Informing a New Mexico Child and Family Services System Blueprint

Voices from Bernalillo County

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Across New Mexico, Town Halls and Focus Groups are being held to guide the development of a Child and Family Services System Blueprint. This project was proposed by House Majority Floor Leader Gail Chasey. It is funded by Governor Michelle Lujan Grisham.

Because Bernalillo County covers a large and diverse geographic area, focus groups were organized into four general quadrants to support fair representation across the county. The quadrants were defined using Interstate 25 (north–south) and Interstate 40 (east–west), as shown in **Figure 1**. Each quadrant hosted three focus groups held in public spaces that were open and accessible to the community. One town hall was also held in a public space within each quadrant. Together, these locations reflected a mix of urban, suburban, and semi-rural communities across the county.

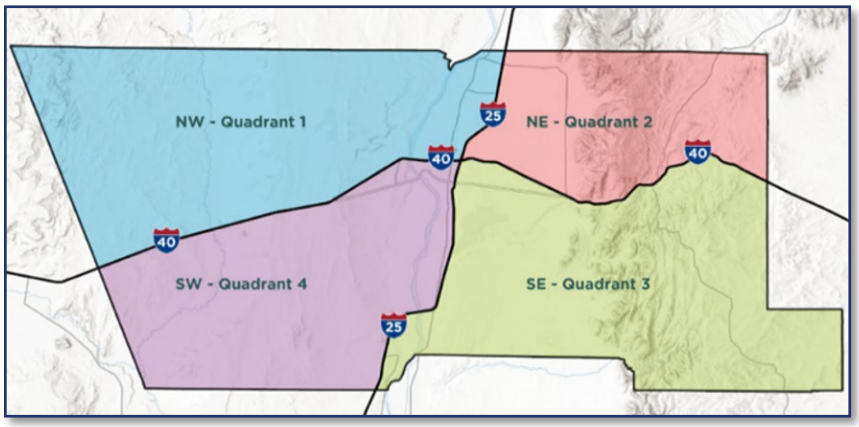

Figure 1 *Visual Representation of Divided Quadrants*

Participation and Recruitment: Focus groups were conducted with residents with lived experience accessing services, while town halls were conducted with service providers and representatives from community organizations. Focus group participants had lived experience accessing at least one of the following service areas: medical and dental care, mental and behavioral health care, food assistance, housing assistance, public transportation, and childcare. Participants shared their experiences accessing services, challenges encountered, and changes or improvements they would like to see across service sectors. Town halls and focus groups were audio recorded and analyzed by Chapin Hall.

Table 1. *Participant Geographic Distribution by Quadrant*

Quadrant	ZIP Codes Represented
Northeast	87107, 87109, 87110, 87111, 87112, 87123
Northwest	87107, 87109, 87113, 87114, 87120, 87121
Southeast	87102, 87105, 87106, 87108
Southwest	87102, 87105, 87121

Participants were recruited through collaborative outreach, with a survey used to register them and determine the quadrant where they lived based on zip code. **Table 1** summarizes the distribution of participants by zip code across the four county quadrants**.** Most participants attended a focus group or town hall held in their home quadrant, though a small number attended sessions in other quadrants. These instances were documented during analysis to assess whether perspectives differed from quadrant-specific patterns. In total, **12 focus groups (three per quadrant)** and **four town halls (one per quadrant)** were conducted. The study included **94** focus group participants and **79** town hall participants representing service providers from **45** organizations across Bernalillo County. **Table 2** presents demographic characteristics of focus group participants by quadrant.

Table 2. *Demographic Characteristics of Bernalillo County Participants by Quadrant*

County (Quadrant)	Town Hall (n)	Focus Groups (n)	Demographic characteristics for Focus Group participants			
			Age	**Gender**	**Race**	**Ethnicity**
Northwest (Quad 1)	8	14	(18 – 24) 14% (25 – 44) 14% **(45 – 54) 57%** (55 – 64) 7% (65 – 74) 7%	**Female, 93%** Male, 7%	**Asian, 50%** White, 36% Black, 7% Native American, 7%	**Not Hispanic, 71%** Hispanic, 29%
Northeast (Quad 2)	19	21	**(25 – 44) 67%** (45 – 54) 14% (55 – 64) 10% (65 – 74) 10%	**Female, 71%** Male, 29%	**Asian, 52%** White, 33% Other, 10% Multiple, 5%	**Not Hispanic, 90%** Hispanic, 10%
Southeast (Quad 3)	28	24	(18 – 24) 13% **(25 – 44) 38%** (45 – 54) 25% (55 – 64) 21% (65 – 74) 0% (75+) 4%	**Female, 79%** Male, 21%	**White, 42%** Other, 21% Asian, 17% Multiple, 12% Black, 8%	**Hispanic, 54%** Not Hispanic, 42% Not Reported, 4%
Southwest (Quad 4)	24	35	(18 – 24) 3% **(25 – 44) 40%** (45 – 54) 23% (55 – 64) 23% (65 – 74) 6% (75+) 6%	**Female, 86%** Male, 14%	**White, 40%** Other, 31% Multiple, 14% Asian, 6% Not Reported, 6% Native American, 3%	**Hispanic, 80%** Not Hispanic, 20%
Total	79	94				

Note: (n) indicates the number of participants by quadrant for town halls and focus groups. Demographic characteristics reflect focus group participants only. "Not Reported" includes participants who did not report race, skipped the question, or whose responses could not be categorized consistently; only two focus group participants across the full sample declined to share racial background. "Other" includes participants who provided open-ended responses that did not align with predefined race categories and includes participants who self-identified as Afghan, Chilean, Cuban, Mexican, Tajik, or Venezuelan.

