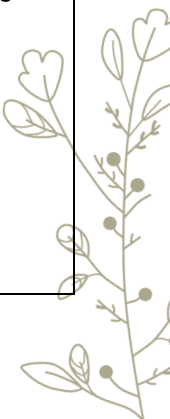
On the first day of the workshop, participants were divided into three breakout groups, with roughly equal representation from the seven stakeholder groups, to identify resources, gaps and opportunities at each intercept of the Youth E-SIM. Each group also included UNM BHTAC facilitators, note-takers 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	• Youth sports programs across Grant, Luna, and Hidalgo Counties (basketball, wrestling, volleyball, recreation centers, skate parks, batting cages) • After-school and enrichment programs including arts, mural programs, fine arts studios, music, dance, bilingual programming, technology, and creative competitions • Police Athletic League programs (serving both boys and girls). • Officers serving as coaches or involved in after-school activities, strengthening relationships with youth • Positive Action after-school program • 4 H programs and recreation centers (Grant County) • Lions Quest youth support groups • Community-based programs including: -Luna Star (dance, music, arts) -Juslee Agency (after hours youth gathering space and activities) -Silver City community center	• Lack of structured, safe youth spaces (e.g., Boys & Girls Clubs, YMCA) • Youth can get in trouble at community spaces, especially without adult supervision • Need for more sports activities for younger kids instead of punishment • Need to establish programs that address lack of social skills, isolation, not just substance use	• Develop one stop, community-based resource centers and “third spaces” for youth • Expand after-school, weekend, and summer programming focused on: -Life skills, job skills, SEL, arts, technology, and creative outlets -Anti-bullying education and restorative approaches • Integrate mentorship programs (school based and community based). • Increase structured, supervised spaces to reduce risk and system involvement • Expand cooperative, noncompetitive activities and shared community spaces • Explore adding youth development organizations (Boys & Girls Clubs, YMCA) • Develop after school programs to keep kids busy with positive things (life skills, job skills) e.g. Big Brothers & Big Sisters • Foster greater community engagement in the development and establishment of after-school programming to build trust and rapport with families





	-Boys Council, Girl Circle, math and reading interventions, Keep County Beautiful -PAX Good Behavior Game (Belle Elementary and upcoming expansion) • Silver City rec center—sports, dance studio, games • Community Partnership for Children (CPC) connects parents with resources, youth sports; A new recreation center free for youth – wrestling, basketball, volleyball, etc. with parents and kids attending		
School-Based Supports	• School-based social emotional learning (SEL), counseling services (Pre K–12), Positive Action, Lions Quest, Strengthening Families, and life skills curricula • Middle school and alternative learning labs for adjudicated or suspended youth (academic remediation, SEL, tutoring) • DARE, CIT trained officers, School Resource Officers (SROs), Police, US Customs and Border Patrol Explorers programs • Suicide prevention, violence prevention, domestic violence and sexual assault prevention programs in schools • Red Mountain Community School model (Luna County): open door, community integrated school with food, clothing bank, health promotion, and family engagement • Mentoring programs for middle school youth • Access to school facilities for programming • Parents as teachers, SBHCs (all 3 counties,	• Bullying (including social media bullying) not adequately addressed; poor follow up and prevention • FERPA and privacy issues limiting coordination • Youth lack safe, supervised spaces after school and on weekends • Insufficient non-sports programming (arts, technology, life skills) • Limited SRO availability in some counties; inconsistent prevention presence • Geographic isolation limiting access to school linked services • Schools sometimes resistant to allowing prevention partners (e.g., NUPAC, DWI prevention) due to competing programs • No community schools in Grant or Hidalgo Counties • Luna County—lack of school counselors; currently recruiting; lack of licensed counselors in the state	• Implement comprehensive, coordinated anti-bullying prevention and response programs • Review and update school policies related to bullying, attendance, and prevention access • Expand SEL for students and families • Strengthen SRO prevention roles and trust building, including expansion to underserved counties • Integrate life skills education into school curricula • Expand evidence-based prevention programs (PAX Good Behavior Game, NUPAC) • Community and charter schools more open to outside prevention and intervention resources • Strengthen formal collaboration between prevention and treatment at middle- and high-school levels • Build infrastructure for community-based Resource Center where prevention programming and SROs can create programming and a third space for children • Expand SRO involvement to Grant County to continue building trust and rapport with kids across schools





	PC and BH for most), food boxes, parent information sessions with therapists, support for homeless students • School counselors Pre-K-12 within elementary counselor and specialist teaching SEL in Luna County across all schools • Misdemeanor program prevention specialists at the schools and teaches prevention at schools in Grant County (psyched on cyberbullying, drug use) for 6, 7 & 8 grade, Clint High School junior & senior education • New Mexico School for the Deaf has outreach program		
Family & Parenting Supports	• Strengthening Families programs available in Luna and Hidalgo Counties	• Limited parent engagement due to work schedules, transportation, incarceration, stigma, or distrust of systems. • Need for parenting education, accountability, incentives, and non-judgmental outreach • Intergenerational trauma, substance exposure in the home, and normalized poverty • Grandparents raising grandchildren need support and respite • Language and cultural barriers, including monolingual Spanish-speaking families and deaf/hard of hearing families • Shortage of childcare providers • Families need support; parenting classes; they have multigenerational trauma, financial instability	• Increase parenting education, family coaching, and multigenerational trauma-informed services • Expand home visiting and community outreach models (“go to them”) • Provide incentives, transportation, clothing stipends, and basic needs supports to increase participation • Target supports for incarcerated or reentering parents, grandparents raising grandchildren, and working families • Ensure bilingual, culturally responsive, and non-punitive engagement approaches • Increase childcare provider capacity and training • Develop programming for pregnant and postpartum women, extending support through early childhood and elementary years • Expand behavioral health services for parents and caregivers (especially single parents and grandparents raising children)





			• Create individualized supports beyond group programs like Strengthening Families • Pool resources to connect parents to state resources & funding • Develop greater outreach and home visitation for parents (e.g. those who fear, have limited trust with law enforcement)
Youth Development & Vocational Supports	• Youth employment and workforce programs: NM Workforce/America Job Center internships, paid work experience, tuition assistance, job skills pathways, economic development training, charter school job readiness • Youth conservation, leadership, and environmental programs (past and current) • University partnerships for internships and workforce training • Quinceres Luna County, hires youth • Explorers program for law enforcement job training and mentoring 16+, physical activity, learning about law enforcement; PD 12+ • Casa mentoring program • New Mexico Tech-Economic development master class give trainings and certifications for Tri-County to build economic development vocational support for youth • Teddy Bear Clinic – EMTs interact with kids and fix their teddy bears to teach about EMT work	• Need GED for some NM Workforce tuition assistance; Limited budget but can still provide assistance while waiting • Very limited jobs for teenagers	• Strengthen long term mentoring pathways (e.g., 6th grade through high school) • Spend more time talking with youth earlier about how they want to be part of society
Mental Health & Substance Use	• Recovery Management, Intensive Outpatient Programs (including virtual), and substance use prevention coalitions • Behavioral Health providers offering prevention, outreach,	• Shortage of child and youth behavioral health providers (especially under age 12) • Lack of licensed counselors in some counties and BH workforce instability	• Expand Recovery Management Centers and evidence-based BH models • Improve provider wellness and retention strategies • Increase mental health training for non-traditional partners (employers, businesses)



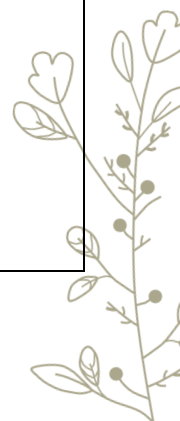


	psychoeducation, mobile clinics, and mobile crisis (limited availability) • Juvenile Probation Officers (JPOs) providing prevention services, strengths-based case planning, and family engagement prior to justice involvement • Border Patrol and National Guard collaboration on DARE and family resource education • Silver regional sexual assault support services & child advocacy center: Violence prevention, DV SA primary prevention in the schools to prevent perpetration and victimization	• Closure or lack of behavioral health centers and detox services • Youth sent out of state for care due to lack of local services • Limited telehealth capacity and access challenges	• Educate businesses about prevention (e.g., vape and alcohol sales to youth) • Embed behavioral health providers in recreational settings without labeling activities as “therapy”
Housing & Basic Needs	• Housing-related supports (opioid recovery housing, student housing grants, McKinney Vento supports) • Public Health services across counties: immunizations, STI testing, family medicine, nutrition, health education • Community partnerships: churches, nonprofits, health councils, DWI programs, food security programs, hygiene kits, shoes, backpacks • Food banks, clothing assistance, scholarships, and emergency support funds • Roadrunner Food Bank • HMS mobile health clinics • National center for frontier communities for youth for food security and environmentalism (Grant County) • Federal grants available to provide support to unhoused students in Luna and Grant County • Behavioral Health Center; Backpack/School Supply	• Severe housing shortages, including loss of low-income housing • Youth and families experiencing homelessness or couch surfing • Transportation barriers across rural counties (services, school, parent involvement) • Food insecurity and unmet basic needs persist for many families • Don’t have a youth shelter in the region. Last one shut down in early 2000’s	• Provide a stipend toward school clothes, transportation and support kids may not have at home • Increase access to transportation for community events and services





	program (across all counties) • Rockin’ The Streets: a scholarship for kids for help with medical bills, cancer treatment, deaths/funerals		
Other Community Resources	• Boot Heel Youth Organization monthly activities; camping, leadership, creativity, and mental health–focused events • Translated and bilingual prevention materials (Spanish/English), bilingual and culturally specific programming • Free or low-cost community activities and public spaces (parks, lakes, fishing days, community events) • National Night Out, DWI programs, and community engagement events involving justice partners • Youth and family engagement events (teen nights, movie nights, bowling, art programs) • Community resource directories and health fairs (behavioral and physical health) • Tri-county collaboration groups working to share resources and reduce duplication • Teen Maze prevention program in Luna that is available tri-county: long standing experiential prevention curriculum (Narcan, substance use, teen pregnancy, law enforcement, job readiness) • Faith-based youth activities • CYFD JJS has some preventative services offered before CJ system involvement, available in all counties	• Awareness gaps: families don’t know that prevention services are available without justice involvement • Insurance and policy restrictions determining care rather than need • Fragmented systems and poor cross-agency communication • Providers, educators, and officers experiencing burnout and lack of wellness supports • Youth recruited into risky or criminal activity due to lack of opportunity and support • Lack of awareness and misconception about prevention programs and that families can access them without CJ involvement • Language barriers for deaf and hard of hearing; limited resources • Need hard copies of Luna County community resource directory	• Create consistent, coordinated, cross agency prevention systems across counties • Strengthen collaboration among schools, families, youth, behavioral health, law enforcement, and community organizations • Pool funding and resources to reduce fragmentation and expand reach • Fund and strengthen existing community coalitions • Increase trauma-informed and destigmatizing training across all systems • Intervene earlier, with younger children, to reduce deeper system involvement later • Remain consistent with programming • Develop website and staff to keep it up to date with resources to collaborate • Staff with people who can help with reporting, data collection and recording to help with sustainability



	• CHI in Luna County CATS prevention, youth and parent prevention presentations, program serves all counties • Department of Health can provide preventive presentations in schools across all counties on vaping, bullying, STD 101 • Luna County Health Council has a community resource directory		
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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	• CIT trained law enforcement, first responders, and crisis teams (capacity varies by county) • Mobile crisis response in Hidalgo County; efforts underway to expand to Grant and Luna • Deming Public Schools district crisis intervention team and outside counselors that come in and provide support depending on the crisis during school hours	• Long crisis response wait times; limited mobile crisis and youth crisis respite options • Crisis response often routed through hospitals with mixed or stigmatizing experiences • Limited mobile crisis coverage; difficulty recruiting and retaining staff	• Develop youth specific crisis systems, respite options, and mobile crisis units • Ensure higher-level supports for community programs during crises or suicidality • Establish crisis triage center and other crisis services in all counties • Training for workforce on responding to crises in non-stigmatizing ways • Incentivize showing up and developing programming for crisis calls by providing a stipend
Child & Family Support / Child Welfare	• Early intervention home based programming (Parents as Teachers)	• Low parent engagement when services are not mandated • Stigma, fear of judgment, and confidentiality concerns • Parents struggling to understand medication impacts and treatment intensity • Limited childcare, extended hour services, and supports for single parents	• Expand childcare services, extended hours, transportation supports, and wraparound care • Develop parent coaching programs (including medication management education) • Strengthen power sharing and trust between families and providers • Expand home-based outreach and community health worker models

		• Housing instability for families and workforce • “Not in my backyard” resistance to supportive housing (especially for adults)	• Ensure culturally responsive, non-stigmatizing service delivery • Develop multi-level mental health stigma reduction campaigns, including: -Parent and family education -School-based mental health curriculum -Community education beyond grades/testing -Spanish language and culturally responsive media (radio, newspapers) • Build or strengthen coalitions focused on youth substance use prevention (smoking, drinking, drugs) • Expand Parents as Teachers to help develop parent coaching programming for medication management & increase awareness
Hospitals & Inpatient Care	• Emergency room in Deming- Mimbres Memorial hospital • If kids need to be hospitalized they go to Cruces or go out of state (El Paso) • Residential treatment Center services for kids (Colorado, Texas) don’t have an RTC locally	• Higher number of private hospitals in region • Deming schools try not to send youth to local hospitals; didn’t have good experiences	• Develop youth residential treatment and aftercare capacity within the region
Mental Health & Substance Use Services	• Behavioral health agencies providing family peer support, psychosocial rehab, CCSS, RBT services, MST, play therapy, trauma-informed therapies, DBT, FFT, EMDR, and case management • Winborn Wellness and Counseling • Intensive Outpatient Programs (IOP), including Charlie Health (virtual group/individual therapy, psychiatry, caregiver and therapist supports) • Recovery Management programs offering long-term family outreach, prevention, re unification, substance use and	• Shortage of licensed behavioral health providers, school counselors, psychologists, care coordinators, and crisis staff • Long waitlists for assessments, therapy, medication management, MST, and residential placement • No local youth residential treatment center, youth shelter, or crisis triage center • Out of county and out of state treatment required due to lack of local services • Provider burnout, unpaid on call expectations, and lack of wellness supports	• Recruit and retain licensed providers, school counselors, crisis staff, and care coordinators • Offer incentives, stipends, and “train the trainer” models (CIT, de-escalation) • Advocate for cross-state licensure and policy reforms • Provide burnout prevention, decompression workshops, and wellness supports • Extending the Re-boot recovery model from ABQ for BHR 6 • JPOs would like to have licensed BH providers in-house so they can diagnose and not send families to other settings • Need to have evening and weekend service hours • Hidalgo – need for providers and to attend Health Council meetings, not just via zoom but



	mental health counseling, parenting groups, aftercare, and court/self-referral options • Sexual assault and domestic violence prevention and outpatient therapy services (Silver Regional SAS, La Casa, Border Area Mental Health, La Pinon) • Medication management providers and outpatient therapy across tri-county areas (limited availability) • Detox services accessed in Las Cruces (Peak, Mesilla Valley); hospitals often used for crisis stabilization • MST (Multisystemic Therapy) providers serving youth (though based outside the region) • Al-A-Teen and AA programs for youth • Family peer support workers in BH agencies—coaching, connecting to resources (all 3 counties) • CCSS • Registered Behavioral Technician (RBT) works with families with children with developmental disabilities	• Difficulty recruiting professionals to rural areas due to housing shortages and quality of life factors • Evidence-based models not always culturally aligned or locally adaptable • Inconsistent program funding and lack of sustainability • Limited volunteers for youth programs (e.g., AA/Al A Teen), compounded by liability concerns • Many clinicians and educators are trained for adults, not children; limited attachment-based and developmental expertise • Limited awareness of positive childhood experiences (PACES) compared to ACEs • Severe shortage of child psychiatrists • CCSS and other services require diagnosis and may prevent people from seeking them • People willing to get substance abuse services need services immediately, if they're willing to go to services • People may get sober while waiting for services and then they don't qualify for services • PCPs can provide med management but don't seem as comfortable--depending on age, presenting concern, dosage • Behavioral health funding is tied to each hour. No funding to cover no-show appointments, meetings with parents and schools	in-person – All service providers come from Luna or Grant with limited access (e.g. only one day a week despite being hired specifically for Hidalgo)
School Health Centers & Systems	• School counselors, social workers, crisis intervention teams,	• Limited school-based health center service hours (especially	• Expand SEL instruction and mental health supports in schools



	wellness rooms, and daily student check-ins • School-based health clinics (medical and limited behavioral health/telehealth) • Social Emotional Learning (SEL) programs in elementary schools and districts • Academic supports (math, reading interventions, internships, learning labs) • School contracted counseling services and external crisis responders • Collaboration between schools, JPOs, and community agencies for referrals and prevention • Silver schools have wellness rooms with social workers • Deming Schools re-examining suicide risk and threat procedures; staff got training recently; have training in suicide response for admin and counselors	evenings, weekends, and summers) • Educators and caregivers often lack behavioral health training • Communication between schools and parents of children who are crossing the border for education (e.g. maybe setting up zoom)	• Create meditation/quiet rooms and trauma-responsive environments • Increase school district collaboration and shared services • Integrate life skills, career readiness, and internship pipelines • Increase number of licensed school counselors in each school
Care Coordination & Policy	• Exceptional informal collaboration across nonprofit organizations	• Fragmented systems requiring families to navigate multiple locations and agencies • Fragmented systems, multiple record systems, and expensive data infrastructure costs • No wraparound services model locally • MCOs do not pay for providers to be sent to schools (Policy issue)	• Create shared cross-county data systems, resource websites, and reporting infrastructure • Fund participation in cross-agency collaboration to reduce silos • Improve engagement of city councils, leadership, and funders in behavioral health planning • Hire a regional liaison to improve communication between the region and the state (BHSD) • Improve partnerships with state agencies • Improve cross-county treatment collaboration and resource sharing • Establish after-care programs to keep reaching out to kids to be engaged and stay on the right path



			• Wraparound services for siblings and families of youth with mental health concerns • Strengthening relationships and education to ensure city council and management are at the table and a part of conversations • Funding for care coordination team (e.g. continuum care or aftercare) to support families and children as they discharge from treatment (e.g. rehab) to ensure behavioral health, medical care and basic needs are being met for youth and their families
Other / Overarching Themes	• La Vida (Luna) provides physical therapy and occupational therapy to youth	• Poor awareness and marketing of available services • Lack of a centralized community hub or shared referral system • Duplication of services alongside unmet needs due to weak coordination • Policy barriers (MCO reimbursement, school service restrictions, licensure issues) • Limited youth voice, community engagement, and inclusion of people with lived recovery experience • Columbus and other rural communities are frequently underserved • Youth who are unenrolled, unhoused, or disconnected from schools fall through gaps • Youths being recruited by cartels for work & “easy money”	• Establish in-person community resource hubs and shared referral systems • Close generational gaps by building healthy alternatives to excessive technology reliance • Strengthen resources for youth so kids feel supported by their community and not recruited by cartels • Re-brand names of services so they aren’t stigmatizing or scare people away • Increase tri-county awareness and resource events; people may want to go to other counties for services • Expand community resource specialists • Fund opportunities for organizations to be less siloed, fund people within agencies to attend meetings once or twice a month to share resources • Fund multiple tiers of intervention: -24/7 crisis stabilization -Short term inpatient (e.g., 2 weeks) -Longer-term residential treatment (e.g., 6 months)

