SOAR: Southwest Outreach Academic Research Evaluation & Policy Center

The State of the Behavioral and Mental Health System in Doña Ana County

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Introduction

The purpose of the Doña Ana County behavioral and mental health assessment is to build a more thorough understanding of the strengths, weaknesses, and gaps in the behavioral and mental health system in Doña Ana County. This report summarizes findings from two surveys, publicly available data, and aggregate data provided by the New Mexico Behavioral Health Services Division that were collected to provide LC3 with the information needed to form a data driven strategic plan that will lay out the critical steps to take to establish the ideal behavioral health system in Doña Ana County. The LC3 Behavioral Health Collaborative is composed of 170 key stakeholders who represent 60 public and private organizations in the behavioral health sector.

This effort was paid for by a grant from the Paso del Norte Community Foundation in El Paso. A copy of the presentation given at the LC3 December meeting can be found at the end of this report, which utilizes visuals to summarize the key findings described in this report.

Data Collection Approach

There were three main phases and sources of data collection for this assessment that are outlined below.

Preliminary Survey

Data collection for the first survey took place in April 2020. Originally planned as in person focus groups, data collection had to change to an online survey due to the onset of the COVID pandemic. All questions were open ended, and the focus was on identifying key areas in the behavioral and mental health system that need to be addressed to establish the ideal behavioral health system in Doña Ana County. This survey was sent to the LC3 listserv with the purpose of providing more focus for the subsequent larger community survey. A total of 61 people from 29 different providers, agencies, and departments completed the survey.

Community Survey

The broader community survey was released in October 2020. Questions were designed to expand upon the main findings identified in the first survey. The purpose of the second survey was to solicit feedback from a wider audience involved in the behavioral and mental health system in Doña Ana, including patients and providers. The survey also aimed at collecting information about the COVID pandemic and how it impacted patients and providers. A total of 216 individuals completed this survey, and the questions, demographics, and detailed responses can be found at the end of this report.

Public Data

In addition to the surveys, relevant public data were incorporated into this report. Sources for these data include the US Census, the University of Wisconsin, New Mexico State University (NMSU), and the New Mexico Public Education Department (NMPED). With this public data, the report offers a more complete and detailed picture of the current behavioral and mental health conditions in Doña Ana. In addition, aggregate data about providers and individuals who have accessed mental and behavioral health services were provided by the New Mexico Behavioral Health Services Division.

Summary of Key Findings

Review of all of these data yielded eight key results that are described below. This summary focuses mostly on the community survey results, as feedback from those who have experience with the behavioral and mental health system yielded ample rich and useful information for the larger effort. Additional data sources are incorporated as well where relevant. All survey questions and response frequencies, including demographics of respondents, can be found at the end of this summary.

1) Lack of access to information

In multiple areas, access to information for both providers and patients was mentioned as an essential aspect of a well-functioning behavioral and mental health system. Unfortunately, access to behavioral and mental health information in Doña Ana was generally rated poorly by providers and patients. In particular, the lack of centralized information impedes patients' access to services and providers' ability to refer their patients effectively. As one participant stated*, "For the general population, there does not seem to be a one-stop-shop for information on behavioral health providers."* Poor access to behavioral and mental health *services* is also associated with lack of access to important information. Indeed, participants believe that many people do not reach out to behavioral health support services simply because they are unsure of how to do so. This is conveyed well by one participant who claimed*: "I also think that there is probably a good amount of resources out there however people struggling knowing what is available and how to get it."*

Additionally, accessing information is particularly difficult for vulnerable populations. In particular, rural communities, especially *low-income* rural populations, often do not receive information or have the technology necessary to access behavioral and mental health information. Indeed, 34% of the Hatch school district and 22% of the Gadsden school district do not have a computer or any type of device. In addition, 54% of the Hatch school district population and 41% of the Gadsden school district do not have an internet subscription. These percentages go up to 79% and 63%, respectively, for households earning less than $20,000 annually (US Census Bureau, American Community Survey 2018 5-year estimates). In general, information about available services does not often reach rural populations. For instance, participants explained that *"Individuals in rural and secluded areas are not informed of services that may be close to their area"* and *"It is difficult to find contact information, especially in rural areas."* Along with income and geographical locations, non-English speakers are often marginalized regarding access to information because information in languages other than English is not always available. Further, poor access to information is also at the core of the lack of collaboration and communication among providers and agencies.

Finally, participants also reported that poor access to information was a critical factor regarding the severe disruptions that occurred after the 2013 shutdown and the COVID pandemic. To facilitate access to information, both providers and patients recommended developing a providers' directory that is easily accessible by everyone. For patients, a providers' directory would facilitate access to contact information and specialization, while for providers, it would facilitate referrals and follow-up.

2) Lack of collaboration, coordination and communication between providers

The second finding that emerged from the data centered on a lack of collaboration, coordination and communication across providers and agencies. It is first essential to reiterate that poor communication

across providers ultimately affects patients, especially vulnerable patients such as non-English speakers, rural groups, undocumented immigrants, non-insurance holders, students, and children. Gaps in communication were mentioned across multiple service types and areas such as school districts, private practitioners, public providers, and law enforcement. There was also agreement across providers about the need to improve referrals across providers in order to develop a wraparound system that would provide patients with effective continuity of care.

It is essential to understand the need for collaboration in Doña Ana and the reasons for such communication and coordination gaps. In terms of the need for collaboration and coordination, participants agreed that coordination across agencies is essential to develop the region's ability to handle severe disruptions such as the 2013 shutdown and the COVID pandemic. Additionally, both providers and patients reiterated the need for a wraparound system that could offer continuity of care. Although such a system is promising and would greatly improve patients' service quality, it is only feasible with a strong collaboration and coordination foundation across all different Doña Ana providers. Lastly, good communication would ensure that all providers, agencies, organizations, and patients receive relevant information in a timely manner.

Regarding the reasons behind the lack of coordination, communication, and collaboration, providers significantly believe that the lack of incentives explains providers' communication gaps. Indeed, collaborating with other providers costs money, time, and effort on the part of the provider. However, there are not enough positive short-term outcomes that could encourage providers to collaborate with other providers. Along with the lack of incentives, there is an intense competition for patients across private providers. Therefore, providers do not financially benefit from referring or sharing information with other providers. Because of the combination of competition and costs, providers are more likely to retain their patients and critical information. In addition to the system's competitive aspect, providers believe that the lack of a shared database with patients' information is an additional barrier to collaboration. Establishing such a database would require a large amount of financial and human resources and would necessitate discussions around patients' sensitive information and confidentiality. Lastly, the lack of easy access to information for providers also leads to poor collaboration as providers do not know where to find information about other providers or who to contact for collaborating.

Despite the gaps in collaboration, coordination, and communication that were observed in the data, there were results that are encouraging in these areas. The creation of the Crisis Triage Center (CTC) is a great example of collaboration and coordination. By offering a safe place for individuals experiencing a mental health crisis to receive proper care and keep them safe, the CTC has the potential to fill a critical need in the Doña Ana behavioral and mental health system. The CTC is an example of effective coordination across agencies and groups. Indeed, the CTC came to fruition through the work of advocates such as Ron Gurley and other local mental health advocates, including NAMI of Doña Ana County and Senator Mary Kay Papen, and recent collaboration and efforts across the Board of County Commission, LC3, RI International, and Las Cruces Health and Human Services. These examples demonstrate that coordination and collaboration is a necessity in order to develop and improve the mental and behavioral health system in Doña Ana.

3) Important information about the COVID Pandemic

The next findings focused on important takeaways in relation to the COVID pandemic. For patients, the main challenges they are facing amid the pandemic include poor access to human and financial resources, barriers imposed by insurance or the lack thereof, and challenges with accessing services.

Regarding resource access, many patients indicated that they do not have access to transportation and they cannot afford services amid the COVID pandemic. Insurance was also problematic for patients, as patients either did not understand the benefits or did not have coverage for the services needed. Lastly, patients were often turned down, put on waiting lists, or had the services they were using shut down during the pandemic. Despite these challenges reported by respondents, more than a third of patients reported not being directly impacted by the COVID pandemic.

Concerning providers, the COVID pandemic has led to severe service disruptions within their organizations. Specifically, some providers observed an increase in patient load through referrals. Other providers lost patients and had to downsize their services, sometimes to the point of shutting down services altogether. In addition, some providers reached their maximum capacity levels, and a few were forced to turn down new patients. Interestingly, both providers and patients reported similar difficulties in implementing telehealth. First, some patients and providers reported lacking the required technology or indicated they do not have a home environment conducive to telehealth. Second, some patients reported they do not trust telehealth and do not know how to use it. Some providers confirmed observing these trends among their clients.

4) The parallels between the COVID pandemic and the 2013 shutdown

Two major disruptive events happened in the last ten years in the behavioral and mental health field in New Mexico: the 2013 shutdown and the ongoing COVID pandemic. Interestingly, there are parallels that can be drawn about the consequences of both events. First, following the 2013 shutdown and during the COVID pandemic, patients experienced disruptions to services they utilized. These disruptions resulted in increased waiting lists and services shutting down, while providers saw a rapid increase in patient loads and organizations operating at maximum capacity.

Second, coordination, collaboration, and communication were missing throughout both events. Providers noted that even though communication across providers was lacking before the COVID pandemic, it became even more complicated to reach out to other providers to coordinate services as the pandemic unfolded. Third, there is a lack of important planning and preparation across the system that allows for effective handling of disruptive events such as the COVID pandemic and the 2013 shutdown. In particular, about half of the participants gave low ratings on the system's ability to quickly respond to changes in policy or environment, the system's ability to maintain services amid unexpected disruptions, and the system's preparation to handle disruptions. Providers reported that more thorough preparation and planning across all agencies and providers would have helped handle these disruptions. It is essential to adopt a holistic approach when analyzing these parallels. In other words, all three issues are closely connected and are not independent of one another.

5) The vulnerable populations appear to be most affected

The survey also helped to shed light on some underlying challenges that are unique to the vulnerable population segments in the behavioral and mental health system in Doña Ana. For instance, one participant explained, *"once you have a more specific demographic such as low income or limited English proficiency, it seems harder to connect to appropriate services."* Here, vulnerable populations refer to rural groups, youth, non-English speakers, undocumented immigrants, low-income individuals, homeless populations, and non-insurance holders. Given that 51% of individuals in Doña Ana County reported a

language other than English is spoken in their home, 24% are living in poverty, and 69% are Hispanic (US Census), information about vulnerable populations are particularly relevant for this report.

In the survey, access to behavioral health services for rural and secluded populations, for non-native English speakers, children, and low-income individuals were all rated poorly. Specifically in terms of non-native English speakers, the lack of bilingual providers and services in the region seems to be a critical barrier to accessing services, as a participant described, *"There has been a discrepancy within the community of finding Spanish speaking providers (counselors). Additionally, it is important the provider is fluent and proficient in the given language."*

Second, access to information and to services for vulnerable populations can sometimes be more difficult as well. People living in rural areas, who do not read English well enough, and homeless populations all face different challenges regarding accessing information. Among rural populations, service availability and transportation remain constant barriers for accessing services. One of the participants described this challenge by explaining that *"Services are limited in the rural areas and transportation to Las Cruces is a barrier."* Moreover, participants reported that most rural populations do not have the technology to access information, do not know how to use it if they have it, and do not know who to contact to receive information.