Analysis Approach: This study used qualitative methods to examine participants' experiences, priorities, and barriers across six service sectors: Medical and Dental, Mental and Behavioral Health, Food, Housing, Transportation, and Childcare. The analysis was descriptive and focused on identifying themes grounded in participants' lived and professional experiences rather than generalizing findings to the full population of Bernalillo County. Written transcripts and translations from all focus groups and town halls were reviewed using qualitative coding techniques. Responses were coded using a structured codebook developed and refined through prior studies in other parts of New Mexico. Multiple researchers participated in the coding process, reviewing shared transcripts, comparing coding decisions, and resolving discrepancies through discussion to support consistency and reliability. When meaningful differences by location appeared, they were noted. The findings below summarize experiences shared by residents and providers and highlight challenges and strengths that may not be visible through numbers alone.

PERSPECTIVE POINTS FROM BERNALILLO COUNTY

This section reflects key themes from the focus groups, highlighting the challenges faced by residents of Bernalillo County.

Broken Systems: Participants consistently described public assistance, health care, housing, and social service systems as broken, inconsistent, and difficult to navigate. Many reported frequent benefit changes without explanation, long wait times, lost paperwork, and conflicting information from different staff or agencies. Recertification and verification requirements were described as repetitive and exhausting, often requiring repeated paperwork, time on the phone or in offices, and ongoing self-advocacy to keep benefits. Poor coordination across departments, high caseworker turnover, and the lack of a reliable point of contact led to benefit interruptions, penalties for missed or delayed paperwork, and wrongful denials. Online systems were widely described as confusing or inaccessible, increasing administrative burden and forcing people to seek help in person. Language barriers, disability, caregiving responsibilities, immigration status, and past trauma further compounded these challenges, especially for those already facing instability.

Rigid Eligibility Rules: Participants described eligibility rules as overly rigid, relying on narrow income cutoffs and fixed categories that fail to reflect real-life circumstances. These rules did not account for basic expenses, caregiving responsibilities, fluctuating work hours, disability-related costs, or unstable employment. Many participants lost benefits after earning slightly above income limits while still unable to meet basic needs. Some reported being encouraged, explicitly or implicitly, to reduce work hours, delay marriage, live separately, or remain unemployed to retain assistance. These challenges were especially pronounced for people with disabilities and caregivers, for whom benefits often failed to cover the true costs of disability, including medical supplies, therapy, transportation, and caregiving. Participants described having to repeatedly recertify eligibility across benefit programs, often requiring extensive paperwork, delays, and repeated phone calls or in-person visits. Rather than supporting progress, systems made stability difficult to sustain and small gains costly.

Perceived Unfairness and Stigma: Participants frequently expressed frustration with perceived inequities in how benefits and services were distributed. Many described observing what they believed to be misuse of resources while working families struggled to access help. These perceptions were reinforced by accounts of poor oversight, lack of transparency, and inconsistent decision-making. Participants also described feeling judged, disrespected, or dismissed by staff and feared retaliation for advocating for themselves, leading some to disengage from services or remain silent even when needs were unmet.

Cycles of Instability and Harm: Across sectors, participants described how ongoing bureaucratic barriers, financial insecurity, housing instability, and unmet health needs led to chronic stress, mental health strain, and family trauma. Instead of acting as a safety net, systems were described as deepening hardship, forcing families into survival mode, and creating lasting consequences for children, caregivers, and communities.

Community Supports Fills Gaps: When formal systems were inaccessible, delayed, or ineffective, participants relied on community, faith-based, and informal networks for support. Churches were frequently described as trusted sources of food, clothing, diapers, household items, utility assistance, and help navigating benefits, often without requiring religious participation. Family members, neighbors, and friends provided childcare, housing, transportation, food, and emotional support during periods of instability. Participants emphasized the importance of trusted intermediaries, such as case managers, community health workers, advocates, and resettlement agencies, in helping families access services and navigate requirements. Participants described staff turnover, difficulty reaching workers, and limited guidance when navigation support was inconsistent. Many expressed a desire for more consistent relationships, clearer plans, and stronger coordination between formal systems and community organizations to prevent crises and support stability.

COMMUNITY-IDENTIFIED CHALLENGES WITH SERVICES

This section summarizes insights from residents and service providers on access to essential services.

Medical And Dental Access: Residents across Bernalillo County described medical and dental systems that are highly visible but difficult to access in practice. While hospitals, community clinics, mobile services, and school-based programs were widely acknowledged, participants emphasized that availability did not translate into timely or usable care. Access varied sharply by age, insurance status, income, and eligibility requirements, with many adults describing being unable to obtain services. Long wait times were described as a defining feature of care. Establishing primary care often took many months, while specialty care and adult dental appointments commonly required waits of six months to more than a year. Missed appointments, insurance changes, or administrative lapses frequently forced residents to restart the process, disrupting continuity of care. Referrals were often slow, difficult to track, or stalled without explanation, with residents describing the need for persistent self-advocacy to access care. Providers cited long-standing capacity constraints, workforce shortages, and high turnover, which residents experienced as frequent provider changes, brief or rushed visits, the need for multiple appointments to address a single issue, and limited opportunities to build relationships with providers. The contributing factors identified as workforce shortages included lower pay, malpractice insurance costs, reimbursement rates in comparison to neighboring states, higher-paying markets, and practitioners leaving after completing training.

Emergency Care as a Default Entry Point. In the absence of timely outpatient care, residents frequently relied on emergency rooms and urgent care as a primary entry point into the health system, a reliance described as a necessity rather than a choice. Emergency settings were used not only for critical illness but also for follow-up care, pain management, prenatal needs, and unresolved chronic conditions. Delays were described as especially harmful for people managing chronic conditions, recovering from hospitalization, or seeking preventive care, including routine pediatric services. Delays in reproductive and prenatal care were described as particularly concerning. Participants reported missed or delayed prenatal testing, limited access to obstetric providers, and appointment schedules that did not align with pregnancy timelines. When outpatient care could not be accessed in time, some turned to emergency departments or obstetric triage, increasing stress and risk. Experiences in emergency departments varied widely, with some describing timely care and others reporting long waits, crowded conditions, limited privacy, and lack of follow-up. Parents and caregivers expressed concern about safety, dignity, and exposure to crisis situations while waiting with children.

