City of Santa Fe

Agenda

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LEAD Task Force

Monday, November 26, 2012
Santa Fe Community Convention Center
Nambe Room, 2nd Floor
201 West Marcy
4:00pm-6:00 p.m.

1. Call to Order – Chairperson Emily Kaltenbach – 5 minutes

2. Approval of Agenda

3. Approval of Minutes – October 29, 2012

3. New Business
   a. Harm Reduction/Treatment System Overview – 20 minutes
   b. Legal System Overview – 20 minutes
   c. Law Enforcement Overview – 20 minutes
   d. What is the meaningful data that we need? – 20 minutes

4. Old Business
   a. Core Values/Principles: What do we want to accomplish? What are the measurable objectives? – 20 minutes

5. Sub-Committee Assignments – 10 minutes

6. Next Meeting December 10, 2012 1pm -5pm Model Development -5 minutes

7. Adjournment

Persons with disabilities in need of accommodations, contact the City Clerk's office at 955-6520 five (5) working days prior to meeting date.

Index Summary of Minutes
LEAD Task force
November 26, 2012

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Approval of Agenda The chair noted that Jerome Sanchez has been nominated to be Vice Chair and this will be an action item on the agenda for the next meeting.	***Ms. Ferlic moved to approve the agenda as amended, second by Mr. Kopleman, motion carried by unanimous voice vote.***	2
Approval of Minutes	***Ms. Ferlic moved to approve the minutes as presented, second by Cathy Anheles, motion carried by unanimous voice vote.***	2
New Business a. Harm Reduction/Treatment System Overview b. Legal System Overview c. Law Enforcement Overview d. What is the meaningful data that we need?	*Informational*	3-22
Old Business a. Core Values/Principles: What do we want to accomplish? What are the measurable objectives?	*Informational*	22
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LEAD TASK FORCE
MINUTES
MONDAY – NOVEMBER 26, 2012
NAMBE CONFERENCE ROOM
SANTA FE, NEW MEXICO
4:00 PM – 6:00 PM

A. Call to order

The meeting of the LEAD Task Force was called to order by the Chair, Emily Kaltenbach at 4:00 pm in the Nambe Room of the Convention Center, Santa Fe, New Mexico. A quorum did exist by roll call.

B. Roll Call

Present:
Emily Kaltenbach, Chair
Thom Allena
Chief Ray Byford
Katherine Ferlich
Major Ken Johnson
Deputy Chief William Johnson
Steve Kopleman
Sheila Lewis
Rachel O'Connor
Pablo Sedillo, III
Cathy Anheles
Marcela Diaz
Laura Brown
Maria Jose Rodriguez Cadiz
Yolanda Briscoe
Jeneen Lujan
Jerome Sanchez
Jessica Dimas
Krishna Picard
Mary Sky Gray

Guests:
Mark Boschelli
Brian Byrnes

Not Present
Mayor Coss, Excused
Cathy Armijo, Excused
Jay Archuleta
Bennett Bauer
Milagro Castillo

Raymond Chavez
Michael Delgado
Angela "Spence" Pacheco
Captain George Ortiz
Lt. Alfred Perez

Others Present:
Fran Lucero, Stenographer

Staff Present:
Terri Rodriguez, Staff Liaison
Richard DeMella, City of Santa Fe – Juvenile Justice Program

C. Approval of Agenda

The chair noted that Jerome Sanchez has been nominated to be Vice Chair and this will be an action item on the agenda for the next meeting.

Ms. Ferlic moved to approve the agenda as amended, second by Mr. Kopleman, motion carried by unanimous voice vote.

D. Approval of Minutes

Ms. Ferlic moved to approve the minutes as presented, second by Ms. Anheles, motion carried by unanimous voice vote.

E. New Business

a. Harm Reduction/Treatment System Overview
Rachel O'Connor, Santa Fe County
Ms. O'Connor met with the Mayor to discuss what some of the efforts have been in terms of Santa Fe County. We are in the early stages of developing a group, about 6 months ago we put together with myself, Laura Brown and some other providers and interested parties, Mark from the community a group called Santa Fe Oh Be it Safe. The idea behind that group was to do a couple of things; 1) to look at reducing drug overdose in Santa Fe County and 2) to look at the Project Lazareth model which is an evident space model of harm reduction that has been used back east and is being rolled out across the county that looks at the use of Narcan in reducing drug overdose and sort of a comprehensive approach that includes harm reduction, the use of Narcan, the development of treatment and a comprehensive education and prevention program. There are a lot of people that have come together for this, we are partnering with the Department of Health in looking at what exists in the community now, what the epidemiology of the issue is in Santa Fe County and in New Mexico, what kind of public policy efforts would be most proactive. I think our major focus is 1) looking at Narcan in terms of harm reduction and what all of us together might be able to do in reducing drug overdose steps through that, and 2) looking at our existing treatment structure; many of you probably know Santa Fe County spends about $1.9 million

dollars in terms of indigent funds to many providers across here. Are we getting the best bang for our buck in terms of the money that we're expending. Is there any way to target those more carefully to really help support the kind of treatment programs that are community based that is also evidence based and might be able to reduce the drug over does issues here in Santa Fe county. We are still struggling to put together the exact mission that we want to accomplish. Laura and Mark were invited to add comments.

