

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

2nd Behavioral Health District
Youth System

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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 main 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 provides a summary of findings from the E-SIM Mapping and Prioritization Workshop conducted in Behavioral Health Region 2 (Bernalillo County, City of Albuquerque, Isleta Pueblo, Sandia Pueblo, and To'Hajiilee Navajo Chapter). A list of acronyms used in this report is included in Appendix A.2.

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

The E-SIM Mapping and Prioritization Workshops take a systems approach, using a specific orientation, to inform regional behavioral health planning. Appendix A.3 includes the NM E-SIM that was adapted for New Mexico from the original Sequential Intercept Model (SIM, Griffen, Helbrun, Mulvey, DeMattero & Schubert, 2015¹) 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 availability of 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 Behavioral Health Region 2 over 2 days (November 20th and 21st, 2025). A copy of the agenda is included in Appendix A.4. Because SIM mapping of the adult system had been conducted between Bernalillo County and the city of Albuquerque from 2019-2025², Regional 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 and the second day focused on the prioritization process. Seventy-one people attended the first day with an additional

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>

² Sequential Intercept Map (SIM) (2019), Gaps Analysis (2021), Joint City and County Strategic Plan (2023), Opioid settlement (2024), and a County Strategic Plan 2025).

18 from the UNM BHTAC for a total of 89 attendees. Fifty-three people attended the second day with 17 people from the UNM BHTAC for a total of 70 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 first morning session, an overview of Region 2 Medicaid Snapshot data (Appendix A.5) was presented to help inform decisions regarding resource allocation (Day 2). These snapshots 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

Adult and youth data were compiled for Behavioral Health Region 2 (BHR2), which included only Bernalillo County residents (Population: 671,747; 31.5% of the state). As the most populated county in the state, the following data profile closely mirrors the state overall Medicaid profile. The Medicaid Snapshot profile does not include tribal data.

Demographics

- **Race/ethnicity:** BHR2’s composition (48.93% Hispanic, 37.75% White NH, 6.81% Other, 3.96% AI/AN, 2.55% Black NH) closely matches statewide figures.
- **Age:** Similarly, age distribution, 20.66% under 18 (vs. 22.06% statewide) and 79.34% over 18 (vs. 77.94% statewide) is consistent with statewide data.
- **Gender:** Gender distribution was also similarly comparable, with 51.0% female and 49.0% male in BHR2 (vs. 50.4% and 49.6% statewide).

Medicaid Data

Tables 1 and 2 provide a profile of mental health diagnoses for youth and adults.

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

Diagnoses	% BHR2	% State
Anxiety Disorder	51.2%	50.6%
Attention Deficit Disorders	22.3%	26.0%
Mood Disorders	18.1%	21.9%
Developmental Disorders	12.5%	11.7%
Conduct Disorders	10.2%	10.1%
Intentional Self Harm & Suicidal Ideation	6.8%	7.1%
Cannabis Use Disorder	4.7%	5.3%
Emotional Disorders Childhood Onset	4.4%	4.6%
Psychotic Disorder	2.4%	3.2%
Eating Disorders	1.9%	1.8%

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

Diagnoses	% BHR2	% State
Anxiety Disorder	59.2%	59.6%
Mood Disorder	37.2%	37.1%
Opioid Use Disorder	16.1%	12.7%
Alcohol Use Disorder	15.4%	17.9%
Stimulant Use Disorder	10.7%	10.7%
Psychotic Disorder	8.2%	7.9%
Cannabis Use Disorder	7.5%	8.3%
Attention Deficit Disorders	7.4%	6.8%
Hallucinogen/Inhalant/Other SUD	6.2%	5.8%
Intentional Self Harm & Suicidal Ideation	5.5%	5.3%

Youth and adult utilization data regarding services, infrastructure and crisis and emergency room visits are provided below.

Service Utilization

- Behavioral Health Outpatient: BHR2 85.2% | NM 86.8%
- Crisis Services: BHR2 22.9% | NM 23.8%
- Intensive Outpatient: BHR2 9.6% | NM 7.2%
- Recovery Services: BHR2 13.7% | NM 9.3%

Infrastructure Utilization

- Prescribers: BHR2 53.3% | NM 49.1%
- Primary Care: BHR2 39.7% | NM 36%
- Psychotherapy Practitioners: BHR2 4.6% | NM 5.4%
- Substance Use Specialists: BHR2 0.8% | NM 0.7%
- Hospitals: BHR2 26.8% | NM 24.2%
- Behavioral Health Agencies: BHR2 24.2% | NM 17.3%

Crisis & ER Utilization

- Crisis Call Rate (2024): BHR2 2.06% | NM 1.32%
- ER Visits for BH: BHR2 17.3% | NM 18.8%

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

During the E-SIM and Prioritization Workshop, participants were divided into three breakout groups with roughly equal representation from the seven stakeholder groups to identify resources, gaps and opportunities at each intercept. Each breakout group also included UNM BHTAC facilitators, note-takers and scribes. Below is a summary of resources, gaps, and action items from all breakout groups; it does not include an exhaustive list of regional resources, rather the resources identified during this 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 are 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	<ul style="list-style-type: none"> • 11 City ABQ community centers • County community centers • After-school programs (athletics, MAD, YDI) • Big Brothers Big Sisters • APS Academies • Summer of Non-Violence • Gateway Youth Shelter • New Day peer drop-in • Breakthrough website 	<ul style="list-style-type: none"> • County centers not accessible for at-risk youth • Centers close at 5 PM • Only one youth drop-in center • Transportation barriers • Homeless youth lack services • Distrust of systems 	<ul style="list-style-type: none"> • Keep centers open later • Expand drop-in centers • Incentivize family participation • Develop services for homeless youth • Increase culturally and linguistically appropriate services • Need more after school programs • Need more transportation to after school programs
School-Based Supports	<ul style="list-style-type: none"> • School social workers • SBHC expansion • SEL at APS • APS contracts with BH providers • ECHO trauma-informed training • School nurses 	<ul style="list-style-type: none"> • Disconnect between Title 1 and BH plans • Lack of clarity on counselor roles • Limited trauma-informed training 	<ul style="list-style-type: none"> • Expand SBHC services • Increase counselors and redefine roles • Train teachers in restorative justice and trauma-informed practices • PED can change regulations to allow social workers to function as school counselors as they have the training • APS, BernCo and City of Albuquerque are using opioid funds to build 26 additional positions to support prevention at elementary, middle and HS
Family & Parenting Supports	<ul style="list-style-type: none"> • Parenting curriculum for CYFD families • Respite care for foster parents • Home visiting programs • Certified family support peers • New Universal Childcare • Family Court • FIT • CARA 	<ul style="list-style-type: none"> • Respite not available for all families • Distrust among parents • Limited awareness of home visiting programs • Universal childcare covers up to age 13 but there are not enough providers 	<ul style="list-style-type: none"> • Expand respite care • Increase awareness of home visiting programs • Build trust through collaborative engagement • Continue follow-up for youth and families after CYFD intervention • Expand Family court established counselling classes
Youth Development & Vocational Supports	<ul style="list-style-type: none"> • Department of Vocational Rehabilitation (DVR) • Supported decision-making legislation, • PED-funded internships, • United Way partnerships • Mentorship programs 	<ul style="list-style-type: none"> • Lack of vocational mentorship programs • Paid internships mostly for enrolled students • Workforce shortages for transitional age youth 	<ul style="list-style-type: none"> • Create employment and mentorship opportunities • Expand internships to disconnected youth • Workforce development initiatives • DVR should be invited into schools for IEP planning
Mental Health & Substance Use	<ul style="list-style-type: none"> • Substance use counseling in schools • Serenity Mesa detox • NMBHC opening detox and PHP • Crossroads Counseling • PCP Universal ACE screening 	<ul style="list-style-type: none"> • Only one youth detox center • Historical and generational trauma • Lack of peer support in schools • Substance use counselors not in every school 	<ul style="list-style-type: none"> • Expand detox and PHP services • Integrate trauma-informed approaches • Add peer support workers in schools • In international district- they screen for ACES and SDH to identify at risk youth, but this is

			<ul style="list-style-type: none"> not available in other zip codes in primary care Every middle school and high school need substance use counsellors
Housing & Basic Needs	<ul style="list-style-type: none"> Amistad New Day Safe Home transitional housing Community-Based Prevention and Intervention (CBPIR) workers Guaranteed-Based Income (GBI) Pilot Project 	<ul style="list-style-type: none"> Insufficient housing services Youth from other counties come to Bernalillo Lack of independent living resources 	<ul style="list-style-type: none"> Add more organizations for unstably housed youth Develop independent living programs Address housing insecurity
Other Community Resources	<ul style="list-style-type: none"> EXPLORA Albuquerque Children's Theater YMCA AYSO I9 sports scholarships Find Health platform Future Focused Education's Youth BH Council Stronger Together Never Alone – group of moms whose children are justice involved Yazzie/Martinez Action Plan Planned CNM program to build workforce for pathway for counselors to serve youth 	<ul style="list-style-type: none"> Limited access to prosocial opportunities Programs fill quickly Lack of funding for non-clinical wellness programs Transportation barriers Lack of centralized resource list 	<ul style="list-style-type: none"> Create wellness benefit program Expand Find Health platform Create a centralized resource platform for families Increase transportation options County could create arts in the parks program so it's free

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	<ul style="list-style-type: none"> UNM Mobile Crisis Team New Day Reception ACS crisis teams CCBHC 988 APS crisis team UNM START Agora 	<ul style="list-style-type: none"> Underutilization of UNM team Lack of awareness of ACS option Workforce shortages MRSS not fully rolled out Inconsistent school crisis policies 	<ul style="list-style-type: none"> Expand drop-in centers Train MRSS staff Increase ACS awareness Standardize school crisis policies Need education of APD officers of how New Day can serve as crisis diversion rather than arresting Need funding for APD education

	<ul style="list-style-type: none"> • Crisis Triage Center • Youth drop-in centers • MRSS • APS Threat Assessment • APS Crisis Team • UNM Walk-in Clinic 	<ul style="list-style-type: none"> • UNM website is difficult to navigate and many stakeholders were unaware of the services 	<ul style="list-style-type: none"> • Include New Day and Probation Officers in the APD Training Academy • Improve coordination between ACS & UNM mobile crisis team
Child & Family Support / Child Welfare	<ul style="list-style-type: none"> • CYFD FINS referrals • Wraparound services • Health & Social Service Centers • Locker 505 • Transgender Resource Center • Cultural organizations • Restorative Justice programs 	<ul style="list-style-type: none"> • Lack of family engagement • Workforce shortages • Immigration fears • Limited culturally responsive services • Burdensome intake 	<ul style="list-style-type: none"> • Workforce development • Cultural competency training • Increase restorative practices • Build trust with CYFD
Hospitals & Inpatient Care	<ul style="list-style-type: none"> • UNM CPC • Sequoia RTC • Children's Psychiatric Center 	<ul style="list-style-type: none"> • Severe lack of RTC beds • Youth sent out of state • Lack of family engagement 	<ul style="list-style-type: none"> • Consider developing in-state RTCs • Expand independent living centers • Create bridging programs • Need better communication from psychiatric hospitals when discharging home and community providers
Substance Use Services	<ul style="list-style-type: none"> • Serenity Mesa • NM Behavioral Care youth detox • Public health offices • AA teen meetings • Youth Al-Anon • CRAFT programs 	<ul style="list-style-type: none"> • Only one youth detox center • Lack of awareness of public health services • Limited harm reduction 	<ul style="list-style-type: none"> • Expand detox options • Integrate Narcan training in schools • Increase harm reduction programs
School Health Centers & Systems	<ul style="list-style-type: none"> • APS SBHC program • APS re-entry programs • ACS school-based violence intervention • Community schools 	<ul style="list-style-type: none"> • Fee-for-service limits integration • Lack of clarity on discipline/truancy • Inconsistent 504/IEP implementation 	<ul style="list-style-type: none"> • Embed health centers in schools • Train staff on BH policies • Expand ACS programs
Care Coordination & Policy	<ul style="list-style-type: none"> • Unitus referral platform • CYFD map of child-serving programs 	<ul style="list-style-type: none"> • Different systems using different platforms • Lack of coordination • HIPAA/FERPA inconsistencies 	<ul style="list-style-type: none"> • Standardize referral systems • Resurrect provider meetings • Train on HIPAA/FERPA
Other / Overarching Themes	<ul style="list-style-type: none"> • YDI gun violence prevention • APS overdose wraparound • Home visiting programs • Transgender Resource Center • All Faiths • Treehouse • NAMI 	<ul style="list-style-type: none"> • Patchwork funding • Workforce shortages • Undocumented youth lack access • Lack of programs for high-need youth • No day treatment • Housing and food insecurity 	<ul style="list-style-type: none"> • Workforce development • Increase respite and caregiver support • Develop programs for high-needs youth • Centralized referral for home visiting • Expand prevention programs

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

Overview: Intercept 3 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	<ul style="list-style-type: none"> • School Resource Officers • CYFD initial contact teams • ACS crisis response with law enforcement 	<ul style="list-style-type: none"> • Limited training on youth behavioral health • Over-reliance on arrest • Lack of diversion options 	<ul style="list-style-type: none"> • Expand diversion programs • Train officers in trauma-informed care • Increase ACS non-law enforcement response
CYFD Initial Contact	<ul style="list-style-type: none"> • CYFD intake workers • Family Services Division • FINS referrals 	<ul style="list-style-type: none"> • High caseloads • Limited family engagement • Lack of culturally responsive practices 	<ul style="list-style-type: none"> • Reduce caseloads • Train staff in cultural competency • Strengthen family engagement strategies
School Police & Threat Assessment	<ul style="list-style-type: none"> • APS Threat Assessment Team • School Police units • Restorative justice programs 	<ul style="list-style-type: none"> • Inconsistent implementation of threat assessment protocols • Lack of mental health integration 	<ul style="list-style-type: none"> • Standardize protocols • Embed mental health professionals in school safety teams
Diversion & Early Intervention	<ul style="list-style-type: none"> • Juvenile diversion programs • Community-based intervention workers • ACS youth programs 	<ul style="list-style-type: none"> • Limited awareness of diversion options • Transportation barriers for families 	<ul style="list-style-type: none"> • Increase outreach about diversion • Provide transportation support for program access

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	<ul style="list-style-type: none"> • Juvenile Probation Officers • CYFD Juvenile Intake • Detention Screening Tools • Youth Assessment and Screening Instrument (YASI) • Children’s Court Attorneys (CCAs) 	<ul style="list-style-type: none"> • High caseloads for probation officers • Limited diversion options at intake • Lack of culturally responsive screening • Is school supporting those that are in probation and still being back in school? 	<ul style="list-style-type: none"> • Expand diversion programs at intake • Train staff on cultural competency • Improve screening tools for behavioral health • CYFD is creating a new case management system call New Mexico Impact — should go live in January 2026. This is to address the data and reporting needs
Initial Processing	<ul style="list-style-type: none"> • Juvenile Detention Alternatives Initiative (JDAI) 	<ul style="list-style-type: none"> • Over-reliance on detention for low-risk youth 	<ul style="list-style-type: none"> • Increase use of JDAI strategies • Provide transportation support

	<ul style="list-style-type: none"> • Community-based supervision programs • Pre-adjudication services • Treatment Foster Care 	<ul style="list-style-type: none"> • Transportation barriers for community programs 	<ul style="list-style-type: none"> • Expand community supervision programs • Expand TFC and also consider TFC enhancements that would include respite and wraparound for higher needs kids
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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	<ul style="list-style-type: none"> • Juvenile Court Judges • Specialty Courts (Drug Court, Family Court) • Court-Appointed Special Advocates (CASA) • Gets an assessment in combination with probation. Probation schedules a triage with DA, parent and youth. Tribes are also invited if applicable. Treatment options offered (e.g. CASA Q for LGBT youth. • The Children’s Court • Community Gun Violence Intervention Program • ICWA Court • Office of Special Education Ombud (OSEO) through Developmental Disability Council (Intercepts 2 & 3) • Motivational Interviewing • CCPS • ACS 	<ul style="list-style-type: none"> • Limited access to specialty courts for rural youth • Delays in case processing • Lack of trauma-informed practices • Limited options available. If youth is not accepted, may be referred to out of state facilities or proceed to sentencing. • Lack of engagement is where JJS struggles— whether family wants to participate or not. That can take a really long time for family to participate • Barrier to care: services are available M-F 8-5; but parents are working from 8-5 M-F. Clinics expand hours of operations to make things more accessible. Judicial courts are also M-F 8-5, now parents also need to take time off work to bring youth to court. 	<ul style="list-style-type: none"> • Expand specialty courts • Train court staff in trauma-informed care • Streamline case processing • APS could be more involved in these pre-sentencing and post-adjudication models so that they could start fresh in a new school. • Bring back Youth and Family Counseling Program • Establishing Youth Mental Health Court • MI Training • ACS: works a lot with youth court and family court; but some challenges with shared languages with people in the court system, in order to help the transition of that youth. We’re not speaking the same language, which makes it harder. • Create more streamlined communication between departments. • Involving peer workers in the court system as youth
Detention & Commitment	<ul style="list-style-type: none"> • Youth Service Center • CYFD Secure Facilities • Residential Treatment Centers (RTCs) • Keshet goes into YDDC and offers 	<ul style="list-style-type: none"> • Insufficient RTC beds • Youth placed out of state • Lack of reentry planning • Sometimes peers with lived experience are not allowed into detention facilities. 	<ul style="list-style-type: none"> • Consider developing in-state RTC capacity • Create reentry programs • Increase family engagement during detention • creating family interventions when a youth has been detained – an opportunity for family to stabilize.

	<ul style="list-style-type: none"> dance programming for youth at risk • Medication Management • Kaseman provides LAIs • PB&J • NMBHI • Transitional Living for Adults • YDDC (youth diagnostic detention center) • Community Custody Program 	<ul style="list-style-type: none"> • Very little therapy available to youth when in jails (pre-adjudication) • Unclear how medication is managed once LAIs started • Pay for staff at detention is low and does not reflect the intensity of skills needed to support trauma focused services 	<ul style="list-style-type: none"> Different from family therapy during visitations. Community based interventions for families. • Opportunities to rent buses and coordinate visits for families when youth are detained • Opportunity to design a therapeutic program with restorative justice focus for youth with SYO charges who may be facing YDDC or prison. • State level recommendation: Change the children's code so that youth charged with serious crimes can have options for community-based recommendations rather than mandating commitment. • Incorporate strengths-based activities within mandated treatment.
Programs for guardianship/kinship	<ul style="list-style-type: none"> • La Plazita has a program PMAC— Parent Making a Change • Southwest Family Guidance • All Faiths 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •

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	<ul style="list-style-type: none"> • Reentry coordinators • CYFD aftercare programs • CYFD Fostering Connections Team • 3 CYFD Reintegration Centers • Community-based mentoring, • Workforce development programs • Transitional Living for Young Adults program YDI and New Day • ACS Re-entry Services with SWEPT • DVR • La Plazita 	<ul style="list-style-type: none"> • Limited housing options for youth post-release • Lack of vocational training • Insufficient family engagement in reentry planning • There does not seem to be special program to come back to school • Attendance For Success Act. But no exceptions for youth in RTC, juvenile correction facilities, etc., then they get referred to CYFD which creates a new cycle. • Lack of service providers in the community 	<ul style="list-style-type: none"> • Expand transitional housing • Develop vocational and job readiness programs, • Strengthen family engagement strategies • Create Resource Reentry Center for youth • For adults, they all get discharged at the same time and get dropped off together. But for youth, it's more scattered. Need more coordination. • Adult RISE reintegration program — create something similar for youth population. • Creating school protocols for justice-involved youth to be reentry. Educating families. • Charter Schools sometimes is more amenable to reentry.