Affordability as the Primary Barrier. Participants consistently identified cost, rather than insurance status alone, as the main barrier to medical and dental care. Many residents were uninsured or underinsured, while others had coverage that still required deductibles, co-pays, or out-of-pocket payments they could not afford. Dental care was described as especially inaccessible for adults, with limited coverage and high costs even for basic restorative services. Adult dental coverage was often described as limited, with preventive services sometimes covered but restorative treatment often denied or unaffordable, leading residents to delaying care and relying on tooth extraction as the only affordable accessible option, resulting in ongoing pain and tooth loss. Fear of medical debt shaped behavior across services, with residents avoiding appointments, delaying referrals, or discontinuing treatment due to concern about unexpected bills, damaged credit, or housing instability. Coverage changes mid-treatment left care incomplete and costs unresolved. These barriers were described as contributors to delayed care, worsening health, and chronic stress, with ripple effects on family stability and children's well-being.

Communication. Many residents reported feeling dismissed, judged, or disrespected during medical encounters. Concerns included rushed visits, limited explanations, inconsistent advice, and care that relied heavily on medication without thorough evaluation. Participants also described gaps in language access and interpretation that undermined consent, safety, and trust, particularly for immigrant and refugee families.

Mental/Behavioral Health Access: Participants described mental and behavioral health needs as widespread and insufficiently addressed across the county. Residents shared experiences of anxiety, depression, trauma, post-traumatic stress disorder (PTSD), suicidal ideation, and chronic stress related to housing instability, financial strain, family separation, and caregiving demands. Caregivers described recognizing early signs of trauma in children but being unable to secure timely or appropriate support.

Residents also described mental and behavioral health services as difficult to locate and poorly advertised, even when need was clear. Programs were described as opening, changing, or closing without clear communication, leaving residents to navigate access on their own during periods of stress or crisis. Providers echoed these concerns, noting that service information is scattered, and residents often do not know where to start or how to move forward. As a result, many residents described needs escalating before support was available.

Limited Availability and Workforce Shortages. Access to mental health services was described as severely constrained by limited capacity and long-standing workforce shortages. Participants and providers identified only a small number of clinics and programs providing outpatient, inpatient, and medication management services, but emphasized that demand far exceeds availability. Waitlists were described as lengthy, particularly for children, court-involved youth, individuals with serious mental illness, and people experiencing homelessness. Providers emphasized that infrastructure investments have not translated into access when staffing is unavailable. They described shortages as structural rather than temporary, shaped by historical funding decisions and agency closures.

Crisis and Urgent Care Gaps. Residents described significant gaps in access to mental health care during periods of severe need. Caregivers shared experiences of identifying warning signs such as suicidal thoughts, severe bullying, or emotional collapse but being unable to secure appointments despite repeated outreach and referrals. Structural requirements, including the need to establish a primary care provider before accessing mental health services, delayed care during critical periods. When people tried to get help during a mental health crisis, the response was often inconsistent and did not result in connection to care or follow-up. Participants shared experiences that led them to believe some responders lacked appropriate training or authority, misunderstood the situation, or disengaged without connecting individuals to care. Police involvement was described as eroding trust and, in some cases, escalating crises. Participants described these gaps as contributing to long-term stress and harm for children, caregivers, and families.

Counseling, Therapy, and Medication. Counseling and therapy were described as essential but difficult to start and sustain, particularly for children and families experiencing trauma. Caregivers reported long delays, inconsistent follow-up, limited provider availability, and challenges navigating insurance and referral systems. Some families secured therapy only through persistent self-navigation, while others never received follow-up after referrals.

Participants raised concerns about quality, including providers perceived as insufficiently trained in trauma-informed care or unfamiliar with individuals lived experiences, leading to care that felt generic, mismatched, or ineffective. Psychiatric medications were frequently described as prescribed with limited explanation or screening, with reports of harmful side effects, cost barriers, and feeling dismissed when concerns were raised.

Cultural, Linguistic, and Trust Barriers. Participants emphasized that effective mental health care must be culturally responsive and linguistically appropriate, yet these elements were often lacking. Language access was described as insufficient, particularly for Spanish-speaking and multilingual communities, with interpretation systems undermining trust and therapeutic connection. Participants noted shortages of bilingual and culturally matched providers and described long waits even when such providers were actively sought. Some residents expressed discomfort with therapeutic approaches that assumed spiritual or religious frameworks that did not align with their beliefs, emphasizing the need for inclusive options rather than one-size-fits-all models.

Access to Food: Residents across all quadrants described food costs as a growing and urgent challenge that outpaces available assistance. Participants emphasized sharp price increases for basic items such as fruits, vegetables, eggs, and other essentials, with food assistance benefits often lasting only part of the month. Fixed or limited incomes made it difficult to absorb rising costs alongside rent, utilities, and transportation expenses. While programs such as SNAP were described as essential, benefits were widely viewed as inadequate to meet household needs, forcing families to reduce food quality, skip meals, or pay out of pocket to get through the month. Residents described food insecurity as an ongoing condition that compounded housing, health, and transportation challenges, with many expressing concerns about impacts on children.

Uneven Geographic and Cultural Access. Food insecurity was described as shaped by where people live and whether available food meets cultural and dietary needs. Residents and providers identified persistent food deserts, particularly in the International District and other low-income areas, where grocery store closures have left limited nearby options. These access gaps were described as concentrated in communities already facing economic and health inequities. Participants also described limited availability of culturally appropriate foods, such as halal items and culturally meaningful ingredients, which reduced choice and increased burden for immigrant and refugee families.

