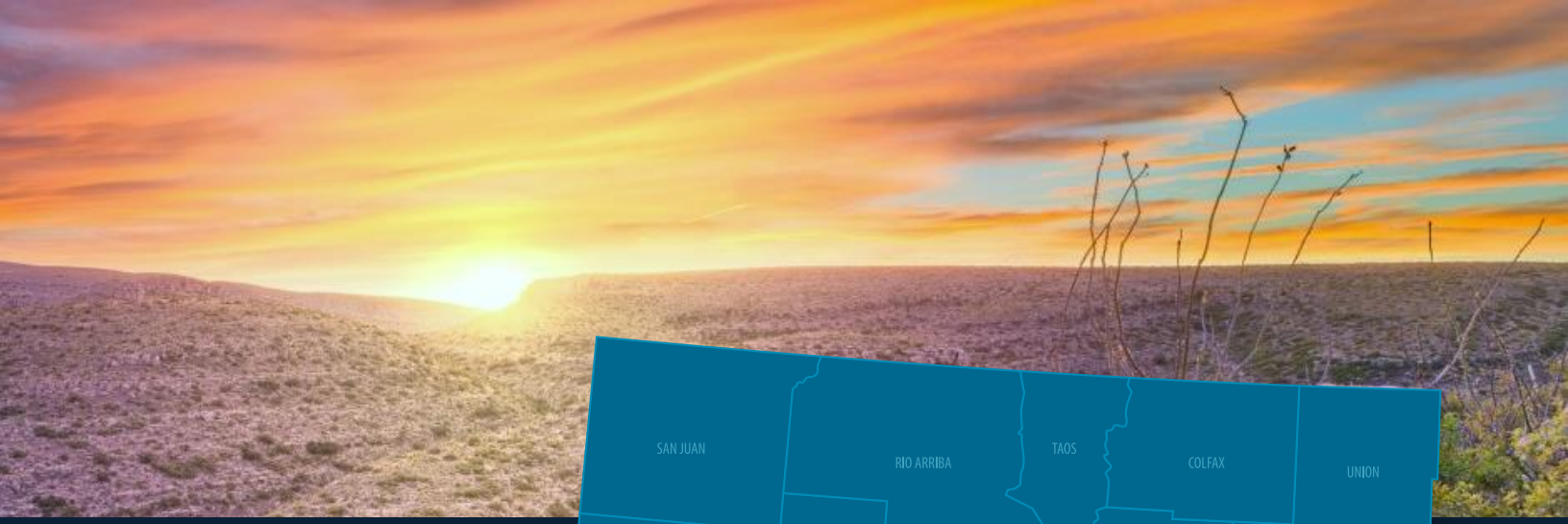

RECOVERY COMMUNITIES AND ORGANIZATIONS IN RURAL SOUTHERN NEW MEXICO:

GAPS, BARRIERS, AND RECOMMENDATIONS

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Executive Summary

This project examined the current practices, services and needs (including discharge planning and care coordination for those recently released from incarceration) for recovery communities and recovery organizations in 14 Health Resources and Services Administration-designated rural counties in Southern New Mexico: Catron, Chaves, Cibola, De Baca, Eddy, Grant, Hidalgo, Lea, Lincoln, Luna, Otero, Roosevelt, Sierra, and Socorro Counties.

We found the gaps, barriers, and recommendations to prevention, treatment and recovery could be clustered into 7 domains: housing, transportation, health care system, employment, substance use disorder (SUD) treatment, justice system, and stigma. While each problem came with its own specific issues, many of the gaps and barriers had overlapping causes and solutions. Many of these gaps are addressable with existing evidence-based and practice-based solutions.

The purpose of this report is to deliver a series of findings and related recommendations. The gaps, barriers, and recommendations were reported through a process of data collection conducted with people living in rural southern New Mexico. For this reason, the contents of this report are specific to this region, and may not include commonly held understandings, interventions, or beliefs about the topic of interest based on experiences gained in other parts of the country or other populations.

How we reached these results

In late 2022, our team conducted interviews and focus groups with a range of experts including Certified Peer Support Workers (CPSWs), Corrections Professionals, and Behavioral Health Professionals, and conducted extensive secondary analysis of existing data to identify the most pressing issues for justice-involved people with SUD and people living with SUD who do not have a history of involvement with the justice system in southern New Mexico. The results presented in this report represent the analysis of these data. The full report includes appendices containing the full analysis of the qualitative data, the interview guide, and resource and data tables.

This project fulfills a core activity of the Health Resources and Services Administration (HRSA) - funded Rural Communities Opioid Response Program (RCORP) project at the Center for Health Innovation (HRSA Grant #GA1RH39543).

Background and Significance

Background and Significance

This project is focused on 14 HRSA-designated rural counties in Southern New Mexico[1]: Catron, Chaves, Cibola, De Baca, Eddy, Grant, Hidalgo, Lea, Lincoln, Luna, Otero, Roosevelt, Sierra, and Socorro. This region of southern New Mexico, herein referred to as Rural, Southern New Mexico (RSNM), has many notable features. The geography features the Chihuahuan Desert, the Gila Mountain range, the Rio Grande River Valley, Carlsbad Caverns, and White Sands National Monument. While the statewide population density is 17.5 persons/mile^2, in the 14 counties featured in this report there are far fewer people overall, at only 6.7 persons/mile^2, covering a land mass of 63,498 miles (population estimates as of July 2021). The region has a rich heritage in farming, ranching, oil/gas, and mining - industries that are dangerous and subject to market fluctuations that endanger worker livelihood.

The rural, diverse, and aging population of these RSNM counties face multiple structural, cultural, and stigma-based obstacles to accessing and utilizing behavioral health care. The region is persistently designated by HRSA as a primary and behavioral health professional shortage area and treatment facilities are scattered across a large geographic area. Because of its proximity to the Mexican border, RSNM has a large Latinx population, where many families have mixed residency status and limited English proficiency. The region is also home to the Mescalero Apache Nation, a portion of the Navajo Nation, the Pueblo of Acoma, the Pueblo of Laguna, the Fort Sill Apache reservation, as well as a large off-reservation Native American population. These structural and demographic issues shape not only the availability of opioids used for non-prescription purposes, but the accessibility of care to treat and recover from substance use disorder (SUD).

Population Demographics

The total population of the 14 counties included in our report, is approximately 425,487.[3] While residents are diverse in socioeconomic status and educational attainment, the percentage of unemployed residents and families living at or below the federal poverty level exceeds both state and national averages (Table 1). The area is also home to a large proportion of older adults and most RSNM counties (9) are majority minority with large proportions of Hispanic/Latinx and American Indian residents (Table1). RSNM's large population of documented and undocumented immigrants from Mexico, many of whom prefer to speak Spanish or have limited English-speaking ability face additional obstacles to accessing and utilizing behavioral health care.

Compared to the national average, RSNM residents report higher rates of a variety of negative physical and mental health outcomes, including diabetes, arthritis, depression, and disability. The leading causes of death in New Mexico in 2021 were (1) heart disease, (2) cancer, (3) COVID 19, (4) unintentional injuries, and (5) chronic lower respiratory disease. Looking more closely at important health indicators for the 14 counties, an average of 32% of children aged 1-17 are living at or below the federal poverty level. Twenty one percent of adults aged 18-64 are living at or below the federal poverty level and living without health insurance. Measures of children's health are salient to this report, specifically those related to adverse childhood events. According to the Annie E. Casey Kid's Count report, there is a reported child abuse rate of 15 per 1,000 children in the 14 counties of interest, averaging across 2018-2021.[4] Youth who report binge drinking across the years 2013, 2015, and 2017 average 17% of all surveyed.

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[1] Doña Ana County is in the area, but not considered rural and therefore not included in our project area.

[2] U.S. Department of Health and Human Services, Health Resources and. Services Administration, Maternal and Child Health Bureau, Retrieved from https://mchb.tvisdata.hrsa.gov/Narratives/Overview/8b609333-f44b-4eeb-a392-f09e56afd404#:~:text=In%202020%2C%20New%20Mexico's%20population,frontier%20or%20sub%2Dfrontier%20areas.

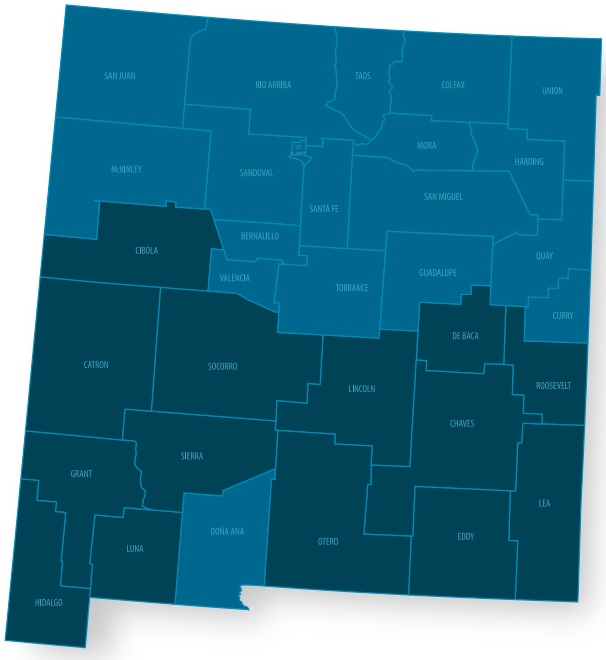
[3] U.S. Census Bureau *2021 American Community Survey 1-year data* Retrieved from https://censusreporter.org/profiles/04000US35-new-mexico/

[4] The Annie E. Casey Foundation, KIDS COUNT Data Center, Retrieved from https://datacenter.kidscount.org/data#NM/2/0/char/0

Table 1. Select Demographic and Socioeconomic Data for RSNM counties

County	Population	American Indian Alaska Native	Asian Pacific Islander	Black	Hispanic	White	Unemployment Rate	Living in poverty
Catron	3,581	2%	0%	0%	17%	80%	6.1%	22.5%
Chaves	65,014	1%	1%	1%	58%	37%	4.9%	21.2%
Cibola	27,284	40%	0%	1%	39%	18%	6.5%	27.9%
De Baca	1,873	0%	0%	3%	61%	36%	4.8%	17.7%
Eddy	61,096	1%	1%	1%	51%	44%	3.3%	14.7%
Grant	28,178	1%	1%	1%	50%	46%	4.3%	22.1%
Hidalgo	4,214	1%	0%	1%	59%	37%	4.2%	22.1%
Lincoln	20,084	3%	0%	1%	34%	60%	4.2%	12.6%
Lea	73,004	0%	1%	3%	62%	30%	4.5%	22.3%
Luna	25,282	1%	1%	2%	68%	28%	8.7%	26.3%
Otero	68,537	5%	2%	3%	40%	46%	5.0%	22.1%
Roosevelt	19,223	0%	1%	2%	44%	50%	4.5%	22.8%
Sierra	11,512	2%	1%	0%	32%	63%	6.6%	25.0%
Socorro	16,605	11%	2%	1%	51%	33%	5.5%	32.3%
NM	2,115,877	8%	2%	2%	50%	35%	4.8%	18.4%
US	331,893,745	1%	6%	12%	18%	59%	3.7%	12.6%

The dark shaded counties in the map represent the 14 Rural Southern New Mexico counties named above.



Gaps, Barriers, and Recommendations

The following gaps, barriers, and recommendations are drawn from the qualitative focus groups and interviews, and secondary data analysis conducted by the project team. The research methodology is included in Appendix A.

This project examined the range of current practices, services and needs for recovery communities in 14 HRSA-designated rural counties in Southern New Mexico: Catron, Chaves, Cibola, De Baca, Eddy, Grant, Hidalgo, Lea, Lincoln, Luna, Otero, Roosevelt, Sierra, and Socorro Counties.

We found the gaps, barriers, and recommendations could be clustered into 7 domains (Table 2): housing, transportation, health care system, employment, substance use disorder (SUD) treatment, justice system, and stigma. While each problem came with its own specific issues, many of the gaps and barriers had overlapping causes and solutions. Many of these gaps are addressable with existing evidence-based and practice-based solutions.

Each domain represents an area for intervention. For example, the Housing domain contains two separate items, 1.a., and 1.b. Each item includes a specific problem identified by participants in the qualitative data collection process. When potential solutions were described during the data collection process, we include those solutions as "Community-Based Recommendations." In the following sections we will discuss the findings for each domain. Including a description of the identified gap or barrier along with community and evidence-based practice recommendations for improvement. (A full table detailing the problems with descriptions and web linked evidence-based practices is in Appendix B.)

Table 2. Domains and Barriers

Domain	Gaps and Barriers
Housing	
1.a.	Not enough housing
1.b.	Available housing does not meet needs
Transportation	
2.a.	Distances between supervision, health care or SUD treatment, work, and home is prohibitive
Health Care System	
3.a.	People with SUD who present to ED with mental health crisis do not receive standard of care
3.b.	People with serious mental illness and SUD have treatment gaps
Employment	
4.a.	The range of employment opportunities for justice-involved people with SUD is limited and can contribute to poor compliance with conditions of parole/ probation
SUD Treatment	
5.a.	Delays in accessing treatment for SUD / Workforce Shortages
5.b.	Difficulty accessing MOUD in rural areas
5.c.	Payment and bureaucracy
5.d.	Linkage and communication gaps (shared with Justice System Domain)
Justice System	
6.a.	Linkage and communication gaps (shared with SUD Treatment Domain)
6.b.	Deficit-based philosophy driving justice system approach to SUD
6.c.	Justice-involved persons require additional life skills support
Stigma	
7.a.	Justice-involved people who have SUD experience high levels of stigma at all levels of their lives
7.b.	Stigma influences access to care for people with SUD

DOMAIN: HOUSING

1.a. Not enough housing

Vast distances between housing, work, and SUD treatment services, poor overall housing quality, and high-cost housing present a major barrier to successful completion of supervision following release from incarceration. These barriers contribute to high rates of unhoused and unstably housed people who live with SUD, placing those people at high risk of exposure to conditions that trigger substance use, including increased access to substances, stress, and limited positive social support.

COMMUNITY-BASED RECOMMENDATIONS:

Build and maintain affordable housing in rural regions of the state

EVIDENCE-BASED PRACTICE RECOMMENDATIONS:

Expanding access to and use of behavioral health services for people experiencing homelessness

- Medication for Opioid Use Disorder (MOUD)
- Motivational interviewing
- Intensive case management
- Community Reinforcement Approach/Adolescent Community Reinforcement Approach
- Peer support

> "Yeah, that's, that's a real issue down south. It's hard to get affordable housing. It's hard to get anybody to want to build affordable housing because if you can ask $2,700 for a one bedroom, why would you want $800? Why would you build anything for HUD? So yeah, I don't know if I have a solution to that but that, that just irks me so much because everybody's trying so hard and the vouchers are there and the money is there, but you can't use it. It's like, well where am I gonna put them? And then they, the house also has to qualify for HUD standards. So yeah, you find somebody renting out their little grandma's casita and then, well, I don't have a back door and it don't have a thumb latch and the window don't open and because we're in rural New Mexico you find that little dinky thing in the side of the road and then it doesn't qualify."
> ***(Case Manager)***

1.b. Available housing does not meet needs

The vast distances that separate housing, employment opportunities, supervision, and SUD treatment create conditions that threaten one or all these variables, as the justice-involved person may be required to travel many hours each day to fulfill requirements. Requirements are typically: earn a wage that pays rent, report for supervision, and receive treatment for their SUD. If these requirements are too burdensome, housing is frequently the first to go.

COMMUNITY-BASED RECOMMENDATIONS:

Build and maintain affordable housing in rural regions of the state

EVIDENCE-BASED PRACTICE RECOMMENDATIONS:

Permanent Supportive Housing (PSH)

- PSH combines permanent housing with a system of professional or peer supports or both that allows a person with mental illness to live independently in the community.
- Supports may include regular staff contact and the availability of crisis services or other services to prevent relapse, such as those focusing on mental health, substance use, and employment.

Housing First

- Housing First is an approach that connects individuals and families experiencing homelessness to permanent housing quickly and without preconditions and barriers to entry, such as sobriety, SUD treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

DOMAIN: TRANSPORTATION

2.a. Distances between supervision, healthcare or SUD treatment, work, and home is prohibitive

Existing transportation programs are not realistic in this region (bus and ride share vouchers don't work in regions where there are no buses or ride share). Additionally, the costs of fuel, insurance, and maintenance of a car can be prohibitive. Transportation needs may frequently necessitate supplementation by a third party.

COMMUNITY-BASED RECOMMENDATIONS:

- Create cohort-style supervisory approach, with group home-based therapeutic approach. All resources located in the same place, reduce the need for transportation, reduce cost of housing.
- CPSWs provide transportation, with a focus on transporting justice-involved persons to high priority meetings such as treatment appointments, court dates, and required supervision appointments.

EVIDENCE-BASED PRACTICE RECOMMENDATIONS:

Modified Therapeutic Community (MTC)

- MTCs alter the traditional Therapeutic Community approach in response to psychiatric symptoms, cognitive impairments, and other impairments commonly found among individuals with co-occurring disorders.
- These modified programs typically have (1) increased flexibility, (2) decreased intensity, and (3) greater individualization.

> "So, we have [small town name], it's 30 miles that way, no bus service. We have [town 2], it is eight miles, we have [town 3], it is 15 miles bus, one time out, one time in, We have [town 4] who's 30 miles, we have [town 5] who's 45. Like, we're so sparsely spread out that if we have a person who is not directly in the middle of town, they're not going to be able to meet their needs as far as…and then our cell service, even if there is Zoom capability or telehealth, there's no reception because we're High Mountain. And so it's, it's really difficult when they do fall off radar to get them back into services quickly or to be able to provide services out to them."
> ***(Certified Peer Support Worker)***

Peer-based Recovery Support Programs

- Formerly justice-involved individuals who are in recovery provide support to other individuals who are also involved, or at risk of becoming involved, in the criminal justice system.

12-step or Other Mutual Aid Groups

- Groups of nonprofessionals who share a problem and support one another through the recovery process.
- May be in-person or virtual

DOMAIN: HEALTH CARE SYSTEM

3.a. People with SUD who present to the emergency department experiencing mental health crisis do not receive standard of care.

People with SUD who present to ED with mental health crisis do not receive standard of care. Healthcare providers outside the behavioral health system are poorly prepared to manage justice-involved patients with SUD. Patients who are living with SUD typically do not receive referral to treatment at time of discharge from ED.

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> I don't feel like the hospital here is very educated on how to handle somebody that's like suicidal or mentally ill and has like real issues, you know? And the way they treat them, they don't help calm 'em or, you know what I mean? I, I just think that there's more education that needs to be for sure with situations. Because if someone is suicidal, they don't need you to be treating handcuffing 'em and treating 'em like they're criminals. You know, they're, they're seeking help. And I just, I don't know, I just think that there's other ways of handling things. ***(Peer Educator)***

COMMUNITY-BASED RECOMMENDATIONS:

- Train medical staff working in small, rural, and community hospitals in best practices for medical management of health crises (including mental health crises)
- Provide linkages for staff working in small, rural, and community hospitals for referrals to treatment programs for SUD

EVIDENCE-BASED PRACTICE RECOMMENDATIONS:

Use of Medication-assisted treatment (MAT) in emergency departments

- Medications approved by the U.S. Food and Drug Administration (FDA) to treat opioid use disorder (OUD) are effective and save lives
- Long-term retention on MAT is associated with improved outcomes
- A lack of availability of behavioral interventions is not justification to withhold MOUD
- Most people who could benefit from MAT do not receive it, and access is inequitable
- Confronting the major barriers to use of MAT is critical to addressing the opioid crisis
- Emergency Department-initiated buprenorphine is a recommended best practice

Peer-based Recovery Support Programs

- Formerly justice-involved individuals who are in recovery provide support to other individuals who are also involved, or at risk of becoming involved, in the criminal justice system.

CPSWs in Emergency Departments[5]

- Hospitals and Emergency Departments (EDs) are an ideal location to intervene with an individual whose opioid overdose has just been reversed, and immediately connect them with appropriate services and support, including MAT.
- CPSWs have the necessary experience and expertise to effectively engage with an overdose survivor in the ED, and they have the potential to reduce the likelihood of relapse, morbidity and mortality among an individual with OUD who presents in the ED as a result of their opioid use.

[5] Additional resource on PSWs in Emergency Departments here: https://pcssnow.org/wp-content/uploads/2018/07/Peer-Support-Workers-in-EDs-Issue-Brief-1.24.19.pdf

3.b. People living with serious mental illness and SUD have treatment gaps

People who have a serious mental illness cycle in and out of emergency departments and incarceration with poor mental health management. This patient population requires consistent psychiatric care, yet the peak/trough effect that accompanies repeat incarcerations contributes to worsening of psychiatric symptoms and difficulty addressing SUD.

EVIDENCE-BASED RECOMMENDATIONS:

Intensive care coordination for children and youth with complex mental and substance use disorders: State and community profiles

- Intensive Care Coordination (ICC) provides a general framework without a specific practice model.
- Wraparound, a team-based care planning approach, includes a comprehensive service array and provider network and is the most frequently used evidence-based approach to ICC to support youth with complex mental and substance use disorders and their families.

Telehealth for treatment of serious mental illness and substance use disorders

- Telehealth modalities for serious mental illnesses (SMI) or SUD may be synchronous (live or real time) or asynchronous (delayed communication between clients and providers).
- Telehealth has the potential to address the treatment gap, making treatment services more accessible and convenient, improving health outcomes, and reducing health disparities.

Treatment considerations for youth and young adults with serious emotional disturbances and serious mental illnesses and co-occurring substance use

- Evidence-based practices that improve outcomes for youth and young adults with co-occurring serious emotional disturbances or SMI and SUD include psychosocial interventions, family behavioral therapy, medication, proactive outreach, and use of web-based and other technologies.

Integrated Mental Health and Substance Use Services (Integrated Treatment for Co-Occurring Disorders)

- Treatment and service provision to support recovery from co-occurring mental and substance use disorders through a single agency or entity.

Assisted Outpatient Treatment (AOT)

- Also known as conditional release, outpatient commitment, involuntary outpatient commitment, or mandated outpatient treatment
- Intended to facilitate the delivery of community-based outpatient mental health treatment services to individuals with SMI who have refused psychiatric treatment in the past, are at risk for deterioration or harming themselves or others, and for whom hospitalization is unnecessarily restrictive.

DOMAIN: EMPLOYMENT

4.a. The range of employment opportunities for justice-involved people with SUD is limited and can contribute to poor compliance with conditions of parole/probation

Low wage work that does not provide a living wage is creating financial difficulties for people with few support systems in place. Rigid schedules do not accommodate time out of the day for SUD treatment appointments or appearing for mandatory supervision. Work is personally unsatisfying and has little room for growth or promotion. These conditions create personal barriers for a newly released justice-involved person who is likely managing multiple stressors and must work in a setting that can be personally and emotionally defeating.

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> One thing that everybody would agree on is there's tons of opportunities for people to go and flip a burger, which gets, addresses the immediate need of putting a paycheck and being compliant with their conditions of release. And we've all been there and done that. There's nothing wrong with that. But how do we get people to a career pathway that is sustaining and provides, you know, not only a source of income that is a livable wage, but also something where someone finds enjoyment and they're invested in their job because that's when they're gonna stay and that's when they're gonna grow. ***(Parole/Probation Officer)***

COMMUNITY-BASED RECOMMENDATIONS:

Increase job training programs inside detention centers

EVIDENCE-BASED RECOMMENDATIONS:

Substance use disorders recovery with a focus on employment

- Institute recovery-friendly employment policies
- Provide policies and resources that support prevention
- Provide supportive intervention policies
- Mandate a drug-free workplace policy

Supported Employment

- Matches and trains people with severe developmental, mental, and physical disabilities where their specific skills and abilities make them valuable assets to employers.