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 referrals to Juvenile Probation Officers (JPOs) and schools to check grades, attendance, and assess needs • JPOs provide strengths-based assessments, referrals, and early engagement with youth (often youth open up more without parents present) • Collaboration between CYFD, law enforcement, JPOs, schools, and nonprofits across counties • Caring, committed SROs and law enforcement presence (including retired officers) contribute to feelings of safety • Community response to collaboration is strong; coalitions know one another and work together • Statewide focus and prioritization on behavioral health	• Insufficient number of SROs across counties due to lack of funding, with some counties having none • Limited JPO visibility and presence when referrals are low • Workforce shortages across behavioral health, SROs, childcare providers, and crisis response teams • At this intercept, JPOs can only encourage; can't enforce • Kids can be truant for simple things like lack of clothes, internet, housing	• Improve coordination among schools, CYFD, JPOs, law enforcement, and nonprofits • Increase the number of SROs focused on mentoring and prevention • Train SROs to deliver prevention education • Explore possibility of adding SROs to schools in Grant and Hidalgo counties
CYFD Initial Contact	• No resources noted	• Stigma around using services and engaging with CYFD and behavioral health • CYFD often perceived negatively; community sees the agency as “taking kids away” • Lack of foster parents; children placed in unsafe or inappropriate settings	• Develop targeted marketing to improve perceptions of CYFD and reduce stigma • Provide education for parents about behavioral health, rights and responsibilities, and relevant laws • Need for more CYFD involvement for safety/living standard checks
School Police & Threat Assessment	• Schools make referrals to counseling, behavioral health services, and diversion resources • Some districts are shifting from discipline-based approaches toward relationship building with students • Use of releases of information to coordinate		• Explore schools as a potential coordination hub



	care and share information • Case-by-case school responses to repeated behavior, with attempts to refer to school counselors before law enforcement involvement		
Diversion & Early Intervention	• Teen Court and restorative/prevention diversion programs (self-referral, parent referral, JPO referral) • Teen Court programs providing community service, jury participation, and first offense diversion (active in some counties, previously available in others) • Diversion options handled on a case-by-case basis prior to formal juvenile justice involvement • Collaboration between SROs, schools, JPOs, JSS, and courts—particularly strong in Luna County • County-wide collaboration and communication across agencies. • Acknowledgment of diversion and prevention as shared responsibility	• Lack of after-hours and weekend services • Difficulty staffing crisis teams, especially in rural areas • Youth diversion and assistance is largely voluntary at this stage; limited ability to ensure follow through • Basic needs (clothing, toiletries, school supplies) are often only available once youth enter the justice system • Lack of centralized coordination or a “one stop shop” at this intercept • Low follow-through once referrals are made • Insufficient aftercare support once diversion or group participation ends • Lack of services and supports after hours and weekends	• Reframe services as supportive rather than punitive • Engage faith-based organizations to leverage existing trust • Include youth, parents, and people in recovery in planning and feedback • Create a one-stop-shop community hub for youth and families • Develop clear referral pathways and shared understanding of roles • Invite courts, law enforcement, schools, CYFD, and community providers to jointly clarify referral processes • Develop stronger continuum of care and aftercare supports from diversion through reentry • Improve trust, consistency, and cultural responsiveness so families remain engaged in services • Develop programs specifically for siblings of court-involved youth to address secondary trauma

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	• JPO and Juvenile Community Corrections (JCC/JJS) addressing basic	• No juvenile services at Intercept 2 level in some counties (Grant, Hidalgo) • No local pre-adjudication detention; closest is Las	



	- needs (stability, supervision, monitoring) • Use of time waivers (up to 120 days) with supervised or unsupervised periods to establish non-criminal activity • GPS ankle monitoring as an alternative to detention • Court related awareness of system gaps, with staff informally filling gaps where possible	Cruces but could go to ABQ or Farmington • Labels like houseless, diagnosis, juvenile delinquent are required for some services	
Initial Processing	• Juvenile Probation Officers (JPOs) conduct pre-adjudication evaluations and informal case handling • Recovery Management Centers (RMC) collaborating with agencies for adjudicated youth assessments, treatment planning, and coordination • Windborn behavioral health services serving tri county populations (large caseload, primarily behavioral interventions)	• Workforce shortages of therapists; providers leave after licensure hours or due to low wages • Long waitlists for therapy and treatment services • Inconsistent competency to stand trial determinations for youth; limited pathways when found incompetent • Children found not competent often returned home with minimal treatment options • High rates of intellectual and developmental disabilities, linked to environmental factors, with limited diagnostic and early intervention services	

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

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

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

Category	Resources	Gaps	Opportunities
Courts	• Judges emphasizing treatment and	• Rural challenges: transportation barriers, school-wide peer overlap	• Explore feasibility of having youth treatment courts and IOPs in region





	rehabilitation over punishment for youth • Children’s Court operating in all counties; Silver City court location provides closer access than other regions • Teen Court • Silver City has a court nearby which is helpful, not as remote and far away. Serves both children and adults • Used to have advocates who participated in different programming.	affecting Teen Court viability • Explore feasibility of youth treatment courts, IOPs, and expanded outpatient options • Develop additional in-home, community-based, and attachment-focused interventions • No teen court in Grant or Hidalgo counties • Teen court funding has been discontinued recently, so some shut down • No youth specialty courts or treatment courts; previous programs discontinued due to funding cuts, low referrals, or perceived harm	
Detention & Commitment	• Border partners for adjudicated youth in Mexico can able to work their community service hours across the border • GPS ankle monitors • 120-day time waiver; supervised or unsupervised time to establish and maintain non-criminal activity	• No juvenile detention center in the region; youth placed far away (Las Cruces, Albuquerque, other state facilities) • Limited inpatient and outpatient behavioral health services; no local IOPs or RTCs • Lack of local facilities increases distance from families, lawyers, and consistency of care • Expensive and logistically challenging to house juveniles outside the region	• Advocate for juvenile facilities and crisis-appropriate placements closer to home
Programs for guardianship/kinship	• No resources noted	• Youth sometimes return from placements with increased trauma due to inadequate or inappropriate resources	

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

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





Table 6: Youth System Intercept 4: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Community Re-Entry Services	• Juvenile Probation Officers (JPOs) create individualized reentry action plans for youth • Local JPOs often set up appointments before release and continue support post probation • Youth returning from placement are assigned case managers • JPOs connect youth to behavioral health services (Recovery Management, Winborn) and support while youth are in corrections • JCC/JJCS provide case management, job support, life skills training, and basic needs assistance, even after probation ends • CYFD provides financial supports for youth aging out of foster care • Identification of youth needs and early referral systems are in place • Reintegration Center in Albuquerque provides service and community connections (regional resource) • Alternative school options for youth who do not succeed in traditional settings (including strong programs in Grant County) • GED programs: WNMU in-person classes; Cesar Chavez evening classes • NM Youth Challenge (Roswell) for eligible youth (no felony/not on probation) • Cesar Chavez School and Workforce Solutions support youth workforce connections • Limited transitional housing available for youth 18+	• Limited support for youth transitioning back from juvenile facilities to schools • No local reintegration centers; youth often go to Albuquerque for intake • Lack of structured, local re-entry programs to support staying out of trouble • Limited or no transitional or reintegration housing for youth (all genders) • No secure or alternative schools in Luna and Hidalgo counties • Reintegration is especially difficult in small communities due to stigma and lack of forgiveness • Social influences (social media, music, peer groups) reinforce problematic behavior • Few prosocial activities or structured pathways post-release • Insufficient parent engagement and support during reintegration • Heavy reliance on grandparents without adequate systemic support • Challenge for youth to reintegrate socially after justice involvement • Limited adult role models and mentors to guide youth toward careers and positive futures • Limited behavioral health workforce; difficulty hiring and retaining therapists • Community organizations often rely on unpaid staff or volunteers to supervise mandated youth • Lack of training for community organizations to support justice-involved youth	• Create welcoming reentry practices when youth return from placement • Develop CPSW (child protective/social work) or similar training opportunities for youth workforce pathways • Create structured local reintegration programming with continued support after discharge • Individualize reentry supports, pathways, and opportunities for each youth • Scaffold reintegration into prosocial settings gradually and intentionally • Continue and expand post probation supports through JPOs and community partners • Develop trade, vocational, and workforce training paired with mentorship • Build pipelines for youth to become peer support workers as a long-term career path • Partner with local businesses to provide jobs, internships, and resources • Help youth access alternative schools, GED programs, and training pathways • Increase parent engagement, parenting education, and coaching • Create Family and Community Resource Centers to centralize services • Train Community Health Workers (CHWs) on youth justice involved resources • Connect youth to healthy lifestyle activities and new peer groups beyond sports • Develop mentoring and coaching models using trusted community members • Identify and support adult mentors to model hope, skills, and opportunity in the region • Hire and retain therapists through improved pay and benefits





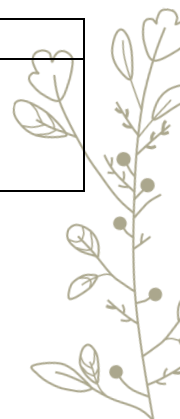
	• Partnerships with local gyms to support healthy activities • Caring grandparents frequently serve as informal supports for youth • Multiple community service placements: -Bike Works – Earn a Bike program -Future Forge (3D tools, carpentry) -The Commons (elder support) -Humane Society -Silver City outreach (meals, wellness services) -Lighthouse Center of Learning (Luna) -Positive Action (Hidalgo) • JPOs coordinate community service hours through evidence-based curricula • T Mobile scholarship support for baseball • Providers and communities in Hidalgo noted as being welcoming to returning youth • Use of natural community supports to avoid unnecessary CYFD involvement when families cannot safely reunify immediately	• Limited programming in smaller or more rural areas (e.g., Lordsburg) • Small number of youth reentering creates difficulty sustaining specialized programs • Lack of meaningful change in community environments youth return to • Absence of clear recovery pathways or “next steps” for many youth • Current Positive Action staff frequently volunteer their time to supervise youth who are mandated to do community service hours	• Provide behavioral health, trauma-informed, and de-escalation training for adults supervising youth • Strengthen tri-county collaboration to reduce reliance on unpaid labor • Increase training and capacity for community organizations hosting community service placements • Strengthen youth leadership, confidence, and self-worth through reintegration programming
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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	• JPOs develop a service plan and work with case management for 6-12 months		





Appendix A.6 Adult 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 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.

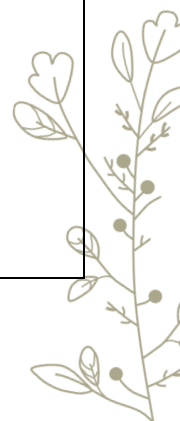
Table 1: Adult System Pre-Intercept: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Community Centers and Libraries	• Senior centers in all counties offering free activities, wellness classes, and social connection • Rec Center in Grant County has an adult basketball league, adult aerobic and dance classes, tai-chi	• Lack of non-drinking clubs/spaces	• Create a centralized community resource hub or reentry center offering prevention, navigation, and follow up • Expand prevention focused, non-alcohol social spaces
Vocational Education Programs	• America’s Job Center NM / Department of Workforce Solutions (job assistance, resume building, paid internships, employer incentives, bonding programs) • Vocational training programs (cosmetology, barber school, car maintenance) • Western New Mexico University access and GED programs • Local job fairs and career trainings • Legal assistance for self-represented litigants (limited Legal Aid availability) • Nursing and healthcare education partnerships • Local learning centers contributing to community leadership pipeline • Youth employment and career development efforts	• Gatekeeping of peer support certification and training • Well-paid flexible jobs for parents are missing • Job opportunities for every level of education • Awareness of training opportunities	• Promote employment opportunities across sectors to strengthen purpose and stability



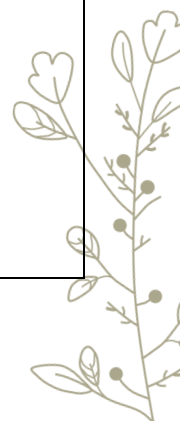


Family and Parenting Supports	• Early intervention and home-based prevention programs (Parents as Teachers; developmental therapy; reunification supports) • Mental health, parenting, and workforce readiness classes (New Mexico Help) • Multigenerational family and community support networks often serving as protective factors • Beginning Years, Families First (early childhood + family supports) • CYFD can help with access to services • HELP – NM provides parenting classes, workforce readiness, daycare for parents who are working in Luna County		
Mental Health and Substance Use	• Primary care providers engaged in prevention and behavioral health screening	• Few in-person behavioral health providers, especially in Hidalgo County; heavy reliance on telehealth • Loss of prior local behavioral health units significantly reduced capacity • High provider turnover, burnout, and inability to retain staff, undermining trust • Services constrained by Medicaid and Medicare reimbursement policies • Small rural populations limit eligibility for state funding • Insufficient training of health professionals in mental health and substance use • Caseloads fill rapidly when staff are hired • Organizations often deliver unfunded services • Lack of culturally and linguistically diverse providers (especially Spanish speaking)	



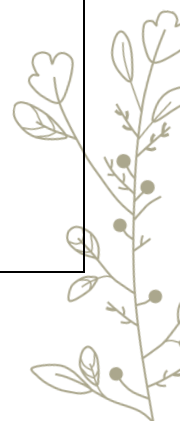


		Numbers served are so small in Hidalgo County that it's often not considered for state programs and funding	
Housing and Basic needs	- Recovery homes in Grant and Luna counties; limited capacity - Domestic violence shelters and healing houses (La Casa, SOS Shelter, Gospel Mission) - Clothing, food, and hygiene resources through food banks, SPIN, Project Community, Silver Linings, RMC pantries, schools, thrift stores, and outreach programs - Utility, rental, and grant assistance programs (SPIN, TLC Transforming Luna County, landlord repair and bonding programs, forgivable loans) - Tent and emergency supply distribution (limited, county specific) - Support for unhoused families (McKinney Vento, Migrant Programs) - Strong cancer support networks including statewide transportation assistance - VA transportation services - National Center for Frontier Communities, food pantry in Grant County - I Can (Hidalgo) teaches cooking classes for commodity - Kitchen Creations (cooking for diabetes) - Grant & Luna counties have Corre Caminos, Corre Cantinas (new name) after-hours safe transportation open - Medical transportation in all three counties, covered by insurance - TLC Transforming Luna County help with deposit, utilities, green cards, gas	- Severe shortage of safe, affordable housing; long waitlists - Housing barriers for people with criminal records or poor credit - Housing stock converted to short-term rentals; limited construction workforce - Lack of senior respite care and caregiving supports - Inadequate built environment accessibility (sidewalks, ADA access, changing facilities) - Limited transportation to providers and hospitals outside county - Gaps in transportation for middle-aged adults - Ambulance shortages, especially in Hidalgo County - Policy changes restricting out of county transport - Limited grocery access in some areas - Lack of internet, phones, and access to online resources - A lot of renters and landlords have stigma and won't rent to people with MH issues	- Increase investment in affordable and supportive housing - Develop reentry housing and women-specific transitional housing - Expand transportation funding and solutions - Address sanitation needs for unhoused adults (e.g., restrooms) - Support landlords through repair funds, bonding, and education - Develop a self-sustainable tiny-home village with time-limited on-site workshops and resources for employment, food/gardening, emotional healing, access to a general store, etc.





	cards, furniture, cleaning supplies, kitchen supplies, teaches budgeting skills. Has occasionally helped across county		
Other Community Resources	• Law enforcement involvement in medication buy back and connection to services • Community paramedicine and EMS home visit programs • Rural health clinics, FQHCs, and medical transportation services (insurance covered) • Community Health Workers (CHWs) conducting home visits, screenings, jail outreach, and care coordination • Faith-based organizations providing support, outreach, and home visiting programs • Community improvement, recreation, and quality of life activities: -Senior and recreation centers (sports leagues, fitness, tai chi, aerobics) -Parks, water parks, skate parks, state parks, museums -Community gardens and beautification programs -Nonprofit outreach events (National Night Out, home visits, warm hand offs) • Free cultural events, arts, and wellness activities • Hidalgo County starting tools for resiliency panel dinner—teach coping skills, BH mostly via telehealth; started for first responders, but all community members are first responders • Tree Lake Park fishing and exercise spaces and rental equipment • Luna County Health Fair • Public health office that offers vaccines & cervical screenings for free	• Limited adult prevention resources and lack of routine screening services • Stigma surrounding mental health, addiction, housing assistance, and help seeking • Lack of empathy toward adults compared to youth systems • Limited public awareness of existing resources despite bilingual materials • Technology barriers prevent access to online information • Fear of addressing ACEs due to insufficient supports • Limited legal services and attorneys • Lack of incentives related to housing, schools, and quality of life	• Launch stigma reduction and education campaigns • Create resource directories, apps, QR codes, and county-specific ShareNM tools • Hidalgo and Luna counties need more Spanish- speaking employees • Finetune Share NM to each county





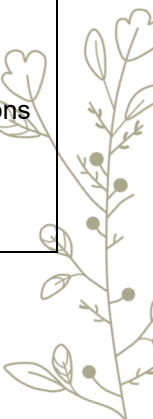
	• Love of Rose supports adults with intellectual disabilities		
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2. Adult System Intercept 0: Community Treatment, Schools and Crisis Services

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

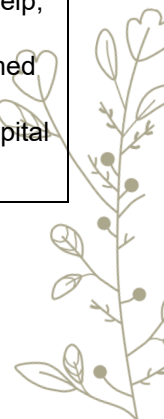
Category	Resources	Gaps	Opportunities/Action Items
Crisis Services	• 988 Suicide & Crisis Lifeline -Spanish-speaking option -Veteran’s option • Peer-led mobile crisis response (Hidalgo County) • Community-based crisis response teams involving law enforcement, CYFD, churches, and advocates • RMC provides on-site de-escalation support when necessary • Informal / “underground” crisis outreach where individual providers volunteer time with officers • Hidalgo County goal to expand a community response team • Emergency hotel vouchers and short-term emergency housing (Hidalgo County) • Transportation assistance (bus tickets) for transient individuals (Lordsburg PD) • Opportunities exist to connect law enforcement with case management and services • Crisis Intervention Training (CIT) available for law enforcement;	• No consistently available crisis stabilization or 23-hour centers • Crisis services often person-dependent instead of system-based • Lack of crisis intervention teams in some counties • Involuntary commitment limited to law enforcement involvement; no local facilities • CIT training not fully recognized for required hours • Rural geography limits ability to send BH providers alone to crisis scenes • 988 System Challenges -Calls routed by area code to out-of-state or incorrect regional resources -Initial lack of accurate local resource knowledge -Too many screening questions before acknowledging lack of capacity -Reduced caller anonymity and drop-off in usage • Limited focus on people with disabilities in crisis response	• Create 23-hour crisis stabilization facilities (and 14-day step-down options) • Partner with hospitals to provide short-term respite instead of jail • Develop: -Crisis intervention teams -Co-response teams (law enforcement + BH) -Volunteer BH crisis teams that transition to paid positions • Ensure each county has more than one on-call responder • Expand community response teams across all counties • Develop mobile crisis teams trained in trauma-informed care and de-escalation • Open dedicated crisis response spaces within hospitals • Create mobile crisis triage teams integrated with law enforcement and clinicians • Re-establish crisis triage and detox centers (e.g., Tu Casa model) • Clarify liability protections for co-response models • Fund crisis services as infrastructure, not optional programs • Use public service announcements to educate community about crisis options

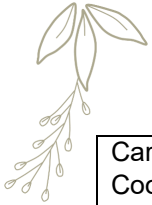


	some officers already trained		
Family Support	- Family outreach and support programs - Schools sending parent informational materials and invitations - Parents as Teachers program - Home visiting programs- Amplified Therapy (developmental therapy 0-3) in Hidalgo County and Southwest Pathways, Welcome Baby program, Ben Archer in Luna County program & CHI	- Generational trauma and lack of coping skills among some parents - Parents under extreme stress with limited support systems	Increase parent support groups and peer-led family supports
Outpatient Mental Health and/or Substance use	- Behavioral health services through HMS, Winborn Wellness & Counseling (sliding scale), Recovery Management Centers (RMC), and limited IOP/treatment court options - Harm reduction services across counties (Narcan, syringe exchange, education, medication lock boxes, sharps containers) - Suicide prevention and crisis training (QPR, MHFA, ABC, CPR, DWI, Narcan) offered through health councils - Support groups for therapists, suicide survivors, caregivers (including virtual options) - Street outreach / drop-in harm reduction services (Silver City) - Community Health Workers (CHWs), Promotoras, and Community Support Workers (CSWs) providing outreach, home visits, and care coordination - Outpatient behavioral health services in all three counties	- No ambulatory detox - Telehealth staffing shortages, especially in Columbus - Too few clinicians, peer support workers, CPSWs, CHWs - High caseloads, low pay, limited incentives for rural practice - Severe shortages of bilingual providers - Limited respite care for families - Limited CEUs and training slots locally - CPSW and peer support certification barriers (rigid criteria, limited offerings) - State training reductions and lack of reimbursement - Insurers not reimbursing certain BH services (e.g., LSAAAs) - MAT stigma and lack of provider buy-in - State resources concentrated in urban areas	- Expand SBIRT and behavioral health screening training for providers - Expand peer support training, certification access, and localized training programs - Integrate peers into hospitals, crisis centers, and community outreach - Advocate for rural specific-funding formulas and benefits to recruit/retain providers - Provide incentives, benefits, and training to reduce burnout - Strengthen hospital and first responder training in trauma-informed care - Expand both medical and social detox capacity - Increase access to local, in-person CEUs - Expand CPSW, CHW, and peer support training pipelines - Advocate for national CPSW certification to improve flexibility - Develop “grow-your-own” workforce pathways starting in schools - Partner with learning centers for local licensing and certification programs - Increase bilingual and culturally responsive services - Normalize harm reduction and reduce stigma through education - Train local providers in MAT and encourage its use