Awareness and Navigation Barriers. Many residents described limited awareness of food resources and difficulty navigating food assistance systems. Participants said they often did not know what programs existed, where to go, or how to use benefits such as Supplemental Nutrition Assistance Program (SNAP) or food pantry services. Information was described as fragmented, outdated, or learned only through word of mouth, internet searches, or trial and error. Access was described as easier when residents received direct help from case managers, schools, or community organizations, highlighting the importance of hands-on navigation support.

Experiences at Food Distribution Sites. Residents described a mix of supportive and discouraging experiences when accessing food pantries and distribution sites. Positive experiences were characterized by clear instructions, respectful treatment, and staff who explained processes and reduced anxiety. In contrast, participants described long lines, unclear rules, inconsistent intake procedures, and being turned away after waiting, sometimes with children. These experiences generated stress, embarrassment, and frustration, discouraging some residents from returning even when food was needed.

Food Quality, Choice, and Household Fit. Participants raised serious concerns about the quality and suitability of distributed food. Residents reported receiving expired, spoiled, or repetitive items, as well as foods that did not align with dietary needs, medical conditions, or cooking capacity. Boxed food was often described as inflexible, leading to waste when items could not be used. Participants emphasized the value of choice-based models that allow households to select foods that meet their needs, reduce waste, and preserve dignity.

Transportation and Physical Access to Food. Transportation emerged as a major barrier to consistent food access. Residents described difficulty reaching pantries due to distance, lack of a vehicle, physical limitations, or the challenge of carrying large food boxes, particularly when using public transit or traveling with children. These barriers often required families to rely on informal support, increasing stress and time burden. Limited delivery options further constrained access for older adults, people with disabilities, and households experiencing homelessness.

Food Access for Vulnerable Populations. Participants emphasized that food assistance often does not align with the realities of being unhoused. Many food distributions rely on items that require cooking, refrigeration, or storage, making them unusable for people without kitchens. This mismatch led to wasted food, reliance on expensive ready-to-eat options, and negative health impacts. Residents and providers stressed the need for more accessible food options, including hot meals and ready-to-eat foods, to support dignity and health.

Housing

High Costs and Ongoing Affordability Strain. Residents consistently described housing as increasingly unaffordable, even for those who are working or living on fixed incomes. Participants emphasized that advertised rents often rose significantly once additional fees, utilities, and insurance were included, pushing monthly costs well beyond what households could realistically afford. Requirements to earn two to three times the rent excluded many working families, while high upfront costs (e.g., first and last month's rent and security deposits) created major barriers to securing housing. Even housing that was initially affordable was described as unstable over time, with rent increases at lease renewal generating ongoing anxiety and fear of displacement.

Limited Availability and Long Waiting Lists. Participants described a severe shortage of affordable and subsidized housing across the county. Residents reported waiting months to years on multiple housing lists, with some describing waits of five to ten years for Section 8 or other subsidized programs. Waiting lists were described as slow-moving, difficult to track, and subject to changing rules that sometimes required reapplication or resulted in loss of position. Providers echoed these concerns, noting that demand far exceeds supply and that many families remain unhoused or housing-insecure while waiting for assistance.

Eligibility, Screening, and Navigation Barriers. Access to housing was described as shaped by rigid eligibility rules, screening practices, and complex administrative processes that do not reflect lived realities. Participants described being denied housing due to income instability, lack of credit, prior evictions, or missing documentation, even when they were otherwise capable of maintaining housing. Background checks, credit requirements, and rental history reviews were described as excluding people with limited or interrupted work histories, disabilities, or past crises. Residents also described discrimination, language barriers, and lack of recourse when denied housing, particularly for immigrants and non–English-speaking households. Successfully securing housing often required extensive personal effort, persistence, and independent research, including applying to multiple lists, contacting landlords directly, and repeated follow-up.

Quality, Safety, and Maintenance Concerns. Residents described persistent quality and safety issues in low-income and subsidized housing. Participants reported unresolved maintenance problems, including mold, pest infestations, broken appliances, roof leaks, and inadequate heating or cooling. Some described property managers as unresponsive or dismissive, leaving residents to live in unsafe or deteriorating conditions. Safety concerns were common, particularly in areas residents perceived as unsafe due to drug activity, violence, or lack of security, making families reluctant to allow children to play outside or feel secure in their homes.

Limited Rental Assistance and Crisis Supports. Short-term rental assistance and emergency supports were described as limited, inconsistent, or unavailable when most needed. Participants reported that assistance funds were often depleted quickly, subject to narrow eligibility windows, or delayed in ways that undermined their usefulness during crises such as domestic violence, job loss, or medical emergencies. Providers described contacting multiple agencies only to find no funds available, leaving households without viable options. These gaps were described as contributing directly to housing loss and increased homelessness. Residents described housing instability as contributing to ongoing stress, health challenges, and family disruption, particularly during periods of crisis.

Experiences of Homelessness and Shelter Barriers. Participants described homelessness as traumatic and difficult to escape. Residents shared experiences of living in cars, hotels, or crowded arrangements with family while waiting for housing assistance. Emergency shelters were widely described as unsafe or inappropriate for families, particularly those with children, due to concerns about violence, lack of privacy, and inability to stay together. As a result, some families avoided shelters altogether, even when housing alternatives were unavailable.

Transportation

Reliance on Personal Vehicles. Residents consistently described personal vehicles as essential for daily life in Bernalillo County. Participants emphasized that work, school, health care, food access, and caregiving were difficult or impossible without a car, given how the region is designed. Many described turning down jobs, limiting work hours, or missing shifts because they could not reliably get to work without a vehicle. Even residents who owned vehicles described access as fragile due to the high costs of gas, insurance, registration, and repairs. When vehicles broke down or fuel became unaffordable, families were left with few alternatives. Participants without vehicles described heightened stress and limited independence, often relying on family members, including children, for transportation.

