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

1st Behavioral Health Region

Jicarilla Apache Nation l Ohkay Owingeh l Pueblo of Santa Clara

Pueblo of San Ildefonso l Pueblo of Nambe l Pueblo of Tesuque

County of Los Alamos l County of Rio Arriba l County of Santa Fe

City of Española l City of Santa Fe l Town of Edgewood l Village of Chama

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I. Background

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

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

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

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

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

II. Overview of E-SIM Mapping and Prioritization Workshop

The UNM BHTAC facilitated the E-SIM Mapping and Prioritization Workshop in the 1st Behavioral Health Region (Los Alamos, Rio Arriba, and Santa Fe Counties) over the course of 2 days (December 18th - 19th, 2025). A copy of the agenda is included in Appendix A.4. Because SIM mapping of the adult system had been recently conducted in the three counties, leadership decided that they would use the workshop opportunity to focus on the youth system. The first day of the workshop focused on mapping existing resources and opportunities in the youth system and the second day focused on the prioritization process. Because of room capacity and the importance of in-person particiption, total attendance was capped at 100 and Behavioral Region 1 received 127 confirmed RSVPs.

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

Sixty-seven people attended the first day with an additional 15 from the UNM BHTAC for a total of 82 attendees. Fifty-eight people attended the second day with 14 people from the UNM BHTAC for a total of 72 attendees. Participants represented a diverse range of perspectives from the following seven groups:

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

During the morning of the first day, an overview of Region 1 Medicaid Snapshot data (Appendix A.5) was presented to help inform decisions regarding resource allocation (Day 2). The snapshot data and additional NM Mortality data were included in participants packets (Appendix A.6). Highlights from the Medicaid Snapshot Data are provided below.

III. Highlights from the Region's Medicaid Snapshot Data

Data were compiled for Behavioral Health Region 1 (BHR 1), which includes Los Alamos, Rio Arriba, and Santa Fe Counties, with an estimated population of 19,675, 39,955 and 157,765, respectively.

Demographics

- BHR 1 has a significantly smaller proportion of American Indian/Alaska Native Medicaid recipients (4.85%) compared to the state (8.60%).
- Hispanic population is similar in BHR 1 (48.90%) vs. state (48.15%).
- Age distribution: BHR 1 has 76.48% adults (18+), slightly lower than the state (77.94%) and 23.52% youth (<18), slightly higher than the state (22.06%).

Behavioral Health Diagnosis

- **Under 18**:
  - Anxiety Disorder is most common (BHR 1: 53.3%, NM: 50.6%).
  - Mood Disorders and Attention Deficit Disorders follow closely.
  - Rates of Cannabis Use Disorder and Alcohol Use Disorder are higher among youth Medicaid Recipients in BHR 1 compared to the rest of the state and rates of Intentional Self Harm and Suicidal Ideation, Emotional Disorders, and Psychotic Disorder are lower.
  - While relatively rare, BHR 1 has higher rates of Eating Disorders compared to the rest of the state (BHR 1: 2.2%, NM: 1.8%)
- **18+**:
  - Anxiety Disorder remains highest (BHR 1: 53.39%, NM: 59.6%).
  - Opioid Use Disorder is significantly higher in BHR 1 (25.73%) vs. NM (12.7%).
  - Alcohol Use Disorder also prevalent in BHR 1 (21.74%) vs. NM (17.9%).

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

Diagnoses	% BHR 1	% State
Anxiety Disorder	53.3%	50.62%
Mood Disorders	24.0%	21.89%
Attention Deficit Disorders	21.1%	26.03%
Developmental Disorders	10.9%	11.71%
Conduct Disorders	8.4%	10.06%
Cannabis Use Disorder	5.9%	5.30%
Intentional Self Harm & Suicidal Ideation	5.7%	7.13%
Emotional Disorders Childhood Onset	3.8%	4.63%
Psychotic Disorder	2.4%	3.23%
Alcohol Use Disorder	2.2%	2.00%

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

Diagnoses	% BHR1	% State
Anxiety Disorder	53.34%	59.6%
Mood Disorder	32.05%	37.7%
Opioid Use Disorder	25.73%	12.7%
Alcohol Use Disorder	21.74%	17.9%
Stimulant Use Disorder	16.40	10.7%
Hallucinogen/Inhalant/Other SUD	10.01%	5.8%
Cannabis Use Disorder	9.09%	8.3%
Psychotic Disorder	7.90%	7.9%
Intentional Self Harm & Suicidal Ideation	5.90%	5.3%
Attention Deficit Disorders	5.17%	6.8%

Service Utilization

- **Outpatient Services**: Region 1 slightly lower (82.6%) vs NM (86.8%).
- **Crisis Services**: Region 1 higher (31.4%) vs NM (23.8%).
- **Intensive Outpatient**: Region 1 higher (9.4%) vs NM (7.2%).
- **Residential/Inpatient**: Region 1 higher (6.6%) vs NM (4.9%).

Provider Utilization

- **Behavioral Health Prescribers:** Less in Region 1 (11.4%) vs NM (14.7%).
- **Primary Care Clinicians:** Less in Region 1 (31.6%) vs NM (36%).
- **Psychotherapy Practitioners:** Similar in Region 1 (5.5%) vs NM (5.4%).
- **Substance Use Practitioners**: More in Region 1 (1.2%) vs NM (0.7%).

Crisis Calls & ER Utilization

- **Crisis Calls per Capita**: Region 1 (1.45% in 2023 → 1.32% in 2024), similar to NM.
- **ER Visits**: Region 1 lower (18.8%) vs NM (24.6%).

IV. Resources, Gaps and Opportunities at Each Intercept of the Youth System E-SIM

On the first day, participants were divided into four 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 3: Youth System Pre-Intercept: Overview of Resources, Gaps and Opportunities

Category	Resources	Gaps	Opportunities
Community Centers & After-School Programs	• After school program, BH prevention, physical activity at San Ildefonso Pueblo • Teen center in Los Alamos • Narcan at public libraries in Los Alamos • Española Teen Center • Santa Fe – Teen Centers and Recreation Centers • Big Brothers, Big Sisters • Boys & Girls Club • SF City Children and Youth Commission • Sports for older kids • SF Mountain Center: outdoor, Therapeutic Adventure program • Gerard's House – After and before school in Santa Fe and soon in Española and Pojoaque • JCC in Rio Arriba County	• Overall lack of funding for programs, especially in Española (highest need, lowest funding) • Cost barriers for youth sports and activities • Rural communities lack youth infrastructure (e.g., Chama) • SF teen center, looking to connect with south side of SF city, not utilized as much as it could be	• Increase awareness and utilization of existing teen centers (Santa Fe, Española) • Expand access to outdoor programs (Santa Fe Mountain Center, cultural initiatives) • Advocate for equitable funding for high-need areas like Española • Secure sustainable funding for youth programs and rural infrastructure
School-Based Supports	• Communities in schools, wrap around direct casework support to 10% of youth in Santa Fe • SAMHSA strategic prevention framework: schools • National Dance Institute in schools • Launching program for McCurdy ministries school, 3rd space wellness • Santa Fe public schools School based behavioral health services • Restorative justice through K-12 • All students 9-12 at Capital High School trained in Mental Health First • 155 participants in teen pregnancy program • Serving Native American students at Capital High and Santa Fe High through Project Aware • School Health Clinics – all youth can access • Rio Arriba 6 pack "meeting with all 6th graders"	• Limited emergency funds for schools • Lack of Community Schools framework in rural areas • High turnover among school officials • Disconnect between school staff and students on BH/SUD awareness • Teachers lack resources for behavioral health support • Resistance to pulling students out for BH services • Preschool expulsion and lack of trauma-informed policies • LA County School students don't live in county • Need to force some changes with school district policy for trauma informed care • Española – School system lacking everything except basketball – No other clubs like music or art	• Implement Community Schools framework in rural areas • Expand Mental Health First Aid and Teen Mental Health First Aid • Trauma-informed classes for teachers and restorative justice practices • Develop life skills workshops and evidence-based curricula • Need for Community In Schools/Community Schools in Española

Family & Parenting Supports	• Universal Child care • Española – Moving Arts – for children and families from Northern New Mexico • Family Resource Center funded by CYFD • Hands Across Cultures – intergenerational behavioral health issues	• Funding for childcare stops at age 12. • Limited emergency funds for families • Limited time for families to access services due to economic pressures • Lack of manuals or guidance for parents on early warning signs for mental health issues • Parent follow-through with behavioral health services	• Increase wraparound services for families • Provide emergency funds and childcare at service locations • Expand programs for grandparents raising grandchildren • Support intergenerational initiatives and mentorship programs • Push for childcare policy changes (extend funding beyond age 12) • Need to track risk factors that are developed in the home
Youth Development & Vocational Supports	• Youth conservation corps programs (RAC STOP) • LANL (Los Alamos National Labs: Northern NM Youth Foundation career pathway program	• Mentorship programs in rural communities •	• Create pipelines and career pathways for youth (paid internships, pre-college programs) • National Latino Behavioral Health Association (expand paid internships) • Española - Northern NM College – Workforce development
Mental Health & Substance Use	• Youth Mental Health First Aid (Rio Arriba County) • Bilingual services • Intensive care management (ICM) • Edgewood: First Choice • Sky Center: NM suicide prevention, free family counseling, prevention & intervention • Las Clinica del Norte: staff provide prevention, SUD, sexuality education • free online classes, Mental health substance abuse issues. In English and Spanish though Serna Solutions • Online Peer Support Group • Telehealth – Brain health – 13 and older, psychiatric treatment • Española – Mountain Center BH services • Española - Animating Neurological Skills, Emotions, Mindsets in Indigenous Communities (ANSMIC – 2 E Consults, LLC)– BH for Native youth and families – Suicide prevention – Teachings around the medicine wheel	• Provider burnout and retention issues • Lack of bilingual therapists/providers • Limited professional development and training for providers • Workforce gaps in rural communities; lack of living wage for peers • Stigma around SUD and mental illness • Fear among youth and parents of system involvement • Lack of emotional language across different languages • Las Clinica del Norte: staffing fluctuates • Youth want in-person services	• Promote culturally responsive programs (e.g., Animating Neurological Skills, Emotions, Mindsets in Indigenous Communities (ANSMIC) medicine wheel teachings, pottery-based processing) • Enhance traditional healing resources and cultural awareness • Create workforce pipelines and career pathways (including ages 18–25) • Provide living wages for peers and pay for BH interns • Expand bilingual therapist recruitment and training • Subsidized training and loan repayment for providers • Subsidized transportation and housing for providers • Use social media and campaigns for stigma reduction • Increase early intervention and screening for BH issues • Expand nutrition and exercise programs with paid staff • Need to follow youth through different stages of potential risk over time • More peer support workers specifically for youth.

	• Las Cumbres Developmental play groups in LA county for pre-schoolers		
Housing & Basic Needs	• Clothing closet in Santa Fe • Free bus system in LA County • McCurdy Ministries (Located in Rio Arriba County.10 different non-profits) doing wrap around support – housing • Adelante program, housing and behavioral health stability • Universal basic income and financial support. 500 dollars to every homeless student to continue attending schools	• Lack of affordable, reliable transportation across rural areas and counties • Geographic isolation and time challenges to access services • Unsafe infrastructure (bike routes, sidewalks, lighting) • Limited affordable housing for families and providers • Off-grid areas with no internet or water • Lack of computer literacy and working phones • Sleep deprivation among youth	• Improve lighting and infrastructure for youth activities • Expand affordable housing for families and providers • Develop computer literacy programs • Address social drivers of health (food, transportation, education) • Affordable housing for teachers • Subsidized transportation
Other Community Resources	• Santa Clara Rez RIDERS, activity based, community action project to give back to the community. • Cultures that already exist • Santa Fe Street Outreach Program • Girls Inc. programs • Warehouse 21 • 100% RA county (ACES), gaps identified • Movie night provided for interaction and support through New Vistas • Title II Juvenile Justice Board • Gun violence prevention • Sexual violence prevention • Española - Tewa Roots Society • Chama - Non-profit Northern NM ROC (Recreation and Outdoor conservation) • Santa Fe – Chain Breakers – Youth services to refurbish bikes for transportation • Abiquiu Northern Youth Project • Santa Fe Community Yoga • Santa Fe - Earth Care – youth climate justice advocacy (YUCCA)	• Lack of safe public spaces and creative outlets for youth (e.g., skate parks) • Warehouse 21 closure removed a vital youth space • Inconsistent eligibility for programs • Fear of immigration enforcement as a barrier to accessing services • Lack of coordinated activities across counties • Volunteer-run programs without sustainable funding • Lack of coordinated activities throughout LA County • Edgewood closer to ABQ, lack of reach to services, transportation, providers • Activities for youth to do at young age, lack of access (sports, dance, cheer, other outlets)	• Create safe public spaces (skate parks, youth centers) • Teens need more activities in LA County • Need better communication amongst different organizations in different counties • Remove competitions amongst organizations

	• Tewa Women United in Española and Santa Fe – trauma prevention work – A'Gin program • Academy of Technology and the Classics – The Mountain Club		

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

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

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

Category	Resources	Gaps	Opportunities/Action Items
Youth Crisis Services	• Santa Fe County mobile crisis team amongst 14 and up youth • ARU – Alternative response Unit – mobile crisis to the county to for people who are 14 and over • Youth drop-in center serving the northern pueblos and tribes • SF youth crisis center is being developed • 988 • National Latino Behavioral Health Association – at McCurdy – Create wellness spaces so that police are not always called, mentorship provided • Mobile Crisis Teams	• No mobile crisis for youth under 14; no youth crisis center in Santa Fe • Lack of immediate connection after crisis; delays in screening • No crisis drop-in center; lack of crisis response teams in Los Alamos • 911 dispatch unaware of Alternative Response Unit (ARU); poor communication about available programs • No crisis center for youth in Santa Fe • Postvention team – crisis that happen in schools, crisis response team needed beyond a sudden death • •Crisis response Indian Child welfare act, but does not cover behavioral health. Lack of crisis response	• Expand youth crisis centers and mobile crisis units (including under 14) • Develop crisis response teams and facilities in Los Alamos; provide 24/7 youth services • Train 911 dispatch and law enforcement on youth engagement and Alternative Response Unit utilization • Crisis response efforts to align with communities to not compete with resources • Need more BH training for EMS
Child & Family Support / Child Welfare	• Casa First Grandparents and kin program • Basic education program for adults • Las Cumbres comprehensive services for families in Española, services and resources for developmentally disabled (autism etc.) • OFRA, state level program to keep children in the home	• No respite services; limited wraparound programs • Generational trauma; grandparents raising grandchildren without adequate support • Families lack education on BH issues; parents unsure how to support youth	• Develop respite services and wraparound programs • Provide emergency funds and childcare at service locations • Expand programs for grandparents raising grandchildren • Support intergenerational initiatives and mentorship programs • Expand CYFD prevention and intervention programs to rural communities

	• Welfare checks with state police in Española when youth is threatening adult • CYFD peer support workers program is in progress • Santa Fe – Sky Center – Free family counseling • CYFD – Peer prevention – called Family Outreach – Case management, financial support • NM Dream Tree – youth housing and counseling, clothing	• Youth with disabilities need more inclusive environments • Infant/Early childhood services in communities • Need better resources to keep families/caregivers together • Need more resources for surrogate caregivers • Need for more children and youth housing as there are children living in CYFD offices	• Fund more family systems programs, family therapy • Incentivize families and youth to access services
Hospitals & Inpatient Care	• Santa Fe Recovery has inpatient rehab that allows children to stay as well • Sky center has relationship with emergency rooms, does postvention after suicidal ideation/attempt/crisis • Peak at PMS Family Center – partial inpatient hospital	• No residential treatment centers for youth in the region; none for girls statewide • Travelling providers at local hospitals, not connected to communities	• Need programs/resources to reduce emergency room visits • Need inpatient youth mental health treatment • Partial hospitalization services • Mental Health hospital in New Mexico, could be both outpatient and inpatient, and serve adults and youth
Mental Health & Substance Use	• Traditional outpatient therapy • Youth Peer Support Specialist • Abrigo services • Presbyterian Medical services, prescribing for adolescents • Youth cottage homes, a place to live while they are going through that treatment • El Centro clinics in RA • Las Clinicas Del Norte: clinical psychologist (works with pain OUD, etc.). • 1 BH provider at First Choice in Edgewood, evening IOP • MST, SW guidance center • In teen clinic, providers screen 1st-12th grade) for early identification • Narcan training at Moving Arts Española • Narcan vending machine • Serenity Mesa • Federally qualified health centers (FQHCs) • Sky center has model for supervision of providers in training	• Long wait times for assessments and services (4–5 months) • Limited detox and dual-diagnosis services for youth • Lack of services for Two Spirit & LGBTQ youth • Age of consent for BH services is 16, creating barriers • Restrictions by Medicaid funding; non-billable services (e.g., supervision, group therapy) • Provider burnout and turnover; administrative burnout due to documentation • Vacant positions for prescribers; lack of psychiatrists and clinical psychologists • Few bilingual therapists; need more Spanish-speaking and culturally diverse providers • Lack of supervision time for providers; not billable • Limited professional network support for providers and peers	• Increase MST footprint and postvention services for suicide/crisis • Create youth detox centers and dual-diagnosis programs • Build culturally safe spaces and programs (e.g., arts, traditional healing) • Increase bilingual and culturally diverse providers; recruit Spanish-speaking interns • Provide living wages for peers; expand peer support programs beyond foster care • Support supervision and professional networks for providers and peers • Incentivize workforce to work in rural areas; loan repayment and housing support • Use social media for stigma reduction and positive youth messaging • Address the lack of providers for high-acuity mental health issues and psychiatric care for youth • Increase services for victims of sexual abuse, especially in rural areas • Expand harm reduction programs and trauma-informed care

	• NM Postvention Team in Santa Fe • Tewa Root Society • SOLACE services for victims of sexual abuse	• Workforce gaps in rural areas; low salaries and lack of incentives • Lack of culturally relevant services and programs • Stigma around BH/SUD; fear of system involvement • Shouldn't need a diagnosis to receive help • Medicaid restrictions; providers reluctant to accept Medicaid or liability • Lack of detox and treatment services for youth • Limited harm reduction programs for youth • Limited services for victims of sexual abuse; long wait times for evaluations (up to a year) • Youth and Family peer support workers • Malpractice insurance costs too high for providers in NM	• Increase awareness of rights for disenfranchised youth (undocumented, out-of-school) • Use technology for stress screening and resource navigation • Provide financial assistance for co-pays and non-Medicaid services • Present positive messaging about youth that are doing well, sustain this across organizations, media, government • Need services between legal system involvement and potential hospital involvement (for SI, crisis, etc.) • Lack of supports for youth from detox or drug rehab • Need continuity of care after rehab
School Health Centers & Systems	• Services being brought to schools in Santa Fe public schools • Sky Center does group therapy in schools • LA has programs that provide services to students that are not AT the school for confidentiality • Restorative justice within the Santa Fe Public Schools • PMS: therapists in schools • SBHC • Prevention teams (Certified prevention specialists, CPSWs) that go into RA schools	• High referral no-show rates for BH services in schools • Lack of trauma-informed training for teachers and crisis response teams • Disconnect between schools and providers; punitive responses to crises • Limited school-based health centers in rural areas • School-to-prison pipeline; inequities per Yazzie/Martinez mandates • Turnover among school officials and staff • No reimbursement for group therapy in schools • Weak school systems; lack of in-school counselors and creative programs • Teacher burnout and lack of compensation for additional responsibilities	• Implement Community Schools framework in rural areas • Expand school-based behavioral health and restorative justice programs • Integrate BH education into curriculum (PE/health) • Provide trauma-informed training and Youth Mental Health First Aid for educators • Create school-level crisis response teams • Increase early intervention and screenings in schools • Implement mindfulness and CBT programs in schools (e.g., Baltimore model) • Train teachers and youth in Youth Mental Health First Aid to create a shared language • Revise suspension policies; provide academic support for suspended/expelled students • Expand restorative justice practices and creative-based interventions in schools • Use stress-screening tools/apps (e.g., "I Am Me") in classrooms • Need mobile services to go to students

			• Arts/Creativity programs with BH providers staffed at the high schools • Awareness for youth in foster care in Santa Fe Schools • Policy needs to change around policy for attendance for school while seeking treatment
Care Coordination & Policy	• High fidelity wraparound, works well at Las Clinicas • Connect Network – referral system in Santa Fe focus on Social Determinants of Health • Santa Fe County team meeting people where they are at in terms of services rendered	• Jurisdictional issues causing coordination gaps • Continuity of care (too long of a wait for outpatient services, loss of communication with youth	• Increase wraparound services for families and caregivers • Break down silos between schools, providers, and government for better coordination • Regular multidisciplinary meetings to reduce silos and improve coordination • Advocate for state collaboration with local organizations and communities
Other / Overarching Themes	• Youth Focus groups with REZ Riders and Santa Clara • Youth community diversion for violence • Juvenile Justice Advisory Board (JJAB) • The KIVA program – Keeping Independent Visions Alive • Innovate and Educate, Youth works • Natural helpers program • Traditional communities in northern part of region • Moving Arts Española has film program and youth diversion program • Hands Across Cultures has media messaging • Sky Center toolkits for protective factors • NLBHA: Circle of care launching in January, youth and elders, talk saves lives, gun safes • Española – Bridge to Health – physical activity promotion • CBPAR Community Based Participatory and Action Research • Tewa women united doing violence/teen dating violence programming	• Lack of youth voice in program design • Lack of trauma-informed care across systems • Youth report boredom due to lack of positive spaces • Need more data shared amongst the separate communities. • Pueblos rely on services that are not 'at the table' (Federal agencies) • ACA plans for people who will be kicked off their insurance • Public Education Department lack of effort and accountability in education change, especially in rural areas that impact mental health and suicide; Unaddressed environmental issues e.g., early bomb detonations impacting ability to heal	• Address social drivers of health (food, transportation, education) • Unified prevention amongst RA and LA county • Need to survey youth about what programs are working and not working • Need inclusive programming amongst different abled youth. • Adult services should be mirrored for Youth • Reconnect with acequia systems collective • Viewing soccer, ballet folklorico, etc. are parts of healing – Culture is therapy for identity development

