

BH Region 1: Community Listening Session

BH Region Region 1: Nation of Jicarilla Apache, **Pueblos of** Nambe, Ohkay Owingeh, Pojoaque, Santa Clara, San Ildefonso and Tesuque, **Counties of** Los Alamos, Rio Arriba and Santa Fe, **Cities of** Espanola and Santa Fe, **Town of** Edgewood and **Village of** Chama

Community Listening Sessions: January 12th, January 14th, January 15th, 2026

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NM Alliance of Health Councils team provided the facilitation

Overview: This document summarizes the **key challenges and barriers** to accessing behavioral healthcare as identified by community members from New Mexico's Region 1, which encompasses Nation of Jicarilla Apache, Pueblos of Nambe, Ohkay Owingeh, Pojoaque, Santa Clara, San Ildefonso and Tesuque, Counties of Los Alamos, Rio Arriba and Santa Fe, Cities of Espanola and Santa Fe, Town of Edgewood and Village of Chama. The insights were gathered during three community listening sessions designed to inform regional behavioral health priorities and planning. The information presented is drawn directly from the feedback, experiences, and perspectives shared and voiced by the community.

The non-identifying demographics provides insight as to which population types (age ranges, gender, ethnicity) and regional areas (by zip code and Tribal/ County affiliation) are most likely facing barriers or lack of access to behavioral healthcare.

Behavioral Health in Region 1: An Analysis of Community Strengths, Systemic Barriers, and a Vision for the Future

Summary:

This document synthesizes the strategic findings from the Region 1 Community Listening Sessions held between January 12th and 15th, 2026.

The following high-impact priorities emerged as the consensus for regional success, all things perfect, what would an effective behavioral health systems of care function:

BH Region 1: Community Listening Session

- **The Paradigm of "System Creation":** Participants emphasized that Region 1 is not merely reforming a broken system but is engaged in "system creation." Current services exist as disconnected fragments; SB3 must **build the foundational infrastructure of a true continuum of care.**
- **A Lifespan Continuum of Care:** The system must provide support across the **entire human developmental trajectory**, from infants (addressing Neonatal Abstinence Syndrome) to youth and young adults, to our seniors (focusing on memory care and specialized psychiatric services).
- **Cultural Relevance and Tribal Sovereignty:** These are not elective considerations but foundational pillars. Meaningful **tribal consultation and linguistic justice must be integrated** into the system's DNA to ensure equitable access for everyone.

1. Systemic Hurdles and Navigational Failures

Despite the landmark potential of SB3, the sessions identified significant friction between the reform's vision and the operational realities of the current administrative and regulatory landscape. **Without addressing these structural bottlenecks, funding will fail to translate into improved clinical and behavioral health outcomes.**

1.1 Workforce Shortages and Provider Burden

Region 1 is currently hampered by a **critical provider shortage**. Strategic analysis **identifies high malpractice insurance costs** as a primary deterrent for providers. To stabilize the workforce, the state must address medical malpractice payout caps and pursue Healthcare Worker Compacts, as advocated by organizations like Think New Mexico. Furthermore, the lack of clinical supervisors prevents a local pipeline of new professionals.

Recommended workforce interventions include:

- **Strategic Incentives:** Implementation of significant wage increases and targeted loan forgiveness programs to retain local talent.
- **The Interdisciplinary Teaching Hospital Model:** Establishing a regional teaching hospital in Northern New Mexico to train a new generation of psychiatrists, psychologists, MSWs, and LCSWs.
- **Administrative Reform:** Loosening the "red tape" and rigid documentation requirements that lead to provider burnout and limit the time available for direct patient care.
- **Invest in Internship Programs:** Work with school-districts to create a "grow our own" workforce pipeline, with scholarship opportunities.

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1.2 Funding and Regulatory Bottlenecks

Participants identified a "black hole" effect where funding, specifically **opioid settlement funds, remains trapped at the city and county levels** due to political inertia. The **state's "Anti-Donation Clause"** remains an antiquated barrier that hinders direct service state partnerships with effective nonprofits. Furthermore, **participants explicitly cited the bureaucracy created by House Bill 252 as a major hurdle**, noting that well-intentioned legislation often results in funds being inaccessible to "boots on the ground" organizations.

1.3 Insurance and Navigational Gaps

The **Medicaid/Medicare intercept creates significant service gaps**, particularly for low-income seniors. For adolescents, the requirement for parental consent to utilize insurance acts as a hard barrier to care. Providers are often forced into a **"billable box", rigid fee-for-service models**, that ignores the holistic, non-clinical supports patients require. To solve this fragmentation, the region must deploy local, **multilingual navigators who understand the cultural landscape** and can guide families and individuals through these administrative labyrinths.