	• Intensive Outpatient Programs (IOP) for mental health and substance use • Psychosocial Rehabilitation (PSR) services (limited in Luna County) • Peer support services across multiple providers (SPIN, HMS, RMC) • Medication Assisted Treatment (MAT) available in limited settings • Methadone services available in Las Cruces • Spravato treatment for treatment-resistant depression • Co-occurring residential treatment and detox (limited availability) • Primary care–supported detox (very limited) • Outpatient psychiatric clinic at Gila Regional (telehealth available) • Urgent care access expanding (Deming opening June; limited weekend access elsewhere) • Bilingual providers (limited but present) • DBT and EMDR therapy options		
Hospitals and Inpatient Care	• SBIRT programs in hospital emergency departments (Gila Regional Medical Center) • Emergency departments providing acute hospitalization (often prolonged stays) • Emergency departments function as default crisis response in absence of alternatives	• Shortage of higher levels of care, inpatient beds, and psychiatric services; long waitlists • No inpatient psychiatric or substance-use treatment facilities locally • Overreliance on emergency rooms with long boarding times • SBIRT case managers and CHWs may not know about all services • Open Beds app isn’t always accurate	• Create inpatient psychiatric facilities focused on dignity, safety, and compassion • Having more peer support trained and familiar with addiction and mental health concerns to support and staff the hospitals • For hospitals to have basic training to not further shame, and be better prepared to help, people with addiction and provide more trauma-informed care • Open up a part of each hospital for a crisis response unit





Care Coordination & Policy		• Poor discharge planning and aftercare coordination • Inaccurate bed availability systems • Funding instability; heavy reliance on short-term grants • Program start/stop cycles eroding community trust • Lack of enforced treatment options for individuals lacking capacity • Community and policymaker stigma toward behavioral health and harm reduction • Underused or closed facilities (e.g., Tu Casa crisis center) • Reliance on grant funding instead of sustainable funding	• Develop an integrated referral and tracking system that supports warm hand offs and continuity of care • Improve coordination and information sharing across agencies, CHWs, peer supports, and hospitals • Build stronger nonprofit capacity and cross-county partnerships • Create local, sustainable systems rather than temporary pilots • Establish feedback loops with state liaisons • Foster collective regional advocacy across counties • Engage local government leadership in behavioral health planning and funding decisions • Advocate for sustainable funding structures, not just grants • Establish pay differentials, tax credits, and incentives for rural providers • Assign state liaisons per judicial district to resolve systemic barriers • Advocate for broader reimbursement (MAT, peer services, LSAAAs) • Explore pathways for medical providers to initiate involuntary commitments • Improve discharge, paperwork, and appointment coordination post-inpatient/detox • Expand warm hand-offs across systems • Advocate collectively across counties to elevate rural needs • Advocate for funding formula in rural counties to be adjusted to fund the increased cost of rural programs
Other	• County health council prioritizing behavioral health and hosting 988 trainings • Gila Regional Medical Center started community paramedicine program in Grant County; EMS can do home visits	• People get stuck if taken out of county and won't call emergency services again	• Create mediation centers and community-based de-escalation supports • Develop and promote comprehensive resource guides and directories • Build self-sustaining recovery communities with on-site services





	• 1 ambulance in Hidalgo County		• Strengthen SEL, prevention, and early intervention efforts in schools
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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	• Law enforcement has significant discretion in deciding arrest vs. other responses (Luna & Grant) • Higher arrest rates in Grant County (reflects enforcement capacity, not necessarily treatment access) • DWI Task Forces (Luna; connected to Corre Caminos) • Law enforcement assisted diversion pilots (limited) • Pre-prosecution options in Luna County (federal cases; very stringent requirements, probation-based dismissal) • Supporting People in Need (SPIN) – nonprofit providing support and engagement • Some officers trained in CIT; training largely happens at the academy level • Pre-prosecution diversion programs (all three counties, DA’s offices)	• Arrest often becomes the only pathway to access behavioral health services • Jail functions as the behavioral health system due to lack of alternatives • No local 72-hour hold options • No behavioral health unit within law enforcement agencies • Limited or non-existent crisis teams across counties • Some crisis centers initially resisted by law enforcement due to liability and voluntary status • Sheriff’s offices and police departments are severely understaffed • Officers lack sufficient behavioral health education, especially in rural areas • CIT training: -Often limited to basic academy exposure -Full 40-hour training difficult due to staffing shortages -Disconnect between BH-focused CIT and law-enforcement focused CIT -Outdated training materials • Minimal statewide MH training requirements for officers • Officers concerned about liability when diverting from arrest	• Expand and mandate CIT and behavioral health training for law enforcement • Provide updated, accredited training in: -CIT -Trauma-informed care -Co-occurring disorders -De-escalation -Disability-informed response • Include full 40-hour CIT training in academy structures • Provide MHFA trainings biannually (or more frequently) for first responders • Develop shared training initiatives across judicial districts • Expand CIT training and ensure it counts toward required hours • Expand Law Enforcement Assisted Diversion (LEAD) models • Advocate for policy changes to: -Allow treatment before arrest -Expand involuntary treatment criteria earlier in crisis -Adjust harm-to-self/others statutory language • Create pathways for treatment even when individuals do not want to press charges • Encourage law enforcement presence at IOPs to build community trust • Reinstate parenting and coping-skills education linked to diversion programs • Build trust so people with records feel safe calling police • Promote a “help shouldn’t hurt” philosophy in first contact





		• No hospital in Hidalgo County; transport required to Grant or Luna • Law enforcement rarely transports individuals to higher-level care (Las Cruces) unless family or hospitals initiate it • Guardianship process for adults is expensive and lengthy • Involuntary treatment criteria are narrow and occur too late (after justice involvement) • Limited diversion pathways prior to arrest • Harm-to-self/others language restricts early intervention • Law enforcement culture sometimes emphasizes arrest over care • Frustration across families, providers, and officers • People with behavioral health needs are frequently victimized • Small-community dynamics where reputations “stick” and change is doubted • Diversion programs affected by DA turnover and shifting priorities, causing loss of trust • 988 calls have dropped based on area code you’re calling from and people were getting connected to resources out of state • People were getting connected to 505 not 575 resources	• Expand pre-and post-adjudication diversion opportunities • Increase face-to-face, on-site services (BH, legal, court related) • Provide cultural competence training for contractors and providers • Explore DWI and other state funding for jail diversion and treatment • Expand supervision capacity to divert people from felony escalation • Align DA, court, and treatment partners around consistent diversion practices • Reduce reliance on detention by strengthening early treatment pathways
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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	• Court support navigator and pretrial service coordination • Emergency rooms serve as entry points for behavioral health screening and referrals • Hospitals required to medically clear individuals before booking into detention • Pretrial Services supporting court reminders, engagement, and connection to help • Some screening and supervision for domestic violence cases tied to misdemeanor compliance	• No facility to restore competency locally • Difficult and lengthy process to obtain medical or treatment guardians • Not enough attorneys to support guardianship proceedings • Many individuals lack family members who can serve as guardians • No supervision structure for people with severe mental illness, overburdening probation • People found incompetent but not dangerous are released and often reenter the system within 30 days	• Develop a standardized assessment process at pretrial • Promote pre-adjudication treatment court models • Replicate Juvenile Justice Continuum of Services for adults • Build an adult justice continuum focused on prevention, stabilization, and reduced recidivism • Build an outpatient competency restoration clinic in the region • Create systems to identify individuals needing treatment guardians • Develop legal pathways and contracts with attorneys to support guardianship • Utilize Honor Guardians and stipends where appropriate • Improve medication adherence supports to stabilize individual during pretrial period • Expand legal services, more attorneys

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	• Treatment Courts in each county (post adjudication; intensive, high risk/high need focus) • Judges, District Attorneys, and Defense Attorneys are accessible and engaged	• No mental health court in District 6 • No veterans court • Treatment courts: -Understaffed and capped (15–17 participants) -Focused mostly on felonies and post adjudication -Lack clear agreements with DAs for charge reduction after completion	• Expand treatment courts to: -Include lower-level offenses -Incentivize completion with sentence reductions • Advocate for a sustainable mental health court in BHR 6 • Develop veteran’s court • Fund and staff additional compliance officers, especially in magistrate court



	• Conditional discharge options that avoid felony conviction in some cases • Misdemeanor compliance programs in Grant and Luna counties (not Hidalgo) • Victim Advocate programs • La Casa advocates for foster youth • Adult probation and parole services • Luna Compliance impaired driving assessment (IDA in all three counties) (DWI program)	• Courts are at capacity and unable to expand programming • Large caseloads (e.g., Grant County ~300 criminal cases, not including misdemeanors) • Many individuals at magistrate level are missed because programs require felony status • Early career professionals leave after gaining experience • Heavy reliance on out-of-state contractors for DA services: -Poor community connection -Lack of cultural competence	• Use courts and counties to advocate collectively for funding and policy change
Treatment and/or Education while in Detention, Jails or Prisons (e.g., MOUD, MAT, other groups)	• RISE (Reach, Intervene, Support, Engage) program: -90-day jail-based transition program -Pre-and post-conviction -Operates in Luna and Grant counties -Staff go with participants to court • Medication Assisted Treatment (MAT) in jail • Jail based mental health programs • SPIN providing classes and programming in Hidalgo jail • SPIN transition support services post incarceration • RMC IOP groups in all three counties (individual and group; referrals through courts) • Treatment court referrals to IOP and related services • DOC and jail-based behavioral health consultations (eligibility based)	• Limited detention-based and community behavioral health programming • Virtual services: -Limit trust and assessment quality -Not accessible or acceptable for some populations • Lack of sustainable funding • Inconsistent DWI funding use across counties	



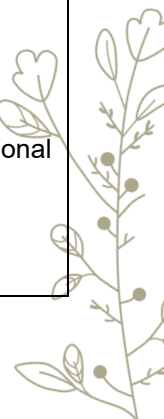


6. Adult System Intercept 4: Community Re-Entry Services

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.

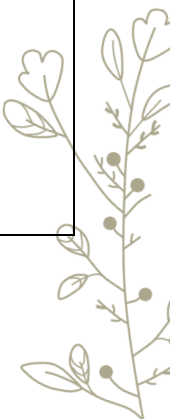
Table 6: Adult System Intercept 4: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities/Action Items
Community Re-entry services	• RISE Program (Luna County): transitional housing, internships, employment pathways for formerly incarcerated individuals • RV-based transitional housing funded by county/city • SPIN: -Reentry support, peer services, and jail-based programming -Collaboration with opioid focused programs and housing supports • Treatment Court (including alumni groups for peer mentoring and support) • Conditional support through extended family networks • Work Opportunity Tax Credit (WOTC) – employer incentive for hiring justice impacted individuals • America’s Job Center: -Resume classes, tuition and trade supports -Driver’s license reinstatement help -Services available across all three counties • Second Chance employers (e.g., mining, truck stops, local industry) • Juslee Counseling Group: -Skill-building activities (crafts, furniture repair) for income generation	• Bias against hiring individuals with criminal records • Severe lack of housing options, especially: -For people reentering from jail -For individuals with sex offenses -For people with serious mental illness • No group homes for adults with diagnoses who cannot live independently • People often return to unsafe or destabilizing environments • Limited aftercare systems (medication continuity, follow up) • System inadequately prepares people for release • People often exit custody already feeling defeated • Some individuals return to jail because it feels more stable than reentry options • People not eligible for RISE (e.g., history of violence or sex offenses) receive little to no support • Barriers to billing for peer support services • If probation is violated outside of RISE eligibility, individuals exit the system without help • Not enough behavioral health providers, therapists, and case managers • Increasing difficulty recruiting and retaining case managers • Limited peer support capacity during gaps in certification/licensure • Severe housing shortages for people reentering • Probation/parole housing requirements difficult to meet when homeless	• Increase peer support within jails and reentry programs • Develop reentry centers to bridge housing, employment, and treatment • Expand housing-first and transitional housing models (tiny homes, RVs) • Create more housing, including: -Group homes for adults with serious mental illness -Safe housing tied to supervision and services • Strengthen reentry aftercare systems, including medication continuity • Provide safer, supportive housing models earlier in life to prevent justice involvement • Ensure foster and kinship placements are adequately screened and supported • Develop flow charts and shared referral pathways across intercepts • Streamline collaboration among courts, BH, housing, and employment providers • Build expedited referral processes with dedicated advocates • Expand Second Chance employment opportunities • Provide stipends or subsidies to employers who hire formerly incarcerated individuals • Promote and locally market WOTC and other employer incentives • Create employer incentives through county or local government tax breaks • Expand recovery and transitional housing, including for lower acuity needs





• Luna County tuition assistance (up to bachelor's level) • Job fairs and faith-based volunteer opportunities • Library services providing internet and computer access • GED, remedial education, and trade opportunities (more common in prison settings) • Recovery housing options (limited; many residents come directly from prison) • Fresh Start Program: -Supports people with opioid use disorder -Move in assistance, rent help (up to 6 months) -Stipends for treatment related needs (not sobriety dependent) • Healthcare foundation (Luna County): -Flexible support for barriers to care (IDs, licenses, certificates) -Scholarships tied to working and returning to serve the county • Medication assistance: -30-day prescription coverage upon release -Secured aftercare provider appointments • Incentive programs for healthy activities (gym memberships, food, household items) • FMCSA program (license retention support – exact scope unclear) • Keep Luna County Beautiful: -Community service opportunities -Volunteer hour oversight (e.g., cleanups)	• Limited transportation to appointments and employment • Loss of IDs, birth certificates, and SS cards among people experiencing homelessness • Basic documentation often requires cash payments • Lack of GED classes (English & Spanish) in all counties • Limited adult remedial education (reading, math) • Loss of WNMU presence in Lordsburg • Fewer local postsecondary and skill building options than within prison systems • Stability requirements may unintentionally block access to housing or aid • Assessments must be completed by corrections officers, delaying referrals • Not enough dedicated funding for probation, parole, and reentry infrastructure • Fragmented funding sources with unclear priorities and timelines • County level planning sometimes excludes frontline stakeholders • Lack of transparency on funding decisions and outcomes • Unclear processes and accountability across agencies • JPO supervises parents who are incarcerated and struggle to reconnect with their children who may be in the judicial system (help parents reentry back in their child's life & home), need behavioral health to come in to home • Office for Peer Support and Recovery gatekeeps training for peer workers	• Create bridge or flex funds for immediate reentry costs (IDs, licenses, small fees) • Develop funds to support peers during licensing gaps • Adjust housing assistance policies to align with real reentry conditions • Embed behavioral health organizations within courts via MOUs • Expand peer support worker training and certification access • Ensure clinical supervision and data sharing agreements for peer placements • Bring back or expand WNMU and local education programs in Hidalgo County • Develop GED and remedial education programs (English & Spanish) • Collaborate with universities and learning centers for “home grown” workforce pipelines • Increase prosocial community activities (gym access, volunteering, faith-based engagement) • Provide technical assistance to map existing resources and gaps • Incorporate opioid settlement, fast track funding allocations FASTRACK, and other funding into a coordinated strategy • Increase transparency in funding decisions, priorities, and outcomes • Use systems-level feedback loops across counties and agencies
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	• Peer support worker programs (in development or expanded in some communities) • Athena Huckaby Las Cruces- advocacy for individuals to rent after incarceration • Have 2 men's transitional homes. Very Christian based • Angel with broken wings reentry in Las Cruces		
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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 & Parole (APO): -Needs assessments (within 90 days) -Compliance supervision and referrals -Misdemeanor compliance programs with screening and follow up (Grant & Luna)	• Parole and probation practices can be rigid and vary by location • High APO caseloads (60+ per officer common)	• Create aftercare systems tied to probation, parole, and conditional discharge • Place peer support staff in every APO office





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 6 has a slightly higher proportion of Non-Hispanic White (38.66%) individuals compared to the state (36.53%).
- The Hispanic population is much higher in BHR 6 (56.87%) vs. statewide (48.15%).
- The Non-Hispanic Black population is slightly lower in BHR 6 (1.00%) compared to the state (1.81%).
- 0.66% of BHR 6 is American Indian and Alaskan Native, significantly lower than the state (8.6%).
- Age distribution: BHR 6 has 78.24% adults (18+), slightly higher than the state (77.94%). BHR 6 has slightly less youth (<18) (21.76%) vs. the state (22.06%).

Behavioral Health Diagnosis

- **Under 18:**
 - For youth under age 18, anxiety disorder is the most common diagnosis, with rates significantly higher than statewide rates (BHR 6: 60.3%, NM: 50.6%).
 - Attention deficit disorder is seen at a higher rate compared to statewide rates (BHR 6: 29.4%, NM: 26.0%).
- **18+:**
 - For adults over 18, anxiety disorder remains the highest diagnosis with rates higher than the state average (BHR 6: 63.0%, NM: 59.6%).
 - Stimulant use disorder is higher in BHR 6 (13.8%) vs. NM (10.7%).
 - Opioid use disorder is seen at half the rate of the state average (BHR 6: 6.2%, NM: 12.7%).

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

Diagnoses	% BHR6	% State
Anxiety Disorder	60.3%	50.6%
Attention Deficit Disorders	29.4%	26.0%
Mood Disorders	25.7%	21.9%
Developmental Disorders	10.7%	11.7%
Intentional Self Harm & Suicidal Ideation	8.3%	7.1%
Conduct Disorders	7.1%	10.1%
Cannabis Use Disorder	6.1%	4.6%
Psychotic Disorder	4.0%	5.3%
Emotional Disorders Childhood Onset	3.0%	3.2%
Alcohol Use Disorder	2.3%	2.0%





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

Diagnoses	% BHR6	% State
Anxiety Disorder	63.0%	59.6%
Mood Disorder	37.4%	37.1%
Alcohol Use Disorder	14.2%	17.9%
Stimulant Use Disorder	13.8%	10.7%
Cannabis Use Disorder	9.1%	8.3%
Psychotic Disorder	8.6%	7.9%
Opioid Use Disorder	6.2%	12.7%
Attention Deficit Disorders	5.1%	6.8%
Intentional Self Harm & Suicidal Ideation	4.9%	5.3%
Hallucinogen/Inhalant/Other SUD	4.8%	5.8%

Service Utilization

- Outpatient services are the most utilized service in BHR 6, similar to the state as a whole (BHR 6: 85.1%, NM: 86.8%).
- Crisis services are utilized slightly less in BHR 6 (20.1%) compared to across the state (23.8%).
- Intensive outpatient utilization is much higher compared to across the state (BHR 6: 13.2%, NM: 7.2%).
- Residential and Inpatient Service utilization is slightly higher compared to the state (BHR 6: 5.7%, NM: 4.9%).

Provider Utilization

- Utilization of Behavioral Health Prescribers is significantly lower in BHR 6 (6.5%) compared to NM (14.7%).
- Utilization of psychotherapy practitioners is similar to the state (BHR 6: 5.5 NM: 5.4%).
- Utilization of substance use specialists is higher compared to the state (BHR 6: 0.9%, NM: 0.7%).

Crisis Calls & ER Utilization

- Crisis call rates decreased from 2023 to 2024 in BHR 6:
 - BHR 6: 2.03% → 1.16%
- ER visit rates for behavioral health conditions are slightly lower in BHR 6 as compared to the whole state (BHR 6: 17.9%, NM: 18.8%).



Behavioral Region 6 vs The State of New Mexico

Examining behavioral health disorder diagnoses, and utilization of services, facilities and infrastructure in Behavioral Region 6 compared to the state of New Mexico.