DOMAIN: SUD TREATMENT

5.a. Delays in accessing treatment for SUD/Workforce Shortages

Justice-involved people with SUD must endure long waitlists before finding room in a treatment program after being released from incarceration. There are not enough healthcare providers in the region to meet the demand. Clinicians who could prescribe medication to aid people with SUD (MOUD) are opting not to do so. There is a lack of licensed behavioral health providers in rural areas overall.

COMMUNITY-BASED RECOMMENDATIONS:

CPSWs and other equivalent “lay” peer helpers are a resource within the recovery landscape, providing a wide range of supportive services

EVIDENCE-BASED RECOMMENDATIONS:

Principles of community-based behavioral health services for justice-involved individuals: A research-based guide

- Eight principles that provide a foundation for a quality, community-based behavioral health treatment system for justice-involved individuals and evidence-based and promising programs and practices.

SAMHSA Peer Support Worker Resource Page

- Individuals who are in recovery provide support to other people in recovery, including those who are involved, or at risk of becoming involved, in the criminal justice system.

Practical tools for prescribing and promoting buprenorphine in primary care settings

- Practical, evidence-based information on prescribing buprenorphine to individuals in need of intervention and discusses implementation considerations and strategies to facilitate primary care provider understanding, planning of activities, and implementation of buprenorphine prescribing.

Treating concurrent substance use among adults

- Current practices associated with improved outcomes for individuals with concurrent substance use and concurrent SUD include FDA-approved pharmacotherapy together with counseling, contingency management together with FDA-approved pharmacotherapy and counseling, and twelve-step facilitation therapy together with FDA-approved pharmacotherapy and counseling.

Treatment of stimulant use disorders

- Current practices associated with effectiveness to address stimulant use disorders include Motivational Interviewing, Contingency Management, Community Reinforcement Approach, and Cognitive Behavioral Therapy.

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> I was looking at Spanish language AA meetings in Southern New Mexico versus English language meetings. The difference is astounding. There's like really just a few. There's some in Las Cruces, there's one in Deming and one or two in Anthony. And I heard a rumor about one that's meeting. I mean that's mostly Doña Ana county-centric other than Deming, right? What, where are the Spanish language meetings in like Alamogordo and Roswell? Right. So, that's just one example of one recovery community. Then thinking about, you know, just how difficult it must be to have a language barrier problem…
> ***(Community Outreach Worker)***

Assertive Community Treatment (ACT)

- Treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for clients' case management and treatment needs.

Forensic ACT (FACT)

- Forensic ACT is an adaptation of ACT for individuals involved in the criminal justice system. FACT provides the same level and type of treatment services of ACT, but also includes interventions targeted to criminogenic risk and need factors.

Academic detailing interventions for opioid-related outcomes: a scoping review

- Emerging evidence-based practice designed to address clinician bias in prescribing MOUD

5.b. Difficulty accessing MOUD in rural areas

People who receive medication for opioid use disorder (MOUD) find difficulties locating a pharmacy that will dispense according to state laws. Dosing schedules for MOUD require close management and access to reliable transportation, pharmacy, and prescribing clinician.

COMMUNITY-BASED RECOMMENDATIONS:

- Enforcement of state policies to improve access to medication
- Enhancement of access to MOUD in rural areas

EVIDENCE-BASED RECOMMENDATIONS:

Academic detailing interventions for opioid-related outcomes

- Emerging evidence-based practice designed to address clinician bias in prescribing MOUD
- 1:1 observation and feedback of clinician prescribing and clinical care for patients receiving MOUD or opioid prescriptions

5.c. Payment and bureaucracy

Health insurance coverage is inconsistent, people with SUD who are on Medicaid struggle to find treatment programs that accept this form of insurance. Treatment programs have their own series of bureaucracy and barriers that can prevent an otherwise eligible person from receiving a space in their program.

EVIDENCE-BASED RECOMMENDATIONS:

Assertive Community Treatment (ACT)

- Treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for clients' case management and treatment needs.

Forensic ACT (FACT)

- Forensic ACT is an adaptation of ACT for individuals involved in the criminal justice system. FACT provides the same level and type of treatment services of ACT, but also includes interventions targeted to criminogenic risk and need factors.

> "We piloted a few programs here during the pandemic. And honestly it was really difficult, and we found that without an onsite medical assistant, it was really challenging. There's also some stuff going on with telemedicine. Walmart, for example, is refusing to fill controlled substances, prescriptions for people that haven't seen the provider in person in, I can't remember if it's one year or two years. And some pharmacies, even though the DEA has not reinstated the Ryan White Act, which prevents opioids and other controlled substances from being prescribed via telemedicine, some pharmacies are instituting these policies on their own. So, we're starting to see sort of a backlash against telemedicine. You know, if we start prescribing via telemedicine in in a rural community, and the only pharmacy in that community then decides to stop filling telemedicine prescriptions, that really leaves people in a bad spot.
> ***(Community Outreach Worker)***

5.d. Transition from pre-release to post-release creates gaps in SUD treatment (shared with Justice System domain)

Linkage and communication between detention pre-release and post-release treatment services does not bridge gap for people needing access to immediate treatment for SUD. Justice-involved people are released from incarceration and typically expected to find their own resources and treatment programs.

COMMUNITY-BASED RECOMMENDATIONS:

Linkage to available and appropriate treatment for SUD for newly released people with SUD, eliminating waitlists and dangerous gap between incarceration and treatment

EVIDENCE-BASED RECOMMENDATIONS:

Critical Time Intervention

- Nine-month, three-stage intervention that develops individualized linkages in the community
- Facilitates engagement with treatment, supports, and housing through building problem-solving skills, motivational coaching, and connections with community agencies.

Selecting best-fit programs and practices: Guidance for substance misuse prevention practitioners

- Information on the value of embedding program and practice selection in a strategic planning process, where to find information on programs and practices and selection, tips for adopting, adapting, and innovating programs and practices and for supporting their successful implementation and continual improvement at the local level.

Comprehensive Case Management for Substance Abuse Treatment

- Focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of an individual's life.
- Effective as an adjunct to treatment for substance use; association with better outcomes as case management can keep clients engaged in treatment and moving toward recovery, and substance use treatment may be more likely to succeed when an individual's other needs are addressed concurrently.

DOMAIN: JUSTICE SYSTEM

6.a. Transition from pre-release to post-release creates gaps in SUD treatment (shared with SUD Treatment domain)

Linkage and communication between detention pre-release and post-release treatment services does not bridge the gap for people needing access to immediate treatment for SUD. Justice-involved people are released from incarceration and typically expected to find their own resources and treatment programs.

COMMUNITY-BASED RECOMMENDATIONS:

Linkage to available and appropriate treatment for SUD for newly released people with SUD, eliminating waitlists and dangerous gap between incarceration and treatment

EVIDENCE-BASED RECOMMENDATIONS:

Selecting best-fit programs and practices: Guidance for substance misuse prevention practitioners

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> I know that people are not getting adequate access to treatment in jail, and I do not doubt that people are sometimes using in the parking lot as soon as they get out. And so, I think that Narcan being given to people as they're leaving is critical. And I think that instituting medication assisted treatment is really critical to help save people's lives. Yeah, I just think too much of it is left up to the individual. Right. They walk out of the detention center and they're free to go wherever they like, which is great on the one hand. On the other hand, if we could connect them immediately to low barrier services, that would be great.
> ***(Certified Peer Support Worker)***

- Embedding program and practice selection in a strategic planning process, where to find information on programs and practices and selection, tips for adopting, adapting, and innovating programs and practices and for supporting their successful implementation and continual improvement at the local level.

Comprehensive Case Management for Substance Abuse Treatment

- Focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of an individual's life.

- Effective as an adjunct to treatment for substance use; association with better outcomes as case management can keep clients engaged in treatment and moving toward recovery, and substance use treatment may be more likely to succeed when an individual's other needs are addressed concurrently.

Critical Time Intervention

- Nine-month, three-stage intervention that develops individualized linkages in the community
- Facilitates engagement with treatment, supports, and housing through building problem-solving skills, motivational coaching, and connections with community agencies.

6.b. Deficit-based philosophy driving justice system approach to SUD

All points of termination return the justice-involved person living with SUD back to incarceration.

COMMUNITY-BASED RECOMMENDATIONS:

Build an asset-based model of transition for justice-involved people that envisions their lives outside the incarceration cycle

6.c. Justice-involved persons require additional life skills support

Newly released people require assistance with basic life skills such as completing forms, using technology, opening a bank account, and applying for vital documents.

COMMUNITY-BASED RECOMMENDATIONS:

CPSWs supported to assist with and teach life skills

EVIDENCE-BASED RECOMMENDATIONS:

SAMHSA Peer Support Worker Resource Page

- Peer worker resources on recovery from a mental health and/or substance use condition.

Peer-based Recovery Support Programs:

- Formerly justice-involved individuals who are in recovery provide support to other individuals who are also involved, or at risk of becoming involved, in the criminal justice system.

DOMAIN: STIGMA

7.a. People with SUD experience high levels of stigma at all levels of their lives

Personal burdens, including experiencing stigma and childhood trauma, are additive, adding to the stresses of daily living upon release. There is an abstinence-only bias that influences how people with SUD are received within the recovery community. Family and friends may adopt stigmatizing behaviors or may have remnant biases recalling the person's errors prior to incarceration.

EVIDENCE-BASED RECOMMENDATIONS:

Expanding access to and use of behavioral health services for people experiencing homelessness

- Evidence-based interventions and their associated behavioral health outcomes including MOUD, motivational interviewing, intensive case management, Community Reinforcement Approach, and peer support.

Substance use disorders recovery with a focus on employment

- Institute recovery-friendly employment policies
- Provide policies and resources that support prevention
- Provide supportive intervention policies
- Mandate a drug-free workplace policy

7.b. Stigma influences access to care for people with SUD

Health care providers demonstrate stigmatizing behavior, choosing not to provide care for this patient population.

EVIDENCE-BASED PRACTICE RECOMMENDATIONS:

Use of Medication-assisted treatment in emergency departments

- Medications approved by the U.S. Food and Drug Administration (FDA) to treat opioid use disorder (OUD) are effective and save lives
- Long-term retention on MAT is associated with improved outcomes
- A lack of availability of behavioral interventions is not justification to withhold MAT
- Most people who could benefit from MAT do not receive it, and access is inequitable
- Confronting the major barriers to use of MAT is critical to addressing the opioid crisis
- ED-initiated buprenorphine is a recommended best practice

Screening and assessment of co-occurring disorders in the justice system

- Evidence-based practices for screening and assessment of people in the justice system who have co-occurring mental and substance use disorders (CODs)
- Approaches for conducting screening and assessment
- Selected instruments for screening, assessment, and diagnosis of CODs in justice settings
- Critical analysis of advantages, concerns, and practical implementation issues (e.g., cost, availability, training needs) for each instrument

Academic detailing interventions for opioid-related outcomes: a scoping review

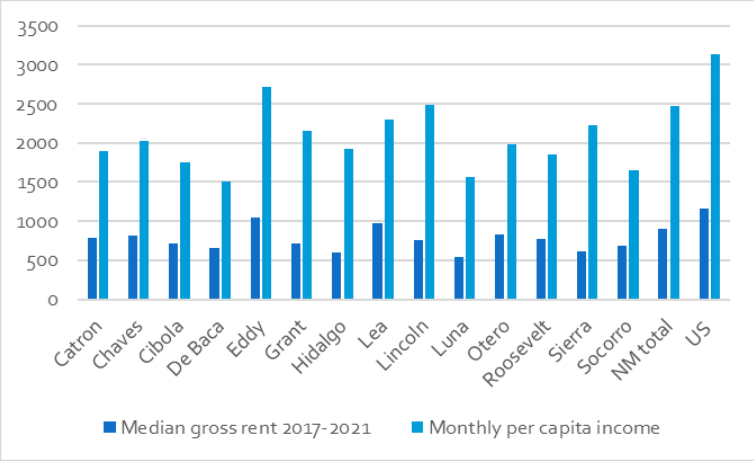
- Emerging evidence-based practice designed to address clinician bias in prescribing MOUD

> “
>
> Well, those, well the physical barriers and emotional barriers, you know, that, that they experience are, are related oftentimes to just feeling, to living on the outskirts of society. So, like living on the fringes of society. And when, when you're in that culture, it can be really difficult to merge into kind of the normal society. It can be really hard to just kind of figure out how to do that. And especially when at that point when you're in that crisis point, often people, you know, are still in their, in their addictions and still suffering from a lot of ongoing trauma or, you know, financial stresses or lack of this and you know, everything that's falling apart around them, which perpetuates more shame and in trauma. So it's, it's, you know, it's, it's difficult for people to connect and to be able to even look you in the eye, you know, if they're going through these things or when they're going through these things. ***(Certified Peer Support Worker)***

Putting the Pieces Together

This report provides a data-based list of suggested evidence-based practices that can be implemented with a goal of improving conditions for people in recovery from SUD and people living with SUD who are or have been recently justice-involved persons. Public officials who can implement these recommendations may be further assisted by the following discussion, in which we explore the multi-level social determinants and structural determinants of health for people in RSNM.

Figure 1: Monthly average rent and per capita income by county, 2017-2021



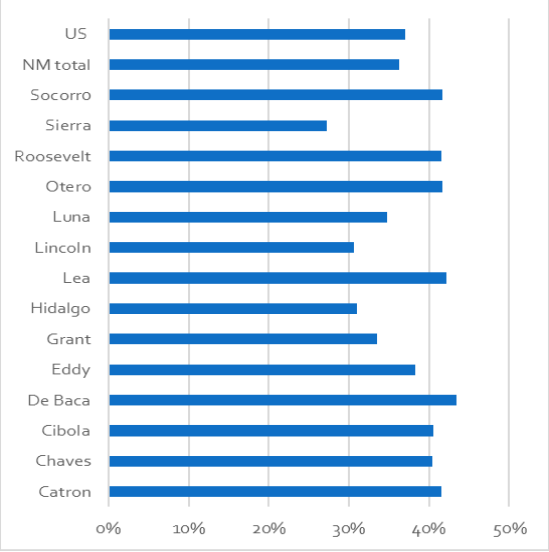
The Healthy People 2030 Social Determinants of Health (SDOH) model defines determinants of health as the "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[6] This model groups the SDOH into five groups: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context. Investment into improving conditions that directly impact the SDOH are known to lead to positive health effects. This project identified multiple levels at which interventions directed toward SDOH could lead to positive outcomes.

Primary Level: Paucity of Resources

At the primary level, limited resources invested in housing, transportation, employment, coupled with barriers accessing SUD treatment have a direct impact on health outcomes for people in recovery and justice-involved people living with SUD. Housing availability and affordability is a serious consideration in RSNM. According to rates published via the U.S. Census.gov website, per capita monthly rent in nearly all the RSNM counties place households within the "cost burdened" (spending more than 30% of income on housing) category (Figures 1 and 2).[7] Unfortunately, most recommendations are postulated on an assumption that housing stock exists, but in rural regions like RSNM, the lack of available housing overall makes subsidized housing an impossibility without costly added infrastructure.

Similarly, public transportation in these rural areas is not a viable option, as there are too few passengers to support mass transit infrastructure or ride share.

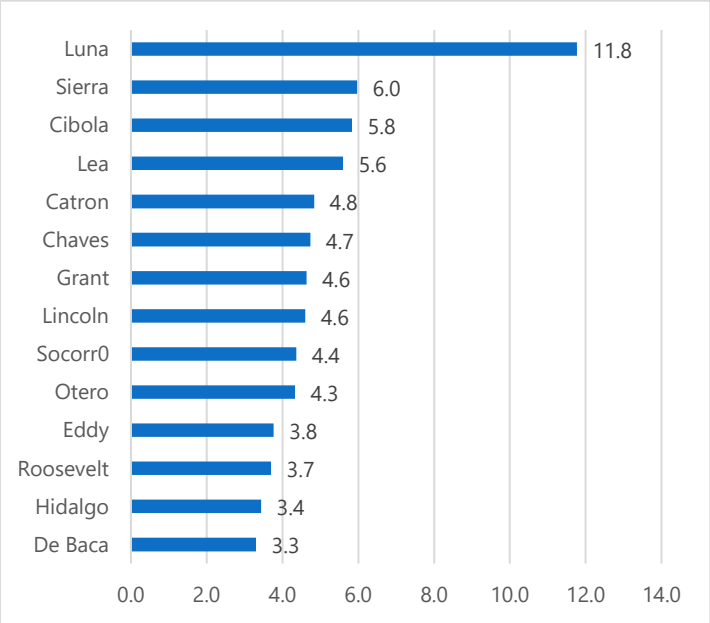
Figure 2: % Rent of monthly income by county, 2017-2021



[6] https://health.gov/healthypeople/priority-areas/social-determinants-health

[7] Sierra County is the one exception, with an average monthly rental rate of $606.00, 27% of the per capita monthly income.

Figure 3. Average unemployment rate (12/2021, 7/2022, 12/2022)



Employment has similar data supporting a resource-poor environment for this region and population. In New Mexico, the median hourly wage is $18.18 (all occupations), and the entry level wage is only $10.96.[8] Over the past year the unemployment rate in New Mexico has dropped the most out of all 50 states and the District of Columbia, but the actual rate is consistent with all other states, at 3.4% (as of February 2023). Comparing unemployment rates by county, the range is limited save for Luna County, which has an overall high unemployment rate and a wide range (12/21: 14.4%, 7/22: 9.3%, 12/22: 11.6%) (Figure 3).

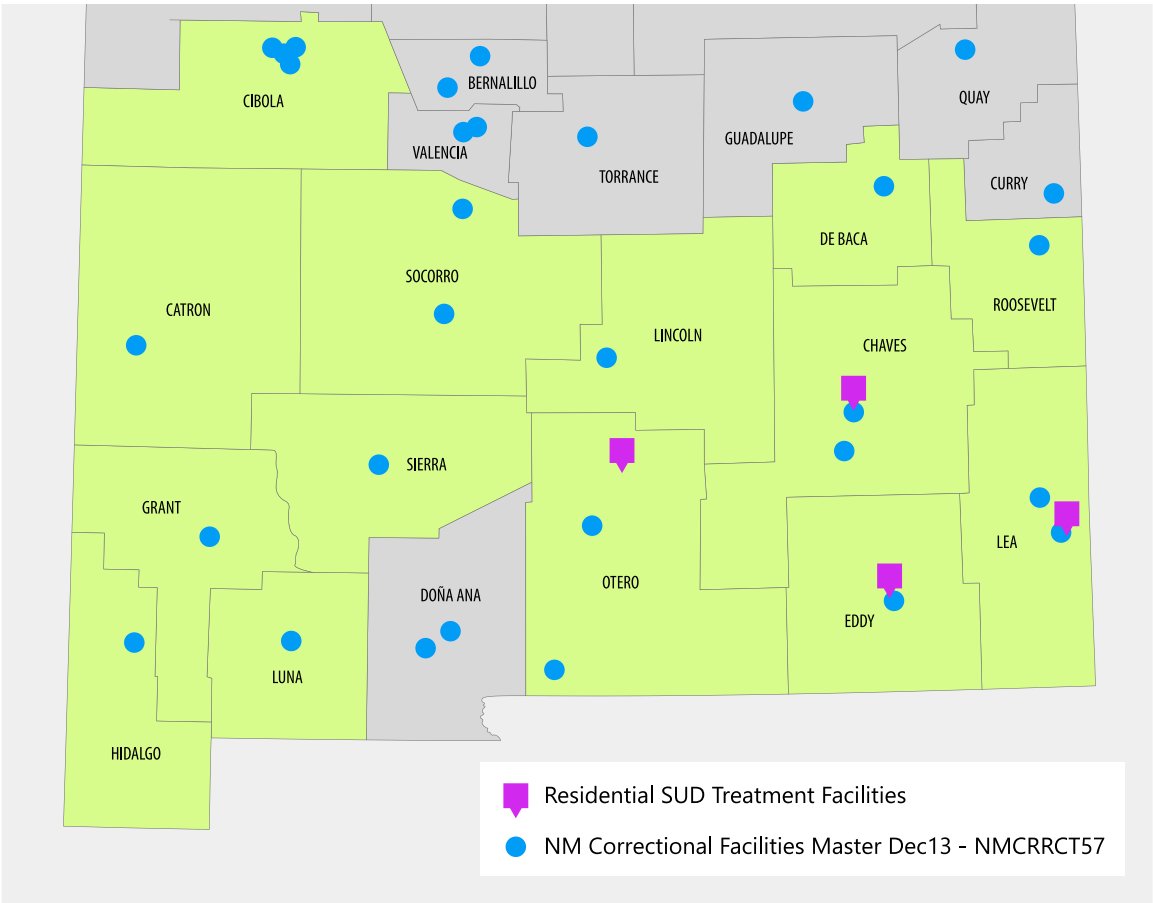
Although estimates vary, approximately 65% of adults in the U.S. prison population have an active and diagnosable SUD,[9] and between 37-44% of adults in the federal and state prison systems have a diagnosable mental health condition.[10] Even though New Mexico is one of the few states that has historically allowed people to remain on Medicaid and enroll in Medicaid while incarcerated if they qualify, access to mental health care and treatment for SUD while in prison is still very limited. Even with broadly inclusive enrollment policies, the uninsured rate in RSNM is still higher than the national average (11.2% uninsured adults 18-65, compared to 10% for US overall).[11] Access to Medication for Opioid Use Disorder (MOUD) is extremely limited in RSNM.

Secondary Level: Where is the care?

As illustrated by these data, the limitations in housing, transportation, and employment combined with high rates of SUD for people who are justice-involved are further complicated by the very few numbers of healthcare providers who choose to prescribe and treat SUD in RSNM. This is best observed through a visual aid, a map displaying a comparison between the locations of correctional facilities in RSNM and inpatient SUD treatment centers that also accepted Medicaid payment that are also located in this region (Figure 4). The following image displays the four inpatient treatment facilities that accept Medicaid insurance (fuchsia arrow) and the corrections facilities (blue dot) in the 14 counties included in this report. This disparity is also seen in the very few numbers of healthcare providers who have prescriptive authority in RSNM who also choose to prescribe MOUD.[12] Appendix D provides a county-by-county detail of the number of prescribers who treat people with MOUD. The prescriber and patient data table also provides a year-by-year count of the number of people who receive methadone treatment and prescribers treating with buprenorphine, by county. Whether the data are retrieved from the New Mexico Board of Pharmacy Prescription Monitoring Program, the SAMHSA referral database, or the New Mexico Department of Health Databook, the result is the same: there are painfully few prescribers available, and even fewer who are actively treating people with SUD using MOUD. Examining where people are receiving MOUD and who prescribes MOUD allows us insight into the systems issues in SDOH gaps in treatment and care.

[8] https://www.dws.state.nm.us/en-us/Researchers/Data/Occupations-Wages
[9] https://nida.nih.gov/download/23025/criminal-justice-drugfacts.pdf?v=25dde14276b2fa252318f2c573407966
[10] https://nami.org/mhstats
[11] U.S. Census Quickfacts
[12] Before removal of the DATA-2000 x waiver requirement: https://www.federalregister.gov/documents/2023/02/13/2023-03012/medications-for-the-treatment-of-opioid-use-disorder-removal-of-the-data-2000-waiver-requirements

Figure 4. Map comparing correctional facilities and Inpatient SUD treatment facilities



The qualitative data adds additional information to the secondary systems-level understanding of the gaps in care. Participants in the interviews and focus groups identified concerns with care provided within hospital systems, specifically emergency departments. There is a need to extend the understanding of care for people with SUD beyond the behavioral health and primary care realms and into the full range of medical care. In this example, emergency department providers are called upon to provide evidence-based care through referral to SUD treatment and expanded understanding of treatment options for people living with SUD, including initiating MOUD in the emergency department setting. See Domain 3.a, (People with SUD who present to the emergency department experiencing mental health crisis do not receive standard of care) for additional guidance and evidence-based practice guidelines related to this concern.