	<ul style="list-style-type: none"> • MCO Care Coordinators • MCOs wellness subsidies • City is collaborating with YDI to build 40 bed campus for young adults. Recovery housing campus for young adults coming out of MDC. • NA and AA- sober community • Charter schools to continue education after detention (E-cademy, School on Wheels, and Freedom) • Sweet Program at Sequoia • PB&J Family Services program • 	<ul style="list-style-type: none"> • Youth connect back to group they left prior to detention • Lack of awareness and knowledge of smaller community organizations- same resources are used over and over • Referrals are made to community resources and youth don't know the referral is made- need better system for warm hand-offs and care coordination • Unclear how youth are directed to healthy resources • Ways to coordinate HIPAA, FERPA, etc. for youth being released from detention, inpatient, RTCs, etc. regarding school- need more transition services at the facility • Housing is a huge need • Families need supports- Navigators for families • Need services to resolve traumas- community centered healing programs • 	<ul style="list-style-type: none"> • More opportunities to meet people where they're at — coming to people that need the services instead of people initiating services themselves. • Coverage for services at any stages in the intercept, but especially for reentry. There are some services that are not covered like Equine, ECT, Transcranial magnetic stimulation (TMS), etc. • Pathways for youth with lived experiences that have experiences in this system. Certification, training, jobs, etc. • State level: hold MCOs accountable for offering resources. • Online schooling could help with maintaining continuity of education. • Need for recovery housing for adolescents. • Need additional workforce to staff these campuses • Better system for warm hand-offs to a diversity of resources (including smaller agency) • Navigators to connect youth and families to resources to increase awareness of options- could be MCOs or other entities • Bundle billing codes and add additional codes to have bundled services like DD Waiver • Improve discharge planning • Access to safe and stable housing • Increase access to community centered healing programs as mentioned in pre-intercept and intercept 0 discussion • Increase connection to work programs
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7. Youth System Intercept 5: Juvenile Community Corrections

Overview: Intercept 5 involves mandated youth supervision and connection to services by juvenile probation and Juvenile Community Corrections (JJC) to further reduce justice involvement of youth. The goal of these programs are 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	<ul style="list-style-type: none"> • Probation services • Community corrections officers • Restorative justice programs • Behavioral health treatment in community • Health Care Managers 	<ul style="list-style-type: none"> • High caseloads for probation officers • Limited access to restorative justice programs • Lack of culturally responsive services 	<ul style="list-style-type: none"> • Reduce caseloads • Expand restorative justice programs • Train staff in cultural competency

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 the five priorities.

At the end of the first day of the Workshop, the UNM BHTAC reviewed the notes taken during the breakout sessions and identified themes (also referred to as Provisional Priority Buckets) that surfaced during the discussion of opportunities. A total of 12 Provisional Priority Buckets were identified and are listed below. During the first session of Day 2, UNM BHTAC presented a summary of the Provisional Priority Buckets and related action items (Appendix A.7). Statewide initiatives that surfaced during the breakout sessions were grouped into an additional category and also included in the PPT in Appendix A.7.

1. Access and Engagement for Youth and Families
2. School-based Supports and Prevention
3. Workforce Development and Sustainability
4. Housing and Basic Needs
5. Crisis Response and Diversion
6. Residential & Intensive Treatment
7. Care Coordination and System Integration
8. Expanding Access to Therapeutic Services
9. Diversion and Early Intervention
10. Specialized Services for High-Needs Youth
11. Re-Entry Coordination and Continuity of Care
12. Education and Vocational Pathways

After the PowerPoint presentation, participants were invited to provide feedback. Through group discussion, the original 12 priorities were refined—some were renamed, some were reorganized—and ultimately consolidated into six priority buckets listed below.

Priority Bucket #1 Prevention

- Access and Engagement for Youth and Families
- School based supports and prevention
- Housing and basic needs
- Education and vocational pathways
- Early Interventions
- Coordination and Continuity of Care

Priority Bucket #2 Workforce Development and Sustainability

- Technical support and funding for community organizations
- Shared understanding of the BH system of care (all components)
- Coordination and Continuity of Care

Priority Bucket #3 Crisis Response

- Access
- System Coordination
- Coordination and Continuity of Care

Priority Bucket #4 System Reform/Integration/Alignment

- Funding for small agencies
- Accreditation and licensing for facility acquisition
- Coordination and Continuity of Care

Priority Bucket #5 System Involved Youth

- Diversion and Deflection from the Justice System
- Reentry or Transition
- Coordination and Continuity of Care

Priority Bucket #6 Access to Appropriate Care

- Expanding access to therapeutic services.
- Specialized services for high-needs youth
- Residential and intensive treatment access
- Care Navigation
- Coordination and Continuity of Care

The six priority buckets were posted on chart paper around the room. Each participant received three dots to mark their top priorities, with each stakeholder group (i.e., health system, legal system, first responders, tribal representatives, government, people with lived experience, and community organizations) using a unique dot color to vote for their highest priorities. The results of the voting by group are summarized in Table 10.

Table 10: Results of Priority Voting by Group

	Health System	Legal System	First Responders	Government	People with Lived Experience	Community Organizations	Tribal Representatives*	Total
Prevention	5	5	1	13	0	7	0	31
Access to Appropriate Care	4	4	0	10	0	4	0	22
System Involved Youth	1	7	1	8	0	3	0	20
Workforce Development and Sustainability	1	1	0	6	0	8	0	16
Crisis Response	2	0	0	5	0	6	0	13
System Reform/ Integration/ Alignment	2	1	1	8	0	1	0	13
Total	15	18	3	50	0	29	0	115

*Isleta Tribal Partners were unable to attend the second day of the event due to staffing shortages

A tie occurred between two categories, with the category Crisis Response and the category System Reform each receiving 13 votes. Participants were asked to vote again to break the tie. System Reform received 18 votes and Crisis Response received 13 votes. There was a proposal to merge Crisis Response with Access to Appropriate Care. The final five priority buckets are listed below.

1. Priority Bucket 1: Prevention (Access, Engagement, School-Based Supports, Housing, Vocational Pathways, Early Intervention)
2. Priority Bucket 2: Access to Appropriate Care/Crisis Response
3. Priority Bucket 3: System-Involved Youth (Diversion & Deflection)
4. Priority Bucket 4: Workforce Development & Sustainability
5. Priority Bucket 5: System Reform / Integration / Alignment

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

After the voting process was completed, participants once again convened into the same breakout groups from the previous day 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, are there additional programs, best practices etc. that need to be identified?
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 priority bucket. While BHTAC facilitators encouraged breakout groups to address the full set of guiding questions, not all groups completed every question. In contrast to the intercept-mapping breakout sessions, facilitators in the prioritization breakout sessions intentionally allowed conversations to evolve organically, recognizing that open dialogue of regional priorities would yield richer insights than rigidly advancing through the question set. As some priority buckets were renamed and reorganized during the large-group session held at the start of the prioritization day (prior to voting), the action items aligned with the five final priority buckets are also presented below.

VI.A Priority Bucket 1: Prevention (Access, Engagement, School-Based Supports, Housing, Vocational Pathways, Early Intervention)

Action Items from the Intercept Mapping Sessions

- Operationalizing Youth Wellness Benefit programs (funding, certification, accessibility).
- Expanding school-based violence prevention programs to all schools (including elementary).
- Ensuring community engagement and outreach beyond schools for disengaged youth.
- Addressing stigma reduction and cultural responsiveness.
- Mapping existing prevention and promotion programs; reducing administrative burden.
- Workforce training for trauma-informed, restorative justice, and culturally appropriate practices.

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

- Integrate Trans Youth Services across all priorities to avoid exclusion and ensure representation
- Ensure youth with disabilities are not left out, including accommodations and disability-inclusive practices.
- Broaden prevention framing:
 - Interest in renaming the bucket to “Prevention, Early Intervention, and Harm Reduction,” or “Prevention, Promotion, Intervention, Harm Reduction” to better capture the full continuum.
 - Messaging should emphasize that prevention is for ALL youth, not only “at-risk” groups.
 - Identify individuals needing services using existing data sources more proactively.
 - Community engagement strategies such as block parties and neighborhood outreach should be emphasized as core program components, not “extras.”
 - School-based violence intervention, including expanding psychoeducational programming to elementary, middle, and high school levels.
 - Gun violence prevention programs led by peers, beyond what APS currently implements.
 - Support for parents, beyond abuse/neglect frameworks, to be strength-based and preventative.
 - Youth wellness benefit programs (e.g., vouchers for sports, arts, community activities).
 - Services for youth who are disengaged or not in school, including paid work opportunities, flexible schedules, and re-engagement supports.

- Culturally appropriate wellness programming and training for all youth-serving professionals.
- Expand priority populations explicitly to:
 - Trans youth
 - Youth with disabilities
 - Poor and marginalized youth
 - Children of undocumented parents
 - Youth not connected to schools

2. Implementation Issues to Consider

Community engagement:

- Engagement must be brought to the community, not dependent on families showing up at institutions.
- Need trusted community-based partners, especially for parental support, respite, and welfare checks, because CYFD involvement may reduce parent trust.
- Must ensure inclusivity and accessibility for marginalized groups (e.g., trans youth, youth with disabilities).

School-based implementation challenges:

- Federal and state funding cuts threaten school-based violence intervention programs.
- Schools cannot absorb new duties. Avoid placing further burdens on teachers; use specialized workforce instead.
- Need programming for home-schooled or out-of-school youth, not only APS students.

Youth Wellness Benefit Program (Voucher-Style Program):

- Whether to use direct-to-family funding (risk: admin burden on families) OR a business/vendor funding model (orgs apply to be reimbursed).
- Developing a vendor certification system similar to SNAP retailers.
- Ensuring low administrative burden for businesses so they are willing to participate.

Need for mapping and inventory:

- Leadership must support mapping of existing prevention, promotion, and intervention programs, including their funding sources and service capacity.

Workforce considerations:

- Many recommendations require specialized workforce expansion (violence intervention, culturally grounded practitioners, wellness professionals).

3. Sustainability Issues to Consider

Funding Stability:

- School-based violence intervention programs face loss of federal/state funding, requiring new long-term funding strategies.
- Need clarity regarding which programs are already well-funded and which need new investments.
- Youth wellness benefit programs require ongoing sustainable funding, possibly through:
 - Medicaid MCOs
 - State universal childcare infrastructure
 - Alternative community-based funding models

Long-term community partnerships:

- Sustainability depends on empowering community organizations and reducing administrative burden so they continue participating as program implementers.
- Maintaining community trust, especially among parents wary of CYFD, requires consistent, reliable, non-punitive support structures.

Inclusive design over time:

- Sustainability requires ensuring that priority populations (trans youth, youth with disabilities, undocumented families, disengaged youth) remain centered in future planning, not treated as add-ons.

Workforce sustainability:

- Retaining a specialized workforce for violence intervention, culturally grounded wellness, and trauma-informed practices requires:
 - Competitive compensation
 - Supportive training systems
 - Clear career pathways

Clear branding and messaging:

- The new framing (Prevention + Promotion + Intervention + Harm Reduction) must be consistently communicated to avoid misuse, misunderstanding, or narrowing of services over time.

VI.B Priority Bucket 2: Access to Appropriate Care/Crisis Response

Action Items from the Intercept Mapping Sessions

- Consideration of the severe lack of RTCs and need for planning (size, type, gender-specific, dual diagnosis).
- Expand mobile response services and crisis stabilization.
- Develop continuum of care (partial hospitalization, transitional care units, respite).
- Address Medicaid reimbursement rates, billing codes, and zoning for group homes.
- Improve family engagement and in-home supports (family preservation models).
- Increase dual diagnosis treatment and culturally appropriate care.
- Reduce waitlists and improve coordination across agencies.

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

Major service gaps and needed programs:

- Lack of Residential Treatment Centers (RTCs) and need to review alternatives such as the Capstone model (Ohio) and Alcove model (California).
- Dual diagnosis treatment programs for youth with co-occurring mental health and substance use needs.
- Specialized group homes for girls with mental-health-specific needs.
- More inclusive access to care, including lowering barriers for youth under age 14.
- Expand mobile response services for youth and ensure community awareness of their availability.

Best practices and models worth adopting:

- Family preservation / intensive in-home therapy models.
- MRSS (Mobile Response and Stabilization Services)
- ABA or skill-building supports in the home
- In-home supports post-discharge to maintain stability
- Open access / treat-first models to simplify entry into behavioral health services.
- More structured group programs, including homogenous group treatment for youth with SUD.

System-level priorities for leadership:

- Strengthen provider and community organization capacity, including addressing burnout.
- Support kinship caregivers and guardians, including expanding program eligibility.
- Ensure culturally appropriate care embedded across service types.
- Holistic supports for youth and families, not just symptom-focused programming.
- Use data to drive decisions—assess actual need before changing or expanding service lines.

2. Implementation Issues to Consider

Service delivery and program design challenges:

- RTCs must provide safe, inclusive environments for trans youth and others with unique needs.
- Need a continuum of housing and service options for youth in crisis. not a single one-size-fits-all model.
- Expand access by bringing services to youth and families, not waiting for self-referral.

Workforce and provider-system challenges:

- Address staff burnout, turnover, and the need to build organizational capacity.

- Need for family counseling to educate families about gender-affirming care, stigma reduction, and suicide-prevention-aligned practices.

Administrative, regulatory, and cross-agency issues:

- Realign RFP evaluation rubrics so community connection and cultural relevance are valued outcomes.
- Reduce burdens on community orgs applying for RFPs.
- Improve coordination across agencies to reduce waitlists and expand access.
- Educate courts on the appropriate use of RTCs, including evidence indicating that they may be ineffective or harmful.
- Address zoning issues affecting group homes.
- Review billing codes and licensure requirements for drop-in urgent care models.

Equity and access considerations:

- Services must be inclusive across ages, accessible to families with barriers such as:
 - Transportation
 - Rigid scheduling
 - Need for in-home delivery

3. Sustainability Issues to Consider

Structural sustainability:

- RTCs may not be effective long-term; relying on them heavily is not sustainable and may produce harm. Systems must build alternatives (in-home models, mobile crisis, group homes).
- Build on existing effective services rather than creating entirely new structures.

Financial sustainability:

- Consider how to:
 - Address Medicaid reimbursement base rates.
 - Remove Gross Receipts Tax for BH providers.
 - Create funding pathways that support mobile response, in-home services, and specialized group homes.

Workforce sustainability:

- Without addressing burnout, retention, and training capacity, programs will not be maintainable over time.

Family and community sustainability:

- Families need ongoing respite, skill-building, therapy, and stabilization supports that continue after treatment episodes. Short-duration interventions are not helpful.

Communication & awareness:

- Sustainability requires strong community awareness campaigns about:
 - Mobile response services
 - Available treatment options
 - Inclusive service pathways

VI.C Priority Bucket 3: System-Involved Youth (Diversion & Deflection)

Action Items from the Intercept Mapping Sessions

- Expand community corrections/connections programs and alternatives to incarceration.
- Increase peer support, navigators, and mentors for justice-involved youth.
- Improve collaboration with tribal communities in the region and clarify leadership roles.
- Provide youth developmental stage training for judges, DAs, PDs, and probation officers.
- Address transportation barriers and create safe access to services.
- Start transition planning at entry, not near discharge.
- Build vocational pathways and paid internships for reentry youth.

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

- Rename Community Corrections Program to Community Connections Program for a more positive framing.
- Expand peer support and navigation services, including:
 - Peer mentors and advocates to help youth overcome “roadblocks.”
 - Navigators who assist with transitions from detention to community services.
- Transportation solutions for youth—public transportation is currently unsafe.
- Access to services in the youth’s home community rather than distant locations.
- Early exit planning for YDTC (Youth Diagnostic and Treatment Center)—start at entry, not 90 days before discharge.
- Increase trade school opportunities for skill-building.
- Explore national models that successfully reduced or eliminated youth detention centers.
- Expand community corrections/connections programs for youth at risk of deeper system involvement.
- Training for all stakeholders (judges, DAs, PDs, POs, school resource officers) on:
 - Maturity assessments.
 - Benefits of treatment vs. discipline.
- TBI (Traumatic Brain Injury) assessments for youth in the juvenile justice system.
- Better understanding of school absence laws, especially for youth with disabilities or health issues.

2. Implementation Issues to Consider

Funding priorities:

- Protect programs at risk due to federal funding changes.
- Invest in alternatives to incarceration (e.g., diversion programs).

Collaboration challenges:

- Improve coordination between counties and tribal communities (Sandia, Isleta).
- Educate stakeholders on tribal youth requirements.

Program design:

- Decide whether to expand existing programs, create new ones, or support small organizations.
- Consider a hub-and-spoke model (large agencies supporting smaller community orgs).

Infrastructure needs:

- County/city partnerships with smaller agencies for brick-and-mortar facilities.

Specific program support:

- Ayuda (drug treatment program).
- Fostering Connections (ages 18–23).

Integrated services:

- Combine disability and mental health supports.

Eligibility adjustments:

- Expand diversion eligibility criteria.

Stakeholder education:

- Ensure consistent language and understanding across systems.

3. Sustainability Issues to Consider

Funding stability:

- Long-term funding strategies for community programs and diversion initiatives.

Scalability:

- Leverage larger agencies to scale programs while supporting smaller organizations.

Community partnerships:

- Maintain collaboration between counties, cities, and tribal entities.

Program continuity:

- Ensure ongoing support for successful programs like Fostering Connections.

Workforce development:

- Train and retain navigators, peer mentors, and specialized staff.

Infrastructure investment:

- Secure permanent facilities for community-based services.

VI.D Priority Bucket 4: Workforce Development & Sustainability

Action Items from the Intercept Mapping Sessions

- Create early career pipelines (high school to CNM/UNM programs).
- Expand peer support certification and training opportunities.
- Address licensure reciprocity and barriers for professionals.
- Increase loan repayment programs and incentives for rural areas.
- Provide paid internships and stipends for youth and early-career professionals.
- Ensure culturally relevant and trauma-informed training for all workforce levels.
- Adjust funding models to include inflation and competitive salaries.

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

- Expand behavioral health services in schools instead of relying on uniformed responders for crises.
- Create workforce pathways for youth:
 - Youth involved in systems could grow into Certified Peer Support Worker (CPSW) roles.
 - Internship programs between mental health facilities and UNM training programs with paid incentives.
 - Utilize the Center for Innovation for youth peer support certification.
 - Remove barriers for youth becoming peer support workers (e.g., felony history).
- Leadership and mentorship development programs for youth and early-career professionals.
- New certification levels:
 - Bachelor's-level LADAC or behavioral health management specialist certifications.
 - Bridge gap between bachelor's and master's level skills.
- Early career pipeline programs:
 - CNM program starting Feb 2026 to recruit students into social work and counseling.
 - Model from Alaska: introduce high school students to behavioral health careers.
- Culturally relevant and trauma-informed training for workforce and administration to drive organizational and systems-level change.
- Expand employment programs for youth re-entering after juvenile justice involvement and disengaged youth.
- School-based APS Academies of ABQ: workforce engagement with paid internships.
- Add family, adult, and peer support roles to RFPs.
- Identify training for child psychiatric nurse practitioners.
- Develop trauma-informed and restorative justice training for educators and school staff.

2. Implementation Issues to Consider

Address workforce barriers:

- Low pay compared to other jobs (e.g., waiting tables).
- Licensing challenges and caps on enrollment in UNM programs.
- APS requires master's degree for counselors but hires at bachelor's level.
- Small applicant pool in NM.
- Supervision and support for CPSWs must be high-quality and ongoing.
- Pair CPSW pathways with diversion programs for better integration.
- Incentives and rewards to retain professionals in BH and school systems.

Policy and funding constraints:

- Medicaid ABA restrictions (only for autism diagnosis in NM).
- Flat funding for providers. They need inflation-adjusted increases.
- Federal changes in professional identification requirements.

Collaboration with educational institutions:

- CNM and UNM programs for pipeline development.

Organizational readiness:

- Ensure trauma-informed and culturally relevant practices extend to administration.

3. Sustainability Issues to Consider

Funding stability:

- Build inflation index into funding opportunities.
- Provide salary increases and benefits to retain workforce.

Workforce development:

- Maintain early pipeline programs and certifications.
- Incentivize long-term careers in behavioral health through stipends and paid internships.

Systemic changes:

- Organizational and cultural shifts to support trauma-informed practices.

Career progression:

- Create clear pathways from entry-level roles to advanced positions.