Mr. Sedillo stated that Santa Fe County Detention Center works very closely with Behavioral Health at Christus St. Vincent's and Mark sits on that committee. What we are doing now is collecting a lot of data in regards to providing to that group that data consistent with those who come through our facility who we call "frequent flyers". We have about 60 of those individuals who are mental health and have dual diagnosis, mental health and substance abuse issues. We have started to collect data and we have a continuous quality improvement team at our facility that is going to be collecting all of that data. We have also implemented about seventeen different programs inside of our facility coming from alcohol anonymous, anger management, NA, parenting skills, stress reduction, substance abuse education, and domestic violence will be coming in to the facility very soon. These groups that we have identified as anger management groups, substance abuse groups and behavioral relapse groups and decision making and enhancement groups we are dealing with. I think that the detention center is focusing on the seriousness of the epidemic that we have in our community in regards to substance abuse and mental health issues. We have a team of therapists that recognize that and we initially take that through our intake through use of our medical screening at the beginning. Our classification gets involved; they start to do a treatment plan with these individuals. However, our length of stay of individuals in our institutions is about 8.5 days. We do have several people who are judge sentenced at our institution who take advantage of these programs. These programs are all voluntary, we cannot make them go to these programs. We try to initiate these programs to get them involved. One of the things we are trying to do is bridge the gap from the therapeutic community that we are trying to establish inside of our institution and the disconnect that we have on the outside with the wrap around services in our community. We want to bridge that gap. We want to work hand in hand with all of the wrap around services. One of our obstacles within our institution is providing all this therapeutic care inside an institution by giving them a continuous case plan. But once they leave then it kind of stops because there are not a lot of resources of wrap around services for those individuals to follow up on in the outside. We are continuing to do a continuous case plan on these individuals because we know they are coming back and we want to gather that data to see where they are going after they leave us. I think it is very important to know that we also provide family education programs in our institution for those individuals who are identified as substance abuse users and bring the family inside of the facility. We have done that a few times already and have a group family setting that we are trying to work with in identifying the problem within the family as well and our therapist is working with them. Again our biggest obstacle is that once they leave we have a disconnect and we are trying to bridge that gap. I know that

with the behavioral health committee at Christus St. Vincent Hospital, we are working to try to find a place or alternatives for incarceration for those individuals who come in with us during different cycles. That in a nut shell is what we are doing in our facility

The Chair asked Mr. Sedillo to address the Trinidad Model.

Mr. Sedillo: The Trinidad Model is part of the behavioral health committee at Christus St. Vincent's, we are going to do a site visit in mid-December to see a placement center which is like a crisis intervention center where the arrest officers or agencies will take them to this place in lieu of going to incarceration. It could be for possession of marijuana, drugs, alcohol abuse. They have a triage team there that makes the assessment and work with that individual and the individuals in the family. However, this place is strictly voluntary and they can walk out the door as soon as they get there. That place location at Trinidad is trying to identify those individuals to work with them and their families. A report will follow.

Questions:
What are the actual programs that are available when they are not incarcerated? Does a list exist?

Ms. Briscoe offered brochures from SF Recovery Center (Exhibit A)
Santa Fe Recovery Center is an outpatient as well as an inpatient substance abuse treatment center in Santa Fe. Some of the others that we have throughout northern New Mexico I am not aware of if they are private or non-profit organizations.

Mr. Boschelli: In the state of New Mexico they currently have core service agencies set up in Santa Fe County which covers SF County, Los Alamos County and Rio Arriba County. The adult core service agencies run by Presbyterian Medical Services (PMS) under the service of Santa Fe Community Guidance Center. That is outpatient, psychotherapy for mental health issues but also for substance abuse issues so we use the term behavioral health. Additionally for that same area for the adults is Life Link which is the second core service agency. How they really want this set up according to the state is to funnel all types of clients to these two core service agencies. For children it would be Teen Builders, which is the core service agency for these three county areas.

Mr. Sedillo: What is the waiting list?