These administrative failures manifest as tangible gaps in service that are further exacerbated by the region's unique geographic and cultural complexities.

2. Geographic and Cultural Challenges

A centralized, one-size-fits-all strategy is functionally incompatible with Region 1, which spans sovereign tribal nations, isolated rural villages, and urban hubs.

2.1 Tribal Consultation and Representation

Region 1 has expressed that current efforts have often **failed to involve Tribes individually and directly**, leading to systems that do not reflect Tribal needs. While the County & Tribal Health Councils and Community Health Representative (CHR) programs are recognized as time-tested models of culturally relevant care, they remain **underfunded and underutilized**. Additional interactions included:

Meaningful Consultation and Representation

Advocates emphasize that tribal inclusion must be more than a formality.

- **Direct Engagement:** Agencies must meet with **tribes individually and talk directly** to community members, not just program governors or leadership.
- **Native Leadership:** There is a demand for increased Native American leadership in mental health planning to **ensure that tribal voices are the**

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primary drivers of policy, rather than being secondary to state or county voices.

- **Bypassing Local Collaboratives:** Participants noted that **tribes are often "implemented" into regions without real communication from the local collaboratives** managing those regions, which is viewed as unfair and ineffective.

Financial Autonomy and Earmarks

A major demand is the direct distribution of funds to tribes to ensure resources reach the "boots on the ground" rather than being tied up in county or city bureaucracies.

- **Direct Funding for Services:** Tribes require **direct funding** for housing, transitional housing, sober living, and case management.
- **Funding Earmarking: Funds should be earmarked specifically for tribes** to prevent them from being "held up" by state or regional entities.
- **Independent Funding Streams:** There is a need for **collaboration funding that is not dependent on federal funds**, allowing for more flexible, community-based planning.

Linguistic and Cultural Sovereignty

Tribal inclusion requires a system that respects and centers the linguistic and spiritual heritage of Indigenous communities.

- **Language Access:** Participants demand **certified interpreters for Indigenous languages** such as Tewa, and Keres. Failure to provide this language access is highlighted as a potential violation of civil rights.
- **Indigenous Providers:** There is a strong preference for **properly licensed therapists who are tribal members and speak the native languages**.
- **Spiritual Integration:** Behavioral health **services must include spirituality and traditional healing practices**, which are currently often unrecognized, unfunded, or stigmatized.

Strengthening Tribal Workforce Assets

Rather than creating new systems, inclusion should focus on empowering existing tribal infrastructure.

- **County and Tribal Health Councils:** A critical function of public health that collaborates at the local and systems level to bridge gaps in services, and drives public health education, prevention, intervention, local systems of care, navigational services, and emergency response efforts.

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- CHR and CHW Support: **Community Health Representative (CHR) and Community Health Worker (CHW)** programs are seen as vital strengths. Demands include cross-training these workers in peer support and crisis response to act as primary navigators. CHRs/CHWs are in partnership with County & Tribal Health Councils which provides a mutual capacity enhancement for these two systems that are currently underfunded and lack sustainability.
- Tribal Justice Support: **Funding for Indian Child Welfare Act (ICWA)** programs and Community Justice Workers is needed to support families and provide legal navigation within tribal contexts

2.2 Rural Isolation vs. Urban Hubs

Transportation remains a barrier to care.

*One participant noted a patient in crisis was transported from Santa Fe to Albuquerque for inpatient care, only to be discharged with no follow-up and no means of returning home. **The region requires "decentralized" services, utilizing mobile crisis units to bring resources into rural communities rather than forcing high-risk patients to travel to urban centers.***

To effectively expand the behavioral health workforce in rural areas, strategies must focus on localized education infrastructure, financial incentives for retention, and regulatory reform to remove barriers for new providers. Community members in Region 1 **emphasized that expanding the workforce is less about reform and more about the creation of a system that currently lacks the necessary foundation**

Infrastructure and Clinical Education

One of the most prominent recommendations is the creation of a unique regional mental health hospital in northern New Mexico.