Partnerships:

- Ongoing collaboration between schools, higher education, and behavioral health facilities.

VI.E Priority Bucket 5: System Reform / Integration / Alignment

Action Items from the Intercept Mapping Sessions

- Develop shared standards, language, and accountability across systems.
- Create centralized data systems (e.g., Falling Colors dashboard).
- Require collaboration in RFPs and provide compensation for after-hours work.
- Address coordination gaps between county, state, and tribal entities.
- Explore Medicaid waiver innovations and local funding streams (e.g., GRT allocation).
- Provide technical support and funding for small agencies to scale services.

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

- Require collaboration in RFPs to ensure that proposals include multi-agency buy-in.
- Compensation for after-hours work: Weekends and evenings for staff supporting youth.
- Explore Medicaid waiver innovations for expanded service options.
- Improve coordination across entities to reduce duplication and gaps.
- Engage providers early: Validate feasibility of proposed plans and identify barriers before rollout.
- Monthly cross-agency meetings: Child-serving organizations convene regularly for alignment.
- Develop centralized data systems for tracking utilization patterns and addressing needs (including for transgender youth).
- Create reports on utilization patterns: Show travel distances and service access for youth statewide.

2. Implementation Issues to Consider

Funding and compensation:

- Pay for monthly meetings among child-serving organizations.
- Provide incentives for after-hours work.

System reform accountability:

- Clarify who is responsible for leading transformation when agencies (e.g., CYFD) are already overburdened.

Shared standards and language:

- Prioritize integration and alignment across systems.

Regional implementation:

- Consider how Region 2 could adopt local strategies for system transformation.

Potential role of HCA/BHSD:

- These agencies could lead or support system-wide changes.

Data and reporting:

- Address concerns about centralized data systems for sensitive populations (e.g., transgender youth).
- Develop utilization reports to inform planning.

3. Sustainability Issues to Consider

Ongoing funding for collaboration:

- Ensure compensation for recurring meetings and after-hours work is built into budgets.

Institutionalizing shared standards:

- Embed common language and practices into policies and contracts.

Long-term data infrastructure:

- Maintain centralized systems for tracking and reporting utilization.

Provider engagement:

- Continue dialogue with providers to adapt plans and remove barriers over time.

Regional and statewide alignment:

- Sustain partnerships between counties, state agencies, and local organizations.

VII. List of Appendices

A.1 Map of Behavioral Health Regions

A.2 Acronym List

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

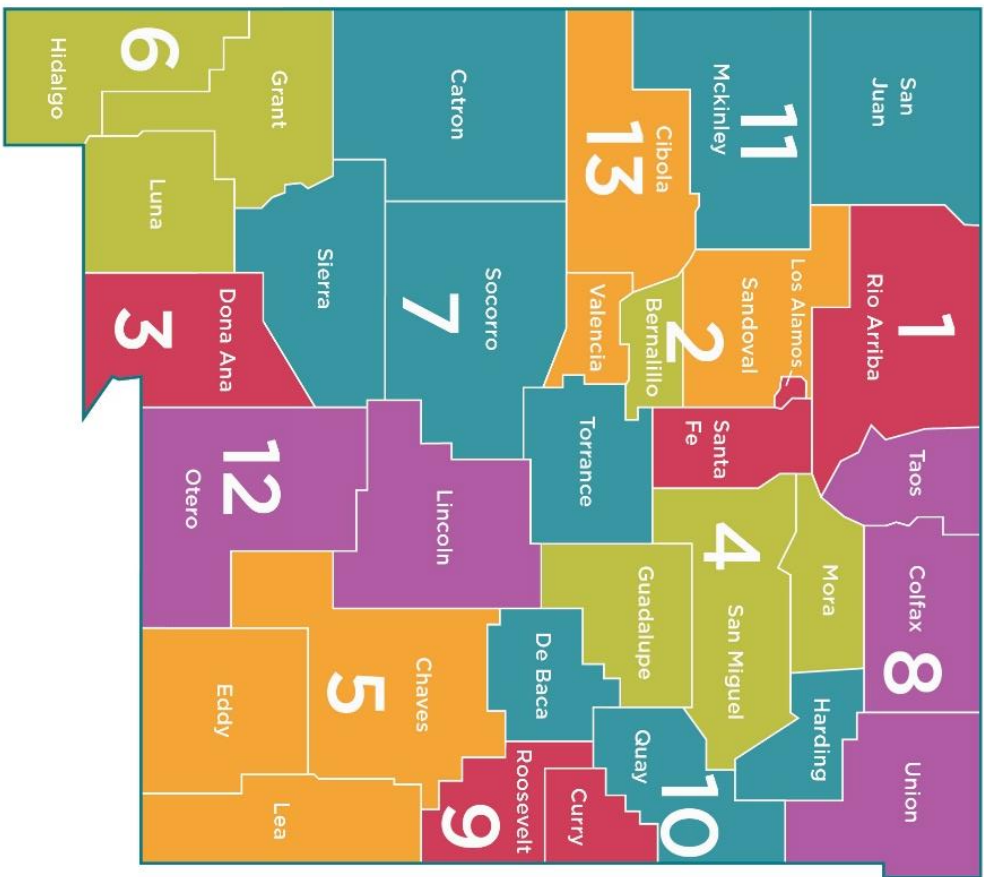
A.4 Workshop Agenda

A.5 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



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

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

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

- Region 6**
- Fort Still Apache Tribe

- Region 12**
- Mescalero Apache Tribe

- Region 8**
- Taos Pueblo
 - Picuris Pueblo

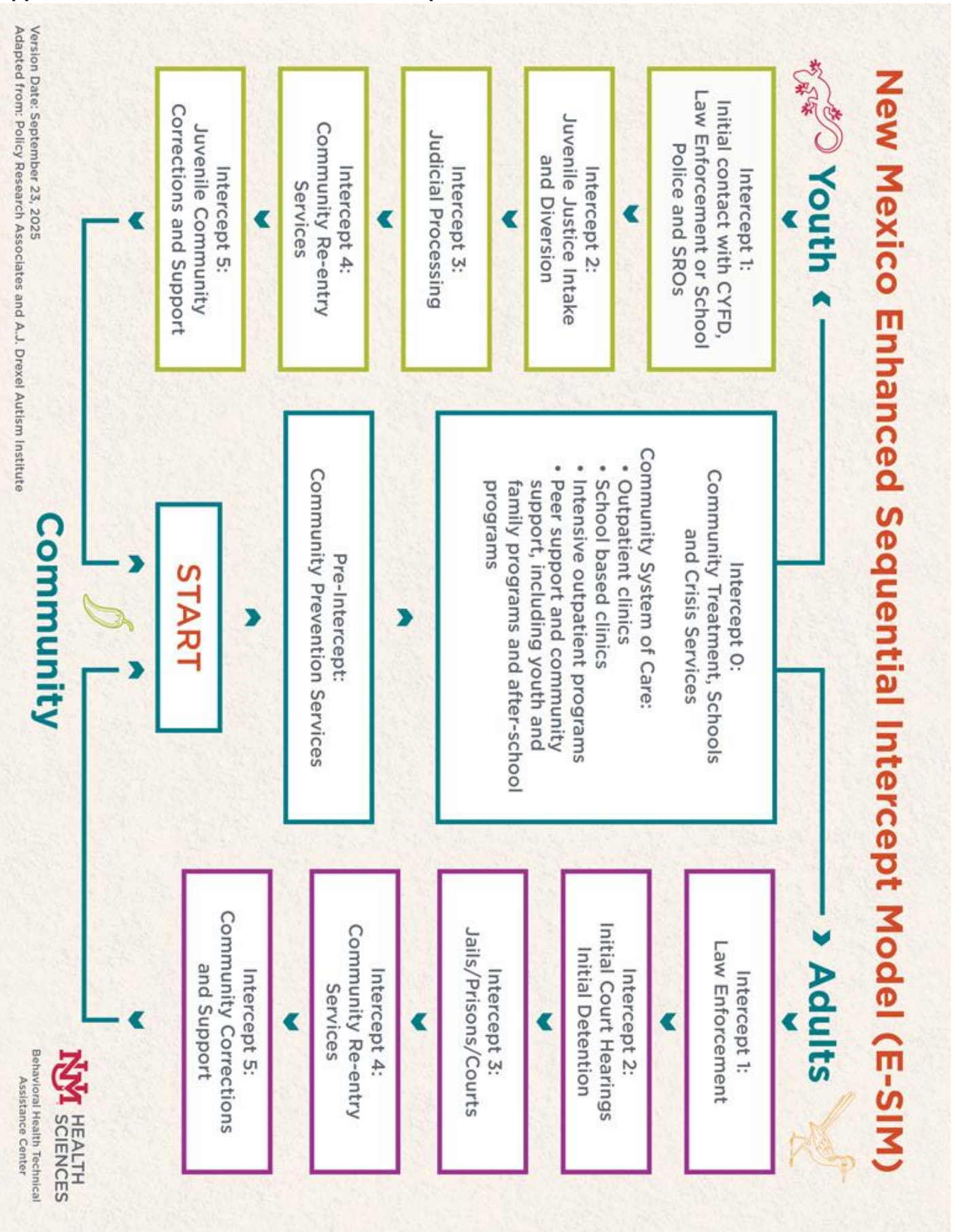
- Region 13**
- Pueblo of Laguna
 - Pueblo of Acoma
 - Pueblo of Cochiti
 - Pueblo of Jemez
 - Pueblo of Zia
 - Pueblo of Santa Ana
 - Santo Domingo Pueblo
 - Pueblo of San Felipe

Appendix A.2: Acronym List

Acronyms List

ACEs	Adverse Childhood Experiences ACT	IHS	Indian Health Service
ADA	American Disabilities Act	IOP	Intensive Outpatient Treatment JJAC Juvenile Justice Advisory Committee JJC Juvenile Community Corrections
AHEC	Area Health Education Center	JJS	Juvenile Justice System
AOC	Administrative Office of the Courts	JJTS	Juvenile Justice Transition Services JPO Juvenile Probation Officer
AOT	Assertive Outpatient Therapy	JPSAB	Juvenile Public Safety Advisory Board JRC Juvenile Reintegration Center
BH	Behavioral Health	LADAC	Licensed Alcohol & Drug Abuse Counselor LC Local Collaborative
BHRIA	Behavioral Health Reform & Investment Act	LCSW	Licensed Clinical Social Worker
BHSD	Behavioral Health Services Division CAPTA Child Abuse Prevention & Treatment Act	LEO	Law Enforcement Officer
CARA	Comprehensive Addiction & Recovery Act	LPCC	Licensed Practical Clinical Counselor
CASA	Court-appointed Special Advocate	MAT	Medication Assisted Treatment MCO Managed Care Organization
CCA	Children’s Court Attorney	MCT	Mobile Crisis Team
CCBHC	Certified Community Behavioral Health Center	MHFA	Mental Health First Aid
CCSS	Comprehensive Community Support Services	MI	Motivational Interviewing
CERT	Community Emergency Response Team CHR Community Health Representative	MOUD	Medication for Opioid Use Disorder MRSS Mobile Response & Stabilization Service
CHW	Community Health Worker	MST	Multisystemic Therapy
CIT	Crisis Intervention Team CPSW Certified Peer Support Worker	NMCD	NM Corrections Department
CRAFT	Community Reinforcement & Family Therapy	OD	Opioid Use Disorder
CSW	Community Support Worker	PHP	Partial Hospitalization Hospital
CTC	Crisis Triage Center	PO	Probation/Parole Officer
CYFD	Children, Youth, and Families Department	QPR	Question, Persuade, Refer
FACT	Forensic Assertive Community Treatment	RTC	Residential Treatment Center
FINS	Family In Need of Services	SBIRT	Screening, Brief Intervention & Referral to Treatment
FFT	Functional Family Therapy	SED	Serious Emotional Disturbance
HC	Health Council	SIM	Sequential Intercept Mapping
HCA	Health Care Authority	SMI	Serious Mental Illness
HERO	Health Extension Regional Office	SR	Supervised Release
HFW	High Fidelity Wraparound	SRO	School Resource Officer
HIE	Health Information Exchange	SUD	Substance Use Disorder SYO Serious Youthful Offender
ICWA	Indian Child Welfare Act	TSC	Transition Service Coordinator
IGA	Intergovernmental Agreement	YO	Youthful Offender

Appendix A.3: The New Mexico E-SIM Conceptual Model



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

Appendix A.4: Workshop Agenda

E-SIM Mapping and Prioritization Workshop Bernalillo County/ Region 2

Thursday, November 20 - Friday, November 21, 2025

Theme: Children, Youth, and Families

Thursday, November 20th — Bernalillo County Building, Albuquerque, NM

Day 1: Mapping of Youth System

- 8:00 AM  Workshop open for Registration, Networking and Light Breakfast
— Ken Sanchez Commissioners Chambers First Floor
- 8:30 AM  Welcome and Overview of Goals for the Next Two Days
— Ken Sanchez Commissioners Chambers First Floor
 - Teresa Gomez, UNM Department of Psychiatry and Behavioral Sciences
 - Dr. Wayne W. Lindstrom, Bernalillo County Deputy County Manager
 - The Honorable David K Thomson, Chief Justice
 - The Honorable Alma Cristina Roberson, Children’s Court Presiding Judge
 - Heather Coyningham, In Partnership with the National Alliance on Mental Illness (NM) and Bristol Myers Squibb
- 9:00 AM  Overview of Bernalillo County Epidemiological and Medicaid Snapshot
— Ken Sanchez Commissioners Chambers First Floor
 - Caroline Bonham, MD, UNM Department of Psychiatry and Behavioral Sciences
- 9:15 AM  Pre-Intercept (Prevention): Mapping Existing Services, Gaps and Opportunities
— Breakout Rooms
- 10:30 AM  Break
- 10:40 AM  Intercept 0: Mapping Existing Services, Gaps and Opportunities
— Breakout Rooms
- 12:00 PM  Lunch
- 12:45 PM  Mapping Intercept 1
— Breakout Rooms
- 1:30 PM  Break
- 1:45 PM  Mapping Intercept 2 and 3
— Breakout Rooms
- 3:00 PM  Break
- 3:15 PM  Mapping Intercept 4 and 5
— Breakout Rooms
- 4:30 PM  Wrap-up and Overview of Goals for Prioritization
— Ken Sanchez Commissioners Chambers First Floor
 - Teresa Gomez, UNM Department of Psychiatry and Behavioral Sciences

Breakout Room 1
Juniper Conference Room, Seventh Floor Room 7W02

Breakout Room 2
Pinon Conference Room, Seventh Floor 7W07

Breakout Room 3
Chambers Conference Room, First Floor 1W11

















E-SIM Mapping and Prioritization Workshop Bernalillo County/ Region 2

Thursday, November 20 - Friday, November 21, 2025

Theme: Children, Youth, and Families

Friday, November 21st — Bernalillo County Building, Albuquerque, NM

Day 2: Prioritization

- 8:00 AM  Workshop open for Registration, Networking and Light Breakfast
— Ken Sanchez Commissioners Chambers First Floor
- 8:30 AM  Welcome and Overview of Goals for the Next Two Days
Review of Discussion from Previous Day with Suggested List of Priorities
— Ken Sanchez Commissioners Chambers First Floor
 - Teresa Gomez, UNM Department of Psychiatry and Behavioral Sciences
- 9:30 AM  Agreement and Consolidation of Priorities for Voting
— Ken Sanchez Commissioners Chambers First Floor
- 10:00 AM  Silent Ranking Using Dots for Final Priority List
— Ken Sanchez Commissioners Chambers First Floor
- 10:15 AM  Break
- 10:30 AM  Review Top 5 Priorities Based on Voting
— Ken Sanchez Commissioners Chambers First Floor
- 11:00 AM  Small Group Discussions of Priority 1
— Breakout Rooms
- 12:00 PM  Networking Lunch
- 12:45 PM  Small Group Discussions of Priority 2
— Breakout Rooms
- 1:45 PM  Small Group Discussions of Priority 3
— Breakout Rooms
- 2:45 AM  Break
- 3:00 PM  Small Group Discussions of Priority 4 and 5
— Breakout Rooms
- 4:00 PM  Review Priorities Together as a Large Group
— Ken Sanchez Commissioners Chambers First Floor
 - Teresa Gomez, UNM Department of Psychiatry and Behavioral Sciences
- 4:45 PM  Thank you and Provide Next Steps
— Ken Sanchez Commissioners Chambers First Floor
 - Dr. Bronwyn Neeser, Hive Consulting Firm, LLC

Breakout Room 1
Ocotillo Conference Room, Seventh Floor 7w08

Breakout Room 2
Pinon Conference Room, Seventh Floor 7W07

Breakout Room 3
Ponderosa Conference Room, Seventh Floor 7W09



Behavioral Region 2 vs The State of New Mexico

Examining behavioral health disorder diagnoses, and utilization of services, facilities and infrastructure in Behavioral Region 2 compared to the state of New Mexico.

County in Behavioral Region 2(BR2): Bernalillo

Objective

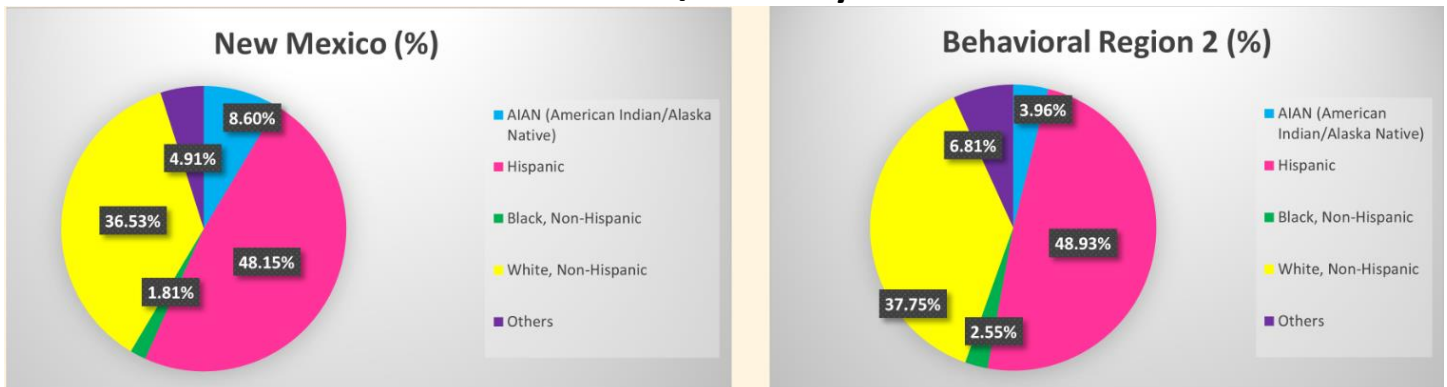
To compare Behavioral Region2 (Bernalillo) with the state on below characteristics