Mr. Boschelli said there is not to be any waiting list at any agency. I have to say the official term but in reality there is same day service delivered to decrease the revolving door. If I can address the services at Christus St. Vincent's; in addition to being a Clinical Director at PMS I am also a Clinical Director for Christus St. Vincent's at the Care Connection which has encompassing the Sobering Center which has a 15-bed unit for individuals with substance abuse issues to be in-patient stay for up to a week. Christus St. Vincent's two years ago decided that community wide

they were not doing enough to help the revolving door of the emergency room as well as the detention center. Christus St. Vincent's did not just look at it as an issue hitting them only. They put together what they call a High Utilizer Group, as Pablo has said, the "frequent flyers". We try not to put a negative stigma to that but call it a high utilize group. Of that, we did a 3-year study of the highest utilizers of the emergency department which you know is about an 8 hour stay. There is a reason for that, the number one reason for that is 80 of those services are used by 10 of the individuals. Those 10 are who we have targeted for the high utilizer group. We broke it down to 25 high utilizers who have spent most of their days in the emergency department and/or in the Santa Fe Detention Center. Christus put dollars behind that and partnered up with PMS to enroll these 25 high end utilizers in to what is called assertive community treatment. They even scholarship these individuals, they paid their bills; that is what they did. They did not have to do this, in fact little known fact is that Christus St. Vincent's was well compensated in the emergency department to have these people repetitively come in. They decided to take a step back and said, "Let's do this differently." As a result of those 25 high-end utilizers and we are talking about these were the most frequent flyers in to the detention center, the decrease of emergency room contact by these top 25 has been over 61 in the year and a half span. That is correct, I can actually go in when I have a broken bone and get treated instead if the 8 hour wait we experience. They have been excited about this program and it is getting national attention as well as attention from the Center for Medicaid Services (CMS), asking how you actually do this. This model is being replicated very similarly, it actually comes from King County and the LEAD program comes from King County. We did our same research but on the behavioral health side not the law enforcement side that you presented from the LEAD agency and that is exactly what they did, they set up a continuum of care service delivery system. This way when they were in the detention center there was coordination to the outpatient core service agencies. From the core service agencies, if they showed up in the emergency department, the emergency department would call those core service agencies – please take these people out of the emergency room. That is taking place at this time, which is what is causing the 61 decrease of increased hospitalizations, removing them from the emergency room and decreasing the behavioral health unit hospitalizations also. It impacts just about everybody at this table because these are the same individuals who do the petty crime for any type of electronic gear to get substances, they will steel from our houses and then sell it. They end up in detention centers so as a result we have a relationship with treatment courts, with homeless courts, municipal court, all of the Judges because these are the same set group of individuals that one, have shown how to do outpatient treatment. They stop showing up in everybody else's domain. This is what is already established in our community and we can build upon this in a much more conjoint fashion.

Chair: I would like to mention that this is exactly the idea behind the Treatment Harm Reduction services work group is to do exactly that, to do define what that model looks like without re-creating the wheel. Asking the question, what does that treatment model look like and who can do that in our community.

Ms. Laura Brown: Physician at Life Link and the Recovery Center – I have been working in the area of addiction medicine for a number of years now. It bears repeating and reminding ourselves, there is a glaring gap in treatment services for on-going maintenance therapy for both alcohol and opiates in Santa Fe. There is access for sober centers and detox facilities and for acute care but for someone who has to be seen not just in the detention center but on the outside in the community, I think we need to keep that front and center. There is a lack of treatment available for people who are not inpatient in a facility.

Mr. Boschelli: The Sobering Center is their substance abuse Behavioral Health outpatient program.

Ms. Briscoe: We do have a waiting list. We have a certain amount of beds at Santa Fe Recovery for indigent, a certain amount of beds for self pay insurance and beds for Native American contacts and county contracts. If we were just indigent we wouldn't be able to be sustainable so we need to have a mix of funding sources because if wouldn't be enough to pay for the 22 beds.

Mr. Boschelli: Those who have been targeted to go from the sobering center to Santa Fe Recovery have been these high end utilizers. They have been successfully placed through Santa Fe Recovery then linked to further outpatient services from Santa Fe Recovery. There have been basically 5 of these individuals who would usually circulate through all of our service delivery systems, end up in the back behind Trader Joe's passed out and then go back to the emergency room and be the highest cost delivery with the lowest bang for their buck. We purposely put them through the Sobering Center in thru Santa Fe Recovery and we have had the best outcomes in that service design. Back to back, they seem to have the longest period of sobriety, a number of these individuals end up in treatment court because they have had numerous misdemeanor cases against them, numerous times in front of the judges. They would like them to be on treatment court. As an outpatient provider, I actually like that too. The ankle bracket is a great investment in our community, it helps cause sobriety and maintain sobriety. It has been a successful tool. Even though we have to show up at treatment court with these consumers we actively bring them to treatment court. Basically they would $1 million dollars each year out of all of our budgets and now we are not seeing that at all. We do have a system if more forcefully funded or it doesn't even have to be more forcefully funded, is the collaboration works quite well.