Third, insurance often poses an additional barrier to services. In Doña Ana, 12% of the population was uninsured in 2017 (www.countyhealthrankings.org), and 49% received Medicaid in 2018 (https://ibis.health.state.nm.us). Moreover, from 2013 to 2017, 18% of the Doña Ana population could not get needed medical care due to the cost (https://ibis.health.state.nm.us). Additionally, many patients have insurance but are not aware of what is covered. The complexity involved with insurance can sometimes overwhelm both patients and providers. In these situations, language can also be a barrier for non-English speakers when it comes to paperwork and benefits. With regards to the uninsured populations, behavioral and mental health services are often inaccessible because they cannot afford it or do not meet Medicaid requirements. This participant describes it by stating, *"I would point out that dearth and limitations of access for a person who does not meet the financial aspects of Medicaid requirements but can't afford personal insurance."*

Concerning undocumented immigrants, some barriers are unique to this population segment. Among them, undocumented people's fear of the legal and immigration system can lead them to avoid reaching out for services. Lack of English proficiency can also make it difficult to seek services individuals may need. As one participant stated, *"Although NM is better than most, Spanish Speakers many times have trouble connecting to a system they believe may cause harm to them (Undocumented Families)."* Lastly, vulnerable populations report more difficulties with the switch to telehealth. For instance, people living in rural and secluded areas are less likely to have the necessary technology to effectively use telehealth. It is also more difficult to communicate on a personal level and build trust with children and families through technology. Lastly, the data suggest that it has become harder to locate homeless patients when relying only on telehealth.

6) Shortage of behavioral and mental health general and specialists providers

In 2018, the ratio of patients to mental health providers in Doña Ana County was 340:1 (www.countyhealthrankings.org). Behavioral Health Services (BHS) data also indicate an increase in the number of patients in the County who received behavioral health services from 8,488 in 2015 to 19,939 in 2019, with a notable increase in crisis treatment center clients (55 in 2015 to 707 in 2019) and opioid

treatment program clients (354 in 2015 to 404 in 2019) in particular. Additionally, BHS data also indicate a decrease in the number of behavioral health agencies in the county from 14 in 2015 to 8 in 2019. Responses collected through the survey reflected this shortage of behavioral and mental health providers as well, especially specialists. Nevertheless, some service areas and population segments are more impacted than others in terms of this shortage. In addition to people being unsure of how to reach out to providers, participants mentioned that insurance, financial resources, and lack of the availability of general services as the most critical challenges in accessing services. Moreover, poor access to services are more severe for vulnerable populations in particular. Among the specific patient segments mentioned by participants, families, parents, and children are significantly affected by the shortage. Regarding the types of services that are needed, participants reported that services such as psychiatric, autism, supportive services, and case management are critically missing in the Doña Ana area.

Lastly, results suggest that the combination of agencies operating at maximum capacity and others shutting down services led to increased waiting lists. The issue around waiting lists remains a persistent problem in the Doña Ana behavioral and mental health system. In some cases, waiting lists can frustrate patients seeking services to the point of giving up. A participant declared that *"The waiting time to see a provider is horrible. It makes you not want to seek out services."* However, waiting times vary depending on the types of services sought, the location, and the patients' background. For instance, participants singled out children's services in particular for their longer waitlists. Participants went on to note that *"it takes a while to place children in facilities. Searching for facilities that will take the child in is a challenge."* According to responses, patients seeking specialized services are more likely to be put on waiting lists, especially low-income, uninsured, and non-English speaking individuals. For example, one participant described, *"There are usually waitlists for services and services can be harder to secure if you need someone who speaks a second language."*

7) Behavioral and mental health in the K-12 school system

The last takeaway from the data focuses on the necessity of developing well-functioning behavioral and mental health system within the K-12 school system. The need to expand behavioral and mental health in the schools is critical. In 2017 in Doña Ana, 36% of high-school students reported having persistent feelings of sadness and hopelessness (https://ibis.health.state.nm.us). Further, 14% seriously considered suicide, 14% made suicide plans, 9% attempted suicide, and 3% were injured in a suicide attempt (New Mexico Youth Risk and Resiliency Survey). Additionally, the 2017 Youth Risk and Resiliency Survey indicated that students faced other difficult circumstances that are worth noting when looking at these figures, including that 11% have skipped school because of safety concerns, 15% were bullied on school property, and 13% reported being electronically bullied.

To address the persistent issues around students' mental health, participants pointed towards potential solutions involving the K-12 school system. First, participants believe that schools and school districts should collaborate more with outside providers to offer services to their students. Results also suggest that it has become complicated for parents and families to access school-based mental health services for their children. The 100% Community Survey Report for Doña Ana County (2020) revealed that the most common difficulties in accessing services in the schools are the lack of counselors and mental health professionals, the lack of specialized services, and the lack of mental health services. Therefore, reaching out to outside private providers appears to be a potential solution to address the schools' gaps in services.

Second, the stigma around behavioral health among students is very strong. According to the report cited above, there are significant differences between participants who sought school-based mental health services for their child and those who did not. These differences are mainly based on ethnicity, primary language, education, school district, and geographical location. It seems from the data that this stigma is different for specific segments of the population, and repercussions carry over to the schools and their students. As a result, providers want schools to adopt an essential role in the conversation about reducing stigma around behavioral health.

Training teachers and staff about behavioral and mental health, including training on trauma, also seems critical to address the stigma around behavioral and mental health in schools. There are two reasons for training teachers and staff that that came across in the data. First, teachers substantially spend more time with students than any other adults in schools. Second, the student-to-counselor ratio in New Mexico is extremely high. According to the National Association for College Admission Counseling (NACAC), the 2015-2016 students per counselor for school districts in Doña Ana County were all very high, including Gadsden (401 – 450 students per counselor), Las Cruces (501 or more students per counselor), Hatch (401 – 450 students per counselor), and Deming (501 or more students per counselor). The American School Counselors Association advises a counselor caseload of 250 students maximum, and all of these districts have a ratio that indicates counselors have many more students to serve than recommended.

Lastly, to go beyond their mission of teaching children, providers would like schools to serve as providers of resources, support, and services to families. One way to do so would be for schools to provide students with behavioral and mental health services throughout their academic progression.

8) The Role of LC3

Overall, participants are pleased with LC3 and want to support the LC3 efforts and goals. For the current movement to continue, participants have three recommendations for the LC3 team. First, participants recommend that LC3 continue to work hard and keep the current momentum going through active partnerships and advocacy. For instance, a participant recommends that LC3 *“Continue to work and collaborate with health stakeholders and community leaders. Partner with local health council, city, county, and state health agencies so everyone is working together from the grassroots, policy, advocacy and funding levels. Building a community care model.”*

Second, participants recommend creating a collaborative platform for providers and agencies. Examples of such platforms include a providers’ directory, or a platform that would facilitate referrals and facilitate access to general and contact information in the areas of behavioral and mental health. Participants were particularly vocal about the need for a collaborative and informative platform. For instance, participants recommended to *“Create a website where providers can communicate and where we can see what else is going on in the community”* or to *“set platform which allows agencies to collaborate regarding each other’s services referral systems etc to help system effectiveness.”*

Participants’ third recommendation is to spread information about LC3 to the general public and to providers. The fact that most participants who completed the survey indicated they were at least a little familiar with the LC3 movement should encourage the LC3 team to further advertise and promote their causes. In addition to promoting their initiatives, participants see the LC3 Collaborative as a great platform for spreading relevant and transparent information related to behavioral and mental health in the Doña Ana region. For example, participants recommend that LC3 *“Maintain communication about*

services available including preventive, educational and specialty programs among members and other community stakeholders" and that LC3 focus on *"Advertising about services, mission, and goals to the public."*

In addition to three recommendations mentioned above, participants also encourage the LC3 team to continue gathering the community, to be more inclusive of patients in their movement, to increase their political influence, including lobbying and funding, and to provide or facilitate training. The creation of the LC3 Policy and Advocacy Committee is a strong example of LC3's political involvement and collaborative efforts, and with the recommendations and areas of focus identified in this report, LC3 has specific directions they can take to help achieve their larger goal of building the ideal behavioral health system in Doña Ana County.

References

Behavioral Health Services Division Data provided in November 2020. Services included in summary statistics: Partial Hospitalization, Screening, Brief Intervention, and Referral to Treatment, Opioid Treatment Program, Crisis Triage Centers (Licensed), Residential Treatment Centers for Youth, Other Specialized Outpatient Services, Psychological Testing, and IMD. Source for data: *Medicaid Management Information System (MMIS) data warehouse.* Additionally, in 2019, HSD rolled out Centennial Care 2.0, which expanded some of the behavioral health services included in these statistics.

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Community Survey – Questions, Respondent Demographics, and Results

Introduction

A total of 216 individuals completed the survey, although not everyone answered all questions. The first part of the survey asked participants to select their role within the behavioral health system that best describes their experience. The most represented roles among our participants are non-profit organizations (n= 73), patients (n= 69), and private providers (n= 35). Some participants selected other roles and types. Among these participants, six identified as parents or foster parents of children who have received services in the past (n= 6), five were either students or interns (n= 5), four identified as community members (n= 4), three were counselors (n= 3), three were rehabilitation workers (n= 3), and two identified as philanthropists (n= 2). All of the organization types can be found in Table One below.

Behavioral Health System Organization		
Behavioral Health Organization Type/Role	Total	
	N	%
Non-profit	73	34%
I am a patient/client who has used behavioral health services in Doña Ana County	69	32%
Private provider	35	16%
Government/Policy makers	29	13%
Medical provider (e.g. doctors, nurses, hospital settings)	20	9%
K-12 School Teacher, Administrator, or other Staff (not Counselor)	17	8%
Higher Education Faculty or Staff	13	6%
Law enforcement/Civil service	10	5%
K-12 School Counselor	7	3%
Other group	25	12%

Table One: Organization Types/Roles Represented in the Survey

If participants were a client or have previously used behavioral health services (n= 125), they were asked to indicate where they received services. Most participants received services in the Las Cruces area (n= 113). For those who indicated other, one each specified coming from White Sands, El Paso, Albuquerque, and Farmington. Table Two below reflects the geographical locations of participants who identified as clients.

Location		
Region	Total	
	N	%
North Valley (e.g. Rincon, Hatch area)	1	1%
Las Cruces	113	90%
South Valley (e.g. Santa Teresa, Sunland Park, Chaparral area)	6	3%
Other location	5	4%
Unique Total	125	

Table Two: Patients Geographic location

If participants were a client or patient, they were then asked to select the services they have sought out or received in Doña Ana in the last ten years. About 60% of patients of behavioral health services

reported having sought general behavioral services. The other services that clients received were family services (n= 35) and social services (n= 34). A total of 9% of respondents indicated, "Other services." Various forms of services were mentioned; however, the most common were Counseling, Depression services, case management, medical and medication management. More details about the distribution of services sought by clients in the last ten years can be found in the Table below.

Behavioral health services sought out or received		
Type of service	Total	
	N	%
General behavioral health	67	60%
Family services	35	31%
Social Services	34	30%
Low-income individual or family services	27	24%
Services for undocumented immigrants	27	24%
Child Services (Outside of K-12 school setting)	26	23%
K-12 School Services	22	20%
Crisis Intervention	22	20%
Substance Abuse and Addiction	16	14%
Domestic Violence Resources	16	13%
Suicide Prevention	15	13.%
Veterans Services	11	10%
Other services	10	9%
Services for rural communities or families	9	8%
Services for individuals whose first language is not English	8	7%
Homeless Services	7	6%
Incarcerated Individuals Services	3	3%
Unique Total	112	

Table Three: Behavioral health services sought out or received

Similar to patients, providers are mainly from the Las Cruces area (n= 108). Those who selected other areas reported practicing in Albuquerque, El Paso, Deming, and Alamogordo. Table Four below specifies the providers' location.