Public Transportation Limitations. Residents described public transportation as unreliable, time-consuming, and unevenly available. Participants reported buses arriving late or not at all, being canceled due to driver shortages, or passing stops without stopping. Routes and schedules were often misaligned with work, school, childcare, and appointment times, requiring residents to leave hours early or miss obligations. Long travel times, infrequent service, multiple transfers, and long walks to bus stops made routine travel exhausting. Service gaps during early mornings, evenings, and weekends further limited access to jobs, schools, churches, and services, particularly outside major corridors. Participants across quadrants described feeling unsafe at bus stops and while riding buses. Concerns included visible substance use, harassment, violence, and disruptive behavior, which made public transit feel threatening, particularly for women, children, refugees, and Muslim community members. Families described children feeling frightened, while caregivers reported constant vigilance while traveling. Participants noted limited security presence and described drivers and staff as lacking the authority or support to intervene, contributing to fear and reluctance to use transit.

Specialized Transportation Limitations. Participants described specialized transportation services, including Medicaid rides and paratransit, as unreliable and inflexible. Residents reported late arrivals, no-shows, incorrect pickups, and rigid rules that prevented caregivers or companions from riding along when assistance was needed. Advance scheduling requirements and long trip times made these services difficult to use, particularly for medical care. When specialized transportation failed, residents described missing appointments or relying on informal support networks.

Childcare: At the time of data collection, recent policy changes, including the announcement of universal childcare, had increased awareness but also created confusion. Many families knew changes were coming but did not understand how the system would work, when it would take effect, or whether it applied to them. Navigating childcare was described as complex and time-consuming, with income limits, documentation requirements, changing household circumstances, and short-term care transitions creating barriers to enrolling in or maintaining care. Providers emphasized that policy expansion had not yet resolved capacity constraints, citing limited physical space, workforce shortages, and insufficient infrastructure to meet demand.

Affordability and Access. Participants reported unaffordable monthly childcare costs, particularly for infants and families with multiple children, along with additional expenses such as diapers and food. As a result, many families relied on relatives for care or avoided formal childcare altogether, limiting work hours, job options, or household income. Some participants described positive experiences with childcare assistance programs, noting that subsidies made it possible to work or care for grandchildren or other relatives. At the same time, eligibility limits, documentation requirements, age cutoffs, and changes in household circumstances were described as barriers to maintaining assistance. Publicly funded and school-based programs were viewed positively when available, but access was uneven due to age cutoffs, enrollment boundaries, limited hours, transportation barriers, and gaps in care

when children aged out of programs. Misalignment between childcare hours and non-traditional work schedules further constrained access, and distance to providers and lack of reliable transportation affected enrollment and attendance.

Trust, Safety, and Quality. Trust strongly shaped childcare decisions. Many participants expressed reluctance to leave children with non-family caregivers, even when care was affordable or available. Concerns included fears of mistreatment, inadequate supervision, staffing shortages, high turnover, and inconsistent child-to-staff ratios. Parents described visiting multiple centers to assess cleanliness, safety, staff attentiveness, and neighborhood conditions. Stories of abuse or neglect reinforced distrust and led some families to avoid childcare entirely. Participants emphasized that consistent staffing, clear communication, visible safety measures, and accountability were critical to building trust.

*Early Intervention and Related Supports***.** Some participants described positive experiences with early intervention and home visiting programs that supported child development and caregiver confidence. These services were valued for developmental screening, guidance, and reassurance during early childhood. Others described delays, missed follow-up, and coordination challenges that limited effectiveness and, in some cases, led children to miss early developmental support.

COMMUNITY GENERATED IDEAS ACROSS ALL SERVICES

This section highlights cross-system changes identified as necessary to improve access and long-term stability.

Align Eligibility with Real Life. Residents called for eligibility rules and benefit calculations that reflect actual household needs, including essential expenses, caregiving responsibilities, shared households, and fluctuating work hours. Participants emphasized the importance of allowing income growth, training, and education without triggering sudden loss of housing, food, health care, or childcare supports.

Simplify Access and Strengthen Navigation. Participants consistently identified simpler, more coordinated access as critical. This included streamlined applications, fewer documentation requirements, clear and consistent information across agencies, and shared systems that reduce the need to reapply repeatedly. Trusted navigators such as case managers, community health workers, and advocates were described as essential for helping residents understand options, complete applications, follow up with agencies, and resolve problems over time, particularly for those facing language barriers, homelessness, disability, or complex needs.

Expand Practical Supports that Stabilize Daily Life. Residents emphasized the value of practical supports that prevent crises, including reliable food access, prepared meals, flexible transportation assistance, and access to basic household and hygiene supplies. Participants highlighted the need for flexible, choice-based supports that adapt to family circumstances rather than rigid program rules.

Invest in Community-Based and Prevention-Oriented Approaches. Participants emphasized solutions rooted in community connection, early support, and accountability. They described the importance of prevention-focused services, culturally responsive care, and spaces that foster trust, belonging, and peer support. Residents also called for greater transparency and responsiveness from public systems, with meaningful investment in community-based organizations and long-term stability rather than short-term fixes.

COMMUNITY GENERATED IDEAS

This section summarizes ideas from focus group participants and providers to strengthen community services.