- **Localized Training Pathways:** By establishing pathways to these careers through training and internship opportunities, rural regions can "grow their own" workforce rather than relying solely on outside recruitment.
- **Youth-Led Crisis Response:** Implementing pilot projects (peer to peer support) can create an **immediate, community-based workforce layer.**

Financial Incentives and Retention

To keep trained professionals in rural and underserved areas, the sources suggest several financial interventions:

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- Increased Wages and Incentives: Participants called for **raising wages for behavioral health workers** to improve retention.
- Loan Forgiveness Programs: Offering **loan forgiveness specifically for providers who commit to practicing in rural areas** is viewed as a critical tool for workforce development.
- BIPOC Leadership Support: **Addressing the cultural, linguistic, and economic barriers that prevent BIPOC students** from achieving licensure or advanced education ensures the workforce reflects the community it serves

2.3 Modern Drivers of Trauma

New clinical strategies must address emerging socio-cultural drivers of trauma:

- **Dopamine Culture / Youth "Narrative of Doom"** : The **rise of digital processing conditions**, including online gaming, social media and online sports betting, is linked to increased youth suicidality and requires specialized intervention.
- **Economic fear/ uncertainty**: The belief that success requires leaving Northern New Mexico.
- **Fentanyl and Child Welfare**: Fentanyl is the primary driver of family separation. Participants emphasized the need to utilize the **2019 law intended to keep families together by supporting parent(s) with substance use disorders**, specifically those with NAS (Neonatal Abstinence Syndrome) infants. Substance use disorders are often met with punishment rather than healing-centered intervention from CYFD.
- **Perinatal Support**: Programs like doula services are essential to fostering parent-child bonding and preventing intergenerational trauma. Stigma from Substance Use during the "bonding period," leading to a lack of doula support and maternal mental health care.

The resolution to these challenges lies in the qualitative "Voices" of those currently operating successful models within the region.

The Sexual Violence Survivor's Reality: "We cannot wait for 'reform' while survivors of sexual violence are left in the dark. Currently, there is a waitlist of 85 survivors seeking services at Solace because funding is not recurring or stable."

3. Community Successes and Gaps

Region 1 possesses a wealth of "organic" strengths that clinical models often ignore. These assets range from **thousands of years of Indigenous wisdom to modern co-location models** that bring services directly to the people.

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Standardized clinical models are often intimidating and sterile. **In a multicultural region, "low-threshold access points" are the real front doors to health.** These programs allow youth to build confidence and find "mirrors" of themselves in leadership roles. When a young person feels seen in a kitchen or a film studio, the clinical encounter becomes secondary to the relationship. **These assets are more effective than office-based therapy because they treat the person within the context of their culture, not just their diagnosis.**

"Despite these profound strengths, our families continue to fall through structural cracks that have existed for decades."

3.1 Success Stories and Models of Excellence

The following models provide immediate templates for regional scaling:

- **Moving Arts Española:** A leader in youth empowerment through creative expression and land-based agriculture.
- **Solace Sexual Assault Services:** A vital resource currently managing a waitlist of 85 survivors, highlighting the desperate need for stable, recurring funding rather than one-time grants.
- **Tewa Women United:** The Yiya Vi Kagingdi (YVK) Doula Project serves as a gold standard for reproductive justice and perinatal mental health.
- **Santa Fe Connect & ShareNM:** An exemplary model for linking social determinants of health (SDOH) to clinical behavioral health outcomes.
- **McCurdy Ministries Campus:** A successful regional model for co-locating multiple nonprofits to streamline service delivery.

The regional foundation is built upon three distinct categories of community strength:

- Tribal and Cultural Programs
- School-Based and Youth Services
- Community Collaborations (County & Tribal Health Councils)

3.2 Specific Population Needs

To support the aging population, 0-5 children, youth, young adults, BIPOC and LGBTQ+ individuals in Northern New Mexico. A multi-generational strategy is required that focuses on specialized clinical care, school-based empowerment (education, prevention, intervention), and state-level legal protections. Community members emphasize that success involves moving beyond traditional office-based models to integrate healing into the environments where these populations live and learn (culturally tailored, traditional healing practices, holistic approaches to health).

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Support for the Aging Population

Participants noted that while youth is often a focus, the "elder" population is frequently underserved in rural and Tribal areas.

- Home and Community Caregivers: There is a high demand for **increased support, training, and funding for family and community caregivers** who allow elders to age in place rather than moving to distant facilities.
- Specialized Facilities: The region **lacks adequate inpatient beds for seniors and requires long-term case management** to help elders navigate complex health systems.
- Medication Management: Success for this group includes **accessible psychiatric oversight specifically tailored to the needs of seniors**
- Transportation: Ensures access to critical, medical and supportive services. Access to transportation for local-based services and non-essential needs.

Safety and Competency for LGBTQ+ Individuals

For the LGBTQ+ community, clinical care must be coupled with cultural humility and legal safety.