Ms. Briscoe: We have someone right now who would not meet criterion for state funding because the Sobering Center has been pretty much helping him/her to not let him/her go back out in the street for 2 weeks. We know that during the holidays this individual is going to go out there and drink or end up being in the hospital over and over again so we need to keep him/her in a safe environment for the next 30 days to make sure that doesn't happen.

Ms. Ferlich: I am curious about the funding stream for indigent clients and is the criteria really limiting. Are you just seeing people that are homeless that are coming in or is it the people that have crime around addiction.

Ms. Briscoe: The (Santa Fe) county has invested in buying a certain amount of beds there is more flexibility in who we can take in to Santa Fe Recovery Center. The criteria in general for somebody coming in for the state is pretty much someone drinking in the parking lot, someone who is in the environment that is not conducive to recovery such as a partner who drinks frequently also medical necessity. Another criteria would be asking if they have ever tried outpatient service before, which I think is not a bad idea. When we first opened we wondered, does this person have a home to let them in, it is not a good use of state funds. We have to follow criteria in order to give them a bed. When we first started it was a revolving door for us as well. Somebody comes in, they relapse and we bring them back in. Have you tried outpatient, did you follow your discharge plan, did you meet with your sponsor, were you going to meetings, did you go to outpatient treatment and if the answer is no to all that then let's try that first. If we see that you are continuing to drink than residential is more appropriate. We look at the appropriate level of care to see what is more appropriate for the individual. It is the same thing with Insurance, they are very strict about who comes in for treatment. You have to meet that criteria or you are encouraged to go outpatient; outpatient is a very viable way of getting recovery. In fact a majority of people get recovery in an outpatient setting.

Mr. Boschelli: So the question for their state dollars called BHSD (Behavioral Health Substance Abuse Division Dollars), for basically any outpatient services for co-occurring clients whether they go to Solace, to Life Link, whether they go to the Santa Fe Community Guidance Center under PMS. The criterion is they have to be what is called core service agency eligible. What that means is a major mental illness plus usually a co-occurring disorder. If they meet that, they are granted as much outpatient services as needed. There are no questions about that, there is no penalty, and there are no limitations about that. The difficulty is that it is outpatient service delivery. In other words, if they don't show up again, they are probably out doing things we don't want them to be doing. There is one exception which is the assertive Community treatment teams run by PMS. This is the team that goes out and finds the clients, there are 55 select clients; they are the highest end utilizers in our community. We actually go out and visit them, if they never show up again, we are there under the bridge literally, finding them, bringing them back in to treatment, bringing them back in to outpatient services. Assertive community treatment is known as a hospital without walls and literally that is the way we operate, prescribing wise, nursing wise, therapy wise, we go out and find the 55 assigned clients. This is the program that has been basically highly utilized by the program out of the hospital. It has been that successful because the program doesn't wait for the clients it goes to the clients.

Ms. Ferlich: Do the users have to be diagnosed with mental illness to get this service?

Mr. Boschelli: Yes.

Ms. O'Connor: I just want to differentiate, Santa Fe County provides a lot of funding for indigent clients as well. It funds some of the programs here; we also fund a whole list of providers that do substance abuse or mental health or a combination of that. It is hard to tell when we are looking at all substance abuse providers or opiate providers, that slims down the number of providers significantly and probably to PMS, Women's Health Services, Santa Fe Recovery Center and Life Link.

Mr. Boschelli: Similarly, Christus St. Vincent's had $450,000 of their St. Vincent's Foundation dollars that they decided to dedicate to agencies that have agreed to work with the high end utilizers. This was a significant change this year instead of just giving out money to agencies that said we need money because there are 85 agencies saying they needed money. They have decided to only fund the agencies specifically agreeing to work with these high end utilizers. That took some political will to make that decision to be a little unpopular with the community however targeting the neediest individuals who are utilizing all of our resources. With that you have an extra bed at St. Elizabeth's Shelter for medically recouping individuals as well as a women outpatient bed at the Casa Familia Shelter. Both of those are getting funded by Christus St. Vincent, as well as La Familia, PACT Team – PMS – solely focused on those individuals that end up before law enforcement. We contacted detention centers and they are eating up our medical bed at the detention center because they can't go in to populous. We then go work with the judge and ask if they can put them on ankle bracelet they are part of the PACT program. You do see some of this revolving door but it is a quick revolving door. That is really how you have to start the program. You GPS the kids; with the ankle bracelet we can track and find out where they are and find out if they have blown dirty. If the judge wants to throw them back in the detention center and if they do the judge will do it for 2 day to show them a lesson then back outpatient. Outpatient services are where there is ample funding, however it is harder to treat. It is better to treat inpatient because you know where they are at. Literally you have them, they are sober. But that is not where beds are going to be at.