MEDICAL AND DENTAL

ACCESS

- → **Expand care delivery beyond traditional clinics (school-based, mobile, community, volunteer-led)**
  "School-based health clinics should be open to families as well." (Provider)
  "Work with APS to open more school-based clinics." (Provider)
- → **Provide after-hours and weekend services**
- → **Ensure undocumented families and children can access medical and dental care**
- → **Reduce insurance-related barriers to care approval**
- → **Allow direct access to mental health services without PCP referral**
  "You shouldn't have to have a primary care provider." (Resident)

AFFORDABILITY & COVERAGE

- → **Invest in preventive care as a cost-saving strategy**
  "A proactive approach to health care… it could be less cost." (Provider)
- → **Create sliding-scale coverage for families above Medicaid eligibility**
  "Some type of low-income program… even if parents have to pay a little." (Resident)
- → **Reduce or eliminate copays, especially for mental health services**
- → **Hold pharmaceutical companies accountable for medication pricing**
- → **Reduce insurer "middleman" control over treatment decisions**
- → **Advance Medicaid reform:** *"Medicaid reform needs to be added."* (Provider)
- → **Recognize healthcare as a basic human right and explore universal coverage**
  "*Every kid should get medical insurance until they're 18."* (Resident)

WORKFORCE CAPACITY

- → **Train and retain home-grown medical and dental professionals**
- → **Partner with colleges to incentivize bilingual and culturally responsive providers**
- → **Retain providers trained in NM teaching hospitals**
  "Government incentives for doctors to stay here." (Provider)
- → **Offer student loan repayment and financial incentives, including rural service**
- → **Reform tort, tax policies and subsidize malpractice insurance to improve retention**
- → **Enable internationally trained professionals, including Mexican dentists, to practice:** *"Bring them into the health sector as community health specialists."* (Provider)
- → **Expand scope of practice for community health workers and nurses**
  "*Expand the scope of practice… nurses… paraprofessionals."* (Provider)
- → ***"Small clinics that just do triage… bridge that gap."*** **(Provider)**

IMPROVING PATIENT EXPERIENCE

- → **Require consistent standards of care for all patients**
- → **Improve provider listening and responsiveness**
  "Doctors really caring about their patients." (Resident)
  "Actually listen… instead of assuming or misdiagnosing." (Resident)
- → **Address racial inequities in pain management**
- → **Reduce over-medication and prioritize appropriate care**
  "Lay off on the meds… they're over-medicating." (Resident)
- → **Expand access to non-pharmaceutical options, such as counseling**
  "They just need counseling." (Resident**)**
- → **Require clear treatment plans, modeled after dental care**
  "Providers should have treatment plans like dental providers." (Provider)
- → **Strengthen provider transparency and accountability**
  "There should be accountability with providers." (Resident)

CARE NAVIGATION & COMMUNICATION

- → **Provide education to help patients navigate care**
  "There's no patient education… no talk in your language." (Resident)
- → **Support patients in knowing what to ask providers**
  "We know what to ask, we know what to say." (Resident)
- → **Expand plain-language communication and translation services**
  "Translation you understand… not scientific words." (Resident)
- → **Improve culturally relevant communication and incentivize bilingual providers**
- → **Establish dedicated geriatric care assistance and referral pathways**
  "A department just for seniors… someone who understands aging." (Resident)
- → **Support community-based forums and centralized crisis/resource hubs**
  "*This kind of gathering… it's very helpful."* (Resident)
  "Somebody who could walk you through it right then and there." (Resident)
- → **Invest in education, culture, and prevention as health interventions**
  "*Educate families and kids on natural holistic medicine."* (Provider)

MENTAL HEALTH

ACCESS, ENTRY POINTS & SYSTEM NAVIGATION

- → **Reduce barriers to initial mental health access**
  "Just making that initial step easier for mental health would probably be a very big resource for us." (Resident)
- → **Remove primary care provider requirement for mental health services**
  "When you're seeking out mental help, you shouldn't have to have a primary care provider." (Resident)
- → **Centralized, one-stop mental health resource hubs**
  "*We need a hub where… they know about all of them*." (Provider)
- → **Fear of accessing care among undocumented families**
- → **Insurance coverage limits and cost as primary access barriers'**
- → **Expand tele-mental health to improve access:** *"Is there an opportunity… giving people easier access via virtual connections?"* (Provider)

WORKFORCE CAPACITY, QUALITY & ACCOUNTABILITY

- → **Ensure qualified, skilled mental health providers**
  "Send people that know what they're doing." (Resident)
- → **Expand *"Certified peer support*."** (Provider)
- → **Improve provider accountability and oversight:** *"People who provide these resources are not accountable… that's how you get stress, how you get mental health."* (Resident)
- → **Increase number of providers serving children from an early age**
- → **Grow the workforce through scholarships and youth career pathways**
- → **Recognize spiritual and non-organic contributors to mental health**
  "Anxiety, depression, the addiction is not because of organic cause… maybe, like, a spiritua intervention." (Provider)'
- → **Address root causes before medication -** *"Focus a little bit more on what's actually going on in somebody's life instead of just… Here's antidepressants."* (Resident)
- → **Bring awareness to spiritual and cultural dimensions of healing**

MENTAL HEALTH EDUCATION, LITERACY & EARLY INTERVENTION

- → **Social media as a mental health awareness and stigma-reduction tool**
- → **State and community collaboration on emotional literacy education**
  "Possibly like the state working with certain agencies or maybe even different, smaller places like counseling to work together to create different educational videos on how to self-regulate and how to just recognize your emotion." (Resident)
- → **Mental health education and emotional literacy embedded in basic education**
- → **Early emotional and mental health education in schools and daycares**
  "*In the schools or even in, like, daycares… teaching these different things so that… they're not just, like, coming into the world with no identity and like no stability."* (Resident)
- → **Community awareness of mental health experiences and how to seek help**
  "The community… is not aware… what they're experiencing or how they can receive help." (Resident)
- → **Mental health as a community-wide priority**
  "We definitely do not have sufficient mental health care… that should be a huge priority." (Resident)

COMMUNITY-BASED, SCHOOL-BASED & OUTREACH MODELS

- → **Community-centered outreach and mutual aid approaches**
  "Finding places… doing outreach and coming together as a community to help each other." (Resident)
- → **On-the-ground, physical presence in communities**
  "Outreach was a big thing… actually being physically out in the community." (Resident)
- → **Use social and community workers instead of police for mental health crises**
- → **Expand restorative practices and trained staff in schools**