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

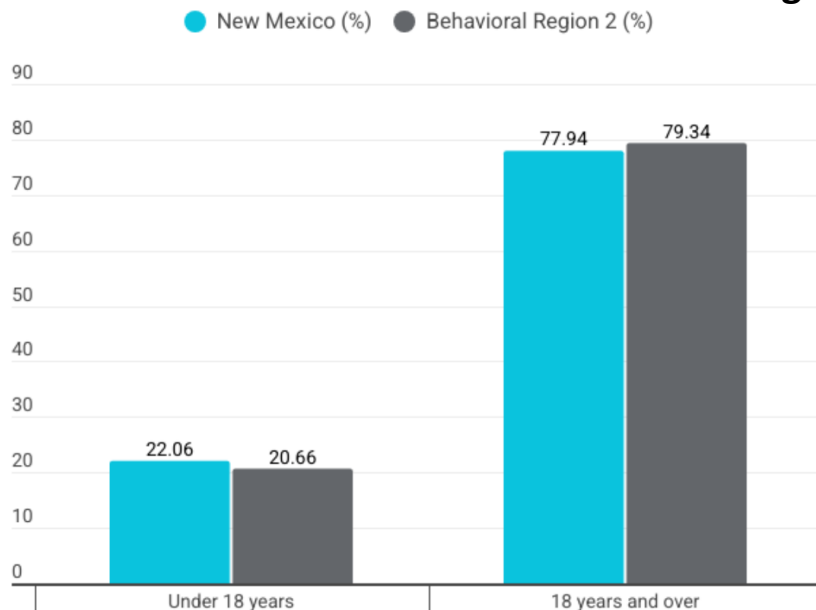
Demographic Comparison

Key demographic factors reveal significant regional variations

Race/Ethnicity



Age Distribution – New Mexico vs. Behavioral Region 2

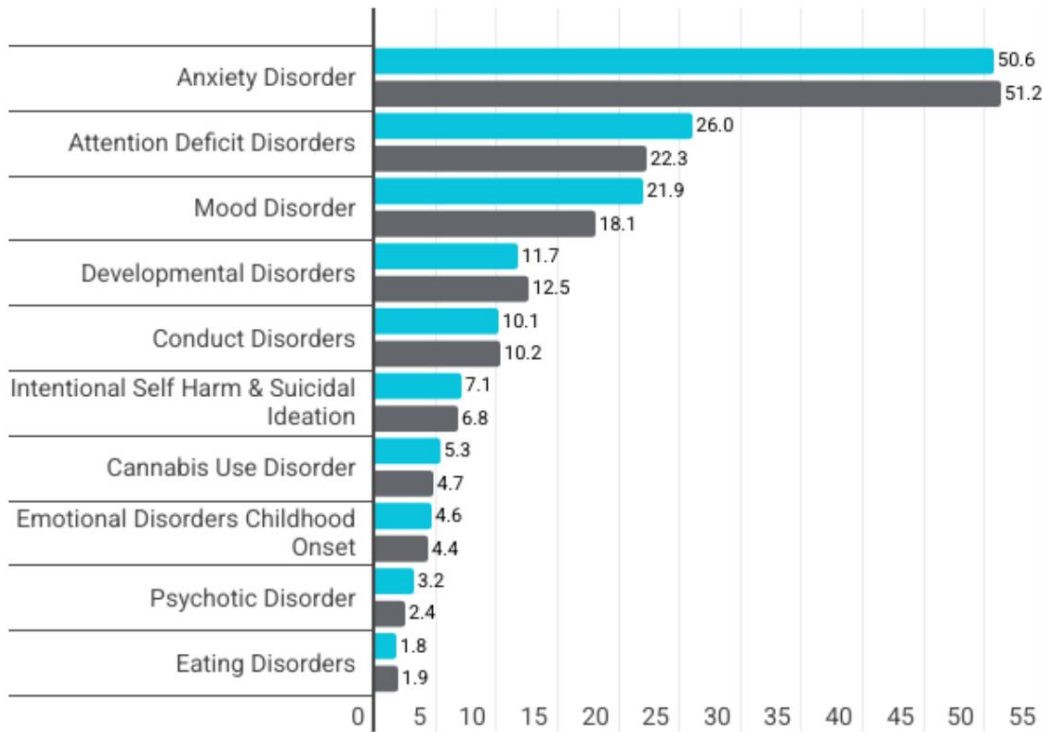


Top 10 behavioral health disorder diagnosis by age group

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

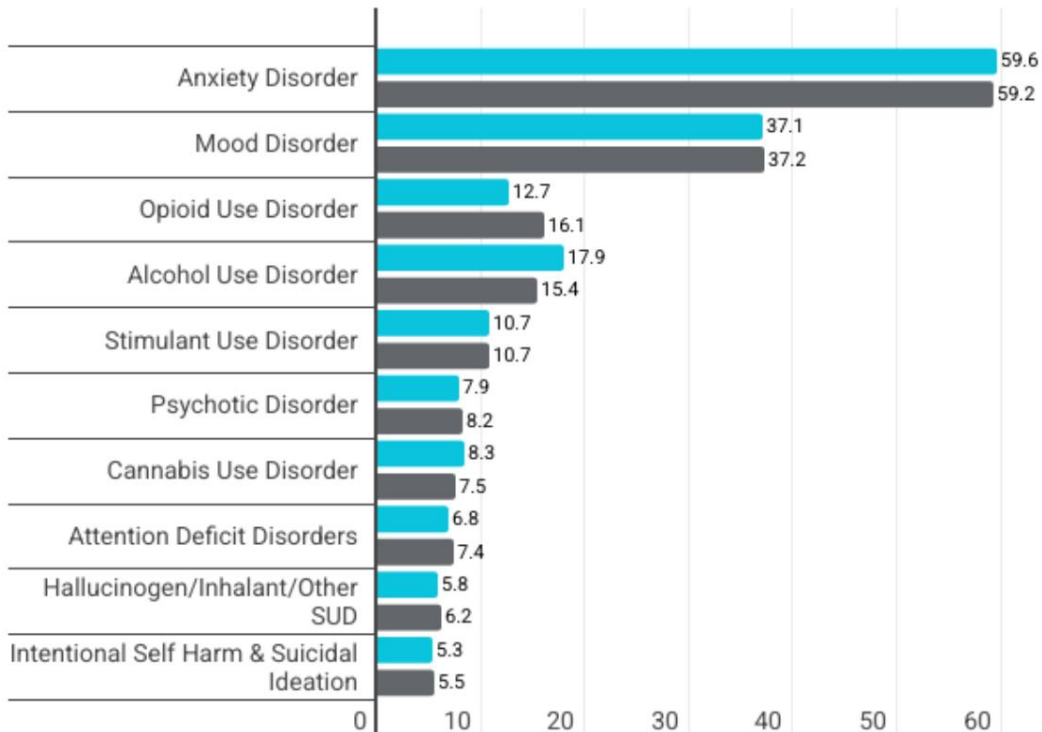
<18-year-olds – New Mexico vs. Behavioral Region 2

● New Mexico (%) ● Behavioral Region 2 (%)



18+ New Mexico vs Behavioral Region 2

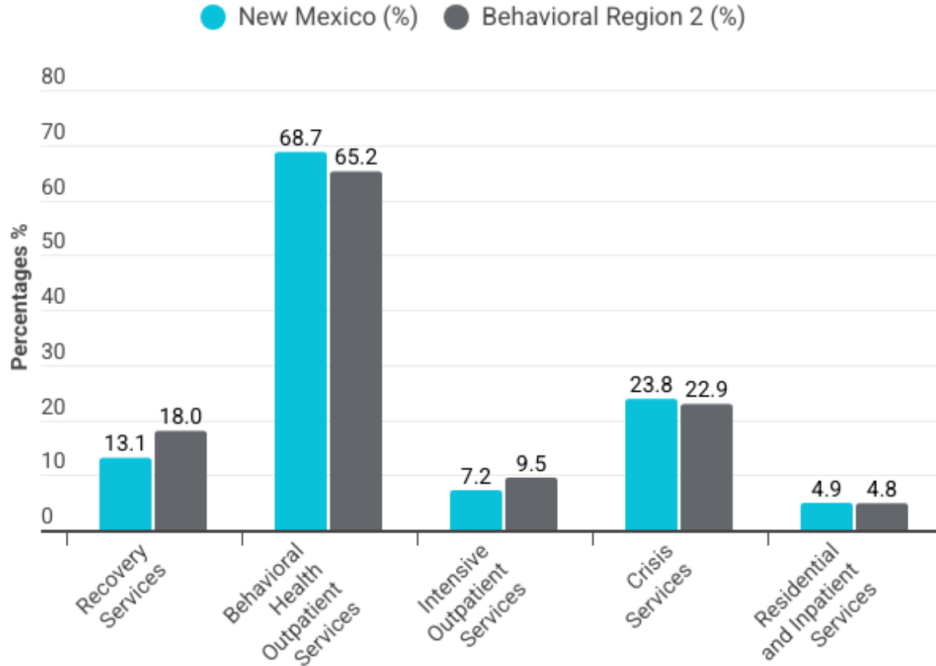
● New Mexico (%) ● Behavioral Region 2(%)



Service Utilization

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

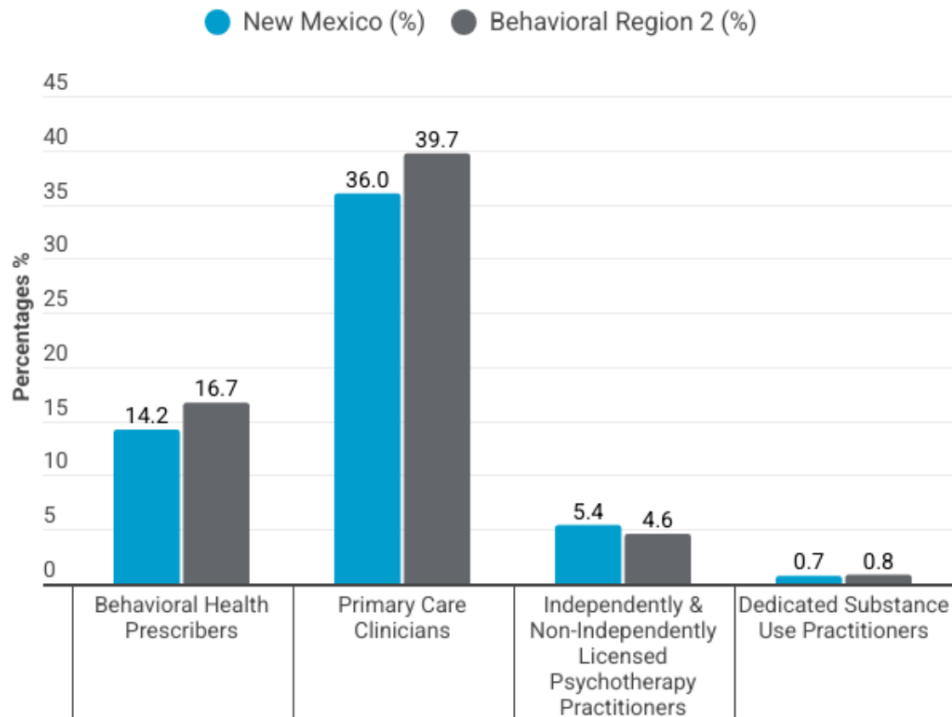
Service Types – New Mexico vs. Behavioral Region 2



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.

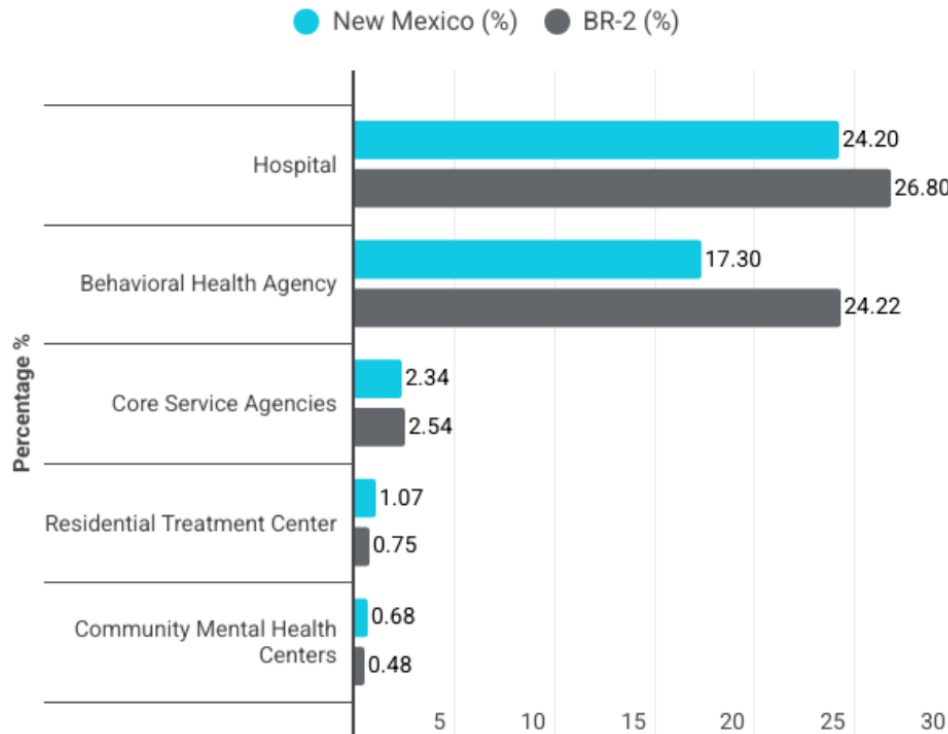
Individuals on Medicaid are more likely to have at least one contact with a prescriber than with a therapist in a calendar year.



Infrastructure Utilization

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

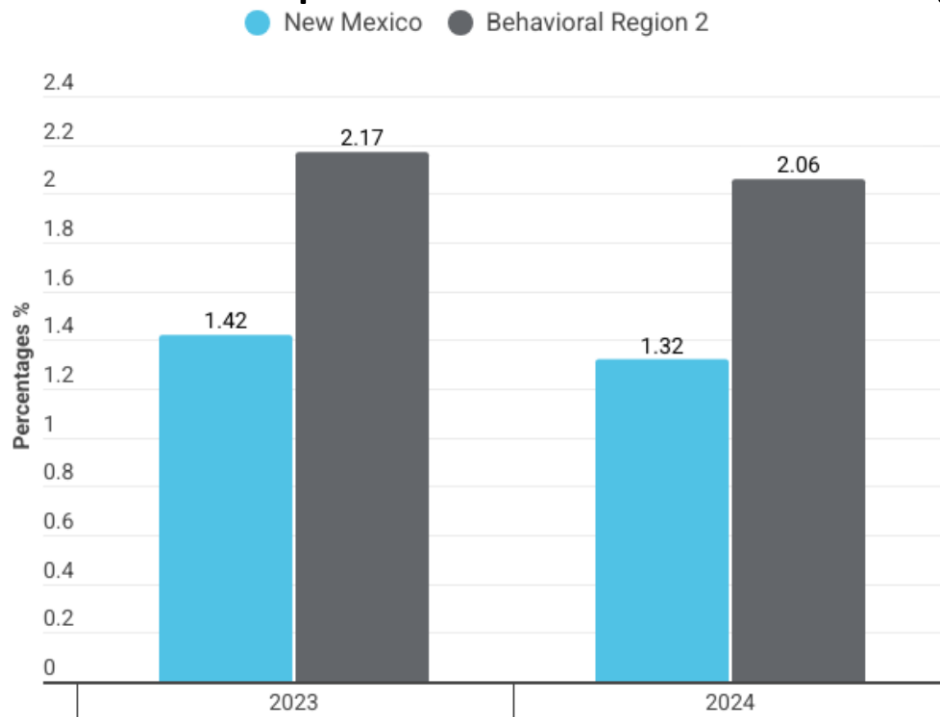
Infrastructure Type – New Mexico vs. Behavioral Region 2



Crisis Call per Capita

Percentage of population who made a crisis call.

Crisis Call Rate Per Capita – New Mexico vs. Behavioral Region 2

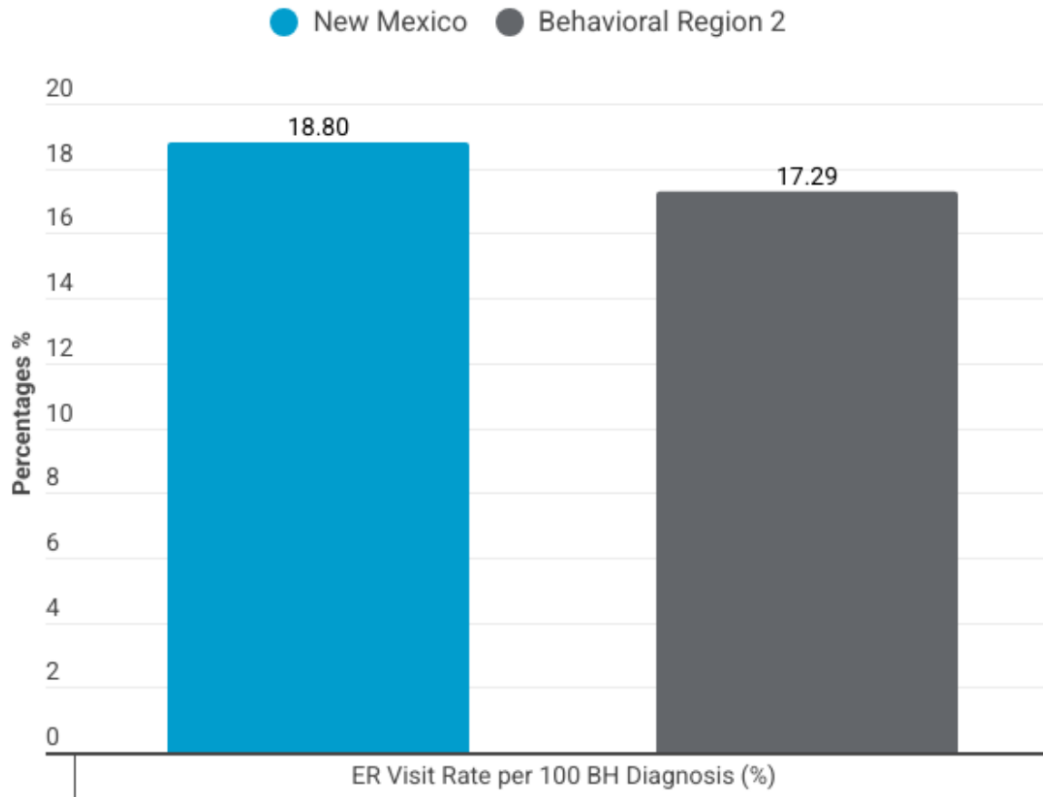


Crisis Call per Capita (cont.)