Location		
Region	Total	
	N	%
North Valley (e.g. Rincon, Hatch area)	1	1%
Las Cruces	108	86%
South Valley (e.g. Santa Teresa, Sunland Park, Chaparral area)	7	3%
Other location	8	10%
Unique Total	119	

Table Four: Providers Geographic location

If participants were a provider, they were then asked to indicate the services they provide. A large portion reported providing general behavioral health (n= 68), family services (n= 66) and social services (n= 61). Other services widely selected include crisis intervention (n= 58), low-income individual or

family services (n= 57), substance abuse and addiction (n= 49), and suicide prevention (n= 45). In addition, 19% of participants selected "other areas." For those participants, the following behavioral health areas were indicated: Trauma services (n= 6), youth (n= 3), disabilities (n =2), PTSD (n= 2), dental (n= 2), food support (n= 2), and peer support (n= 2). Other areas applying to participants' services included LGBTQ services, housing services, depression services, family services, and therapy. More information about the behavioral health services provided by providers who responded to the survey can be found in the table below.

Behavioral health services provided		
Type of service	Total	
	N	%
General behavioral health	68	54%
Family services	66	53%
Social Services	61	49%
Crisis Intervention	58	47%
Low-income individual or family services	57	46%
Substance Abuse and Addiction	49	40%
Suicide Prevention	45	36%
Child Services (Outside of K-12 school setting)	36	29%
Homeless Services	34	27%
Services for rural communities or families	33	27%
Domestic Violence Resources	28	23%
Services for undocumented immigrants	26	21%
Services for individuals whose first language is not English	25	20%
Other areas	24	19%
K-12 School Services	22	17%
Incarcerated Individuals Services	22	18%
Veterans Services	18	14%
Unique Total	124	

Table Five: Provider Behavioral Health Services Offered

Providers were also asked to identify the age group that best reflects their primary audience. About half of the providers reported working equally with children and adults (n= 63). In contrast, 27% reported working only with adults. More information about providers' primary audience can be found below.

Primary Audience		
Age group	Total	
	N	%
Equally with both groups	63	50%
Adults (ages 18+)	34	27%
Children (Under 18)	28	22%
Unique Total	125	

Table Six: Provider’s Primary Audience

All participants were asked if they attended at least one LC3 meeting in the last six months. Most respondents have not attended an LC3 meeting during this time (n= 137). About a quarter of

participants did attend at least one LC3 meeting in the last six months (n= 54). More information about participant's attendance at LC3 meetings can be found in Table Seven below.

Attendance of LC3 Meeting		
Response	Total	
	N	%
Yes	54	27%
No	137	67%
Unsure	13	6%
Unique Total	204	

Table Seven: Attendance at an LC3 Meeting within the Last Six Months

Access to Services

Next, participants were asked to identify challenges with accessing services in the region and reasons why services may be difficult to access, and they could select multiple responses. Overall, two-thirds of participants believe that people are unsure how to reach out to providers (n= 139). Participants also indicated there are challenges with insurance and paying for services (n= 127), that this area lacks services in general (n= 117), and that rural populations are more restrained in accessing services (n= 104). Also, 13% of participants selected other challenges. For those that specified other challenges, the most common challenges listed include transportation (n= 5), the lack of coordination and collaboration across agencies (n= 4), patients' stigma and mentality about behavioral and mental health (n= 4), and the lack of qualified providers (n= 4). More information about participants' responses about challenges with accessing services can be found in Table Eight below.

Challenges in access to services		
Population or Reasons for Challenge	Total	
	N	%
People are unsure how to reach out to providers	139	67%
Challenges with insurance and paying for services	127	61%
Lack of services available in general	117	56%
Rural and remote settings	104	50%
English as a second language populations	97	46%
No accessible directory or source for behavioral health services available	95	46%
Undocumented populations	90	43%
Other challenges	27	13%
Unique Total	209	

Table Eight: Challenges in Access to Services

Participants were then asked to rate the quality of different components of Behavioral and Mental Health in Doña Ana County. Looking at vulnerable populations, referring to patients whose first language is not English, patients who live in rural and secluded areas, patients with low income, and children, results indicate that their access to services can improve. More specifically, 42% reported poor access to services for non-English speakers, and 70% reported either fair or poor access to services for low-income patients.

In addition, access to specialized services, access to directory providers, access to information, and timely access to services received low ratings. Specifically, 39% reported poor availability of specialized services and 44% reported poor access to a directory of providers. On the other hand, a positive response was yielded about access to behavioral health services among the general population, where 27% characterized this as either excellent or good.

If participants rated "Fair" or "Poor" in any area below, they were given the opportunity to explain their responses in a subsequent comment section. The summary of these comments can be found after the table. In particular, participants went on to describe that vulnerable segments of the population were more likely to be impacted by poor access to services, that there was a critical shortage of providers and specialists, that access to information and resources was often difficult, and that patients over suffer through long waitlists before accessing services. In addition, other minor themes around poor access to services were also included. More information about access to services in Doña Ana can be found in Table Nine below, as well as in the qualitative summary following the table.

Quality of Behavioral Health Services in Doña Ana											
	Excellent		Good		Fair		Poor		No Basis for Opinion		Total N
	N	%	N	%	N	%	N	%	N	%	
Availability of facilities.	5	2%	66	31%	83	39%	44	21%	14	7%	212
Availability of specialized services.	5	2%	38	18%	69	32%	82	39%	19	9%	213
Access to an easy to use directory of behavioral health providers.	8	4%	36	17%	54	26%	91	44%	20	10%	209
Availability of information about available services in the region.	4	2%	40	19%	75	35%	77	36%	16	8%	212
Access to behavioral health services among the general population.	7	3%	50	24%	87	41%	57	27%	11	5%	212
Access to behavioral health services for individuals whose first language is not English.	5	2%	22	10%	52	25%	88	42%	44	21%	211
Access to behavioral health services among low income individuals.	7	3%	34	16%	76	36%	72	34%	22	10%	211
Access to behavioral health services among rural and secluded populations.	2	1%	16	8%	42	20%	113	54%	36	17%	209
Access to behavioral health services for children (under 18 years old).	5	2%	47	22%	71	33%	62	29%	28	13%	213
Timely access to services (e.g. little to no waitlists or long times until an appointment is available).	8	4%	20	10%	70	33%	93	44%	20	10%	211

Table Nine: Quality of Behavioral Health Services

Qualitative Responses About Access to Services (N= 121)

Access to Services for Vulnerable Populations (n= 80)

First, participants described additional hurdles that vulnerable populations and minorities face in terms of accessing services (n= 80). Specific population segments discussed include undocumented immigrants, English language learners, low-income individuals, students, individuals with low and no insurance, and individuals who live in rural areas. Among vulnerable populations listed, patients with weak or no insurance (n= 16), adolescents and children patients (n=15), non-English speakers (n= 15), and patients living in rural areas (n= 18) were particularly represented across participants' responses. Participants stated multiple reasons why insurance (including Medicaid, Medicare, and Obamacare) sometimes present a barrier to accessing services. First, some patients cannot afford service fees due to a lack of insurance coverage and complex eligibility requirements. Some participants also explained that Medicaid and Medicare beneficiaries sometimes get better access to covered services than patients' private insurance. Lastly, complicated insurance paperwork and requirements can sometimes get in the way of emergency services, and insurance might sometimes prevent providers from accepting new clients.

Youth were a particular segment that were mentioned several times regarding the availability and access to services (n= 15). For instance, the lack of facilities and specialized services specifically dedicated to children, including psychologists, therapists, and inpatient and outpatient treatment, were significant concerns among participants. Furthermore, the lack of bilingual providers is an additional hurdle that prevents non-English speakers from receiving proper mental and behavioral health care (n= 15). Patients living in rural areas also suffer from inadequate access to services, mainly due to limited transportation availability and poor access to information (n= 18). Regarding other segments of vulnerable populations, participants explained that undocumented immigrants might suffer from a strong stigma around them about behavioral and mental health and a fear of reaching out due to their legal status.

Shortage of Providers and Specialists (n= 70)

Participants also described a critical shortage of providers (n= 70), especially high-quality specialist providers and facilities (n= 20). Those services and facilities include serious mental health, autism, eating disorders, parents counseling, medication assisted treatment, pediatric psychiatry, and therapists. According to participants, the lack of providers is one of the leading causes of poor access to services. The shortage in providers also leads agencies to operate at maximum capacity (n= 10), resulting in providers being unable to accept new patients. Additionally, the lack of providers often impacts families, parents, and children (n= 6). Regarding services areas, the lack of supportive services and case managers stood out in the comments (n= 4).

Lack of Access to Information and Resources (n= 47)

The lack of access to information to the general public is the third issue about service access and availability that emerged from participants' responses (n= 47). More specifically, participants explained that patients often struggle to find information and resources available in the community, whether digitally or physically. Concerning information specific to providers, such as contact information and specialties, many participants noted the lack of a providers' directory (N= 15), which would be helpful for addressing access issues. It is also essential to note that, according to participants, the vulnerable

populations mentioned above are less likely to have access to information and resources. Therefore, providers strongly suggest creating a directory that both providers and patients could access, facilitating referrals and public access to information.

Long Waitlists (n= 28)

Lastly, participants highlighted that long waitlists remain a prevalent barrier to accessing behavioral and mental health services. One of the main reasons for long waitlists is, as highlighted previously, a combination of lack of providers and specialists available and agencies already operating at their maximum capacity. As a result, respondents described observing either long waitlists for new patients or agencies simply rejecting new patients.

Other Responses About Access and Availability to Services

Participants also mentioned other themes throughout their open-ended responses. These themes include limited access to mental and behavioral services in school (n = 4), the presence of stigma around mental and behavioral health (n = 3), and providers' low quality of services (n = 3). More information about participants' open-ended responses about access and availability to mental and behavioral health services in Doña Ana County can be found in Table Ten below.

Themes on The Lack of Availability and Access to Services			
Themes	**N**	**Subthemes**	**Example Quotes**
Lack of services for vulnerable populations	80	No Insurance – Medicaid – Medicare Youth – Children Non-English speakers Low-Income Rural population Undocumented immigrants Students Homeless	*“once you have a more specific demographic such as low income or limited English proficiency [it] seems harder to connect to appropriate services”* *“I think undocumented consumers may be scared to reach out”* *“students without Medicaid or insurance have no access to mental health services”* *“It is difficult to find contact information, especially in rural areas. Rural or remote areas have little to no services for our families”*
Lack of providers and services	70	Specialized services For families and parents Agencies at maximum capacity Supportive services Quality services	*“DAC faces a lack of providers, a lack of providers who can serve underserved populations”* *“there are a very few quality mental health practitioners in Las Cruces”* *“Limited of specialized services offered in Doña Ana County. Not enough providers”* *“We also need to increase access to information as well as increase access to mental health and behavioral health services for families with young children.”*

Lack of access to information for general public	47	Lack of collaboration Information and resources locations Promoting information Rural populations	*"I also think that there is probably a good amount of resources out there however people struggling knowing what is available and how to get it"* *"Clients ordinarily state they have no idea where to start in their search for services."* *"Individuals with low income and living in secluded areas might not have a cell phone or tv where they can see services being promoted."*
Long waitlists	28	Specialized services Children - Youth	*"Timely access, some people still experience long wait times or wait lists."* *"Shortage on psych's especially for children, the wait time on an appointment is like a month or two out and sometimes it's emergency based especially for children."*
Lack of providers directory	15	Poor referrals Lack of access to contact information	*"I have difficulty finding specialized services for clients, don't know of a directory of providers but know providers from my work in the community, haven't seen info on services in the region other than my agencies"* *"Clients ordinarily state they have no idea where to start in their search for services. Providers also have limited knowledge in where referrals should be made"* *"Unreliable information about providers on net searches and no reliable directory system."*
Others	10	Limited services in schools Stigma Low service quality	*"Not enough therapists in schools"* *"Counseling and mental health services should be spoken about more and seen as something that is important for all people to keep us healthy"* *"The quality of services in this area is highly deficient."*

Table Ten: Themes on The Lack of Availability and Access to Services

Coordination of Services

Providers and community members were then asked how well they think different behavioral health providers work together to coordinate services to provide patients with the wraparound services they need. Overall, participants reported poor coordination of wraparound services, as 70% indicated that providers work together "somewhat well" or below. Specific responses about how well respondents think providers work together to coordinate services in Doña Ana can be found in Table Eleven below.