FOOD

ACCESS

- → **Bring grocery options into underserved areas:** *"We need a Aldi's here. Why not?"* (Resident)
- → **Public or community-owned grocery models where private retailers won't invest:** *"A county owned or city owned grocery store… you're just not going to get an outside retailer to come in there."* (Provider)
- → **Expand mobile and community-based food distribution in communities**
- → **Community-led once-weekly grocery stores**
- → **School-based food access beyond the cafeteria:** *"Distributing unused food from schools to the community."* (Provider)
- → **School site-based pantries so food is available when needed**
- → **Delivery models for people who cannot travel**
- → **Create food runners to deliver food:** *"Amazon is going to provide delivery services with Roadrunner to assist in distribution."* (Provider). *"Amazon can do so much more… but we just don't have the capacity."* (Provider)
- → **Wider access windows and after-hours distribution. After-hours delivery services.**

NAVIGATION

- → **Reduce paperwork and administrative burden**
  "No barrier… they can just get what they need and not have to fill out a form." (Provider)
- → **Improve information design and scheduling clarity**
  "If they put the flier, they can also put more information." (Resident)
- → **Centralized food resource navigation:** *"A person to orient you on how to access these resources… navigating the system is really hard."* (Resident)
- → **Eliminate gatekeeping and unfair distribution practices:** **"***Individuals acting as gatekeepers… pick and choose who gets what… people don't feel seen or heard."* (Provider)

IMPROVE EXPERIENCE

- → **Reduce stigma and normalize food access**
  "Partnered with local grocery stores… families could go in with no stigma." (Provider)
- → **Work collectively to address stigma around food banks and pantries**
- → **Improve scheduling and convenience for working families**
  "Have boxes ready… time to pick up the kids." (Resident)
- → **Cooking support and usability:** *"Maybe they just need recipes to prepare food."* (Residen
  "Put a recipe in [distributed food boxes]." (Resident)
- → **Sponsor Uber rides to and from food distribution sites:** **"***Why can't you use your SNAP dollars to get an Uber?"* (Provider).
- → **Prepped meals to-go distributed at end of day (for unhoused)**

REDUCING COST BARRIERS AND BENEFIT GAPS

- → **Address benefit cliffs and "in-between" eligibility**
  "I'm in that little threshold where I make too much… even if they give me $40, I'll be happy." (Resident)
- → **Universal or extended child food benefits -**
  "Give benefits for the kids… doesn't matter if you work or not." (Resident)
- → **Reduce cost gouging and profit-driven food systems**
- → **Policies should prioritize quality food for all communities, not profit**
- → **Non-cost-gouging food prices**

QUALITY

- → **Prioritize fresh, nourishing food (produce + protein)**
  "Definitely fruits and vegetables… protein and things to nourish the children and the families." (Resident)
- → **Food boxes should support complete meals**
  "Revisit… dairy… grains and protein… so we're able to make a meal." (Resident)
  "Especially because you have more kids…" (Resident)
- → **Food safety and quality standards**
  "If I wouldn't eat it, why am I giving someone else to eat it?" (Resident)
  "They don't want to receive expired food because their immune system is not set up for that." (Resident)
- → **Medically appropriate and diet-specific food**
  "*Customized… to their diet… like fresh fish as an option."* (Resident)
  "A lot of food pantries don't take that into consideration." (Resident)
- → **Culturally specific food options (e.g., green/red chile, tortillas, lamb, Indian bread)**
  "Culturally sensitive items at locations." (Provider)

WORKFORCE

- → **Take care of volunteer-led distribution, including training and recognition**
- → **Equity training for people handing out food**
- → **Community engagement in operations**
  "Facebook… announce for volunteers… different culture nationality." (Resident)
  "Committee members… promotion for the community from different nationality." (Resident)
- → **City-wide support from NM vendors and restaurants**
  "Maybe these big company stores need to donate." (Resident)

HOUSING

ACCESS

- → **Ensure housing access before people become homeless:** *"It needs to be access to everyone that needs it so they don't become homeless."* (Resident)
- → Reduce upfront move-in costs (rent, deposits, fees)
  "Reduce the entry… having the first month's rent and the last month's rent and a security deposit." (Provider)
- → **Remove predatory application and administrative fees**
- → **Expand Housing First options and expand options for people with pets**
- → **Increase the supply of low-income and affordable housing**: *"It would be nice to see a lot of lower-income housing units… There's not very much."* (Resident)
- → **Build more housing at rates that match local economic conditions**
- → **Reform zoning to allow higher density and diverse housing types**
  "There's way too much… R-1 single family zoning. It doesn't allow duplexes… small apartments." (Provider)
  "We recommend any kind of vertical build." (Provider)
- → **Concentrate housing along transit corridors:** *"If you concentrate the building of housing in these areas, it solves both of those problems."* (Provider)
  "The city could rezone areas around transit to make it inhabit it in a greater rate." (Provider)
- → **Converting old bank buildings into community housing**
  "Why can't those be converted for… youth housing or community housing or low-income housing." (Provider)
- → **Expand cooperative and shared-equity housing models**
  "They pay for it just like equity." (Provider)
  Cooperative housing can lower costs, build community, and support shared resources
- → **Subsidize casitas in people's backyards if rented affordably for the first 3 years**
- → Safe and sustainable livable housing in all neighborhoods
- → **Expand eligibility beyond crisis-based categories:** *"Why can't we have family friendly townhomes like this? […] where you don't have to have a mental health. You just have to be homeless and have family."* (Resident)
- → **Address gaps for disabled adults without children:** *"I'm disabled. I can't work… a lot of programs are made just for moms."* (Resident)
- → **Pair college students/youth with elders**

AFFORDABILITY

- → **Cap rent increases and strengthen public oversight of rent practices:** *"Put a cap on rental companies to not gauge the rent out so much?"* (Resident)
  "This should be… the government to put monitoring and rental control." (Resident)
- → **Stop landlords from buying large numbers of properties**
- → **Limit the number of homes corporations and individuals can own**
- → **Limit Airbnb**
- → **Expand income-based and permanently affordable housing**
  "They can provide to low-income families to give them a chance to become a house owner." (Provider)
- → **Increase funding for more affordable housing**