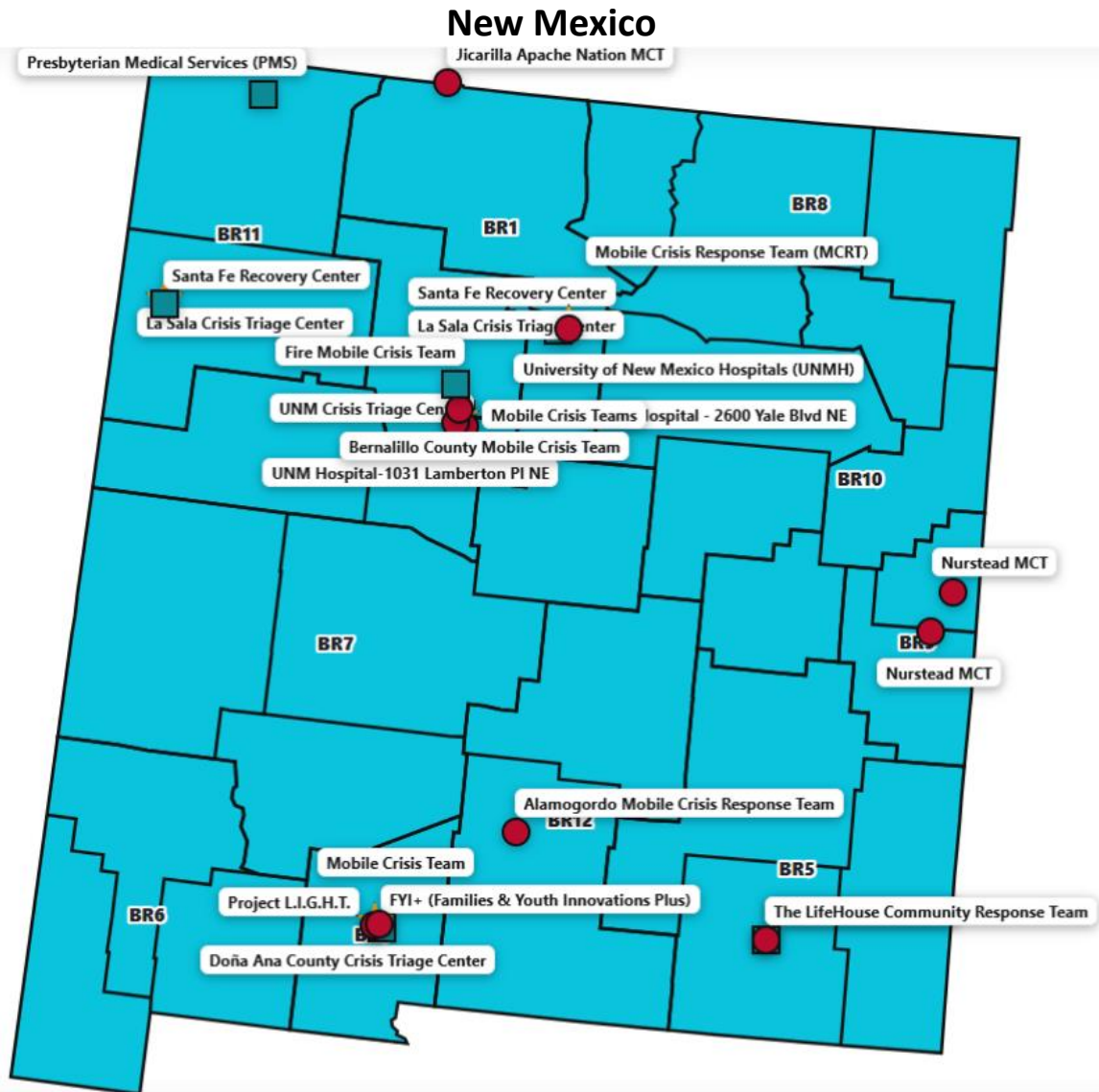


Emergency Room Utilization

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



CCBHC, CTC, Mobile Crisis



● Mobile Crisis Team
 ■ CCBHC
 ★ Crisis Triage Center

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

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

Behavioral Region 2



● Mobile Crisis Team
 ■ CCBHC
 ★ Crisis Triage Center

Name	County	BR	Address	Zip Code	Type
UNM Hospital	Bernalillo	BR2	2600 Yale Blvd NE	87106	CCBHC
	Bernalillo	BR2	1031 Lambertson PI NE	87107	
	Bernalillo	BR2	2600 Marble Ave NE	87106	
UNM Crisis Triage Center	Bernalillo	BR2	2600 Marble Ave NE	87106	Crisis Triage Center
Mobile Crisis Teams	Bernalillo	BR2	1210 San Mateo Blvd SE	87108	Mobile Crisis Team
Bernalillo County Mobile Crisis Team	Bernalillo	BR2	415 Silver Avenue SW, Albuquerque, NM 87102	87102	Mobile Crisis Team
Fire Mobile Crisis Team	Bernalillo	BR2	6840 2nd St NW Ste 301, Albuquerque, NM 87107	87107	Mobile Crisis Team

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 (BR2)	
	Beneficiary N=217,656	%	Beneficiary N=65,191	%
Recovery Services	28,500	13.09%	11,710	17.96%
PSW	4,707	2.16%	1,456	2.23%
CCSS	20,270	9.31%	8,906	13.66%
PSR	362	0.17%	135	0.21%
CSW	7,215	3.31%	2,769	4.25%
FSW	155	0.07%	35	0.05%
CHW	0	0.00%	0	0.00%
BMS	1,113	0.51%	132	0.20%
BT	2,044	0.94%	944	1.45%
BHOP Services	188,968	86.82%	55,523	85.17%
BH Workforce	106,765	49.05%	34,738	53.29%
BH-Prescribers	32,061	14.73%	10,879	16.69%
Psychiatrist	10,700	4.92%	5,613	8.61%
PsyNursePract	20,228	9.29%	5,343	8.20%
PrescPsychologist	2,704	1.24%	426	0.65%
PrimaryCare	78,429	36.03%	25,905	39.74%
Independently and Non-Independently Licensed Psychotherapy Practitioners	11,814	5.43%	3,026	4.64%
Psychologist	861	0.40%	169	0.26%
LCSW/LISW	4,824	2.22%	892	1.37%
LPCC	4,506	2.07%	1,417	2.17%
LPAT	27	0.01%	0	0.00%
LMFT	482	0.22%	148	0.23%
LMSW	1,225	0.56%	309	0.47%
LMHC	1,533	0.70%	405	0.62%
LAMFT	48	0.02%	2	0.00%
Dedicated Substance Use Practitioners	1,480	0.68%	410	0.63%
LADAC	629	0.29%	155	0.24%
LSAA	882	0.41%	260	0.40%
CADAC	0	0.00%	0	0.00%
Intensive Outpatient Services	15,741	7.23%	6,225	9.55%
IOP	12,049	5.54%	5,660	8.68%
PartialHosp	1,051	0.48%	92	0.14%
ACT	1,555	0.71%	262	0.40%
MST	1,455	0.67%	342	0.52%
FFT	11	0.01%	4	0.01%
HEDIS	1,073	0.49%	97	0.15%
Crisis Services	51,804	23.80%	14,914	22.88%
ED	41,094	18.88%	11,409	17.50%
UrgentCare	21,369	9.82%	7,031	10.79%
MobileCrisis CTC	1,854	0.85%	464	0.71%
Crisis Intervention	1,476	0.68%	450	0.69%

New Mexico Mortality Rates

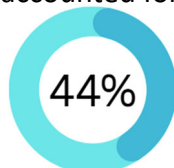
Examining Suicide Deaths, Alcohol-Related Deaths, and Drug Overdose Deaths in the state of New Mexico

Overview

Overall Crisis

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

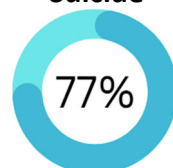
In 2021, these causes accounted for



of all deaths among residents aged 12–34

Rates far exceed national averages:

Suicide



higher than U.S. average

Drug-induced deaths:



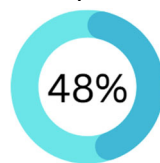
Demographics & Geography



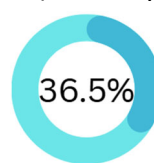
Population: 2.1 million

Race/Ethnicity:

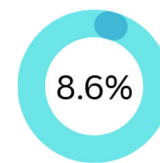
Hispanic



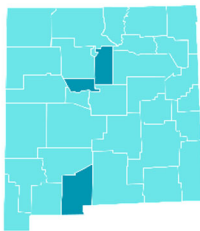
White (non-Hispanic)



Native American



Urban concentration:



50% of residents live in

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

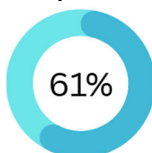
Rural/frontier context:



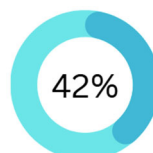
25 of 33 counties have <15 people per square mile, limiting access to care

Comorbidity of Mental Health and Substance Use

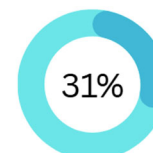
Youth (Grades 9–12):



report mental health concerns

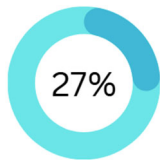


use ≥1 substance

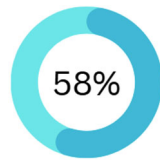


have both (co-occurring mental health + substance use disorder)

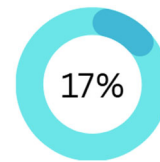
Adults:



report mental health concerns

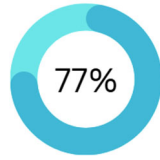


use ≥1 substance



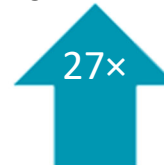
have both (co-occurring mental health + substance use disorder)

Substance Use:



of youth suicide attempters used at least one substance

Youth using **4+ substances** were



more likely to be injured in a suicide attempt

Alcohol-Related Deaths

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

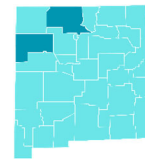
1 in 5 deaths among working-age adults



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

Alcohol misuse linked to

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



Highest Rates by NM County: McKinley, Rio Arriba

Drug Overdose Deaths

- Overdose death rate has tripled since 1990

Recent surges in



methamphetamine and fentanyl deaths



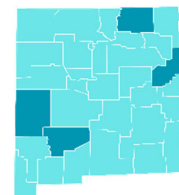
Substance use costs New Mexico about \$890 million annually (as of 2007)



Highest Rates by NM County: Bernalillo, Rio Arriba

Suicide & Mental Health

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



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

Populations at Highest Risk

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

Equity and Systemic Context

Health disparities are amplified by



- rural isolation
- economic
- inequality
- historical trauma

Urgent need for prevention intervention efforts that are:



- integrated
- culturally responsive
- equity-driven

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

Demographics: New Mexico

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

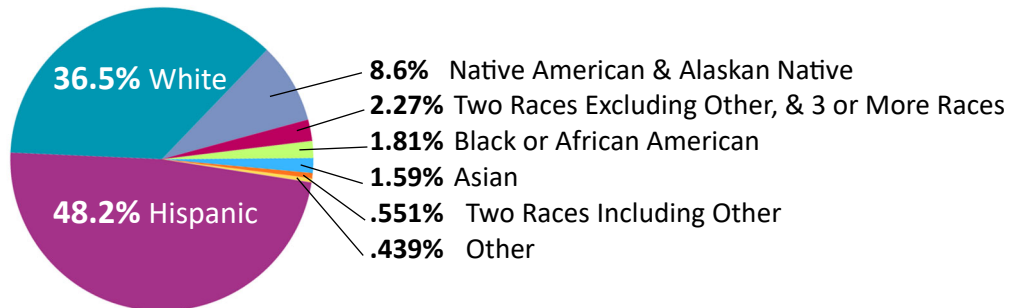
Population

Source: U.S. Census

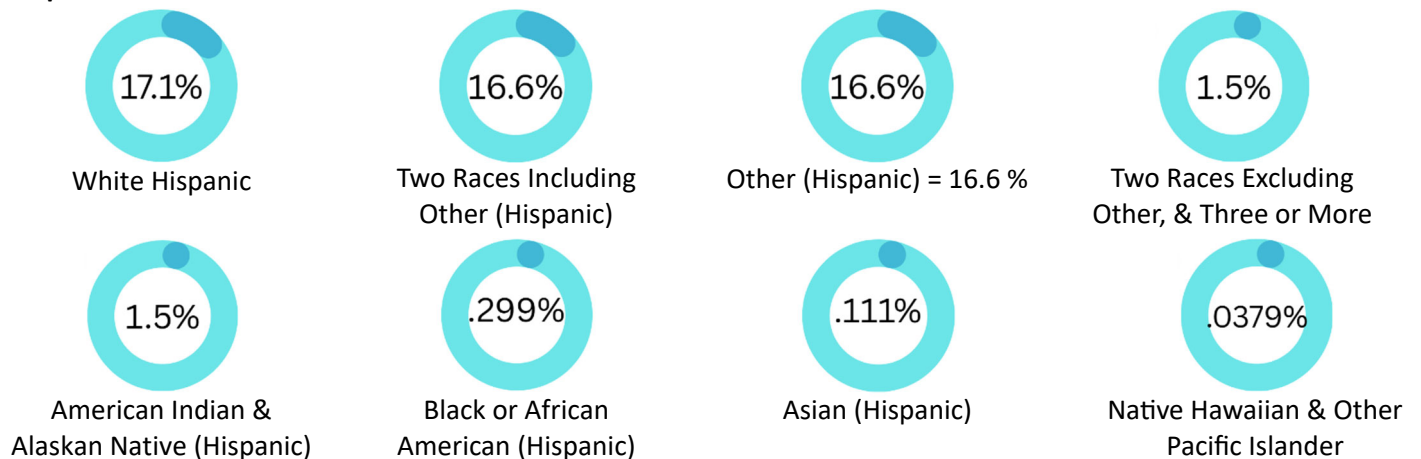


Population: 2,117,522

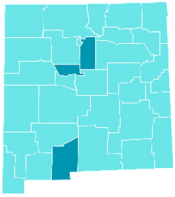
Race/Ethnicity



Hispanic breakdown:



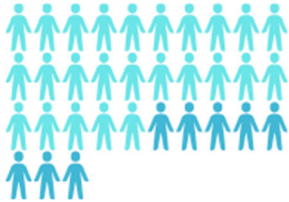
Rural/Frontier



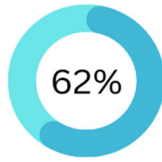
50% of residents live in

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

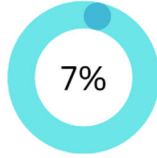
These 3 counties make up only 6% of the state's total land area



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

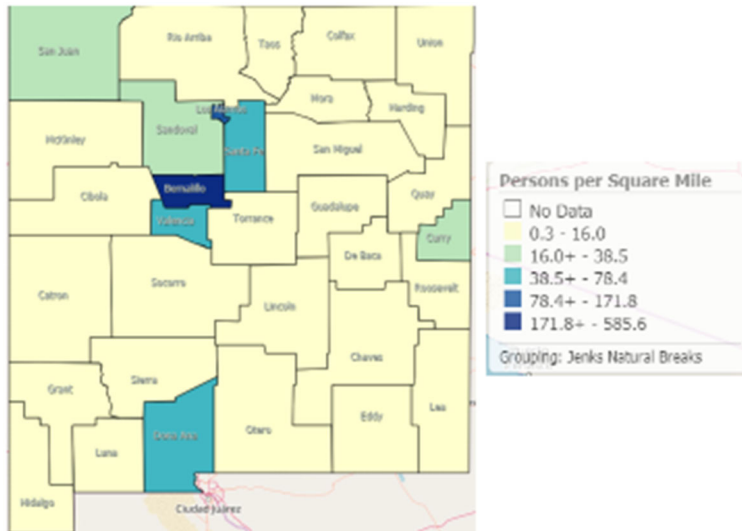


62% of the population resides in seven urban counties (including Bernalillo County, home to one-third of the state's residents)



7% 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>

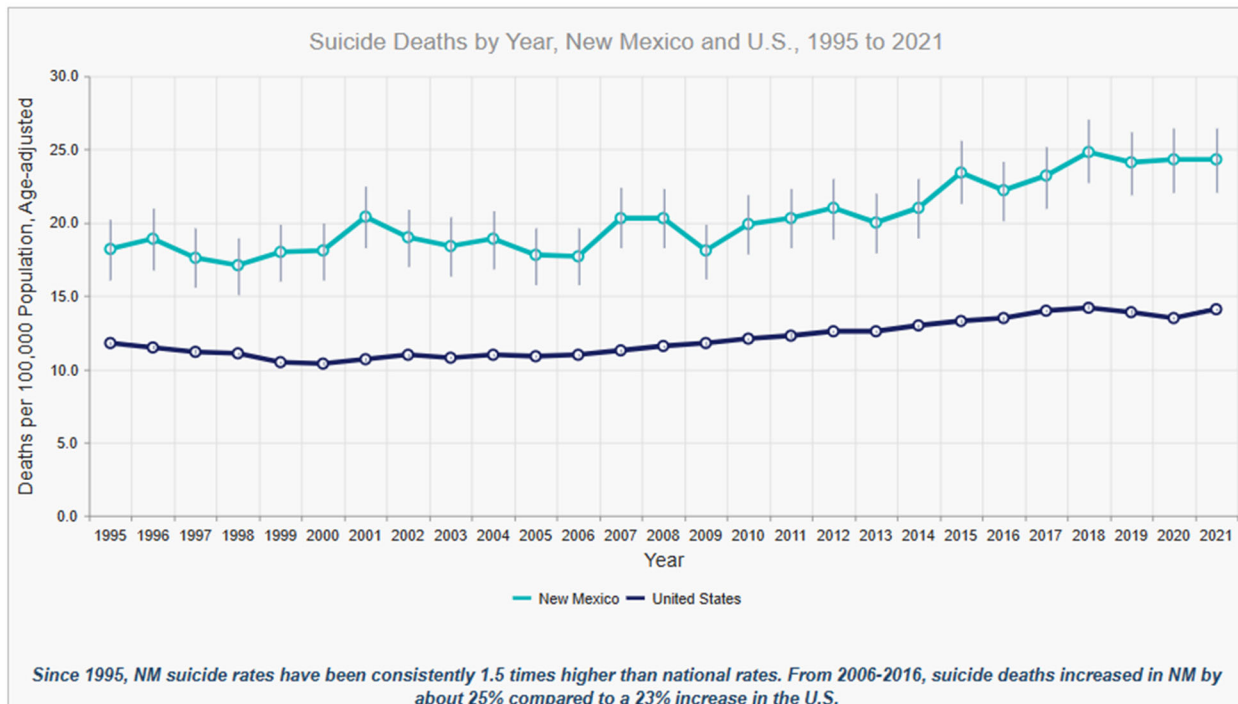
The suicide death rate is defined as the number of deaths attributed to suicide per 100,000 population.

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:

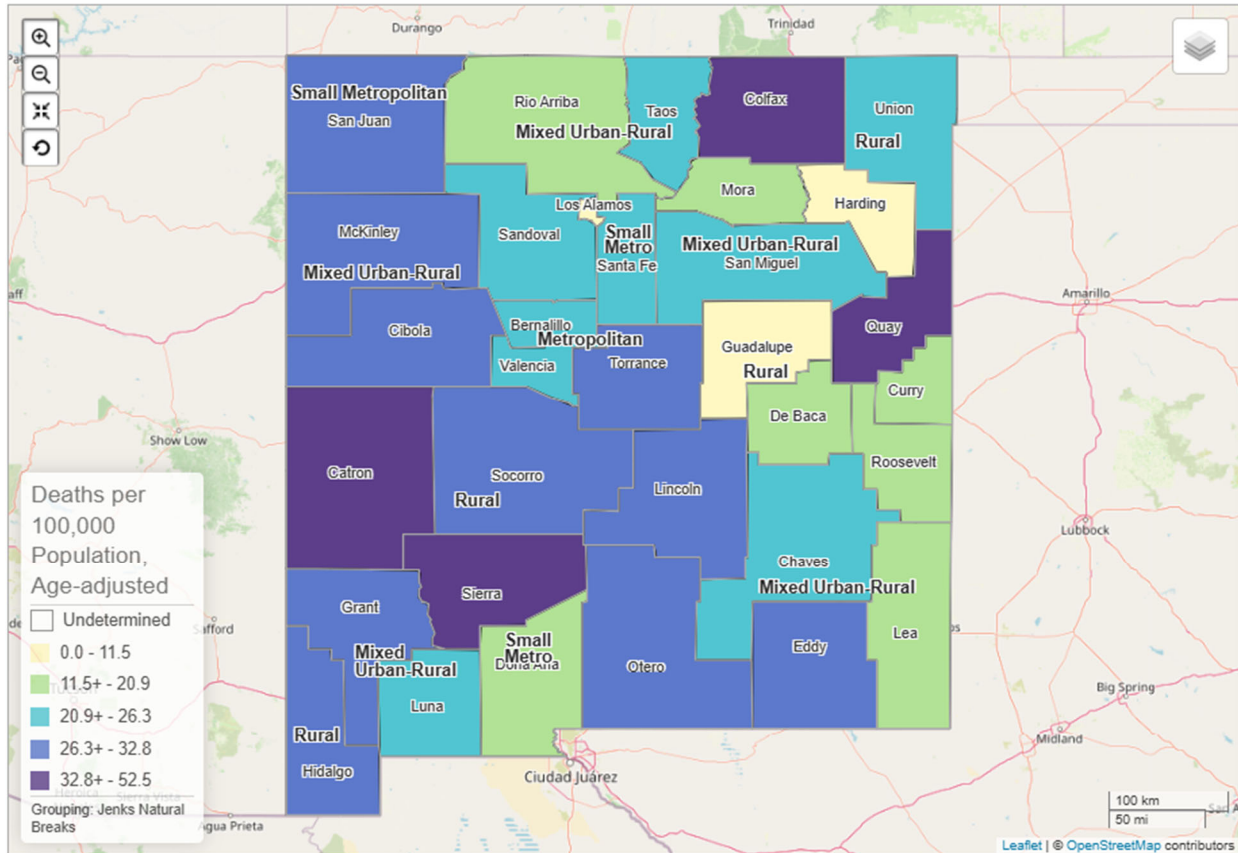
<ul style="list-style-type: none"> ○ Mental disorders, especially clinical depression ○ Previous suicide attempt ○ Alcohol and substance abuse ○ Family history of suicide ○ History of child maltreatment 	<ul style="list-style-type: none"> ○ Feelings of hopelessness or isolation ○ Barriers to mental health treatment ○ Loss (relationships, social connections, employment, finances) ○ Physical illness
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Suicide Deaths by Year, NM and US