County in Behavioral Region 6: Grant, Luna, Hidalgo

Objective

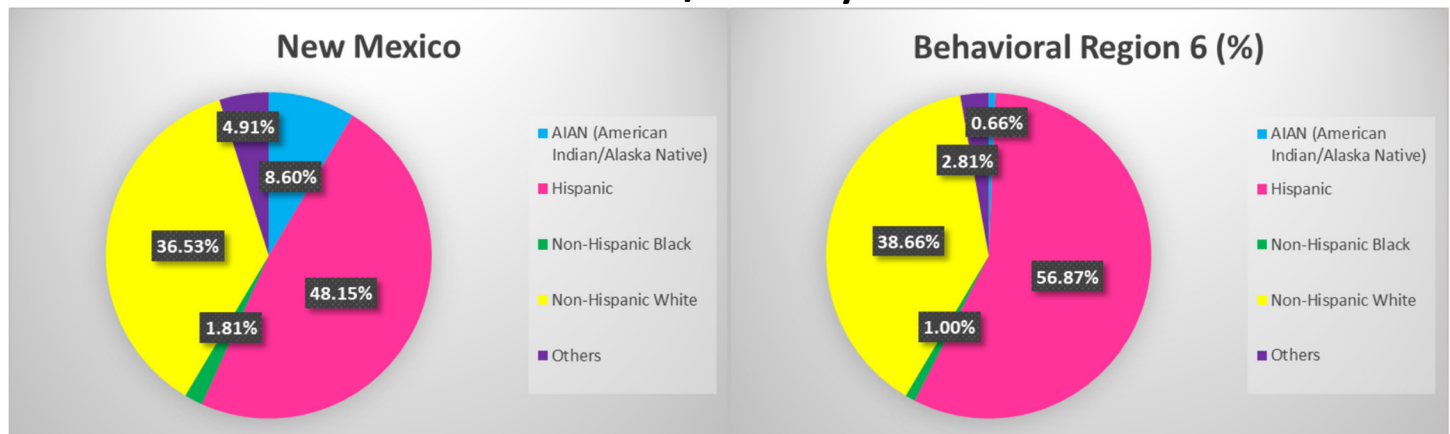
To compare Behavioral Region 6 (Grant, Luna, Hidalgo) with the state on below characteristics

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

Demographic Comparison

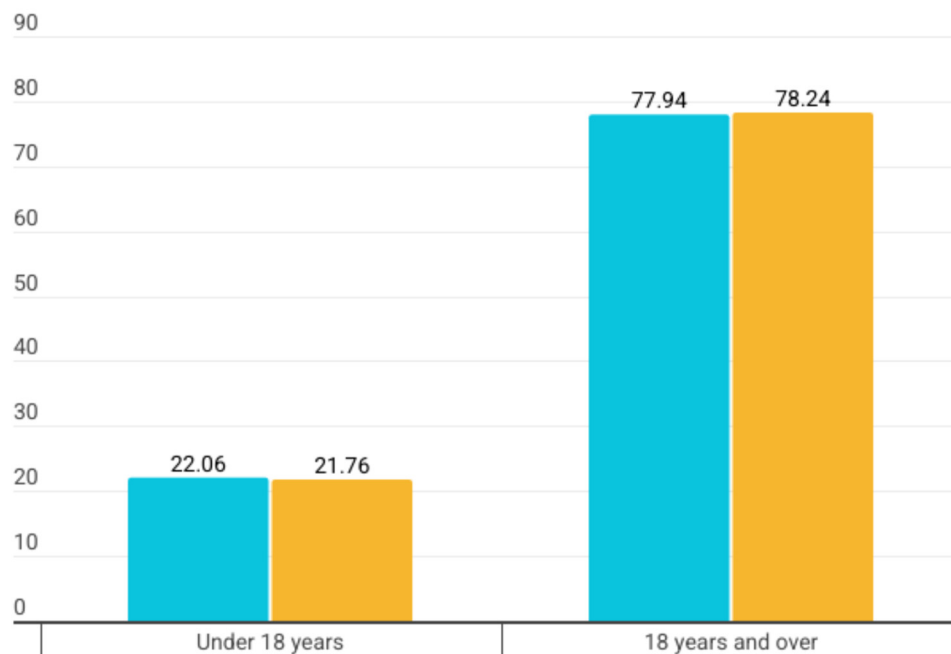
Key demographic factors reveal significant regional variations

Race/Ethnicity



Age Distribution – New Mexico vs. Behavioral Region 6

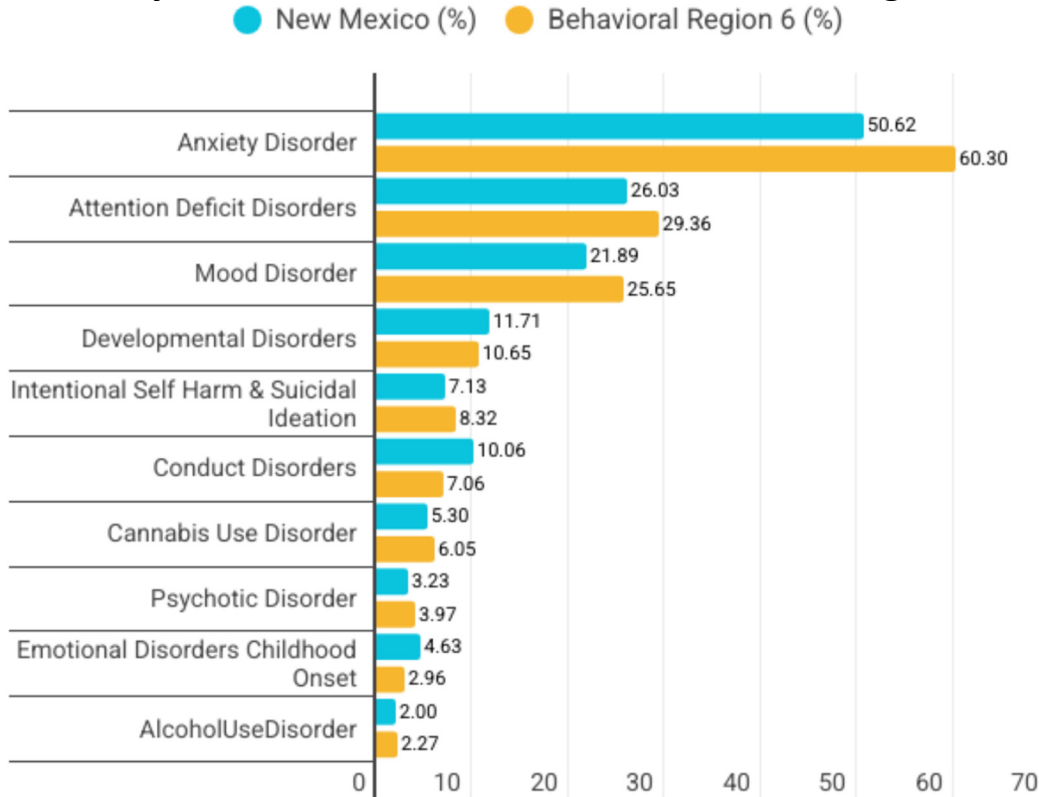
● New Mexico (%) ● Behavioral Region 6 (%)



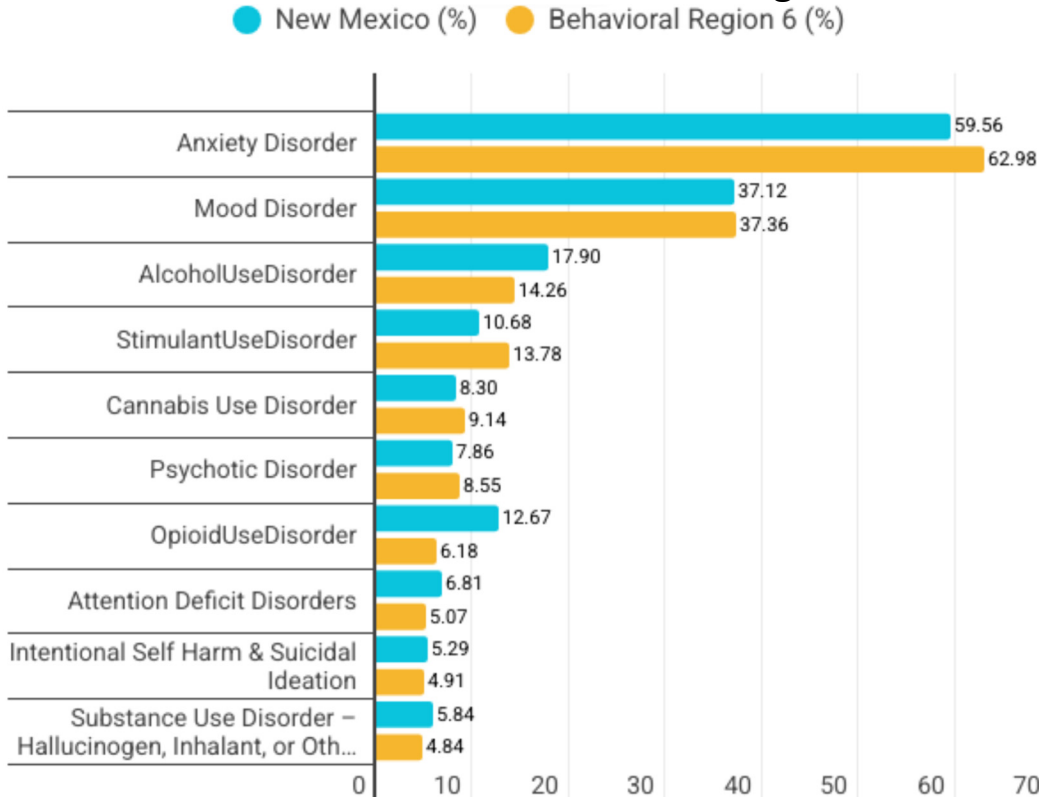
Top 10 behavioral health disorder diagnosis by age group

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

<18-year-olds – New Mexico vs. Behavioral Region 6



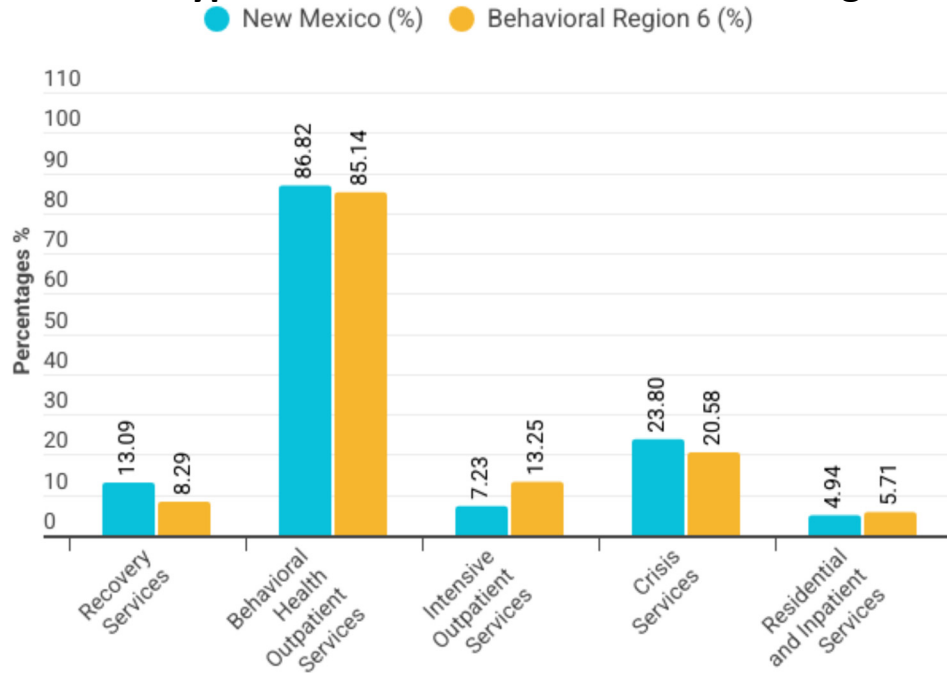
18+ New Mexico vs Behavioral Region 6



Service Utilization

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

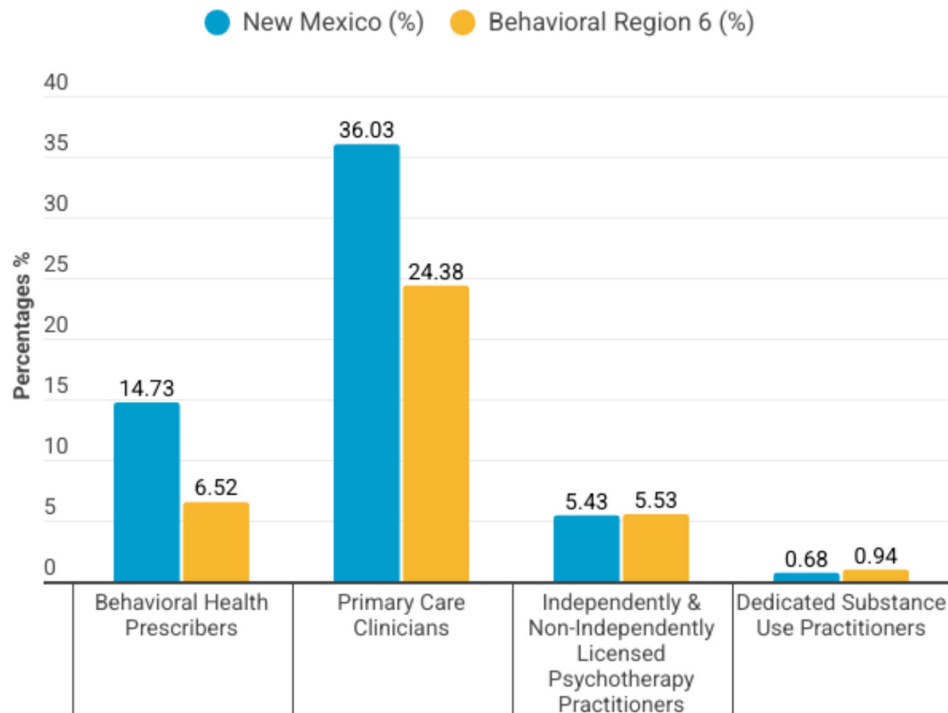
Service Types – New Mexico vs. Behavioral Region 6



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.

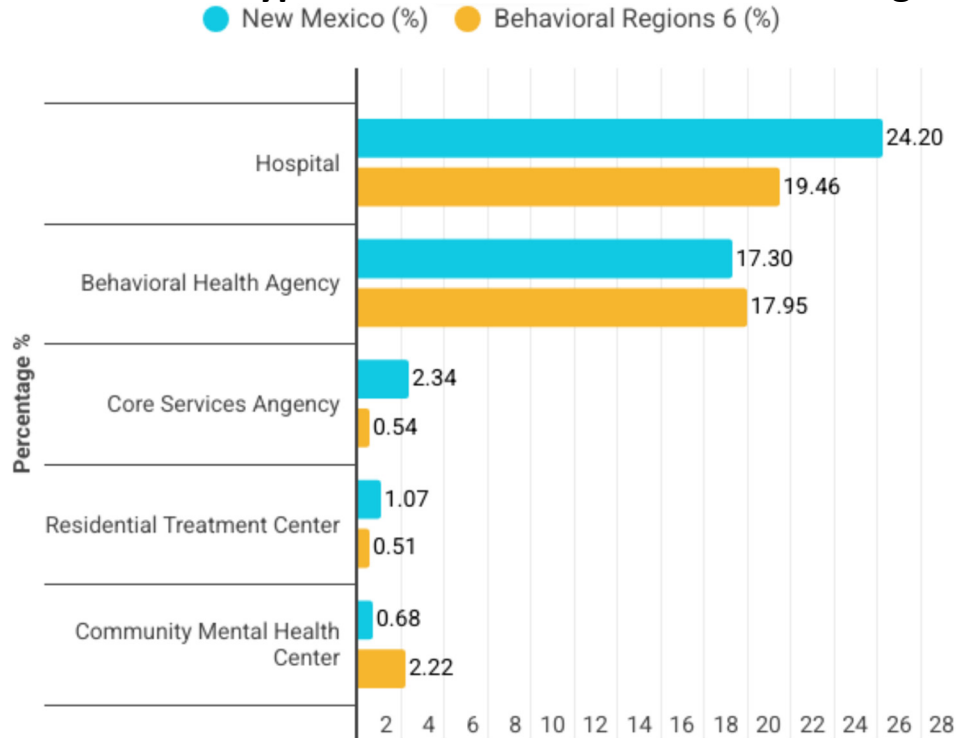
Individuals on Medicaid are more likely to have at least one contact with a prescriber than with a therapist in a calendar year.



Infrastructure Utilization

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

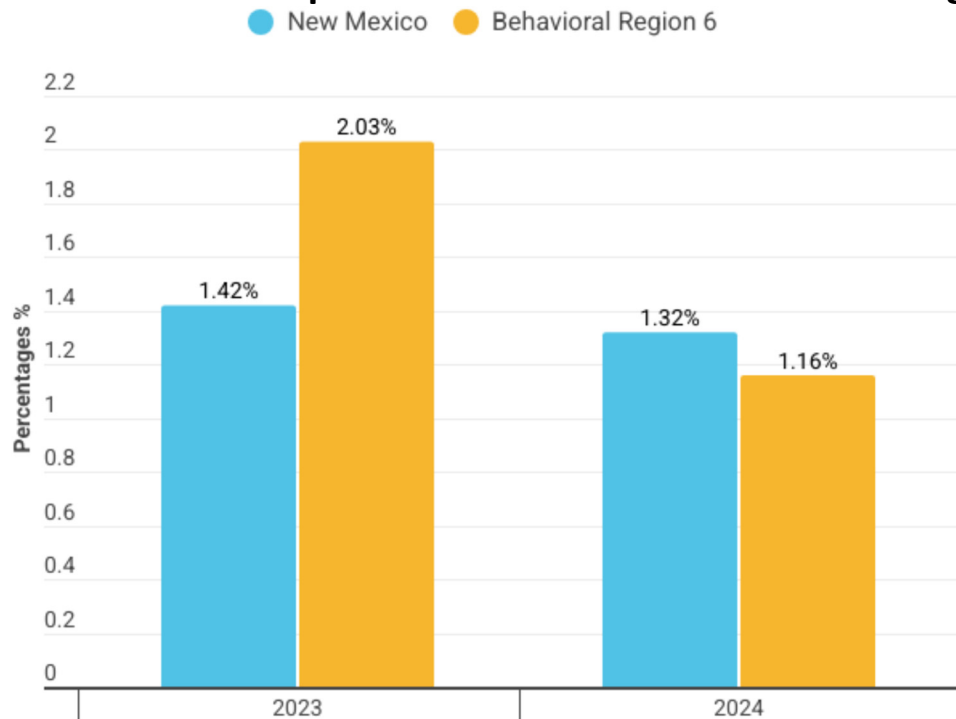
Infrastructure Type – New Mexico vs. Behavioral Region 6



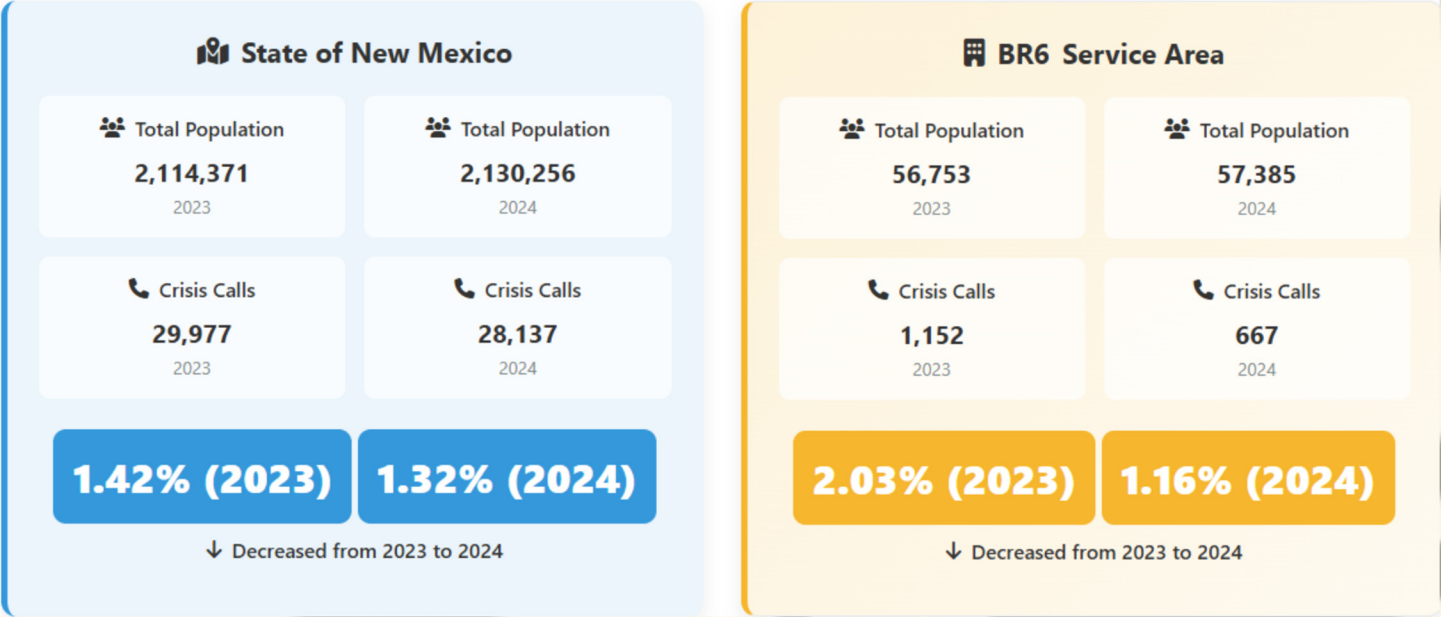
Crisis Call per Capita

Percentage of population who made a crisis call.