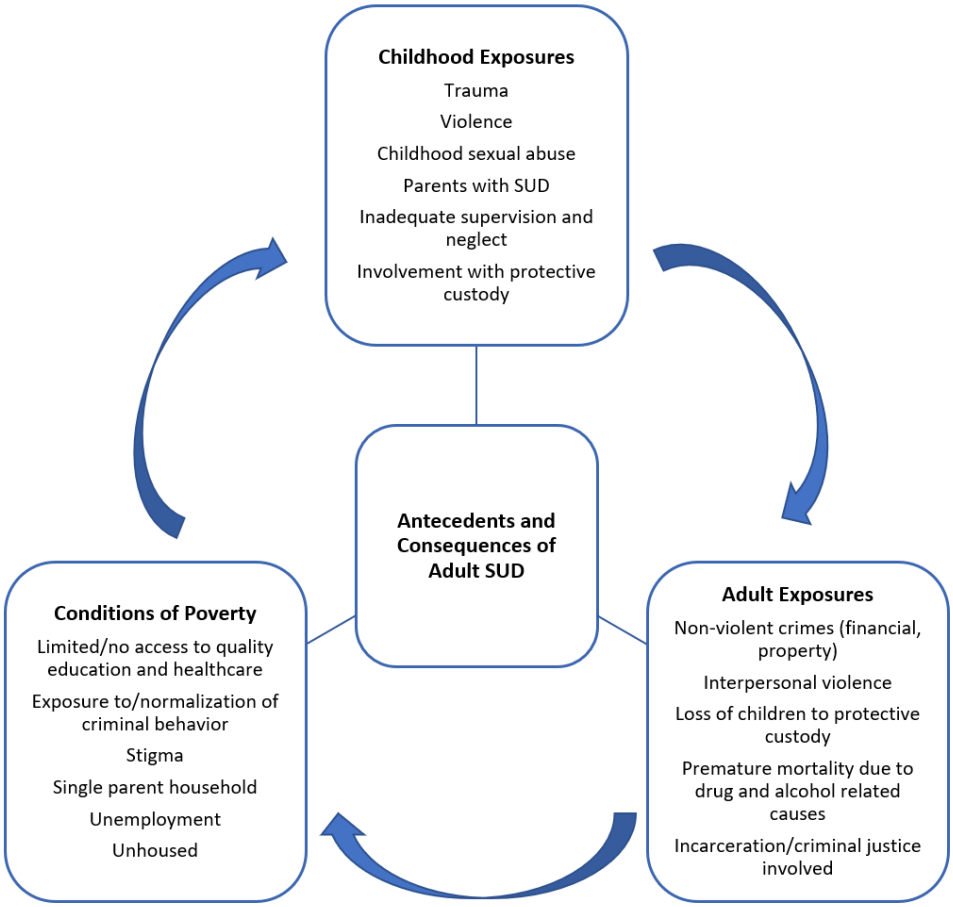
Tertiary level – Structural and social issues

Taking a broad view of the concerns voiced by the participants in this project forces a conversation about larger structural and social issues that have created a multi-generational cycle of incarceration, SUD, and the associated antecedents and consequences. Most notably, living as a person with a history of justice-involvement and SUD comes with pervasive recognition that stigma is keenly felt throughout society at all levels of engagement. Addressing this stigma requires also addressing another deeply entrenched bias observed in the justice system, that people who have been justice involved and have been living with a SUD will always be in that cycle and will always return to the justice system.

In figure 5, we provide a diagram mapping out the cycle of antecedents and consequences of adult SUD as were described by the participants in the interviews and focus groups. As they explained, people caught in this cycle had multiple exposures throughout the course of their life starting in childhood, with each stage perpetuating the cycle of SUD. Childhood exposures to trauma, violence, childhood sexual abuse, parental SUD, inadequate supervision, neglect, and involvement with protective custody predispose people to exposures and situations that perpetuate the same cycle.

Continued exposures as an adult, including involvement in non-violent crimes, violence, trauma, and in the justice system further reinforce engagement in adult SUD. The third part of this cycle, happening at any point in the person's lifespan, is living under conditions of poverty. Each of these conditions, which include having limited or no access to quality healthcare and education, exposure to and normalization of criminal behavior, unemployment, unstable housing, and feeling stigmatized by any or all the exposures named in this cycle, both pre-disposed and reinforced behaviors of adult SUD.

Figure 5. Cycle of Antecedents and Consequences of Adult SUD

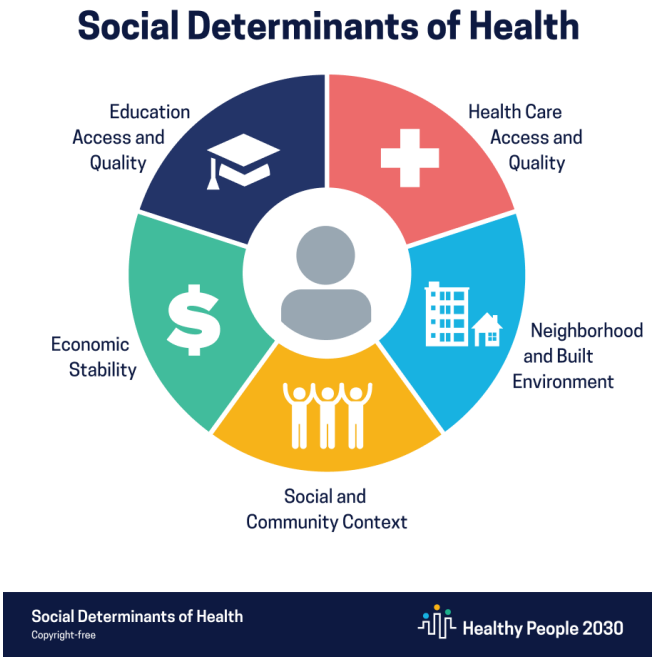


The cycle describing the antecedents and consequences of adult SUD is not provided as a template for intervention. The cycle is a summary of the qualitative research findings meant to help direct policy makers and others as they identify where best to invest efforts. Understanding that adult SUD comes from social and structural conditions outside the person's control is critical to building sustainable change for those people who live in this cycle and are impacted by these exposures.

With the antecedents and consequences cycle as a foundation, structural and social determinants of health can be isolated for deeper consideration. Each of the priority areas identified in the Healthy People 2030 coincide with the domains identified in this report: housing (neighborhood and built environment), stigma (social and community context), employment and living at or below the federal poverty threshold (economic stability), and access to SUD treatment and health care (health access and quality) (figure 6). Although education access was not specifically identified in our research, it was named as an antecedent within the cycle of adult SUD.

The Healthy People 2030 goals include objectives that support the findings of this report. Although these objectives are beyond the scope of this project, additional resources that include evidence-based practices, leading health indicators, and policy suggestions can be found on the Healthy People 2030 website at https://health.gov/healthypeople. One critique of this resource is the focus on highly populated regions of the U.S., with a bias against rural and frontier regions of the country.

Figure 6. Healthy People 2030 Social Determinants of Health



Conclusion

Although this report focuses specifically on recovery communities and the needs of justice-involved people living with SUD as well as people who are in recovery, the seven domains discussed in this report represent opportunities for vital infrastructure development that can benefit all New Mexicans. This report represents a process of inquiry, community guidance, in-depth and multi-level analysis, and investigation of potential solutions. The recommendations and linked evidence-based practices provided within this report provide tangible and realistic strategies for addressing serious human conditions. The foundation exists, it is our hope that this product can be part of building stronger recovery communities into the future.

Appendix A. Research Methodologies

Qualitative Data: Focus Groups and Individual Interviews

The purpose of the qualitative data collection was to assess the recovery services and discharge planning and care coordination for formerly incarcerated and reentering individuals as well as people who are in recovery in the 14 counties in Southern New Mexico.

Participants

A total of 21 people participated in the interviews and focus groups. Participants were recruited to participate if they fit the following criteria:

- Behavioral health providers
- Corrections leadership and workers
- Drug and Treatment Court and Pre-Trial service workers
- Peer support workers and recovery community members

We recruited participants using purposive snowball sampling, which allowed us to reach eligible participants using our existing contacts and then work with those contacts to reach extended networks. This strategy provided us with a list of individual providers, pretrial services workers, parole and probation officers, and CPSWs working in treatment court, corrections, and recovery organization settings in the service area. We also emailed this list with an invitation to participate in a focus group, directing recipients to an online pre-screening webpage. Every person who met eligibility criteria via the pre-screening website was contacted by text, email, and telephone to schedule participation in a focus group or individual interview.

Data collection process

Data were collected in the months of September, October, and November 2022. All data were collected remotely, using a web-based conferencing interface. The meetings were recorded and transcribed by the web-based conferencing interface; these transcriptions were retained for analysis purposes. All data were de-identified to prevent unintentionally violating the privacy of participants in this project. Participants responded to a pre-designated interview guide that included questions about the participants' professional background, understandings about the issues surround SUD in SRNM, understandings regarding the paths people take during and following release from jail or prison in SRNM, and their perspectives regarding recovery and SUD. The interview guide is included as Appendix F.

Qualitative Data Analysis

The interview and focus group transcripts and all written notes from the data collection sessions were uploaded to NVivo v.11.7, a qualitative data analysis computer application. Using NVivo to organize, sort, and categorize the dataset, I (Haozous) followed the following procedure, using a descriptive thematic content analysis approach.[13,14] I selected this approach for two reasons. First, as this dataset was relatively small, I did not anticipate the need for a more sophisticated qualitative methodological approach to achieve the aims of the project. Second, given the time constraints and the very tangible outcomes needed, I determined that a basic descriptive approach would more than suffice, as there is little need to delve into theoretical positioning to meet the needs of this project.

[13] Sandelowski M. Whatever happened to qualitative description? *Research in Nursing & Health*. 2000;23(4):334-340. doi:10.1002/1098-240x(200008)23:4<334::aid-nur9>3.0.co;2-g

[14] Sandelowski M. What's in a name? Qualitative description revisited. *Research in Nursing & Health*. 2010;33(1):77-84. doi:https://doi.org/10.1002/nur.20362

The process of analysis was very straightforward. I initially generated a codebook of theoretical codes, drawing from the interview guide to produce the preliminary coding scheme. These codes addressed the research questions and provided a set of milestones that I could use to guide myself as I coded each transcript. Thus, each main question and probe in the interview guide received a corresponding code in the codebook, ordered according to placement in the interview guide to help facilitate rapid coding. Using these preliminary codes, I then set about applying the codes to a randomly selected transcript. Finding a relatively good fit between codes and transcript, I made some small adjustments and added additional clarifying and contextual codes to the codebook. With the codebook in good functioning order, I coded the full dataset.

During the coding process, I added additional emergent and contextual codes, identified by their recurring and thematic content. When coding was complete, I began the process of interpretation. Interpretation required multiple steps of data manipulation to help find patterns and build categories from the coded data. Some categories were easily quantified, in which case I simply built spreadsheets and summed subcategories. Others required more cognitive work, including examining the coded data segments from multiple perspectives. To do this, I used the "mind map" feature in NVivo to help summarize and visualize the data, extrapolating the key concepts and identifying commonalities and differences across the dataset. I also examined the dataset for unanswered questions and missingness- this type of "reading between the lines" analysis identified areas where participants were addressing issues by not speaking directly to the question but alluded to responses then confirmed these responses later in the interviews.

After an iterative process of manipulation, examination, and exploration of the dataset from a wide range of perspectives, I was able to organize a set of categories into findings for this summary. As with most qualitative datasets, there is no way to fully reproduce the richness of the complete dataset. The findings presented here address the questions from the project and give a broadened perspective to the experiences of people who live and work in the field of substance use disorder recovery communities. All quotes are verbatim transcriptions.

Mixed Methods Methodologies

The final report contains a list of seven key domains with related gaps, barriers, and recommendations. These domains and related material were identified through a mixed methods analysis in which we integrated the results from the qualitative data analysis with a comprehensive analysis of existing state and federal datasets and reports. The process of mixed methods analysis entailed a series of comparisons between the qualitative analysis results and examination of the status in the 14 RSNM counties. This allowed us to identify the key domains and prioritize areas of highest need based on existing data, then link to existing evidence-based practices.

Mixed Methods Data Sources

- SAMHSA Evidence Based Practices Resource Center https://www.samhsa.gov/resource-search/ebp
- New Mexico Human Services Department Databook 2022, www.hsd.state.nm.us
- Health Professional Shortage Areas, hrsa.gov
- New Mexico Workforce Solutions, Labor Force and Unemployment www.dws.state.nm.us
- Housing Affordability in the U.S., Pew Research Center, pewresearch.org
- Healthy People 2030, health.gov
- 2021 Poverty Guidelines, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, www.aspe.hhs.gov/2021-poverty-guidelines
- Housing and Urban Development www.hud.gov
- National Low Income Housing Coalition nlihc.org
- U.S. Census Bureau Quickfacts
- Medicaid Enrollment by County of Residence, HSD.state.nm.us
- National Institute on Drug Abuse nida.nih.gov
- National Institute of Corrections nicic.gov
- National Institute of Justice nij.ojp.gov
- American Society of Addiction Medicine asam.org

- National Alliance on Mental Illness nami.org
- Psychology Today Database on Substance Use Disorder Treatment Resources www.psychologytoday.com/us/treatment-rehab/new-mexico
- PubMed pubmed.ncbi.nlm.nih.gov
- American Hospital Association www.aha.org
- Rural hospitals program www.hrsa.gov
- CDC Wonder wonder.cdc.gov
- NM IBIS ibis.doh.nm.gov
- Annie E. Casey Foundation https://datacenter.kidscount.org/
- New Mexico Board of Pharmacy Prescription Monitoring Program https://www.nmpmp.info/
- SAMHSA Buprenorphine Practitioner Locator www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator

Appendix B. Barriers, Opportunities, and Recommendations

Domain	Problem	Detailed description of barriers (drawn from interviews and focus groups)	Related recommendations (drawn from interviews and focus groups)	Existing evidence-based or best practice resource (See Appendix H for annotated bibliography of SAMHSA resources)
Housing				
1.a.	Not enough housing	Distance, low quality, and unaffordable housing contribute to high rates of unhoused and unstably housed	Build and maintain affordable housing in rural regions of the state	**Expanding access to and use of behavioral health services for people experiencing homelessness** https://store.samhsa.gov/sites/default/files/pep22-06-02-003.pdf
		Shelters for unhoused are unsafe or a threat to recovery		
1.b.	Available housing does not meet needs	Vast distances between housing, work, supervision, and treatment for SUD threaten conditions of parole	Build and maintain affordable housing in rural regions of the state	**Permanent Supportive Housing (PSH)** PSH combines permanent housing with a system of professional or peer supports or both that allows a person with mental illness to live independently in the community. Supports may include regular staff contact and the availability of crisis services or other services to prevent relapse, such as those focusing on mental health, substance use, and employment. https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509 **Housing First** Housing First connects individuals and families experiencing homelessness to permanent housing quickly and without preconditions and barriers to entry, such as sobriety, SUD treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry. https://files.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf
Transportation				
2.a.	Distances between supervision, health care or SUD treatment, work, and home is prohibitive	Existing transportation programs are not realistic in this region (bus and ride share vouchers don't work in regions where there are no buses or ride share)	Create cohort-style supervisory approach, with group home-based therapeutic approach. All resources located in the same place, reduce the need for transportation, reduce cost of housing.	**Modified Therapeutic Community (MTC)** MTCs alter the traditional Therapeutic Community approach in response to psychiatric symptoms, cognitive impairments, and other impairments commonly found among individuals with co-occurring disorders. These modified programs typically have (1) increased flexibility, (2) decreased intensity, and (3) greater individualization. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2572263/

Domain	Problem	Detailed description of barriers (drawn from interviews and focus groups)	Related recommendations (drawn from interviews and focus groups)	Existing evidence-based or best practice resource (See Appendix H for annotated bibliography of SAMHSA resources)
		The region is characterized by long distances between populated areas, and cost of fuel, maintenance, and insurance is prohibitive		12-step or Other Mutual Aid Groups: Groups of nonprofessionals who share a problem and support one another through the recovery process. Groups are in-person or virtual.
		Transportation needs picked up by an outside party	CPSWs provide transportation to critical meetings and appointments	**Peer-based Recovery Support Programs** Formerly justice-involved individuals who are in recovery provide support to other individuals who are also involved, or at risk of becoming involved, in the criminal justice system. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers
Health care system				
3.a.	People with SUD who present to ED with mental health crisis do not receive standard of care	Healthcare providers outside the behavioral health system are poorly prepared to manage justice-involved patients with SUD	Train medical staff working in small, rural, and community hospitals in best practices for medical management of health crises (including mental health crises)	**Use of Medication-assisted treatment in emergency departments** https://store.samhsa.gov/sites/default/files/pep21-pl-guide-5.pdf Buprenorphine and methadone have been shown to decrease mortality. Research shows that buprenorphine was associated with a lower risk of overdose during active treatment compared to post- discontinuation. Studies show that ED-initiated buprenorphine with facilitated transitions to outpatient care leads to better health outcomes and is cost-effective.
		Patients who are living with SUD do not receive referral to treatment at time of discharge from ED	Provide linkages for staff working in small, rural, and community hospitals for referrals to treatment programs for SUD	**Peer-based Recovery Support Programs** Formerly justice-involved individuals who are in recovery provide support to other individuals who are also involved, or at risk of becoming involved in the criminal justice system. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers https://pcssnow.org/wp-content/uploads/2018/07/Peer-Support-Workers-in-EDs-Issue-Brief-1.24.19.pdf https://hsc.unm.edu/medicine/departments/psychiatry/cbh/docs/earheart-crisanti-peer-support-workers-in-the-ed-final-report---combined.pdf

Domain	Problem	Detailed description of barriers (drawn from interviews and focus groups)	Related recommendations (drawn from interviews and focus groups)	Existing evidence-based or best practice resource (See Appendix H for annotated bibliography of SAMHSA resources)
3.b.	People with serious mental illness and SUD have treatment gaps	People who have a serious mental illness cycle in and out of ED and incarceration with poor mental health management		**Intensive care coordination for children and youth with complex mental and substance use disorders: State and community profiles** https://store.samhsa.gov/sites/default/files/d7/priv/samhsa-state-community-profiles-05222019-redact.pdf **Telehealth for treatment of serious mental illness and substance use disorders** https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf **Treatment considerations for youth and young adults with serious emotional disturbances and serious mental illnesses and co-occurring substance use.** https://store.samhsa.gov/sites/default/files/pep20-06-02-001.pdf **Integrated Mental Health and Substance Use Services (Integrated Treatment for Co-Occurring Disorders)** Treatment and service provision to support recovery from co-occurring mental and substance use disorders through a single agency or entity. https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366 **Assisted Outpatient Treatment (AOT)** AOT, also known as conditional release, outpatient commitment, involuntary outpatient commitment, or mandated outpatient treatment, is intended to facilitate the delivery of community-based outpatient mental health treatment services to individuals with SMI who have refused psychiatric treatment in the past, are at risk for deterioration or harming themselves or others, and for whom hospitalization is unnecessarily restrictive.
Employment				
4.a.	The range of employment opportunities for justice-involved people with SUD is limited and can contribute to poor compliance with conditions of parole/ probation	Low wage work that does not provide a living wage		**Substance use disorders recovery with a focus on employment** https://store.samhsa.gov/sites/default/files/pep21-pl-guide-6.pdf **Supported Employment** Matches and trains people with severe developmental, mental, and physical disabilities where their specific skills and abilities make them valuable assets to employers. https://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-Kit/SMA08-4364

Domain	Problem	Detailed description of barriers (drawn from interviews and focus groups)	Related recommendations (drawn from interviews and focus groups)	Existing evidence-based or best practice resource (See Appendix H for annotated bibliography of SAMHSA resources)
		Rigid schedules do not accommodate time out of the day for SUD treatment appointments or appearing for mandatory supervision		
		Work is personally unsatisfying, little room for growth		
SUD Treatment				
5.a.	Delays in accessing treatment for SUD / Workforce Shortages	Justice-involved people with SUD must endure long waitlists before finding room in a treatment program after being released from incarceration.		**Treatment of stimulant use disorders** https://store.samhsa.gov/sites/default/files/pep20-06-01-001.pdf **Assertive Community Treatment (ACT)** Treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for clients' case management and treatment needs. https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344 **Forensic ACT (FACT)** Forensic ACT is an adaptation of ACT for individuals involved in the criminal justice system. FACT provides the same level and type of treatment services of ACT, but also includes interventions targeted to criminogenic risk and need factors. **Practical tools for prescribing and promoting buprenorphine in primary care settings** https://store.samhsa.gov/sites/default/files/pep21-06-01-002.pdf **Treating concurrent substance use among adults** https://store.samhsa.gov/sites/default/files/pep21-06-02-002.pdf **Academic detailing interventions for opioid-related outcomes: a scoping review** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8687092/ Emerging evidence-based practice designed to address clinician bias in prescribing MOUD

Domain	Problem	Detailed description of barriers (drawn from interviews and focus groups)	Related recommendations (drawn from interviews and focus groups)	Existing evidence-based or best practice resource (See Appendix H for annotated bibliography of SAMHSA resources)
		There are not enough healthcare providers in the region to meet the demand. Clinicians who could prescribe medication to aid people with SUD (MOUD) are opting not to do so.		**Practical tools for prescribing and promoting buprenorphine in primary care settings** https://store.samhsa.gov/sites/default/files/pep21-06-01-002.pdf **Treating concurrent substance use among adults** https://store.samhsa.gov/sites/default/files/pep21-06-02-002.pdf **Academic detailing interventions for opioid-related outcomes: a scoping review** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8687092/ Emerging evidence-based practice designed to address clinician bias in prescribing MOUD
		Lack of licensed behavioral health providers in rural areas	CPSWs and other equivalent "lay" peer helpers are a resource within the recovery landscape, providing a wide range of supportive services	**Principles of community-based behavioral health services for justice-involved individuals: A research-based guide** https://store.samhsa.gov/sites/default/files/d7/priv/sma19-5097.pdf **SAMHSA Peer Support Worker Resource Page** https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers
5.b	Difficulty accessing MOUD in rural areas	People who receive medication for opioid use disorder (MOUD) find difficulties locating a pharmacy that will dispense according to state laws	Enforcement of state policies to improve access to medication	**Academic detailing interventions for opioid-related outcomes: a scoping review** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8687092/ Emerging evidence-based practice designed to address clinician bias in prescribing MOUD
		Dosing schedules for MOUD require close management and access to reliable transportation, pharmacy, and prescribing clinician	Enhancement of access to MOUD in rural areas	
5.c	Payment and bureaucracy	Health insurance coverage is inconsistent, people with SUD who are on Medicaid struggle to find treatment programs that accept this form of insurance		

Domain	Problem	Detailed description of barriers (drawn from interviews and focus groups)	Related recommendations (drawn from interviews and focus groups)	Existing evidence-based or best practice resource (See Appendix H for annotated bibliography of SAMHSA resources)
		Treatment programs have their own series of bureaucracy and barriers that can prevent an otherwise eligible person from receiving a space in their program.		**Assertive Community Treatment (ACT):** Treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for clients' case management and treatment needs. https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344 **Forensic ACT (FACT)** Forensic ACT is an adaptation of ACT for individuals involved in the criminal justice system. FACT provides the same level and type of treatment services of ACT, but also includes interventions targeted to criminogenic risk and need factors.
5.d.	Linkage and communication gaps (shared with Justice System Domain)	Linkage and communication between detention pre-release and post-release treatment services does not bridge gap for people needing access to immediate treatment for SUD	Linkage to available and appropriate treatment for SUD for newly released people with SUD, eliminating waitlists and dangerous gap between incarceration and treatment	**Selecting best-fit programs and practices: Guidance for substance misuse prevention practitioners** https://www.samhsa.gov/sites/default/files/ebp_prevention_guidance_document_241.pdf **Comprehensive Case Management for Substance Abuse Treatment** https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4215.pdf **Critical Time Intervention** Nine-month, three-stage intervention that develops individualized linkages in the community and facilitates engagement with treatment, supports, and housing through building problem-solving skills, motivational coaching, and connections with community agencies. https://www.criticaltime.org/cti-model/
Justice System				
6.a.	Linkage and communication gaps (shared with SUD Treatment Domain)	Linkage and communication between detention pre-release and post-release treatment services does not bridge gap for people needing access to immediate treatment for SUD	Linkage to available and appropriate treatment for SUD for newly released people with SUD, eliminating waitlists and dangerous gap between incarceration and treatment	**Use of medication-assistance treatment for opioid use disorder in criminal justice settings** https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf **Screening and assessment of co-occurring disorders in the justice system** https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf **Critical Time Intervention** Nine-month, three-stage intervention that develops individualized linkages in the community and facilitates engagement with treatment, supports, and housing through building problem-solving skills, motivational coaching, and connections with community agencies. https://www.criticaltime.org/cti-model/
6.b.	Deficit-based philosophy driving justice system approach to SUD	All points of termination return the justice-involved person living with SUD back to incarceration.	Build an asset-based model of transition for justice-involved people that envisions their lives outside the incarceration cycle	