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

Category	Resources	Gaps	Opportunities
Law Enforcement & SROs	• School Resource Officers: CYFD contract with public schools, to screen for suicide/crisis after • "Fun time with a first responder" at Santa Clara, building relationships to enable Youth to ask for help • NLBHA: Connecting Our Voices – has law enforcement participants in coalition	• Response time for responding to calls • BIA – Law Enforcement. Lack of BIA officers • Youth perception of law enforcement • Improve law enforcement perception of community	• Foster connections between law enforcement and communities; cross-generational engagement
CYFD Initial Contact	• In-kinship placements for children going into CYFD custody • Team Builders – continue to work with the family during their time in CYFD • CYFD Programs: Prevention/Intervention programs – provide intensive family support services • Keeping Families Together • Families in need of services (FINS) referral as alternative to justice involvement via CYFD • MST utilized by CYFD • Individual therapy and medication management utilized by CYFD: sky center, teambuilders • CYFD juvenile justice releasing RFP federal office of juvenile justice and state funds in February/March (JJSC and Juvenile continuum funding) • CYFD can handle services informally • Juvenile probation officers in CYFD	• No 24-hour child care; day care hours not feasible for many families • CYFD understaffed and overstressed; caseworker burnout • CYFD screening process needs improvement; cases close without family support • No evidence-based case management; lack of standardized protocols • Disconnect between CYFD, CPS, and JJS; poor coordination and communication	• Assess CYFD services to identify barriers and goals; secure funding for case management • More financial assistance for caregivers. Trauma informed child care for caregivers who these children are placed with from CYFD

	• CYFD staff mandated to do trauma-informed care training, which is open to community		
School Police & Threat Assessment	• Schools are notified about delinquency if the child is able to go back to school • Youth sent to clinic for evaluation before they can go back to school	• Schools resistant to pulling students out for intervention; lack of buy-in for programs • Bureaucratic silos between schools and government agencies • Litigation from youth to schools; punitive responses leading to criminalization • RAI scoring system for arrests is problematic; statewide issue	• Streamline resource identification for educators and administrators
Diversion & Early Intervention	• Youth Community Interruption pilot in Santa Fe County – for diversion before probation • PIVOT – works with Uplift youth (Previously Santa Fe Youth Court) diversion arm • Moving Arts in Española; PIVOT (Providing Innovative and Vital Opportunities for Transformation) diversion program • Deacon Trujillo in San Isidro - Transformers Diversion program • Uplift Youth (Teen Court), looks at what services are needed/soft referral. Takes referral from schools and CYFD • County by county juvenile justice coordinating council • Behavioral Health Case management in Santa Fe County • ICM – Intensive case monitoring receiving restorative justice funding	• No youth-specific diversion and deflection programs like ENGAGE; LEAD program discontinued for youth • State appropriated funds cannot be used for non-state entities • Buy-in from law enforcement for diversion is difficult, few champions in departments, diversion isn't part of protocol	• Scale Youth Community Interruption pilot and PIVOT diversion programs statewide • Create youth-specific diversion and deflection programs for low-level crimes • Improve law enforcement and school system buy-in for diversion programs • Establish CJCC subcommittee for youth; increase engagement with Children's Youth Commission • PIVOT needs to be expanded – Appropriate crisis intervention team personnel – police over-react and leads to incarceration /criminalization

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

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

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

Category	Resources	Gaps	Opportunities
Juvenile Justice Intake	• Same day assessment for youth with SI in Santa Fe	• Time barrier for DA's office and Judges. • Youth age 14+ can decide/ deny treatment. Parents are still in charge • Nothing in Tribal communities • No use immunity order written into children's code, if the child has an assessment, it can be used in case against child • JPO frustration with lack of coordinated response earlier in youth offense history • Lack of juvenile competency evaluation • CYFD in Rio Arriba County offices are understaffed • DA in Rio Arriba has high turnover (resource issue) • No consideration of sovereignty among tribal lands about leveraging of services • Lack of Safety nets • CYFD is not spending their funds	• Coordination between systems and counties to fast-track cases and needs of youth • Sharing data between systems • Write use immunity orders into youth code (state opportunity) • Need intentional partnership and resource leveraging for the tribes
Initial Processing	• No resources noted	• Pre-prosecution diversion process is not fully formalized (diversion program, referral back to JPO, or dismissed) • Blanket mental health/biopsychosocial screening for all justice involved	• Need funding for psycho/social evaluation once there's involvement w/ the courts. • Need funding for assessments

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

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

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

Category	Resources	Gaps	Opportunities
Courts	• Teen Court Programs • Court Liaisons which provide training for	• Need drug court in Rio Arriba again, concern that AOC decided that there was not enough need	• Support for specialty courts when there are times of low utilization • Improve process for how to redirect to services for when

	justice involved people • Designated children's court w/ designated judge • DA monthly meetings • Los Alamos restorative justice program • Española – CASA (Court Appointed Special Advocates) at McCurdy	• Juvenile specialty courts (drug and treatment) needed but lack of funding • Dismissed cases can lead to no services • Punitive courts and probation processes • Mechanisms to use and understand children's codes	case is dismissed, such as through care coordination (like Unite Us) • Expand Unite Us to include juvenile system • Expand the child's code, and train District attorneys to use properly – Rewrite in context, add neuroscientific finding in this training • Mentorship of DAs - Region 13 model to be implemented in Region 1
Detention & Commitment	• Sequoyah • PEAK partial hospitalization program in Rio Arriba, can transport from Santa Fe • Serenity – substance residential for girls • Awareness of open residential beds – for support on finding a bed call 833-SW-NURSE	• Some youth should not be at Sequoyah, but there are not a lot of other options • No youth RTC for females, only one for sexualized behaviors • Families feel like they are not involved with services at the PEAK • No level of separation by offense, youth become influenced by older kids and adults • Youth have to go to San Juan or Farmington if judge wants incarceration as there are no juvenile detention centers in region, families don't have resources to go up to see youth • No Santa Fe Youth Detention Center • Service after Peak 45 days • Mental health professionals needed in facilities • High waitlist for residential treatment for boys • Awareness of open/underutilized residential beds	• Juvenile buildings in SF could be replicated across region, and for low level offenses; could teach vocational skills • Making sure risk-need levels are not mixed together • Juvenile detention centers are usually county funded, could be state funded • Grow the Peak Behavioral Health programming/services • Implement Animating Neurological Skills, Emotions and Mindsets in Indigenous Communities (ANSMIC) • Create environmental (public) spaces for youth such as through Peak for cultural awareness and identity development and healing through traditional practices of Spanish and indigenous culture • Explore Atlanta Model to address grief/bereavement among adjudicated youth • Strategically place residential treatment centers throughout the state
Programs for guardianship/kinship	• No resources noted		• Need expanded view on who is a legal guardian

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

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

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

Category	Resources	Gaps	Opportunities
Community Re-Entry Services	• Youth Works and Youth Build (federal) programs- GED, life skills, construction skills, culinary arts – Works with youth who have left the juvenile justice system • Santa Fe – Justice involved youth with jobs to build resume and connect to jobs • Peak – A step down from residential – Family and individual therapy, life skills • Northern NM Economic Development – Teach construction through the Workforce Integration Network (WIN) program • Justice Health liaisons with post release needs such as Housing. • Mentorship programs such as Bridge to Success. • PIRE – re-entry tool kit for youth • Equine therapy • Transition facilities in ABQ and Eagles Nest (up to 3 months), get follow-up therapeutic and life skills services • LANL will hire people if they complete certain Santa Fe community college courses	• Counseling for youth coming out of justice involvement • Need more services like Peak • Lack of supports once out of detention – Need for case management and scaffolding back into society • Jails may be perceived as a safe space when family and community is not safe – But do not like being in custody nonetheless • RISE program only for adults • No MAT, IOP services for youth in Santa Fe • When youth are released from incarceration, they are told what to do, but not how to do those things • Lack of wrap around • Family and home environment can be trigger for use • Lack of family involvement in reentry • Not knowing what services are available in correctional facilities • Poverty	• Expand Peak services • Better involve families in re-integration • Comprehensive array of services in community and involvement with families • Workforce to enter into when part of juvenile programs • Develop open, positive places for youth to be themselves where they can explore jobs and other resources • Thorough and consistent supports • Foster dog care program for youth for relationship building • Continuous data collection and monitoring of individuals when they leave the system • Continuum of care • Peer support – mentoring from people who have left the system • Preferential scholarship for school/training and jobs in the community • Self-development in the process of job seeking and strategies – “Know thyself” • Cultural identity and language Re-identify/re-connection with cultural identity • Transitional or permanent housing • Post-release navigation and access to general health/mental health education • Increase case management and amplify peer support workers to continue link with all services needed to prevent the cycle • Need transitional living programs • Need resources upon release from incarceration (resume, rent, etc.) • Need workforce for Youth Shelters in Santa Fe • Need resources on how to be successful upon being released from incarceration • Need better re-enrollment process in schools • Need tribal familial support for families impacted by youth incarceration

			• Develop youth-version of Escondido program • Increase mental health literacy for family • Family involvement important to prevent relapse and when youth are transitioning back into community • Assessment of underlying BH needs during transition prior to reintegration • Economic development outside of just BH/peer opportunities to get out of poverty, ground up needs/voice of community/community driven solutions • Involvement of elder knowledge in program development • Connect employers with educational opportunities/certification and make correctional and legal system aware of opportunities • Create recovery friendly community

7. Youth System Intercept 5: Juvenile Community Corrections

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

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

Category	Resources	Gaps	Opportunities
Juvenile Community Corrections	• JPO can connect to community BH services • NJCC Juvenile community corrections – one is Santa Fe County and Rio Arriba County • Ankle monitoring being available • Rio Arriba JCC: facilitated through RAC STOP, refers to individual therapy, MST and into multiple systems	• Stigma of ankle bracelet and general involvement in justice system • Lack of providers • Adjudication needed to get JCC services • Lack of accountability for community corrections programs • Lack of staff for correctional programs/detention	• Increase funding for juvenile probation • Avoid charges being on their record using variant level of supervision • Create middle ground for probation between supervised and unsupervised probation • Utilize JCC funding in SFC • Create one-stop-shop for JCC services • Broaden JCC services to include youth that are pre-adjudication • Technical assistance to corrections mandated with state • Tracking system to remove or retrain corrections employees who do not use trauma-informed practices

V. The Prioritization Process and Results from the Prioritization Voting

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

SIM reports from the previously conducted adult SIM workshops were reviewed and from these reports the following priorities were identified for the adult system for each county:

Rio Arriba:

1. Expanding Training to Law Enforcement Officers
2. Expanding Access to Housing
3. Developing Low-Barrier Detox Services
4. Expanding Utilization of Certified Peer Support / Certified Peer Support Workers (CPSWs)
5. Instituting a Mobile Crisis Unit

Santa Fe:

1. Same-Day / Immediate Services
2. Expand Access to Housing
3. Develop Detox Housing for People with Severe Mental Illness
4. Implement Peer-Led Probation
5. Increase connection to reentry resources

Los Alamos:

1. Increase behavioral health supportive services
2. Develop & implement a mobile crisis response/Co-Responder Model
3. Institute community mental health & substance use treatment

At the end of the first day of the child focused E-SIM workshop, the UNM BHTAC reviewed the previously identified priorities for the adult system and all notes taken during the breakout sessions and identified themes (also referred to as Provisional Priority Buckets) that incorporated the previously identified adult priorities along with topics that surfaced during the discussion of opportunities. A total of 10 Provisional Priority Buckets were identified and are listed below. During the first session of Day 2, UNM BHTAC presented a summary of the Provisional Priority Buckets and related action items (Appendix A.7). Throughout the PowerPoint presentation, participants were invited to ask clarifying questions.

1. Priority Bucket A: Workforce and Pipeline Development
2. Priority Bucket B: Access and Capacity
3. Priority Bucket C: Schools and School-Based Supports
4. Priority Bucket D: Justice and Diversion
5. Priority Bucket E: Crisis Services
6. Priority Bucket F: Family and Caregiver Support
7. Priority Bucket G: Social Determinants of Health
8. Priority Bucket H: Prevention, Cultural and Community Spaces
9. Priority Bucket I: Coordination and Data
10. Priority Bucket J: Funding and Policy

The 10 priority buckets were posted on chart paper around the room. Each participant received three dots to vote for their top three 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 10.

1. **Workforce and Pipeline Development**
2. **Access and Capacity**
3. **Prevention, Cultural and Community Spaces**
4. **Schools and School-Based Supports**
5. **Family and Caregiver Support**

Table 10: 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: Workforce and Pipeline Development	9	5	1	10	4	14	2	45
Priority Bucket B: Access and Capacity	15	2	1	7	3	11	0	39
Priority Bucket C: Schools and School-Based Supports	4	4	0	7	5	15	2	37
Priority Bucket D: Justice and Diversion	2	3	0	7	3	8	0	23
Priority Bucket E: Crisis Services	3	1	1	3	0	10	0	18
Priority Bucket F: Family and Caregiver Support	6	2	0	6	2	16	2	34
Priority Bucket G: Social Determinants of Health	2	2	0	0	0	8	0	12
Priority Bucket H: Prevention, Cultural and Community Spaces	11	2	1	7	3	15	0	39
Priority Bucket I: Coordination and Data	2	1	0	5	0	4	2	14
Priority Bucket J: Funding and Policy	1	3	2	2	0	9	2	19
Total	55	25	6	54	20	110	10	280

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

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

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

The following section summarizes break-out session discussions related to each of the five top priority buckets. The action items aligned with the five final priority buckets are also presented below. For the discussion below, the five priority buckets are identified using numbers rather than the letters used during the prioritization process described above.

VI.A Priority 1: Workforce and Pipeline Development

Action Items from the Intercept Mapping Sessions

- Build, recruit, and retain a diverse behavioral health workforce (Spanish speaking, AIAN, peer and evaluator roles) through loan repayment and subsidized training/housing
- Ensure all workforce positions, including peers, receive living wages
- Support non-traditional roles (peer support/respite reimbursable), trauma trained providers
- Enhance workforce supports (financial, burnout mitigation, retention programs)
- Create workforce pipeline development partnerships (e.g., Northern NM College)
- Provide preferential scholarships and paid apprenticeships for local education/training and community-based jobs
- Formalize career pathways and paid internships for youth
- Increase workforce capacity in underserved counties (especially Rio Arriba & Santa Fe)
- Create 24/7 safe spaces to explore jobs and access resources
- Ensure life skills-building and GED pathways
- Provide subsidized housing for providers to serve nearby communities

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

Create clear workforce pipelines:
- High school → vocational programs → higher education → behavioral health careers.
- Expand vocational opportunities (e.g., Moving Arts Española, GED pathways, trade schools).
- Build mentorship programs within community organizations and integrate peer support workers.

Cultural and linguistic representation:
- Recruit providers who reflect community diversity (race, ethnicity, disability, ASL).
- Honor tribal cultural practices and avoid imposing conflicting systems.
- Address disability and recruit this diversity group as service workers as they bring deeper knowledge about the experience of people with disabilities.

Incentives and financial supports:
- Scholarships, stipends, loan repayment, housing assistance for providers.
- Signing bonuses and fair pay for bilingual providers.
- Support scholarships for tribal community members who are experiencing a gap or lack support in the school to workforce pipeline.

Trauma-informed and recovery-ready workplaces:
- Promote wellness and self-care to reduce burnout.

Policy and advocacy:
- Develop guidelines for diverse provider recruitment.
- Legislative involvement for sustainable funding and workforce retention.
- Be able to bill for indirect services

Community infrastructure:
- Expand community centers for GED and workforce pathways.
- Create spaces for mental health services and recovery events.
- Use the strength of community voice and knowledge.

Innovative learning approaches:
- Hands-on teaching methods, experiential learning, and vocational tracks.

Programs leveraging lived experience:
- Pathways for Certified Peer Support Workers (CPSWs) and individuals with lived experience.

2. Implementation Issues

Pipeline gaps in rural communities:
- Lack of resources and infrastructure for workforce development.
- Support nurse practitioner field/training instead of MD

Higher education vs. community priorities:
- Misalignment between academic programs and tribal/community needs.
- High schools and colleges need to work together.
- Higher education doesn't prepare individuals to work in tribal communities.

Funding and operational challenges:
- Heavy reliance on inconsistent grant cycles.
- Need for stipends and financial support during training.
- Leaders must model transparency and openness to feedback.

Collaboration requirements:
- High schools, colleges, and community organizations must coordinate.

Legislative and policy barriers:
- Need for laws supporting retention and incentives for rural providers.

Transportation and housing:
- Barriers for students and professionals in rural areas.

Limited job creation:
- Need to create positions for behavioral health specialists and peer support workers.

3. Sustainability Issues

Workforce burnout and turnover:
- Requires ongoing wellness programs and supportive work environments.

Funding:
- Move away from short-term grants; establish stable funding scaffolds.
- Rework funding scaffold to make sure funding distribution is prioritized amongst those most in need.

Retention strategies:
- Incentives for rural providers, housing assistance, and fair wages.
- •Advocacy/Education to CEOs at rural FQHCs for better incentivization to build sustainable workforce.

Community-based support:
- Build strong partnerships with mature organizations for outreach and continuity.

Policy-driven sustainability:
- Legislative advocacy for long-term workforce development.

Peer support and mentorship:
- Continuous training and supervision for peer workers.

Avoid reliance on traveling providers:
- Focus on "grow our own" strategies for local workforce development.

VI.B Priority 2: Access and Capacity

Action Items from the Intercept Mapping Sessions

- Enhance specialized teams (MST/ACT)
- Expand access to core services (crisis, inpatient, outpatient) region-wide
- Increase resources for cases where both medical needs and BH/SUD diagnoses need addressing
- Expand and enhance current successful programs and consider use of hub and spoke model to expand access in rural communities
- Invest in rural infrastructure and increase opportunities in rural areas to deliver youth programs and school-based BH services where SBHCs are lacking
- Provide privacy spaces where youth can seek services and information
- Leverage open enrollment and word-of-mouth referral strategies to increase access to services
- Grow capacity at existing programs (e.g., Peak Behavioral Health, Sky Center, Darrin's Place) to expand access
- Provide Rio Arriba inpatient rehab that allows youth to be with patients/caregivers
- Expand SUD treatment options for youth/families; inpatient youth mental health beds and partial hospitalization options
- Same day service / Immediate service / walk-in access
- Help create / identify pathways where youth can live away from homes that foster triggers
- Increase the continuum of care capacity. Formalizing the pathway that individuals follow (Detention / Inpatient > Residential > Step-down > Community Services
- Expand detox options (including low-barrier, same-day), and develop access to detox housing for people with severe mental illness
- Ensure step-down services post treatment
- Increase inpatient psychiatric services
- Grow programs outside Medicaid
- Assist residents with Medicaid eligibility
- Expand partial hospitalization options and in-patient youth mental health placements
- Rebuild therapeutic foster care via CYFD

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

Mobile and Crisis Services:
- Create mobile counseling centers and crisis teams to reach rural and tribal communities.
- Retrofit AVAN medical mobile units for behavioral health services.

Youth and Family Access Points:
- Develop safe third spaces for youth in rural areas comparable to urban spaces.
- Expand in-school resources for children and families, especially immigrant families.

Data and Resource Sharing:
- Implement data-sharing platforms between state and tribal entities.
- Create regional access lists for interpreters/translators and invest in language services (e.g., Propio).

Transportation Solutions:
- Partner with regional transit systems and subsidize travel costs for mobile crisis teams.

Community Infrastructure:
- Use community centers, libraries, and vacant buildings for telehealth and service hubs.
- Leverage land grants and outdoor spaces for healing and programming.

Funding and Billing Innovations:
- Expand flexible funding pools for non-profits and agencies.
- Cover co-pays for individuals who don't qualify for Medicaid/Medicare.

- Introduce new billing codes for behavioral health and housing services.

Mentorship and Engagement:
- Create mentorship programs in schools and arts-based initiatives.

Language and Cultural Access:
- Train and reimburse interpreters; ensure linguistic diversity in services.

2. Implementation Issues

Geographic Barriers:
- Long distances between communities make provider travel difficult.

Policy and Regulatory Challenges:
- Anti-donation clauses hinder infrastructure development.
- Lack of rural healthcare differential for billing and reimbursement.

Funding and Eligibility:
- Agencies and consumers lack education on Medicaid eligibility.
- Individuals with insurance often cannot afford co-pays.

Workforce Limitations:
- Shortage of interpreters and trained staff for mobile units.

Infrastructure Gaps:
- Limited affordable spaces for organizations.
- Need for office-share programs and leveraging vacant state buildings.

Technology Needs:
- Starlink or similar solutions for mobile units in remote areas.

Billing and Reimbursement:
- Modify billing codes; create mechanisms for alternative funding when claims are denied.

3. Sustainability Issues

Stable Funding:
- Ongoing funding for mobile units, crisis centers, and mentorship programs.
- Diversify funding sources beyond Medicaid and grants.

Workforce Retention:
- Address workforce shortages and overhead costs for organizations.

Physical Space:
- Ensure sustainable access to physical spaces for community-based organizations.

Language Access:
- Maintain interpreter networks and language support services.

Community Partnerships:
- Build long-term collaborations with land grants, schools, and local agencies.

Shared Service Models:
- Explore office-share programs and service-in-lieu-of-payment arrangements.