The Chair asked Mark how many of the 25 high utilizers are opiate users.

Mr. Boschelli: 10 that are opiate pain utilizers and we have not been able to successfully address them as emergency room contacts until we participate in the opiate group. That is where they are going to be addressed best as they are prescribed opiate individuals as well as street opiate individuals. They tell everyone they are going to die but they are not the ones that are going to die. They are the ones that go to the emergency room for treatment but they are not the ones that will have difficulty. The ones who are using heavy amounts of alcohol actually seizure and die, the ones using high amounts of benzodiazepines actually seizure and die. The opiate users, when they show up in the emergency room, they just want medications and unfortunately we have done what we call intermittent reinforcement at times we give them some opiates and other times we don't. The emergency department at this time

has stopped giving out opiates for pain individuals. This has caused somewhat of a crisis for our community, on the other hand you have to start somewhere so Life Link has seen an increase of these individuals as well as Women's Health Services, and Santa Fe Guidance Center also works with them. We have to be a little careful on how we squeeze this bubble because it is going to come out somewhere else.

Chair Kaltenbach: The Mayor has asked us to look at the opiate users in relationship to property crimes and this group can make recommendations beyond that. What we have decided to do is to look at the high end users that are opiate users and are potentially committing property crimes. Does the committee have thoughts about broadening that? Do we think that this is a good target group to start our LEAD program with?

Ms. Brown: One perspective would be to include like we have with SOS, prescription drugs, Santa Fe Opiate Safe. A lot of us have acknowledged the ultimate is benzodiazepine and when mixed opiates, those are the people that over dose and die. Detox from benzodiazepines is problematic also from alcohol. One wan to broaden it slightly to say prescription drug as opposed to just opiates.

Chair Kaltenbach: The question here with our whole group is 1) we are reducing the harm and improving the health of our community as well as reducing the crime and make a safer community as a result of addiction really leading to criminal acts in our community. We don't need to have a full discussion but I would like everyone to think about them as 2 goals that develop this model. It is a mixture of drugs so we do have to approach treatment from that perspective and then the question to law enforcement; "who are those individuals that you see re-occurring through the system that are addicted to opiates."

Mary Sky Gray: Harm Reduction - Attempt is to reduce harm, not necessarily to get people in to treatment so we are funded by the state to do harm reduction in Rio Arriba County. We have a client base that is very trusted in terms of the relationship we have built with them, we do Narcan training and our staff has saved people's lives and reversed the effects of over does. We have clients that are trained and can save each others' lives. It is effective and it is amazing that the state funds us as it is a controversial program. We work really hard with law enforcement to make sure that people understand is not only with people. We do food distribution, needle exchange (we exchange one dirty needle for a clean needle), womb care (we have a nurse that goes out with us once a week) and one of the key components to harm reduction is meeting the client where they are at and working with what you have to get them where they need to go. Where they think they need to go not where we think they need to go. When they are ready for services we work with Santa Fe Recovery Center and others to help connect them with their services. We have exchanged about 40,000 needles a month if not more in Rio Arriba. This year about 3 lives have been saved and since the program came in to existence there were probably about 20 lives saved. The other piece that is very important is that any client that we work with has to register so there is a card and a process and we track it with the state, we

have strong risk management policies and procedures to help with the safety of the client and the staff. Need to build a trust base as some are afraid to talk.

Healthcare for the Homeless is now available for needle exchange and Narcan Monday through Friday, 8am to 5 pm from a recent grant from the state to support that. There is also some outreach through the Santa Fe Resource and Opportunity Center, Tuesday and Friday (former Pete's Pets) for needle exchange and Narcan.

Do we know how many needles are exchanged?

Those statistics will be gathered from the Health Department. Sky will assist in getting those statistics and information will be sent to the committee by e-mail.

Chair: What I am hearing is that we don't have one centralized document that lists all of our treatment and harm reduction and social support services, or does that document exist?

Ms. Terri Rodriguez: There are different kinds of versions that come out at different times, the one that tries to keep up with the services in the community is the Adelante Program of SFPS and she puts out a comprehensive list of where to find services in Santa Fe.

Chair: That sounds like something that this group has to have especially when addressing treatment resources. We will definitely pull together a resource list for our internal work so the working group has a basic clearinghouse of resources.

Ms. Lewis: There are some on line resource lists – My Community.org and also the social service resource directory. A new one that is coming on line will also have on-going support services to assure that the information is up to date.

b. Legal System Overview –Sheila Lewis – What were the other alternatives.
(A chart has been put together by Ms. Lewis that she will e-mail to the committee, not provided to the stenographer).