Crisis Call Rate Per Capita – New Mexico vs. Behavioral Region 6

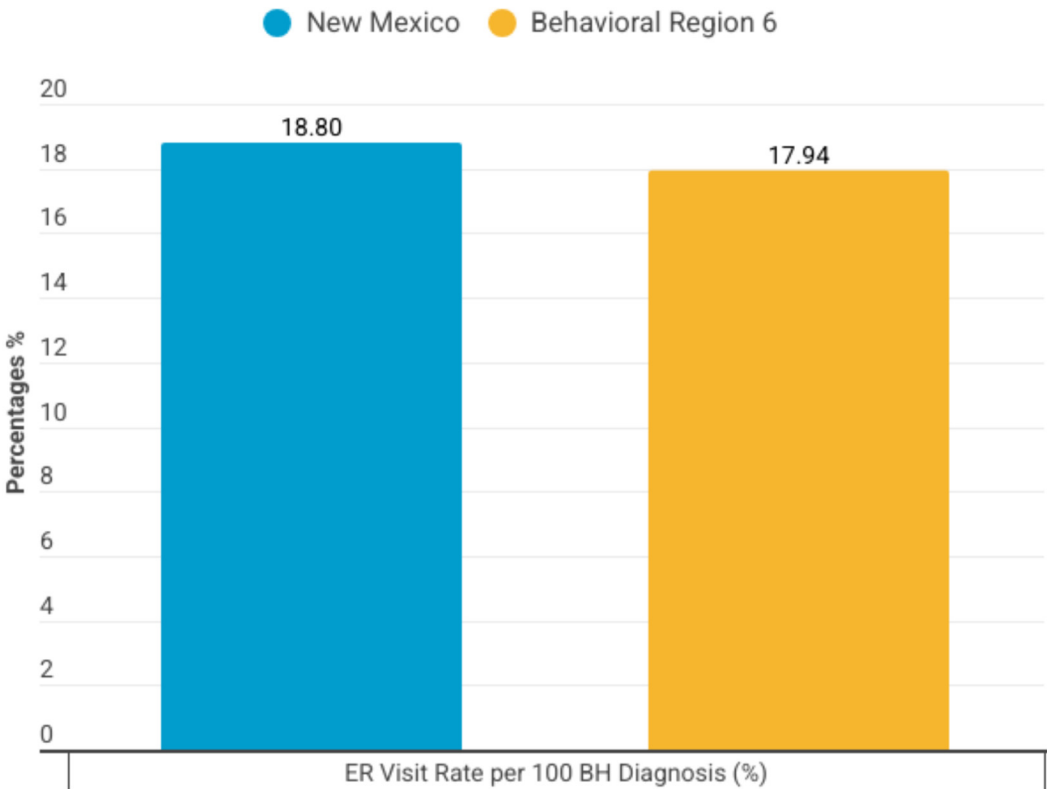


Crisis Call per Capita (cont.)



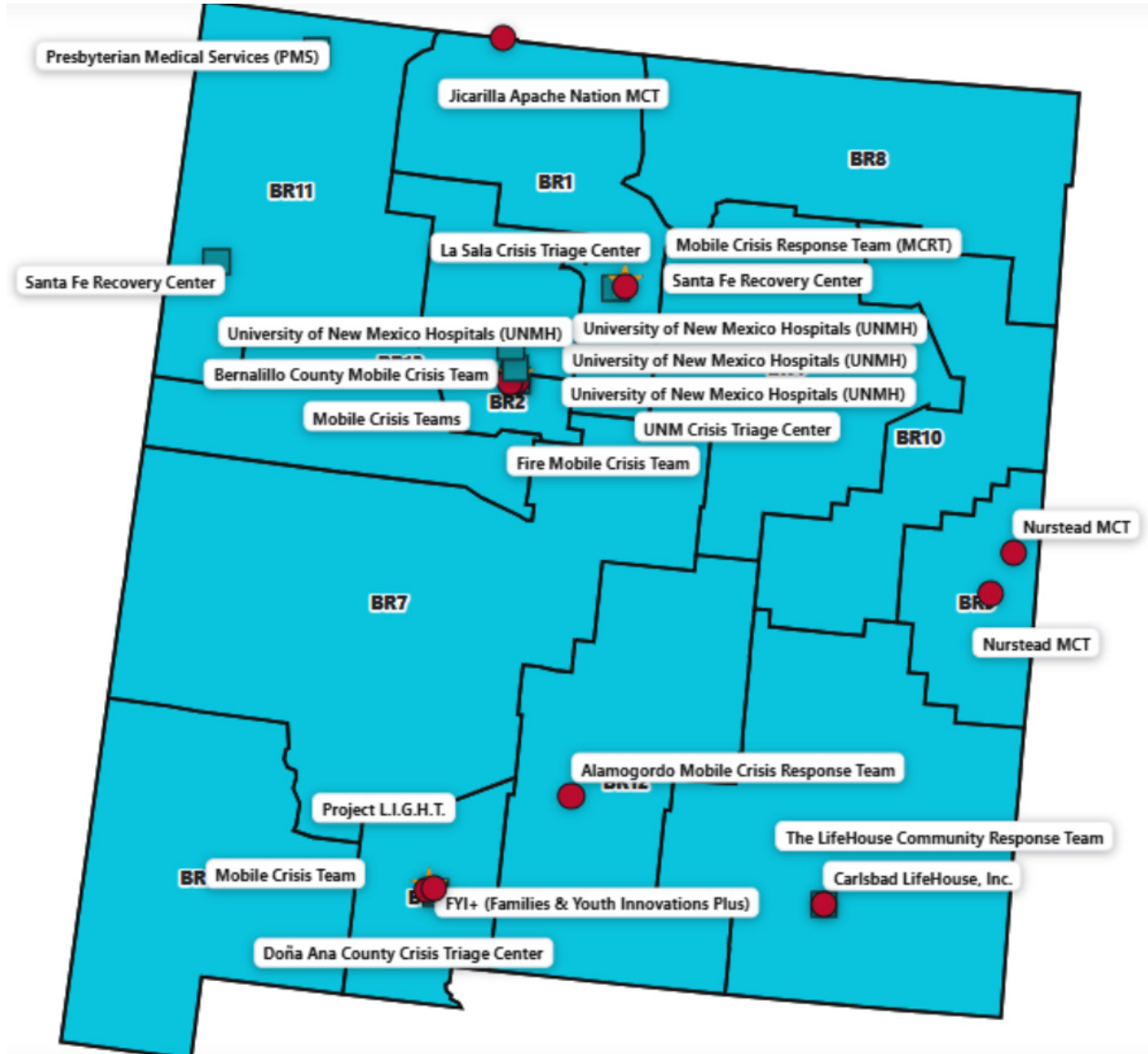
Emergency Room Utilization

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



CCBHC, CTC, Mobile Crisis

New Mexico

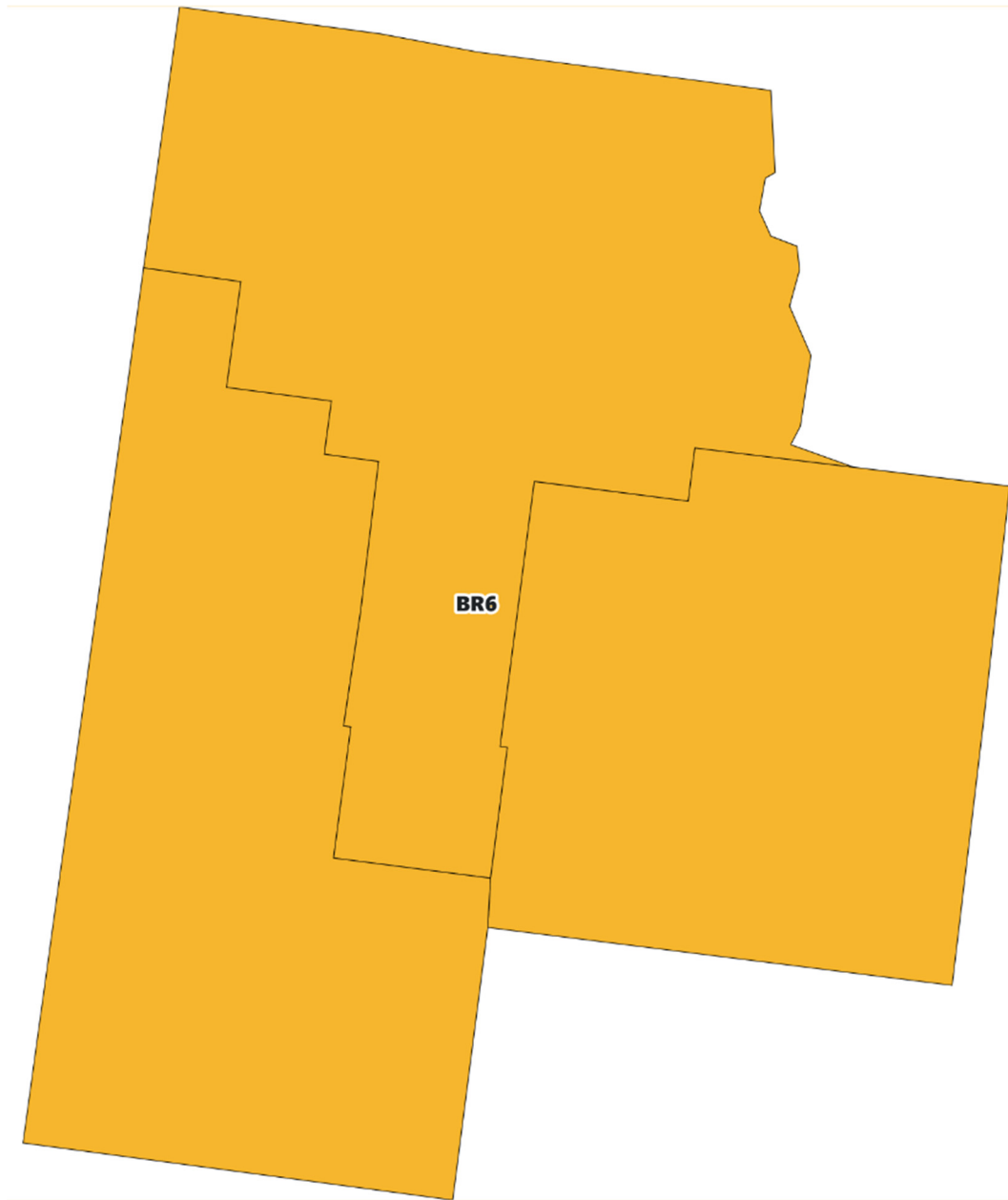


● Mobile Crisis Team ■ CCBHC ★ Crisis Triage Center

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 6



● Mobile Crisis Team ■ CCBHC ★ Crisis Triage Center

Name	County	BR	Address	Zip Code	Type

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 (BR6)	
	Beneficiary N=217,656	%	Beneficiary N=7,214	%
Recovery Services	28,500	13.09%	598	8.29%
PSW	4,707	2.16%	242	3.35%
CCSS	20,270	9.31%	105	1.46%
PSR	362	0.17%	23	0.32%
CSW	7,215	3.31%	252	3.49%
FSW	155	0.07%	1	0.01%
CHW	0	0.00%	0	0.00%
BMS	1,113	0.51%	99	1.37%
BT	2,044	0.94%	13	0.18%
BHOP Services	188,968	86.82%	6,142	85.14%
BH Workforce	106,765	49.05%	2,323	32.20%
BH-Prescribers	32,061	14.73%	470	6.52%
Psychiatrist	10,700	4.92%	75	1.04%
PsyNursePract	20,228	9.29%	360	4.99%
PrescPsychologist	2,704	1.24%	61	0.85%
PrimaryCare	78,429	36.03%	1,759	24.38%
Independently and Non-Independently Licensed Psychotherapy Practitioners	11,814	5.43%	399	5.53%
Psychologist	861	0.40%	44	0.61%
LCSW/LISW	4,824	2.22%	184	2.55%
LPCC	4,506	2.07%	138	1.91%
LPAT	27	0.01%	0	0.00%
LMFT	482	0.22%	4	0.06%
LMSW	1,225	0.56%	32	0.44%
LMHC	1,533	0.70%	58	0.80%
LAMFT	48	0.02%	9	0.12%
Dedicated Substance Use Practitioners	1,480	0.68%	68	0.94%
LADAC	629	0.29%	29	0.40%
LSAA	882	0.41%	49	0.68%
CADAC	0	0.00%	0	0.00%
Intensive Outpatient Services	15,741	7.23%	956	13.25%
IOP	12,049	5.54%	680	9.43%
PartialHosp	1,051	0.48%	37	0.51%
ACT	1,555	0.71%	5	0.07%
MST	1,455	0.67%	246	3.41%
FFT	11	0.01%	0	0.00%
HEDIS	1,073	0.49%	38	0.53%
Crisis Services	51,804	23.80%	1,485	20.58%
ED	41,094	18.88%	1,295	17.95%
UrgentCare	21,369	9.82%	446	6.18%
MobileCrisis CTC	1,854	0.85%	21	0.29%
Crisis Intervention	1,476	0.68%	8	0.11%



Appendix A.8 New Mexico Mortality Data

New Mexico Mortality Rates

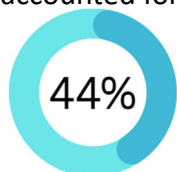
Examining Suicide Deaths, Alcohol-Related Deaths, and Drug Overdose Deaths in the state of New Mexico

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

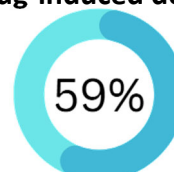
Rates far exceed national averages:

Suicide



higher than U.S. average

Drug-induced deaths:



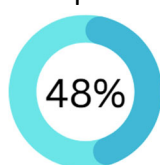
Demographics & Geography



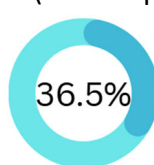
Population: 2.1 million

Race/Ethnicity:

Hispanic



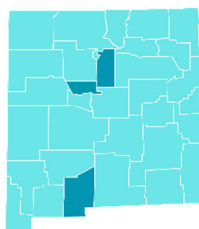
White (non-Hispanic)



Native American



Urban concentration:



50% of residents live in

- Bernalillo,
 - Doña Ana, and
 - Santa Fe Counties
- (6% of land area)

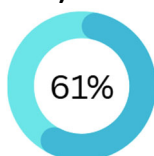
Rural/frontier context:



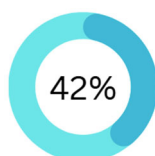
25 of 33 counties have <15 people per square mile, limiting access to care

Comorbidity of Mental Health and Substance Use

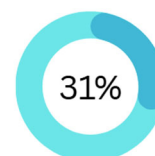
Youth (Grades 9–12):



report mental health concerns

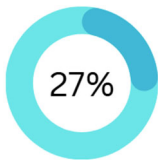


use ≥1 substance

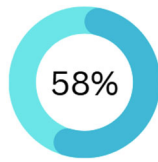


have both (co-occurring mental health + substance use disorder)

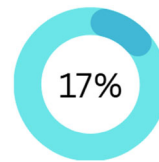


Adults:

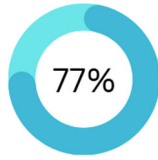
report mental health concerns



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

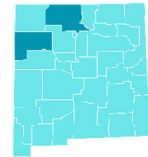
1 in 5 deaths among working-age adults



(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



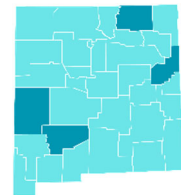
Substance use costs New Mexico about \$890 million annually (as of 2007)



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>

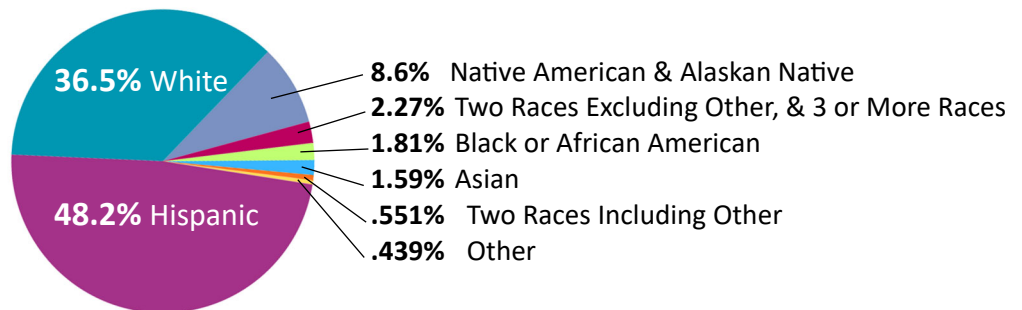
Population

Source: U.S. Census

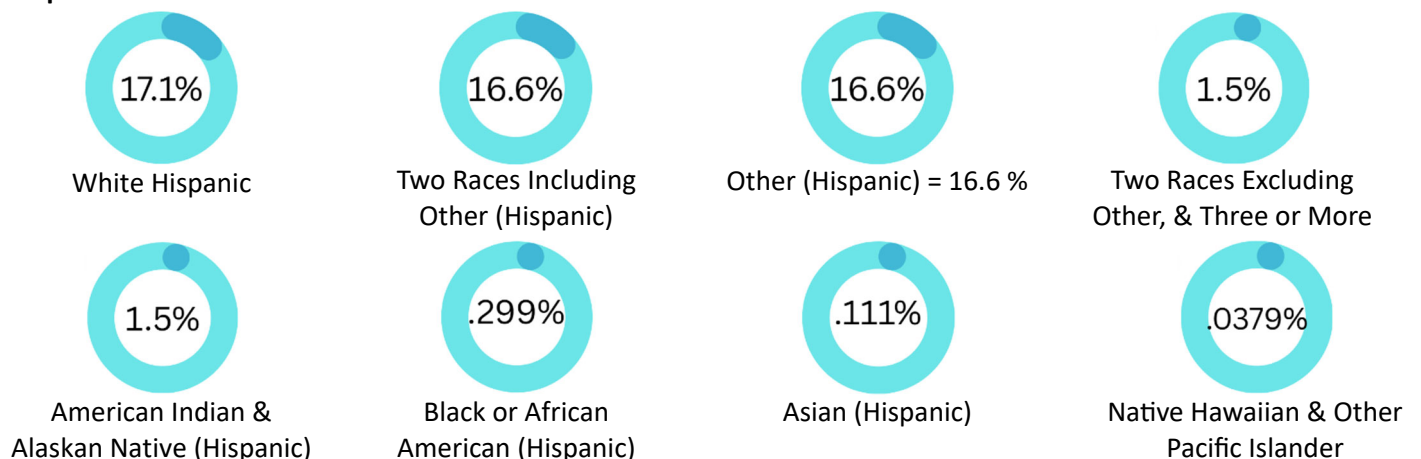


Population: 2,117,522

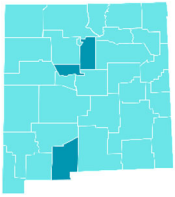
Race/Ethnicity



Hispanic breakdown:



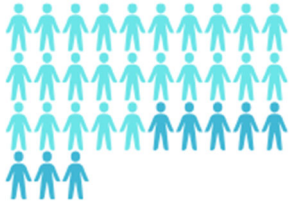
Rural/Frontier



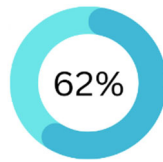
50% of residents live in

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

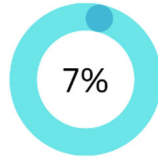
These 3 counties make up only 6% of the state's total land area



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

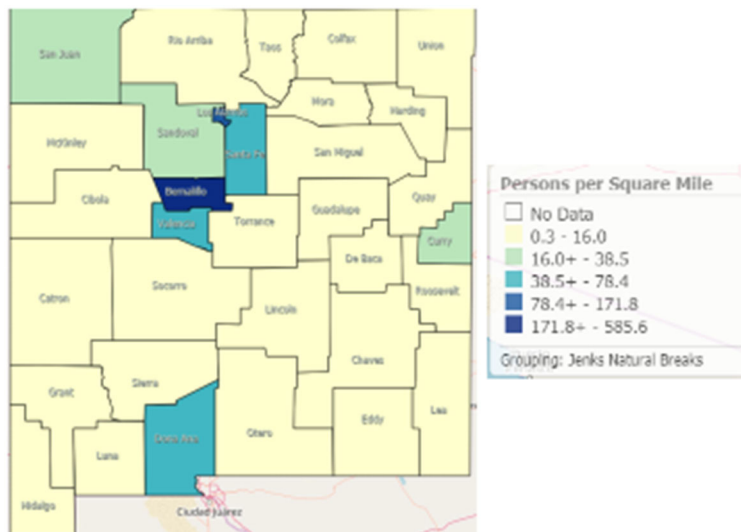


of the population resides in seven urban counties (including Bernalillo County, home to one-third of the state's residents)



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>

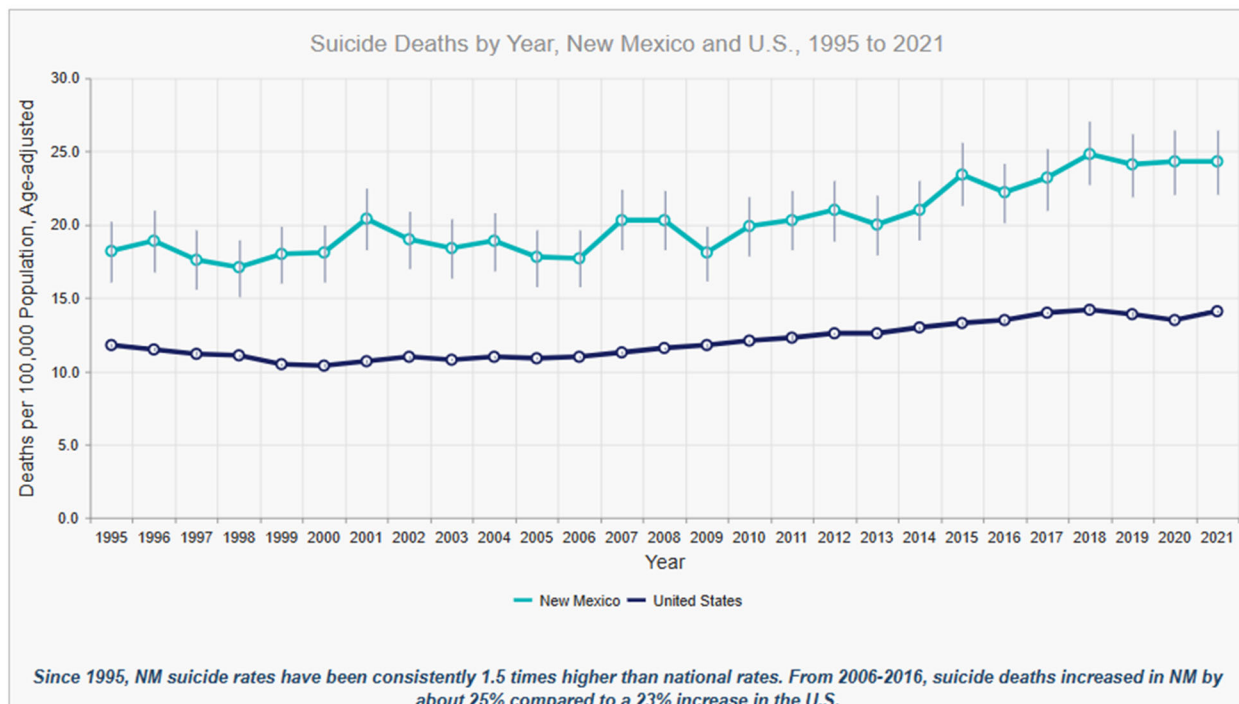
The suicide death rate is defined as the number of deaths attributed to suicide per 100,000 population.