VI.C Priority 3: Prevention, Cultural and Community Spaces

Action Items from the Intercept Mapping Sessions

- Create and promote culturally safe spaces, recovery friendly and culturally responsive programs (e.g., ANSMIC Animating Neurological Skills and Mindsets in Indigenous Communities, medicine wheel, pottery-based processing, neurological/somatic wellness, grief/bereavement models)
- Support intergenerational initiatives (Hands Across Cultures, Northern Youth Project)
- Develop, maintain, and expand land-based/outdoor and culturally anchored programs (Spanish/Indigenous traditions)
- Use arts/local practices (Moving Arts, acequia engagement) as therapy
- Build safe public spaces (skate parks, youth centers) and improve lighting/infrastructure for youth activities
- Develop transitional services for Tribal youth
- Increased awareness of rights for disenfranchised youth (undocumented citizens, those not in school, etc.)
- Establish a foster dog program that helps youth build life skills including responsibility, healthy attachment and social skills
- Cultivate connection across generations, involvement of elder input in the development of programs
- Promote positive sports and creative-based interventions for non-sports youth
- Scale Bridge to Health (stress/aggression & physical activity modules) across schools/community programs

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

Community-Based and Cultural Initiatives:

- Create pilots for best practices centered on arts, culture, and outdoor spaces; leverage **land grants** for safe spaces and economic development.
- Promote environmental justice as part of mental health prevention.
- Implement culturally appropriate youth centers and community schools (currently lacking in RA County).

School-Based Prevention and Education:

- Student body-wide behavioral health and substance use awareness programs.
- Shared education for staff and students (e.g., Mental Health First Aid).
- Embed behavioral health providers and wraparound services in schools.

Youth Engagement and Empowerment:

- Youth-led media campaigns and technical skill-building (digital media, app development).
- Programs for beautification projects and creative expression (murals, arts).
- Expand youth centers for teens and tweens.
- Youth age 15 – 20: Voice that the skate park is important and asked for it to be fixed.

Technology and Innovation:

- Develop apps for emotional check-ins and support (e.g., I AM ME).
- Use Care in Contacts (texts/cards) for mental health outreach.

Family and Maternal Health:

- Monitor new mothers for extended periods as a preventive measure.

Basic Needs and Accessibility:

- Expand public services like showers and housing for unhoused youth.
- Ensure low-barrier/no-cost access to services for families.

Funding for Community Organizations:

- Allocate flex funds for housing, transportation, legal fees, traditional healing, and workforce needs.

- Support nonprofits to create peer support positions and jobs for CPSWs/CSWs.
- Create a process for RFPs that are culturally and community based.

2. Implementation Issues

Infrastructure and Space:
- Lack of affordable and available physical spaces; need to utilize vacant schools and community centers.
- Limited spaces open during evenings/weekends for youth programming.

Workforce Challenges:
- Workforce burnout and shortage of staff for expanded programs.

School System Barriers:
- Disconnect between school staff and students on BH/SUD awareness.
- Shrinking school populations and closures; need partnerships with school boards.

Funding Gaps:
- Insufficient funding for teen/tween programs and nonprofits.
- Limited reimbursement for organizational services.

Community Engagement:
- Not enough youth voices in planning; need youth-led listening sessions.

Policy and Cultural Barriers:
- Need culturally responsive RFP processes.
- Address stigma around creative projects (e.g., murals seen as graffiti).

Technology Integration:
- Develop and implement software/apps for emotional monitoring in classrooms.

3. Sustainability Issues

Stable Funding:
- Ongoing funding for pilots, youth centers, and cultural programs.
- Flex funds from MCOs (e.g., Molina) for housing, traditional healing, and workforce support.

Workforce Retention:
- Address burnout and provide incentives for staff in community programs.

Physical Space Sustainability:
- Maintain affordable spaces for nonprofits and youth programs.

Community Buy-In:
- Continuous engagement of youth and families to ensure relevance.

Technology Maintenance:
- Keep apps and software updated and accessible.

Program Longevity:
- Embed programs into schools and community structures for continuity.

Equity and Inclusion:
- Ensure services remain low-barrier and culturally appropriate.

VI.D Priority 4: Schools and School-Based Supports

Action Items from the Intercept Mapping Sessions

- Implement Community Schools frameworks (Española & rural), expand SBHCs, and increase school-based BH services in rural areas (replicate ABQ School-Based Violence Intervention model)
- Create school-level crisis response teams beyond postvention
- Integrate BH/SUD screenings for all youth, classroom stress tools/apps (e.g., 'I Am Me'), and Youth Mental Health First Aid for educators/mentors/students
- Revise suspension policies to align with restorative justice; expand restorative justice practices across districts
- Establish wellness rooms (e.g., Rio Arriba/National Latino BH Assn initiative)
- Provide trauma-informed classes for teachers and more in-school experts (e.g., partial hospitalization-linked supports during school day)
- Ensure academic support for suspended/expelled students
- Use schools as access hubs
- Replicate alternative education models (e.g., Valencia County) with required school buy-in
- Address competing priorities within the school system re: focus on academic success vs health
- Update attendance policies to support youth seeking treatment
- Reduce stigma associated with students with ankle monitors through policy/messaging
- Increase awareness and resource navigation for teachers/counselors/administrators and foster awareness for youth in foster care within schools.

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

Community Partnerships in Schools:

- Embed community-based organizations in schools to provide wraparound services, personalized casework, and therapeutic approaches.
- Expand school-based health centers and integrate behavioral health services for all grades.

Family Engagement:

- Develop family engagement policies and incorporate parents/guardians into school-based programs.
- Provide emergency funds for families (transportation, housing, utilities).

Restorative Practices and Policy Alignment:

- Create standardized restorative justice codes of conduct across districts.
- Strengthen school board connections and buy-in for behavioral health initiatives.

Early Childhood and Career Pathways:

- Focus on early childhood centers and address the preschool-to-prison pipeline.
- Implement vocational and culturally based learning and create career pathways for youth in behavioral health.

Mental Health and Wellness Programs:

- Expand Mental Health First Aid and Teen Mental Health First Aid starting in middle schools.
- Offer training for educators on behavioral health and symptom identification.
- Create support groups for students, teachers, and parents (e.g., One Circle model).

Innovative Learning and Engagement:

- Promote outdoor learning spaces and culturally relevant education.
- Address social media and telecommunication literacy for students.

Ambassador Programs:

- Develop school ambassador programs to implement action items and connect students with resources.

2. Implementation Issues

Cost and Resource Constraints:
- Programs like Communities in Schools are expensive to implement and require significant funding.
- Limited emergency funds for families and schools.

Workforce Challenges:
- Shortage of trained staff for behavioral health services in schools.
- High turnover among school officials and administrators.

Policy and System Barriers:
- Differences between traditional school models and community school frameworks.
- Resistance from teachers/admin to allow students to access behavioral health services during school hours.

Operational Challenges:
- Early school start times impacting mental health.
- Chronic absenteeism intertwined with behavioral health issues.
- Lack of understanding of BH/SUD issues leading to soft suspensions.

Technology and Social Media:
- Need for guidance and training on social media use and ethics.

Buy-In and Awareness:
- School boards need education and buy-in for budgeting and policy changes.
- Engage superintendents and boards to align with Yazzie/Martinez considerations.

3. Sustainability Issues

Funding Stability:
- Secure long-term funding for wraparound services, emergency funds, and school-based health centers.

Workforce Retention:
- Maintain a trained workforce for behavioral health services in schools.

Policy Continuity:
- Ensure continuity among school officials and administrators to avoid disruption.

Scalability:
- Programs must be rapidly scalable and adaptable to rural communities.

Community and Family Engagement:
- Ongoing involvement of parents, guardians, and community partners.

Training and Education:
- Continuous training for educators, school boards, and administrators on behavioral health.

Infrastructure:
- Maintain physical spaces for outdoor learning and community school frameworks.

VI.E Priority 5: Family and Caregiver Support

Action Items from the Intercept Mapping Sessions
- Provide family-level Peak-like step-down services and interventions and evidence-based curricula (parental trauma, relationship building), wraparound case management, and family integration services
- Offer stipends to families who follow through on BH/SUD connections

- Involve families in reintegration following justice involvement including an assigned liaison
- Create support programs for grandparents raising grandchildren (navigation + financial assistance)
- Assist families with economic development to ensure greater rates of getting out of poverty
- Increase early childhood interventions, value-added services for children <6, and guardian navigation so families understand available services
- Strengthen partnerships with existing programs (Gerard's House, ASDMIC, Boys & Girls Club, Tewa Women United, etc.) to expand reach and opportunity to share best practices
- Help families learn how to build a community of resources so that youth do not feel they need to leave the community
- Hold family-centered meetings at schools; expand peer support for families (pay during certification)

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

Grandparents Raising Grandchildren:
- Expand programs like Las Cumbres and House Bill 252 stipends for grandparents and caregivers.
- Provide wraparound supports for grandparents and caregivers, including financial assistance.
- Senior centers to receive resources to support seniors involved in youth care as caregivers.

Family-Centered Behavioral Health:
- Enhance family integration in behavioral health services, including crisis triage and mobile crisis.
- Build culturally relevant services that uplift traditions and reduce stigma.

Childcare and Safe Spaces:
- Offer childcare drop-off at service locations and during crisis interventions.
- Create child-safe spaces while families access services.

Transportation and Housing:
- Increase family transportation services and address rural isolation.
- Need resources for unhoused family supports.

Economic and Community Supports:
- Make workspaces family-friendly and incentivize resorts for family workshops.
- Provide financial literacy programs and stipends to increase family engagement.

Education and Prevention:
- Educate families to reduce stigma around BH/SUD services.
- Continue healthy relationship training and access to contraception.
- Healthy relationship programming as well as access to contraception education.

Mentorship and Cultural Engagement:
- Develop arts-based mentoring programs for families and youth.

Provider Training:
- Standardize care and training for BH providers focusing on family systems.

Early Intervention:
- Expand programs for early intervention and education for families.

2. Implementation Issues

Resource Gaps:
- Limited resources in rural communities and lack of infrastructure for family supports.

Service Fragmentation:
- Services are not co-located; families must navigate multiple locations.

Workforce Challenges:
- Youth service providers often do not serve families; need cross-training.

Transportation and Childcare:
- Lack of transportation and safe childcare options during service access.

Stigma and Fear:
- Families fear system involvement; stigma around SUD and mental illness.

CYFD Capacity:
- CYFD lacks capacity to support youth; community must fill gaps.

Training Limitations:
- Providers have limited training on family systems; time spent assisting families often not billable.

Community Resistance:
- Some communities unwilling to accept assistance due to cultural or trust issues.

3. Sustainability Issues

Funding Stability:
- Secure ongoing funding for stipends, childcare, transportation, and wraparound services.

Workforce Retention:
- Maintain trained staff for family-centered services and CPSW/CSW roles.

Infrastructure Development:
- Build and maintain physical spaces conducive to family healing and co-located services.

Cultural Integration:
- Ensure programs remain culturally relevant and community-driven.

Policy Support:
- Advocate for legislation supporting family stipends and caregiver programs.

Community Engagement:
- Continuous education and stigma reduction to maintain family participation.

VII. List of Appendices

A.1 Map of Judicial Districts

A.2 Acronym List

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

A.4 Workshop Agenda

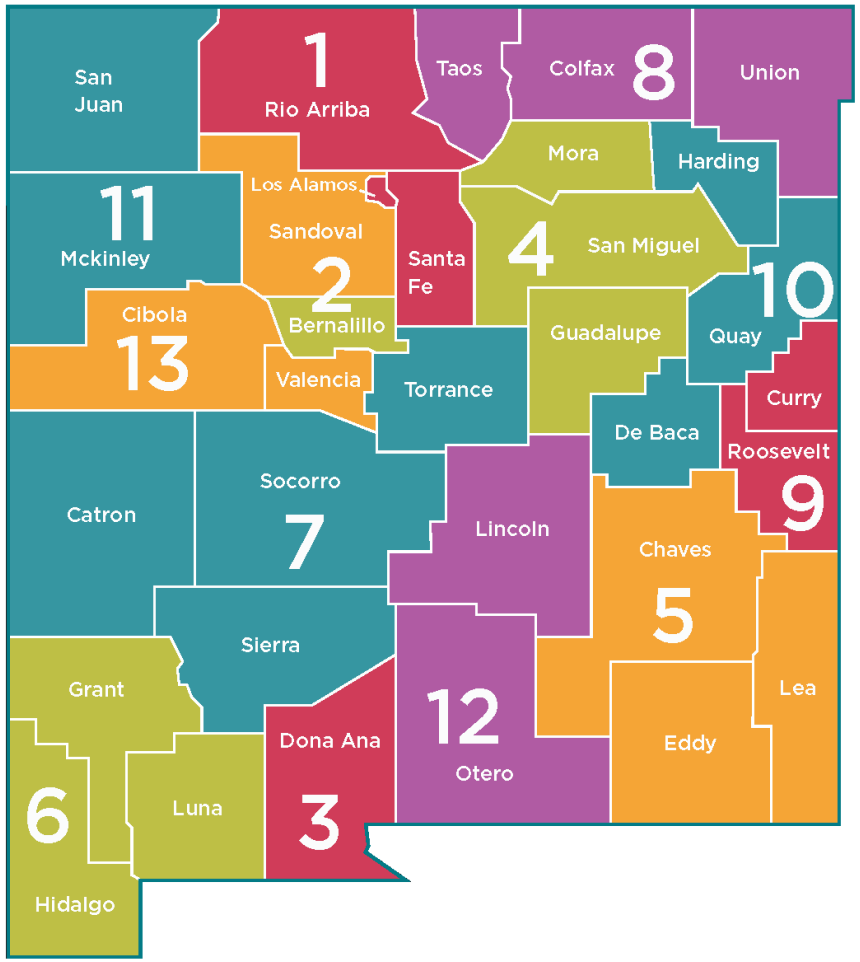
A.5 Region Specific Medicaid Snapshot Data

A.6 New Mexico Mortality Data

A.7 PPT of Provisional Priority Buckets

The NM Behavioral Health Reform Investment Act

HEALTH SCIENCES
Behavioral Health Technical Assistance Center



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

Region 2
- Pueblo of Isleta
- Pueblo of Sandia

Region 6
- Fort Still Apache Tribe

Region 8
- Taos Pueblo
- Picuris Pueblo

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

Region 11
- Navajo Nation
- Pueblo of Zuni

Region 12
- Mescalero Apache Tribe

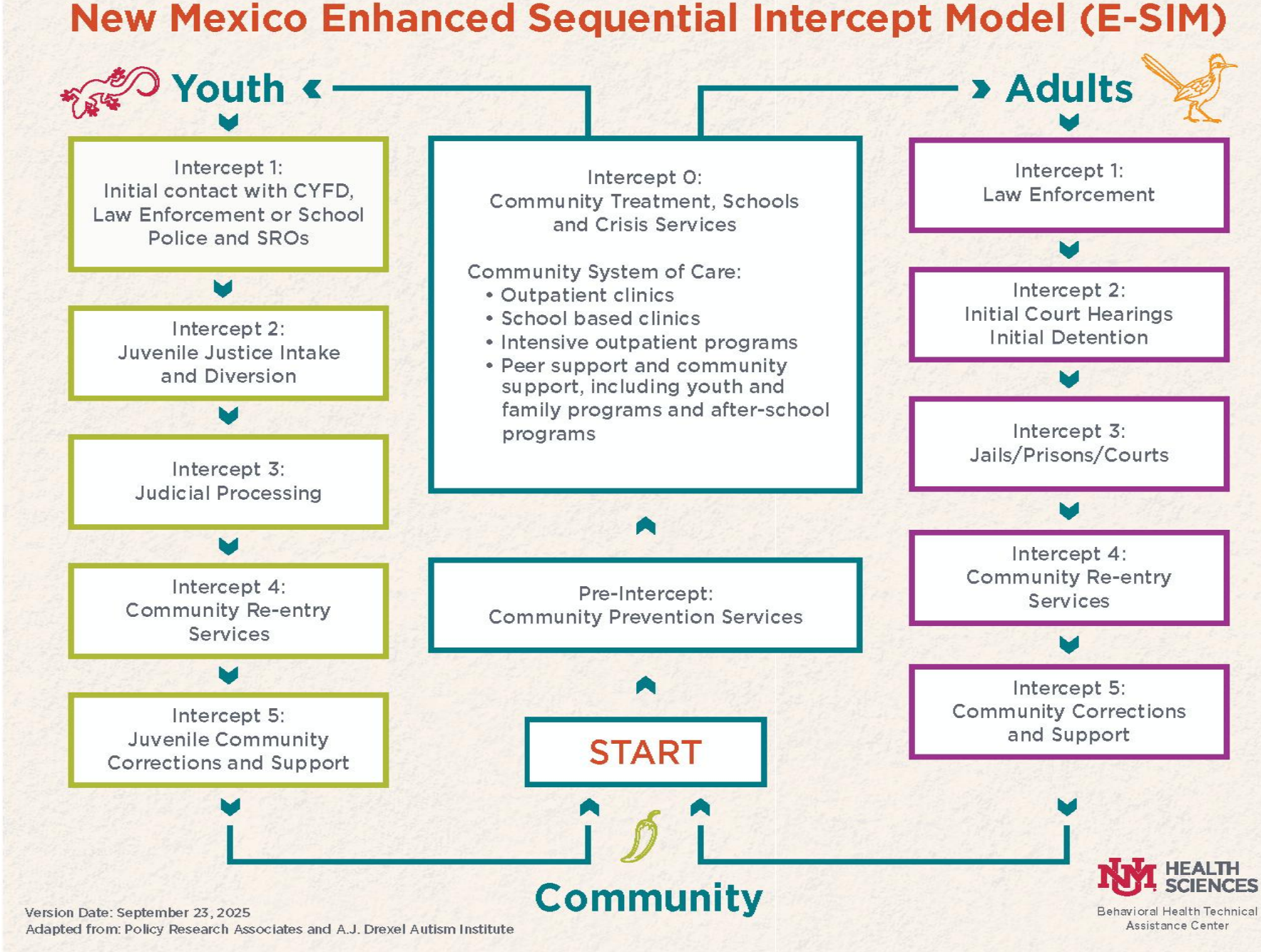
Appendix A.1 Map of Judicial Districts

Appendix A.2 Acronym List

Acronyms

ABQ	Albuquerque
ACA	Affordable Care Act
ACEs	Adverse Childhood Experiences
ACT	Assertive Community Treatment
A'Gin	Respect Means Respect
AIAN	American Indian and Alaska Native
AOC	Administrative Office of the Courts
ARU	Alternative Response Unit
ASL	American Sign Language
BH	Behavioral Health
BHR	Behavioral Health Region
BHRIA	Behavioral Health Reform and Investment Act (aka SB3)
BHTAC	Behavioral Health Technical Assistance Center (UNM)
BIA	Bureau of Indian Affairs
CASA	Court Appointed Special Advocate
CBT	Cognitive Behavioral Therapy
CBPAR	Community Based Participatory Action and Research
CEO	Chief Executive Officer
CJCC	Criminal Justice Coordinating Council
CPS	Child Protective Services
CPSWs	Certified Peer Support Workers
CSW	Community Support Worker
CYFD	Children, Youth and Families Department
DA	District Attorney
E-SIM	Enhanced Sequential Intercept Model
EMS	Emergency Medical Services
ER/ED	Emergency Room/Emergency Department
FINS	Family in Need of Services
FQHCs	Federally Qualified Health Centers
GED	General Educational Development
HCA	Health Care Authority
ICM	Intensive Case Management
IOP	Intensive Outpatient Program
JJAB	Juvenile Justice Advisory Board
JCC	Juvenile Community Corrections
JJSC	Juvenile Justice Continuum of Services
JPO	Juvenile Probation Officer
JJS	Juvenile Justice System
KIVA	Keeping Independent Visions Alive
LA	Los Alamos
LANL	Los Alamos National Laboratory
LEAD	Law Enforcement Assisted Diversion
LGBTQIA2S	Lesbian, Gay, Bi-Sexual, Transgender, Queer or Questioning, Intersex, Asexual, Two-Spirit
LLC	Limited Liability Company
MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
MD	Doctor of Medicine
MI	Mental Illness
MST	Multisystemic Therapy
NHBLA	National Latino Behavioral Health Association
NJCC	New Mexico Juvenile Community Corrections
OFRA	Office of Family Representation and Advocacy
OUD	Opioid Use Disorder
PE	Physical Education
PIRE	Re-Entry Toolkit for Youth
PIVOT	Promoting Innovative and Vital Opportunities for Transformation
PMS	Presbyterian Medical Services
RA	Rio Arriba
RAC STOP	Rio Arriba County Substance, Treatment, Outreach and Prevention Program
RAI	Risk Assessment Instrument
RezRIDERS	Reducing Risk through Interpersonal Development, Empowerment, Resiliency and Self Determination (UNM)
RFP	Request for Proposal
RISE	Reentry, Integration, Support and Empowerment
ROC	Recreation and Outdoor Conservation
RTC	Residential Treatment Center
SAMHSA	Substance Abuse and Mental Health Services Administration
SBHC	School-Based Health Center
SF	Santa Fe
SI	Suicidal Ideation
SRO	School Resource Officers
SUD	Substance Use Disorders
SW	Southwest
UATC	Urban Adventure & Training Center
WIN	Workforce Integration Network
YUCCA	Youth United for Climate Crisis Action

New Mexico Enhanced Sequential Intercept Model (E-SIM)



Version Date: September 23, 2025
Adapted from: Policy Research Associates and A.J. Drexel Autism Institute

HEALTH SCIENCES
Behavioral Health Technical Assistance Center

Region One Youth Behavioral Health Workshop

Santa Fe Community College, Santa Fe, New Mexico
December 18 - 19, 2025

Youth Performances Provided by Moving Arts Espanola

Agenda for Day 1: Mapping of Youth System

8:30 AM — ***Workshop open for Registration*** — Jemez Room

9:00 AM — **Welcome and Land Acknowledgement** — Jemez Room
- Teresa Gomez (MC), UNM Department of Psychiatry and Behavioral Sciences