There are good things about the problems, everything works a little bit for some people but may not be great for everyone. You can get several types of disposition, sentenced or go to jail or get a conditional discharge or a deferred sentence. It will be complicated as it will say one thing on paper but the courts have interpreted them differently.

List of problems
With a conditional discharge it can be used for habitual purposes, it you get one prior you get one year, two priors you get four years, 3 priors you get eight years added on to this new crime you are charged with and it can be done by each count. If you are picked up for felony this and felony that, several of them, you could easily rack up 24 years for minor crimes because it is habitual. The Judge has opportunity to not

approach that window of opportunity. You don't want that window to be so big that people go to prison because they have committed a minor crime but they have a record for a prior felony. The other bad thing about conditional discharges and deferred sentences is that they can be found on the internet now. To be in the program you cannot have any prior felony convictions for any crime in the prior 10 years, cannot have been revoked for unsatisfactorily discharged from probation, cannot have participated in a similar program in the past 10 years. If you mess up in the program and you are kicked out you are really out for 10 years; that is a long time to be out. The most important one on pre-prosecution aversion is no _____, or you are automatically out and any possession of a significant amount, and significant not being a legal term it is up to the Judge to decide what the Judge thinks is significant and the DA. Ultimately what can happen is the DA can say, "I don't like this guy, he has been around the block too many times or he just doesn't have the right attitude." He/she could be out of the pre-prosecution aversion.

Drug courts can be great and I will comment in general terms as I don't know specifically about drug courts in Santa Fe. The criticism of it is that they cherry pick, they want successful numbers so they are picking people in to drug court, screening for people who are going to succeed. Granted there are people who don't succeed, they don't succeed at the emergency room, they continue to come back and back. Drug court doesn't work for that population for sure. Also, there are penalties for violations and a violation of drug court can be anything from a positive urinalysis, etc., making bad choices, going to jail for a couple of days. People on substance abuse don't make good choices. Booking people in and sending people out is a labor intensive concept and that turn around doesn't help them and it certainly doesn't help the people. In general, they take low level offenders and those aren't the people that are committing the crimes, it doesn't do a lot for public safety. There was a great bill introduced called Alternative to Incarceration and it really did a lot of things, ended a lot of problems and basically said that someone could get arrested, case could be put on hold and if they finished the program the case would go away. It is the best offer we have had this far and the Legislature has bought in to it several time but the Governor has not signed it. So that is not an option right now but may be it will be at some point.

There is something call re-entry drug court, which I would say probably has not been heard of. Re-entry drug court is something that the department of corrections can go to the judge who has the case of a particular individual and say, "we believe this person is ready for community service". The Department of Corrections with limited resources, I don't know about lawyers either, it requires that the individual go through this very labor intensive process, and to the best of her knowledge it has never been done. The Judges don't want to do it, they put in their sentence, they remember the guy the day of sentencing they don't know what he is like now, 8 years later and they don't want to take the chance so they are very reluctant.

We have plain Penalties. Penalty for a small amount of marijuana, lots of ways around it; that can go away, that is not the big problem. It is possession above 8 oz.

which is a felony here. Trafficking of any amount is a felony and people need to understand what trafficking means. In the movies, people tend to pass around a joint, which is trafficking. Once you hand any amount of drug to another human being that is traffic so it is possible for people to be arrested for what we might think is a very minor amount of charges but they look like trafficking charges.

I have old statistics on Drug Crimes from the Department of Corrections.
21% of all people in prison are in for drug crimes with a minimum of 5 year stay.
One that was most interesting was 39.9% of women are in for drug charges and 19.2% of men are in for drug charges.

Other resource information that can be sent to the task force members:
Penalties for Convictions, how many years can you get for a crime.
Paraphernalia distribution.
Statute for re-entry drug court.
2005 – Data from the Sentencing Commission on the percentage of those in prison on drug crimes.

Mr. Kopleman – The Association of Counties contracted with the Sentencing Commission to update the survey that they had done for us in 2004. It doesn't deal with prisons but it deals with jails. (Mr. *K*opleman will get a copy over to the Staff Liaison for distribution to the task force.)

Ms. Lewis commented that Mo Maestas is the sponsor of the bill – Relating to Control Substances and Substance Abuse and Crime Prevention Act.

Chair: A note on that bill, it was not pre-booking. If it we are looking at pre-booking diversion the Act that was introduced was very much in the Judges control. They have the authority to decide if someone would actually be diverted in to treatment or not. That person would have already been booked and perhaps incarcerated and charged and that is when the diversion occurred. What we are charged to look at is the pre-booking.

Ms. Lewis: It is critically important and that is one of the reasons I wanted to present this. Once you are in the booked system all the way in you have a life sentence. A life sentence is you will not be able to get a job or a house, etc., I have to say I have so many people that tell me that their life is over because they can't get these things off their past record. Whether it is a conviction or an arrest they can't past it.