Domain	Problem	Detailed description of barriers (drawn from interviews and focus groups)	Related recommendations (drawn from interviews and focus groups)	Existing evidence-based or best practice resource (See Appendix H for annotated bibliography of SAMHSA resources)
6.c.	Justice-involved persons require additional life skills support	Newly released people require assistance with basic life skills such as completing forms, using technology, opening a bank account, and applying for vital documents.	CPSWs assist and teach these life skills	**Peer-based Recovery Support Programs**: Formerly justice-involved individuals who are in recovery provide support to other individuals who are also involved, or at risk of becoming involved, in the criminal justice system. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers
Stigma				
7.a.	Justice-involved people who have SUD experience high levels of stigma at all levels of their lives	Personal burdens, including experiencing stigma and childhood trauma, are additive, adding to the stresses of daily living upon release.		**Expanding access to and use of behavioral health services for people experiencing homelessness** https://store.samhsa.gov/sites/default/files/pep22-06-02-003.pdf **Substance use disorders recovery with a focus on employment** https://store.samhsa.gov/sites/default/files/pep21-pl-guide-6.pdf
		There is an abstinence-only bias that influences how people with SUD are received within the recovery community		
		Family and friends may adopt stigmatizing behaviors or may have remnant biases recalling the person's errors prior to incarceration		
7.b.	Stigma influences access to care for people with SUD	Health care providers demonstrate stigmatizing behavior, choosing not to provide care for this patient population		**Use of Medication-assisted treatment in emergency departments** https://store.samhsa.gov/sites/default/files/pep21-pl-guide-5.pdf Buprenorphine and methadone have been shown to decrease mortality. Research shows that buprenorphine was associated with a lower risk of overdose during active treatment compared to post- discontinuation. Studies show that ED-initiated buprenorphine with facilitated transitions to outpatient care leads to better health outcomes and is cost-effective. **Screening and assessment of co-occurring disorders in the justice system** https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf **Academic detailing interventions for opioid-related outcomes: a scoping review** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8687092/ Emerging evidence-based practice designed to address clinician bias in prescribing MOUD

Appendix C. Evidence Based Practices – Drug Treatment Court Best Practices and Resources

Drug Treatment Court Best Practices and Resources | Source: National Drug Court Resource Center[15]	
Best Practice Standard	**Screening and Assessment Tools**
Description	Evidence-based assessment tools should be used to determine what individuals are admitted to treatment court programs. Screening tool results indicate which individuals are in need of a more in-depth assessment. These resources provide an overview of the specific tools that have been empirically validated for use with the treatment court population in making that determination.
Resources Link	https://ndcrc.org/best-practice-resources/screening-and-assessment-tools/
Related SAMHSA Resource	Tip 31: Screening and Assessing Adolescents for Substance Use Disorder https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4079.pdf Screening and Assessment of Co-Occurring Disorders in the Justice System https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf
Best Practice Standard	**Equity and Inclusion**
Description	Ensuring that all individuals have equal access to & retention within treatment court programs is an issue to which all programs should attend. These resources will assist treatment court stakeholders with examining programmatic data for the purposes of identifying and addressing issues of inequity and/or exclusion.
Resources Link	https://ndcrc.org/best-practice-resources/equity-and-inclusion/
Related SAMHSA Resource	Advisory: Mental and Substance Use Disorder for People with Physical and Cognitive Disabilities https://store.samhsa.gov/sites/default/files/pep19-02-00-002.pdf Tip 37: Substance Abuse Treatment for Persons with HIV/AIDS https://ndcrc.org/wp-content/uploads/2022/01/TIP_37_Substance_Abuse_Treatment_for_Persons_with_HIV-AIDS.pdf Tip 51: Substance Abuse Treatment: Addressing the Specific Needs of Women https://ndcrc.org/wp-content/uploads/2022/01/TIP_51_Substance_Abuse_Treatment_Addressing_the_Specific_Needs_of_Women.pdf Tip 53: Addressing Viral Hepatitis in People with Substance Use Disorders https://ndcrc.org/wp-content/uploads/2022/01/TIP_53_Addressing_Viral_Hepatitis_in_People_With_Substance_Use_Disorders.pdf Tip 55: Behavioral Health Services for People who are Homeless https://ndcrc.org/wp-content/uploads/2022/01/TIP_55_Behavioral_Health_Services_for_People_who_are_Homeless.pdf Tip 56: Addressing the Specific Behavioral Health Needs of Men https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4736.pdf Tip 59: Improving Cultural Competence https://ndcrc.org/wp-content/uploads/2022/01/TIP_59_Improving_Cultural_Competence.pdf Tip 61: Behavioral Health Services for American Indians and Alaska Natives https://store.samhsa.gov/sites/default/files/d7/priv/tip_61_aian_full_document_020419_0.pdf

[15] https://ndcrc.org/best-practice-resources/

Best Practice Standard	Substance Use and Mental Health Treatment
Description	Providing participants with access to a continuum of substance use disorder (SUD) treatment (and co-occurring disorder treatment) services is a hallmark feature of the treatment court model. A wealth of empirical research has found that programs providing participants with access to treatment services that address criminal thinking patterns have positive outcomes. These resources outline what specifical clinical treatment modalities are most effective with the treatment court population (and known sub-populations).
Resources Link	https://ndcrc.org/best-practice-resources/substance-use-and-mental-health-treatment/
Related SAMHSA Resource	Tip 26: Treating Substance Use Disorder in Older Adults https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-011%20PDF%20508c.pdf Tip 33: Treatment for Stimulant Use Disorders https://store.samhsa.gov/sites/default/files/pep21-02-01-004.pdf Tip 34: Brief Interventions and Brief Therapies for Substance Abuse https://ndcrc.org/wp-content/uploads/2022/01/TIP_34_Brief_Intervention_and_Brief_Therapies_for_Substance_Abuse.pdf Tip 35: Enhancing Motivation for Change in Substance Use Disorder Treatment https://ndcrc.org/wp-content/uploads/2022/01/TIP_35_Enhancing_Motivation_for_Change_in_Substance_Use_Disorder_Treatment.pdf Tip 38: Integrating Substance Use Treatment and Vocational Services https://ndcrc.org/wp-content/uploads/2022/01/TIP_38_Integrating_Substance_Abuse_Treatment_and_Vocational_Services.pdf Tip 41: Substance Abuse Treatment: Group Therapy https://ndcrc.org/wp-content/uploads/2022/01/TIP_41_Substance_Abuse_Treatment_Group_Therapy.pdf Tip 42: Substance Use Disorder Treatment for People with Co-Occurring Disorders https://ndcrc.org/wp-content/uploads/2022/01/TIP_42_Substance_Use_Treatment_for_Persons_With_Co-Occurring_Disorders.pdf Tip 45: Detoxification and Substance Abuse Treatment https://ndcrc.org/wp-content/uploads/2022/01/TIP_45_Detoxification_and_Substance_Abuse_Treatment.pdf Tip 48: Managing Depressive Symptoms in Substance Abuse Clients during Early Recovery https://ndcrc.org/wp-content/uploads/2022/01/TIP_48_Managing_Depressive_Symptoms_in_Substance_Abuse_Clients_during_Early_Recovery.pdf Tip 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4381.pdf
Best Practice Standard	**Drug/Alcohol Testing**
Description	Treatment court programs must continuously monitor participants' use of drugs/alcohol throughout their term of enrollment. These resources provide practitioners with the information needed to design and implement a sound drug/alcohol testing regimen.
Resources Link	https://ndcrc.org/best-practice-resources/drug-alcohol-testing/
Related SAMHSA Resource	N/A

Best Practice Standard	Trauma Informed Practices
Description	Providing participants with access to a continuum of substance use disorder (SUD) treatment services is a hallmark feature of the treatment court model. A wealth of empirical research has found that a high percentage of treatment court program participants have experienced trauma which is often a catalyst for the use of drugs/alcohol and criminal justice system involvement. These resources provide an overview of which trauma-informed practices are most effective in addressing the needs of treatment court participants.
Resources Link	https://ndcrc.org/best-practice-resources/trauma-informed-practices/
Related SAMHSA Resource	Tip 57: Trauma-Informed Care in Behavioral Health Services https://ndcrc.org/wp-content/uploads/2022/01/TIP_57_Trauma-Informed_Care_in_Behavioral_Health_Services.pdf
Best Practice Standard	**Recovery Support Services**
Description	Participants will receive complimentary treatment and social services that are known to influence the use of drugs/alcohol and criminal recidivism. Research has demonstrated the importance of addressing participant needs in the areas of housing, employment, education, childcare, transportation, health, peer support, etc. These resources will provide you with insight regarding how best to address the recovery support needs of treatment court participants.
Resources Link	https://ndcrc.org/best-practice-resources/recovery-support-services/
Related SAMHSA Resource	Tip 30: Continuity of Offender Treatment for Substance Use Disorders from Institution to Community https://ndcrc.org/wp-content/uploads/2022/01/TIP_30_Continuity_of_Offender_Treatment_for_Substance_Use_Disorders_from_Institution_to_Community.pdf
Best Practice Standard	**Families and Parenting**
Description	Participants will receive complimentary treatment and social services that are known to influence the use of drugs/alcohol and criminal recidivism. Given the devastating impact substance use has on families and the role of family in the recovery process, programs that provide participants with access to parenting/family treatment services have positive outcomes. These resources provide an overview of specific evidence-based resources (i.e., family-based treatment, parenting curricula, etc.) that are effective with the treatment court population.
Resources Link	https://ndcrc.org/best-practice-resources/families-and-parenting/
Related SAMHSA Resource	Tip 36: Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues https://ndcrc.org/wp-content/uploads/2022/01/TIP_36_Substance_Abuse_Treatment_for_Persons_with_Child_Abuse_and_Neglect_Issues.pdf Tip 39: Substance Use Disorder Treatment and Family Therapy https://ndcrc.org/wp-content/uploads/2022/01/TIP_39_Substance_Use_Disorder_Treatment_and_Family_Therapy.pdf
Best Practice Standard	**Case Management**
Description	Participants will receive complimentary treatment and social services that are known to influence the use of drugs/alcohol and criminal recidivism. Case management is a fundamental feature of the treatment court model and these resources provide an overview of how to provide effective case management services within your treatment court program.
Resources Link	https://ndcrc.org/best-practice-resources/case-management/
Related SAMHSA Resource	Tip 27: Comprehensive Case Management for Substance Abuse Treatment https://ndcrc.org/wp-content/uploads/2022/01/TIP_27_Comprehensive_Case_Management_for_Substance_Abuse_Treatment.pdf

Best Practice Standard #	MAT and Opioid Use Disorder Treatment
Description	Many treatment court programs across the US/Territories have had to modify/expand their menu of clinical treatment services in order to meet the needs of individuals with opioid use disorder. The use of pharmacological interventions to address opioid-use disorders has been deemed an effective treatment modality within the population served by treatment courts. These resources highlight what treatment services have been found to be effective among the treatment court population and how MAT can complement other clinical treatment modalities.
Resources Link	https://ndcrc.org/best-practice-resources/mat-and-opioid-use-disorder/
Related SAMHSA Resource	Tip 63: Medications for Opioid Use Disorder (updated 2021) https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf Tip 63 Executive Summary https://ndcrc.org/wp-content/uploads/2022/01/TIP_63_Medications_for_Opioid_Use_Disorder_Executive_Summary.pdf SAMHSA MAT Website https://www.samhsa.gov/medications-substance-use-disorders
Best Practice Standard	**Technology**
Description	The work of treatment court programs across the US/Territories increasingly involves the use of technology. Recent technological advancements have been designed for and implemented within the treatment court context. These resources provide an overview of the options available and evidence regarding strengths and challenges.
Resources Link	https://ndcrc.org/best-practice-resources/technology/
Related SAMHSA Resource	N/A

Appendix D. Behavioral Health Provider and Patient Data by County[1]

County	New Mexicans served by Methadone programs, 2019/20/21[2]	Medicaid Behavioral Health Prescribing Providers 2021[2]	SAMHSA Dec 2020[3] Buprenorphine Prescriber/ County	SAMHSA Dec 2023[3] Buprenorphine Prescriber/ County	Medicaid Behavioral Health non-Prescribing Providers 2021[2]	# of Medicaid Beneficiaries who access services / BH provider Jan-Oct 2021[2]	DOH June 2020[2]			DOH Jan 2020 Gap Analysis[4]			County Health Prof Shortage Area[5]
							Mat Prescriber	Inpt	Outpt	Mat Prescriber	Inpt	Outpt	Full or partial
Catron	-	10	1	-	2	17.5	-	-	1	-	-	1	Full
Chaves	326/371/288	159	6	8	64	32.2	4	1	4	3	1	3	Full
Cibola	-	79	3	3	19	22.3	3	1	9	2	1	9	Full
De Baca	-	3	-	-	5	57.6	-	-	1	-	-	1	Full
Eddy	-	112	8	8	32	31.3	4	1	4	2	1	4	Full
Grant	-	77	10	8	62	39.8	2	1	5	1	1	5	Full
Hidalgo	-	5	1	-	8	84.4	2	-	2	1	-	2	Full
Lea	-	116	6	5	42	19	1	-	2	1	-	2	Partial
Lincoln	-	40	3	3	38	20.2	1	-	1	1	-	1	Partial
Luna	-	51	3	5	43	57.3	-	-	4	-	-	4	Partial
Otero	-	147	5	4	78	31.9	4	1	7	1	1	7	Full
Roosevelt	-	24	2	2	19	23.7	1	-	2	1	-	2	Full
Sierra	-	40	2	4	18	70.1	2	-	4	1	-	4	Full
Socorro	-	56	9	9	22	22	6	-	3	3	-	3	Partial

1. These are point in time datasets, and do not reflect constantly changing rates. 2. NMDOH 2022 Databook: https://www.hsd.state.nm.us/wp-content/uploads/Prog.pdf ; 3. SAMHSA Buprenorphine Practitioner Locator; 4.DOH 2020 Gap Analysis Report: https://www.nmhealth.org/publication/view/marketing/5596/ 5. Counties can be partial shortage or whole county health professional shortage areas. https://www.ruralhealthinfo.org/charts/5?state=NM source originator: / HRSA.gov/2022

Appendix E. Statewide & Regional Resources & Directories

- The ShareNM[14F] online directory: https://sharenm.org/nm-resources
- NM Community Data Collaborative at the Center for Health Innovation: https://nmcdc.maps.arcgis.com/home/index.html
- 211 (phone): provides free information and referrals to health and human services, government agencies, and community based organizations.
- Groundworks New Mexico Non-Profit Directory: https://www.groundworksnm.org/nonprofit-directory
- State of NM Aging & Long-Term Services & Disabilities Services Directory: https://newmexico.networkofcare.org/aging/services/index.aspx
- State of New Mexico Health & Human Services Data Book: https://www.hsd.state.nm.us/wp-content/uploads/Data-Book-2022-FINAL-Spring-2022-lo-res.pdf
- The online *Social Services for New Mexico Students Map*[13F] *(Map)* provides geographic locations with data for over 400 provider organizations across New Mexico identified by PIRE as they compiled the Culturally-Responsive Socials Services for NM Students Inventory in 2022.
- Lincoln County Health & Wellness Guide: https://issuu.com/buyanddesign.com/docs/2023_health_and_wellness_guide

Housing Resources

- NM Mortgage Finance Authority Housing Assistance: https://housingnm.org/find-housing
- Public Housing Contacts in NM: https://www.hud.gov/sites/dfiles/PIH/documents/PHA_Contact_Report_NM.pdf
- Western Regional Housing Authority: http://wrha-nm.org/ providing rental assistance under the Housing Choice Voucher and Low Rent Public Housing programs through the Department of Housing And Urban Development. Counties: Valencia, Torrance, Catron, Socorro, Sierra, Grant, Luna, and Hidalgo.
- Eastern Regional Housing Authority: (575) 622-0881. Counties served: Chaves, De Baca, Eddy, Guadalupe, Harding, Lincoln, Otero, and Quay.

Educational Resources (for southern NM)

- Office of Peer Recovery and Engagement - https://yes.nm.gov/nmhr/s/office-of-peer-recovery-and-engagement?language=en_US
- Adult Basic Education / High School Equivalency / GED in NM: https://hed.nm.gov/students-parents/adult_education/for-adult-students-and-families/high-school-equivalency-hse
- **Alamogordo**: New Mexico State University – Alamogordo, (575) 439-3812, nmsua.edu/academic-affairs/adult-education
- **Carlsbad**: New Mexico State University – Carlsbad, (575) 234-9250, carlsbad.nmsu.edu/departments/adult-education-department
- **Chaparral**: Doña Ana Community College Chaparral Learning Center, (575) 824-2010, dacc.nmsu.edu/ae
- **Grants**: New Mexico State University – Grants, (505) 287-6683, aegrants@nmsu.edu, grants.nmsu.edu/about/campus-services/adult-education.html
- **Hobbs**: New Mexico Junior College, (575) 492-2629, kferrell@nmjc.edu, nmjc.edu/community/adult education
- **Las Cruces**: Doña Ana Community College Workforce Center, (575) 528-7477, dacc.nmsu.edu/ae
- **Roswell**: Eastern New Mexico University – Roswell, (575) 624-7000, roswell.enmu.edu/adult-education
- **Ruidoso**: Eastern New Mexico University – Ruidoso, (575) 258-1730, ruidoso.enmu.edu/academics/adult-basic-education
- **Silver City**: Western New Mexico University, (575) 574-5101, aes.wnmu.edu

Residential Substance Use Treatment Facilities (for rural southern NM)

- Carlsbad Lifehouse, Inc, 1900 Westridge Road, Carlsbad, NM 88220 - https://www.lifehousecarlsbad.com/
- Four Directions Treatment and Recovery Center, Mescalero Apache Tribe - https://yes.nm.gov/nmhr/s/office-of-peer-recovery-and-engagement?language=en_US https://mescaleroapachetribe.com/fdtrcm/
- Humphrey House, 3821 West College Lane, Hobbs, NM 88242 - http://www.gclcnm.org/
- Recovery Services of New Mexico, LLC MedMark Treatment Centers Roswell - 1107 South Atkinson, Roswell, NM 88203 - https://www.recoverynewmexico.com/roswell-clinic

Resources for Southern NM from Social Services Directory for NM Students (PIRE, Sept 2022)

Name of Organization	Full Address	Website	Phone Number	County/ies Served	Services Offered
Carlsbad Battered Families Shelter	520 N 6th St, Carlsbad, NM 88220	https://carlsbadshelter.com/	(575) 885-4615	Eddy	Shelter, 24-hour crisis line, individual sessions, educational groups, and support groups, referrals
Carlsbad Community of Hope	1314 S Canal St, Carlsbad NM 88220	https://www.hopenm.org/	(575)200-1377	Eddy	emergency shelter, meals (faith-based)
Carlsbad transitional housing (7 day stay	315 W Bronson, Carlsbad, NM 88220	https://www.facebook.com/CTHHS88220/	(575) 200-3095	Eddy	Transitional Housing provides people with help after a crisis that involves homelessness. The Emergency Shelter provides temporary shelter for families and individuals in a safe, drug and alcohol free environment
CASA	500 N. Main St. Ste. 310, Roswell, NM, 88201	https://casakids.org/		Chaves	Housing assistance, clothes, food, support groups, MH therapy, etc.
Casa Q	PO Box 36168, Albuquerque, NM 87176	https://www.casaq.org/	505-565-5810	Bernalillo	safe living through housing, services and advocacy for LGBTQI+ youth
Catholic charities of southern New Mexico	510 S Lincoln Ave. Roswell, NM 88203	https://catholiccharitiesdlc.org/	(575) 622-1636	Chaves	Immigration legal services, with community partners and volunteers provide counseling, emergency cash for housing, education
Catholic charities of southern New Mexico	125 W Mountain Ave. Las Cruces, NM 88005	https://catholiccharitiesdlc.org/	(575) 527-0500	Dona Ana	Immigration legal services, with community partners and volunteers provide counseling, emergency cash for housing, education
Cavern City Child Advocacy Center	1313 W Mermod, Carlsbad NM 88220	https://www.senmcac.com/home	575-200-3929	Eddy	provide child abuse prevention and awareness training to children; SANE (Sexual Assault Nurse Examiner) services; refer victims to appropriate follow-up services
Domestic Violence Resource Center	625 Silver SW, Suite 185, Albuquerque, NM 87102	www.dvrcnm.org	Main 505-843-9123 or Helpline 505-248-3165		advocacy, case management, immediate help

Name of Organization	Full Address	Website	Phone Number	County/ies Served	Services Offered
EPICS (Education of Parents on Indian Children with Special Needs)	2201 Buena Vista Dr. SE, Suite 201, Albuquerque, NM 87106	https://www.epicsnm.org/	(505) 767-6630	All	EPICS is a Community Parent Resource Center serving New Mexico families who have Native American children with disabilities or developmental delays.
Faith Hope and Love Foundation nonprofit which helps with finding housing, helping with housing costs, clothes	933 N Canal St, Carlsbad, NM 88220	https://www.fhlcarlsbad.org/	(575) 941-2022	Eddy	provide help in times of financial distress by assisting individuals with the following needs: food (pantry referrals), shelter (rent/mortgage), clothing, educational scholarship/financial assistance, life skills, financial counseling/budgeting, mentoring, and/or other basic human needs; assistance with the medical related financial needs of our Cancer Warriors in Carlsbad
Families & Youth Inc	1320 S Solano Dr, Las Cruces, NM 88001	https://fyiplusnm.org/	575-522-4004	Dona Ana	therapy & treatment, housing, child welfare, health & nutrition, resources & referral
Foundry Home	2317 Jackson St, Carlsbad, NM 88220	https://www.senmcac.com/foundryhome	888-808-2775	Eddy, Lea	low-barrier youth crisis shelter that provides beds for up to eight youth, ages 12-17 for twenty-one days; case management
Guidance Center of Lea County	2130 West Bender, Hobbs, NM, 88240	https://www.gclcnm.org/	575-391-0185, 575-392-2231, 575-393-3168	Lea	Wrap around services – parents who have gone for addiction, family therapy, play therapy, mental health. Also housing
Hope Harbor Transitional Home	PO Box 1136 Capitan, NM 88316			Lincoln	Housing for women and children impacted by DV
I-Launch, Navajo project	Dine Education Center #205, Window Rock Blvd, Window Rock, AZ, 86515	http://www.nnosers.org/overview.aspx	928-871-6338	McKinley, San Juan, Cibola	promote social-emotional wellness for young children (pre-natal to age eight) on the Navajo Nation. Screening and assessment; enhanced home visiting through increased focus on social and emotional well-being; mental health consultation in early care and education programs; family strengthening and parent skills training; and integration of behavioral health into primary care settings
Job Corps Albuquerque	1500 Indian School Rd NW, Albuquerque, NM 87104	https://albuquerque.jobcorps.gov/			housing, classes, career training
Job Corps Roswell	57 G Street, Roswell, NM 88203	https://roswell.jobcorps.gov/		Chaves	housing, classes, career training