Coordination of wraparound services		
Rating	Total	
	N	%
Extremely Well	3	2%
Very Well	24	12%
Somewhat Well	62	32%
Slightly Well	46	24%
Not Well at All	27	14%

I have not used coordinated services	34	17%
Unique Total	196	

Table Eleven: Coordination of Wraparound Services

Participants were also asked to identify the specific types of services that they think need to coordinate more effectively. All offered categories received a high percentage of responses, however, most respondents agreed that school districts (63%), private practitioners (63%), public providers (60%), law enforcement (58%), and physical health providers (58%) were the services with the strongest need for better coordination. For participants who specified there were other types of services in need of better coordination, the services mentioned most often were housing and in-house options (n= 8), general mental and behavioral health providers (n= 6), youth and juvenile services (n= 4), and peer support (n= 3). Other types of services listed also included psychiatrists, substance abuse services, judicial and carceral services, medical providers, and therapists. More information about the services that participants listed as in need of better coordination in Doña Ana can be found in Table Twelve below.

Services in need of better coordination		
Type of Service	Total	
	N	%
School districts	112	63%
Private practitioners	112	63%
Public providers	106	60%
Law enforcement/civil service	104	58%
Physical health providers	104	58%
Hospitals	101	57%
Domestic violence shelters/resources	81	46%
Other types of services	23	13%
Unique Total	178	

Table Twelve: Specific Services in Need of Better Coordination

In addition, participants were asked what service areas need to coordinate with each other more effectively. Similar to the previous questions, all responses options received high agreement. The specific services areas that stood out were social services (66%), crisis intervention (61%), general behavioral health (61%), family services (60%), and substance abuse and addiction (59%). Participants who indicated there were other service areas in need of better coordination went on to list case management (n= 2), youth services (n= 2), and psychiatrists (n= 2). More information about the service areas in need of better coordination can be found in Table Thirteen below.

Service areas in need of better coordination		
Type of service	Total	
	N	%
Social Services	121	66%
Crisis Intervention	112	61%
General behavioral health	111	61%
Family services	110	60%
Substance Abuse and Addiction	107	59%
Low-income individual or family services	105	57%

K-12 School Services	98	54%
Suicide Prevention	97	53%
Domestic Violence Resources	95	52%
Child Services (Outside of K-12 school setting)	93	51%
Homeless Services	92	50%
Services for rural communities or families	90	49%
Services for undocumented immigrants	90	49%
Services for individuals whose first language is not English	89	49%
Incarcerated Individuals Services	79	43%
Veterans Services	78	43%
Other areas	12	7%
Unique Total	183	

Table Thirteen: Service Areas in Need of Better Coordination

As it relates to coordination of services, participants were also asked to rate the *quality* of behavioral health services in the county based on their experience. Overall, respondents gave relatively low ratings across all five areas listed, as at least 60 percent of participants rated each area as either fair or poor. More information about the perceived quality of coordination and communication in the behavioral health system in Doña Ana County can be found in Table Fourteen below.

Quality of Behavioral Health Services in Doña Ana County - Coordination											
	Excellent		Good		Fair		Poor		No Basis for Opinion		Total N
	N	%	N	%	N	%	N	%	N	%	
Coordinating of care between providers about patients who move through the behavioral health system.	5	3%	39	21%	61	32%	53	28%	31	16%	188
Provider follow up about patients care as they move through the behavioral health system.	6	3%	28	15%	57	30%	64	34%	33	18%	
Communication between providers about the same clients they both have cared for/ interacted with.	4	2%	30	16%	58	31%	58	31%	36	19%	186
Communication between different providers in the region in general.	4	2%	30	16%	51	27%	65	35%	36	19%	186
The referral process from one provider to another provider.	5	3%	35	19%	70	37%	46	25%	32	17%	188

Table Fourteen: Quality of Behavioral Health Services - Coordination

Participants who rated "Fair" or "Poor" in any of the areas above were asked to explain their ratings in a subsequent comment box. They reported an overall lack of collaboration and communication across providers, agencies, organizations, and patients. Participants also insisted on the need for a centralized

referral system for all providers and agencies. Lastly, participants also described the need to develop an integrated wraparound system to provide continuity of care to patients.

Communication and Collaboration (N= 60)

Participants had the opportunity to share their perspectives on the current state of collaboration and communication among mental and behavioral providers in Doña Ana County. Three main points emerged from participants' open-ended responses:

1. There are clear indicators of a lack of collaboration and communication among providers.
2. There is a strong need for a robust and transparent referral system.
3. There is also a need for implementing continuity of care and a wraparound system for patients.

Lack of Collaboration and Communication

Overall, participants overwhelmingly agree on the lack of collaboration and communication across providers, agencies, and organizations (n = 25). However, multiple explanations emerged among participants' responses. First, providers and agencies tend not to share information they might have among each other (n = 5). This is mostly due to providers competing against each other for patients and funding. Thus, providers do not have any financial, professional, or business incentives to share information (n = 5). Regarding providers who tend to avoid sharing information, medical providers were specifically indicated as being protective of their data (n = 4).

The Need for a Referral System

The second issue that arose from participants' responses is the necessity for a robust and inclusive referral system. At the core of the need for a referral system are two elements. First, there is a lack of follow-up with patients after consulting with providers (n = 5). Second, the need for a referral system goes along with the necessity to facilitate the access to information for patients and providers highlighted previously. Participants indicated that a referral system would also facilitate patients' transition from one provider to another, ultimately helping patients to receive the best care possible.

The Need for an Integrated Wrap-Around System

Lastly, participants highlighted a need for developing a wraparound service system that would promote patients' continuity of care (N= 8). As explained above, creating a referral system that is accessible by providers would be an essential step towards providing continuity of care. Additionally, collaboration and communication would also become critical elements in the development of a wraparound system. Medical providers were specifically brought up for not sharing crucial information with providers, such as patients' admitting evaluations, in the data. Additional information about these themes identified in the comments and example quotes for these areas can be found in Table Fifteen below.

Themes on the Lack of Communication and Collaboration Among Providers			
Themes	**N**	**Subthemes**	**Example Quotes**
Lack of collaboration and communication	**25**	No sharing of information Competition among providers Medical providers	*"Communication between providers needs improvement - there are times we don't even know what each other are doing or the services we are providing."* *"Coordination in Las Cruces does not exist in any meaningful way. Each practice is determined to indicate that they are the best choice (none of them are) while actively dissuading cooperation with more specialized practices."* *"I also think that private providers do not participate in sharing as they cannot be compensated for the time it takes to collaborate"* *"I feel medical, hospitals, and service providers tend not to communicate much even about patients seen in common."*
Lack of referral system	**15**	No patients' follow-up Lack of access to information for providers and patients	*"communication between providers can improve in relation to services offered, how to access care/ each other's referral process"* *"Lack of helpful information about who one is being referred to and their credentials."* *"The referral process if not followed up with and follow through at times gets lost in the process"*
Lack of continuity of care	**8**	Need for wrap-around system Need for referral system	*"Need for an integrated care continuum for our patients. It is important to develop a community care planning process that can be implemented."* *"I do not see providers coordinating care with each other to wrap services around a client. The providers talk about wanting to collaborate in community meetings, but I do not see it happen in actual care for people"* *"and the mental hospitals - there is virtually ZERO communication from hosp to outpatient f/u appt... It's a struggle to obtain admitting evaluation"*

Table Fifteen: Themes on the Lack of Communication and Collaboration Among Providers

Disruptions to the System and Other Needs

Providers and community members were asked to rate how well prepared the Doña Ana County mental and behavioral health system was to handle the disruption in services due to the COVID pandemic. Almost all respondents (90%) indicated that the system was "Somewhat Prepared" or below, suggesting that preparation can stand to improve. More information about participants' responses about the system's ability to handle the Covid disruption to services can be found in Table Sixteen below.

Preparation to handle disruption due to COVID		
Rating	Total	
	N	%
Extremely Prepared	2	1%
Very Prepared	15	8%
Somewhat Prepared	74	41%

Slightly Prepared	58	32%
Not Prepared at all	31	17%
Unique Total	180	

Table Sixteen: System Preparation to Handle Disruption due to COVID

Participants were then asked to rate different areas of behavioral and mental health in Doña Ana County that centered on stability and foundation of the system. When asked about the system's ability to maintain services amid unexpected disruptions and the system's ability to quickly responded to changes in policy or environment, 55% and 52% of participants, respectively, responded either fair or poor. Interestingly, 46% of participants reported provider cultural knowledge and sensitivity are either good or excellent, which contradicts some of the comments shared below. Furthermore, it is also important to note that 39% and 35% of respondents did not have a basis for opinion when asked about data and record storage for providers and insurance processes. More information about participants' responses about the quality of behavioral health services in Doña Ana amidst disruptions can be found in Table Seventeen below.

Quality of Behavioral Health Services in Doña Ana County – System Foundation and Stability											
	Excellent		Good		Fair		Poor		No Basis for Opinion		Total N
	N	%	N	%	N	%	N	%	N	%	
The system's ability to quickly respond to changes in policy or environment.	4	2%	57	31%	67	36%	29	16%	27	15%	184
The system's ability to maintain services amid an unexpected disruption (pandemic, shutdown).	6	3%	56	31%	63	35%	36	20%	20	11%	181
Data storage and record keeping among providers in the region.	4	2%	50	28%	38	21%	17	9%	71	39%	180
Insurance processes (consistency in decisions, provider understanding of policy).	5	3%	51	28%	35	19%	26	14%	64	35%	181
Provider cultural knowledge and Sensitivity.	11	6%	72	40%	41	23%	23	13%	33	18%	180

Table Seventeen: Quality of Behavioral Health Services – System Foundation and Stability

If participants rated "Fair" or "Poor" in any of the areas above, they were asked to briefly explain their ratings. A total of 43 participants supplemented their ratings. They reported that Doña Ana's poor ability to manage disruptions primarily originates from a lack of collaboration across providers and agencies (n= 7), a lack of planning (n= 5), and the limitations around using technology with patients (n= 4), such as difficulties to connect with patients or poor access to technology. Other responses about challenges with managing service disruptions included providers' lack of cultural knowledge and awareness (n= 3), a lag in services (n= 3), and an increased impact on vulnerable populations (n= 3). Lastly, other themes brought up about the system not handling disruptions well included a lack of leadership, difficulties in adopting new changes, and poor personal contact with patients. More information about participants' comments about the system’s ability to handle service disruptions be found in Table Eighteen below.