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:

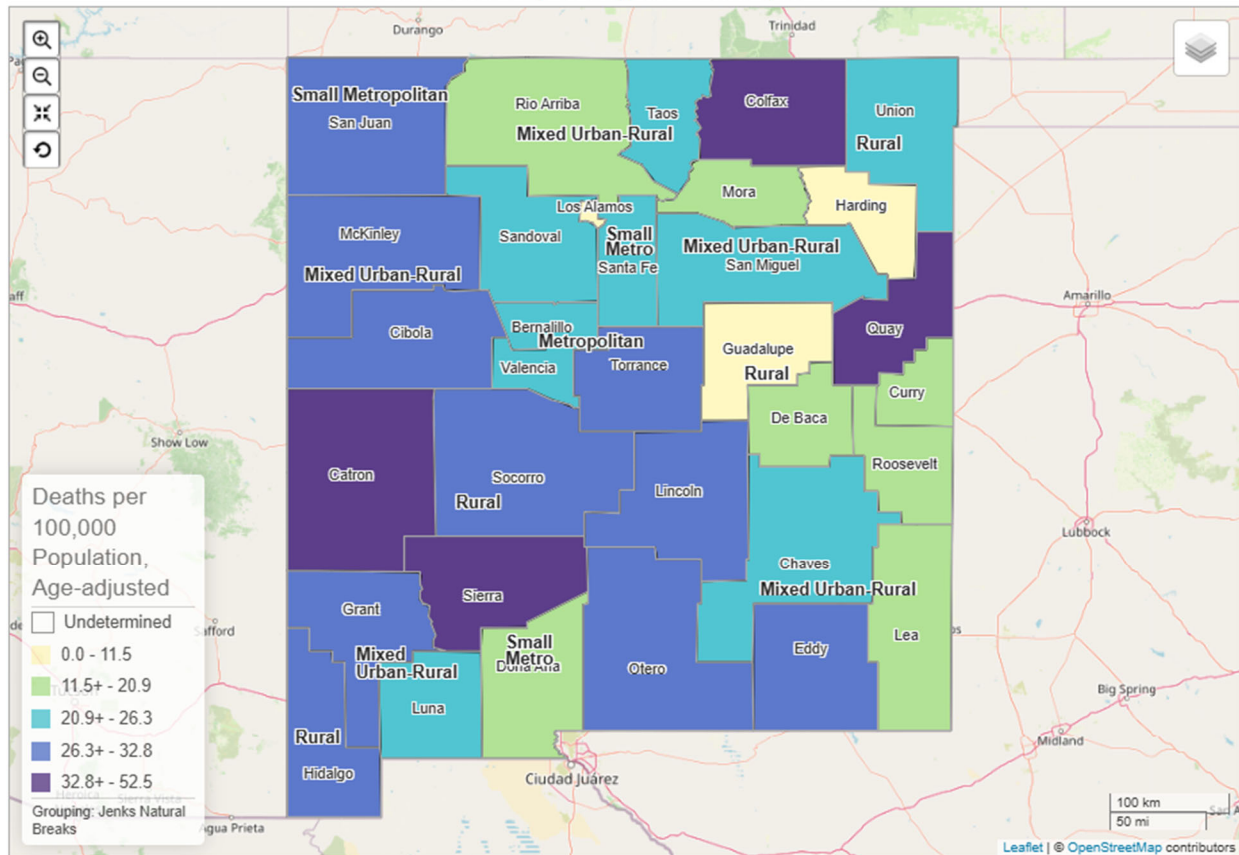
○ Mental disorders, especially clinical depression ○ Previous suicide attempt ○ Alcohol and substance abuse ○ Family history of suicide ○ History of child maltreatment	○ Feelings of hopelessness or isolation ○ Barriers to mental health treatment ○ Loss (relationships, social connections, employment, finances) ○ Physical illness
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Suicide Deaths by Year, NM and US



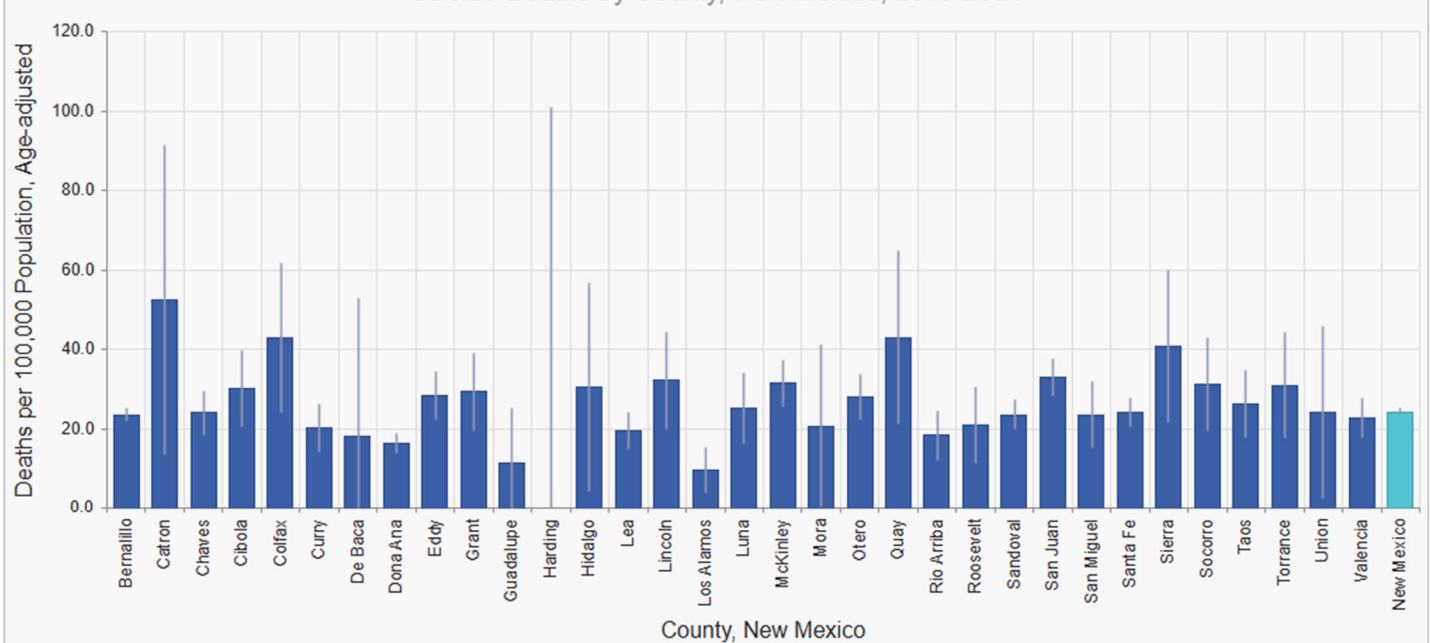
Suicide Deaths by Year, by County, NM

Suicide Deaths by County, New Mexico, 2017-2021



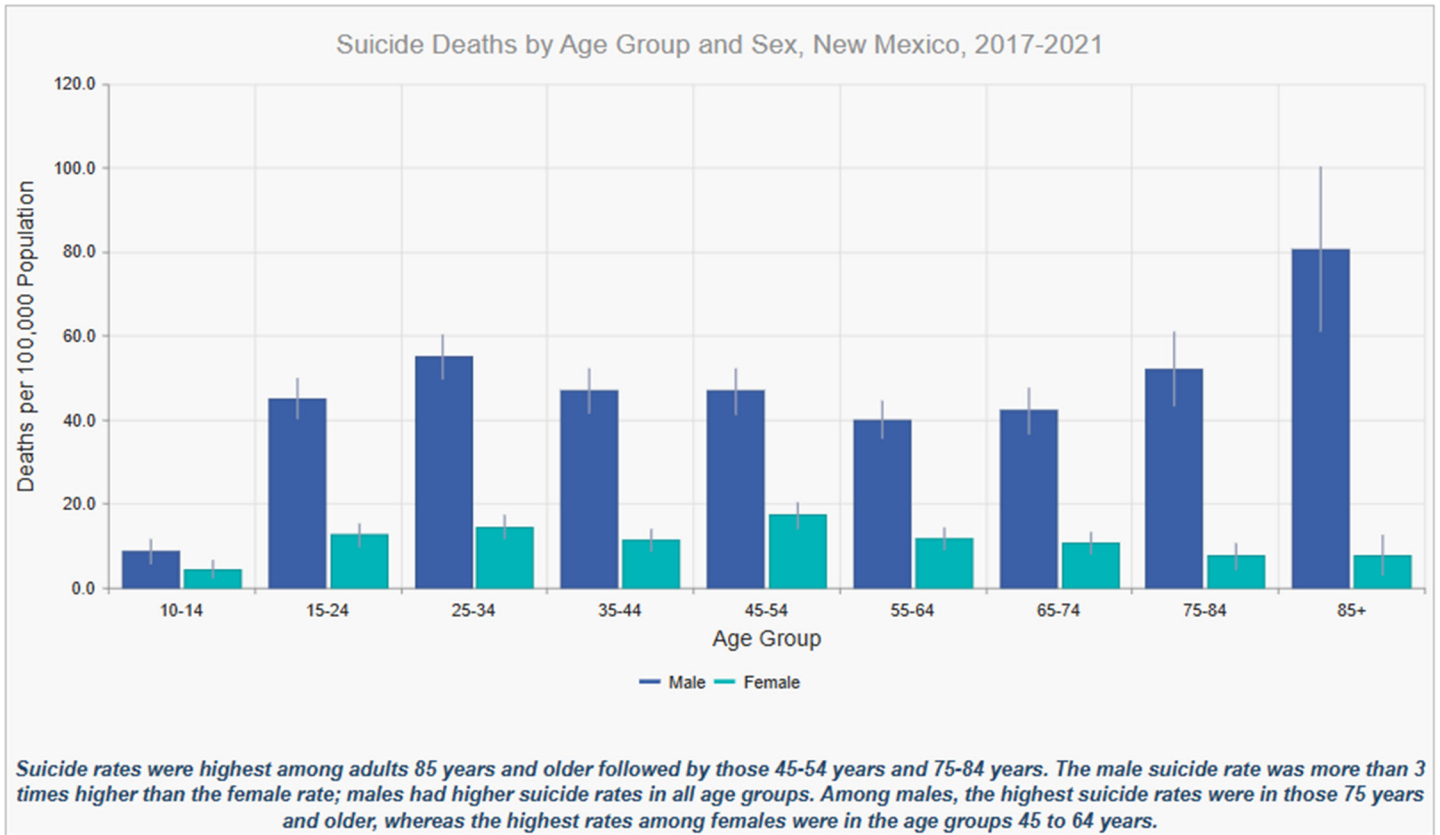
Suicide Deaths by County, NM

Suicide Deaths by County, New Mexico, 2017-2021

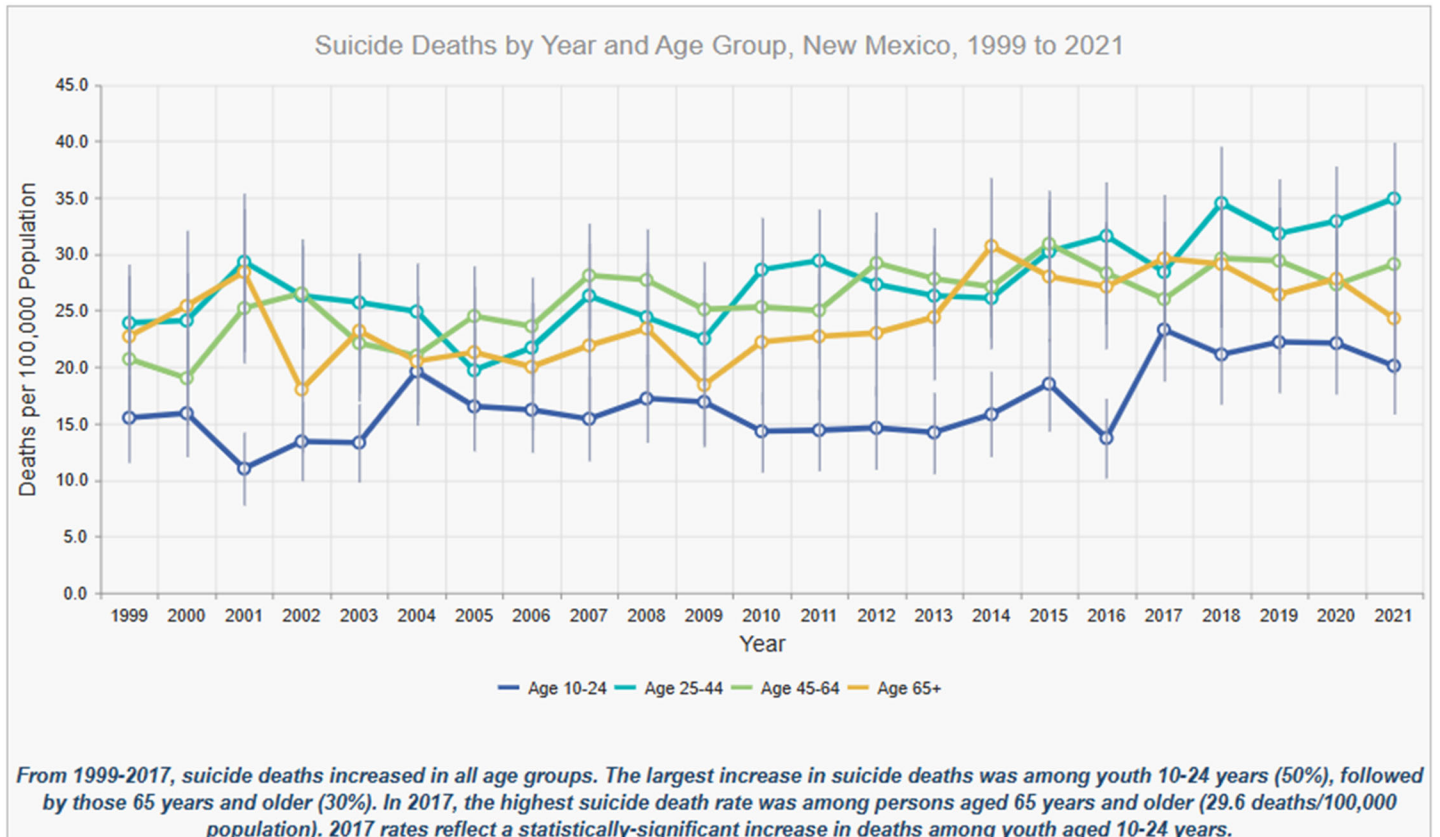


From 2013-2017, 20 NM counties had age-adjusted suicide rates that were significantly higher than the 2016 U.S. rate. NM counties with the highest suicide rates included Catron, Hidalgo, Grant and Sierra Counties in the Southwest; Quay County in the Southeast; and Taos, San Miguel and Torrance Counties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