Name of Organization	Full Address	Website	Phone Number	County/ies Served	Services Offered
Johns Hopkins Center for American Indian Health Honoring Life Program	P.O. Box 3770, Shiprock, NM 87420	www.honoringlife.org	(505) 368-4038	San Juan	aims to prevent suicide by providing case management services to reduce risks, promote resilience and facilitate connections to care among Navajo and other Native youth 10-24 years of age
La Pinon Child Advocacy Center & KidTalk Warmline	850 N Motel Blvd Ste B, Las Cruces, NM 88007	https://www.lapinon.org/	(575) 526-3437 (main), 575-636-3636 (KidTalk)	Dona Ana	crisis services, medical advocacy, counseling & community outreach related to sexual violence and child abuse to individuals, families and the community. Statewide KidTalk offers children someone to talk to, and provides a safe place for a child to reach out where someone will listen and offer non-judgmental unconditional support
Lea County Child Advocacy Center	114 W Snyder, Hobbs NM 88240	https://www.senmcac.com/home	575-964-2064	Lea	provide child abuse prevention and awareness training to children; SANE (Sexual Assault Nurse Examiner) services; refer victims to appropriate follow-up services
Lutheran Family Services	230 Truman Street, NE, Albuquerque, NM 87108	https://www.lfsrm.org/			Refugee services, prevention, foster care, adoption, early childhood education
Lutheran Family Services	250 S. Main Street, Las Cruces, NM 88001	https://www.lfsrm.org/		Dona Ana	Refugee services, prevention, foster care, adoption, early childhood education
Mesilla Valley Community of Hope	999 W. Amador, Las Cruces, NM 88005	http://www.mvcommunityofhope.org/	575-523-2219	Dona Ana	Housing services, case management, legal assistance, medical referrals, facilities, resources.
Mesilla Valley Housing Authority	926 S San Pedro St, Las Cruces, NM 88001	https://www.mvpha.org/	(575) 528-2000	Dona Ana	safe, decent, and affordable housing coupled with programs that provide opportunities and incentives for our families to graduate from subsidized housing into economically-independent lifestyle
National Indian Youth Council	6201 Uptown Blvd. NE Ste. 203, Albuquerque, NM 87110	https://niyc-alb.com/workforce-development-program/	(505) 247-2251	Bernalillo, McKinley, Dona Ana, San Juan	workforce development program is designed to empower urban Native Americans to achieve educational and economic success. For instance, the program provides career coaching, work experience, classroom training, and other services to those who reside within the Albuquerque/Las Cruces, Farmington, and Gallup service areas

Name of Organization	Full Address	Website	Phone Number	County/ies Served	Services Offered
Native American Disability Law Center	905 W. Apache Street, Farmington, NM 87401	nativedisabilitylaw.org			The Native American Disability Law Center is a private nonprofit organization that advocates for the legal rights of Native Americans with disabilities. Through advocacy and education, we empower Native people with disabilities to lead independent lives in their own communities.
Navajo Nation Division of Behavioral & Mental Health Services	Window Rock, AZ	https://www.nndbmhs.org/treatment-services/outpatient/adolescent-outpatient/	(928) 871-6240 /6235	McKinley, San Juan, Cibola	comprehensive, clinically-managed services, medium intensity residential services, to tribally-enrolled adolescents (13-17) suffering from substance abuse/dependence and related co-occurring problems including mental health disorders; Building Bridges of Hope comprehensive suicide prevention program
New Day - Safe Home	2820 Ridgecrest SE, Albuquerque, NM 87108	https://www.ndnm.org/		Bernalillo	Housing for young people
Ngage New Mexico	3880 Foothills, Suite A, Las Cruces, NM, 88011	https://www.ngagenm.org/		Dona Ana	Work with cradle to college, advocating for policy change.
NM Coalition Against Domestic Violence	2340 Alamo Ave. SE #120, Albuquerque, NM 87106	https://www.nmcadv.org/	505-246-9240		support, training, and technical assistance for New Mexico programs serving children, their parents, and caregivers impacted by domestic violence
NM Legal Aid	505 Marquette Avenue NW, Albuquerque, NM, 87102	https://www.newmexicolegalaid.org/	1-833-545-4357	Statewide	New Mexico Legal Aid provides free services to eligible low-income New Mexico residents with civil (non-criminal) matters. Our services range from education, advice and brief services, to full representation in some cases.
Parents Reaching Out	2501 Yale Blvd SE Suite 200, Albuquerque, NM 87106	https://parentsreachingout.org/	(505) 247-0192	all	individual support to families of and/or youth with disabilities in the areas of early childhood, education and healthcare; no-cost trainings workshops and support groups; Provide family-friendly materials and publications related to early childhood, education and health
Pecos Valley Regional Education Cooperative #8	2218 W. Grand Avenue, Artesia, NM 88210	http://pvrec8.com/	(575) 748-6100	Chaves, Eddy	offers support and guidance to school districts and families within our region
Pegasus Legal Services for Children	3201 4th St. NW Albuquerque, NM 87107	www.pegasuslaw.org	505-244-1101		civil legal services to vulnerable children and youth in NM, including kinship guardianship, guardian ad litem, youth law including emancipation, access to health and mental health care, family law for young parents, more

Name of Organization	Full Address	Website	Phone Number	County/ies Served	Services Offered
Region #9 Education Cooperative	1704 Sudderth Dr., Ruidoso, NM 88345	https://www.rec9nm.org/	(575) 257-2368	Lincoln, Otero	School Based Health Clinics, Physical & Mental Health Counseling, Family Services, Services for Children with Disabilities, Youth Career Education, Social Work Programs, Early Intervention Education Programs, Child Find, Interagency Collaboration, and technology supports
Regional Educational Cooperative #6	1500 S. AVE. K STATION 9, Portales, NM 88130	https://www.rec6.net/	(575) 562-4456	Curry, DeBaca, Quay, and Roosevelt	birth to three services for families and infants / toddlers, Pre-K early childhood education, school-based health services including physical health, behavioral health, and prevention-based education, distance and technology-based learning, technical assistance, professional development and direct Education support staffing.
Regional Educational Cooperative #7	315 E. Clinton St., Hobbs, NM 88240	https://hobbsschools.net/department/rec7	575-393-0755	Lea	special education, professional development, special projects
The High Mountain Youth Project Evening Drop-in Center	637 Sudderth Dr, Ruidoso, NM 88345	highmountainyouth.org	(575) 808-8633	Lincoln	4-9pm daily for students ages 12-19 - safe haven, homework, access computers, school supplies, laundry, showers, homework help, snacks, dinner. 2:30-9pm on early release days.
The Nest Domestic Violence Shelter and HEAL	26374 US Highway 70 East, Ruidoso Downs, New Mexico 88346	http://helpendabuseforlife.org/	(866) 378-6378	Lincoln	Housing for women and children impacted by DV. Free language services are available at HEAL & The Nest" in English, Spanish, Apache and Navajo.
Transgender Resource Center NM	149 Jackson St. NE, Albuquerque, NM 87108	https://tgrcnm.org/	505-200-9086		support transgender, nonbinary, and gender nonconforming communities through direct services, education, and advocacy
United Way of Carlsbad & South Eddy County	116 S Canyon St, Carlsbad, NM 88220	https://www.uweddyco.org/	(575) 887-3504	Eddy	raising and investing dollars, also working collaboratively with a whole range of community partners to achieve lasting results (in areas of education, healthcare and financial stability)
Valencia shelter services	445 Camino Del Rey Dr Suite E., Los Lunas NM 87031	https://www.vssnm.org/	24 HOUR HOTLINE: 505.864.1383	Valencia	crisis line, domestic violence/sexual assault shelter, transitional housing, batterers intervention group, legal advocacy program, prevention education, mental health therapy

Appendix F. Acronym Dictionary

AA	Alcoholics Anonymous
ACT	Assertive Community Treatment
CPE	Certified Peer Educator
CPSW	Certified Peer Support Worker
CHW	Community Health Worker
CCSS	Comprehensive Community Support Services
DWI	Driving While Intoxicated
IOP	Intensive Outpatient Treatment
MOUD	Medications for Opioid Use Disorder
NA	Narcotics Anonymous
RSNM	Rural Southern New Mexico
OPRE	Office of Peer Recovery and Engagement
PSW	Peer Support Worker
PREA	Prison Rape Elimination Act
PO/PPO	Probation Officer/ Probation Parole Officer
RISE	Reach Intervene Support and Engage
RDA	Residential Drug Abuse (program)
RPD	Roswell Police Department
SMI	Serious Mental Illness
SUD	Substance Use Disorder
UA	Urinalysis

Appendix G. Qualitative Interview Guide

Interview Guide – <u>Key informants – Recovery for Criminal Justice Involved</u>[16]

Thank you so much for taking part in an interview today. ADD Intros: our names are (insert facilitator names) and we work for the Pacific institute for Research and Evaluation. We have been asked by the Center of Health Innovation to conduct this interview. The purpose of this interview is to help us understand the range of current practices, services and needs for recovery communities within the 14 counties in Southern NM served by the HRSA / RCORP (Rural Communities Opioid Response Program) project. We are specifically interested in:

- Care coordination for formerly incarcerated and newly released from treatment programs
- People in recovery without recent re-entry experience (including family of those in recovery)

What we learn from you will be used to help assess unmet needs and identify opportunities to improve the current system. The information with be combined with information from other interviews and focus groups to provide recommendations to organizations working with individuals in recovery, including those involved in the criminal justice system, recently released from incarceration, being released from treatment, as well as those individuals seeking support and community. We are also interested in potential funding sources to increase capacity for recovery communities and recovery community organizations.

Given your role (in behavioral health service provision in rural Southern New Mexico) we are especially interested in your perspective about how services work for people who are criminal justice involved, and especially the incarcerated: what happens before, during and after their incarceration.

We will take notes so that we can remember what we talked about today, and with your permission we would also like to record the session *for transcription purposes and for future review by the RCORP/HRSA team. We can turn off the recorder at any time.*

We understand that you may not be able to answer some of these questions. *Your answers to our questions are totally voluntary and will be kept confidential from those outside of CHI or PIRE who are involved in this project.*

We anticipate that this interview will take approximately 60 minutes.

May I now record?

I will begin by asking about your work, your role, and your interactions with individuals with behavioral health and substance use issues in your community.

There are no right or wrong answers. Do you have any questions before we proceed?

1. First of all, can **you briefly describe your work and background in relation to people experiencing substance use/ mental health or in other words, behavioral health issues** in rural southern (southeastern, southwestern) NM? ***Probe*** for length of time working/living, populations served, different kinds of positions in relation to BH and recovery.

2. Briefly, what **substances** (alcohol, drugs) are most **commonly used** in Rural Southern NM? How would you describe **the issues and problems** these substances create for residents?
   - What are some of the issues/factors that contribute to these problems with substances?
   - What resources are available to people who substance use issues in Rural Southern NM?

[16] Two other interview guides were created: one for peer support workers and one for individuals connected to treatment courts

3. For some context, what happens to people with **substance use/mental health or in other words, behavioral health issues** who are **involved in the criminal justice system**?
Probe – Describe to me the typical situation about someone's involvement in the system? At what age do people first get involved? What are their family situations like? Economic?

   To the best of your knowledge…..*(if participant has little knowledge move quickly to q4)*

   - What happens to people **with behavioral health (substance use/mental health) needs** when they first get involved in the criminal justice system? (How is their involvement in criminal justice system related to their behavioral health? *(according to respondent, make sure to establish if necessary a distinction between SU/MH. Probe for MH vs SU.)*
   - What happens to people with these needs **as they progress through the system**? (How is it learned that they have mental health and substance use issues? When? When and how are services made available to them? What kinds of services? Are these services also available to them prior to their involvement in the system? Why or why not?)
   - What **behavioral health services (substance use/mental health)** are available to these individuals **in prison or in jail** and how do they access them? How **are prison and jail** different? (When and how are services made available to them? What kinds of services? Are these services also available to them prior to their involvement in the system? Why or why not?)
   - To the best of your knowledge, what **other** services are available in the inside to people who use/d drugs? (Prompts: Harm reduction/treatment/recovery/pre-release course/GRE/housing-link/employment, Reentry in-reach programs?). What kind of support is offered to their families?

4. For these next questions we wish to focus on the needs of people when they are released. What typically happens **when people from rural southern NM <u>are released</u> from jail or prison**? What happens especially when people being released have concerns related to their behavioral health?

   To the best of your knowledge…..

   - What does discharge planning look like? Who does it? How? How is it different for those with mental health or substance use issues?
   - How are people anticipating release linked to *recovery supports - pre-release*? (What does that look like? Who provides that service? Is it required or voluntary?)
   - How are people in jail and prison provided *access to recovery peer support workers*? (When does it happen? Who provides that access? on the inside? after release?)
   - How are people anticipating release provided information about available resources for employment and/or housing? (When? Who provides it?)
   - How do you learn about what happens to people after release from incarceration?

5. **How would you define or describe recovery**, especially as it looks or could look in rural southern NM?
   a. What would help people in recovery here in RSNM? (specific services, supports, information, education….? How available are they to RSNM?)
   b. What organizations or institutions do you feel best support recovery? Are they here in RSNM or are there models elsewhere?
   c. How easy or hard is it to access recovery services and resources? How quickly can people in your community get treatment when they need it? What might make it hard for people in your community to access the services they need? Why might they choose not to access services, even if they are experiencing substance use or mental health issues? What types of barriers might they experience, including payment, wait times, online options? what have people shared about their experiences….)?
   d. How could existing services could be improved to increase access and quality of care or to increase equity across populations? Do certain populations of people have a more difficult time accessing recovery services? What are they? What/which additional services you think would be valuable?

6. When you think of justice-involved individuals who seem to have successfully navigated recovery (support systems), what factors do you think led to their success? Why would you say they were successful?
    a. Can you tell me a story about a justice-involved person who was **not successful**? Why do you think they were challenged? Why would you say they were not successful? What would unsuccessful mean to you? What were the barriers to successful release?)

7. What are some *resources that support and help people seeking recovery from issues with substance use or their mental health* in your community/Rural Southern New Mexico?

    Thinking especially about those who are not criminal justice involved…..

    a. How do people in RSNM/your community learn about recovery services or opportunities? (Media? Online? Podcasts? Medical Providers? School? Courts? Friends?)
    b. Can you share the names of programs and agencies in your community/ies that support and help people experiencing mental health and substance use issues? From your perspective, how well do they serve justice-involved people?
    c. How can existing recovery services be expanded or improved?

8. We are planning to support '**recovery communities'** in rural southern NM. What would that look like? What features should such communities have? Think big picture. No idea is too wild. What have you heard or seen about successful recovery communities in other places? Do you think they would work here?

9. Is there anyone you recommend we speak to about these issues especially for RSNM? We're interested in speaking with peer support workers, community advocates for recovery, individuals who have been successful and/or experienced challenges in navigating recovery, and others who might be willing to share their ideas.

10. We have already covered a lot of ground in this interview, but is there anything else you might want to share about the service system, community strengths and weaknesses, or issues involved in meeting the needs to community members experiencing mental health/behavioral health/substance use needs in Rural Southern NM?

Thank you so very much for taking the time to meet with us today!

Appendix H. SAMHSA Evidence-Based Practices Annotated Bibliography

This document is a summary of SAMHSA evidence-based practice resources available through the SAMHSA Publications Index at https://store.samhsa.gov.

Title: **Expanding access to and use of behavioral health services for people experiencing homelessness**

https://store.samhsa.gov/sites/default/files/pep22-06-02-003.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness. SAMHSA Publication No. PEP22-06- 02-003. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2023.

Ending housing instability and homelessness is critical for improving public health and community wellbeing. Studies show much higher rates of physical health issues and mental health and/or substance use disorders among populations experiencing homelessness than among people who are stably housed. People experiencing homelessness often face a decline in their physical and mental health while sheltered or unsheltered; therefore, this is an important window for initiating mental health and/or substance use disorder treatments. This guide provides strategies and implementation considerations for behavioral health providers and others practitioners to:

- Engage people currently experiencing homelessness
- Build strong relationships with these individuals
- Offer effective mental health and/or substance use disorder treatments
- Improve retention in recovery efforts

The guide includes four case studies to highlight strategies for providing treatment and recovery support services to people experiencing both unsheltered and sheltered homelessness. Additionally, it presents considerations for evaluation and quality improvement.

Title: **Intensive care coordination for children and youth with complex mental and substance use disorders: State and community profiles**

https://store.samhsa.gov/sites/default/files/d7/priv/samhsa-state-community-profiles-05222019-redact.pdf

Substance Abuse and Mental Health Services Administration, Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders: State and Community Profiles. SAMHSA Publication No. PEP19-04-01-001. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2019.

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and often includes the exchange of information among participants responsible for different aspects of care. Intensive Care Coordination (ICC) is defined as having seven components: • Assessment and service planning; • Accessing and arranging for services; • Coordinating multiple services; • Access to crisis services; • Assisting the child and family in meeting basic needs; • Advocating for the child and family; and • Monitoring progress. This 2019 ICC profiles report provides information on current implementation across 40 states that completed a self-report, with a particular emphasis on using Wraparound. It contains specific information on eligibility criteria, evidence-based screening tools, evidence-based practices,

credentialing requirements for care coordinators, integration with physical health care services, role of psychiatry in ICC, financing mechanisms including Medicaid vehicles and managed care organizations, rates and billing structure, staff training and tracking outcomes. This report not only provides a brief overview of the nation's ICC implementation landscape but also details the specifics of implementation enabling interested states to expand and improve ICC strategies.

This updated profiles report is intended to assist states interested in improving outcomes for children and youth with complex mental and substance use disorders by developing or revamping ICC. ICC using high quality Wraparound is one approach to care that improves clinical and functional outcomes while reducing the cost of care for these children and youth. This resource includes lessons learned from 40 states and a small number of local jurisdictions that have implemented ICC, with and without high quality Wraparound, and is intended to support innovation around state planning, program improvement, finance reform and continuous quality improvement for jurisdictions embarking on or continuing their ICC implementation efforts. In an effort to promote peer-to-peer exchange, key informant contact information is included for each profile. ** New Mexico is included in this report. **

Title: **Community Engagement: An essential component of an effective and equitable substance use prevention system**

https://store.samhsa.gov/sites/default/files/pep22-06-01-005.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). Community Engagement: An Essential Component of an Effective and Equitable Substance Use Prevention System. SAMHSA Publication No. PEP22-06-01-005. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2022

By engaging community members, prevention systems learn firsthand from individuals and community systems about substance use problems and social determinants that influence behavioral health. Community engagement brings together the skills, knowledge, and experiences of diverse groups to create and/or implement solutions that work for all members of the community. This guide focuses on how community engagement can play a critical role in the equitable scale-up of evidence-based programs and policies within the substance use prevention system. The guide presents what we know about community engagement from research studies, reporting on common community engagement activities and outcomes. It also discusses practical considerations drawn from on-the-ground experience regarding how to participate effectively in community engagement.

Title: **Practical tools for prescribing and promoting buprenorphine in primary care settings**

https://store.samhsa.gov/sites/default/files/pep21-06-01-002.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA): Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings. SAMHSA Publication No. PEP21- 06-01-002. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.

In 2019, 1.6 million people aged 12 or older, across the United States, reported an opioid use disorder (OUD) in the past 12 months. This number likely underestimates the true prevalence of OUD. Opioid prescription records reveal that the number of patients without a formal OUD diagnosis who use opioids at high levels is five times the number of patients formally diagnosed with OUD.1 This suggests that a significant number of individuals within primary care practices may need diagnosis and treatment.

The primary care setting is a critical intervention point to increase diagnosis and treatment for patients with OUD. The American Academy of Family Physicians asserts that primary care providers' delivery of patient-centered and compassionate care to diverse populations uniquely positions them to address the needs of patients with OUD. This

resource document provides practical, evidence-based information for primary care providers and practices on prescribing buprenorphine to individuals in need of intervention. It discusses implementation considerations and strategies for primary care providers and primary care organizations to facilitate their understanding, planning activities, and implementation of buprenorphine prescribing.

Title: **Treating concurrent substance use among adults**

https://store.samhsa.gov/sites/default/files/pep21-06-02-002.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA): Treating Concurrent Substance Use Among Adults. SAMHSA Publication No. PEP21-06-02-002. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.

Despite the increased prevalence of individuals using multiple substances at the same time, limited research exists on evidence-based treatment practices that have demonstrated improved outcomes for individuals who use more than one substance. Therefore, there is a need to identify and assess the effectiveness of treatment practices so that clinicians and organizations have the necessary resources and evidence-based practices to assist this population.

The guide presents three evidence-based practices that engage and improve outcomes for individuals with concurrent substance use and concurrent substance use disorders:

- FDA-approved pharmacotherapy together with counseling to treat two substance combinations: 1. alcohol and cocaine dependence and 2. cocaine and opioid dependence
- Contingency management together with FDA-approved pharmacotherapy and counseling to treat two substance combinations: 1. cocaine and opioid use and dependence and 2. cocaine dependence and alcohol and opioid use
- Twelve-step facilitation therapy together with FDA-approved pharmacotherapy and counseling to treat two substance combinations: 1. cocaine and opioid dependence and 2. opioid and other substance dependence The guide provides considerations and strategies for clinicians and organizations implementing evidence-based practices.

These approaches will assist clinicians, behavioral health organizations, primary care providers, insurers, and policy makers in understanding, selecting, and implementing evidence-based interventions that support adults with concurrent substance use and/or concurrent substance use disorders.

Title: **Telehealth for treatment of serious mental illness and substance use disorders**

https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders. SAMHSA Publication No. PEP21-06-02-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.

SMI and SUD impact millions of Americans. Barriers to accessing care include access to appropriate services and providers, stigma associated with SMI or SUD, and competing priorities (e.g., employment and caregiving responsibilities).

Telehealth is the use of two-way, interactive technology to provide health care and facilitate client-provider interactions. Telehealth modalities for SMI or SUD may be synchronous (live or real time) or asynchronous (delayed communication between clients and providers).

Telehealth has the potential to address the treatment gap, making treatment services more accessible and convenient, improving health outcomes, and reducing health disparities.

Title: **Substance use disorders recovery with a focus on employment**

https://store.samhsa.gov/sites/default/files/pep21-pl-guide-6.pdf

Substance Abuse and Mental Health Services Administration: Substance Use Disorders Recovery with a Focus on Employment and Education. HHS Publication No. PEP21-PL-Guide-6 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.

Sustained recovery from SUD is significantly tied to meaningful and purposeful work-life balance. Employment is an important factor for achieving sustained recovery and financial independence.

This guide provides an overview of issues, challenges, policies, and practices related to employment for individuals in recovery. It summarizes the state of the science through an evidence review of the known effectiveness of programs providing employment supports to individuals with SUD. Finally, the guide provides expert panel consensus recommendations of key program elements to support individuals with employment-related recovery.

Title: **Treatment considerations for youth and young adults with serious emotional disturbances and serious mental illnesses and co-occurring substance use.**

https://store.samhsa.gov/sites/default/files/pep20-06-02-001.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment Considerations for Youth and Young Adults with Serious Emotional Disturbances/Serious Mental Illnesses and Co-occurring Substance Use. Publication No. PEP20-06-02-001. Rockville, MD: National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 2021.

Treatment services for youth and young adults living with SED/SMI who may have or be at risk for co-occurring SUD have improved in recent years. However, an opportunity exists to broaden the availability and utilization of these services. For this reason, knowledge, and implementation of interventions to improve engagement and treatment in clinical settings are essential.

This guide presents three evidence-based practices that engage and improve outcomes for youth and young adults with co-occurring SED/SMI and substance misuse or SUD. These approaches will assist clinicians, behavioral health organizations, primary care providers, schools, insurers, transformation experts, and policy makers to understand, select, and implement evidence-based interventions that support youth and young adult mental health. These include psychosocial interventions, family behavioral therapy, medication, proactive outreach, and use of web-based and other technologies.