NAVIGATION & SYSTEM DESIGN

- → **Reduce division and improve system coordination:** *"All these agencies… are all competing with each other for the same funds."* (Resident)
- → ***"Use technology… to actually help the community."* (Resident)**
- → **Expand housing navigation beyond traditional offices: Housing services in schools, workplaces, libraries, and pop-up public sites**
- → **Eliminate gatekeeping and preferential treatment/access**
- → **Reduce scheduling barriers for working households**
- → **SAFE OUTDOOR SPACES:** "SOS— has worked in Las Cruces"
- → *"Teach financial literacy in the basics of home owning."* **(Provider)**
- → **Alternative revenue streams for housing development:** *"Solar energy farming… generate income to build houses."* **(Provider)**

QUALITY & TENANT PROTECTIONS

- → ***"Standardize rental applications and create some sort of tenant rights."* (Provider)**
- → **Strengthen landlord accountability, enforcement, and tenant protections**
- → **Penalties for landlords who put tenants in danger by not maintaining buildings**
- → **Hotline to report illegal charges, shut offs, or fees without fear of eviction**
- → **Talk about and teach housing rights in school**

TRANSPORTATION

ACCESS, SAFETY & RELIABILITY

- → **Improve safety and security on buses: "***There need to be more like security in the buses."* (Resident)
- → **Every bus has both a driver and a safety assistant**
- → **Train people in rehabilitation programs as safety assistants**
- → **Increase security support without alienating or over-policing riders**
- → **Increase routes, frequency, and reliability:** *"They should put on more buses."* (Resident)
- → **Ensure equitable service across neighborhoods**
- → **Standardize schedules across locations (same frequency regardless of area)**
- → **Expand service to rural and underserved areas: "***City buses should be available in rural areas too!"* (Resident)
- → **Offer options beyond fixed-route buses**
- → **City-run or publicly regulated ride services:** *"What if… the drivers were actually on the city's payroll?"* (Provider)
- → **Subsidized ride-share vouchers:** *"If you gave them a code, it would partially or fully cover their ride."* (Provider)
- → **License informal fixed-route drivers ("peseros")**
- → **Allow low-cost ($1) street-based drivers on major corridors**
- → **Improve SunVan and microtransit reliability**
- → **Keep transit financially accessible without excluding working riders**
- → **Maintain affordability while improving service:** *"I think you need to bring the price back."* (Resident)
- → **Expand bus passes and fare supports:** *"Possibly implementing more of… bus passes."* (Resident)
- → **Integrate transit with other basic needs:** *"Why can't you use your SNAP dollars to get an Uber?"* (Provider)

WORKFORCE & OPERATIONS

- → **Recruit and retain more drivers so additional routes can be added**
- → **Reduce hiring barriers (e.g., outdated drug-testing timelines)**
- → **Subsidize CDL training in exchange for service:** *"Some kind of agreement to work with the city as the driver."* (Provider)
- → **Partner with APS to create high-school transit career pathways**
  "Incentivizing younger kids… to get their CDL." (Provider)

INFRASTRUCTURE, NAVIGATION & USER EXPERIENCE

- → **Build sidewalks and safe walking routes to bus stops**
  "Making sure that there are sidewalks… is really important." (Provider)
- → **Improve bike and pedestrian infrastructure**
- → **Add storage space on buses and bike valet stations**
- → **Help people learn how to use the bus system**
- → **Encourage leadership visibility (leaders riding the bus)**
- → **Place outreach organizations on buses**
- → **Make bus stops more family-friendly**

SYSTEM COORDINATION & INVESTMENT

- → **Invest in public transportation to improve reliability and safety**
  "Invest in public transportation to make more reliable." (Provider)
- → **Coordinate across agencies and planning zones**
  "What kind of coordinated efforts are occurring…?" (Provider)
- → **Streamline systems using best practices from other cities**
  Denver model — safer, faster, predictable service

CHILDCARE

CHILDCARE ACCESS & NAVIGATION

→ **Strengthen referral pathways through trusted entry points (e.g., WIC, community organizations):** *"Having the state team up with organizations like that… when somebody goes into the WIC office… they're able to refer them back to this place… working interconnectedly."* (Resident)

→ **Improve awareness of available childcare resources:** *"Finding out more resources, I think, would help."* (Resident)

→ **Create alternative verification steps when employer paperwork is a barrier** **"***If the boss doesn't wanna fill out a paper, there should be some other sort of step."* (Resident)

CHILDCARE SUPPLY & PROVIDER CAPACITY

→ **Expand childcare capacity by supporting home-based providers** *"Make it more accessible and easier for people… to have a daycare in their home."* (Provider)

→ **Support unlicensed providers in becoming licensed** *"You first want to know what would it take to get them to become licensed."* (Provider)

→ **Partner with schools to expand before- and after-school care** *"Childcare programs may be partnered with APS… before and after school."* (Provider) *"It would be great if they would look more into providing before and after school care."* (Provider)

→ **Address seasonal gaps through school-based and subsidized programs** *"Before and after school programs… will not be open during the breaks… schools should be open because this is their community."* (Provider)

WORKFORCE & OPERATIONS

→ **Establish minimum compensation standards for childcare workers** *"A minimum wage for daycare workers… depending on their qualifications."* (Provider)

→ **Provide licensing, screening, and background-check support through partnerships** *"Partnered with APS to provide background services."* (Provider)

→ **Maintain strong safety and screening expectations in childcare settings** *"Background checks… drug testing… mental health."* (Resident)

PAID LEAVE & FAMILY SUPPORT POLICIES

→ **Explore state-level paid maternity and parental leave** *"Maybe we could do it as a state… for new moms or new parents."* (Provider)

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