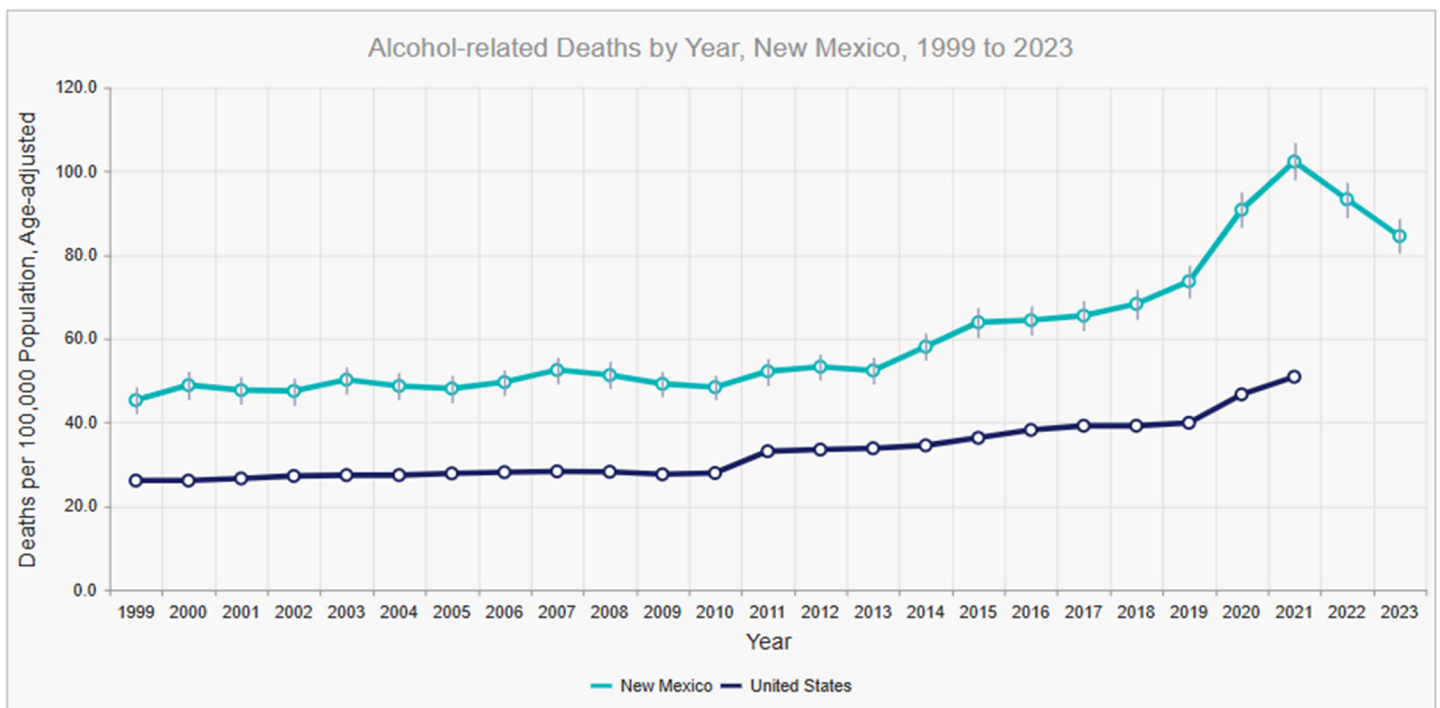
1 in 5 deaths among working-age adults



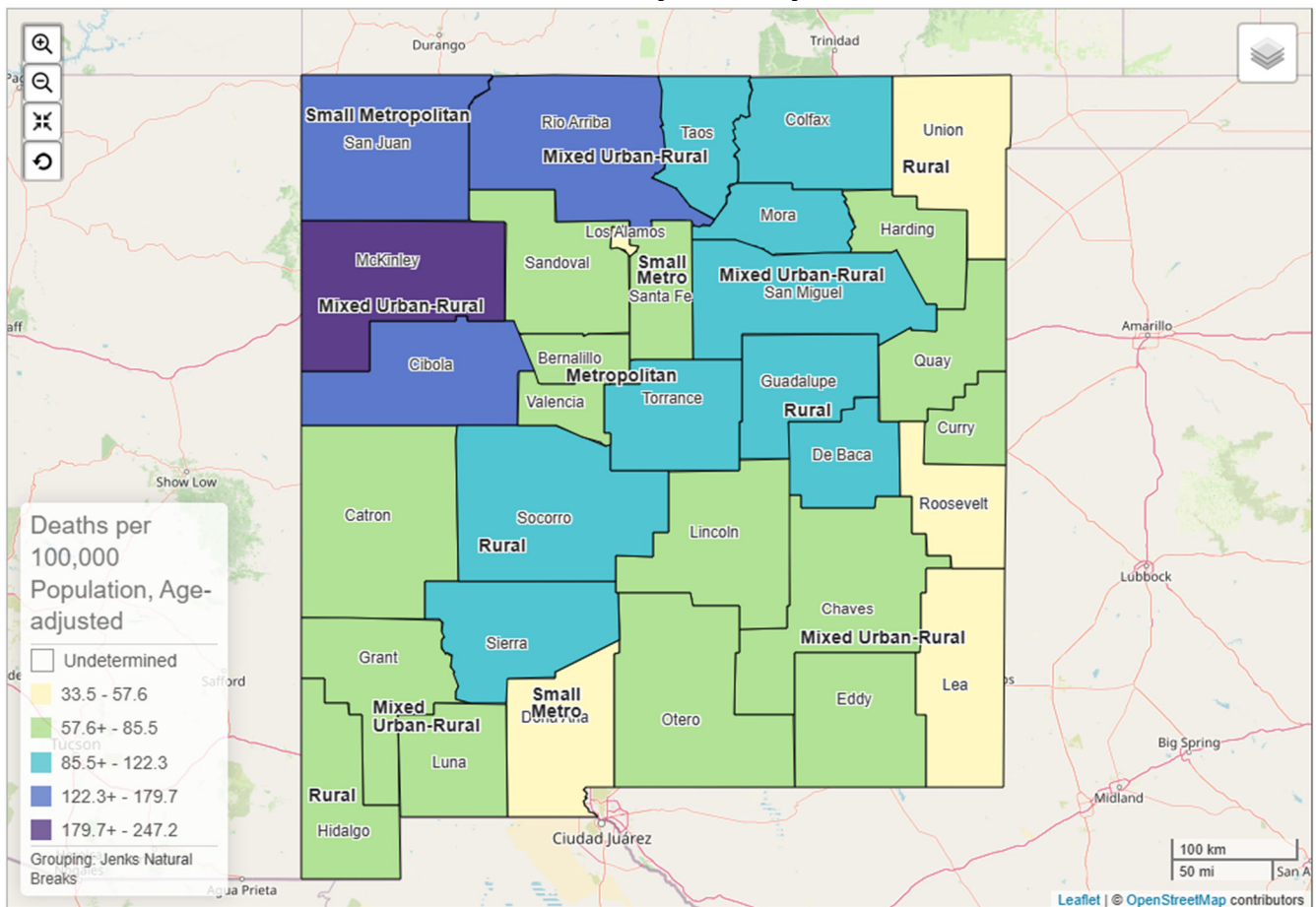
(ages 20–64) is alcohol-related

— This is twice as high as the national rate

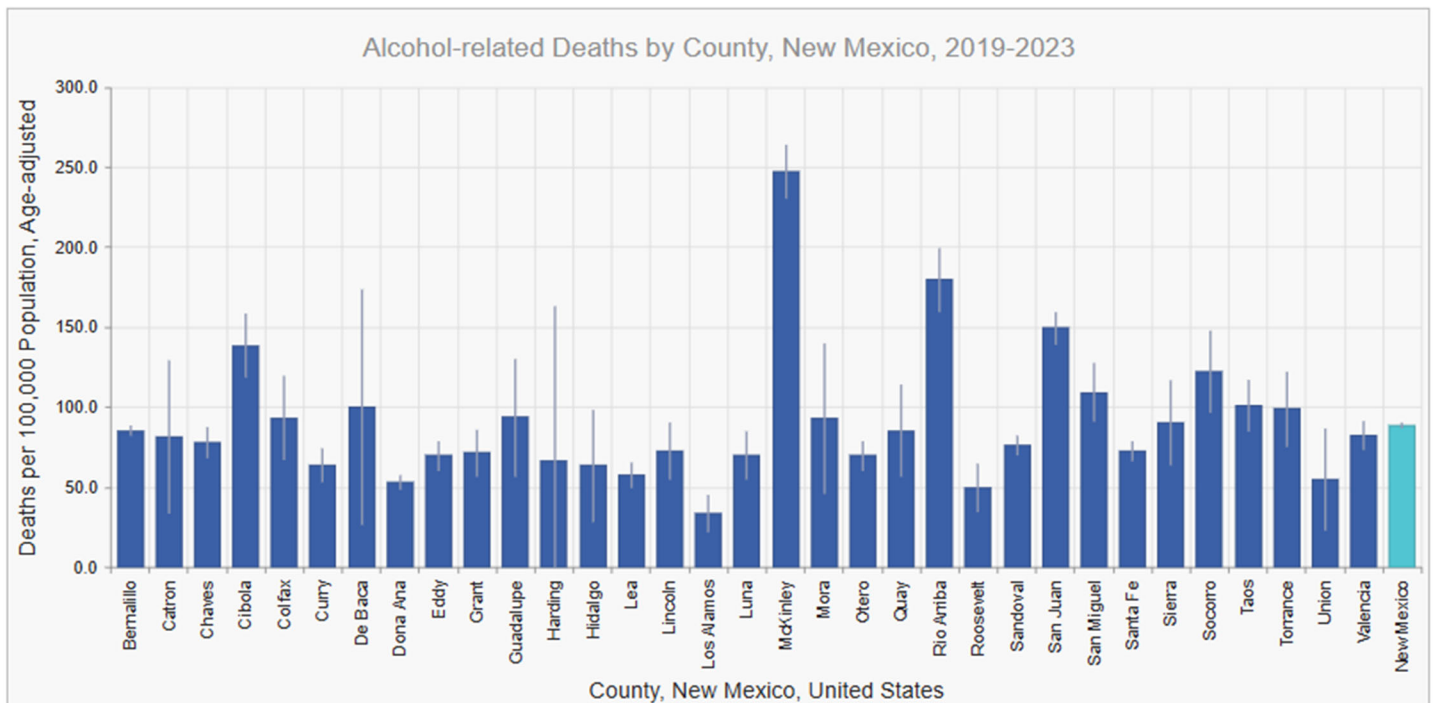
Alcohol-Related Deaths by Year, NM



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

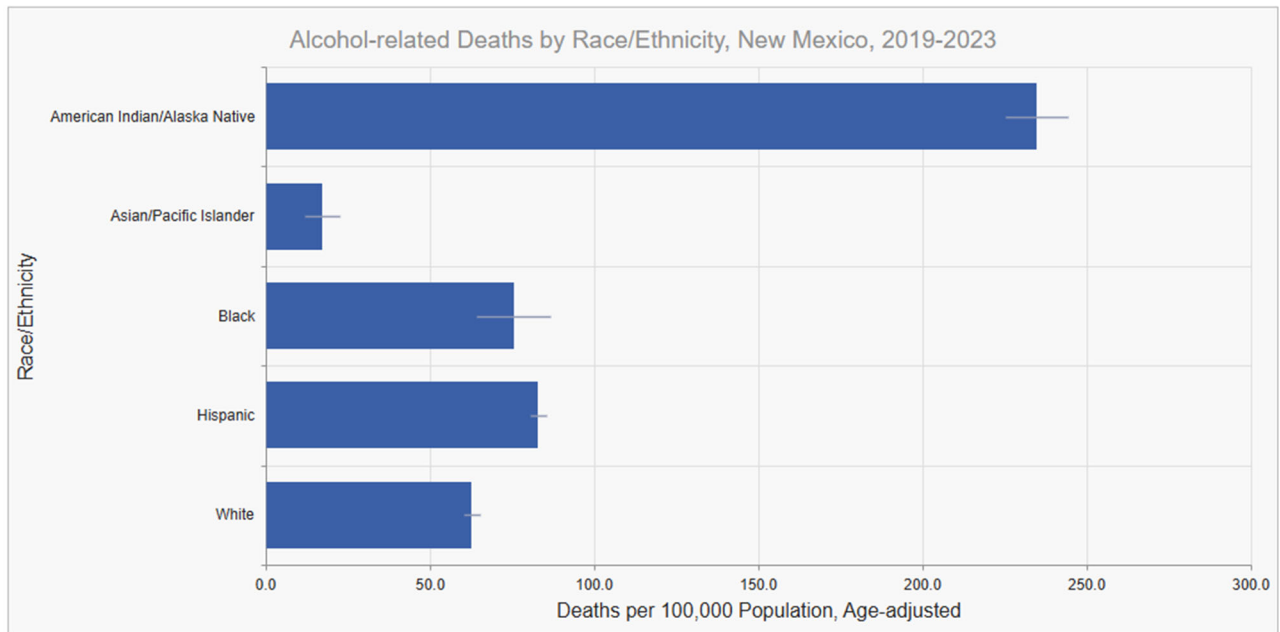


Alcohol-related Deaths by County, NM

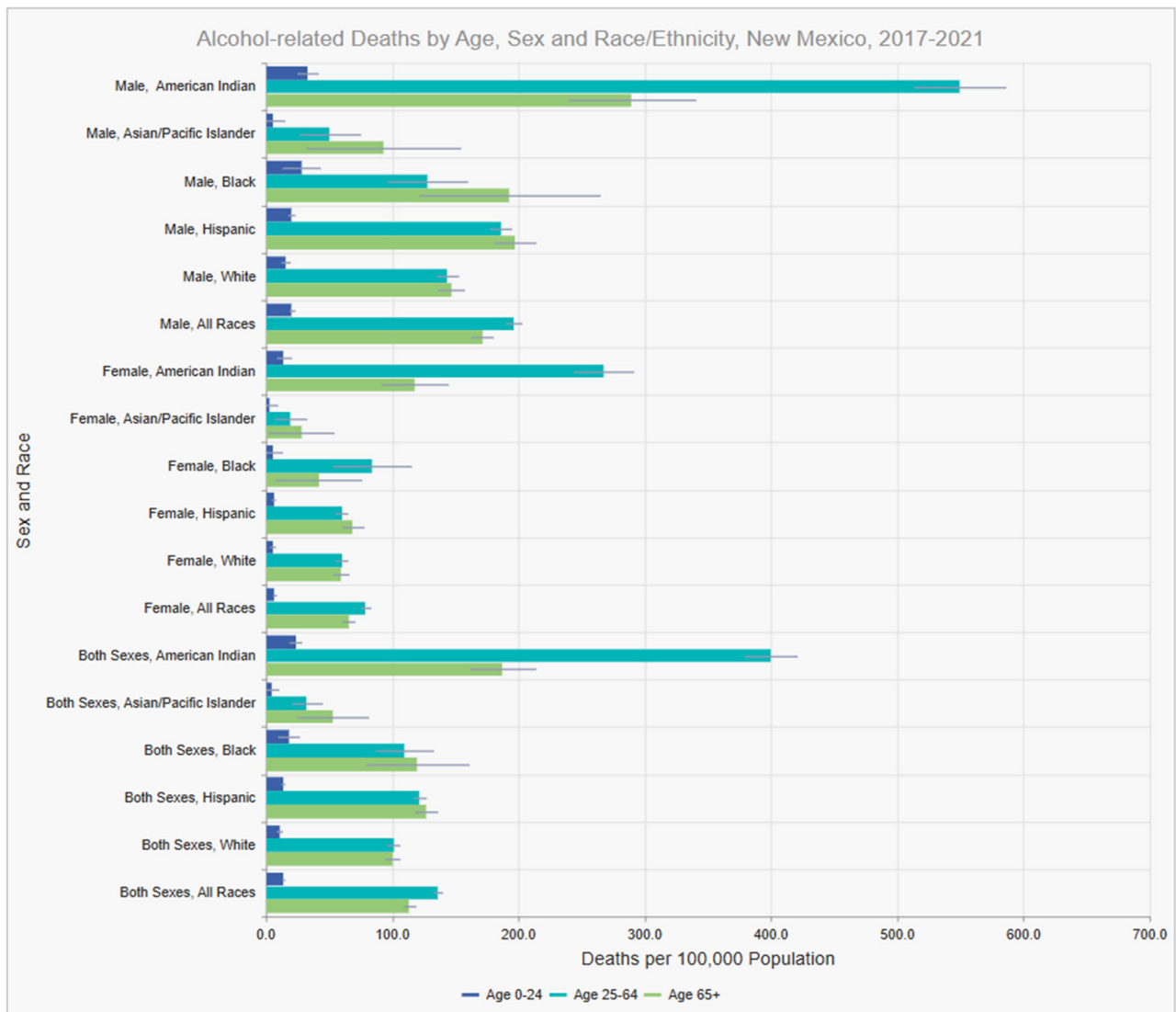


Rio Arriba and McKinley counties have the highest rates of alcohol-related death, with rates more than twice the state rate and more than three times the national rate. Several other counties (Cibola, Mora, San Juan, San Miguel, Socorro, Taos, Sierra, Catron, Guadalupe, Quay, and Hidalgo) have a substantial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

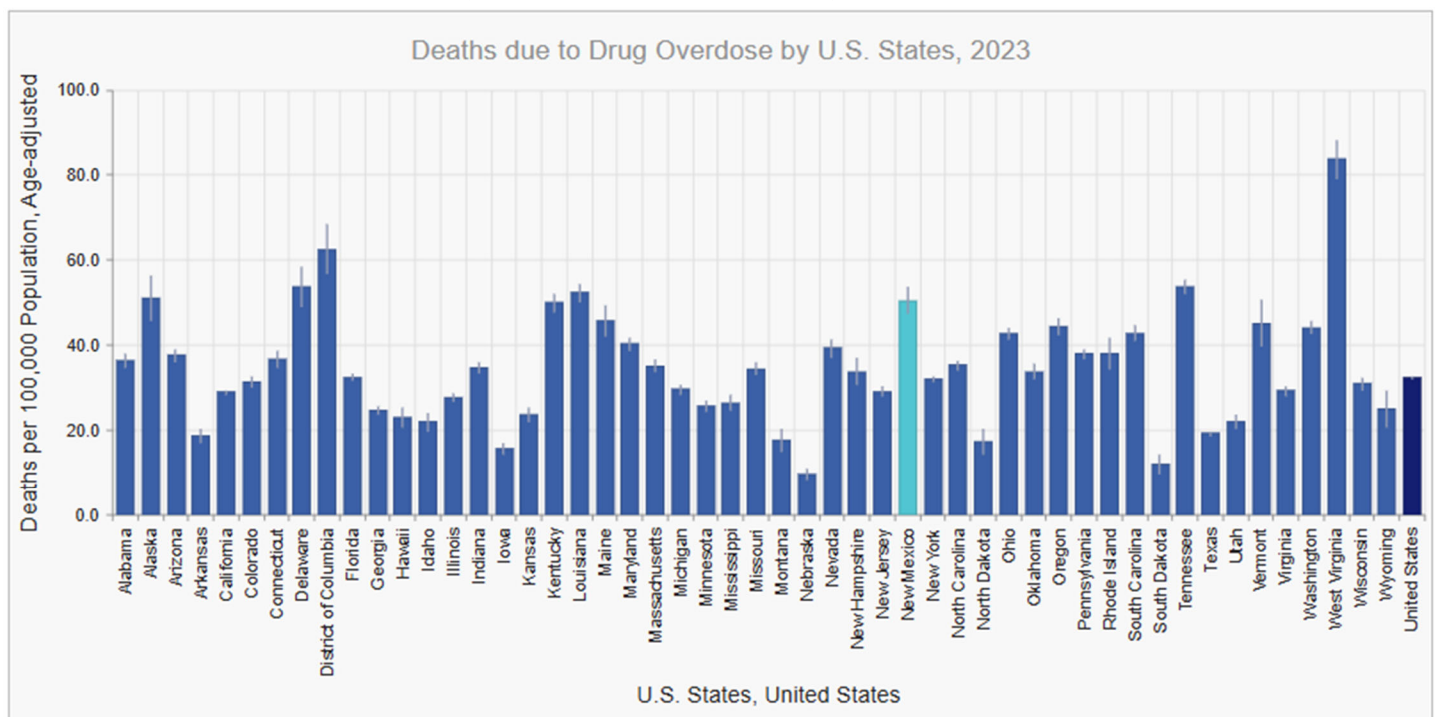
Source: New Mexico's Health Indicator Data & Statistics - <https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html>

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.