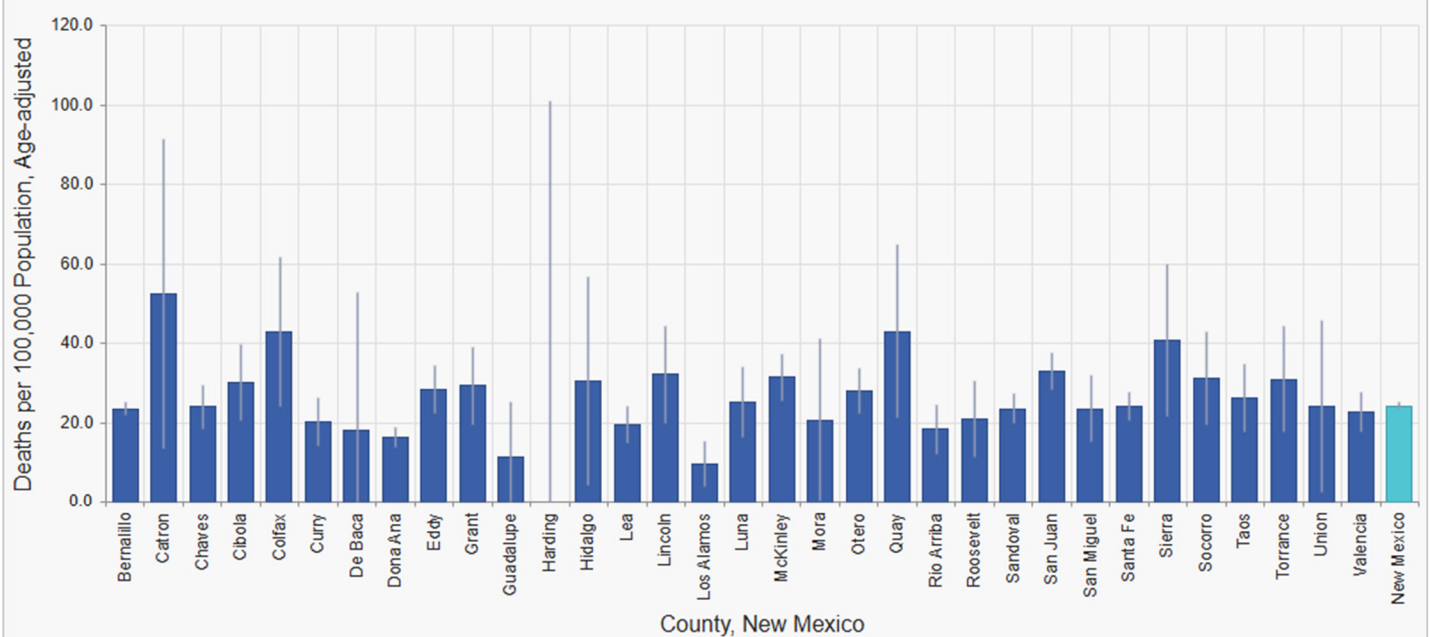
Suicide Deaths by Year, by County, NM

Suicide Deaths by County, New Mexico, 2017-2021



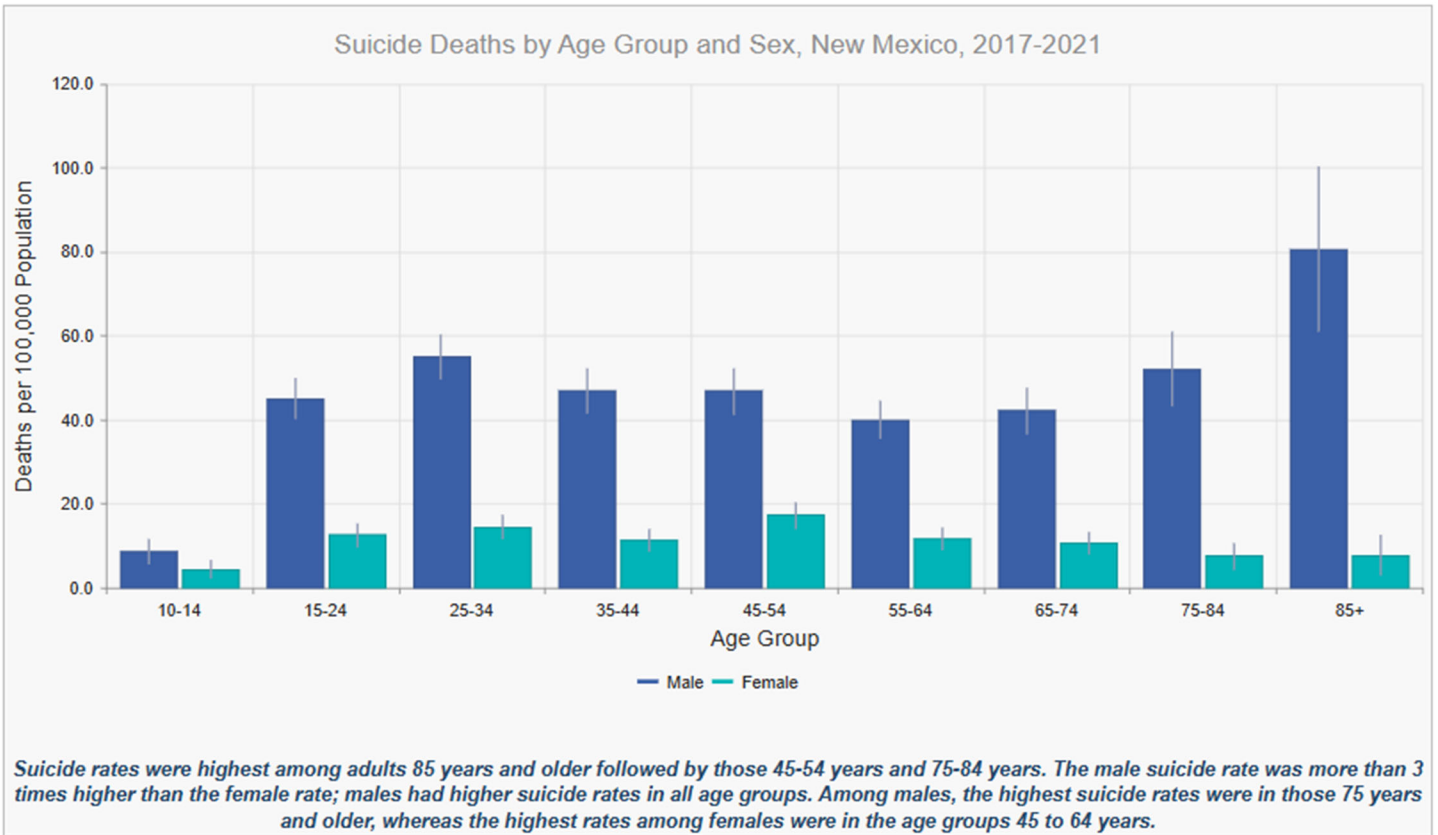
Suicide Deaths by County, NM

Suicide Deaths by County, New Mexico, 2017-2021

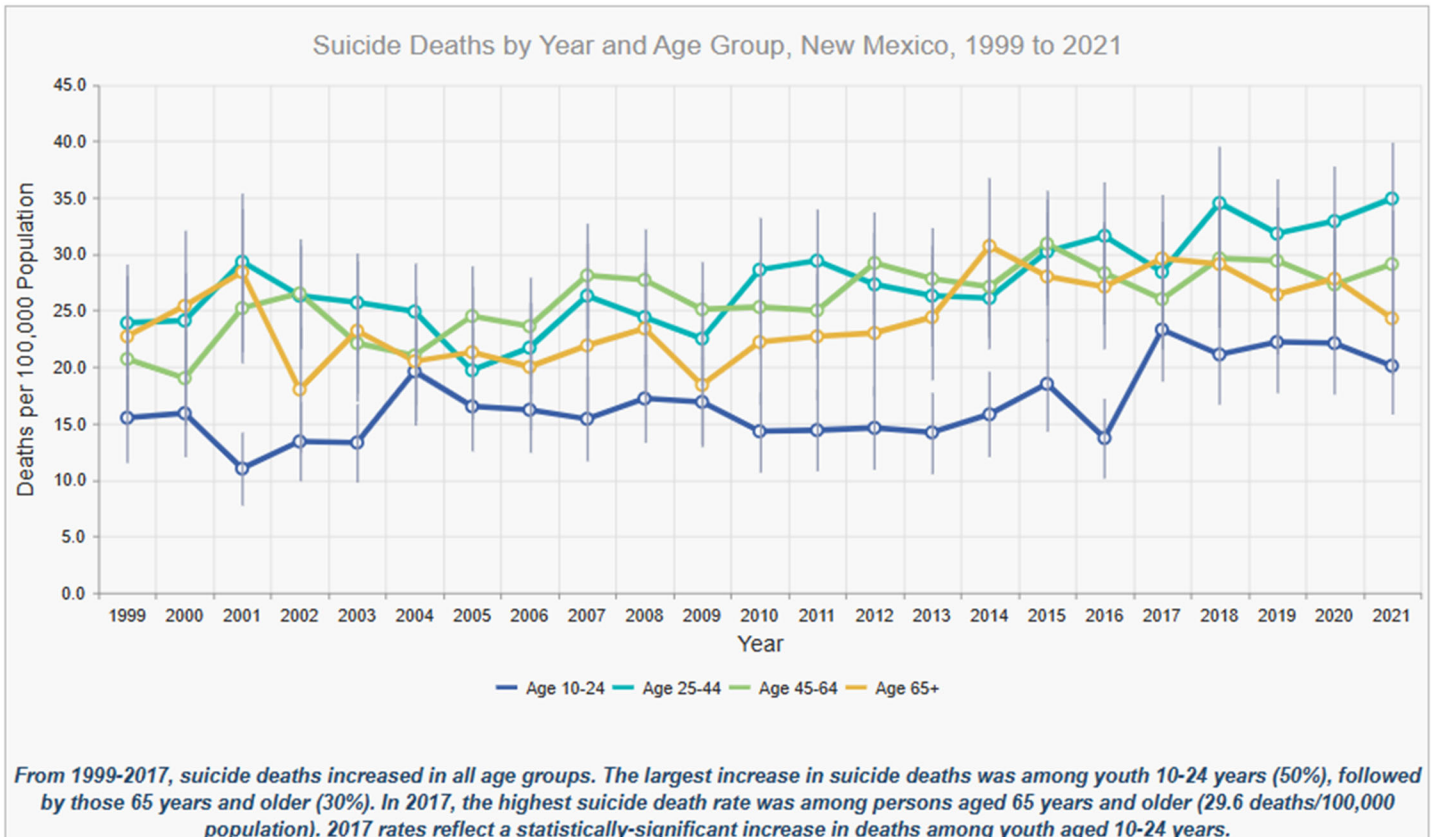


From 2013-2017, 20 NM counties had age-adjusted suicide rates that were significantly higher than the 2016 U.S. rate. NM counties with the highest suicide rates included Catron, Hidalgo, Grant and Sierra Counties in the Southwest; Quay County in the Southeast; and Taos, San Miguel and Torrance Counties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

Suicide Deaths by Age Group and Sex, NM



Suicide Deaths by Year and Age Group, NM



Alcohol Related Deaths

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

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

Alcohol Related Deaths

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

Nationally:

1 in 10 deaths among working-age adults



(ages 20–64) is attributable to alcohol

In New Mexico:

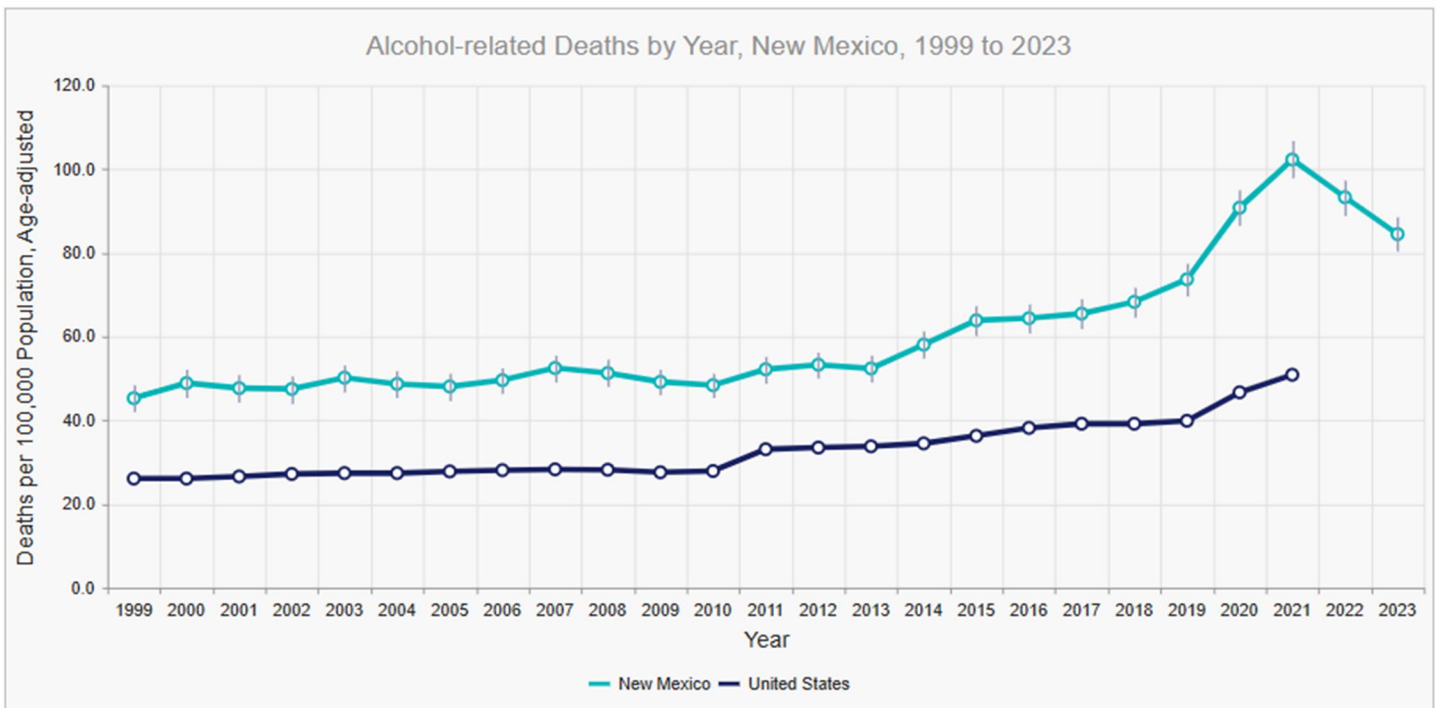
1 in 5 deaths among working-age adults



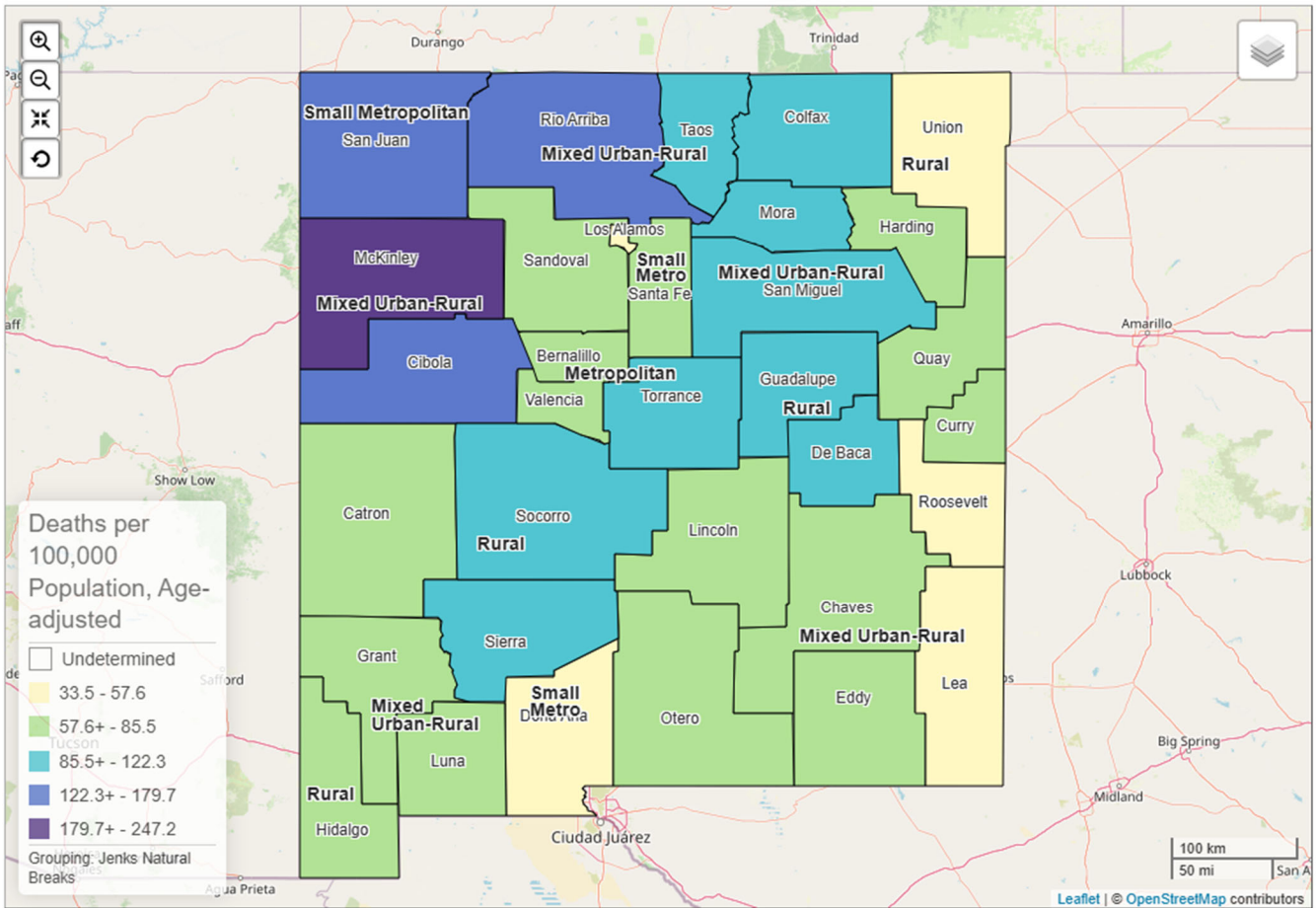
(ages 20–64) is alcohol-related

— This is twice as high as the national rate

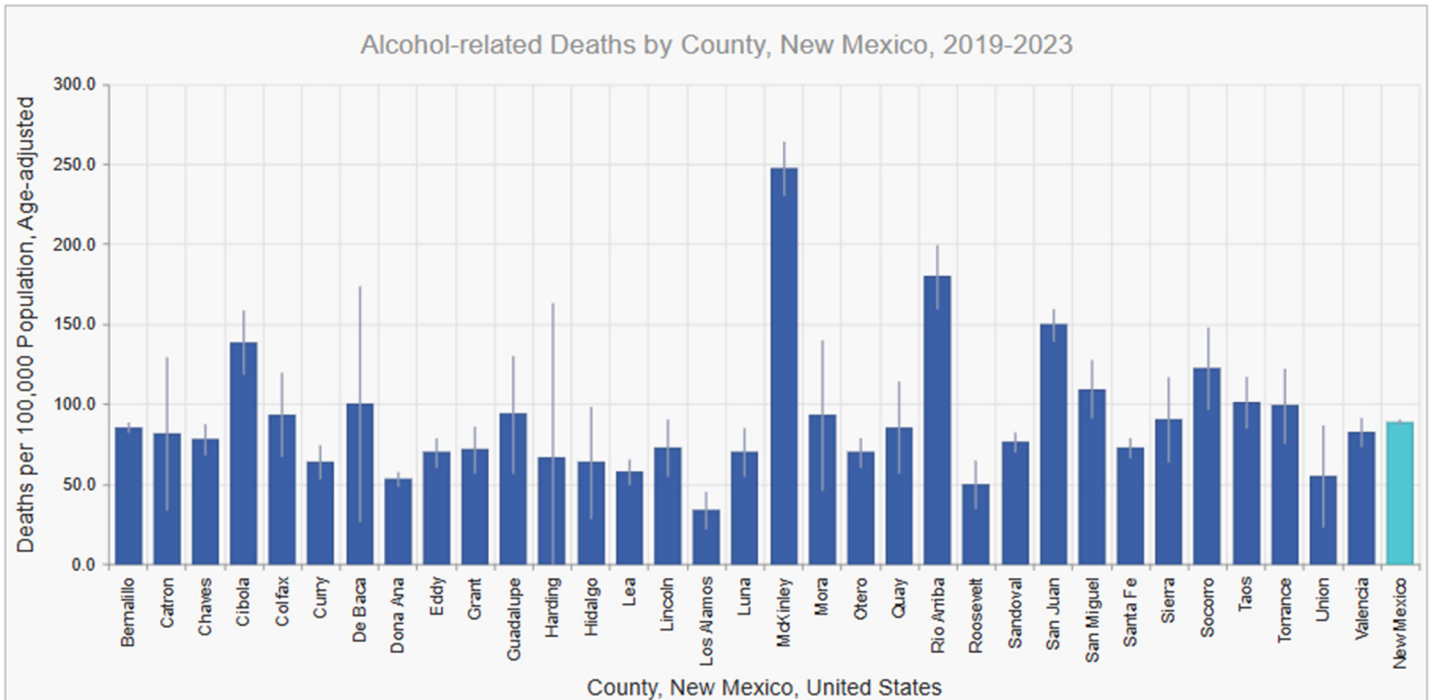
Alcohol-Related Deaths by Year, NM



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

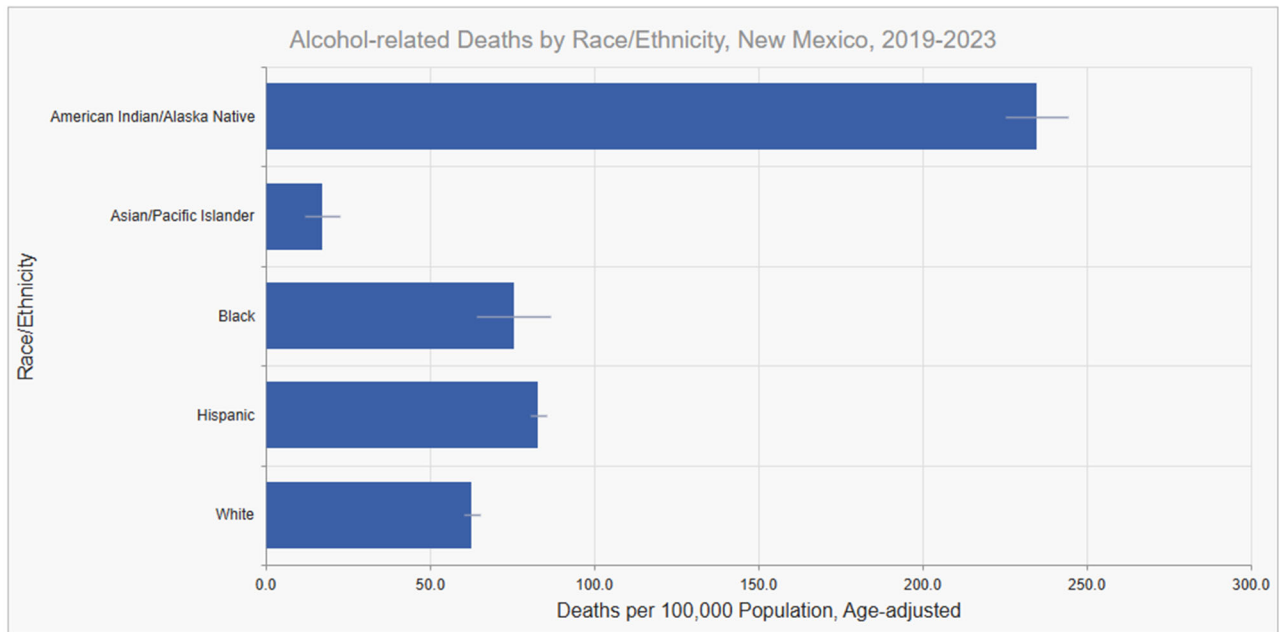


Alcohol-related Deaths by County, NM

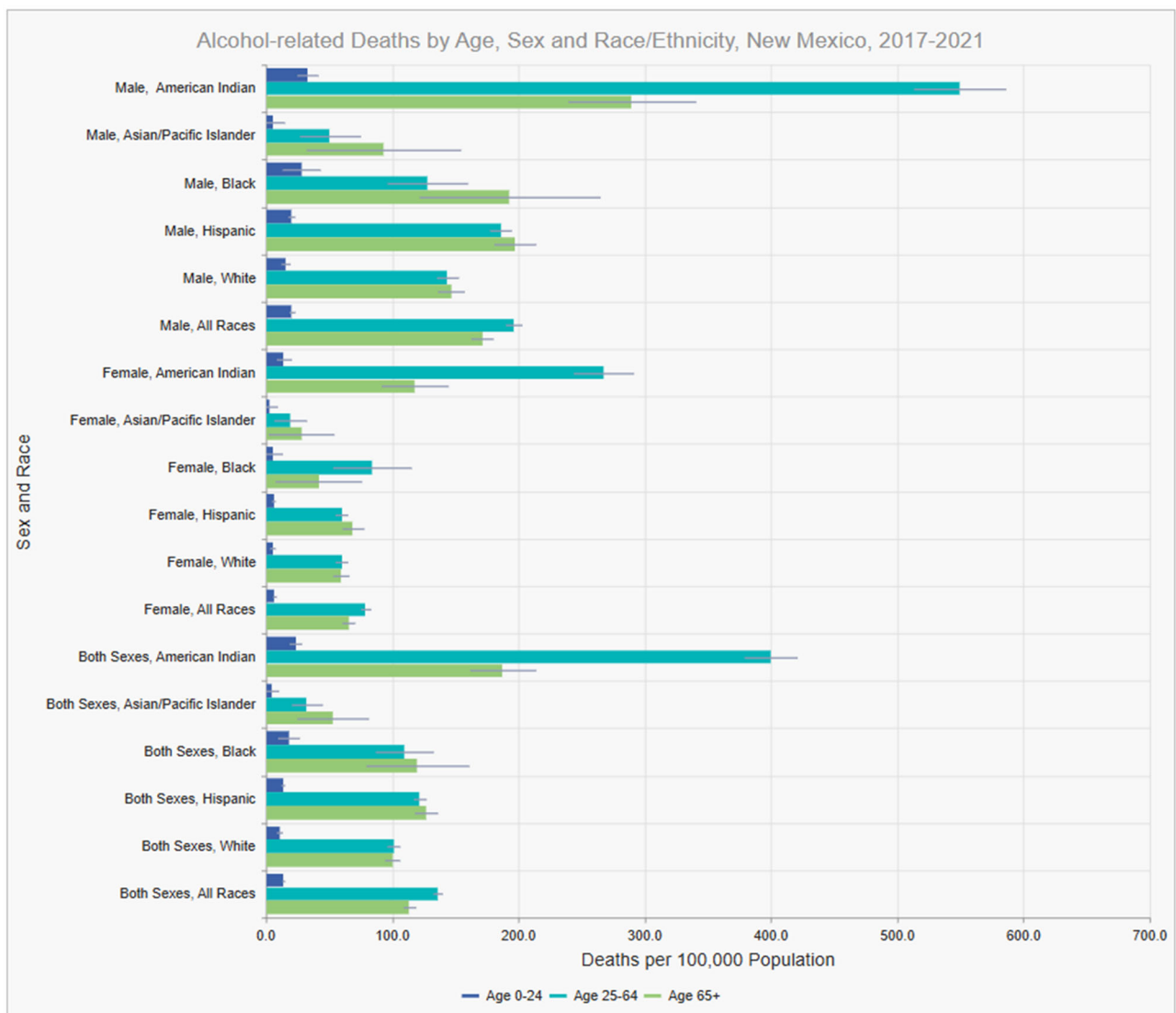


Rio Arriba and McKinley counties have the highest rates of alcohol-related death, with rates more than twice the state rate and more than three times the national rate. Several other counties (Cibola, Mora, San Juan, San Miguel, Socorro, Taos, Sierra, Catron, Guadalupe, Quay, and Hidalgo) have a substantial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

Alcohol-related Deaths by Race/Ethnicity, NM



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



Drug Overdose Deaths

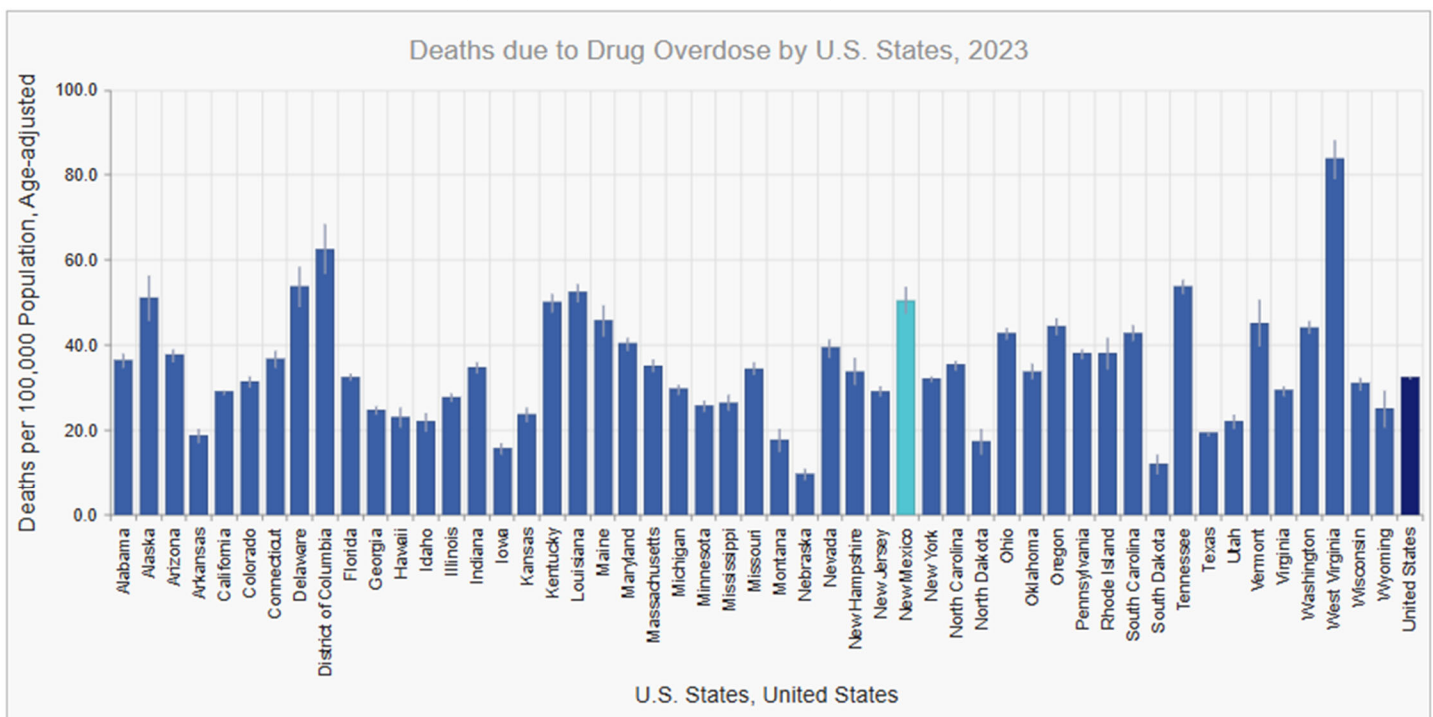
Source: New Mexico's Health Indicator Data & Statistics - <https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html>