Themes on Challenges with Handling Disruptions to the System		
Themes	**N**	**Example Quotes**
Lack of collaboration across providers and agencies	7	*"Our system is comprised of many private providers that are not connected to a collaborative effort. So understand who is available, using tele- health, times etc. has been hard to find out."*
Lack of planning	5	*"We can do more to plan and prepare."* *"No one had a template or model. Services were shut down too early in Doña Ana county and people did without."*
Technological limitations	4	*"We were only permitted to conduct telephone sessions - this was a real struggle with younger folks (kids don't talk on the phone these days-they text)"* *"Virtual treatment is limited by a lack of infrastructure, support and resources for clients."*
Lack of centralized information	3	*"There is not a centralized space that access information to allow for an easy exchange amongst providers"* *"There is not an accurate listing of providers and it is difficult for new providers to get on panels."*
Lack of cultural knowledge and awareness	3	*"Cultural knowledge and sensitivity are non-existent in the area. Providers approach their work with the assumption that the community is a monolith."* *"Provider's cultural knowledge and sensitivity has always been an issue. Continuing education on cultural humility for certain populations must be ongoing and not a one time thing. It should be a "must" for every employee at every organization/provider/agency/hospital."*
Lag in services - Recovering system	3	*"With so many independent practitioners who had to seek out tele-medicine options on their own (rather than there being an established, govt managed access point) there was a significant lag in availability of services."*
Vulnerable population more affected	3	*"I don't feel that COVID addressed the poor and individuals that did not speak English."* *"During this pandemic, I am not sure we are providing the support to those who needed to get away from their homes due to poor conditions."*

Table Eighteen: Themes on Disruptions of System and Other Needs

Experience with the LC3 Behavioral Health Collaborative

Providers and community members were asked about their familiarity with the LC3 Behavioral Health Collaborative. According to the responses, there was a near equal split between individuals who know what this group does and those who have no idea who this group is (26% each), though several participants have at least a little familiarity with LC3. More information about participants' familiarity with LC3 can be found in Table Nineteen below.

Familiarity with LC3		
Rating	Total	
	N	%
Yes, I know who this group is and what they do	49	26%
No, I have never heard of this group at all	48	26%
Yes, I know a little information about this group and what they do	32	17%
I have heard of this group but do not know anything about what they do	29	16%
Yes, I know some information about this group and surrounding counties what they do	29	16%
Unique Total	187	

Table Nineteen: Familiarity with LC3

Participants were then asked how they know about LC3, if applicable to them. Many participants (27%) reported attending LC3's monthly meetings, while several indicated they have a co-worker or friend who is a member or that they have read articles about this group in the local paper. Participants who selected they have heard of LC3 through other ways listed Families and Youth, Inc. (n= 4), through email distributions (n= 4), through the Community Survey distribution (n= 2), and through other organizations' meetings (n= 2). More information about how participants have heard of LC3 can be found in Table Twenty below.

How participants knew of LC3		
Method	Total	
	N	%
I am a member	30	22%
A coworker is a member	22	22%
I attended their monthly meetings	39	27%
I have read articles about them in the local newspaper	28	20%
I have attended an event they advertised	17	12%
I have asked to speak at their meetings	3	2%
They have asked me to speak at their meetings	4	3%
They have asked someone at my organization to speak at their meetings	8	6%
I have a friend or family member who is involved with LC3	36	26%
Other Ways	14	10%
Unique Total	139	

Table Twenty: How Participants Knew of LC3

Participants were then asked to specify how impactful they feel the LC3 group has been in the behavioral health system in Doña Ana County. Most participants reported that LC3 had either been very or somewhat impactful in the behavioral health system in Doña Ana. More specifically, 33% believe that LC3 is very impactful, while 42% responded somewhat impactful. More information about participants'

perspectives on LC3's impact on the behavioral health system in Doña Ana County can be found in Table Twenty-One below.

Impact of LC3 in behavioral health system		
Rating	Total	
	N	%
Extremely Impactful	13	9%
Very Impactful	46	33%
Somewhat Impactful	59	42%
Slightly Impactful	13	9%
Not Impactful at All	10	7%
Unique Total	141	

Table Twenty-One: Impact of LC3 in Behavioral Health System

Participants were then asked to describe what LC3 can do to support collaboration between behavioral health providers. A total of 43 participants responded to the question, and these individuals emphasized the importance of maintaining the collaborative effort initiated by LC3 (n= 19), focusing on creating a collaborative platform for providers and agencies to access (n= 16), and continuing to inform the general public and providers about the behavioral and mental health system in Doña Ana (n= 12). Table Twenty-Two below provides more information about participants' recommendations for how LC3 can support collaboration between behavioral health providers.

Themes on Supporting Collaboration Between Behavioral Health Providers			
Themes	**Subthemes**	**Count**	**Example Quotes**
Maintaining the collaborative effort	Facilitate conversations	19	*"Continue to work and collaborate with health stakeholders and community leaders. Partner with local health council, city, county, and state health agencies so everyone is working together from the grassroots, policy, advocacy and funding levels. Building a community care model."* *"Continue to hold meetings and continue to create community partners in order to better serve the families in Doña Ana county"*
Create a collaborative platform for providers and agencies	Platform for referrals Platform for general information Platform for contact information and specialization	16	*"Create a website where providers can communicate and where we can see what else is going on in the community."* *"Create a directory of providers and what areas they specialize in that other providers and families can access, advocate for an increase in providers in all agencies, showcase different agencies/providers in our area and what they specialize in to increase awareness* *"set platform which allows agencies to collaborate regarding each other's services referral systems etc to help system effectiveness"*
Spread information to the general	Social Media Advertisement Showcase services available	12	*"Maintain communication about services available including preventive, educational and specialty programs among members and other community stakeholders"* *"Advertising about services, mission, and goals to the public."*

public and providers	Public awareness		*"Create a directory of providers and what areas they specialize in that other providers and families can access, advocate for an increase in providers in all agencies, showcase different agencies/providers in our area and what they specialize in to increase awareness"*
Gather the community	Involve different segments of the community in the LC3 mission	6	*"Facilitate conversations between provider organizations and law enforcement/EMS around certificates of evaluation. Facilitate communication with schools regarding how best to coordinate behavioral health supports for their students in a way that make sense."*

Table Twenty-Two: How LC3 Can Improve Provider Collaboration

Demographics

Near the end of the survey, respondents were asked to provide basic demographic information. Results indicate that English is the primary language among almost all respondents (95%) and about one third of respondents each are between 25 to 40 years old or 51 years old or more. More information about participants' primary language and age groups can be found in Tables Twenty-Three and Twenty-Four below.

Primary Language		
Language	Total	
	N	%
English	178	95%
Spanish	7	4%
Other Language	2	1%
Unique Total	187	

Table Twenty-Three: Participant's Primary Language

Age group		
Age	Total	
	N	%
18 to 24	8	4%
25 to 40	65	35%
41 to 50	43	23%
51 or over	67	36%
Choose not to disclose	4	2%
Unique Total	187	

Table Twenty-Four: Participant's Ages

Participants were also asked to specify their race/ethnicity. Most participants indicated they were either White (48%) or Latino/Hispanic (47%). When looking next at gender, a strong majority (77%) of respondents were female. More information about participants' race and ethnicities and gender can be found in Tables Twenty-Five and Twenty-Six below.

Race/Ethnicity		
Classification	Total	
	N	%
American Indian or Alaska Native	7	4%
Asian	1	1%
Black or African American	3	2%
Latino/Hispanic/Hispanic American	86	47%
Native Hawaiian or Pacific Islander	0	0%
White	89	48%
Choose not to disclose	12	7%
Unique Total	184	

Table Twenty-Five: Participant's Race/Ethnicity

Gender		
Classification	Total	
	N	%
Male	39	21%
Female	143	77%
Non-binary	1	1%
Prefer to self-describe	0	0%
Choose not to disclose	4	2%
Unique Total	187	

Table Twenty-Six: Participant's Gender

Impact of Service Disruptions for Patients and Community Members

Community members and patients were asked about the impact of the mental and behavioral health services shutdown from 2013. First, they were asked to specify the number of years they have been a patient or client in the Doña Ana area behavioral health system. Responses were relatively spread out, though the most common length of time was more than ten years (23%), with almost as many indicating they were a patient for less than one year or one to two years. More information about the length of time that patients have been involved in the behavioral health system in Doña Ana County can be found in Table Twenty-Seven below.

Years being a patient/client		
Years	Total	
	N	%
Less than one	23	21%
One to two	24	22%
Three to five	19	17%
Six to ten	18	17%
More than ten	25	23%
Unique Total	109	

Table Twenty-Seven: Years Patient/Client in Doña Ana Behavioral Health System

Participants were then asked *how* the 2013 behavioral health shutdown impacted them. Most participants reported to not have been affected by the 2013 shutdown, whether they were in New

Mexico (34%) or not in the state nor the field of behavioral health (27%) at the time. Of those who indicated they were impacted, the most cited result was that the shutdown made communication and collaboration more difficult (16%), with several participants indicating they could not find the services needed (12%), or that patients needed to rebuild trust and relationships with new providers (12%). For those who were impacted in other ways not listed, they specified being put on a waitlist due to providers being at-capacity (n= 5), having access to their services disrupted (n= 4) (including access to medications), and losing trust in the system and other providers (n= 4). More information about ways patients were impacted by the 2013 behavioral health shutdown in New Mexico can be found in Table Twenty-Eight below.

Impact of 2013 shutdown		
Impact	Total	
	N	%
I was in New Mexico, but I was not impacted by the shutdown.	38	34%
I was not in the state or in the behavioral health field during that time.	30	27%
Collaboration and communication between my providers became more difficult.	18	16%
I was impacted by the shutdown in other ways.	16	14%
I could not find the services I needed.	13	12%
I had to rebuild trust and relationships with new providers I had to find.	13	12%
Services I tried to access were at capacity and could not accept me.	11	10%
Services I used were shutdown.	11	10%
Someone in my family had to find new providers because the ones they used were shutdown.	9	8%
I could not afford to use behavioral services I needed.	6	5%
I could not find any information about services in Doña Ana County.	6	5%
I did not have transportation to the services that I needed.	1	1%
I found new providers but they were far from where I live.	1	1%
Unique Total	113	

Table Twenty-Eight: Impact of 2013 Shutdown

Participants were then asked to select the challenges they had encountered in the last few months as it relates to the COVID pandemic specifically. Similar to the responses above, about 35% of patients did not encounter any challenges during the pandemic. For those that were impacted, these patients reported that the pandemic resulted in services not accepting new patients or having long waitlists (28%) and that collaboration and communication between their providers became more difficult (16%). Interestingly, these challenges are similar to the impact of the 2013 shutdown.

Three other important challenges emerged from patients' responses: Challenges related to resources, challenges related to insurance, and challenges related to telehealth. Concerning access to resources, 8% of patients stated they cannot afford needed behavioral health services, and 4% reported not having access to transportation to needed services. Concerning insurance challenges, 10% indicated they do not know their insurance benefits, and 6% do not have their services covered by insurance. Concerning telehealth challenges, four elements emerged:

- 9% of patients reported they do not have a home environment conducive to telehealth.
- 6% reported they do not have the necessary technology for telehealth.

- 6% do not trust telehealth.
- 4% do not know how to use telehealth.

Additionally, 10% of patients reported they have encountered other challenges due to the COVID pandemic. For those that specified being affected in other ways, they reported encountering many issues with technology (n= 6), including connecting through telehealth. A few participants each also indicated that providers are not accepting new patients, have observed increased waitlists, loss of trust with telehealth, financial problems, and feelings of isolation and stress. More information about challenges that patients have encountered due to the COVID pandemic can be found in Table Twenty-Nine below.