Chair Kaltenbach: I want to add one more thing before we go to questions; I spoke to DA Spence Pacheco today, she wanted to extend her continued support for this project. They are very much committed to making this happen. What she is most concerned with is that if there isn't a treatment system then we won't be successful. She is asking this group to put some energy at the front end to creating that model and developing but she also shared with me some data from the pre-prosecution program that they are running. In 2001they had 124 individuals in their pre-prosecution

program, of that 55 were there for possession. Of those, 44 were successful which meant that they followed through with their individualized plan. It didn't necessarily mean that they didn't reoffend but they were successful. This year so far there are 100 referrals for the pre-prosecution, 50 are for possession and so far they have had 4 not be successful. Their success rate is going up. DA Pacheco wanted everyone to know that and they are committed and they will figure out their legal part.

Ms. Briscoe: One of the challenges is the Judge will insist that they go to treatment; that is the way of getting out of going to jail. However the challenge of that is if you have been there for 3 months you are no longer meet criteria for treatment so you could rot away in jail.

Sheila: Am I correct that I heard that when people get out of jail and they want to go in to treatment the treatment provider says that you haven't been out long enough to demonstrate your commitment to sobriety.

Ms. Briscoe: No, it is not a commitment it is just that it is so much time that they haven't used then they no longer meet criteria for state funding and they would need criteria for health insurance.

Mr. Sedillo: That may change because now that we have a therapeutic community inside our facility with treatments with licensed therapist who deal with their addiction. That could change and we advocate for that to change, this is why we are doing the continuous case plan for these individuals.

How do we know they are sober in jail?

We do ask that, did you use while you were in jail?

Mr. Sedillo: Getting in to public safety that is a big issue inside institutions because now we have curtailed contraband coming in to our facilities. Now what is happening is they are getting arrested for misdemeanor charges such as shop lifting, vagrancy and they are the mules that come in. They already know that we are stopping the contraband coming in from a lot of other sources and now they are getting charged for misdemeanor charges. Last week we found 12 needles, x-amount of packages of heroin on a misdemeanor charge. I talked to the individual and he said he was supposed to bring it in. We are stopping that quite a bit. I am a big proponent of zero tolerance in our institutions. I have been in corrections for many years and I can tell you it will never be stopped but as long as you can control it. We have had over 76 referrals to our Sheriff Department that we have stopped contraband coming in to our facilities by people with misdemeanor charges because that is the word in the street. Get arrested for petty charge and bring in the stuff and we are catching it daily.

Mr. Boschelli: What is the term pre-booking mean if that is what we are sanctioned to look at? I need to know what that definition means because it seems pretty acute

and we would need to set up an acute situation that actually gets addressed before they show up anywhere else.

Chair: I can speak to it from the LEAD model in Seattle, but that is a question for these work groups that will have to determine eligibility and what that process. There is a model process work group and that is a question for that group to actually come back for a recommendation and also eligibility workers will prove eligible. The pre-booking in their model is that an officer who may have otherwise arrested someone may have taken them to the jail to be booked. Instead, the paper work is filled out but that person is actually handed off directly to a case manager who works in that treatment program who does an individualized care plan and assessment at that time. So there is a warm hand off from the arresting officer so to speak to the case manager. So that person never technically gets booked in to the jail. They could get booked in to jail at a later date and that is the question for the eligibility work group, we need to decide who is eligible. Using the Seattle example, if someone near eligibility is that they can't be a violent offender, they may have had a control substance but they cannot have had a violent past. Let's say that if at that time of the arrest that violent past wasn't identified, the DA in their model can actually say no, this person is not eligible for that diversion, in fact, they should be booked. That is why the paperwork actually gets developed in case there has been a true arrest in booking a person at a later date.

Mr. Boschelli: That seems from my naivety 24 hours very quick so they don't show up at the detention center, and we have law enforcement who want to get back in to the street. I don't want to speak for law enforcement but they want to get back in to their patrols.

Chair: I don't know if law enforcement will speak to this, this is a good segway to hear from law enforcement.