Opening Poem
- Joyce Shourotte, Mixed-media artist and youth advocate from Ohkay Owingeh, NMSA graduate, and recent Santa Fe Youth Poet Laureate

Opening Remarks
- Greg Schaffer, Santa Fe County Manager

Why Are We Here?
- Anne Ryan, Santa Fe County Community Services Director

Overview of the Day and UNM Orientation
- Dr. Caroline Bonham, UNM Department of Psychiatry and Behavioral Sciences

9:30 AM — **Overview of Regional Medicaid Snapshot and State Epidemiological Data** — Jemez Room
- Dr. Caroline Bonham, UNM Department of Psychiatry and Behavioral Sciences

10:00 AM — **Pre-Intercept (Prevention): Mapping Existing Services, Gaps and Opportunities** — Breakout Rooms

11:00 AM — ***Break***

11:15 AM — **Intercept 0: Mapping Existing Services, Gaps and Opportunities** — Breakout Rooms

12:15 PM — **Lunch:** ***With performances by the Lightning Boy Foundation Champion Hoop Dancers, Moving Arts Flamenco segment led by Mina Fajardo and Jose "Chuscales" Valles with youth dancers, and BBoy BGirl dancers and solo singers***

1:15 PM — **Mapping Intercept 1** — Breakout Rooms

2:15 PM — ***Break***

2:30 PM — **Mapping Intercept 2 and 3** — Breakout Rooms

3:30 PM — ***Break***

3:45 PM — **Mapping Intercept 4 and 5** — Breakout Rooms

Breakout Room 1
Room 408
Breakout Room 2
Room 410
Breakout Room 3
Room 412

4:30 PM — **Wrap-up, Overview of Day Two, and Adjourn** — Jemez Room

HEALTH CARE AUTHORITY

Bristol Myers Squibb

NAMI New Mexico

HEALTH SCIENCES
Behavioral Health Technical Assistance Center

Region One Youth Behavioral Health Workshop

Santa Fe Community College, Santa Fe, New Mexico
December 18 - 19, 2025

Youth Performances Provided by Moving Arts Espanola

Agenda for Day Two: Prioritization

8:30 AM — ***Workshop Open for Registration***
— Jemez Room

9:00 AM — **Welcome and Land Acknowledgement**
— Jemez Room
- Teresa Gomez (MC), UNM Department of Psychiatry and Behavioral Sciences

Opening Song
- Jacob Maruffo, Solo Youth Singer

Opening Remarks
- Dr. Layne Kalbfleisch, LC18 Chair

Overview of the Day
- Teresa Gomez, UNM Department of Psychiatry and Behavioral Sciences

Breakout Room 1
Room 408
Breakout Room 2
Room 410
Breakout Room 3
Room 412

9:20 AM — **Review and Discussion of Day One with Suggested List of Priorities**
— Jemez Room
- Teresa Gomez, UNM Department of Psychiatry and Behavioral Sciences
- Dr. Caroline Bonham, UNM Department of Psychiatry and Behavioral Sciences

10:15 AM — **Ranking of Final Priority List**
— Jemez Room

10:30 AM — ***Break***

10:45 AM — **Review of Top Five Identified Priorities**
— Jemez Room

11:15 PM — **Small Group Discussions of Priority 1**
— Breakout Rooms

12:15 PM — **Lunch:** ***With youth performances by Moving Arts Espanola including Mexican Folk Dance Suite led by Carmelita Archuleta***

1:15 PM — **Small Group Discussions of Priority 2 & 3**
— Breakout Rooms

2:15 PM — **Small Group Discussions of Priority 4 & 5**
— Breakout Rooms

3:15 PM — ***Break***

3:30 PM — **Small Group Discussions of Other Priorities**
— Breakout Rooms

4:30 PM — **Adjourn**

Behavioral Region 1 vs The State of New Mexico

Examining behavioral health disorder diagnoses, and utilization of services, facilities and infrastructure in Behavioral Region 1 compared to the state of New Mexico.

County in Behavioral Region 1: Santa Fe

Objective

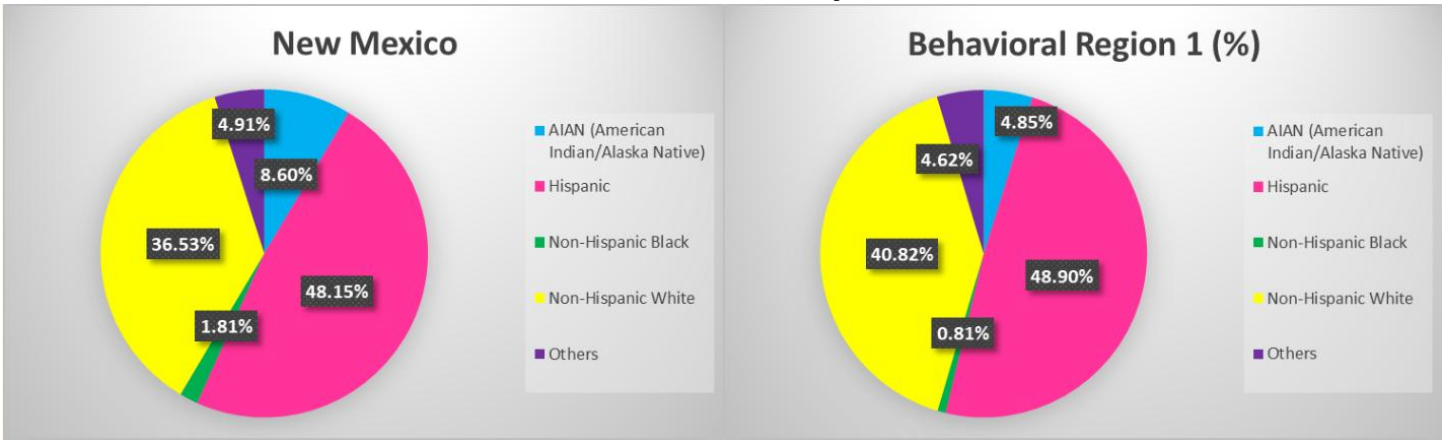
To compare Behavioral Region 1 (Santa Fe) with the state on below characteristics

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

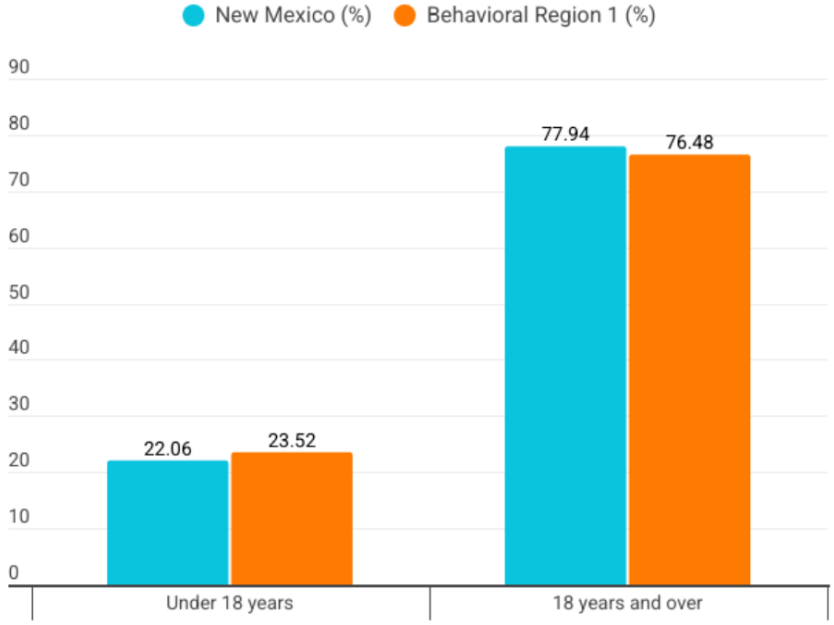
Demographic Comparison

Key demographic factors reveal significant regional variations

Race/Ethnicity



Age Distribution – New Mexico vs. Behavioral Region 1



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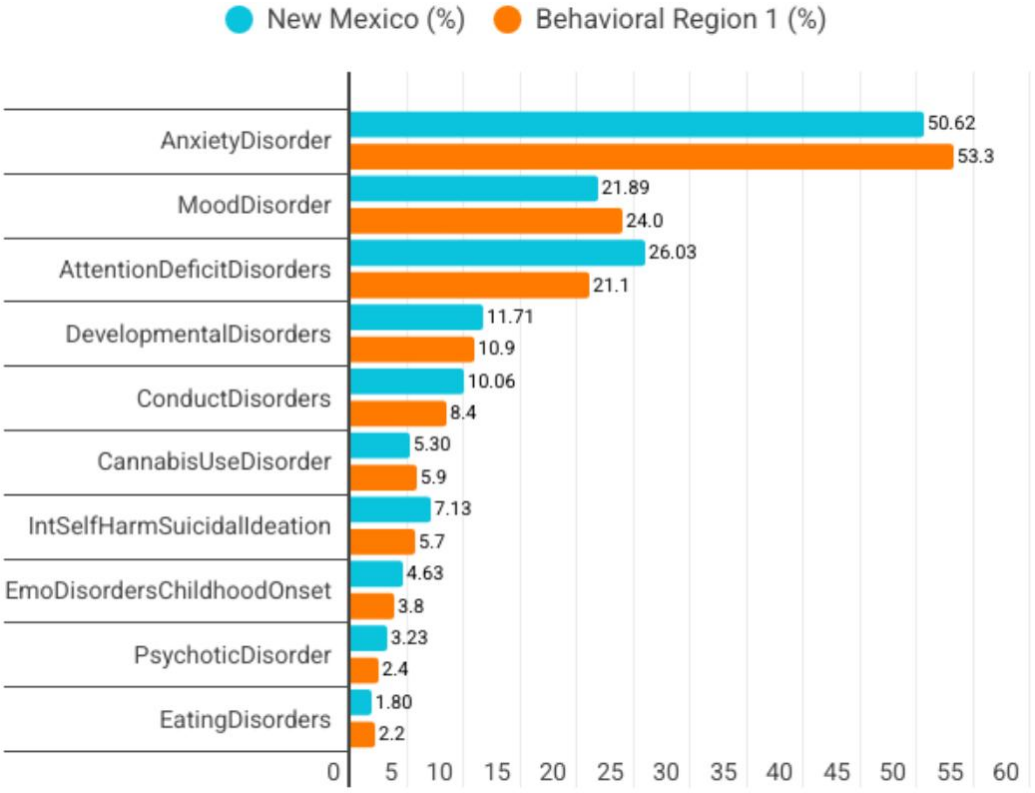
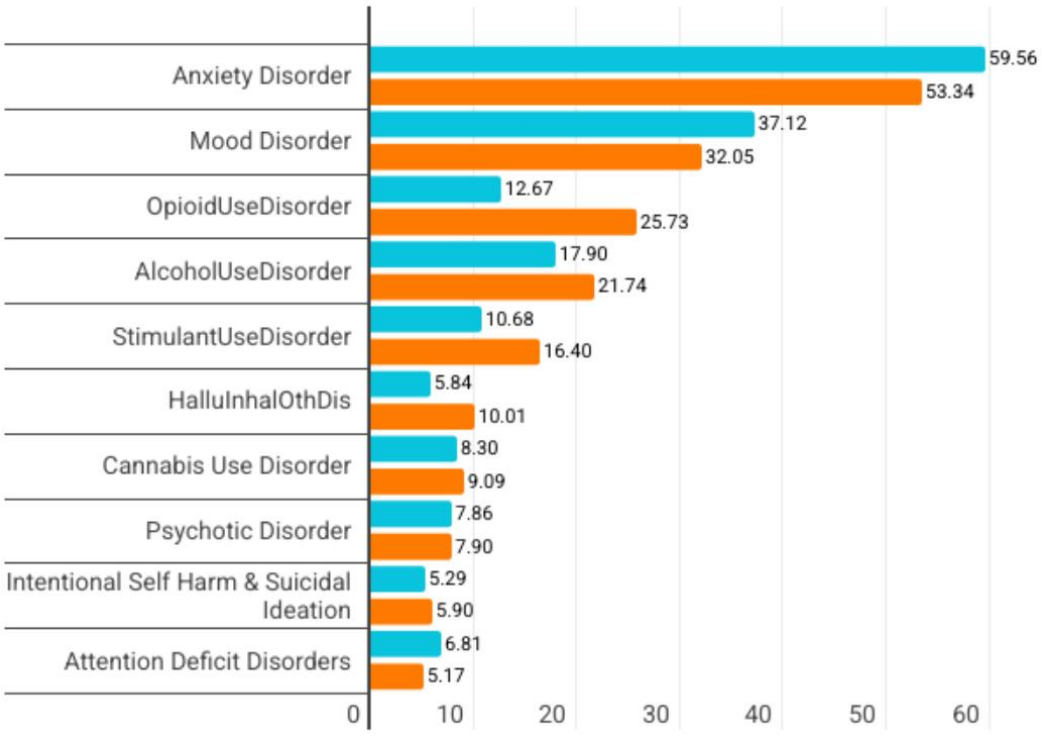
Top 10 behavioral health disorder diagnosis by age group

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

<18-year-olds – New Mexico vs. Behavioral Region 1



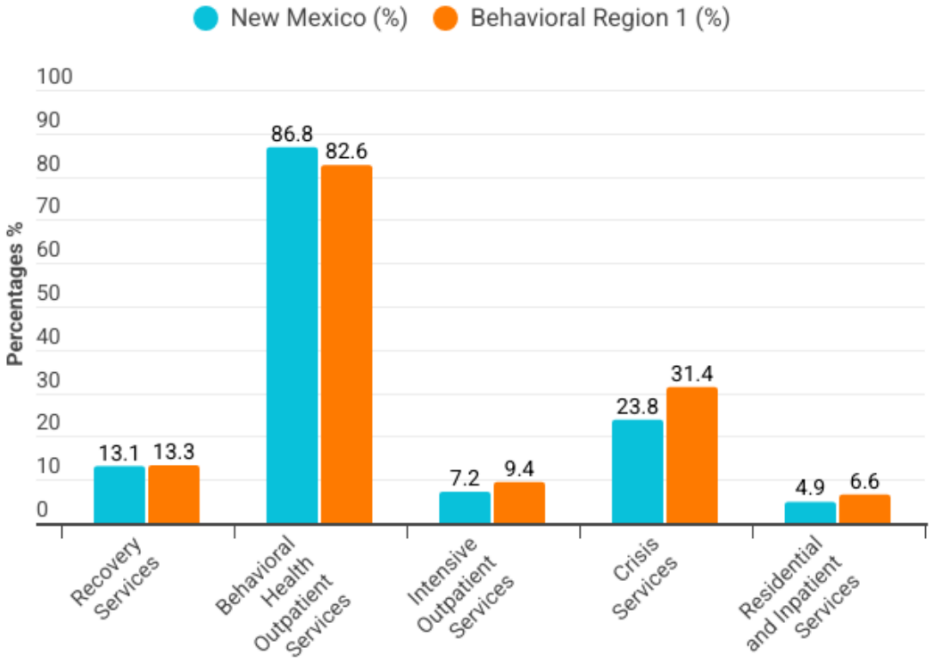
18+ New Mexico vs Behavioral Region 1



Service Utilization

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

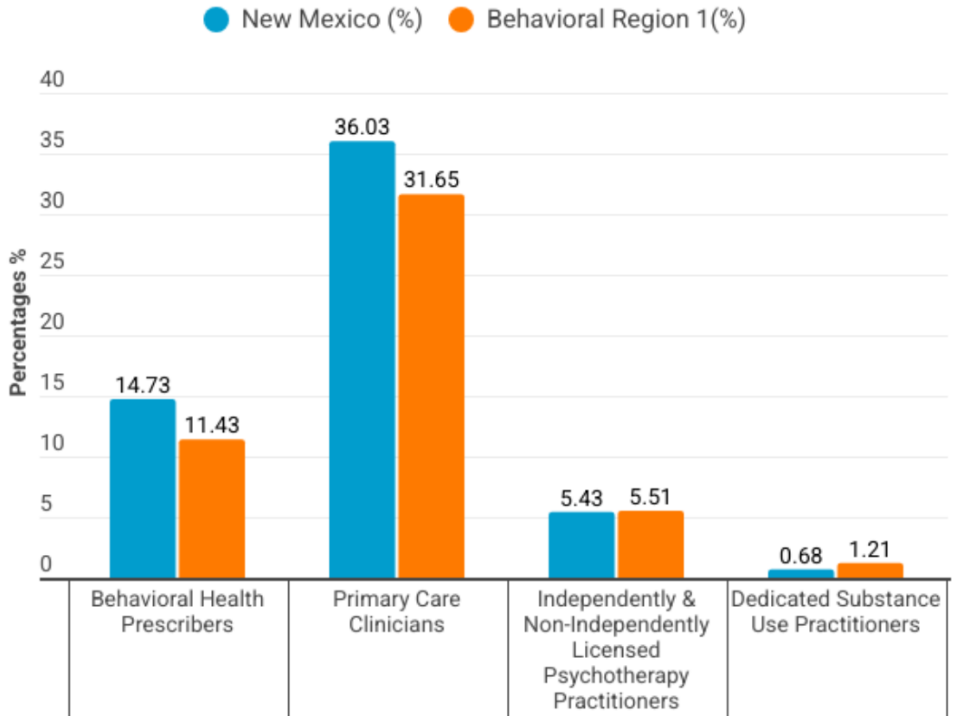
Service Types – New Mexico vs. Behavioral Region 1



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.

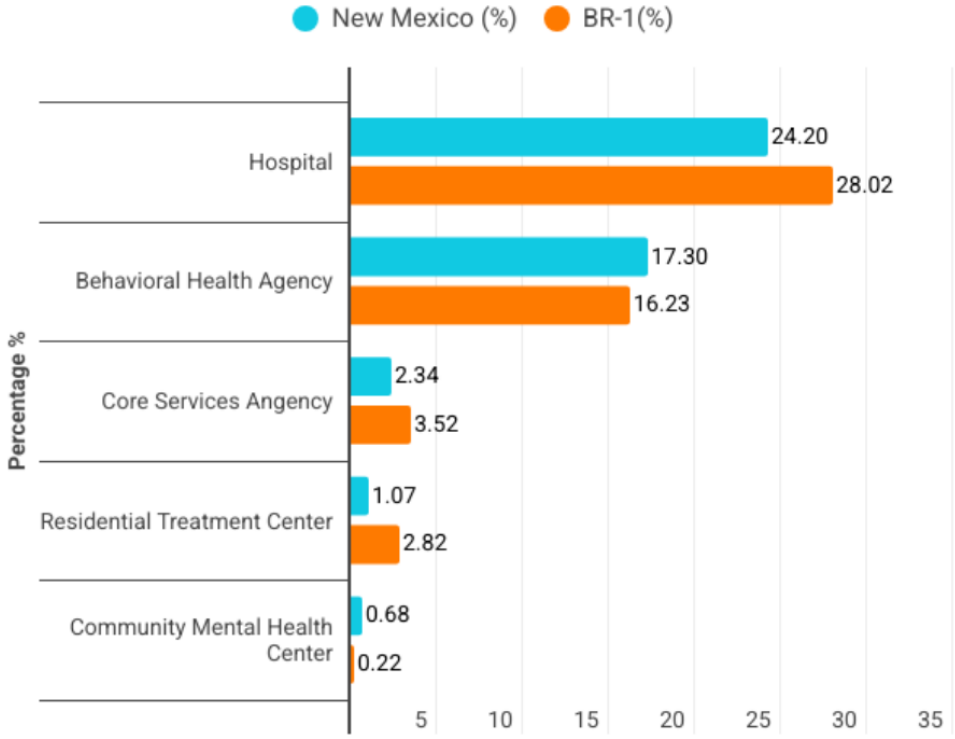
Individuals on Medicaid are more likely to have at least one contact with a prescriber than with a therapist in a calendar year.



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 1



Crisis Call per Capita

Percentage of population who made a crisis call.

Crisis Call Rate Per Capita – New Mexico vs. Behavioral Region 1

Crisis Call per Capita (cont.)