Challenges due to COVID pandemic		
Challenge	Total	
	N	%
I have not encountered any challenges during the pandemic	37	35%
The services I need are not accepting patients/has too long of a waitlist	30	28%
Collaboration and communication between my providers became more difficult	17	16%
Other challenges	11	10%
I do not understand the benefits that were available to me through my insurance	11	10%
I do not have a good home environment for telehealth/virtual session with my providers (e.g. no privacy, space that works well for remote sessions	10	9%
Services I used were shutdown	9	9%
I cannot afford to use behavioral health services I need	8	8%
Someone in my family had to find new providers because the ones they used were shutdown	7	7%
I do not have the technology needed for telehealth sessions with providers	7	7%
I do not trust telehealth/virtual health options	6	6%
I cannot find any information about services I need in Doña Ana	6	6%
I do not have insurance to cover the services that I need	6	6%
I do not have transportation to services that I need	4	4%
I do not know how to use telehealth/virtual health	4	4%
I found new providers, but they are far from where I live	2	2%
Unique Total	106	

Table Twenty-Nine: Challenges Due to COVID Pandemic

Provider Questions

Providers were also asked a series of questions, starting with the number of years they have worked in their behavioral health sector. Many (39%) have worked in this sector for more than ten years, and the rest of the responses were relatively spread out across the other durations listed. More information about provider's time working in the Doña Ana behavioral and mental health system can be found in Table Thirty below.

Years being a provider		
Years	Total	
	N	%
Less than one	13	12%

One to two	16	14%
Three to five	19	17%
Six to ten	20	18%
More than ten	43	39%
Unique Total	111	

Table Thirty: Year Being a Providers

Providers were also asked about the impacts of the 2013 shutdown from their perspective. Many providers who responded indicated they were not affected by the 2013 shutdown because they were not in the state of New Mexico or they were not in the field at the time (30%), or simply indicated they were just not impacted by the shutdown (19%). On the other hand, providers who were affected by the 2013 shutdown reported that collaboration became more difficult (29%) and noticed an increase in patients and referrals (17%). The increase in patient load put some organizations at capacity (11%), and in some cases led to providers having to turning new patients down due to being at capacity (7%).

Lastly, 14% of providers indicated they were impacted by the shutdown in other ways. These providers reported an increase in difficulties with accessing services and referring patients (n= 5), having an overwhelming sense of fear of losing their job, business, practice, or license (n= 3), or seeing their staff leaving for other jobs (n= 3). More information about ways providers were impacted by the 2013 shutdown can be found in Table Thirty-One below.

Impact of 2013 shutdown-*Providers*		
Impact	Total	
	N	%
I was not in the state or in the field during that time.	29	30%
It became more difficult to collaborate with other providers.	28	29%
I was in the area, but I was not impacted by the shutdown.	18	19%
I had an increase in patients and referrals from others whose providers shut down.	16	17%
I was impacted by the shutdown in other ways	14	14%
I had to build trust with new patients.	11	11%
I had an increase in patients and referrals and it put my organization at capacity.	11	11%
I had to turn new patients/clients down because my organization was at capacity.	7	7%
I lost patients or had to downsize my services.	7	7%
I had to shut down my services.	5	5%
Unique Total	97	

Table Thirty-One: Impact of 2013 Shutdown - Providers

Providers were asked to select the challenges they have encountered in the last *few months* as the COVID pandemic continues. Responses were similar to the impacts they reported from the shutdown above. Specifically, 39% of providers reported difficulties collaborating with other providers amidst the COVID pandemic. Further, providers reported important challenges in other areas during the pandemic in particular:

- 20% of providers observed an increase in patients and referrals.
- 15% of providers admitted to not having the capacity to handle the increase in patients and referrals.
- 13% stated that the increase in patients and referrals put their organizations at capacity.

- Unfortunately, 5% of providers had to shut down their services.

Also, provider’s responses indicated that telehealth has been difficult. First, 34% of providers reported that clients do not know how to use telehealth, while 23% believe that their clients do not trust telehealth. In addition, 9% of providers do not have a conducive home environment for telehealth, and 8% do not have the necessary technology to perform telehealth properly.

Lastly, 13% of providers reported having encountered other challenges in the COVID pandemic. These providers detailed their difficulties in implementing telehealth (n= 8) and using technology (n= 5). The issues reported with telehealth included the lack of personal connection and engagement and the feeling of absence of safety and security. Providers also indicated that many clients do not have the equipment nor the knowledge to use the necessary technology. As a result, vulnerable populations such as youth, the elderly, rural populations, and homeless individuals are more likely to be left behind by switching to telehealth. Lastly, providers also reported difficulties with adjusting their workflow, communication with staff, and overall structural organization (n= 5) during the pandemic. More information about providers' challenges due to the COVID pandemic can be found in Table Thirty-Two below.

Challenges due to COVID pandemic-*Providers*		
Challenge	Total	
	N	%
It has become more difficult to collaborate with other providers.	35	39%
My clients do not know how to use telehealth.	31	34%
My clients do not trust telehealth or virtual sessions.	21	23%
I have not encountered any challenges during the pandemic	18	20%
I have had an increase in patients and referrals from others whose providers shut down.	18	20%
My organization does not have the capacity to meet the need of an increase in patients.	14	15%
I lost patients or had to downsize my services.	13	14%
Other challenges	12	13%
I have had an increase in patients and referrals and it put my organization at capacity.	12	13%
I do not have a conducive home environment for telehealth session with clients (e.g. private, quite space).	8	9%
I do not have the technology needed for telehealth sessions with clients.	7	8%
My organization does not have the skillset needed to meet the new needs we are seeing due to the pandemic	7	8%
I had to shut down my services.	4	4%
I had to turn new patients/clients down because my organization was at capacity.	3	4%
Unique Total	91	

Table Thirty-Two: Provider Challenges Due to COVID Pandemic

Providers were then asked what areas need to be addressed to increase the region's capacity to handle severe disruptions (behavioral health system shutdown, pandemic). Most providers reported that coordination between agencies (73%) and funding (72%) are the most critical areas to address to improve the region's capacity to handle disruptions. However, other options received a high number of

responses as well. Specifically, 60% of participants believe that the region also needs a shared database across providers with patient information and training for organizations. More information about the areas that need to be addressed to increase the region's capacity to handle severe disruptions can be found in Table Thirty-Three below.

Needs to address disruptions		
Needs	Total	
	N	%
Coordination between agencies	82	73%
Funding	81	72%
Shared database or integrated system with patient information across providers	67	60%
Training for organizations	67	60%
Technology needs	63	56%
Leadership capabilities of organizations	48	43%
Other areas	2	2%
Unique Total	112	

Table Thirty-Three: Behavioral Health Needs to Address Disruptions

Providers were also asked to rate how easy it is coordinate services or collaborate with other providers in the region. As the results from the previous question suggest, 55% of providers responded that coordination with other services in the region is either difficult or very difficult. Also, 17% of providers indicated this question is not applicable to them, which is important to note. More information about perceived ease of collaboration with other providers in the region can be found in Table Thirty-Four below.

Ease of coordination		
Rating	Total	
	N	%
Very Easy	1	1%
Easy	31	27%
Difficult	52	45%
Very Difficult	12	10%
Not applicable to me	20	17%
Unique Total	116	

Table Thirty-Four: Ease of Coordination Among Providers

Continuing the line about collaboration, providers were then asked to select the main challenges they face when collaborating and coordinating with other providers. Most providers believe that the lack of a shared database across providers is the main challenge for collaboration and coordination between providers (61%). In addition, providers reported that insurance and healthcare policy make coordination more difficult (44%). Other critical challenges towards coordination and collaboration include a lack of motivation from providers to collaborate (28%), a lack of knowledge on how to collaborate (22%), and how to reach other providers (17%). Providers who selected other challenges reported being already overwhelmed with work and lack of incentives to collaborate with other providers. While some providers believe that collaboration and communication are not valued highly enough, other providers stated that the lack of positive outcomes and concrete actions slows down collaboration between

providers. More information about the main challenges with collaboration between providers can be found in Table Thirty-Five below.

Main challenges		
Challenges	Total	
	N	%
There is not a shared database or integrated system with patient's information across providers	55	61%
Insurance and healthcare policy make it difficult to collaborate	40	44%
Other providers don't want to collaborate	25	28%
Other providers don't know how to collaborate	20	22%
I don't know how to reach to other providers	15	17%
The providers I need/want to collaborate with do not exist in this region	11	12%
Other challenges	8	9%
Unique Total	90	

Table Thirty-Five: Main Challenges with Collaboration and Coordination Among Providers

Providers who work in K-12 schools or directly with children were asked to rate the perceived importance of several areas regarding the development of the ideal behavioral health system for K-12 school systems in Doña Ana County. Overall, out of the 82 participants who responded to the question, most items listed were rated as important or extremely important, with all items having at least 50% of respondents indicating as extremely important for helping create the ideal behavioral health system for children. More information about the importance of different tasks with creating the ideal behavioral health system for K-12 can be found in Table Thirty-Six below.

Importance of tasks for building an ideal behavioral health system in K-12											
	Extremely Important		Very Important		Somewhat Important		Slightly Important		Not Important at All		Total N
	N	%	N	%	N	%	N	%	N	%	
Including mindfulness and meditation in the schools.	41	50%	15	18%	17	21%	6	7%	3	4%	82
Teaching students about behavioral health.	57	70%	18	22%	4	5%	1	1%	2	2%	82
Training teachers and school staff about behavioral health.	64	78%	13	16%	3	4%	0	0%	2	2%	82
Reducing the stigma around behavioral health.	67	82%	9	11%	3	4%	1	1%	2	2%	82
Providing continuous support for families and children throughout their progression in school	64	79%	9	11%	6	7%	0	0%	2	3%	81

Offering recommendations and guidelines for home care/mobile services.	50	63%	17	21%	10	13%	1	1%	2	3%	80
Providing families and students with resources and access to behavioral health services through the schools.	66	81%	8	10%	5	6%	0	0%	3	4%	82

Table Thirty-Six: Importance of Tasks for Building an Ideal Behavioral Health System for Schools System

Finally, providers were asked to list other suggestions for creating the ideal behavioral health system for K-12 schools. They reported increasing global family support (n= 5), including improving or maintaining funding dedicated to students and families' health (n= 3) and increasing family involvement (n= 3). Participants also suggested strengthening collaboration and coordination between providers and schools (n= 4) and teaching teachers and parents about behavioral and mental health (n= 5), including services and resource locations. More information about the suggestions for creating the ideal behavioral health system for K-12 schools can be found in Table Thirty-Seven below.