Title: **Use of Medication-assisted treatment in emergency departments**

https://store.samhsa.gov/sites/default/files/pep21-pl-guide-5.pdf

Substance Abuse and Mental Health Services Administration: Use of Medication-Assisted Treatment in Emergency Departments. HHS Publication No. PEP21-PL-Guide-5 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021.

The prevalence of OUD has reached epidemic proportions in the United States.

The ED, with its continual accessibility (24 hours a day/ 7 days a week/365 days a year), offers a unique option to combat this escalating crisis and save lives.

Individuals presenting with life-threatening conditions such as overdose or seeking treatment for withdrawal symptoms or other complications of OUD can find the care they need. The ED visit provides an opportunity to identify individuals needing treatment, offer motivational strategies to enhance acceptance of treatment, initiate evidence-based interventions, and provide direct linkages for ongoing medical management and community services.

This guide focuses on evidence-based interventions for the initiation of MAT in EDs, specifically buprenorphine. It provides guidance on developing programs to provide these clinical services, overcoming challenges, and successful implementation strategies.

Title: **Treatment of stimulant use disorders**

https://store.samhsa.gov/sites/default/files/pep20-06-01-001.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020.

Stimulant use is rising and becoming a public health crisis similar to the opioid epidemic. Illicit stimulants, like cocaine and amphetamines, are more accessible and have evolved to be purer, cheaper, and more potent. Stimulants are harmful to the cardiovascular system and can cause lung and brain diseases, stroke, and even death.

Treating addiction to stimulants is critical, but especially challenging. Unlike opioids, there is no FDA-approved medication currently available for stimulant use disorders.

People who misuse opioids— which suppress the functioning of the central nervous system—and stimulants in combination, often do so to reverse or modulate the effect of the other.

This guide presents four evidence-based programs and practices that address treatment of stimulant use. It supports SAMHSA's Strategic Plan Objective 3.4 to:

"Support the identification and adoption of evidence-based practices, programs, and policies that prevent substance use, increase provision of substance use disorders treatment, and enable individuals to achieve long-term recovery."

This guide covers cocaine and amphetamine-type stimulants that increase alertness and energy; heighten arousal; elevate blood pressure, heart rate, and respiration; and cause behavioral excitement. The guide also recognizes the misuse of prescription stimulants, such as dextroamphetamine and methylphenidate, found in medications used for conditions like attention-deficit hyperactivity disorder (ADHD), narcolepsy, and depression.

Title: **Preventing the use of marijuana: Focus on women and pregnancy**

https://store.samhsa.gov/sites/default/files/d7/priv/pep19-pl-guide-2.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). Preventing the Use of Marijuana: Focus on Women and Pregnancy. SAMHSA Publication No. PEP19-PL-Guide-2 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2019.

Currently, there is no evidence on individual programs for the prevention of marijuana use among pregnant and postpartum women, and there is a need to address this research gap. This guide draws from evidence-based practices and strategies for the prevention of substance use issues (e.g., alcohol, tobacco). Elements from these evidence-based approaches may apply to marijuana use prevention, and may help clinicians and community-based providers address the risks associated with the use of marijuana by pregnant and postpartum women.

There is a misperception of safety associated with marijuana use. Some women report strong beliefs about using "natural remedies" such as marijuana to address pregnancy-related symptoms such as nausea and anxiety.

Before clinicians and community-based prevention providers can communicate about the adverse health consequences that may be associated with marijuana use before, during, and after pregnancy, it is helpful to understand the existing evidence around the effects of marijuana exposure on fetal and infant outcomes.

Title: **Substance misuse prevention for young adults**

https://store.samhsa.gov/sites/default/files/d7/priv/pep19-pl-guide-1.pdf

Substance Abuse and Mental Health Services Administration: Substance Misuse Prevention for Young Adults. Publication No. PEP19-PL-Guide-1 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2019.

Young adults (18-25 years) are at an increased risk of substance misuse. Individuals in this age range are typically self-focused and engaged in exploring their identities, experiencing increased independence and new choices and possibilities, as well as changes in residence, employment, education, and relationships.

These emerging adults also have some of the highest rates of alcohol and substance misuse. While often described as youthful "experimentation" that is transitional in nature, substance misuse among young adults can have devastating consequences to an individual's health and social support system. For some, the pattern of misuse in young adulthood may lead to more problematic use and progression to SUD.

This guide discusses effective prevention practices to mitigate risk factors associated with substance misuse and promote protective factors among:

- all young adults generally;
- young adults at significantly higher risk for substance misuse; and
- young adults who are not diagnosed with a SUD but are engaging in substance misuse.

Title: **First episode psychosis and co-occurring substance use disorders**

https://store.samhsa.gov/sites/default/files/d7/priv/pep19-pl-guide-3_0.pdf

Substance Abuse and Mental Health Services Administration: First-Episode Psychosis and Co-Occurring Substance Use Disorders. Publication No. PEP19-PL-Guide-3 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2019.

The transition to adulthood can be a stressful process for young adults as they become more self-sufficient and face important life decisions that can shape their futures. The transition to adulthood can be especially challenging for young people who experience an emerging serious mental illness such as first-episode psychosis and who have a cooccurring substance use condition. When first-episode psychosis and substance misuse occur together, outcomes tend to be poorer in both the short and long term.

For young people experiencing first-episode psychosis, reducing or stopping substance misuse yields significant improvements in psychotic symptoms, depressive symptoms, and the young person's ability to lead a meaningful life. Reducing or stopping substance use early in the experience of psychosis also predicts better long-term outcomes.

Coordinated Specialty Care (CSC) is an integrated approach in which multi-component services are provided by clinicians with training and experience in working with young adults with first-episode psychosis and their families. This collaborative approach respects the autonomy and expertise of young people as part of the treatment process and allows young people and their families to feel better, gain hope for the future, and move towards recovery. CSC can support

interventions to address substance misuse and substance use disorders that are provided alongside services for first-episode psychosis.

Title: **Use of medication-assistance treatment for opioid use disorder in criminal justice settings**

https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf

Substance Abuse and Mental Health Services Administration: Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings. HHS Publication No. PEP19-MATUSECJS Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2019.

Following incarceration, individuals with OUD enter back into the environment where their substance use originated. Unfortunately, this puts the individual at high risk for relapse. Further, their tolerance for opioids is reduced while incarcerated. This puts the individual at high risk for overdose.

This guide focuses on policies and practices that can be implemented to intervene during an individual's time in the correctional system and upon release that moderate and mitigate the risk of overdose for persons with OUD after release.

One Piece of a Multipronged Approach

Research shows that implementing evidence-based practices requires a multipronged approach. This guide is one piece of an overall approach to implement and sustain change. Users are encouraged to review the SAMHSA website for additional tools and technical assistance opportunities.

Title: **Screening and assessment of co-occurring disorders in the justice system**

https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf

Substance Abuse and Mental Health Services Administration. Screening and Assessment of Co-occurring Disorders in the Justice System. HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

No Abstract. This guide examines a wide range of evidence-based practices for screening and assessment of people in the justice system who have co-occurring mental and substance use disorders.

Title: **Selecting best-fit programs and practices: Guidance for substance misuse prevention practitioners**

https://www.samhsa.gov/sites/default/files/ebp_prevention_guidance_document_241.pdf

Substance misuse and related behavioral health problems such as injury, addiction, and overdose are pressing personal and public health concerns. To successfully address these problems in states, tribes, jurisdictions, and communities, prevention planners need information about the effectiveness of available programs and practices. They also need to know how to determine which options have the greatest potential to work well in their unique settings and how to proceed if no viable options are available.

To help meet these needs, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed this guidance document, Selecting Best-Fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners. This resource places the selection of programs and practices within the broader context of evidence-based prevention. Specifically, it explores the following:

- The value of embedding program and practice selection in a strategic planning process
- Where to find information on programs and practices and how to choose among them

- Tips for adopting, adapting, and innovating programs and practices and for supporting their successful implementation and continual improvement at the local level

Supporting materials at the end of this resource provide additional information on these topics.

Title: **Principles of community-based behavioral health services for justice-involved individuals: A research-based guide**

https://store.samhsa.gov/sites/default/files/d7/priv/sma19-5097.pdf

Substance Abuse and Mental Health Services Administration: Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide. HHS Publication No. SMA19-5097. Rockville, MD: Office of Policy, Planning, and Innovation. Substance Abuse and Mental Health Services Administration, 2019.

This document is intended to assist community-based behavioral health providers in their clinical and case management practice with people with mental and substance use disorders who are currently involved with or have a history of involvement in the adult criminal justice system. The focus of this document is on services provided in the community rather than in institutional settings (i.e., jail, prison, or hospital). The information provided is intended to be used in practice and is therefore appropriate for any staff providing direct services in community settings. However, to practice these principles, organizations may need to reconsider staff training, evidence-based practices, and other programmatic elements to ensure that staff providing direct services have the information, policy support, and resources needed. This document is also intended for agency leaders and program developers who are responsible for shaping how their organizations deliver community-based services. The Principles provide a foundation for realizing a quality, community-based behavioral health treatment system that is responsive to all individuals with mental and substance use disorders and skilled in serving those with histories of justice involvement.

The eight principles and accompanying frequently asked questions (FAQs) in this document are based on the most current and relevant research. Resources are also included that provide additional information and tools to achieve quality practice.

Title: **Comprehensive Case Management for Substance Abuse Treatment**

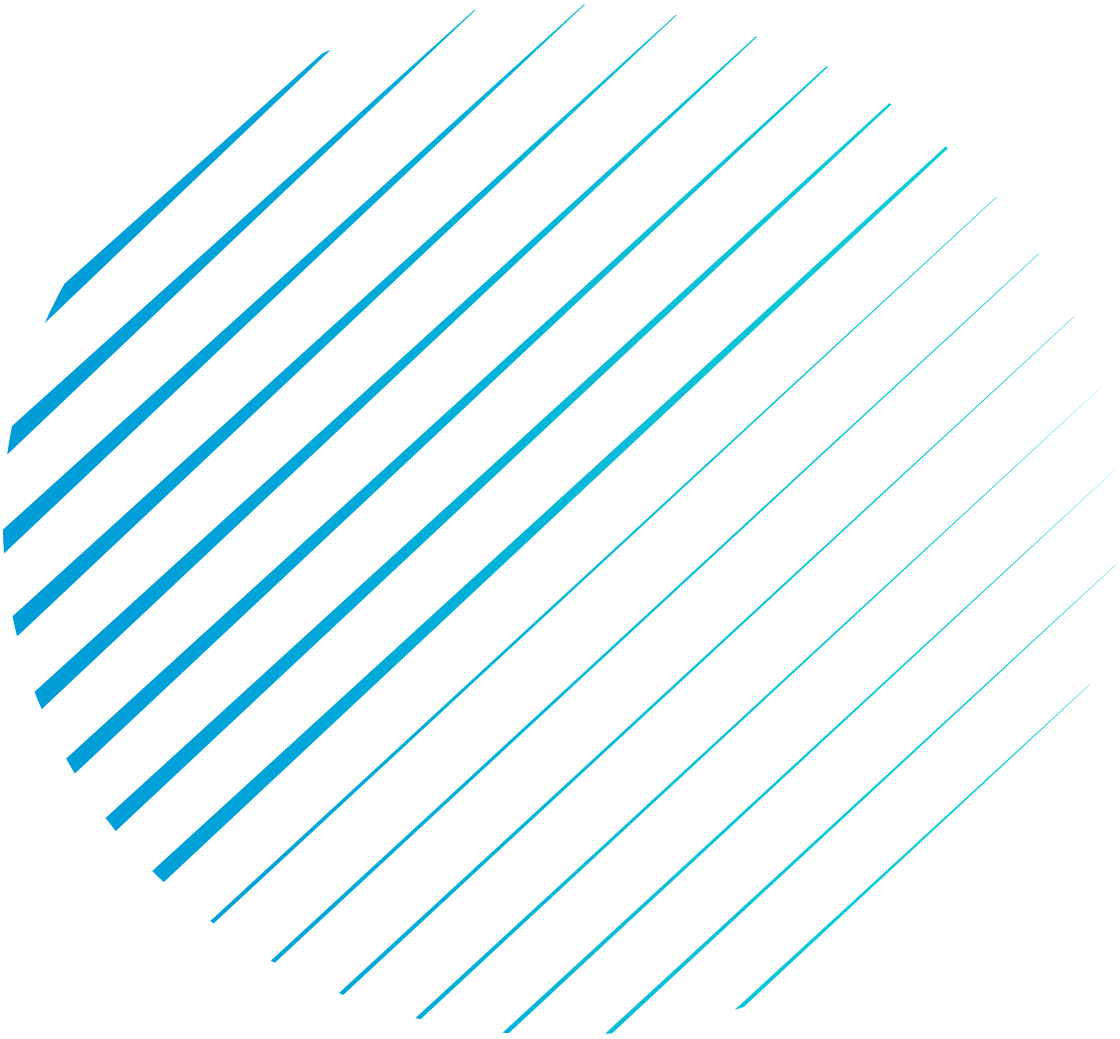
https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4215.pdf

Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 15-4215. Rockville, MD: Center for Substance Abuse Treatment, 2000.

Although it defies precise definition, case management generally can be described as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. The Consensus Panel that developed this TIP believes that case management lends itself to the treatment of substance abuse, particularly for clients with other disorders and conditions who require multiple services over extended periods of time and who face difficulty in gaining access to those services. This document details the factors that programs should consider as they decide to implement case management or modify their current case management activities. When implemented to its fullest, case management will enhance the scope of addictions treatment and the recovery continuum. A treatment professional utilizing case management will:

- Provide the client a single point of contact for multiple health and social services systems
- Advocate for the client
- Be flexible, community-based, and client oriented
- Assist the client with needs generally thought to be outside the realm of substance abuse treatment

Appendix I:
RCORP Recovery Communities: Qualitative Findings



JANUARY 19, 2023

EMILY HAOZOUS, PHD, RN, FAAN

PACIFIC INSTITUTE FOR RESEARCH AND EVALUATION

Contents

Executive Summary

Generations of public health, health policy, recovery communities, recovery organizations, and corrections professionals have been stymied in their efforts to find effective strategies for treating and preventing substance use disorder (SUD). New Mexico has been struggling with this issue for over 40 years, and a recent introduction of the synthetic opioid, Fentanyl, has only increased the urgency felt within the state towards finding sustainable solutions.

This report presents the results of a qualitative analysis of 21 professionals dedicated to supporting justice-involved people with SUD and people in recovery without recent re-entry experience. Findings from this report are intended to inform leaders, health professionals, and other interested people as they invest time and resources into this population-wide concern.

In this analysis we identify a cycle of incarceration and substance use disorder in rural and remote parts of Southern New Mexico, leaving people who are justice involved and living with a SUD with few options for breaking a perpetual and multi-generational circle of poverty and exposures to traumatic adverse events.

Participants in this project identified strategies that can move people out of this cycle and into recovery. Those strategies include engaging with certified peer support workers, building a clear pathway for treatment services for people with SUD wherever they are, including during incarceration and immediately upon release, addressing stigma across the culture, and finding resources to build economically accessible, comprehensive wrap-around treatment services across the state.

This report is a supplement to the full Final Report, providing in-depth detail on qualitative results only.

Overview

The purpose of this report is to respond to two questions:

How can organizations, institutions, and individuals support the development of SUD recovery communities, recovery coaches, and recovery community organizations?

How can organizations, institutions, and individuals enhance discharge planning and care coordination for people leaving inpatient treatment for SUD and/or the criminal justice system.

This report is a summary of an analysis of qualitative data collected during the months of September-November 2022. These data were written transcripts of online interviews and focus groups conducted with a broad range of people who all share either a professional or personal interest in how we can improve conditions for people who have been involved in the justice system and are living with substance use disorder (SUD) in rural southern New Mexico (RSNM).

This project is focused on the following 14 rural counties:

Catron, Chaves, Cibola, De Baca, Eddy, Grant, Hidalgo, Lincoln, Lea, Luna, Otero, Roosevelt, Sierra, and Socorro.

This report includes several sidebar boxes highlighting innovative practices. These innovations are bright spots in the recovery community landscape and are indicated by a text box that looks like this.

A note about terminology

Language matters. This report discusses different groups of people, many of whom are positioned within intersecting identities of marginalization within the context of the larger society. In writing about these groups, there are different ways to identify or refer to the people and populations. Although I do my best to describe and reference people using their preferred terminology as a matter of respect for all persons, there are times when I may misuse or mistakenly use a term or phrase. Unless there is a clear preferred term used in the dataset, my sources for terminology about groups and communities are the CDC guide on Preferred Terms for Select Population Groups and Communities and the NIH Guide, Words Matter – Terms to Use and Avoid When Talking About Addiction.

Findings

Participants

Due to the small sample size, topic, and need to maintain confidentiality, the participant characteristics are limited to general geographic region and occupational field. The participants represented a range of geographic regions with a majority living and working in rural southern New Mexico (RSNM). Of those who lived in southern New Mexico, only a small portion lived in and around Las Cruces, the most population dense region in this part of the state. The occupational range of the participants was highly representative of the desired population we sought for this project. Peer support workers held a wide variety of positions, including working in and for behavioral health organizations and contracting/freelance. People who identified as working in corrections include those within the judicial system, inside detention centers, and probation/parole officers. Finally, people included in behavioral health were those who worked in organizations or facilities that provided treatment for SUD.

Table 1. Participant Characteristics

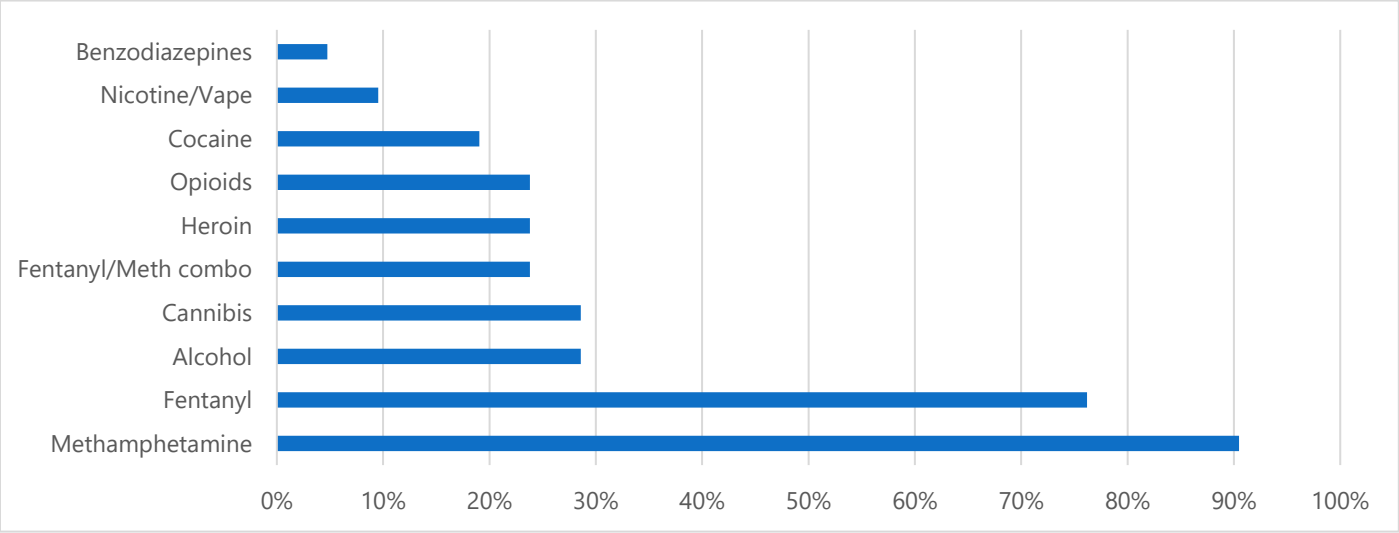
Participants (n=21)	%
Gender:	
Male	24
Female	71
Decline to state	2
Total	100%
Counties Represented:	
Northern	10
Statewide	10
Dona Ana County	50
14 Southern Counties*	60
Total	100%
Occupations:	
Peer support	43
Corrections	38
Behavioral health	24
Total	100%

*Southern counties represented: Chaves, Sierra, Lincoln, Luna, Lea, Grant

Drugs Used

We asked participants to identify which substances are most used in the communities in which they work. Participants overwhelmingly identified methamphetamine (19 people, 90%) and fentanyl (16 people, 76%) as the most common substances seen in their communities. Only one person (5%) reported benzodiazepines (valium, Ativan, Xanax) in their community. Fentanyl mixed in combination with other drugs was reported by a quarter of the participants (5 people).

Figure 1. Commonly used drugs, ranked by percentage reported



This disturbing trend was remarkable because it was observed as very disruptive to the people found with the drug. Participants stated that many times, people were not aware that fentanyl was mixed into the intoxicant they believed to be ingesting, a potentially fatal error.

In this verbatim quote[17] from a focus group with participants from Chaves, Grant, and San Juan Counties, five participants discuss the issue of fentanyl mixed with other drugs. In this text segment, the participants discuss a rising phenomenon, that fentanyl is mixed with other drugs without the knowledge of the person purchasing and using the drug. The participants here share their concerns regarding the safety for the people with SUD disorder, as well as their fears regarding changes in the patterns with drug trafficking.

Participant 1	**If it's not fentanyl itself, it's meth laced with fentanyl.**
Participant 2	I see the exact same thing partially cuz we're in the same area, but a lot of my clients who do meth aren't aware that there's fentanyl laced in it until I tell them. And **so, it's an unknowing use of fentanyl**.
Participant 3	I'll piggyback on that too. We've seen a huge increase in fentanyl use. We've seen a huge decrease in heroin specific. We still have the meth, and we have a lot of alcohol. What we're seeing too is, is even inside of the jail and the limitation that they have with the drug testing is **when people do use in the detention center it is fentanyl**
Participant 4	And D, did you have anything you wanted to add to that too?
Participant 5	I guess I'm, I'm seconding being everybody here. Yeah, I see it everywhere. It's the, the, especially I guess that's the scariest about this is that people aren't, don't know they're using it and like, they'll come in for a UA [urinalysis] and they'll be like, "Oh I, you know, I slipped, I did whatever." And I'll be like, "Okay, what'd you use?" And they'll be like, "meth." And we do a UA and they're like test positive for fentanyl and they didn't know that. So like, you know, that's, that's very very**, I mean it's dangerous on its own and then not knowing you're taking it is just horrid. (**10/31/2022[18])

Themes

This remarkable dataset converges a diverse collection of world views and life experiences, including people who have career military backgrounds, people in recovery who have lived unhoused and been involved with the criminal justice system, and behavioral health providers working across the spectrum of care. Across these interviews, the voices are unified in their respectful attention to the systematic gaps and barriers to recovery for justice involved people living with SUD.

Overall, this dataset was about patterns of behavior that move in circles and what can be done to break the circle. Within this, five themes emerged from the qualitative data:

1. Conditions that precipitate and perpetuate SUD for people who are involved in the criminal justice system.
2. Barriers across systems that prohibit access to SUD treatment
3. Transition from incarceration
4. The role of peer support workers
5. The path to sustained recovery and how to support healthy recovery communities

The five themes and corresponding take-home summary findings align with the seven key domains contained in the final project report. These domains become the core of the final report, recommendations, and evidence-based practices. Table 2 is a summary of the themes, summary findings, and domains.

[17] Verbatim quotes retain the verbal ticks and repeated words that frequently occur in natural speech. The use of verbatim quotes helps in preserving the voice and integrity of the participants and provides the reader with additional context with which they can evaluate the trustworthiness of the data interpretation.

[18] To protect identities, participant quotes are provided by recording date. Participant numbers are used only within each verbatim exemplar quote to distinguish between speakers and are not consistent throughout this document. Thus, participant one in this exemplar quote is not the same as participant one in another exemplar quote. Recording dates are provided to demonstrate the wide variety of participant voices represented in the dataset.

Theme 1. Context and Conditions.