State of New Mexico

Total Population	Total Population	Crisis Calls	Crisis Calls
2,114,371	2,130,256	29,977	28,137
2023	2024	2023	2024

1.42% (2023) **1.32% (2024)**

↓ Decreased from 2023 to 2024

BR1 Service Area

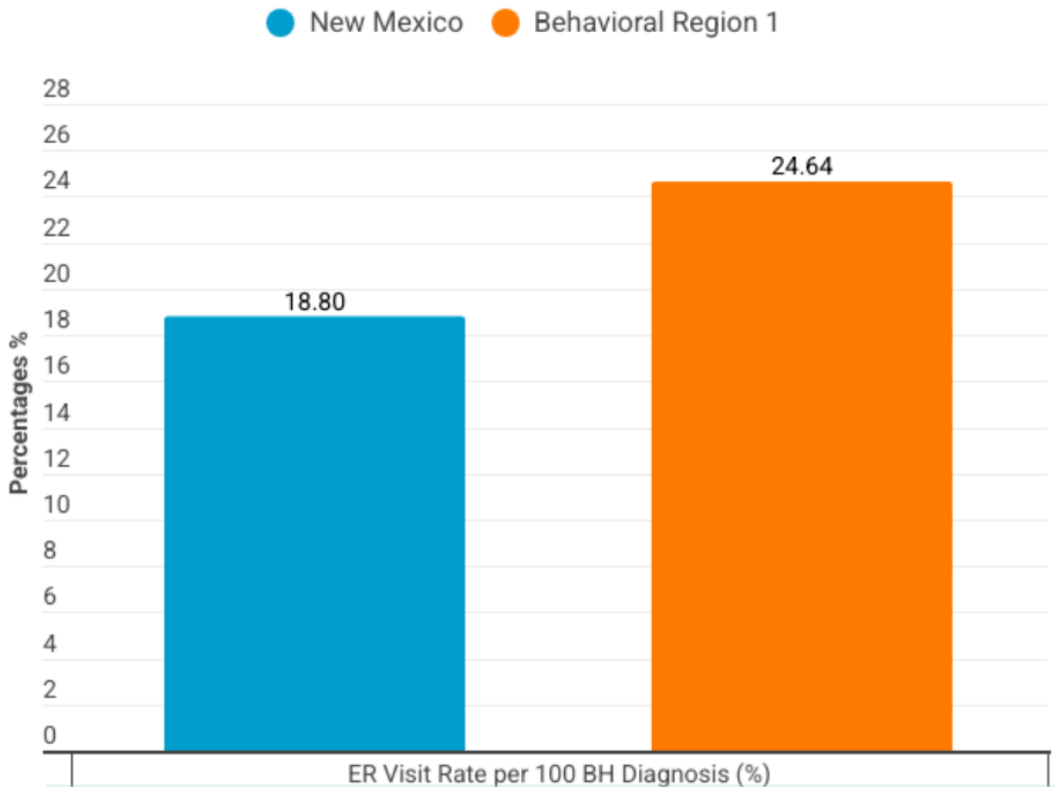
Total Population	Total Population	Crisis Calls	Crisis Calls
215,276	217,395	3,115	2,875
2023	2024	2023	2024

1.45% (2023) **1.32% (2024)**

↓ Decreased from 2023 to 2024

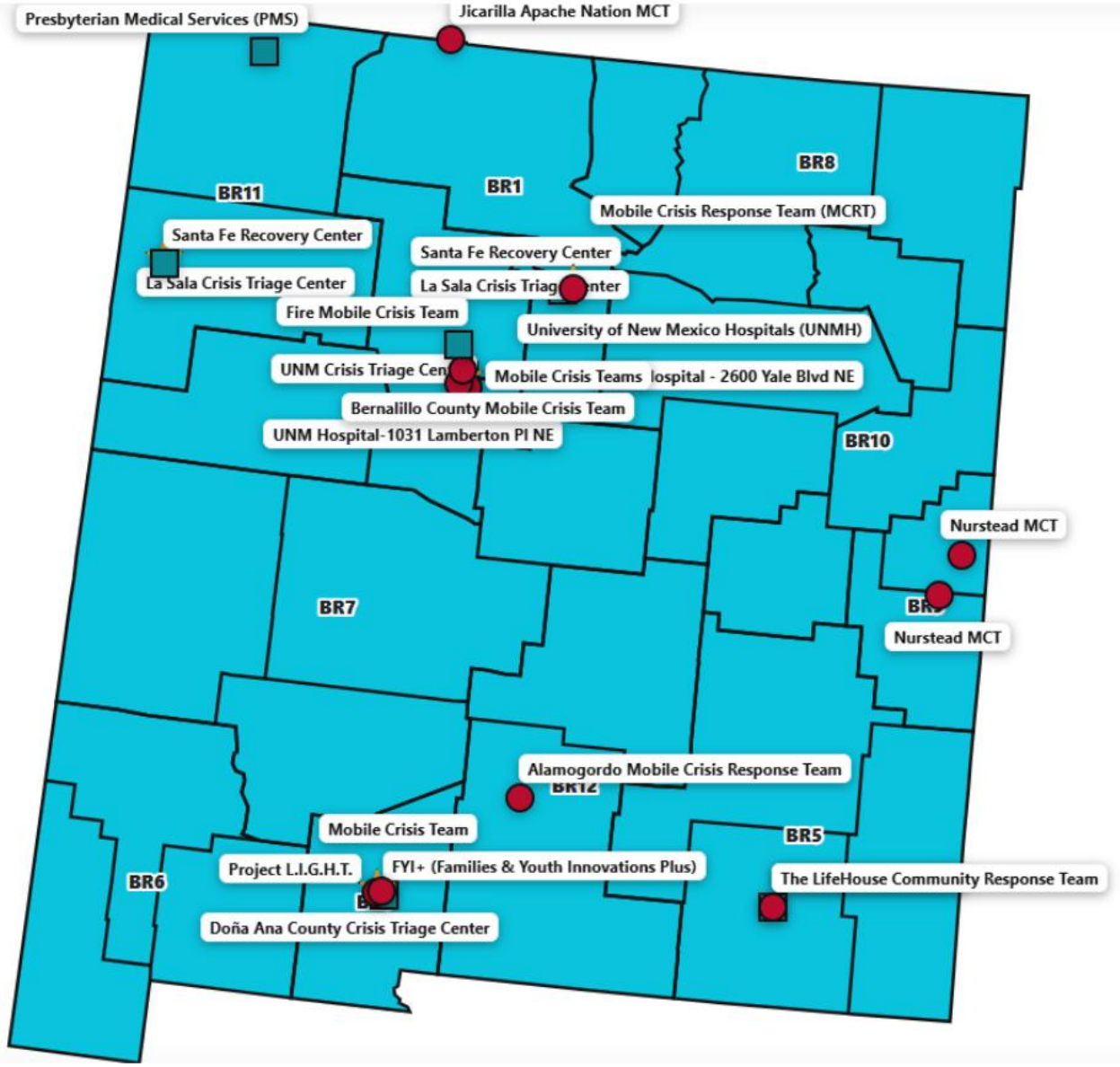
Emergency Room Utilization

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



CCBHC, CTC, Mobile Crisis

New Mexico

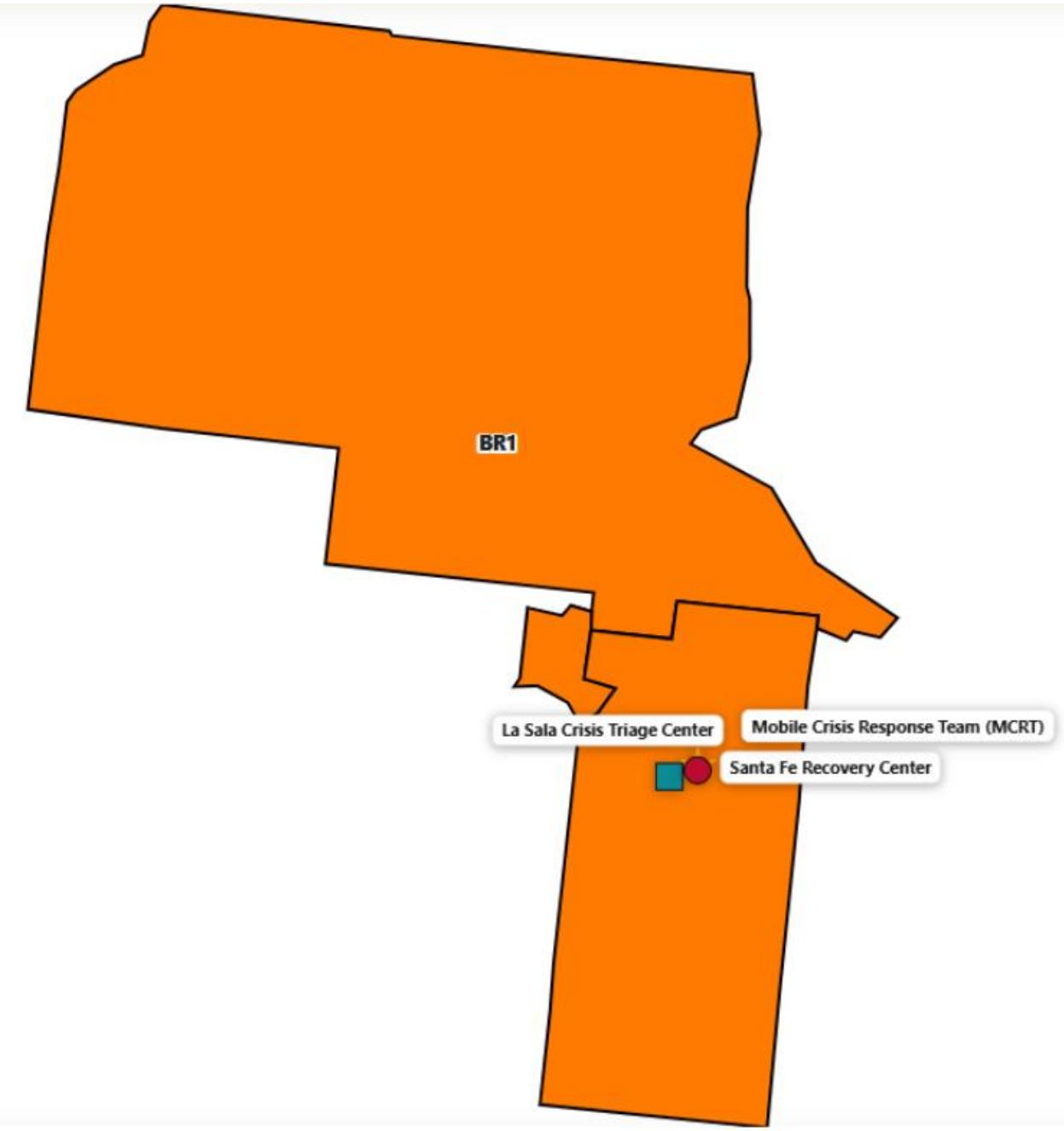


● Mobile Crisis Team ■ CCBHC ★ Crisis Triage Center

Name	County	BR	Address	Zip Code	Type
Presbyterian Medical Services (PMS)	San Juan	BR11	1001 W Broadway Suite E & D, Farmington	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 Lamberton 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 1



Mobile Crisis Team CCBHC Crisis Triage Center

Name	County	BR	Address	Zip Code	Type
Santa Fe Recovery Center	Santa Fe	BR1	2504 Camino Entrada	87507	CCBHC
La Sala Crisis Triage Center	Santa Fe	BR1	2052 Galisteo St	87505	Crisis Triage Center
Mobile Crisis Response Team (MCRT)	Santa Fe	BR1	2052 Galisteo St	87505	Mobile Crisis Team

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 (BR1)	
	Beneficiary N=217,656	%	Beneficiary N=25,844	%
Recovery Services	**28,500**	**13.09%**	**3,442**	**13.32%**
PSW	4,707	2.16%	1,197	4.63%
CCSS	20,270	9.31%	1,890	7.31%
PSR	362	0.17%	15	0.06%
CSW	7,215	3.31%	1,246	4.82%
FSW	155	0.07%	11	0.04%
CHW	0	0.00%	0	0.00%
BMS	1,113	0.51%	159	0.62%
BT	2,044	0.94%	198	0.77%
BHOP Services	**188,968**	**86.82%**	**21,341**	**82.58%**
BH Workforce	**106,765**	**49.05%**	**10,950**	**42.37%**
BH-Prescribers	**32,061**	**14.73%**	**2,954**	**11.43%**
Psychiatrist	10,700	4.92%	1,081	4.18%
PsyNursePract	20,228	9.29%	1,464	5.66%
PrescPsychologist	2,704	1.24%	523	2.02%
PrimaryCare	**78,429**	**36.03%**	**8,179**	**31.65%**
Independently and Non-Independently Licensed Psychotherapy Practitioners	**11,814**	**5.43%**	**1,425**	**5.51%**
Psychologist	861	0.40%	24	0.09%
LCSWLISW	4,824	2.22%	474	1.83%
LPCC	4,506	2.07%	668	2.58%
LPAT	27	0.01%	22	0.09%
LMFT	482	0.22%	17	0.07%
LMSW	1,225	0.56%	118	0.46%
LMHC	1,533	0.70%	263	1.02%
LAMFT	48	0.02%	1	0.00%
Dedicated Substance Use Practitioners	**1,480**	**0.68%**	**314**	**1.21%**
LADAC	629	0.29%	137	0.53%
LSAA	882	0.41%	183	0.71%
CADAC	0	0.00%	0	0.00%
Intensive Outpatient Services	**15,741**	**7.23%**	**2,430**	**9.40%**
IOP	12,049	5.54%	1,968	7.61%
PartialHosp	1,051	0.48%	119	0.46%
ACT	1,555	0.71%	289	1.12%
MST	1,455	0.67%	102	0.39%
FFT	11	0.01%	1	0.00%
Crisis Services	**51,804**	**23.80%**	**8,127**	**31.45%**
ED	41,094	18.88%	6,395	24.74%
UrgentCare	21,369	9.82%	3,416	13.22%
MobileCrisis CTC	1,854	0.85%	222	0.86%
Crisis Intervention	1,476	0.68%	118	0.46%

New Mexico Mortality Rates

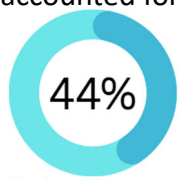
Examining Suicide Deaths, Alcohol-Related Deaths, and Drug Overdose Deaths in the state of New Mexico

Overview

Overall Crisis

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

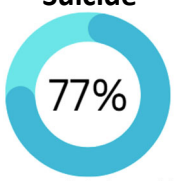
In 2021, these causes accounted for



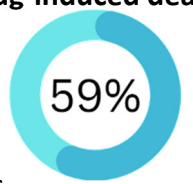
of all deaths among residents aged 12–34

Rates far exceed national averages:

Suicide



Drug-induced deaths:



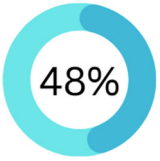
higher than U.S. average

Demographics & Geography

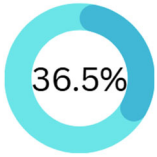
Population: 2.1 million

Race/Ethnicity:

Hispanic

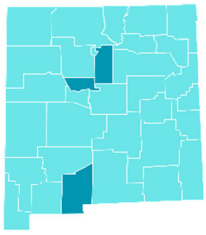


White (non-Hispanic)



Native American

Urban concentration:

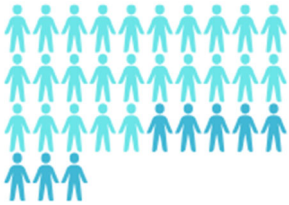


50% of residents live in

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

(6% of land area)

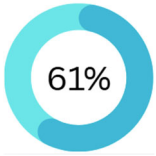
Rural/frontier context:



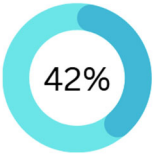
25 of 33 counties have <15 people per square mile, limiting access to care

Comorbidity of Mental Health and Substance Use

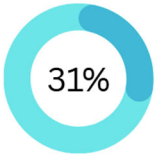
Youth (Grades 9–12):



report mental health concerns

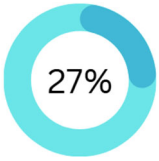


use ≥1 substance

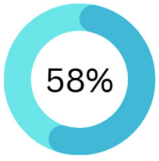


have both (co-occurring mental health + substance use disorder)

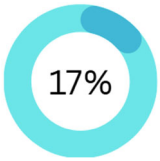
Adults:



report mental health concerns

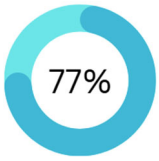


use ≥1 substance



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

Substance Use:



of youth suicide attempters used at least one substance

Youth using **4+ substances** were

more likely to be injured in a suicide attempt

Alcohol-Related Deaths

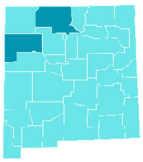
- **Highest alcohol-related death rate in the U.S. since 1997**

1 in 5 deaths among working-age adults

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

Alcohol misuse linked to

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



Highest Rates by NM County: McKinley, Rio Arriba

Drug Overdose Deaths

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

Recent surges in

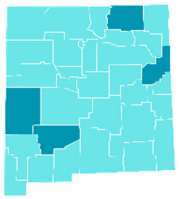
methamphetamine and fentanyl deaths

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

Highest Rates by NM County: Bernalillo, Rio Arriba

Suicide & Mental Health

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



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

Populations at Highest Risk

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

Equity and Systemic Context

Health disparities are amplified by

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

Urgent need for prevention intervention efforts that are:

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

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

Demographics: New Mexico

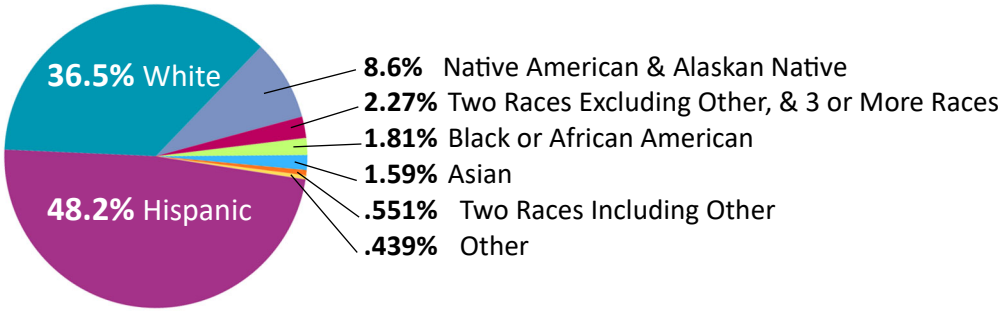
Source: https://datausa.io/profile/geo/new-mexico

Population

Source: U.S. Census

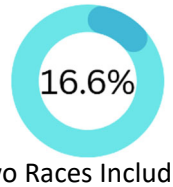
Population: 2,117,522

Race/Ethnicity



Hispanic breakdown:

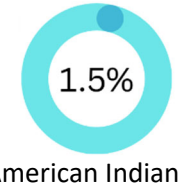
White Hispanic



Two Races Including Other (Hispanic)

Other (Hispanic) = 16.6 %

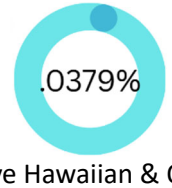
Two Races Excluding Other, & Three or More



American Indian & Alaskan Native (Hispanic)

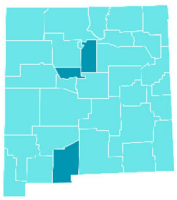
Black or African American (Hispanic)

Asian (Hispanic)



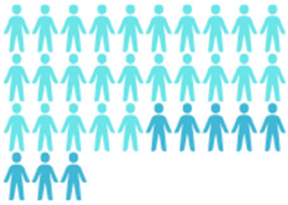
Native Hawaiian & Other Pacific Islander

Rural/Frontier

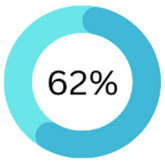


50% of residents live in
- **Bernalillo,**
- **Doña Ana, and**
- **Santa Fe Counties**

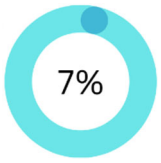
These 3 counties make up only 6% of the state's total land area



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

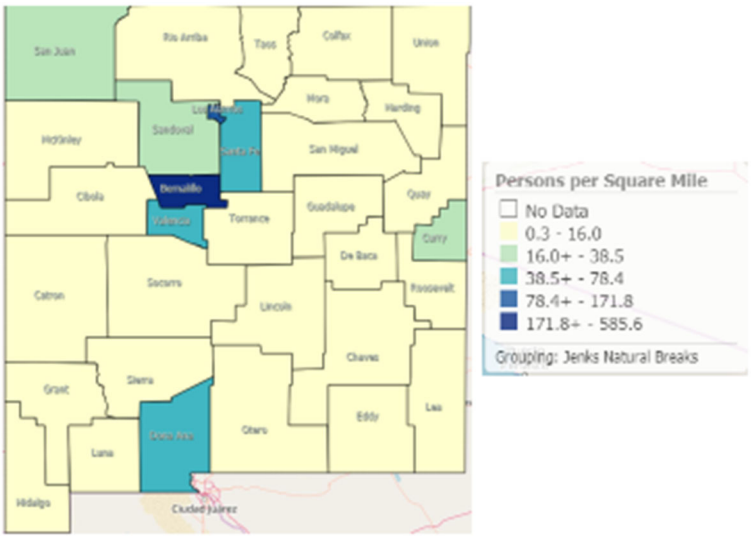


of the population resides in seven urban counties (including Bernalillo County, home to one-third of the state's residents)



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

Estimated Population County by County - Population Density, 2017



NM Co-morbid "Deaths of Despair"

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

Suicide, Overdose, Alcohol-related *Deaths*

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

Estimated Population *Affected* (2021)

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

Substance *Use and Suicide*

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

Disparities and Equity Findings

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

Suicide & Self-Injury

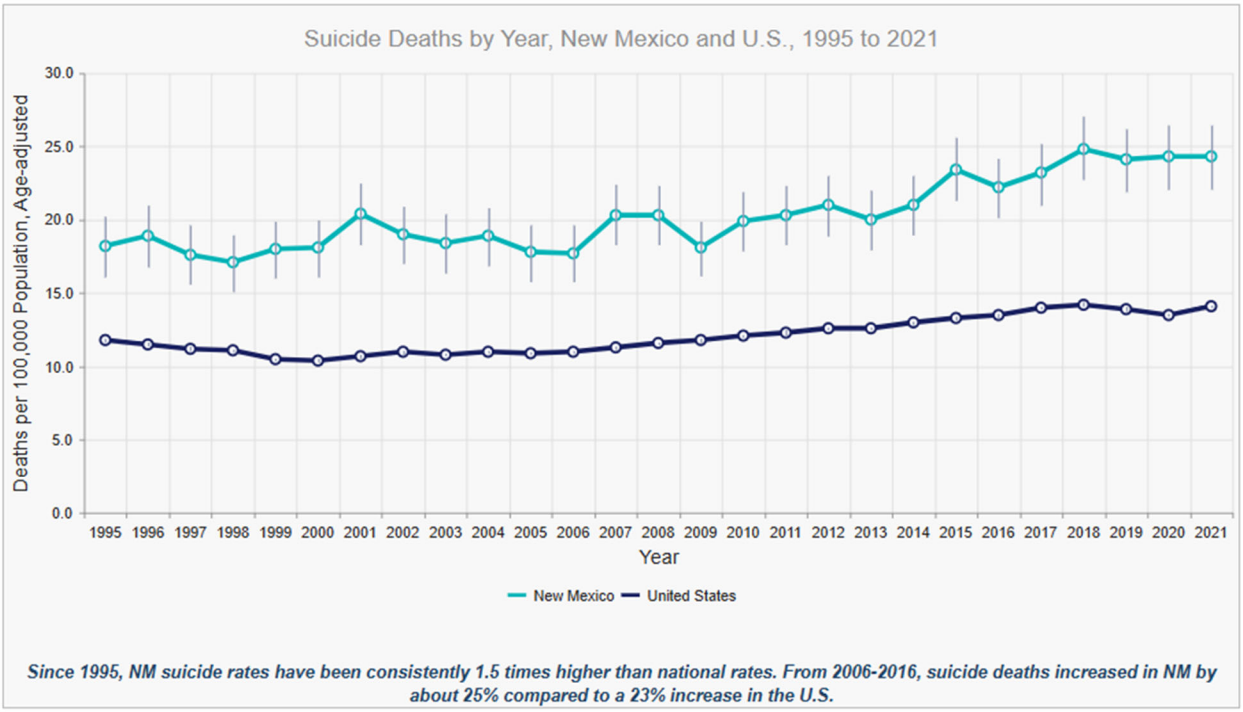
Source: New Mexico's Health Indicator Data & Statistics - https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html