Themes on Creating an Ideal Behavioral Health System for K-12 Schools		
Themes	**Count**	**Example Quotes**
Increase family support	5	*"Providing support for home visiting, interventions to support families, increased family involvement."*
Teach teachers and parents about behavioral and mental health	5	*"All New Mexico schools need to be Trauma Informed like in California."* *"Increase in professional development around mental and behavioral health."*
More collaboration between providers and schools	4	*"further engagement/collaboration between public schools and behavioral health"* *"Arrange for consulting therapists to assist schools on specialty issue such as telehealth."*
Increase/Maintain school funding	3	*"Keep school-based health centered funded"* *"increase funding and providers"*

Table Thirty-Seven: Themes on Creating an Ideal Behavioral Health System for K-12 Schools

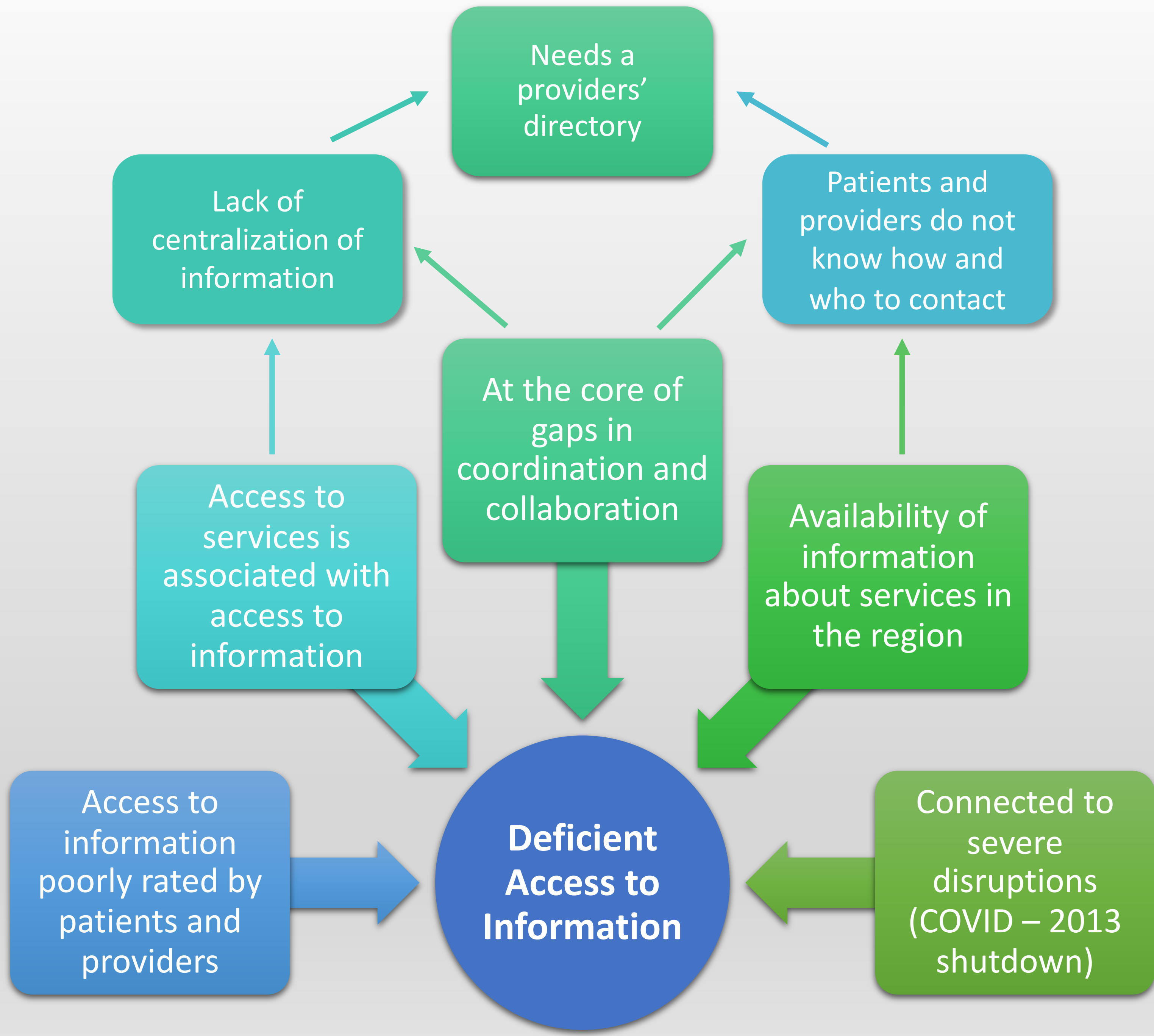
SOAR: Southwest Outreach Academic Research Evaluation and Policy Center

LC3 Community Survey

Dr. Rachel Boren – SOAR Center Director

Germain Degardin – SOAR Senior Project Specialist

December 15th, 2020

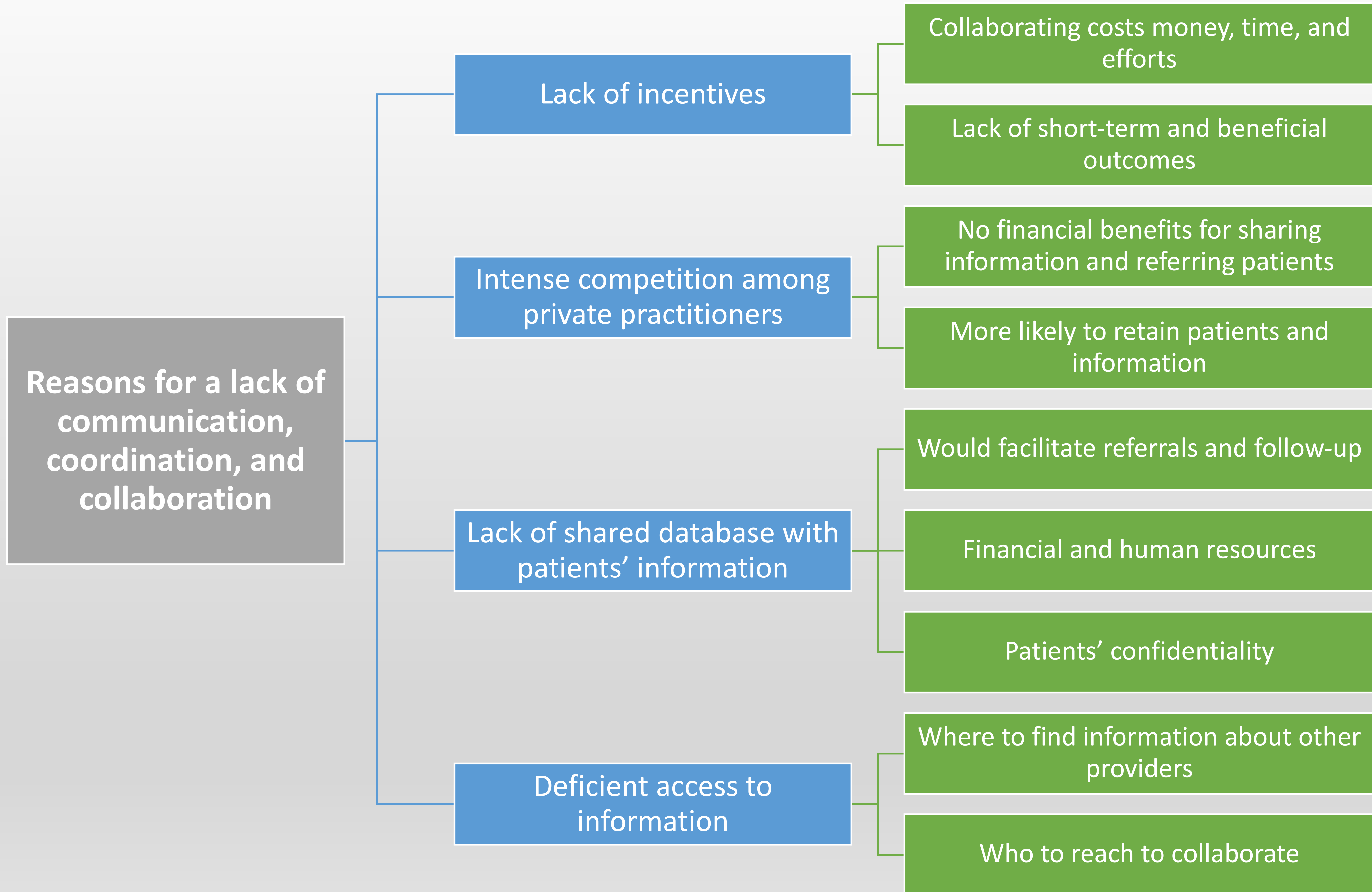

Needs a providers' directory
Lack of centralization of information
Patients and providers do not know how and who to contact
At the core of gaps in coordination and collaboration
Access to services is associated with access to information
Availability of information about services in the region
Access to information poorly rated by patients and providers
Deficient Access to Information
Connected to severe disruptions (COVID – 2013 shutdown)

Lack of Communication, Coordination, and Collaboration

Ultimately affects patients

Uninsured
Low-income
Non-English speakers
Undocumented
Children-Youth
Rural population
Students

Referrals across providers
Coordination of wraparound services


Reasons for a lack of communication, coordination, and collaboration
Lack of incentives
Collaborating costs money, time, and efforts
Lack of short-term and beneficial outcomes
Intense competition among private practitioners
No financial benefits for sharing information and referring patients
More likely to retain patients and information
Lack of shared database with patients' information
Would facilitate referrals and follow-up
Financial and human resources
Patients' confidentiality
Deficient access to information
Where to find information about other providers
Who to reach to collaborate

Why do we need better communication, coordination, and collaboration?

Transportation
Afford services

Do not cover services
Do not understand benefits

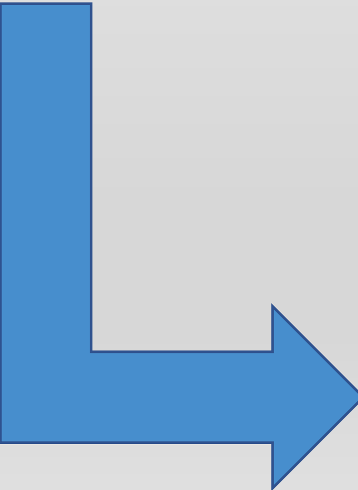
Important Information about the COVID pandemic

Had to shut down services

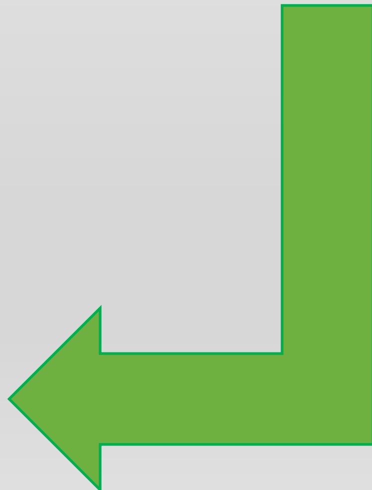
Poor access to human and financial resources	Poor or no insurance
Patients	
Access to services	More than a 1/3 of patients not impacted by the pandemic