Understanding the context and conditions that exist for people with SUD who have been part of the criminal justice system is prerequisite when trying to address this complex and systematic issue. There were two fundamental contextual pieces that arose in the data analysis fitting into this category. The first is the antecedents and consequences that characterize the profile of many of the people fitting into this population of interest. The second is understanding the many barriers to daily living that exist for people who are newly transitioned out of the criminal justice system.

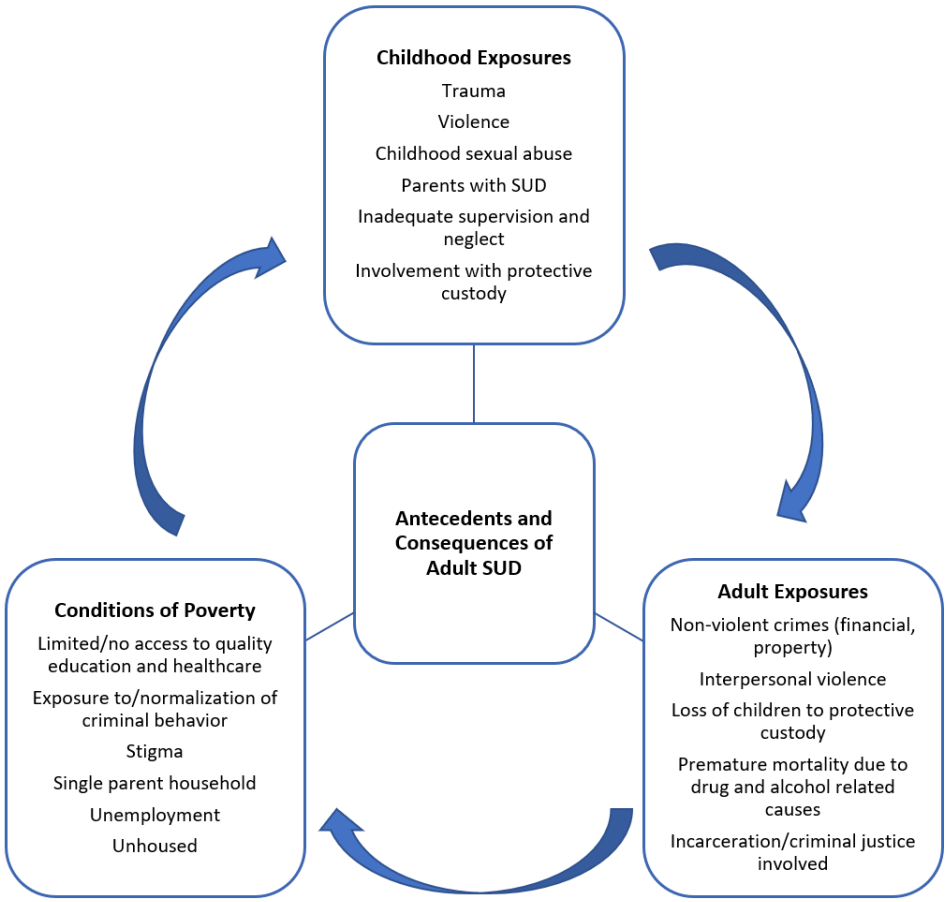
Table 2. Qualitative Data Themes

Theme	Summary Finding	Domain
Context and Conditions	Recurring cycle of childhood experiences and exposures, adult experiences and exposures, and conditions of poverty characterize justice-involved people with SUD	Housing Transportation Employment
	Returning citizens have a feedback loop in which SUD, poverty, and incarceration continuously repeat when safety net structures are not in place	Justice System
Barriers across systems	The justice system culture is focused on circular and deficit-based thinking when envisioning outcomes for justice-involved people with SUD	Justice System
	SUD treatment options are very limited. The most limited are those insured by Medicaid and those requiring high levels of care	SUD Treatment
	MOUD is a viable treatment for opioid use disorder	SUD Treatment
	Abstinence-only culture excludes evidence-based treatment options for people with OUD.	Stigma
Treatment and transition from incarceration	Bureaucratic barriers and lack of resources prevent the effectiveness of existing programs and procedures to treat SUD within justice system	SUD Treatment
	Pre-release procedures are not sufficiently anticipating the needs of people with SUD	SUD Treatment Justice System
	People with serious mental illness have additional needs requiring specialized attention beyond what they currently receive	Health Care System
Workforce shortages and CPSWs	CPSWs are uniquely positioned to assist justice-involved people with SUD across the recovery spectrum	SUD Treatment
	CPSWs provide a range of services and are essential partners in building and maintaining recovery communities	SUD Treatment
The path to sustained recovery	Defining recovery is centered on preventing recidivism and finding personal fulfillment	SUD Treatment
	Breaking cycles of incarceration and SUD requires building societal and social support safety nets that center on destigmatizing practices and practical support	Stigma
	Ideal recovery settings provide wrap-around services with the right treatment at the right time, tailored to meet the person's unique needs	SUD Treatment

ANTECEDENTS AND CONSEQUENCES

In setting the stage for the interviews and focus groups, we asked participants to tell us about the problems that substances like alcohol and drugs create for residents in the areas where they work, and if there were other issues that contribute to those problems. Almost unanimously, participants connected intergenerational trauma and childhood adverse events to adult SUD. When examined collectively, a profile of the population of adults with SUD who were identified as part of the community of interest emerged with clear antecedents and consequences (figure 2). Although this profile was not universal, there was consensus that a multigenerational cycle of childhood exposures combined with the conditions of poverty led to early initiation of substance use. In rural and remote regions of the state and with little access to quality healthcare, these young people then aged into adults with SUD who were involved with the criminal justice system. These adults would then resume this same cycle by perpetuating the same behaviors and conditions that had contributed to their own circumstances.

Figure 2. Antecedents and Consequences of Adult SUD



This quote from a participant who works in the corrections systems sums up this cycle well, describing the complex relationships between adverse childhood events, economic conditions, and intergenerational trauma and their influences on adult SUD.

> "I would say that for the majority of the population that I see, they are experiencing drugs at a young age. Most of the time they see that with their parents' use, they have high ACEs scores. They might see emotional, physical abuse, possible sexual abuse. And then their economic status is, is probably not very stable. I mean, we have, we have people that are experiencing that poverty experience, low literacy experience… And so I would say in general, people that are coming into the system with substance use issues started at a young age and have continued to increase. And that's kind of sometimes their avenue coming into the criminal justice system, whether they're property damage or stealing to get money for drugs or, you know, they just get caught up in crime with gang life, et cetera, et cetera. But it's different for everybody." (9/27/22)

BARRIERS TO DAILY LIVING

> "So, when they are released from incarceration, you know, there's the immediate needs that need to be met, like a roof over their heads and food. But most of the individuals that are within New Mexico are releasing to supervision. And then part of that requirement is to go check in with your probation parole officer and then to, you know, begin following your conditions of release. And that means not engaging in, you know, criminal behavior or substance use. And within New Mexico, the probation parole officers really recommend people for substance use treatment, recommend people for assessments, get people engaged in the help that they need. But sometimes their hands are tied… they'll be, you know, violated and go back into the system, which doesn't help anybody. So, I think it's that cyclical." (9/27/22)

As the above participant quote describes, once a person is released from incarceration, they are required to meet a series of needs. Some requirements are mandated by the court and include regular supervisory visits with their probation or parole officer, seeking treatment for SUD, and performing community service. Other needs may not be mandated as part of the terms of their parole/probation but facilitate the completion of these requirements. To see a full description of the levels of supervision and terms of parole, see Appendix A.

Unfortunately, there are multiple barriers in place that can prevent returning citizens with SUD from easily meeting these many demands. Participants in this project described the frustrating conflicts they observed and experienced as they assisted people who had been recently released from incarceration, specifically naming challenges with finding housing, transportation, and employment. In this analysis, it was evident that the easiest path for returning citizens would be to resume the lifestyle that had caused them to become incarcerated in the first place. The combination that includes poverty, limited social support, and unresolved trauma would easily direct a person to return to the maladaptive behaviors that contributed to their prior experiences in the criminal justice system.

Participants described a process of incarceration and substance use disorder (SUD) (figure 3) that illustrates the pressures of having to find housing, employment, and food while also meeting the mandatory requirements of their release. Within these pressures was the constant lack of resources- limited affordable housing, few jobs that paid a living wage, long waiting lists for treatment for SUD, no reliable transportation, and the many pressures found in trying to reestablish themselves within their families and communities while also managing the stigmas of living with the burdens of a SUD and having a history with the criminal justice system.

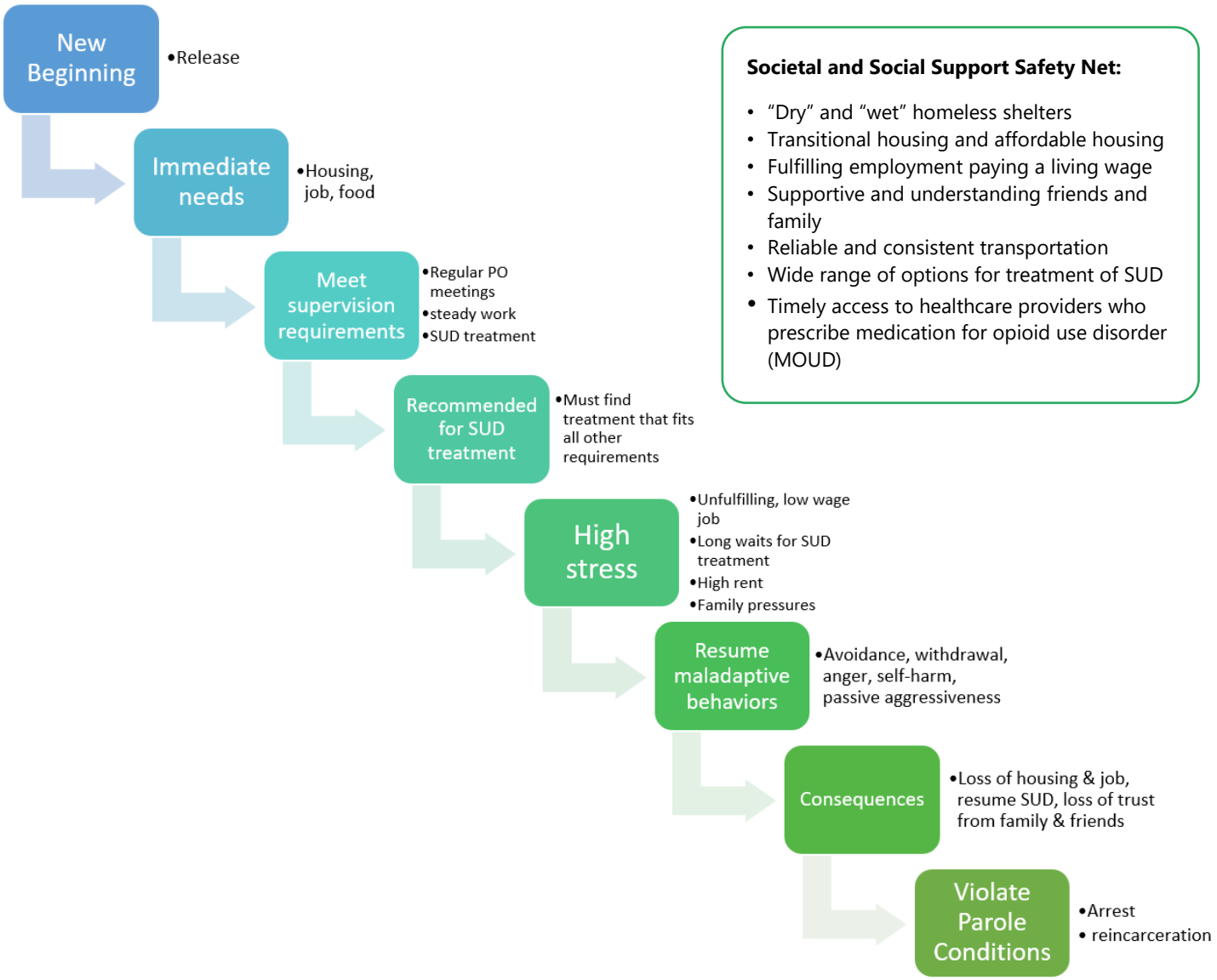
Finding housing was seen as extremely difficult, with very few low-income units available and space in transitional housing and homeless shelters hard to find. Housing location was critical, as a person's home had to be close enough to their workplace and the office of the probation/parole officer so they could attend required supervision meetings. Case managers and probation/parole officers noted that people who were unhoused were difficult to monitor for supervision, and more difficult to reach when services did become available, creating a cascading effect. Finally, for those who were unhoused and had SUD, there was easier access to drugs and alcohol, placing their recovery in jeopardy.

Finding employment was extremely challenging, especially for those living in the rural southern counties in New Mexico. Participants noted that many employers were not aware of incentives that were available to worksites that hired justice-involved people. They also described the difficulties that justice-involved people had with low-wage jobs due to rigidity with work schedules and their need to report for regular supervision with their parole/probation officers, and/or report for regular urine tests. Finally, participants described how entry-level positions did not provide a living wage and were not personally fulfilling, leaving the employees unmotivated to follow through when met with challenges at work.

The lynchpin in these challenges was the lack of reliable transportation for people living in the predominantly rural and under-resourced regions of southern New Mexico. Even though bus vouchers and other payment opportunities do exist to pay for ride-share services, most communities in southern New Mexico do not have such services. Where public transportation does exist, it does not reach where people need to go, behavioral health services are too far away, and distance between locations translates to prohibitively long travel times. Even for people who do own their own vehicles, the cost of fuel is an added burden that prevents justice-involved people from meeting all their needs. To illustrate the hardship that transportation creates, a Peer Support Worker describes the efforts they make to assist clients in seeking care for SUD:

"Well, here in Lea County, we, we don't even have a rehab or a detox center. We don't even have a homeless shelter. Like, so we have to, to get somebody care here, you have to drive over an hour and a half, maybe two hours. Like, I chose one of my clients to a detox rehab that would work with her psychosis all the way up in Española. And that was a six-hour drive." (11/1/2022)

Figure 3. Stepwise flow from release to reincarceration



Theme 1 Take Home Points:

- A recurring cycle of childhood experiences and exposures, adult experiences and exposures, and the conditions of poverty are characteristic of many justice involved people with SUD.
- Returning citizens have a feedback loop in which SUD, poverty, and incarceration continuously repeat unless there is a social and societal safety net in place.

As is illustrated in figure 3, the pressures of meeting requirements of release, finding treatment for SUD, and managing day-to-day stresses of family, friends, housing, transportation, and employment are overwhelming for newly returning citizens. Without a strong social and societal safety net (figure 3, Safety Net Box), many people will resume maladaptive coping behaviors, which lead to consequences that ultimately cause the person to violate the terms of their release. In violation, the person will be returned to the carceral system, repeating the cycle.

Theme 2. Barriers Across Systems.

Circular systems and access to treatment clustered together in this theme, providing important background information regarding the overall mindset behind how the justice system works when considering the management of people with SUD, and the larger environment in which people who are living with SUD must negotiate when trying to access treatment for SUD.

CIRCULAR SYSTEMS.

In reading through the transcripts, it was very clear that the criminal justice system is very procedures-based. A striking number of experts in the criminal justice system would respond to interview questions by attempting to explain the processes and procedures that are in place to address specific issues and conditions:

> Just to kind of give you a quick snapshot of what that looks like within the institutions… (9/27/22)
> So I guess, let me back up with, when someone becomes incarcerated, they have a… (9/27/22)
> So when, when somebody, so the way the legal process works is that when… (9/1/22)
> So let me just run you through the process right quick. So when a defendant is… (10/31/22)
> Once we have that, then we… (10/31/22)
> So once they start with us, let's say that we… (10/31/22)
> I'm trying to think what else, what happens after, let's say they successfully complete the program. What happens after is… (10/31/22)

These process-oriented explanations were useful because they described the many ways the state's criminal justice system is trying to meet the needs of justice-involved people with SUD. When I explored these responses for the unspoken meanings, I found these process-oriented explanations would have a clear start to the procedure, but frequently lacked a point of termination. The start of the process was clear, but once the person has cleared that first starting point, the route on the map loses definition. It would make the most sense that the point of termination would be release from incarceration or termination of parole or probation, but there were too many contingencies along the path for a process to reach that point. Most frequently, the termination point was a parole violation and return to prison or reporting to the parole board.

This type of repetitive process and procedures description suggests an underlying circular framework that underpins the larger justice system. Even when the interviewer tried to frame the questions with a recovery focused direction, the participant would focus on violations:

> Interviewer: And you remain connected to the, to the folks that have a parole plan while they're on parole. Do you continue to, to work with them on their resources and support and what's happening with them in community after the period of parole?
> Participant: So once a release, tell me if I'm wrong, but I'm understanding the question wrong, but for what I, what I'm understanding that you're wanting to know is how, if we let the facility know if they're actually doing what they're supposed to?
> Interviewer: Yes
> Participant: Yeah. So, if they're not doing what they're supposed to, like, if they're testing positive, not going to treatment, we do have to submit preliminary reports to the parole board and letting them know that they're in violation. (10/25/22)

ACCESSING TREATMENT FOR SUD

Barriers to accessing SUD treatment are substantial for anyone seeking treatment, particularly those living in very rural and under-resourced areas like southern New Mexico. Building recovery communities that have long-term sustainability within a region requires a baseline understanding of the current conditions for all populations, beyond those who are justice involved.

Treatment for SUD can be categorized into levels of acuity and need. Chronic daily users may require a medical detox, which is a resource-intensive, multi-day inpatient stay due to the health risks involved.[19] Following detox, inpatient treatment is the most intensive and typically requires a multi-week stay in a dedicated location, in which the person is monitored and treated by a multidisciplinary team that includes a combination of medical, nursing, pharmacy, social work, and behavioral health staff. Similar programs exist in the outpatient setting but are less intensive and costly due to the lack of overnight stays, but still qualify as intensive outpatient treatment (IOP). Finally, a wide range of treatment options exist with varying levels of contact with treatment-oriented professionals beyond a formal IOP. Non-IOP outpatient programs can include regular attendance at support group meetings including but not limited to Alcoholics Anonymous or Narcotics Anonymous, assistance from a certified peer support worker, participation in therapy-oriented activities, and so on. Following discharge from a formal treatment program, the evidence-based approach is to transition to a continuing care program, which may look like transitional housing or wrap-around care, with built-in supportive services in place to serve as a safety net.

Access to any treatments for SUD depends on location and availability of resources. For example, there are fewer treatment options available for people who rely on Medicaid than for those with private insurance, as is explained by this participant, a CPSW from southern New Mexico:

> I mean, insurance is a huge problem. Yes. If people have private insurance, they can pretty much write their own ticket to go wherever they like. And if they have Medicaid, their choices are extremely limited. …Yeah. So I think it really varies. I think for like a white, like English speaking master's degree-having person like me, like it would be, you know, and I have private insurance through a private company, it would be pretty easy, you know. (11/9/22)

People who would be best served by an inpatient treatment program find the most barriers. Inpatient treatment facilities are almost always at capacity, with long wait periods for the few available beds. Payment policies, intake rules regarding COVID vaccine status, criteria for eligibility, and even their ability to manage medical detox can prevent people from qualifying for their programs. Participants noted that facilities can be unexpected access points for opioids, further exacerbating the same issues the patient population is trying to remedy.

People with opioid use disorders (OUD) may find their best choice for treatment is to choose medication for opioid use disorder (MOUD, also known as MAT, or medication-assisted treatment). In rural and remote parts of the state, there are challenges to finding a healthcare provider who will prescribe MOUD. Participants described delays to initiate care with providers, leaving some returning citizens without necessary opioid replacement medication to manage symptoms of dependency. In situations such as this, it is common for people with SUD to resume using opioids to maintain daily responsibilities and requirements of their parole/probation. During the COVID-19 pandemic laws related to dispensing opioid replacement medication have been temporarily waived, allowing for psychiatrists to prescribe medication via telemedicine. Even with these policy changes, some pharmacies have refused to dispense MOUD, eliminating an essential medical treatment for people with SUD. Depending on the medication, transportation can create additional issues, due to the dosing schedule and dispensing protocols requiring daily in-office doses.

Stigma surrounding treatment for SUD strongly influenced how and where people could access treatment. The example provided earlier illustrates how stigma is a barrier to care- even though clinicians are trained to treat people with SUD, they are not seeing patients with SUD. Participants described a culture of abstinence-only recovery in the state, this value permeated the treatment facilities and was reflected in the paucity of detox facilities, inpatient treatment programs, and access to MOUD throughout the state. Participants reflected on how an abstinence-only culture excludes people who rely

[19] Shah M, Huecker MR. Opioid Withdrawal. [Updated 2022 Sep 9]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK526012/

on MOUD to maintain their recovery. They also believed that education within the criminal justice and behavioral health systems could address this misconception and help the recovery community become more tolerant.

> I feel like possibly for therapists, more continuing education on what recovery is, would be incredibly helpful. I think most providers know the *idea* of what MAT is, but they really don't know *what* MAT is. I think that would be very helpful. I think we've been very abstinence based in New Mexico and abstinence is definitely one way to go about it, but it's not the only way to go about it. And if you're not abstinent once, does that mean you're not in recovery? Once again, I disagree with that, but how to get the word out to the population. (9/14/22)

Theme 2 Take Home Points:

- The criminal justice system culture is focused on circular and deficits-based thinking when considering justice-involved people with SUD.
- There is extremely limited access to treatment for people with SUD, particularly for those with Medicaid and those requiring higher levels of care.
- MOUD / MAT is a viable treatment for Opioid Use Disorder.
- Abstinence-only culture excludes important treatment options for people with SUD.

Theme 3. Treatment and Transition from Incarceration.

Treatment for SUD for people who are incarcerated or anticipating release from incarceration is fraught with complications. Thematically, the data were clustered into three subcategories in this dominant theme: what happens within the walls, the path to treatment for SUD outside the walls, and care for people with serious mental illness.

WITHIN THE WALLS.

Participants working at the administrative side of the carceral system understood the process for treatment and the scope of need. As this participant stated,

> "…our estimates in Doña Ana County are about 40% of people coming into the jail have an opiate use disorder. I mean, compared to the general population, that's a huge number, right?" (11/9/22)

Even with this understanding, treatment for SUD for people who are incarcerated follows an uncertain path. Upon entry, the process from court ordered screening to receiving treatment can be lengthy and complicated by multiple variables. Access to treatment can depend on location, whether a person is in jail or prison, length of sentence, and the actual crime committed. A person convicted of a driving while intoxicated (DWI)-related charge will automatically be referred for DWI screening. If found eligible, they will receive treatment, which is a 10-week, 4-hours/week treatment program. Longer and more intensive drug and alcohol treatment programs are less accessible, and may depend on more fleeting conditions, including whether the person is observably enduring detox and is reported by a cellmate or podmate, whether they are within the 2-year window prior to release, whether their facility has access to a treatment program, and whether there is a spot available for that person when they need it.

> "…if they do get sentenced to incarceration, sometimes they sentence them to the RDA (residential drug abuse program), which is a program in prison. I'm not familiar with the program, but I have heard from different offenders that they have told me they were not able to offer the RDA program due to not having spots available or the program not being provided to them." (10/25/22)

Professionals working within the walls of the criminal justice system understood the paucity of available treatment options, observing the lack of realistic treatment modalities for people serving sentences lasting longer than two years and the overwhelming need for services for all people with SUD within the system.

So, we're scratching the surface of need. We have 12 participants, but we could probably have 1200 who would probably benefit from the service. (9/1/22

As was clear in the previous theme, Circular Systems, the procedural plan was in place, but the reality of the under-resourced systems left many people without treatment for their SUD. These gaps in their plan left them vulnerable in the six-month transition period leading up to release.

THE PATH TO TREATMENT.

According to participants, there are clear processes for people anticipating release. Approximately six months prior to release, a re-entry team will convene to coordinate a care continuance plan. The purpose of this plan is to identify the returning citizen's needs post-release, as determined by medical and mental health staff, educational staff, a classification officer, and security. Although not all participants were clear on who is participating, there was consensus that a re-entry coordinator or transitional coordinator would help identify the feasibility of the plan, working in collaboration with a parole officer. The returning citizen would be recommended to participate in pre-release workshops, which might include mock job interviews, financial literacy classes, and health workshops that cover basic healthcare topics and information about infectious diseases. Other career readiness activities might also take place, depending on availability, including soft skills job training workshops and working with a Goodwill case manager.