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

Suicide & Self-Injury Related Deaths

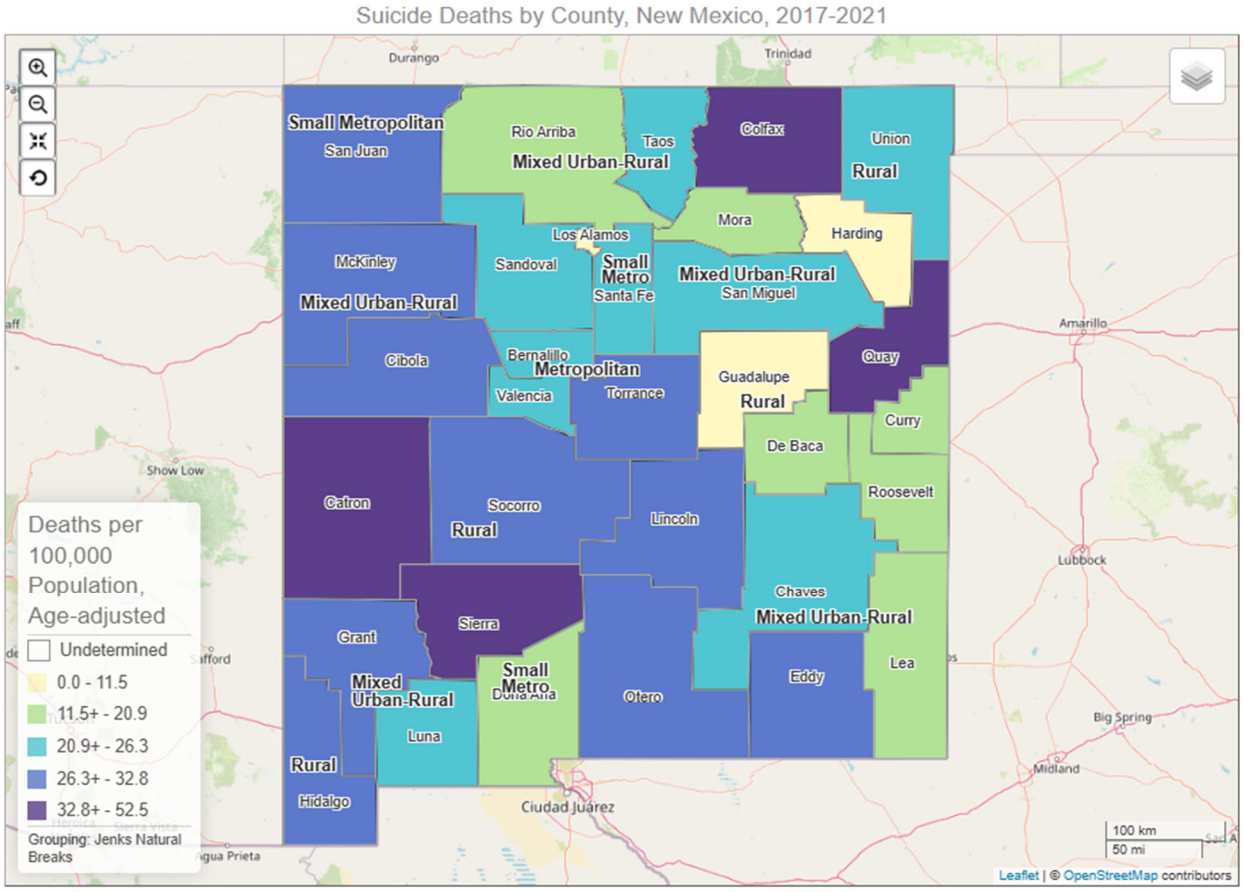
- Suicidal behaviors are a major public health concern and a leading cause of morbidity and mortality in New Mexico.
- In 2018:
  - Suicide was the 9th leading cause of death overall in New Mexico.
  - It was the 2nd leading cause of death among individuals aged 5–34 years.
  - It was the 4th leading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

Suicide Deaths by Year, NM and US

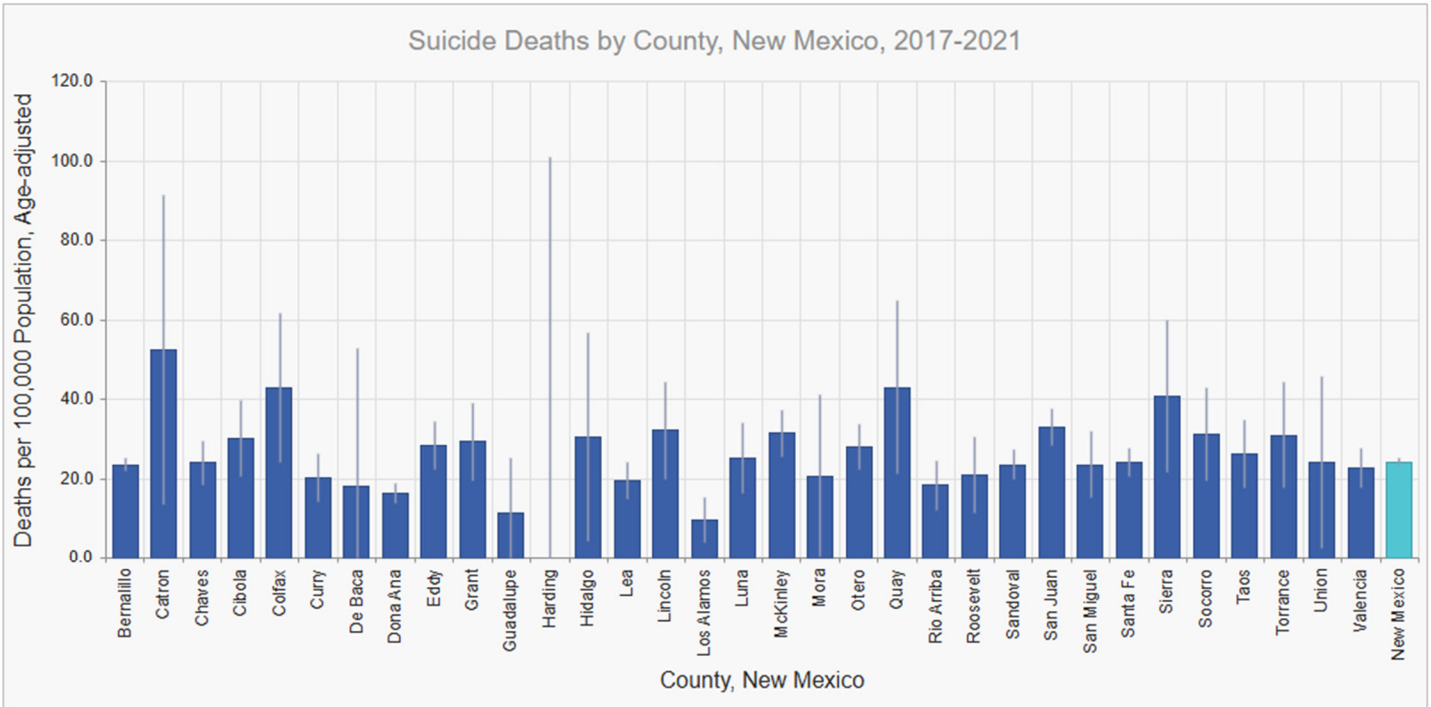


Since 1995, NM suicide rates have been consistently 1.5 times higher than national rates. From 2006-2016, suicide deaths increased in NM by about 25% compared to a 23% increase in the U.S.

Suicide Deaths by Year, by County, NM

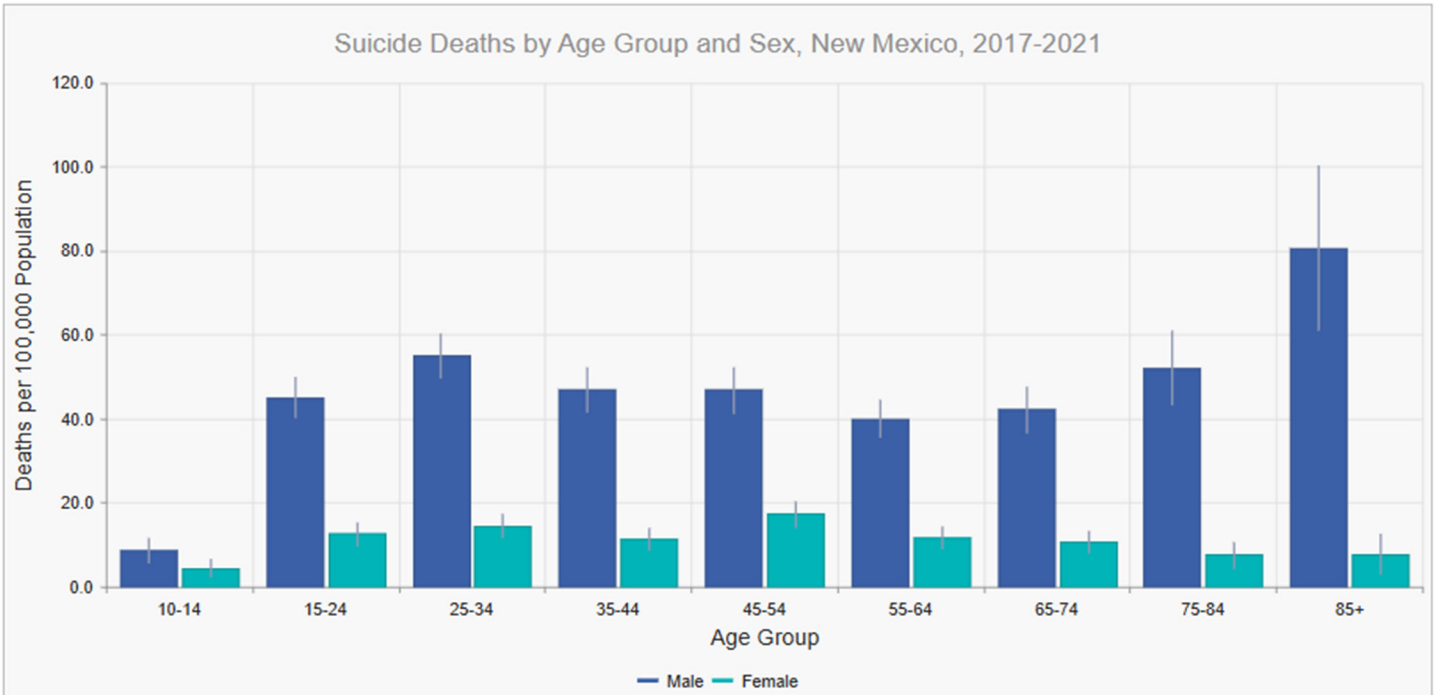


Suicide Deaths by County, NM



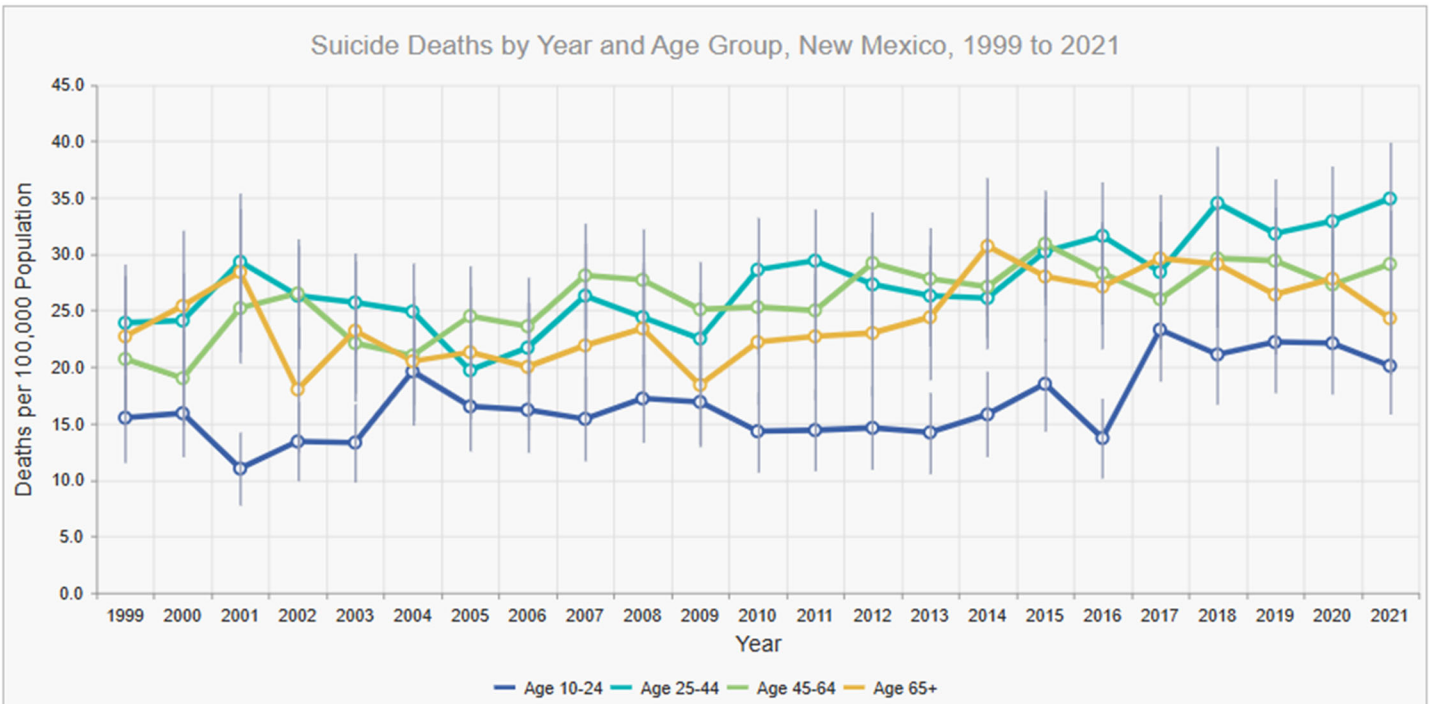
From 2013-2017, 20 NM counties had age-adjusted suicide rates that were significantly higher than the 2016 U.S. rate. NM counties with the highest suicide rates included Catron, Hidalgo, Grant and Sierra Counties in the Southwest; Quay County in the Southeast; and Taos, San Miguel and Torrance Counties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

Suicide Deaths by Age Group and Sex, NM



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

Suicide Deaths by Year and Age Group, NM



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

Alcohol Related Deaths

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

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

Alcohol Related Deaths

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

Nationally:

1 in 10 deaths among working-age adults

(ages 20–64) is attributable to alcohol

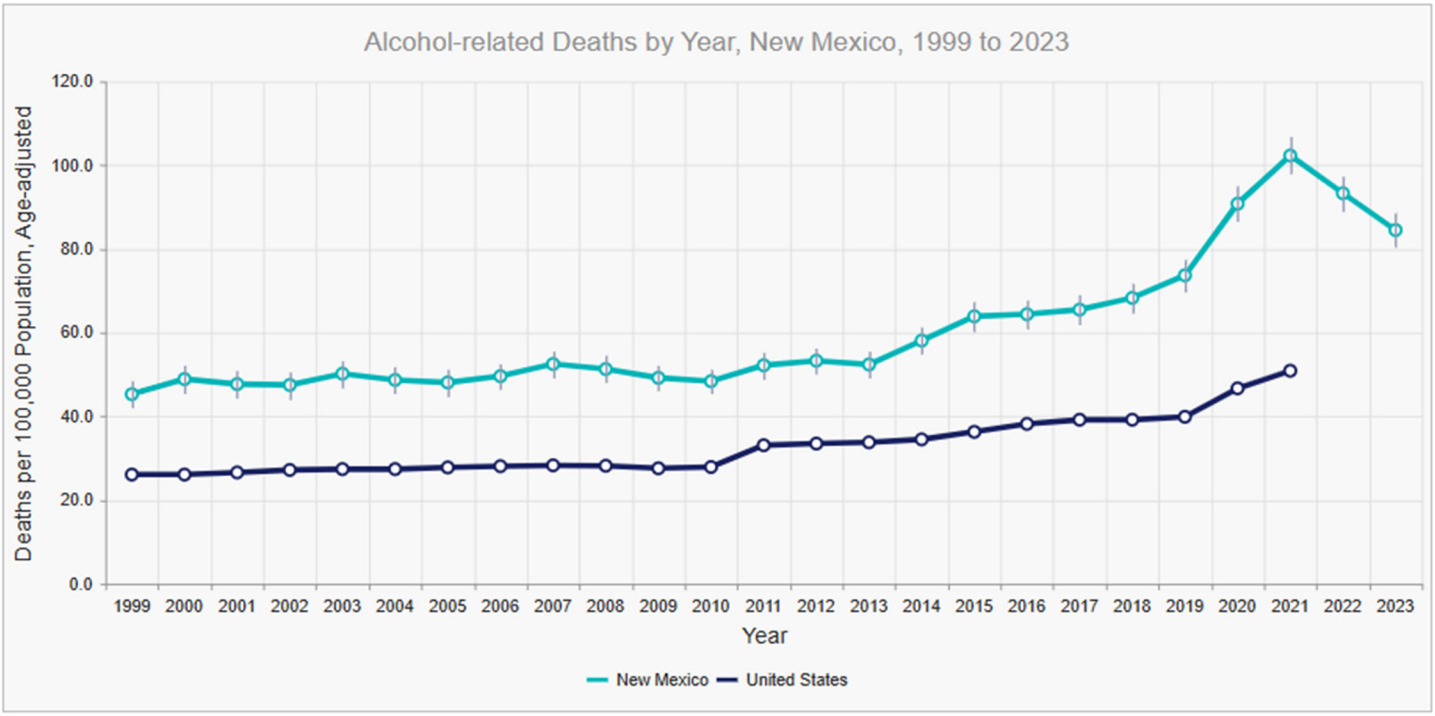
In New Mexico:

1 in 5 deaths among working-age adults

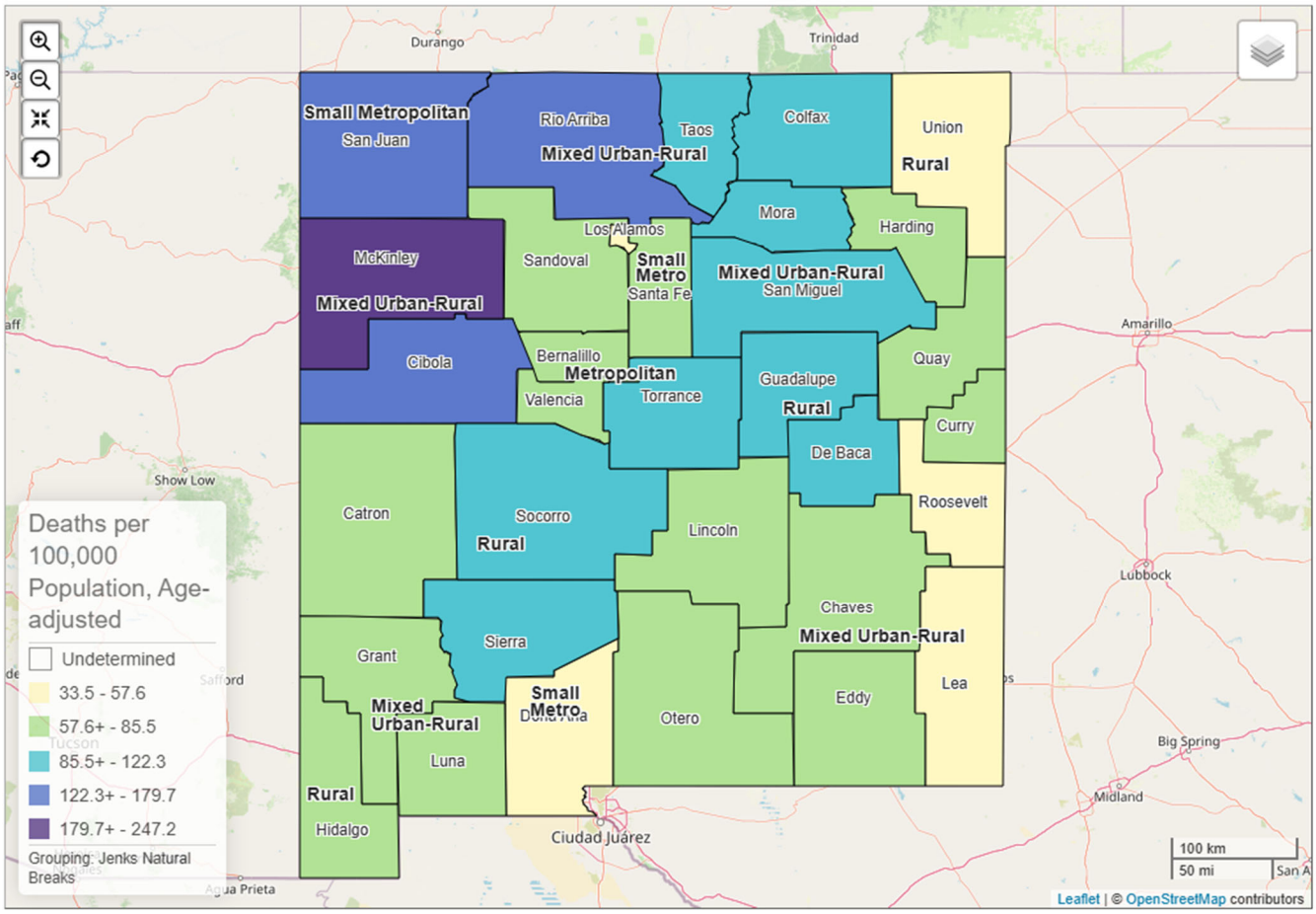
(ages 20–64) is alcohol-related

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

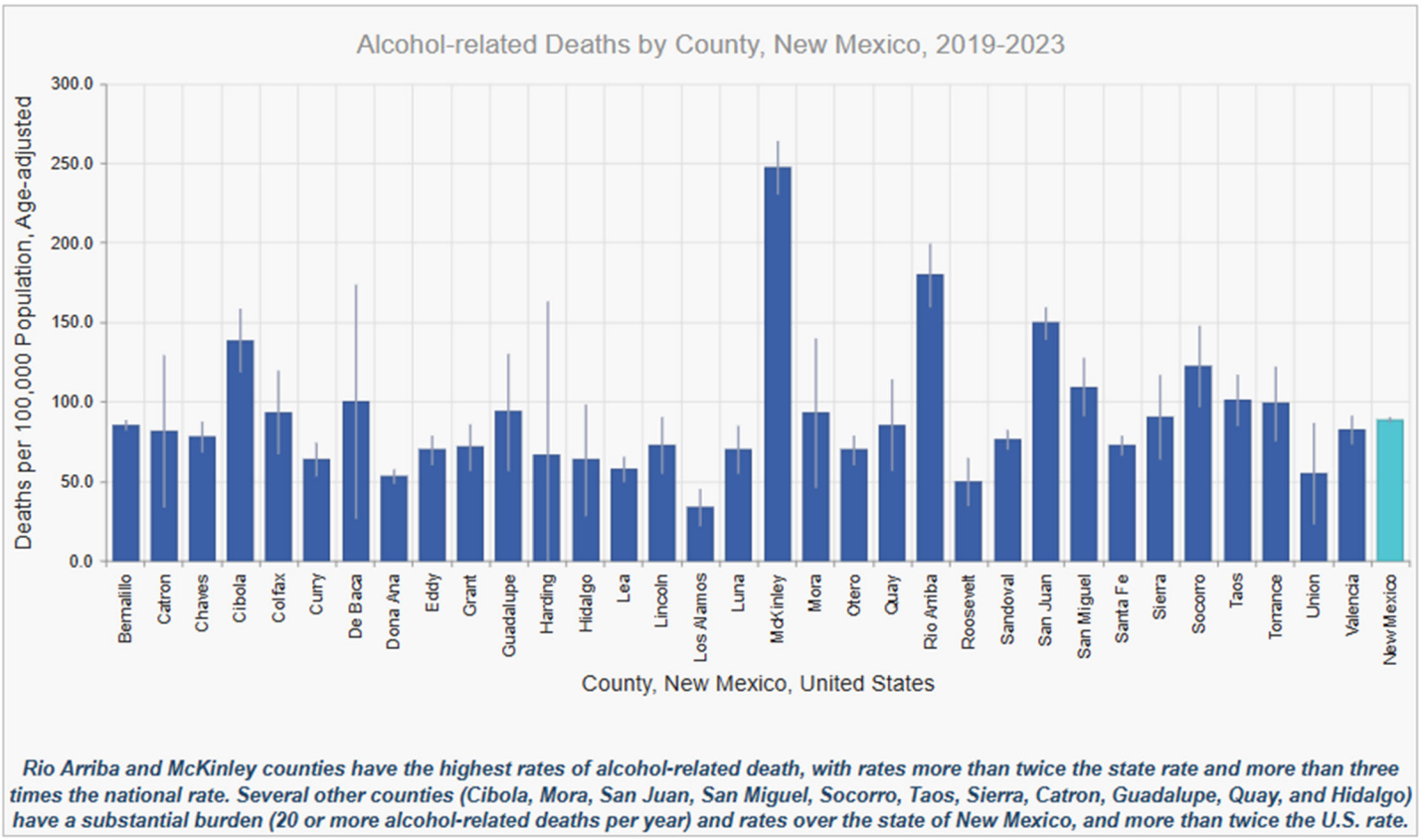
Alcohol-Related Deaths by Year, NM



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

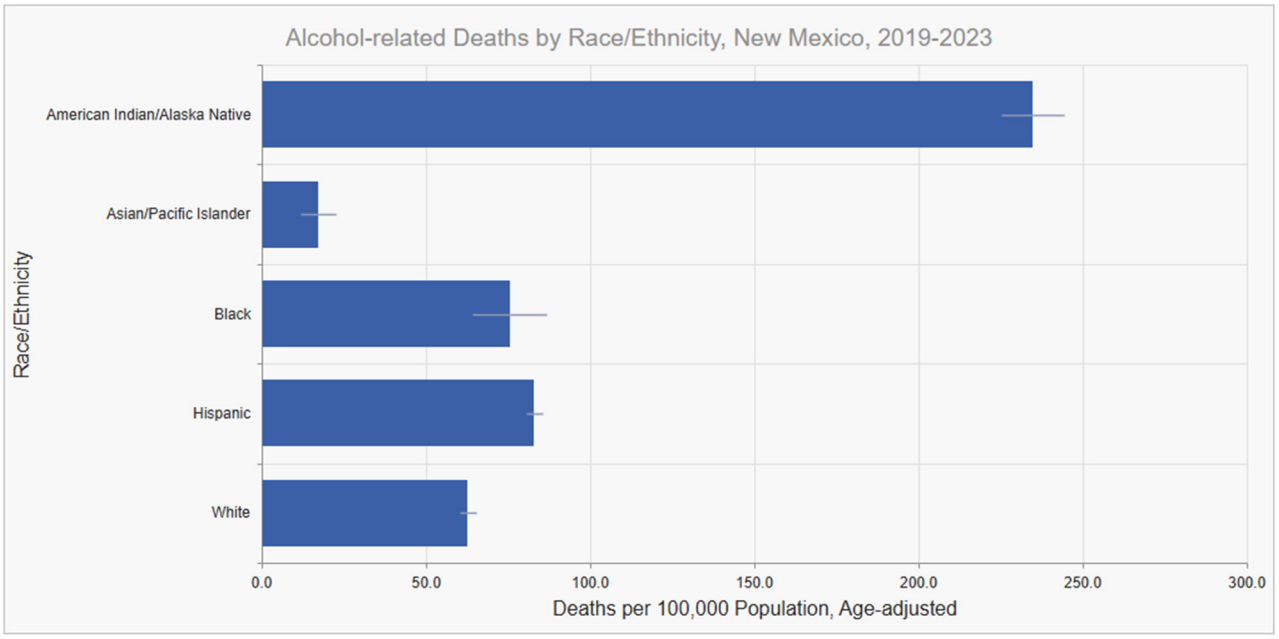


Alcohol-related Deaths by County, NM

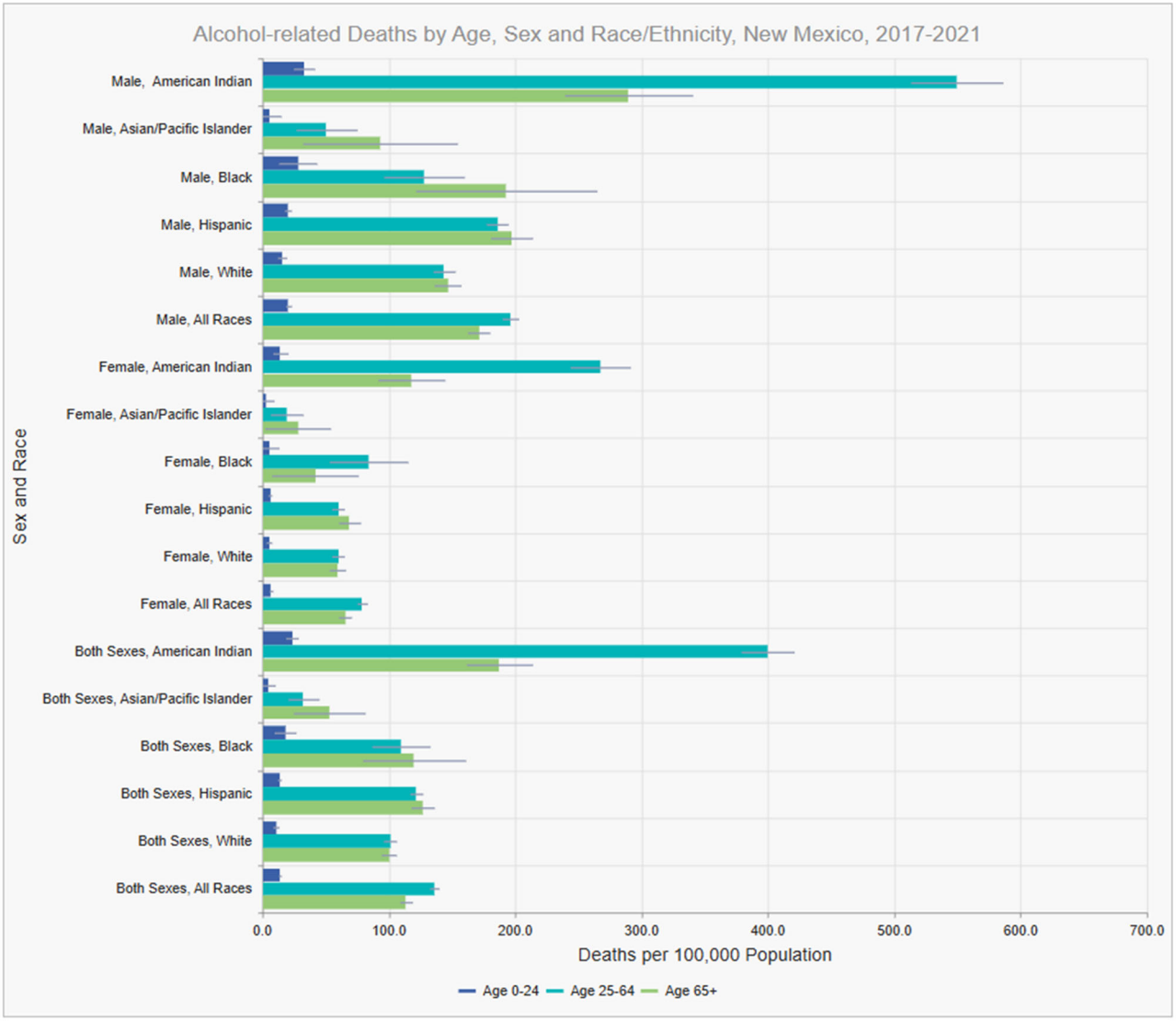


Rio Arriba and McKinley counties have the highest rates of alcohol-related death, with rates more than twice the state rate and more than three times the national rate. Several other counties (Cibola, Mora, San Juan, San Miguel, Socorro, Taos, Sierra, Catron, Guadalupe, Quay, and Hidalgo) have a substantial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

Alcohol-related Deaths by Race/Ethnicity, NM



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



Drug Overdose Deaths

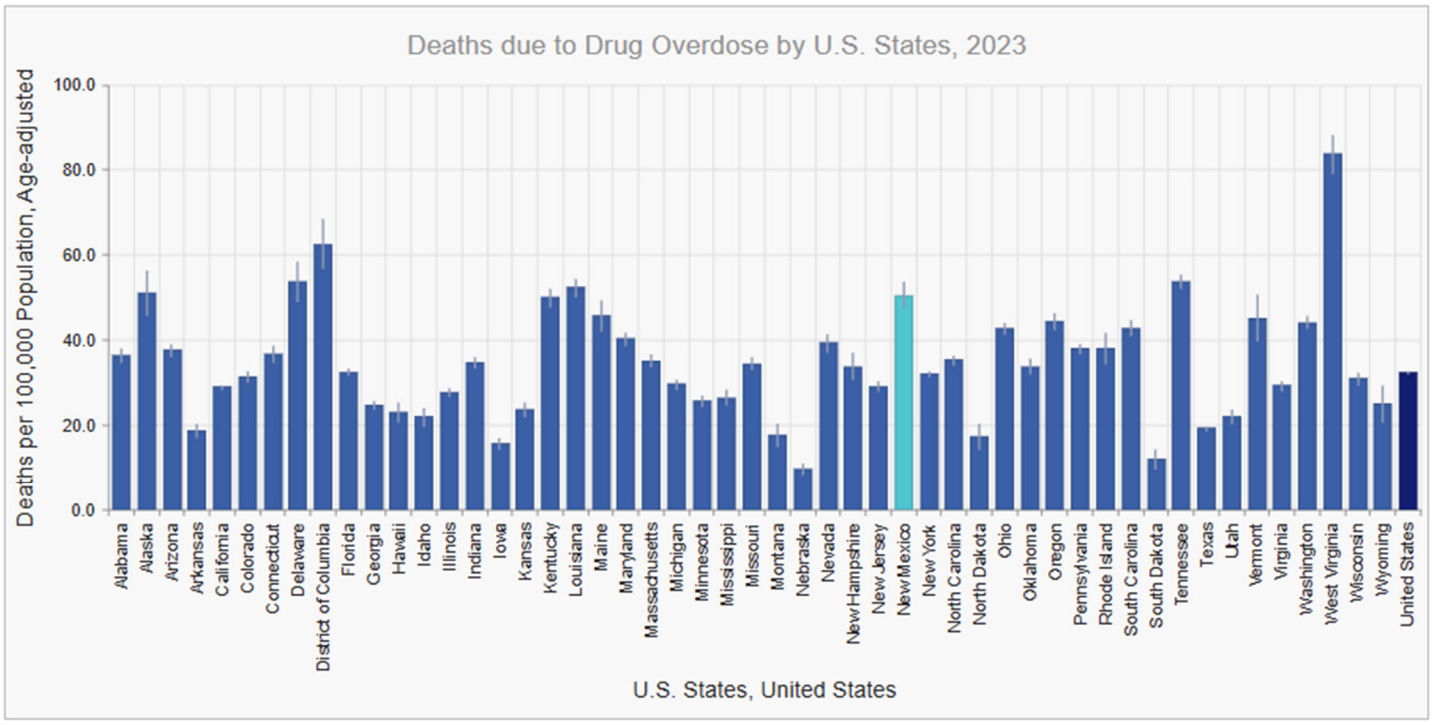
Source: New Mexico's Health Indicator Data & Statistics - https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html

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

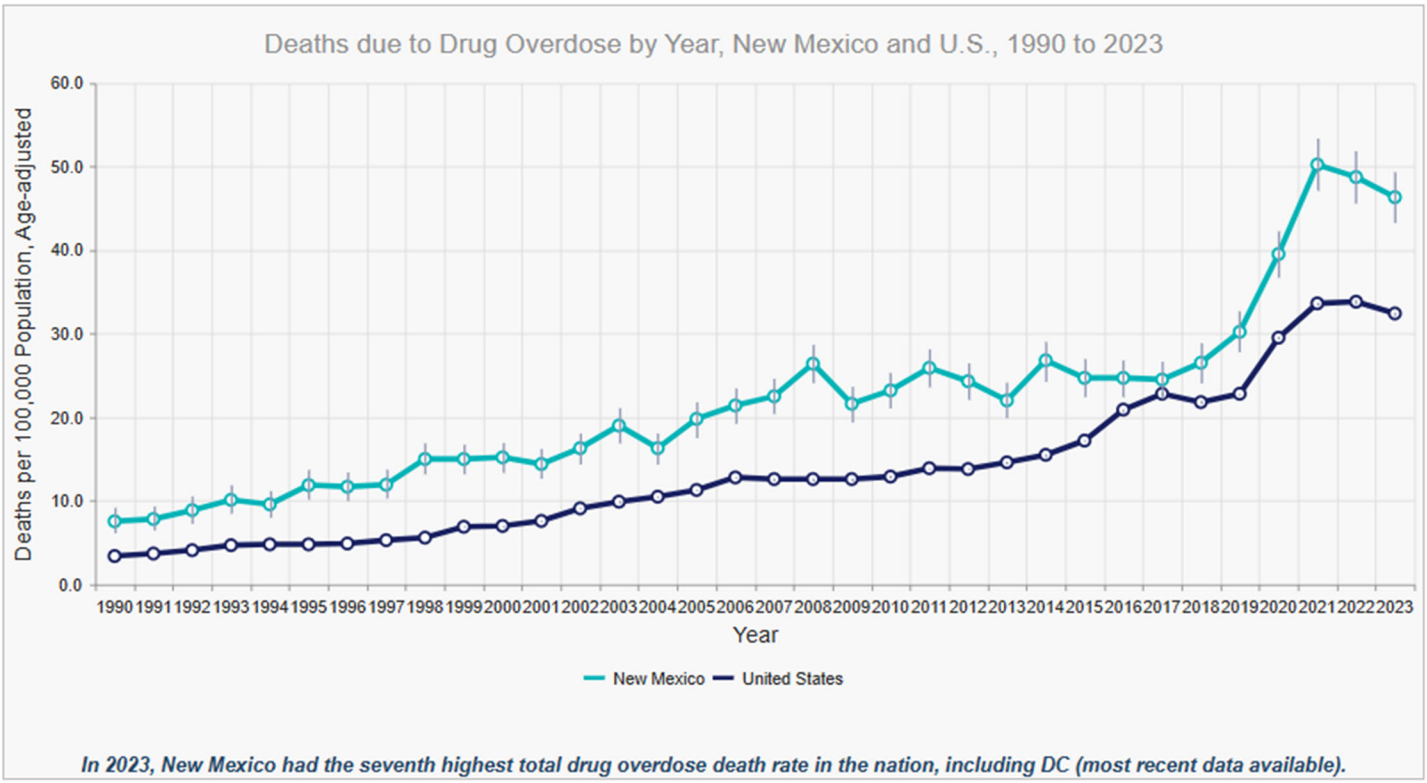
Drug Overdose Deaths

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

Drug Overdose Deaths by U.S. States



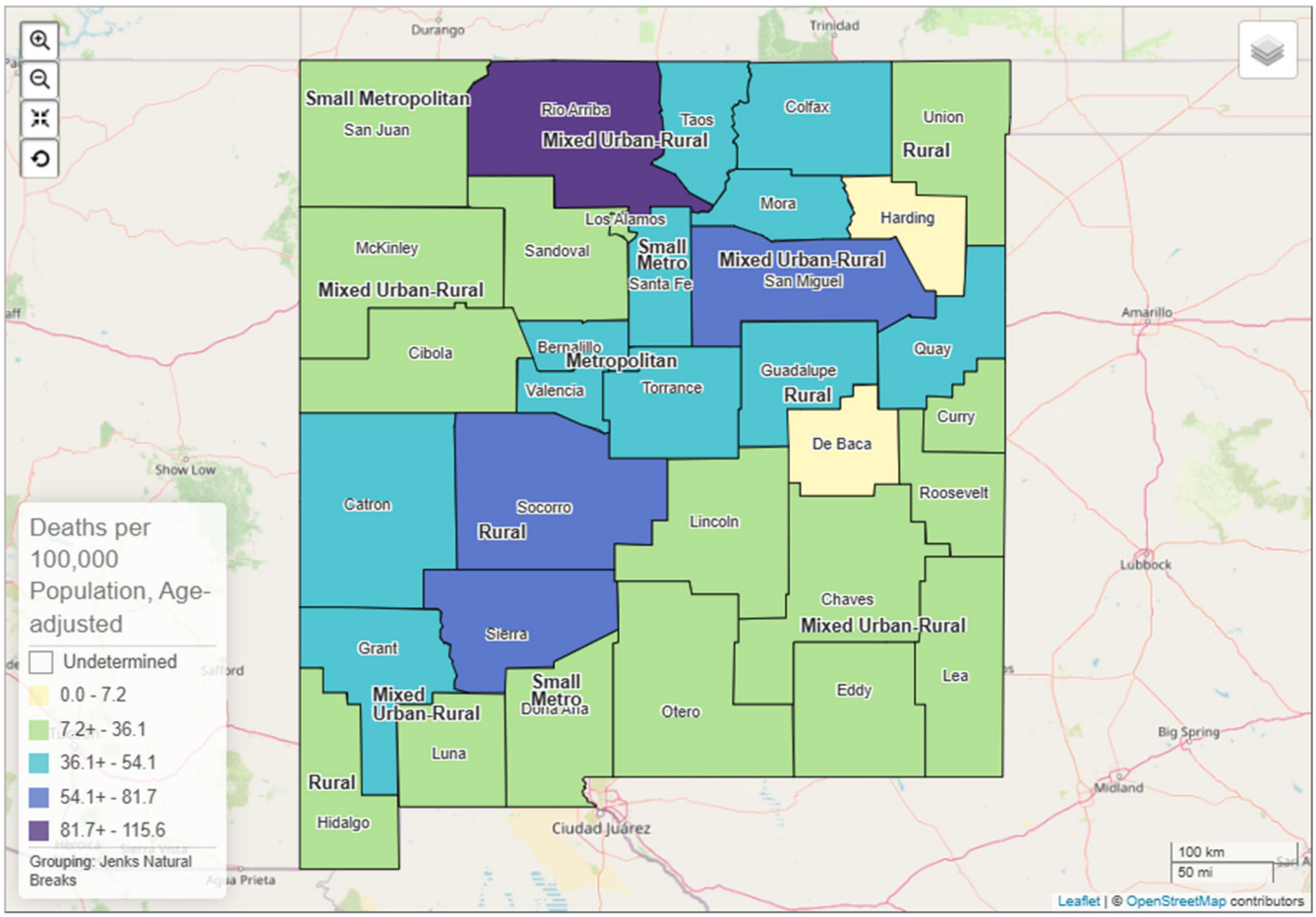
Drug Overdose Deaths by Year, NM and U.S