- Cultural Humility/ Informative Training: It is essential that **providers and administrators are trained in trauma-informed care specifically for the LGBTQIA+** community to dismantle existing stigmas.
- Safe Spaces: Community members expressed a need for **safe environments for LGBTQ+, Native, and undocumented youth** where they can develop skills and passions without fear of discrimination or intervention by federal authorities

Empowerment for Youth

The vision for youth success centers on early intervention and non-traditional healing spaces

- Youth-Led Crisis Response: A major recommendation is a pilot project to **train young adults (ages 25 and under) to respond directly to youth in crisis**, providing a peer-based alternative to police response.
- Healing through Expression: Organizations like Moving Arts Española are highlighted as community strengths, **using arts, film, and land-based activities to build resilience** and leadership building outside of clinical settings.

BH Region 1: Community Listening Session

- Removing Access Barriers: For teens, **the requirement of parental consent to use insurance is a significant hurdle that needs reform to ensure timely access to confidential care**

4. A Vision for the Future

The success of this transformation is anchored in high-level regional indicators: a marked **decrease in drug and alcohol-related deaths** and a substantial **reduction in suicide rates**.

These metrics are the ultimate barometers of regional health, indicating whether our infrastructure is **capable of proactive intervention before a crisis occurs**. Realizing this vision requires a rigorous analysis of the community-based assets already present in our soil.

Focus	Current System State	Envisioned 5-10 Year Success State
Access & Equity	Barriers based on ability to pay; 2–3 month wait times for specialists.	Open access regardless of pay; wait times reduced to 24–48 hours.
Navigational Support	Ensuring individuals and families have access to multi-lingual navigational support for navigating complex healthcare systems	An integrated system, “no wrong door” approach, and interoperable system between state (CLR/ 988) and local navigational support (Santa Fe Connect, Sharenm, 211, etc.)
Language and Cultural Relevance	Limited language access and Indigenous inclusion.	Culturally adapted services; tribal leadership and spirituality integrated.

BH Region 1: Community Listening Session

Continuum of Care	Crisis-driven; focused on the back-end (ER/Jail).	Comprehensive care from perinatal support to elder care.
Systems of Care Networks	Lack of resources to sustain and enhance the frontliners, Community Health Representatives (CHRs), Community Health Workers (CHWs) and County & Tribal Health Councils.	Strengthening critical community-based functions of healthcare to serve communities in a relevant and meaningful way, meeting communities where they are.
Workforce	Severe shortages; burnout due to administrative "red tape."	Stable provider networks; interdisciplinary teaching facilities in-region.
State & Local Alignment	Lack of state collaboration and support of nonprofit service providers	Alignment, collaboration, and sustainability for serving communities more effectively
Population Focus	Fragmented support for specific age groups.	Seamless life-cycle support from infants (NAS care), youth, young adults, adults to elders.

You cannot reform a system that does not yet exist, this is a creation process. The most important lesson from Region 1 is that we are in the Infrastructure Creation phase, engaging and involving a variety of aspects of care, from education, prevention, diversion, intervention, crisis response, navigational, clinical and medical. **Success requires building a "strong foundation" of types of facilities, resourcing existing systems of community-based services and building a strong workforce while simultaneously funding the "time-tested" traditional models that have sustained our people for generations.** Creating a system that works means ensuring there is "no wrong door", only an open one, and for systems (both local and state) to work together, enabling the state to invest in local service providers.

BH Region 1: Community Listening Session

Demographics Overview

Total Registrants: 325	Total Unique Participants: 195
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Attendees joined multiple sessions accounting for the difference of “actual participants” vs “unique participants”. Unique participants account for 60% of registrants.

Attendance was highest during the first session on January 12th. **31 individuals (16%) showed high engagement by attending more than one session.**

Session Date	Registered for Date	Actual Attendees	Attendance % (of Intended Date)
Monday, January 12th	126	106	84.13%
Wednesday, January 14th	104	67	65.42%
Thursday, January 15th	95	66	69.47%

Participation Engagement from Registrations:

60 % from registrations led to participation

Outreach was most effective in Santa Fe and Rio Arriba Counties, with the highest conversation rate from registration to attendance. The great tribal participation included: **Navajo Nation**, which had 4 Registration, with 2 attending and **Ohkay Owingeh Pueblo** who welcomed 5 registration with 3 participating.