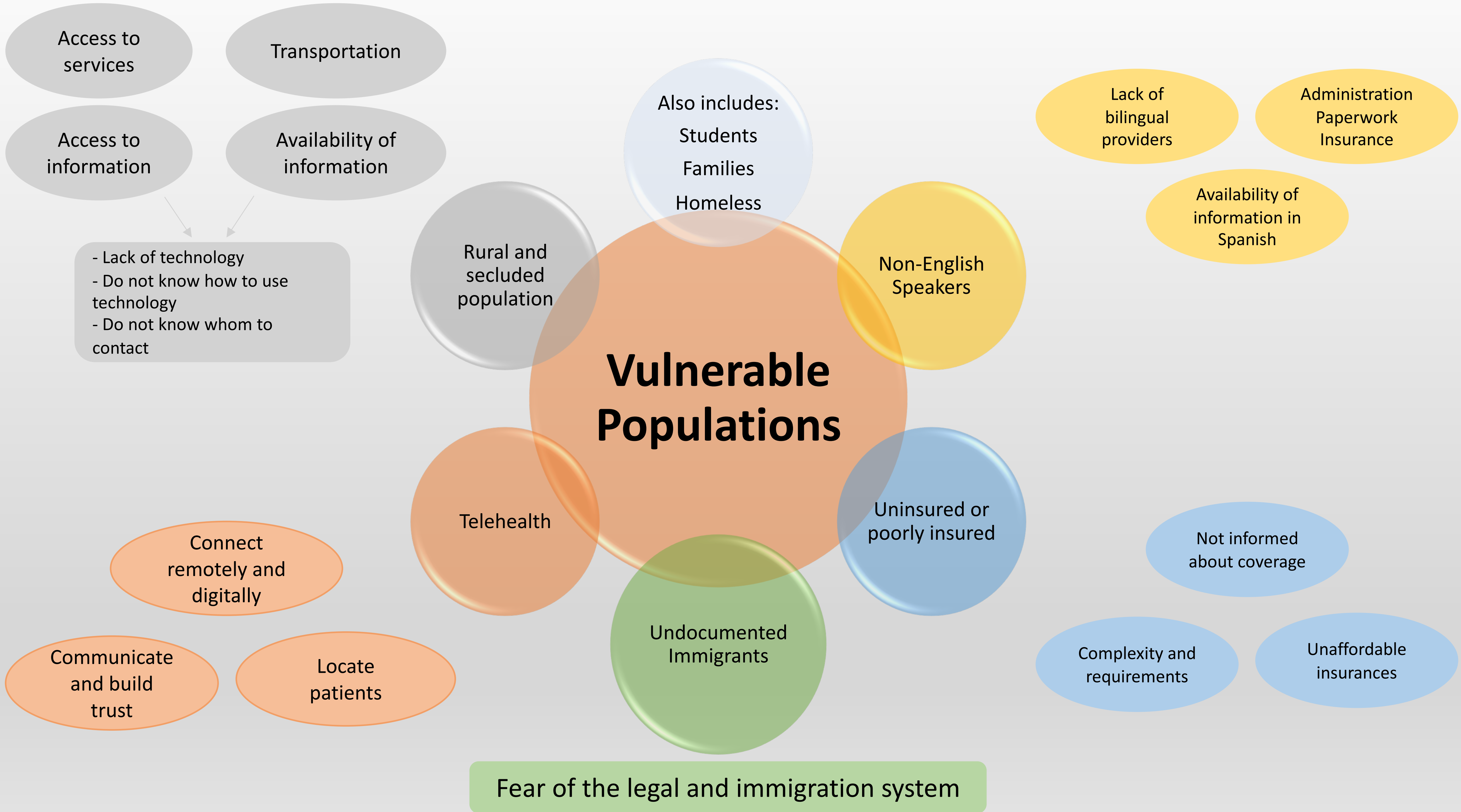
Increase in patients load	Lost patients – downsized services
Providers – Severe disruptions and organizational complications	
Reached maximum capacity	Turned down new patients

Waitlists
Turned down
Services were shutdown



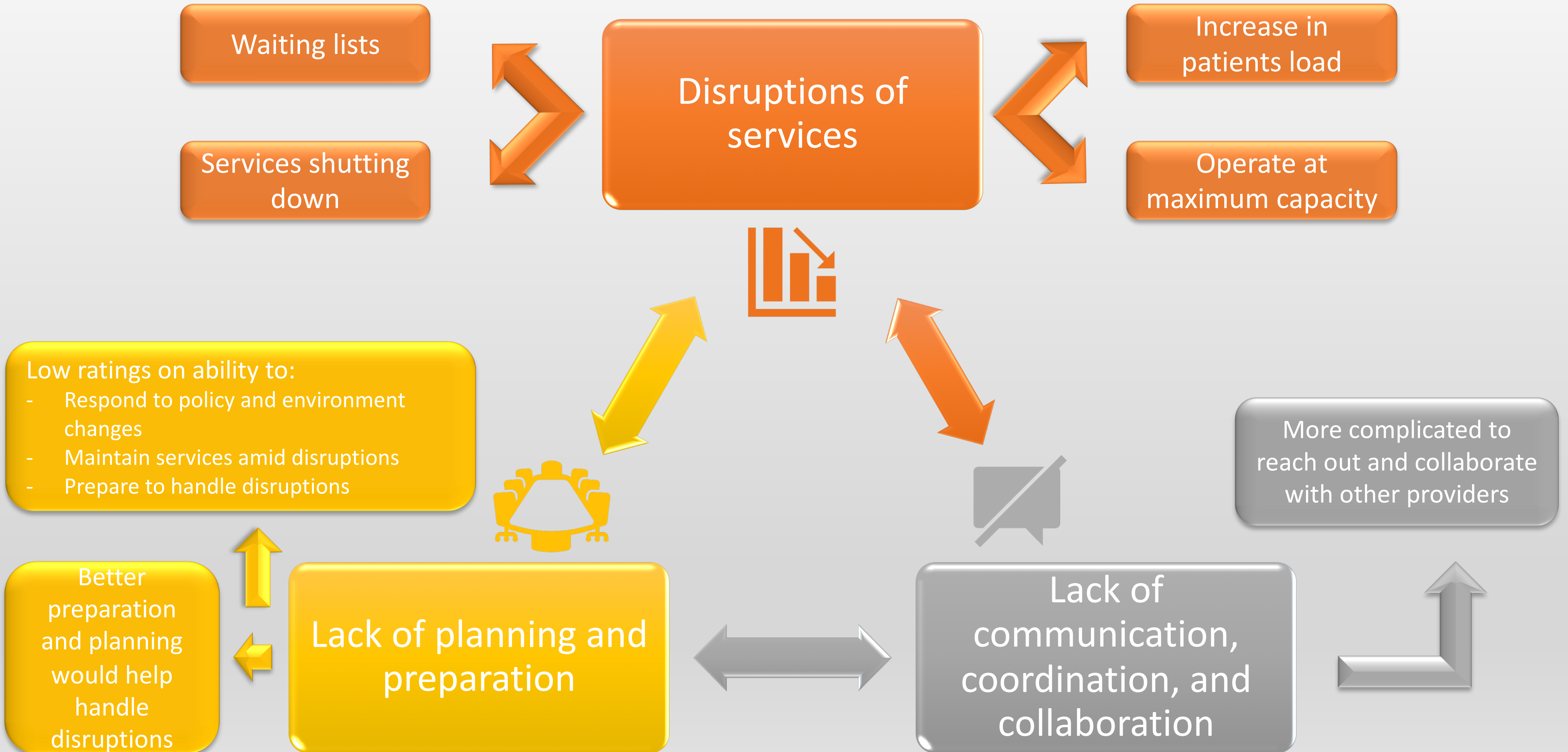
Lack of required technology	Home environment not conducive to telehealth
Common difficulties with telehealth	
Lack of trust in telehealth	Do not know how to use telehealth

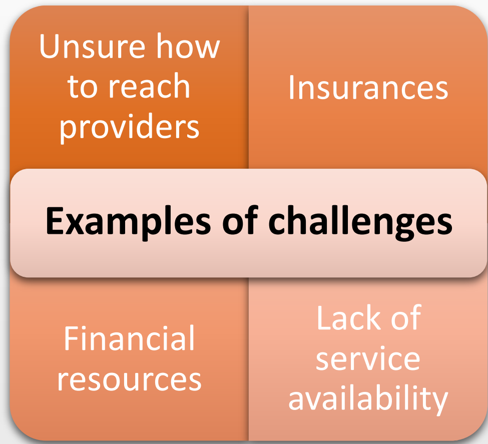




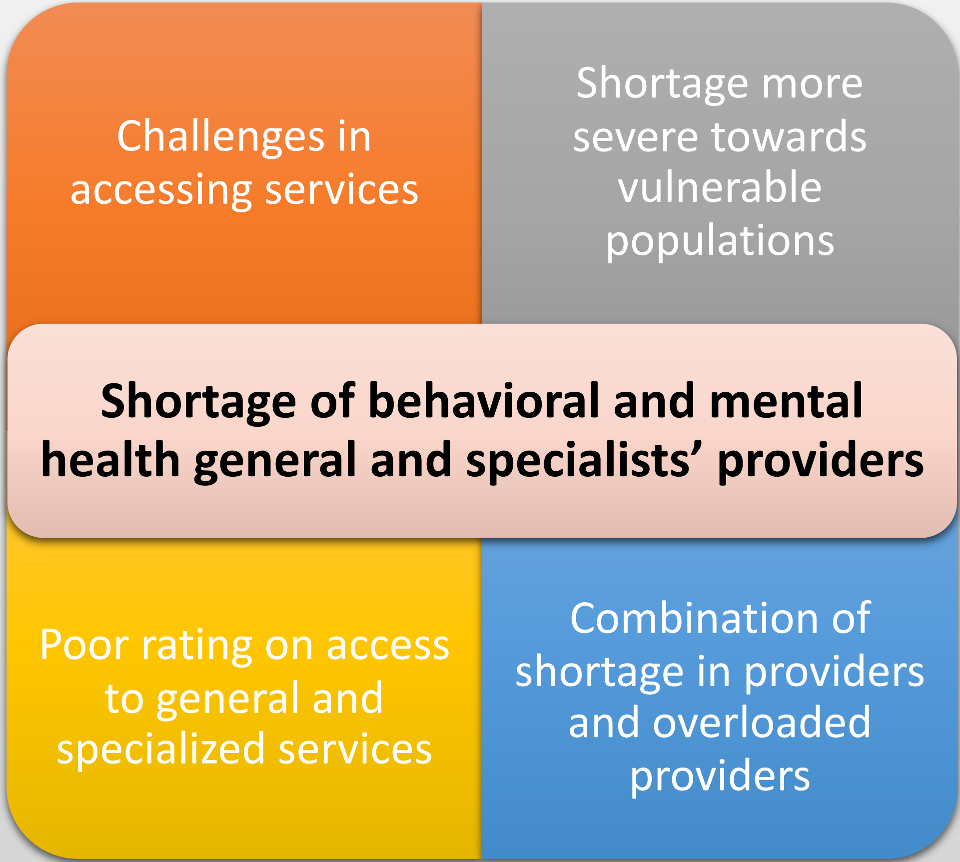
Access to services
Transportation
Access to information
Availability of information
- Lack of technology
- Do not know how to use technology
- Do not know whom to contact
Also includes:
Students
Families
Homeless
Rural and secluded population
Non-English Speakers
Lack of bilingual providers
Administration Paperwork Insurance
Availability of information in Spanish
Vulnerable Populations
Telehealth
Uninsured or poorly insured
Not informed about coverage
Complexity and requirements
Unaffordable insurances
Connect remotely and digitally
Communicate and build trust
Locate patients
Undocumented Immigrants
Fear of the legal and immigration system

The parallels between the COVID pandemic and the 2013 shutdown





Population segments: Families, parents, children



Service types: Psychiatric, autism, supportive services, and case management

In 2018, the patient-to-mental health providers ratio in Doña Ana was **340:1**

Source: University of Wisconsin County Health Rankings

Depends on services sought, location, patients' situation:

- Children's services
- Specialized services
- Low-income
- Uninsured
- Non-English speakers

Increase in waitlists

Can frustrate patients to the point of giving up

The need for behavioral and mental health in the K-12 school system

36% of high-school students in Doña Ana reported feeling of sadness and hopelessness
14% seriously considered suicide

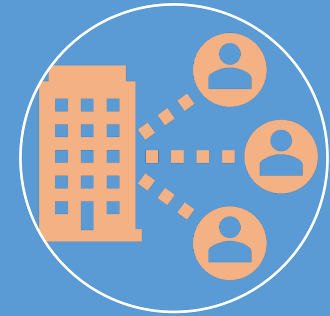
14% made suicide plans
9% attempted suicide
3% were injured in a suicide

Source: New Mexico Youth Risk and Resiliency Survey Results (2017).

Collaborate with outside providers

Address the stigma around behavioral health

Provide training to teachers and staff



Provide resources and support to students and families

Thank you!

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