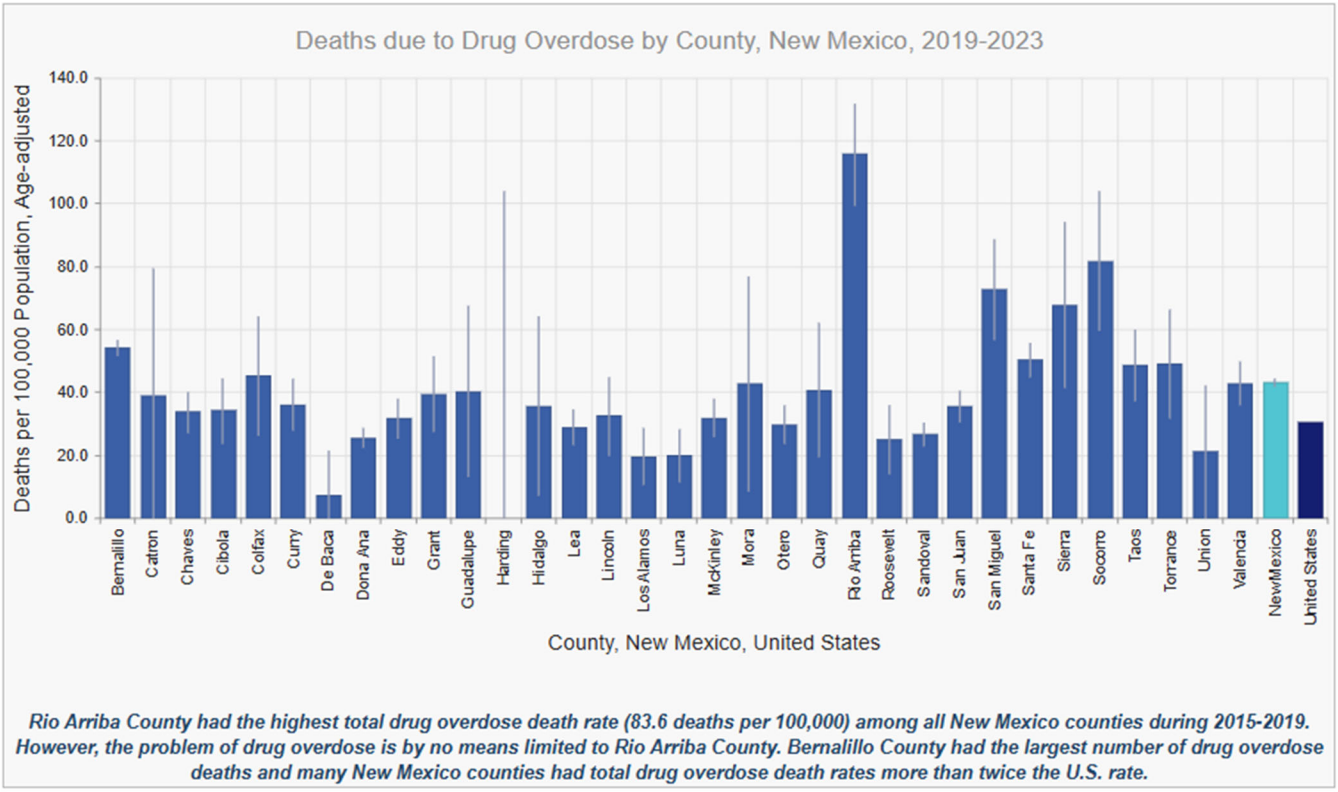
In 2023, New Mexico had the seventh highest total drug overdose death rate in the nation, including DC (most recent data available).

Drug Overdose Deaths by County, NM

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

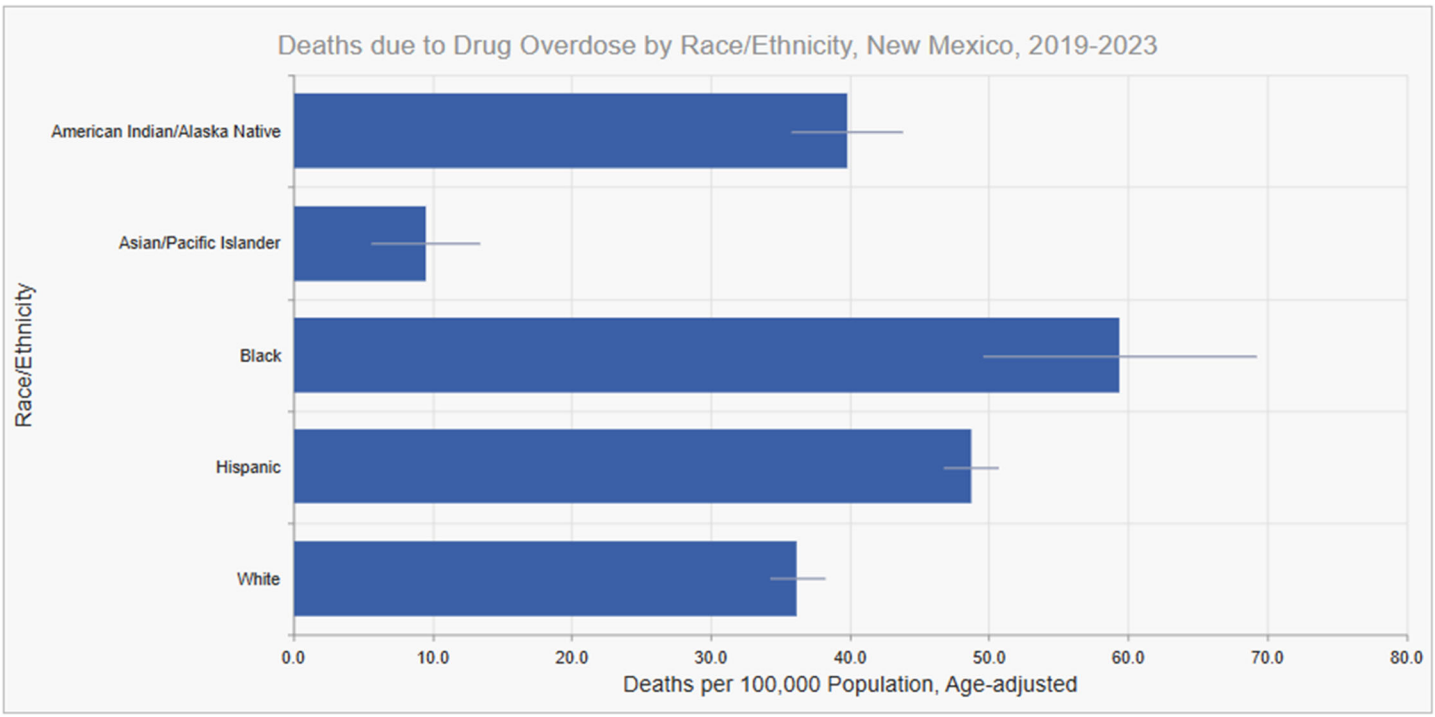


Drug Overdose Deaths by County, NM



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

Drug Overdose Deaths by Race/Ethnicity, NM

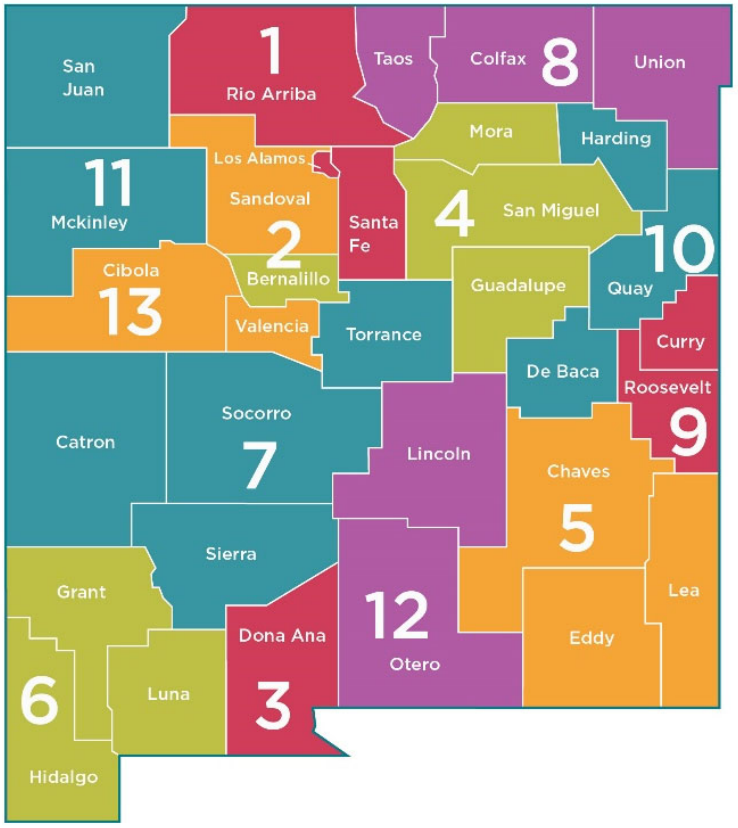


Region/ County

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

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

The NM Behavioral Health Reform Investment Act



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

Region 2
- Pueblo of Isleta
- Pueblo of Sandia

Region 6
- Fort Still Apache Tribe

Region 8
- Taos Pueblo
- Picuris Pueblo

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

Region 11
- Navajo Nation
- Pueblo of Zuni

Region 12
- Mescalero Apache Tribe

Region 1

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

Per 100k, Age-Adjusted

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

Region 2

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

Per 100k, Age-Adjusted

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

Region 3

- Doña Ana

Per 100k, Age-Adjusted

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

Region 4

- Guadalupe, Mora, San Miguel

Per 100k, Age-Adjusted

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

Region 5

- Chaves, Eddy, Lea

Per 100k, Age-Adjusted

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

Region 6

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

Per 100k, Age-Adjusted

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

Region 7

- Catron, Sierra, Socorro, Torrance

Per 100k, Age-Adjusted

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

Region 8

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

Per 100k, Age-Adjusted

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

Region 9

- Curry, Roosevelt

Per 100k, Age-Adjusted

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

Region 10

- De Baca, Harding, Quay

Per 100k, Age-Adjusted

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

Region 11

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

Per 100k, Age-Adjusted

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

Region 12

- Lincoln, Otero

Per 100k, Age-Adjusted

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

Region 13

- Cibola, Sandoval, Valencia

Per 100k, Age-Adjusted

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

Region 1 Priorities

Priority Buckets

- Priority Bucket A: Workforce and Pipeline Development
- Priority Bucket B: Access and Capacity
- Priority Bucket C: Schools and School-Based Supports
- Priority Bucket D: Justice and Diversion
- Priority Bucket E: Crisis Services
- Priority Bucket F: Family and Caregiver Supports
- Priority Bucket G: Social Determinants of Health
- Priority Bucket H: Prevention, Cultural and Community Spaces
- Priority Bucket I: Coordination and Data
- Priority Bucket J: Funding and Policy

A: Workforce and Pipeline Development

- Build, recruit, and retain a diverse behavioral health workforce (Spanish speaking, AIAN, peer and evaluator roles) through loan repayment and subsidized training/housing
- Ensure all workforce positions, including peers, receive living wages
- Support non-traditional roles (peer support/respite reimbursable), trauma trained providers
- Enhance workforce supports (financial, burnout mitigation, retention programs)
- Create workforce pipeline development partnerships (e.g., Northern NM College)
- Provide preferential scholarships and paid apprenticeships for local education/training and community-based jobs
- Formalize career pathways and paid internships for youth

A. Workforce and Pipeline Development (Con't)

- Ensure life skills-building and GED pathways
- Provide subsidized housing for providers to serve nearby communities
- Increase workforce capacity in underserved counties (especially Rio Arriba & Santa Fe)
- Create 24/7 safe spaces to explore jobs and access resources

B: Access and Capacity

- Enhance specialized teams (MST/ACT)
- Expand access to core services (crisis, inpatient, outpatient) region-wide
- Increase resources for cases where both medical needs and BH/SUD diagnoses need addressing
- Expand and enhance current successful programs and consider use of hub and spoke model to expand access in rural communities
- Invest in rural infrastructure and increase opportunities in rural areas to deliver youth programs and school-based BH services where SBHCs are lacking
- Provide privacy spaces where youth can seek services and information
- Leverage open enrollment and word-of-mouth referral strategies to increase access to services

B: Access and Capacity (Con't)

- Grow capacity at existing programs (e.g., Peak Behavioral Health, Sky Center, Darrin's Place) to expand access
- Provide Rio Arriba inpatient rehab that allows youth to be with patients/caregivers
- Expand SUD treatment options for youth/families; inpatient youth mental health beds and partial hospitalization options
- Same day service / Immediate service / walk-in access
- Help create / identify pathways where youth can live away from homes that foster triggers
- Increase the continuum of care capacity. Formalizing the pathway that individuals follow (Detention / Inpatient > Residential > Step-down > Community Services

B: Access and Capacity (Con't)

- Expand detox options (including low-barrier, same-day), and develop access to detox housing for people with severe mental illness
- Ensure step-down services post treatment
- Increase inpatient psychiatric services
- Grow programs outside Medicaid
- Assist residents with Medicaid eligibility
- Expand partial hospitalization options and in-patient youth mental health placements
- Rebuild therapeutic foster care via CYFD

C: Schools and School Based Supports

- Implement Community Schools frameworks (Española & rural), expand SBHCs, and increase school-based BH services in rural areas (replicate ABQ School-Based Violence Intervention model)
- Create school-level crisis response teams beyond postvention
- Integrate BH/SUD screenings for all youth, classroom stress tools/apps (e.g., 'I Am Me'), and Youth Mental Health First Aid for educators/mentors/students
- Revise suspension policies to align with restorative justice; expand restorative justice practices across districts
- Establish wellness rooms (e.g., Rio Arriba/National Latino BH Assn initiative)
- Provide trauma-informed classes for teachers and more in-school experts (e.g., partial hospitalization-linked supports during school day)
- Ensure academic support for suspended/expelled students

C: Schools and School Based Supports (Con't)

- Use schools as access hubs
- Replicate alternative education models (e.g., Valencia County) with required school buy-in
- Address competing priorities within the school system re: focus on academic success vs health
- Update attendance policies to support youth seeking treatment
- Reduce stigma associated with students with ankle monitors through policy/messaging
- Increase awareness and resource navigation for teachers/counselors/administrators and foster awareness for youth in foster care within schools.

D: Justice and Diversion

- Expand diversion/deflection (PIVOT, Uplift, Teen Court restorative justice)
- Incorporate school-based alternatives (with GED pathways)
- Train law enforcement on youth engagement and trauma-informed crisis response; integrate CIT
- Culturally adapt LEAD/ENGAGE/ReRoute for youth, and establish a system to track certification / recertification in chosen models
- Update training on the Children's Code (neuroscience-informed); mentor DAs (Region 13 → Region 1)
- Conduct blanket biopsychosocial/mental-health screenings for justice-involved youth; separate youth by risk-need; maintain funding for specialty courts
- Strengthen court interfaces (meetings with judges), use Children's Court/children's attorneys, and advocate JPO practices that keep cases open long enough to connect youth to services

D: Justice and Diversion (Con't)

- Develop a peer mentoring network for youth on re-entry: Integrate youth/ adult peers in the systems as a support service in facilities
  - Can help facilitate the process of release for individuals needing help reintegrating. Mentors would be trained and paid
- Reintegration services that ease the process of living upon release (resume writing, rental assistance, etc.). A comprehensive post-release case management program with warm hand-offs and scaffold supports
- Embed mental health professionals in juvenile probation
- Develop peer led probation
- Create a Certified Peer Support Worker-led probation track with case management services
- Peer-specific supervision
- Support early law enforcement diversion strategies through early education/understanding roles in the system

D: Justice and Diversion (Con't)

- Consider mandatory youth treatment where appropriate
- Introduction of trauma-informed police response and knowledge of recovery services
- Ensure step-down services post intensive treatment
- Increase transparency of law enforcement activities and priorities
- Maintain and expand specialty court programs, particularly drug and treatment courts for youth
- Foster community–law enforcement connections to reduce criminalization and improve service understanding
- Develop peer probation programs for youth with connection to case management (modeled on adult peer probation program)

E: Crisis Services

- Establish/expand youth crisis triage centers, MRSS mobile response (crisis teams instead of law response), and youth-specific Alternative Response Units
- Develop and implement co-response model
  - Overdose response with naloxone
  - Including LPCCs/Peers
- Add Crisis response facility in Los Alamos
- Standardize behavioral health training for EMS and 911 dispatch (ARU)
- 24/7 services not dependent on payment or diagnosis

F: Family and Caregiver Supports

- Provide family-level Peak-like step-down services and interventions and evidence-based curricula (parental trauma, relationship building), wraparound case management, and family integration services
- Offer stipends to families who follow through on BH/SUD connections
- Involve families in reintegration following justice involvement including an assigned liaison
- Create support programs for grandparents raising grandchildren (navigation + financial assistance)
- Assist families with economic development to ensure greater rates of getting out of poverty
- Increase early childhood interventions, value-added services for children <6, and guardian navigation so families understand available services

F: Family and Caregiver Supports (Con't)

- Strengthen partnerships with existing programs (Gerard's House, ASDMIC, Boys & Girls Club, Tewa Women United, etc.) to expand reach and opportunity to share best practices
- Help families learn how to build a community of resources so that youth do not feel they need to leave the community
- Hold family-centered meetings at schools; expand peer support for families (pay during certification)

G: Social Determinants of Health

- Expand affordable housing for teachers/families and transition-age 18–19 youth
- Expand participation in the Housing Task Force
  - Obtain copy of current comprehensive plan for the City of Española, participate in update of 2026 comprehensive plan
- Fund and expand public transportation (including subsidized options), collaborate on bike routes and refurbishing programs (e.g., Chain Breakers)
- Address SDOH needs (food, transportation, education) and use FindHelp for community-wide navigation
- Identify funding source for needed documentation (ssn, birth certificates, state id's, etc that are needed to access/enter housing
- More accessibility to intensive case management specific to housing

H: Prevention, Cultural and Community Spaces

- Create and promote culturally safe spaces, recovery friendly and culturally responsive programs (e.g., ANSMIC Animating Neurological Skills and Mindsets in Indigenous Communities, medicine wheel, pottery-based processing, neurological/somatic wellness, grief/bereavement models)
- Support intergenerational initiatives (Hands Across Cultures, Northern Youth Project)
- Develop, maintain, and expand land-based/outdoor and culturally anchored programs (Spanish/Indigenous traditions)
- Use arts/local practices (Moving Arts, acequia engagement) as therapy
- Build safe public spaces (skate parks, youth centers) and improve lighting/infrastructure for youth activities

H: Prevention, Cultural and Community Spaces (Con't)

- Develop transitional services for Tribal youth
- Increased awareness of rights for disenfranchised youth (undocumented citizens, those not in school, etc.)
- Establish a foster dog program that helps youth build life skills including responsibility, healthy attachment and social skills
- Cultivate connection across generations, involvement of Elder input in the development of programs
- Promote positive sports and creative-based interventions for non-sports youth
- Scale Bridge to Health (stress/aggression & physical activity modules) across schools/community programs

I: Coordination and Data Sharing

- Connect systems (e.g., 211); reduce silos via regular cross-organization meetings
- Establish “Pool of Peers” to help support navigation with capacity to transport individuals to resources
- Support access to medication upon discharge from inpatient
- Continue JJS summits for connection and communication
- Create CYFD liaisons, collocate multidisciplinary teams (e.g., Team Builders with CYFD)
- Ensure CCSS coordination with JPO/family-identified team members
- Improve data sharing between systems
- Establish dashboards for diversion, placement, treatment plans, outcomes
- Address confidentiality / communications while sharing resources

I: Coordination and Data Sharing (Con’t)

- Clarify distinctions and collaboration across CPS vs JJS
- Strengthen RAC STOP Rio Arriba County Substance Treatment Outreach and Prevention– probation–schools coordination
- Improving communication and coordination between schools and BH providers
- Systems training to reduce fragmentation and silos
- Establish a CJCC/JJCC youth subcommittees; collaborate with juvenile justice advisory board
- Create a “one stop shop” for JCC services; broaden JCC services that include youth that are pre-adjudication
- Establish health councils that can help direct the expansion of services (county & Tribal)
- Connect Program / 211 ability to call for any services 24/7: 211 to filter to a Peer Navigators network

J: Funding and Policy

- Advocate equitable funding for Española
- Form multi-county funding partnerships (e.g., Los Alamos National Labs Foundation, Santa Fe Community Foundation)
- Identify sustainable funding for programs, particularly those that have ebbs and flows in client load
- Invest in rural program infrastructure
- Broaden sliding scale/fee waivers beyond FQHCs
- Expand funding sources for programs serving non-Medicaid recipients

Additional Statewide Initiatives

- Strategically site residential treatment centers (RTCs) statewide; address girls' RTC shortages and boys' waitlists
- Establish real-time placement navigation and bed awareness tools (incl. 833-SWNURSE)
- Extend childcare funding beyond age 13 and ensure eligibility consistency
- Create a statewide mental health hospital
- Make High Fidelity Wraparound certification more timely/feasible