Prior to release, the parole officer is responsible for ensuring the returning citizen will have access to the resources they will need for success, including housing, potential employment or financial support, required community service opportunities, and healthcare. At the time of release, returning citizens are given release information folders that contain a map to their probation officer's office, a community resource guide, and information about the local bus routes, department of workforce solutions, fidelity bonding, and workforce opportunity tax credits. Participants in this project agreed that people belonging to undocumented immigrant populations had special difficulties in this transition because their housing options had additional limitations, and there are fewer resources available to support them once they are released. Additionally, recovery services that meet the needs of non-English speakers are harder to find. They also observed that people who are convicted sex offenders are also hard to serve because they have an additional set of restrictions that prevent them from living in certain areas, taking specific jobs, and more stringent supervision requirements.

For people with SUD, the path to treatment is far less clear. Ideally, people who are identified as having a SUD and have completed a residential drug abuse program are released to a sober living or transitional living community upon release. This is the understanding from the administrative perspective, and the best-case scenario from a SUD treatment perspective. Even with this understanding, there was no consensus regarding how a person with SUD would transition to any level of treatment upon release, from full-time inpatient to finding recovery meetings. Some believed a social worker was part of the re-entry team, others thought the parole officer coordinated this transition. Others believed this was in the purview of the re-entry coordinator or transitional

One thing that I did with that pilot project... I bought a suburban, an eight-person suburban... because what everybody realizes that there's a lot of transportation issues out there, they can't get to work, they can't get to treatment etc. So I thought, well what does it look like if we provide a transitional living house there and we put everybody in that transitional house and this reentry coordinator worked directly with the probation/ paroles [officers] and said, "Let's take 'em everywhere, Let's just see what that looks like. Is there more success when they are able to not have transportation barriers?" And so, you know, we're doing that right now.

So, it started off with the probation parole officers waking up early, getting to the people on supervision's house at 6:00 AM, taking them to work and dropping them off, and doing the same on the back end, picking them up and bringing them back. And that created a different rapport than what we've seen before. Cuz they had their, you know, it's like, "hey, here's some morning coffee, let's talk about the day ahead." And then they were able to wrap up the day and say, "How was work today?" And so, it created a different rapport with the POs, which I thought was great. (9/27/22)

coordinator. Most dismally, most believed this critical step to re-entry and recovery was the sole responsibility of the returning citizen, who is left to self-advocate and coordinate.

In the following quote, a participant familiar with the justice system speaks to his concerns with the self-advocacy approach with people released from jail. In this interview, he described the long waits and bureaucratic and financial difficulties people in his region experienced trying to find detox and rehab facilities that met their needs.

> "I know that people are not getting adequate access to treatment in jail, you know, and I do not doubt that people are sometimes using, using in the parking lot as soon as they get out, you know, And so I think that Narcan, you know, being given to people as they're leaving is critical. And I think that instituting medication assisted treatment is really critical to help save people's lives. I think too much of it is left up to the individual. Right. You know, they walk out of the detention center and they're free to go wherever they like, which is great. You know, on the one hand, on the other hand, Right. If we could connect them, you know, immediately to low barrier services, that would be great." (11/9/22)

Participants reiterated frequently that reliance on self-advocacy as the main driver linking people with SUD to treatment was insufficient. Instead, participants agreed that a seamless transition plan for people with SUD would result in better long-term recovery outcomes.

SERIOUS MENTAL ILLNESS.

Participants were clear that there is no one-size-fits-all solution when designing treatment and recovery communities for people SUD. The path to recovery is as individualized as each person's path to SUD and incarceration. Within the treatment options available both within the walls and upon release from incarceration, participants recognized that there were specific shortcomings for people who live with serious mental illnesses (SMI) that are characterized by periods of psychosis, including major depression and anxiety, bipolar disorder, and schizophrenia.

Participants mentioned a "chicken and egg" problem with some mental health issues, questioning whether chronic SUD had caused a SMI or the SMI predisposed the person to a SUD, seemingly unaware of the existing research tying SUD, SMI, life stressors, and adverse childhood events.

> I think probably one of the issues that we struggle with the most is figuring out which come first, the chicken or the egg. Did we have the substance abuse issue before the mental health issue or vice versa, because we found that a lot of substances will, you know, bring on the onset of psychosis and different things like that. So, we struggle with that part a little bit. And that's what we see the trend, you know, around here is we have a lot of people with mental health issues that are engaging in substances. (11/1/22)

People who are living with SMI and SUD were observed to get caught in an incarceration cycle that created additional stresses on the criminal justice system without providing any long-term benefits for the justice-involved individuals. Starting with the understanding that many people with SMI from rural counties may not have consistent access to qualified mental health care in their home communities, participants noted that the only source of consistent mental health care they receive is in prison. In preparation for discharge, the re-entry coordinator or transition coordinator will work to find extra support, including identifying a psychiatrist so their medical care can continue after release. Patient privacy laws prevent patient records from being transferred to the parole officer, but minor medical information will be included on the re-entry paperwork, flagging the need for medical follow-up, but there is still a high risk that the person's medical needs fall through the cracks during this transition period. As noted previously, transitioning anyone to treatment for SUD is already complex, this need is similarly difficult for people with SMI.

Participants noted that crisis and emergency department staff are ill prepared to meet the needs of people who are suicidal, psychotic, and posing a risk to themselves and others. Similarly, emergency departments are poorly equipped to address SUD-related psychosis and suicidal behaviors. In the following quote, the participant describes the shortcomings found when people with SUD present to their local hospital with a mental health crisis.

> I don't feel like the hospital here is very educated on how to handle somebody that's like suicidal or mental and has like real issues, you know? And the way they treat them, they don't help calm 'em or, you know what I mean? I,

> I just think that there's more education that needs to be for sure with situations, you know. Because if someone is suicidal, they don't need you to be treating handcuffing 'em and treating 'em like they're criminals. You know, they're, they're seeking help. And I just, I don't know, I just think that there's other ways of handling things and that this should be approached and I'm hoping that this will somehow educate me to where I need to learn or go or what for that, you know what I mean? (11/14/22)

Other participants noted that people with SUD had to be coached to explicitly state they were suicidal to receive medical or psychiatric care for their mental health symptoms. They also noted that healthcare providers did not refer patients to SUD treatment programs or help patients find detox programs following a SUD-related crisis.

Participants also noted a pattern of repeat arrests with people with SMI and SUD in which the justice-involved person would be found not competent to stand trial, assessed as "not dangerous" and have their case dismissed. With their case dismissed, they would be released back to the same situation in which they had been prior to their arrest, leading to the next arrest. Without supportive housing, consistent psychiatric care, and substantial resources, the cycle would repeat ad infinitum, another example of the circular patterns seen throughout the data.

Theme 3 Take Home Points:

- Although there are programs and procedures in place to treat SUD within the criminal justice system, conditions, bureaucratic barriers, and lack of resources prevent their effectiveness.
- Pre-release procedures are not sufficiently anticipating the needs of people with SUD.
- People with serious mental illnesses have additional needs requiring specialized attention beyond what they currently receive.

Theme 4. Workforce Shortages and Peer Support Workers.

Throughout this analysis, specific professional roles emerged as essential in building positive and sustainable recovery communities for people who are justice involved. Parole and probation officers provide the mandated supervision, and often are a source of accountability for people with SUD. The behavioral health workforce and specifically those working in SUD treatment were noted as critical to helping diagnose, treat, and ultimately breaking the circle of repeat arrests for people with SUD who are justice involved. As one participant noted, New Mexico state policies have contributed to disruptions in behavioral health care over the past decade, further exacerbated by a nation-wide behavioral health workforce shortage that began during the COVID-19 pandemic.

The role of the certified peer support worker (CPSW) and certified peer educator has emerged to fill this workforce gap. The CPSW was frequently noted throughout the data as a key part of the recovery support community. Certified Peer Educators are trained and serve within the incarcerated population, either as people in recovery who are part of the population or as people who are working with a behavioral healthcare system paid to train inmates to become CPSWs. Duties within the facility include peer counseling, participating in training workshops as a peer educator, and assisting with discharge plans. Once released, certified peer educators can transition to become CPSWs six months after successfully completing their requirements of release.

Once certified, the work of a CPSW in the community varies depending on the setting, individual interests, job requirements, and skillset of the individual. CPSW in the community fill many gaps across the recovery spectrum, essentially creating the foundation of the recovery community for many returning citizens as they rebuild their lives after release. Probation and parole officers described how CPSWs helped support their supervisees throughout the probation/parole period and beyond. In this context, the CPSW makes frequent contacts with the returning citizen to check in, identify potential needs such as housing, transportation, and finances, and work with the probation/parole officer to find solutions. Within the behavioral health system, CPSWs have more flexibility than other positions, particularly given their geographic proximity and more personal relationships with the clients.

As one CPSW explained, their agency contracted with a detention center to receive returning citizens as part of their discharge planning. The process with that behavioral health agency was to assign everyone a care coordinator and a CPSW to help with health insurance and other healthcare linkages. The care coordinator could manage much of the bureaucratic components from their office, but anything involving direct contacts with the client had to be managed by the CPSW. This included providing transportation for clients, a need that has already been observed as a major barrier to maintaining recovery and continued compliance with the conditions of parole/probation. The CPSWs in this agency were a valued part of the support team, providing a wide range of care needs, as described by this participant:

> So, our CPSWs provided tons of case management, and really what that means is they are interacting with that client a minimum of once a week. And it's usually way more than that. It's usually three or four times a week that they're really interacting with that client. That's giving them transportation to doctor's appointment, making sure they're appearing in court. Because one of the biggest things for a violation is failure to appear. And so, we really making sure that our clients appear in court as so that keeps them stabilized where they're not making those very easy to do mistakes. And so they do that. We continue to make sure all of their basic needs are met. We help them get housing, help them get jobs, and then we also, after they complete like 90 days' worth of treatment, we provide another 90 days after care. So, we're touching base with them no less than a minimum of four times a month. So, we're just really hands on. There's a lot of handholding to me that goes on with CPSWs, but that's what it takes to make it work. (11/1/22)

Table 2. Roles and tasks performed by CPSWs

Overall	Inside the walls	In community
• Contribute personal experience • Know the difficulties of recovery • Trustworthy- are not representatives of any government agency • Help clients feel engaged and understood • Help communicate client needs • Mentoring and life skills coaching • Help navigating the system(s) • Have personal knowledge about SUD programs and best practices • Advocacy • Facilitate meetings		
• Peer education	• Addictions and behaviors • Opioids and Narcan • Stress management • Communicable disease prevention • Addictions and behaviors • Monkeypox, COVID-19 • Prison Rape Elimination Act (PREA) • Build discharge plans	• Help getting paperwork (social security card, driver's license, birth certificate) • Help filing for aid (SNAP, TANF, etc) • Help with forms for housing, jobs • Supportive voice on the phone/text • Support for family members • Lead skills classes in community • Help with transportation • Remind about important events- court dates, parole/probation meetings • Help find resources

CPSWs held an intensely engaged role within the lives of returning citizens, yet they also maintained the necessary professional distance needed to continue in their role. Some participants who identified themselves as CPSWs explained their motivations for taking on this position in the community. All shared a desire to contribute to their community in a substantive way, but each CPSW had their own individual motivation as well. Several explained that they were returning citizens and had exposure to CPSWs through a

friend or family member, triggering their own interest in the job. Others were trained as peer educators while incarcerated, so the transition to CPSW was a natural next step. One individual described his desire to be present for friends:

> That's why I signed up to, you know, to get certified as a CPSW is helping other people… I go down the road and I run into all buddies that are in their addiction. I can just [sit] right here and I run into about two or three of 'em and they're struggling. And, you know, I tell 'em, I'm not here to judge you, but whenever you're ready, you know, you can reach out and, you know, talk and whatever you need, you know… (11/15/22)

Finally, CPSWs had a unique perspective on their role in the lives of the returning citizens with whom they worked. Their personal experiences informed their understanding of the natural history of SUD, giving them special insight into the causal conditions that had led people to their services as well as the best approaches for managing problems they encountered in their roles. Because their roles were less defined, they had flexibility to provide navigation, transportation, and as one participant stated, "*we're just really hands on. There's a lot of handholding to me that goes on with CPSWs, but that's, that's what it takes to make it work*" (11/1/22). The CPSWs who participated in this dataset described the very fundamental day-to-day functions that stymied many returning citizens. Filling out official paperwork, finding job listings, getting medications, and even making medical appointments were routine tasks in their daily work. Ultimately, CPSWs filled in the life skills gaps that many recovering citizens had not learned during their lives prior to incarceration due to their early initiation of substance use and other social and societal factors.

Theme 4 Take Home Points:

- Certified Peer Support Workers (CPSWs) are uniquely positioned to assist justice involved people with SUD across the recovery spectrum.
- CPSWs provide a wide range of services, making them an essential partner when building recovery communities.

Theme 5. The Path to Sustained Recovery.

Amidst the cyclical patterns of incarceration and SUD, participants brought forward a vision of sustainable recovery that included the resources necessary to build supportive recovery communities. Thematically, this clustered into three sub-categories: defining recovery, best conditions for recovery, and describing the ideal recovery community.

DEFINING RECOVERY.

During the interviews and focus groups, we asked participants to share how they defined recovery for people with SUD. The responses varied greatly, based on the professional role and personal experience of the participant, but there were several areas of consensus. Overall, recovery was defined by externally observable lifestyle changes that fell under the rubric of "productive member of society": does a person have a meaningful job, can they pay their rent, do they have a supportive social group, do they have a religious or spiritual community. Participants also agreed that recidivism was a measurable metric of recovery, noting that people who had found their way to effective treatment for SUD also avoided the justice system.

> …mine would be a reduced recidivism for sure. It is ensuring that when these clients are leaving our program, they have the tools and resources in hand to be able to handle anything that comes their way. Because when we, when we're dealing with true addicts, relapse is always going to be a part of their life. And so, we want to ensure that they have that relapse prevention plan in place. They have their support systems. They're linked up with NA or a sponsor of some sort so that they have the capability to reach out if they ever get into trouble. Again, my main goal is to make sure that they stay off the grid for criminal justice. It's, it's all about recidivism for me. (9/1/22)

Participants were not in agreement regarding the role that sobriety plays in recovery. For many, abstinence is not the only definition of recovery. Two participants commented on the ongoing work of recovery, that it is not a goal one achieves but

instead is a moment-by-moment struggle that follows a person throughout their life. For this reason, those who opposed the abstinence definition of recovery advocated for a continuum-based perspective, as this participant describes:

> I think we need to expand our minds about what recovery looks like, because then I think that will allow more individuals into the system. If that makes sense, if we can expand it and not put these limits on well, recovery means that you have a coin that says you've been clean for a year or whatever, you know, that's, I think then we could let more people in our services. (9/14/22)

Ultimately, participants agreed that although, as this participant stated, "*I think recovery is different for everybody,*" (9/14/22) and their shared goal was to keep people out of the justice system and enjoying a positive and fulfilling lifestyle.

BEST CONDITIONS FOR RECOVERY.

Returning to the first theme, in which I presented the Incarceration and SUD cycle, there were multiple points in which a timely intervention, support, or resource could break the cycle and redirect the justice involved person with SUD towards a positive path of recovery. Participants who were working with this population and who had lived these circumstances had many suggestions for how to create the best conditions for recovery. Summed together, those conditions create a societal and social support safety net for people with SUD. Some parts of the safety net are more abstract and require shifts in cultural and the stigma surrounding justice involvement and SUD in general. Other suggestions are tangible ideas regarding how resources are allocated and distributed.

From a cultural, societal level, participants proposed a safety net system that offered well-informed and compassionate care. They saw people who had supportive and understanding family and friends reaching success in their recovery with more ease than those who lacked these social ties. They also felt that people thrived when they had a support system that was recovery-positive instead of stigmatizing or still based in a lifestyle that focused on substance use.

So we have basically a state approved employment training provider that is providing training for heavy equipment. [And] we have two, our first two graduates happened within the past month. Two women certified as heavy equipment training providers. We have eight more graduating soon and working with the Department of Workforce Solutions and everyone below that, including the employment training provider. Those with those funds come the prerequisite that one, it's a growing job sector, that there's a, a career pathway moving forward and that the Department of Workforce Solutions and those local workforce boards, their piece of that puzzle is that they work with a case manager, their case manager to work with an individual prior to release to really focus on employer connections and they work to get them a job post-release. (9/27/22)

At the more practical level, the best conditions for recovery included access to practical and affordable transportation and housing. Personally meaningful employment was noted to help motivate people to succeed in their recovery. People who had a team that included a knowledgeable attorney and a probation or parole officer who carried a small caseload were more likely to have access to the treatment resources they needed. Similarly, maintaining treatment programmatic continuity was noted to help people make a logical stepwise progression through their recovery. These practical considerations could be summed up as providing access to whatever resources a person needed when they needed them.

DESCRIBING THE IDEAL RECOVERY COMMUNITY

Regardless of their background, every participant's description of an ideal recovery community shared the same characteristics. These dream communities provided the Societal and Social Support Safety Net resources outlined in the previous section- the cultural shift away from stigma towards support, and the societal support in place to help people who have many restrictions, and few personal resources build a new life.

Recognizing that recovery is individualized, the ideal recovery community has access to the right services at the right time, tailored to each person's needs. There is no waiting list and no delays to join- this was an explicit requirement of the dream recovery community. Similarly, payment or insurance is not a barrier to joining this community. This community

promotes healthy choices and a healthy environment for all people as a community, instead of the current model, which is seen to isolate out people in recovery. There is support across the community to facilitate building and rebuilding healthy relationships with children and family, often a painful or difficult path in the life of a justice involved person with SUD. In this community, every person has access to the basic resources for daily living, which include a home with electricity, water, food, and transportation. People are also given assistance to find other resources, which might look like receiving help applying for WIC, Medicaid, or SNAP. It might look like help finding work or getting a high school diploma or college degree. Finally, people have timely access to medical treatment and SUD treatment that meets their needs, including nonjudgmental access to MAT.

These wraparound service-oriented treatment programs do exist in some communities already. Comprehensive wrap-around care is the ideal recovery community model, and those few that exist were praised as exceptional resources for their regions.

Theme 5 Take Home Points:

- Defining recovery for justice involved people with SUD is centered on preventing recidivism and helping people find personal fulfillment.
- Breaking the cycle of incarceration and SUD requires building a societal and social support safety net composed of destigmatizing practices and practical support for people with SUD.
- The ideal recovery community has accessible and comprehensive wrap-around care that provides the right treatment services at the right time, tailored to each person's unique needs.

Conclusion

Reading about the lived experiences of the 21 participants who shared their time and knowledge with us for this project provided me with rich insight into the many seemingly impossible challenges people who are living with SUD and are justice involved must endure. I also noted the dedication of those people who have dedicated their lives to serving this population and the vast need for resources to address the many barriers every person in this difficult field must manage. Each person discussed the difficulties they negotiated daily, whether it was a lack of staff to meet the needs of the community, inscrutable health insurance policies, the cost of gas and the distances they had to drive daily, or the frustration of seeing the same faces in their courtrooms, over and over, these experiences illustrated how urgently we must work to find better and more sustainable solutions.

These data demonstrated that we are caught in cycles of circular thinking, limiting our ability to look past the existing outcomes to imagine a different way of living. Whether these circles are limiting our ability to see justice involved people as anything other than people who will eventually end up back in the prison, or they are pre-destined to fail due to policies that position people with SUDs with almost no resources and a series of life-altering challenges immediately upon release from prison.

Fortunately, the data also provide us with a series of tangible next steps, which include creating societal and social safety nets, so people are caught and carried forward once released. Recovery communities that contain comprehensive wraparound services already exist. This is no longer an impossible problem; we must only look outside the circle.

Appendix A. Levels of Supervision

Supervision Conditions and Special Programs

This list of supervision conditions and special programs details the overall conditions recently released justice-involved individuals are required to follow, according to types of offense. In addition to these different levels of supervision, people are often required to participate in additional requirements, such as counseling or restitution.[20]

Parole- The release to the community of an inmate of an institution by decision of the board or by operation of a law subject to conditions imposed by the board and to its supervision. Has very explicit terms of release, which include employment, drug testing, travel, ownership of weapons, education, etc.

Probation- Less likely to re-offend, do not fit the criteria of any special programs. Sometimes placed into standard supervision if they are pending acceptance in special programs. Has same requirements for release as parole.

Intensive supervision- High risk offenders, typically includes gang members, repeat felons, and violent offenders. More stringent requirements.

Community Corrections- community-based supervision. Offenders have greater treatment needs, focused on behavioral health services. Often serves as a diversionary program for people who would otherwise be incarcerated. Tiered program starting with 6-month inpatient, then moving from there, with classifications for employment, education, or medical. People have to engage in treatment/counseling and living requirements and have specific reporting requirements according to tier.

Drug Court- Specific for people with SUD. Has the same terms as parole/probation, with flexibility related to substance use disorder.

Standard Parole Supervision

Per statute NMSA 31-21-5, parole means "the release to the community of an inmate of an institution by decision of the board or by operation of law subject to conditions imposed by the board and to its supervision".

1. I will report to my Parole Officer as directed. I will not abscond from parole, as evidenced by my failure to report where I cannot be located, after reasonable efforts, at my place of approved residence and employment.

2. If I am paroled or transferred to the custody of another State, I will abide by the rules in effect in that State, as well as the parole conditions imposed by the New Mexico Adult Parole Board.

3. I must seek and obtain permission from my Parole Officer before changing residence. I must secure a travel permit from my Parole Officer before any travel out of the county to which I am being supervised.

4. I will demean myself as a law-abiding citizen. I will notify and advise my Parole Officer of any arrest within 24 hours (felony or misdemeanor).

5. I must maintain acceptable behavior and conduct which shall justify the opportunity granted to me by the New Mexico Adult Parole Board.

6. I will not illegally possess, use, or sell any narcotic drug, controlled or synthetic substance, or drug paraphernalia. I will not consume or buy intoxicating beverages, nor will I enter what is commonly known as a bar or lounge where intoxicants are sold.

7. I will submit to substance testing at my Parole Officers discretion.

8. I will not knowingly associate with any person who is a detriment to my parole. I will have no gang contact, attire, or paraphernalia.

9. I will not buy, sell, own or have in my possession, at any time, firearms, ammunition, or other deadly weapons of any kind.

10. I will seek and maintain verifiable employment, education, or community service (if not employed) and notify my Parole Officer immediately in the event of termination or change of employment.

11. I will permit my Parole Officer or Corrections Officials to visit me at all reasonable times, places, and will submit to reasonable warrantless searches per New Mexico Corrections Department policy.

12. I will refrain from driving any motor vehicle without a valid NM driver's license, registration, and insurance.

13. I will comply with all conditions and fines imposed by the judgment and sentence, as ordered by the court.

[20] https://www.cd.nm.gov/divisions/probation-and-parole/

Appendix B. Acronym Dictionary

AA	Alcoholics Anonymous
ACT	Assertive Community Treatment
CPE	Certified Peer Educator
CPSW	Certified Peer Support Worker
CHW	Community Health Worker
CCSS	Comprehensive Community Support Services
DWI	Driving While Intoxicated
IOP	Intensive Outpatient Treatment
MOUD	Medications for Opioid Use Disorder
NA	Narcotics Anonymous
OPRE	Office of Peer Recovery and Engagement
PSW	Peer Support Worker
PREA	Prison Rape Elimination Act
PO/PPO	Probation Officer/ Probation Parole Officer
RISE	Reach Intervene Support and Engage
RDA	Residential Drug Abuse (program)
RPD	Roswell Police Department
SMI	Serious Mental Illness
SUD	Substance Use Disorder
UA	Urinalysis