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

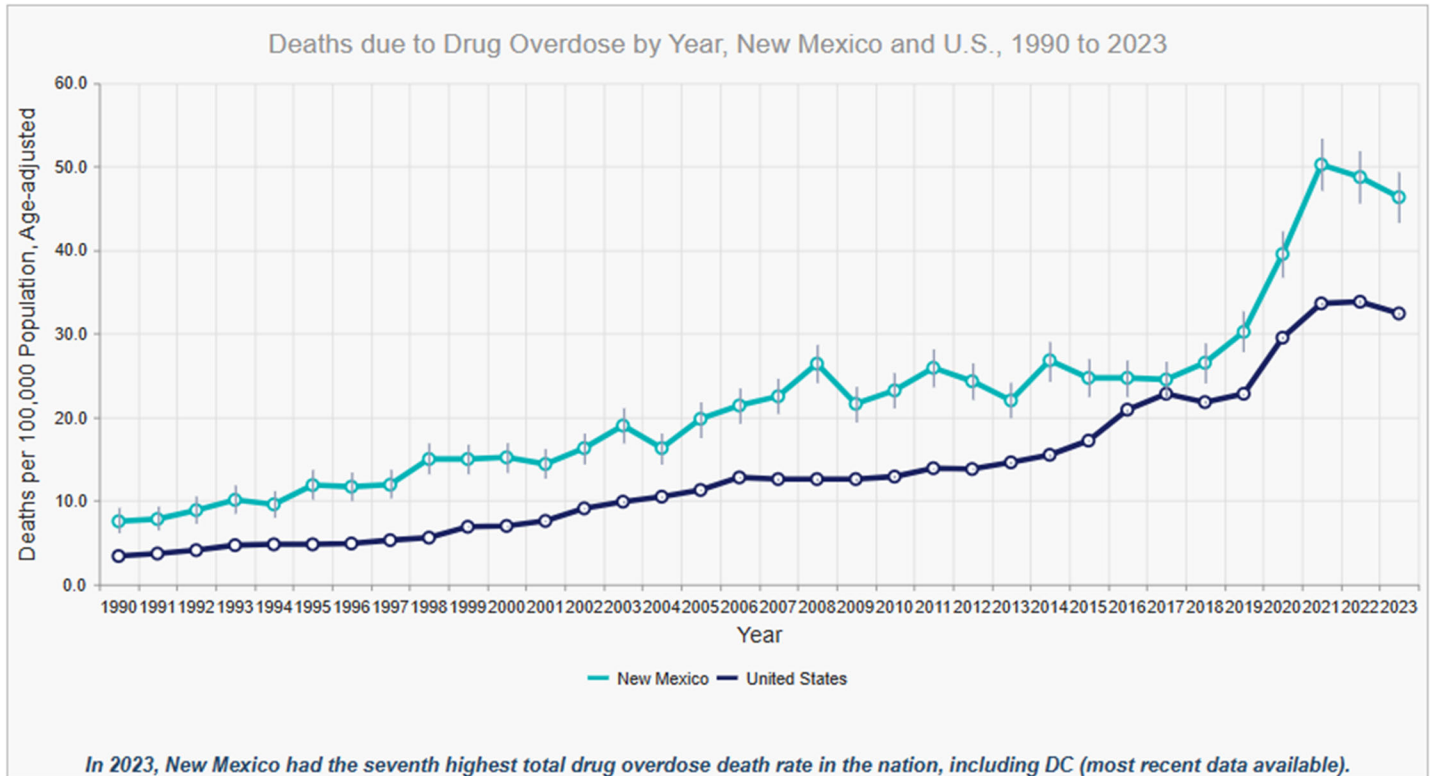
Drug Overdose Deaths

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

Drug Overdose Deaths by U.S. States

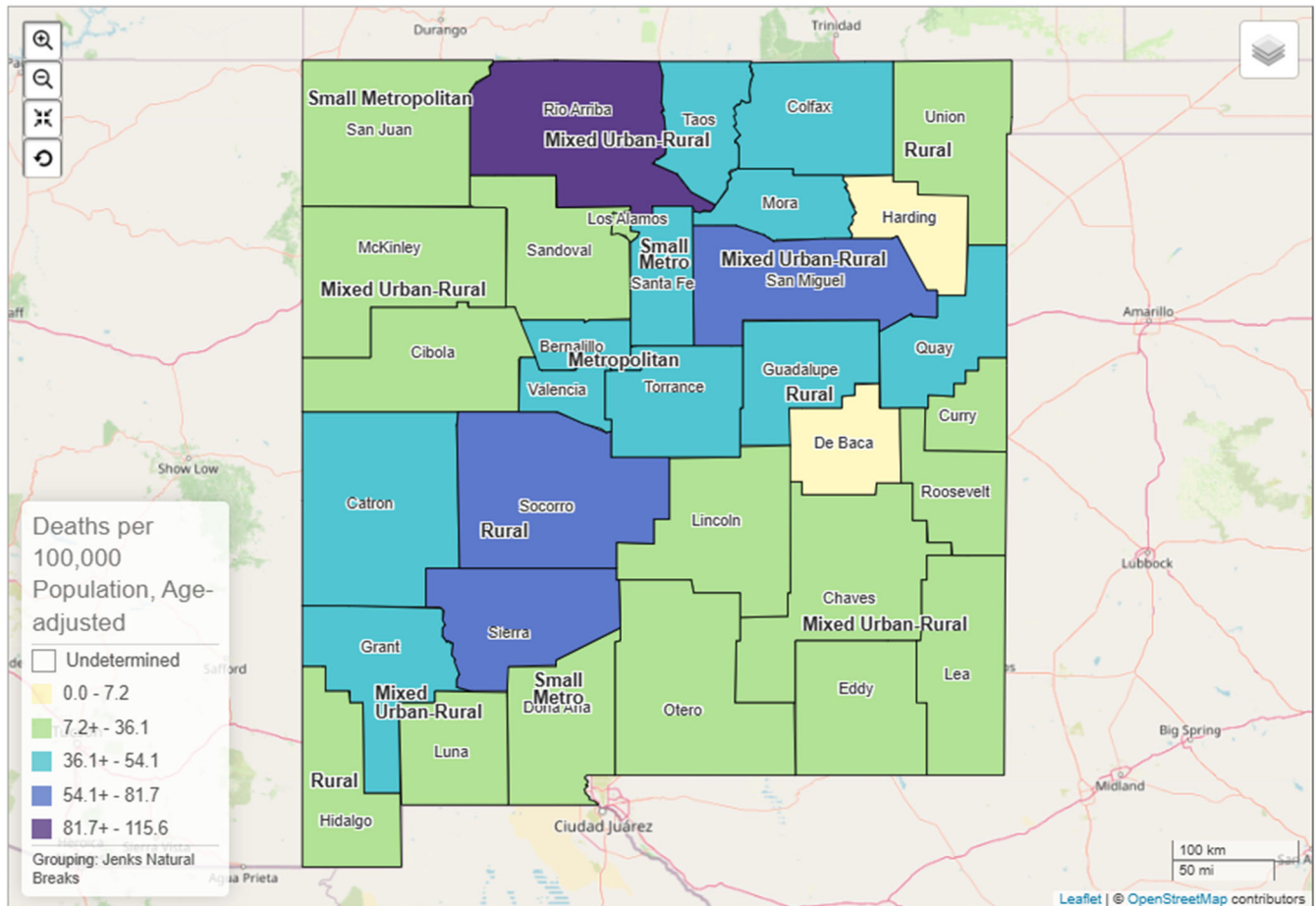


Drug Overdose Deaths by Year, NM and U.S

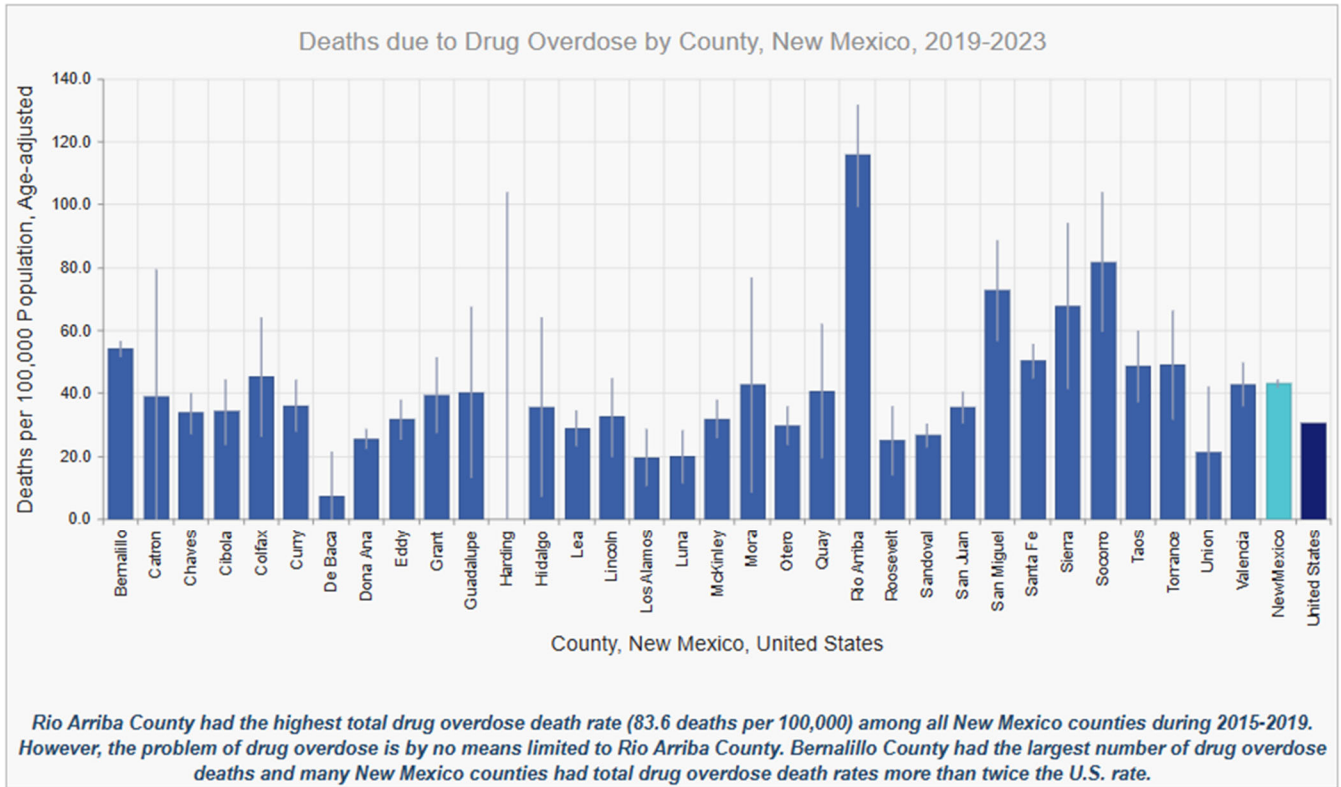


Drug Overdose Deaths by County, NM

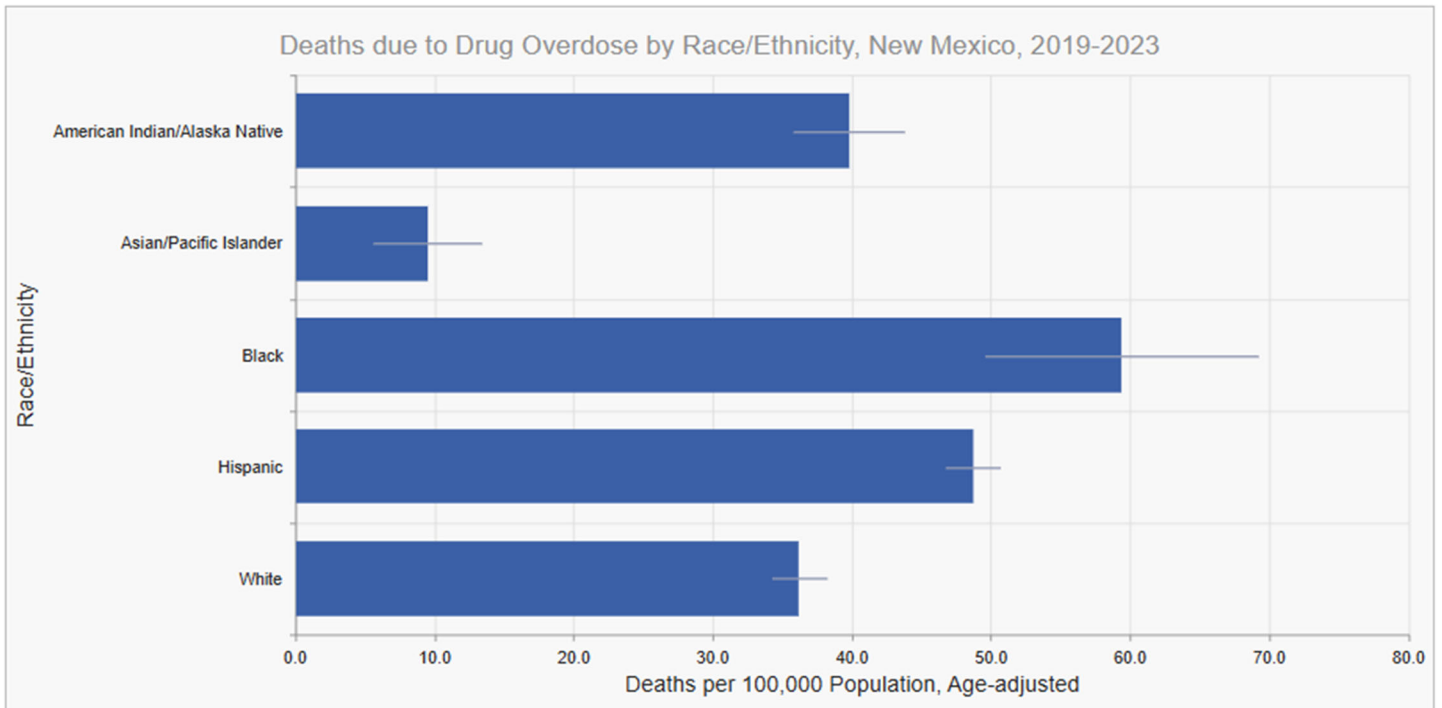
Deaths due to Drug Overdose by County, New Mexico, 2019-2023



Drug Overdose Deaths by County, NM



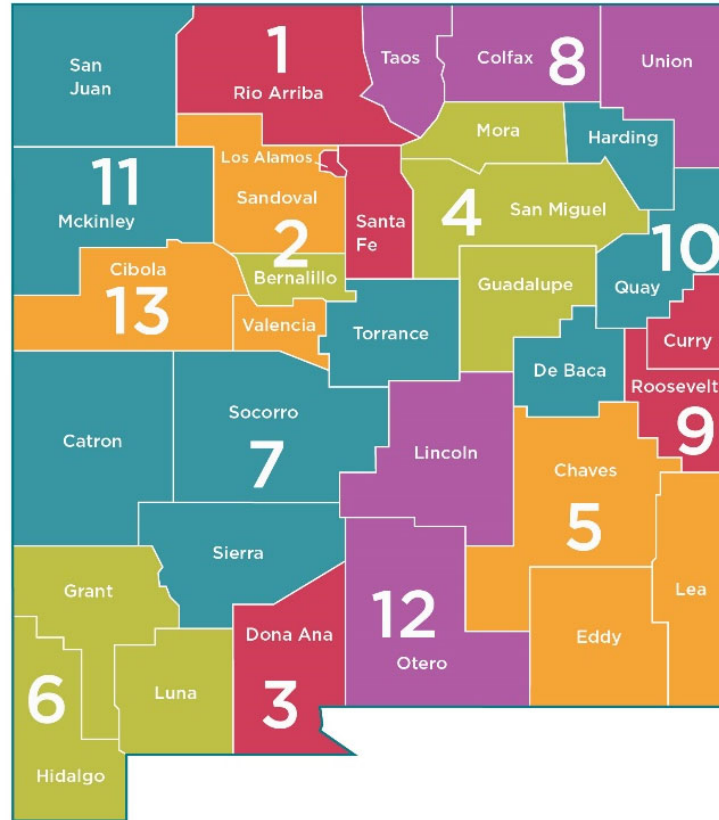
Drug Overdose Deaths by Race/Ethnicity, NM



Region/ County

Source: New Mexico's Health Indicator Data & Statistics - <https://ibis.doh.nm.gov/indicator/view/SuicDeath.Cnty.html>
 Suicide Deaths, Alcohol Related Injury Deaths, and Deaths Due to Drug Overdose.

The NM Behavioral Health Reform Investment Act



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)

E-SIM Priorities BHR 2

**Priority Bucket 1:
Access &
Engagement for
Youth and Families**

1. Expand drop-in centers for youth and transition-age groups (safe, age-appropriate spaces).
2. Extend community center hours and add mentorship programs to engage middle/high school youth.
3. Develop services for disengaged and homeless youth, including outreach and wraparound supports.
4. Create parent resource centers and expand respite care for all families (not just foster).
5. Use social media strategically to link youth to services and reduce stigma.
6. Services for youth disengaged from school and/or their families- could be priority for this funding
7. Hiring youth- peer based support
8. Have opportunities for youth voice in this planning process
9. Community centers should be open later and have mentorship programs
10. Safe places for young people to access services (specifically for their age group- transition age use)- drop-in centers or other similar places
11. Provide ongoing support for parents and families during and after initial contact.
12. Expand YDI Family Outreach and CBPIR programs for voluntary engagement before formal charges.
13. Create community education campaigns about available resources and diversion options.
14. Develop collaborative outreach strategies to reduce stigma and build trust with families.
15. Incorporate culturally and linguistically appropriate services for diverse communities.
16. Bring back Youth and Family Counseling Program in Children's Court and expand to Family Court.
17. Mandate family involvement in treatment planning for better outcomes.
18. Provide respite care and wraparound supports for families of high-needs youth.
19. Offer gas cards and transportation assistance for families accessing services.
20. Create culturally responsive and linguistically appropriate services for diverse families.
21. Expand hours of operations to make things more accessible.
22. More parenting supports including virtual and hybrid supports; Need to support stable home environments
23. Develop parent resource centers at early intercepts to reduce stigma and improve navigation.
24. Need more support for caregivers – especially grandparents caring for children.
25. Need more respite for caregivers.

**Priority Bucket 2:
School-Based
Supports &
Prevention**

1. Increase school counselors and social workers for all students, not just those with IEPs.
2. Expand School-Based Health Centers (SBHCs) to include behavioral health, ACEs screening, and family supports.
3. Train teachers and staff in trauma-informed practices, restorative justice, and disability inclusion.
4. Embed mentorship and tutoring programs (e.g., Academies of ABQ) with behavioral health components.
5. Implement universal ACEs and SDH screening in schools and primary care settings.
6. Develop services specific for youth with mental health and disabilities
7. Substance use counselling in middle school and high school.
8. PED change regulations to allow social workers to function as school counselors as they have the training
9. Expand ACS violence intervention programs to all high schools and middle schools.
10. Embed school health centers more deeply into schools with flexible funding models.
11. Increase access to restorative practices in schools to reduce punitive discipline.
12. Provide Narcan and harm reduction training in all schools (integrate with CPR/First Aid).

**Priority Bucket 3:
Workforce
Development &
Sustainability**

1. Increase behavioral health workforce capacity through licensure support, certification programs, and salary adjustments.
2. Develop culturally and linguistically appropriate services (CLAS standards) and train providers accordingly.
3. Create career pathways for youth-serving professionals via CNM/UNM programs.
4. Embed peer support roles in prevention and wellness programs.
5. Provide ongoing training for educators and providers on trauma-informed and strengths-based approaches.
6. Provide CIT (Crisis Intervention Team) training for all APS SROs and school police.
7. Train law enforcement, APS SROs and school police on diversion resources and culturally responsive practices.
8. Expand workforce training for trauma-informed and restorative approaches across APS and CYFD.
9. Incentivize clinicians to obtain DBT and EMDR certifications and work with high-needs youth.
10. Expand workforce for rural areas and under-12 populations through funding and training.
11. Offer motivational interviewing training for court and probation staff.
12. Provide funding for after-hours services to accommodate working families.
13. Recruit more child psychiatrists for youth with severe emotional disturbance.
14. Center for Innovation: have a youth peer support certification system.
15. Incentivize agencies to stay open in the evenings and weekends
16. Develop culturally relevant training for Indigenous, immigrant, and unhoused youth populations.
17. Increase staffing for behavioral health specialists in schools and community programs.
18. Increase BH workforce salaries and access to licensure/certification programs.
19. Train providers on culturally responsive care, including LGBTQ+ and immigrant youth needs.
20. Add peer and family support roles to all behavioral health RFPs.
21. Develop trauma-informed and restorative justice training for educators and school staff.
22. Create career pathways through partnerships with NM colleges for youth-serving professions.
23. Create shared standards and definitions across all entities so they have a starting language.
24. Train and certify peer mentors with lived experience to support youth transitions.
25. Provide strong supervision and trauma-informed support for peer workforce to prevent burnout.
26. Increase behavioral health workforce capacity for re-entry and community corrections programs.
27. Offer motivational interviewing and restorative justice training for staff in re-entry programs.
28. Incentivize agencies to provide after-hours services for working families

**Priority Bucket 4:
Housing & Basic
Needs**

1. Expand housing services for youth and families, including transitional and independent living options.
2. Develop collaborative programs to address food insecurity and transportation barriers.
3. Increase shelters and safe spaces for unstably housed youth (beyond Amistad and New Day).
4. Create youth wellness benefit programs to fund community-based activities and prosocial engagement.
5. Integrate housing support into wraparound services for families at risk of separation.

**Priority Bucket 5:
Crisis Response &
Diversion**

1. Educate law enforcement on New Day diversion and non-law enforcement crisis response options.
2. Improve coordination between ACS and UNM Mobile Crisis Team.
3. Expand MRSS (Mobile Response and Stabilization Services) capacity and provider network.
4. Increase awareness of crisis response policies in schools (e.g., parental consent, intervention protocols).

**Priority Bucket 6:
Residential &
Intensive Treatment
Access**

1. Establish in-state RTCs for all genders, including non-adjudicated youth.
2. Create RTC capacity for girls (currently lacking).
3. Expand independent living centers for youth transitioning out of care.
4. Develop bridging programs between inpatient care and school re-entry.
5. Increase detox options beyond Serenity Mesa for youth with SUD.

**Priority Bucket 7:
Care Coordination &
System Integration**

1. Standardize HIPAA and FERPA interpretation across agencies for better data sharing.
2. Resurrect CYFD map of child-serving programs and make it public-facing.
3. Expand closed-loop referral systems (align Unitus and state platforms).
4. Create centralized referral system for home visiting and wraparound services.
5. Implement Handle of Care protocol between APS and APD for crisis communication.
6. Bern Co can develop website to register orgs and be one stop shop for finding out about services.
7. Resurrect monthly meetings between child providers and child serving organizations.
8. Expand 311 services.
9. Need better communication from psychiatric hospitals when discharging to home and community providers.
10. Improve collaboration between 911 and 988 dispatch systems for behavioral health calls.
11. Standardize protocols for jurisdictional issues between APS police, APD, and juvenile justice.
12. Enhance coordination between APS Threat Assessment Team, ACS, and JJS for integrated response.
13. Create shared standards and definitions across agencies for consistent language and expectations.
14. Develop a single-point assessment system that can refer youth to appropriate services quickly.
15. Review and update Children's Code to allow community-based responses before probation.
16. Expand restorative justice practices in schools and law enforcement interactions.
17. Implement monitoring of social media for prevention and early intervention of violence.
18. Build holistic youth narratives that include strengths and protective factors, not just deficits.
19. Increase funding for community-based programs like La Plazita and New Day to sustain diversion efforts.
20. Modify Children's Code to allow community-based recommendations instead of mandatory commitment.

**Priority Bucket 7:
Care Coordination &
System Integration
continued**

21. Expand DD waiver eligibility to include younger youth for early intervention.
22. Improve data systems (e.g., NM Impact) for tracking youth outcomes and service gaps.
23. Standardize maturity assessments for judges and court staff to inform decisions.
24. Streamline communication between ACS, courts, CYFD, and schools for coordinated care.
25. Streamline HIPAA/FERPA protocols for sharing school and health information during transitions.
26. Bundle billing codes for re-entry services similar to DD Waiver to ensure comprehensive care.
27. Hold MCOs accountable for providing subsidies for wellness activities and navigation support.
28. Develop community-centered healing programs to address trauma and prevent recidivism.
29. Create pathways for Assertive Community Treatment (ACT) and PSR models adapted for youth.
30. Have the centralized database around person's BH, legal, school, etc. history
31. Develop a centralized resource directory for families and providers (public-facing, easy to access).
32. Create universal data-sharing platform across schools, health providers, and courts.
33. Standardize protocols for HIPAA/FERPA interpretation to improve care coordination.
34. Implement flowcharts and decision trees for service navigation ("If this, then that").
35. Expand Find Health platform to include all youth resources across intercepts.

**Priority Bucket 8:
Expanding
Therapeutic Services**

1. Expand the way therapeutic services look- such as experiential services
2. Increase access to restorative practices- help youth give back to the community
3. Support community-based organizations that have limited funding but have great connections to youth and families (rather than build new services)
4. Access is predicated on having a specific diagnosis or have burdensome intake processes- increase youth agency- focus on individual needs of youth
5. Policy/ funding mechanism changes in primary care setting to integrate more behavioral health.

**Priority Bucket 9:
Diversion & Early
Intervention**

1. Expand CCP (Community Connections Program) for youth at risk of deeper system involvement.
2. Develop more diversion programs beyond substance use infractions (e.g., behavioral health-related incidents).
3. Increase awareness of existing diversion resources like New Day and La Plazita Institute among law enforcement and schools.
4. Need more diversion programs in general.
5. Create protocols for early SRO engagement to build rapport before issues escalate.
6. Integrate family peer advocates at this intercept to support communication and reduce fear.

**Priority Bucket 10:
Specialized Services
for High-Needs Youth**

1. Establish RTCs for youth with IDD, ASD, psychosis, and severe behavioral needs (currently referred out of state).
2. Expand START program for home-based support for youth with ASD and pair with Treatment Foster Care.
3. Create Youth Mental Health Court for adolescents with serious emotional disturbance.
4. Develop kinship/guardianship programs for grandparents and caregivers.

**Priority Bucket 11:
Re-Entry
Coordination &
Continuity of Care**

1. Create youth-specific Resource Reentry Centers modeled after adult RISE programs for immediate post-release support.
2. Develop standardized school re-entry protocols for justice-involved youth, including credit recovery and accommodations.
3. Improve discharge planning to include school records, treatment plans, and medication management.
4. Implement warm hand-off systems between detention, community providers, and families to ensure continuity.
5. Expand Medicaid re-entry waiver to cover youth transitioning from detention or RTCs.
6. Work with schools around attendance system. Attendance system is automatic which then triggers referral to CYFD. Then it could trigger a referral to JPOs, etc.
7. Assigning case managers, navigators.

**Priority Bucket 12:
Education &
Vocational Pathways**

1. Partner with charter schools and alternative education programs (e.g., E-Cademy, School on Wheels) for flexible re-entry.
2. Expand vocational programs like SWEPT and work-based learning opportunities.
3. Create paid internships and mentorship programs for youth with justice involvement.
4. Integrate GED and trade school options into re-entry planning.

Additional State Recommendations

- PED change regulations to allow social workers to function as school counselors as they have the training
- Resurrect CYFD map of child-serving programs and make it public-facing.
- Review and update Children’s Code to allow community-based responses before probation
- Modify Children’s Code to allow community-based recommendations instead of mandatory commitment.
- Expand DD waiver eligibility to include younger youth for early intervention.
- Bundle billing codes for re-entry services similar to DD Waiver to ensure comprehensive care.
- Hold MCOs accountable for providing subsidies for wellness activities and navigation support.
- Policy/ funding mechanism changes in primary care setting to integrate more behavioral health.
- Expand Medicaid re-entry waiver to cover youth transitioning from detention or RTCs.