Geography Overview:

Breakdown by Zip Code (Input by Registration)

Nearest City or Tribal/Pueblo Affiliation	Associated Zip Codes	Registrant Count	Attendee Count
Santa Fe	87507, 87505, 87501, 87508, 87506, 87504,	182	110

BH Region 1: Community Listening Session

	87502, 87503, 85707, 87111, 87592, 87594		
Española	87532, 85732	32	15
Albuquerque	87110, 87102, 87109, 87112, 87111, 87107, 87105, 87104, 87106, 87108, 87113	22	14
Los Alamos	87544	7	6
Ohkay Owingeh Pueblo	87566, 87532	5	3
Edgewood	87015, 87035	5	0
Navajo Nation	87410, 87415, 87301	4	2
Rio Rancho	87144, 87124	4	2
Taos Pueblo	87571	3	0
Nambé Pueblo	87506	2	2
San Ildefonso Pueblo	87506	2	2

BH Region 1: Community Listening Session

Santa Clara Pueblo	87532	2	2
Cochiti Pueblo	87072	2	2
Mescalero Apache Tribe	88340	2	2
Deming	88030	2	2
Chimayó	87522	2	2
Chama	87520	2	2
Roswell	88201, 88202	2	2
Tesuque Pueblo	87506	2	1
Santo Domingo Pueblo	87052	2	1
Pojoaque Pueblo	87506	2	1
Picuris Pueblo	87553	2	1

BH Region 1: Community Listening Session

Las Vegas	87701, 87711	2	1
Alcalde	87511	2	1
Belen	87002	2	0
Jicarilla Apache Tribe	87528	1	1
Isleta Pueblo	87022	1	1
San Felipe Pueblo	87001	1	1
Fort Sill Apache Tribe	88030	1	1
Abiquiu	87510	1	1
Socorro	87801	1	1
Farmington	87402	1	1
Lordsburg	88045	1	1

BH Region 1: Community Listening Session

Columbus	88029	1	1
Cuba	87013	1	1
White Rock	87547	1	1
Raton	87740	1	1
Corrales	87048	1	1
Flora Vista	87415	1	1
Galisteo	87540	1	1
Chili	87537	1	1
El Guique	87566	1	1
Denver	80209	1	1
Santa Cruz	87567	1	1
Additional Areas (Listed as	87567, 87510, 87537, 87010, 87016, 87582	8	0

BH Region 1: Community Listening Session

"Statewide" serving*)			
TOTAL	—	325	195

Affiliation Overview:

Affiliation	Registered	Attended	Attendance Rate of Registered vs Attended
Community Member	73	34	46.6%
County Employees	43	21	48.8%
Non-Profit	42	30	71.4%
Other	33	20	60.6%
Community Coalition / Collaborative Partner	28	19	67.9%
State Agency	25	17	68.0%

BH Region 1: Community Listening Session

County or Tribal Health Councils	25	21	84.0%
Care Management Organizations	9	6	66.7%
Outpatient Treatment Centers	9	7	77.8%
High-Education	8	5	62.5%
Hospitals / Clinics	8	6	75.0%
Legislator / Govt Official / Tribal Govt	7	3	42.9%
For Profit	6	2	33.3%
IHS / 638 Clinics	3	1	33.3%
School-Based Clinics	2	1	50.0%
Tribal Service Providers	1	1	100.0%
Inpatient Treatment Centers	1	1	100.0%

BH Region 1: Community Listening Session

Tribal Affiliation	1	0	0.0%
Philanthropy	1	0	0.0%
TOTAL	325	195	60.0%

“Other” Affiliations Include:

City Councilors (Santa Fe & Española), Legislative Aides, Lobbyist for Pojoaque Pueblo, County Compliance Office, Judiciary, Law Office of the Public Defender, Magistrate DWI Treatment Court, PreK-12 Public Education, Southwestern College, Hospital Social Worker, Center for Independent Living, Mental Health Clinicians (Private Practice), County & Tribal Health Councils, NM Alliance of Health Councils, Kinshipper of drug-addicted child, Member with lived experience, Share NM, City of Santa Fe employees, Department of Health (DOH) staff, Consultants to the City.

Gender Overview:

Gender	Registered	Attended
Female	232	142
Male	78	43
Prefer not to say	8	4
Non-Binary	3	2

BH Region 1: Community Listening Session

Agender	1	1
Androgynous	1	1
Genderfluid	1	1
Genderqueer	1	1
TOTAL	325	195

Ethnicity Overview:

**Note: The data below reflects the specific, and sometimes compound, identities shared by registrants which accounts for the increased number vs registrations..*

Ethnicity	Registered	Attended
White / Caucasian	134	81
Hispanic / Latino	120	72
American Indians / Alaskan Native	35	22
Prefer Not To Say	21	13

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Black / African American	10	4
Ethnicity Provided Individually* Ashkenazi Eastern European Black Native South Asian	3	1
East Asian	2	2
TOTAL	325	195