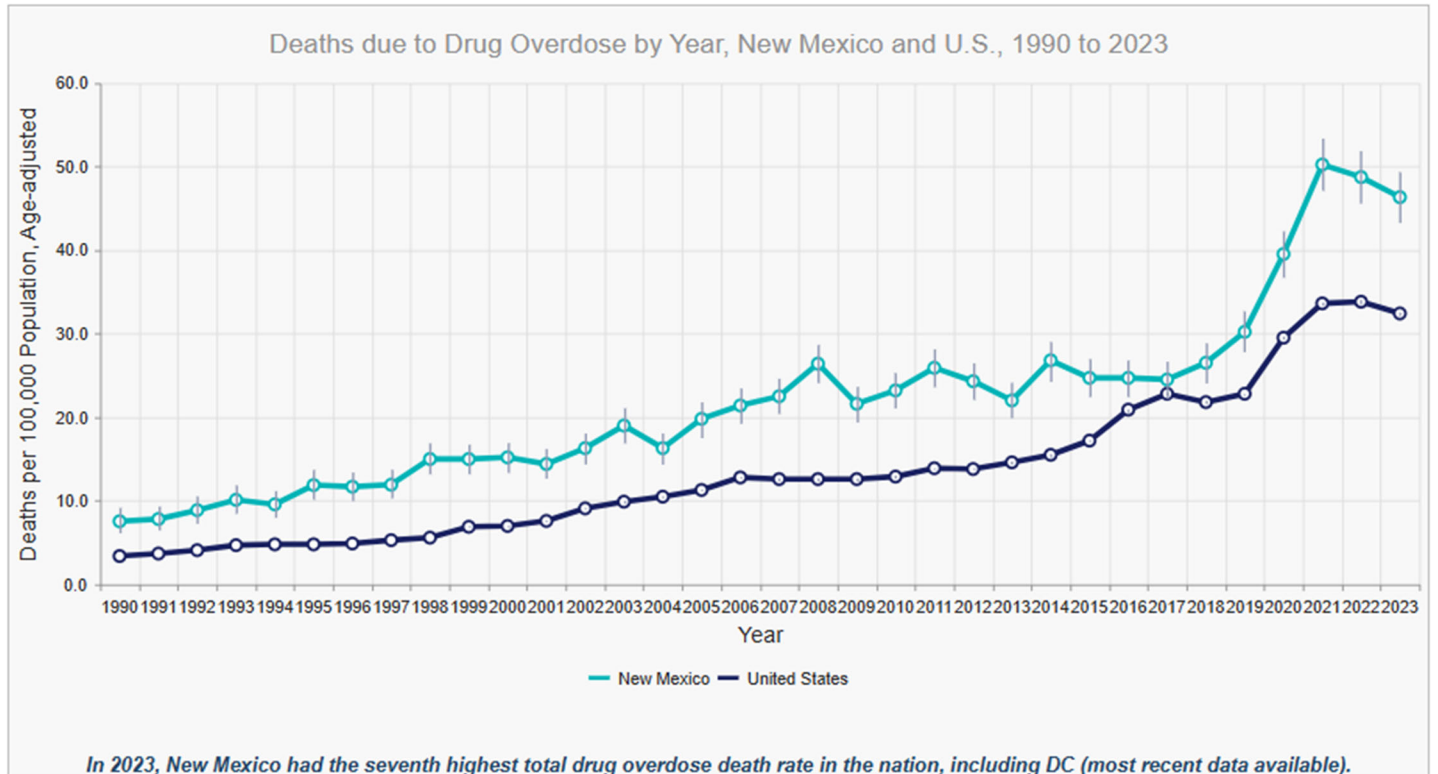
Drug Overdose Deaths

- **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

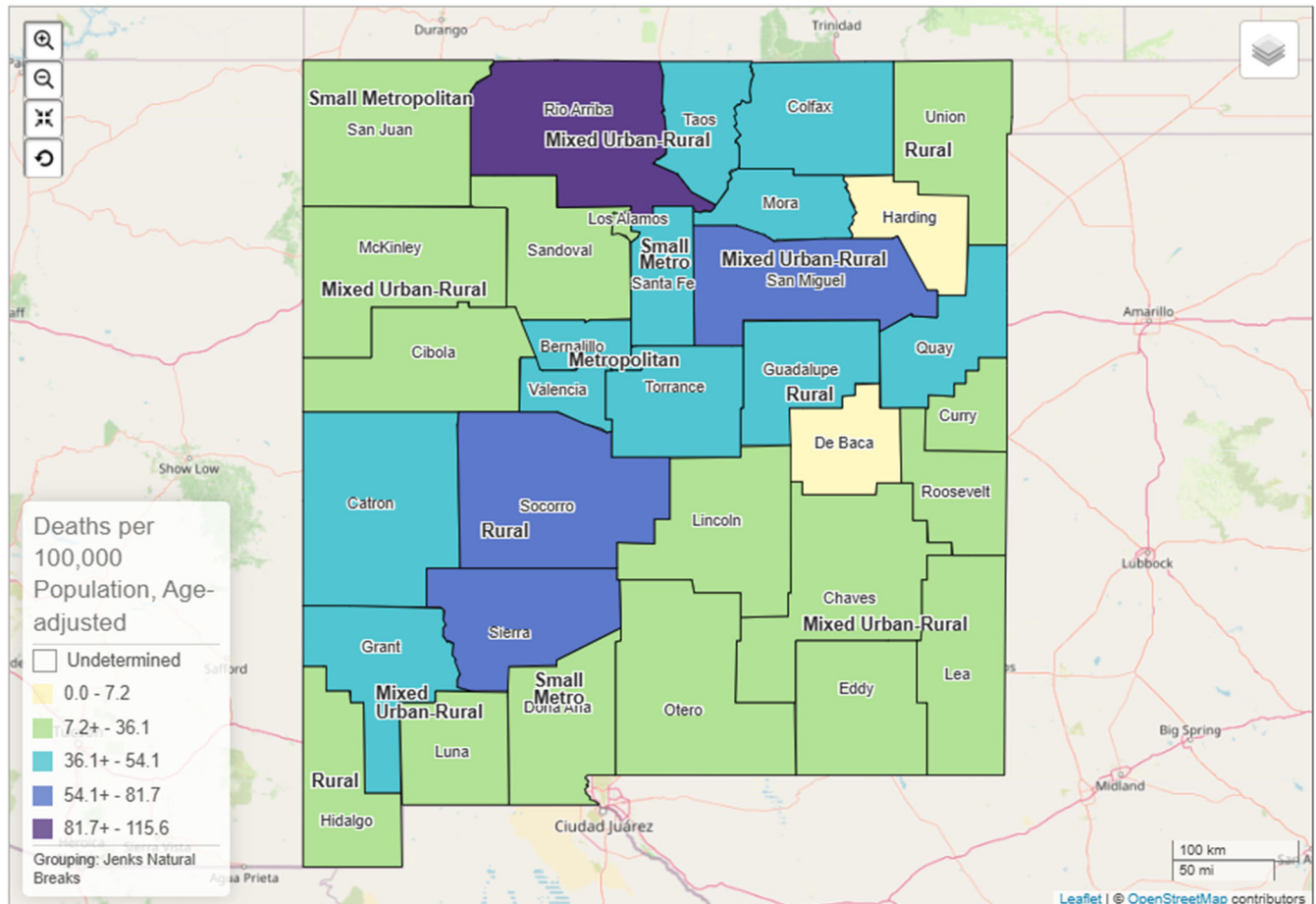


Drug Overdose Deaths by Year, NM and U.S

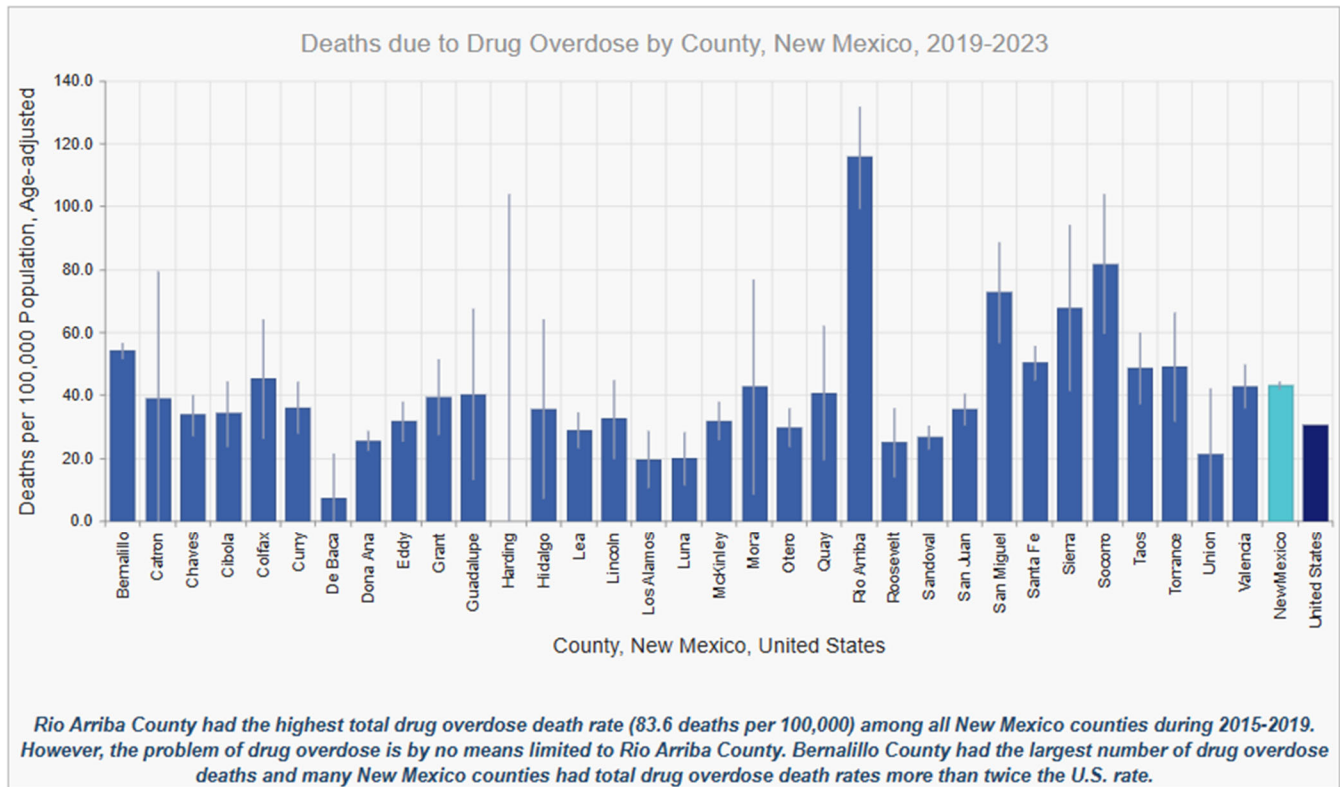


Drug Overdose Deaths by County, NM

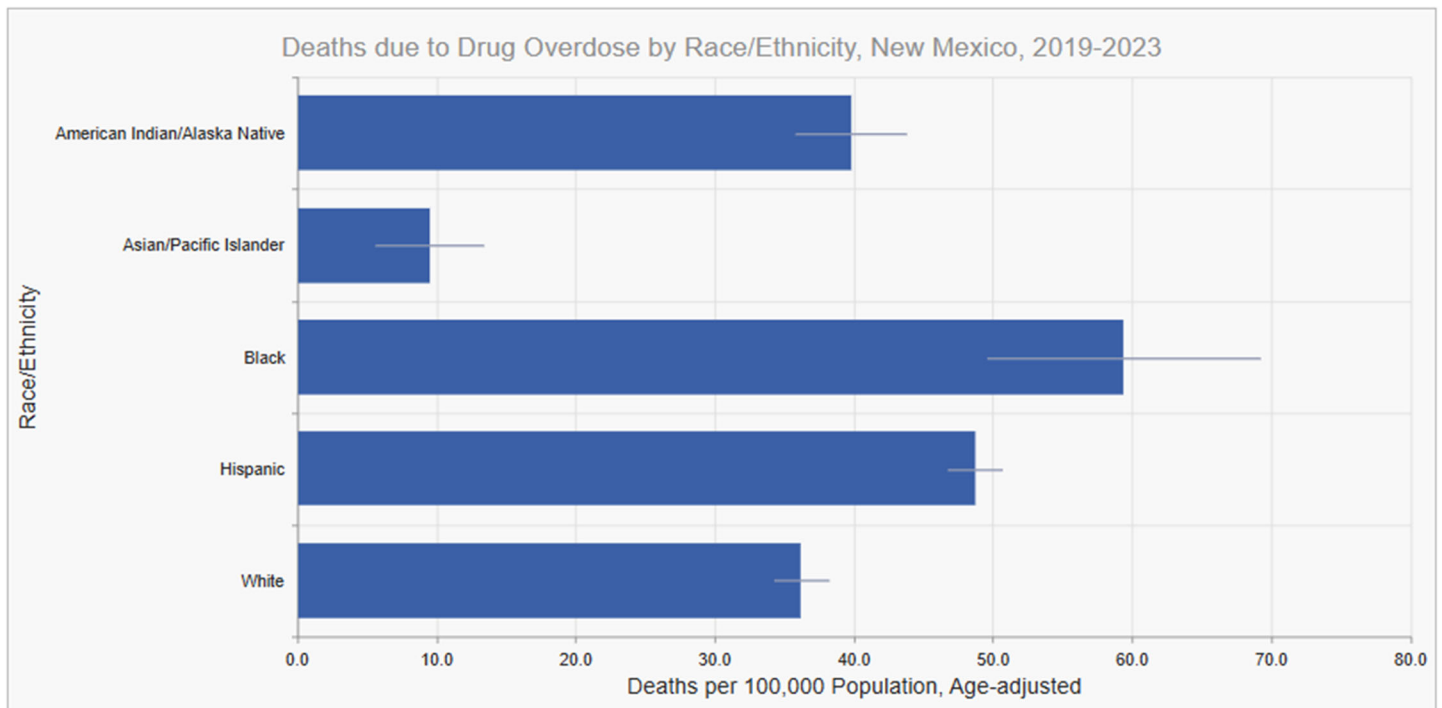
Deaths due to Drug Overdose by County, New Mexico, 2019-2023



Drug Overdose Deaths by County, NM



Drug Overdose Deaths by Race/Ethnicity, NM

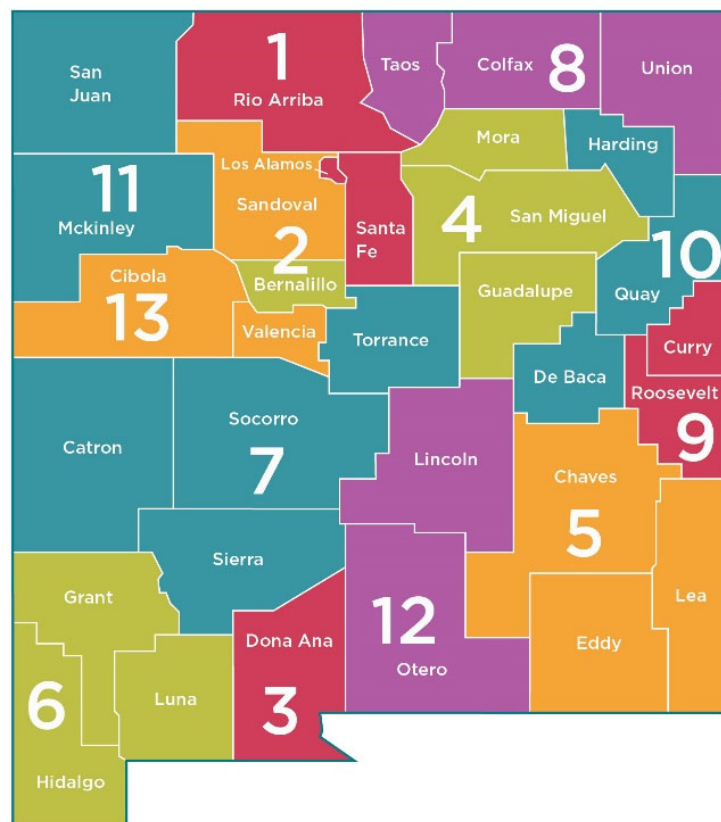


Region/ County

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

Per 100k, Age-Adjusted

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

Region 6

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

Per 100k, Age-Adjusted

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

Region 7

- Catron, Sierra, Socorro, Torrance

Per 100k, Age-Adjusted

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

Region 8

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

Per 100k, Age-Adjusted

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

Region 9

- Curry, Roosevelt

<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 6 Priorities

A. Crisis Services and Stabilization

- Establish a mobile crisis program, informed in de-escalation and trauma-informed care, and trained to make appropriate referrals.
- Implement co-response teams that have funding, equipment, training, and time to respond together
- Build a 23-hour crisis triage center in each county and one region-wide 14-day facility,
- Connect treatment providers to prevention programs to provide support and share information when crises or suicidality come up
- Open up a part of each hospital for a crisis response unit
- Recruitment and retention of volunteer first responders (including considering stipends)
- CIT teams in each county, to be on call 24/7
- Regular MHFA Training for First Responders
- Clarify the liability around co-response teams





B. Care Coordination

- Improve process for getting paperwork, appointments, and discharge information from inpatient and detox settings
- Connect crisis triage center to care coordination system with warm handoffs and ability to transport individuals to other agencies
- Create a system of aftercare (e.g., 30 day supply of medication)
- Create expedited referral processes for justice-involved individuals across intercepts (e.g., flowcharts with specific updated resources)
- Partner with a hospital instead of jail for stabilization
- Fund agencies to attend meetings once or twice a month to share resources.
- Funding for a local coordination team to support families and children as they discharge from treatment (e.g., rehab) to ensure behavioral health, medical care, and basic needs are being met for youth and their families
- Share resources across counties

B. Care Coordination

- Direct funding to community health workers or local non-profits to provide case management (build on trust)
- Improve partnerships with the state by hiring a liaison to communicate between the region and BHSD
- Invite courts, law enforcement, schools, etc., to be at the table to discuss/clarify referral processes
- Implement an in-person one-stop-shop community hub for resource awareness and accessing resources
- Develop a website and hire staff to keep it up to date
- Create a community engagement one-stop shop center in Luna County
- Fund existing resource community coalitions so they are stronger
- Train CHWs on youth resources
- Engage faith-based resources in care coordination efforts





C. Access to Treatment and Recovery Services

- Implement MST services
- Create a residential treatment center in the region to alleviate transportation barriers
- Embed behavioral health providers in recreational centers to facilitate activities with families or children without calling it therapy
- Intervene earlier (with younger children) for prevention and intervention services
- Fund different tiers of intervention for youth: 24/7 crisis stabilization, 2-week inpatient, 6-month treatment
- Develop evidence-based programming that fits with community culture
- Ensure CPSWs are trained and familiar with addiction and mental health concerns to support and staff the hospitals
- Expand training for peer support services for people who are local and provide more localized training
- Expand peer support in the jails

C. Access to Treatment and Recovery Services

- Promote “back to basics” of on-site social workers for improved recovery
- Peer support in every APO office
- Place peer support workers hired by behavioral health agencies in the probation offices and provide oversight and clinical supervision with an MOU for the exchange of information and collaboration
- Expand Recovery Management Center (RMC) program – across Luna and Grant County
- Create opportunities for positive social activities that support recovery
- Increase parent support groups or peer-led groups for parents with youth with behavioral health conditions
- Expand detox, both medical and social
- Utilize evidence-based practices to instill hope (e.g. New Hope for People with... series)





D. Housing and Basic Needs

- Create a women’s transitional home
- Build and maintain outhouses or porta-potties for people who don’t have homes
- Create more group homes for people with significant impairment
- Address safe housing for young children and youth
- Prioritize funding for transportation to access services and programs
- Develop a self-sustainable tiny-home village with on-site workshops and resources for employment, food/gardening, emotional healing, access to a general store
- Create a Silver Lining Home in Luna County
- Expand recovery housing
- Allocate funding to support youth who are unhoused with clothing and the provision of transportation

E. Justice, Diversion and Re-entry

- Connect people with gym membership on release
- Expand opportunities for pre-adjudication diversion for felonies and misdemeanors
- Advocate for a sustainable MH court
- Expand LEAD model for diversion programming
- Develop an outpatient competency restoration program
- Fund and staff an adult justice continuum of services (e.g. similar to juvenile justice continuum of services)
- Expand treatment court for misdemeanors and incentivize completion and compliance
- Expand pre- and post-adjudication diversion opportunities
- Create a system to identify people who need treatment guardians and a pathway forward legally





E. Justice, Diversion and Re-entry

- Create an assessment process at pre-trial
- Explore the feasibility of having youth treatment courts and IOPs in the region
- Implement peer support for youth upon release (to help find jobs etc.)
- Create infrastructure to help coordinate community service opportunities for justice-involved youth, combined with mentorship efforts
- Create reintegration programming to strengthen youth self-confidence, self-worth, and leadership skills
- Create a re-entry center that provides a structured, safe environment (e.g. limited outside distractions) and staffed with licensed professionals to support people transitioning out of jail. Include robust programming (e.g. filling out a job application with a record)
- Develop a fund to cover reentry needs and costs (e.g., \$5 to get a license and other documentation)

F. Workforce Capacity and Development

- Develop a pipeline to support youth to train as peer support workers
- Increase access to supports for providers to prevent burnout
- Hire therapists as county employees to provide jobs with benefits
- Develop incentives for interns and local youth to stay in the area
- Provide SBIRT training
- Expand requiring CIT and behavioral health training for law enforcement
- Train local providers in MAT
- Provide training on cultural competence and awareness for out-of-state contractors
- Recruit more Spanish-speaking providers in Hidalgo and Luna counties
- Provide CEUs locally for in-person and high-quality training
- Advocate for restoring WNMU workforce programs in Hidalgo County





G. Systems, Policy and Infrastructure

- Explore funding options, such as scholarships for Medicare patients
- Ensure alignment of all regional BH funding and planning e.g. opioid and fast track funds
- Bridge funds for agencies when hiring clinicians and peers who have long delays for certification, licensing and credentialing
- Address school policies and state laws around bullying
- Employ staff who can help with reporting, data collection, and recording to help with sustainability
- Strengthen relationships and education to ensure the city council and management are at the table and a part of conversations
- Build tricounty collaboration and infrastructure to limit the amount of time people volunteer to support youth

G. Systems, Policy and Infrastructure

- Assign a liaison with the state to address barriers in each judicial district
- Coordinate efforts to bring people and organizations together to strengthen partnerships
- Get technical assistance to develop a flow chart/ plan for how to integrate all the resources locally and build on what programs and resources already exist (e.g., treatment courts, RMC)
- Create a resource directory app/QR code for access via phones
- Create a hub for resources to access in one place
- Finetune Share NM to each county
- Develop a mediation center and communication skill-building training for community members





H. School Based Supports

- Increase the number of licensed school counselors in each school
- Increase Social Emotional Learning classes in schools
- Holistic coordinated bullying prevention and intervention program; includes teachers, school admin, parents, providers
- Expand School Resource Officers and pair them with student peer mentors
- Develop a robust mentorship program that focuses on middle school students
- Create meditation/quiet rooms in schools
- Integrate life-skills training in schools, e.g., from health, to changing tires
- Strengthen formal collaboration between prevention and intervention treatment between middle and high schools
- Develop more community schools

I. Youth, Family and Parental Supports

- More comprehensive support for basic needs for families, including social-emotional learning for families
- Expand parenting support & engagement (e.g. through Parents as Teachers) to develop parent coaching to support youth with behavioral health conditions
- Have CHWs or other health educators support parents with questions around medication management
- Provide more behavioral health services for parents/caregivers
- Develop wraparound programs for the siblings and families of court-involved youth
- Strengthen mentoring programming for parental involvement and integration in their kids' lives
- Develop greater outreach and home visitation for parents
- Develop programming for pregnant women and post-partum support and education to continue through the child in elementary school
- Expand childcare services, extended hours, and pick up services





I. Youth, Family and Parental Supports

- Increase access to healthy lifestyle activities and opportunities for new peer groups
- Partner with local businesses to provide resources to youth (e.g., gym memberships, sports equipment, and fees)
- Fund the existing recreation center in Luna County in collaboration with SROs and counselors
- Expand after-school programming (e.g., Big Sister Big Brother, life skills, Boys & Girls Club, YMCA)
- Address the emerging generation gap that is heightened by new technology
- Improve community connections by better utilizing spaces already existing for cooperative activities
- Help youth access alternative school and GED options
- Expand and support the Police Athletic League to promote positive role models and sports opportunities
- Develop a Family Community Center

J. Outreach, Stigma Reduction and Prevention

- Increase tri-county awareness and resource events; people may want to go to other counties for services
- Consider Mental Health First Aid training in community-based settings to spread awareness to individuals who are not already connected to healthcare and BH services
- Build awareness of services through marketing strategies
- Multi-level anti-stigma campaign
- Teaching people with a justice history that it's ok to call the police.
- Educate businesses providing vapes or alcohol to youth
- Develop programs to address youth who are vaping, smoking, having sex, etc. (already engaging in risky behaviors)
- Encourage law enforcement to introduce themselves at IOPs to strengthen community relations





State level initiatives

- Establish incentives for individuals to work in rural health care and specialized BH trainings and bilingual providers (pockets of tax credits, theoretically, people could advocate for higher rates)
- Advocate for funding formula in rural counties to be adjusted to fund rural programs
- Advocate for cross-state BH licensure
- Advocate for regional structure to train and certify CPSWs
- Ensure foster system families are adequately screened to provide support and safety
- Work with state agencies to address background check requirements when employing individuals in recovery with histories of justice involvement
- Develop marketing to improve the perception of CYFD and, more importantly, develop trusting relationships with the community
- Advocate for reimbursement for LSAA's across counties