Municipal Court: Represents the pre-prosecution and I refuse to saddle a young person with something that is going to ruin their lives. I don't have any set criteria, but first offenders will get their lecture, if I haven't seen you before you aren't getting a break. I am a member of this community and a human being and I use the care approach. As far as their records go, you are right about the deferred and the conditional discharge. There are a lot of arguments that a conviction is a conviction, no matter what you call it. What is different about municipal court is that we are not on line and because of the sheer volume, we never will be. When I pre-prosecute someone, they are out, it is with me. It is very rare that we have to come to an agreement with the Judge. Municipal court is still different what will show up if they got arrested on NCI forever. Unless they are applying for a high level security clearance job and somebody wants to go to the Municipal Court and ask for a record on that person is probably not going to find it. I wanted to clarify this point of information.

c. Law Enforcement Overview – How does the process work now?
Deputy Chief Johnson/Detective Sgt. Jerome Sanchez:

Once an officer makes the decision to make an arrest, right now we transport them out to Hwy. 14 to the detention center. That process from the time they leave the scene and start driving out there could take anywhere from 30-45 minutes to several hours depending on the individual. It depends on the amount of paperwork, whether it is a felony charges, misdemeanor charges, whether or not the person has a medical problem or has recently used or is intoxicated and needs to get medically screened. Sometimes they have to get transported back to St. Vincent's hospital. It varies and typically I would say that process is about an hour to an hour and a half.

Mr. Boschelli: So, we would want to mimic that time, is that correct, ideally? At least mimic what they are use to.

Chief Johnson: I am providing just a rough average. It could be shorter or it could be much longer. I don't think an hour or so would not be a realistic goal. When Officers are spending a lot of time at the jail facility and then maybe if they have to transfer them back to the hospital and wait not knowing how long that will take to get them back to the jail, that is a lot of time the officer is not out in the street doing the proactive work they need to be doing.

Sgt. Sanchez: We will need to have some type of data base that we will have to utilize because there are different offenders at different times of day so some of the officers may not know all of the players so you might get even a rookie officer also that doesn't know the frequent flyer, the guy we are trying to target. There has to be something developed with us to see if the individual is eligible or not. If we can get everything streamlined it would reduce all of that paperwork and we could do the screening process and hand the person over and the officer is back on the street. If there is any follow up on paperwork we can attain that and get it to the DA's office.

Ms. Lewis: Q: Is everyone on COMSTAT and are these records on arrests that officers make whether formally or informally is there a need to keep your numbers up? Would there be a way for those officers who are involved in those programs to get out of that mentality and not count as they are not booking them? I am not sure how you can compensate them for the time it takes.

Deputy Johnson: We did away with that system several years ago, it does not exist. In my opinion it used to be like a report card. We are not looking for quantity we are looking for quality. We are looking for the probable cause. We used COMSTAT not to evaluate the productivity of our officers we look to see where our resources should be focused.

Mr. Boschelli: Do you know who the offenders are? I ask because there are a number of treatment providers in this room and we know who we have in treatment. My difficulty is I don't want to be blind leading the blind because a number of those

individuals could possibly be in treatment. Maybe unsuccessfully but preferably be in treatment. According to work ethics I cannot tell you who they are, but I would not like to be duplicative and say that we have to put them in treatment when they are already in treatment. I bring this up because this is one of the first things we noticed at Christus St. Vincent's, the repetitive people, if they were linked up to services it was easier to dust off that linkage and say how do we make that linkage stronger and successfully. Low energy, low amount of input but target that individual because they are already linked up. Similarly, it seems that we have offenders that are repetitive petty crime offenders who are trying to get whatever electronics that they need for substances; that would be helpful to know. I am trying to narrow down this field because we saw that on an individual basis and that is how we decreased the high utilizers in the emergency room services. We had to be specific, it wasn't global, it wasn't a statement of what we wanted to do with the group we just said let's get this individual in treatment.

Deputy Chief Johnson: I believe I know where you are going with that and yes, collectively we could probably come up with a list. Each different industry or group here could come up with their own list, but what I would suspect is that most everybody in this room either has some type of regulation, rule or policy or law preventing them from sharing information. What worries me is that my group may not match yours or the next groups, and so on. Collectively we need to find a way to circumvent all of these restrictions and find out who we can best offer these services to. (Personal opinion) It is my experience in the past that everybody has their own area of expertise and I think I mentioned this before, their own little pot of gold and they are looking for help yet we never sit down and collaborate. We never say how can we address and solve this problem. I think we can come up with a good list of who we think would be the best candidates if we share what we can share.

Chair: One of the questions we should ask and the model process group should have this conversation is that again, the Seattle group (use as an example), the person has to consent and say yes. They have a choice, "do you want to go to jail or do you want to get deferred into a case management care." Through that consent process they could say, "Do you allow us, taking into consideration of the HIPAA rules, to check if you are currently in treatment." There could be a way to share that information.

Deputy Johnson: It is easier for us to share our information with you vs. the agency sharing with us. To be honest with you, I don't think we would really want to know as I don't think that serves the purpose.

Mr. Boschelli: How this has worked really well successfully with Christus is that Christus would say, "This is our problem child, here it is." We are able to work with the detention center around that problem child as well as work with at least one or two of the outpatient clinics. Through discussions we collaborate with the information and without violating HIPAA I think we can possibly work with this situation. It works quite well and in my view it would be driven by law enforcement as you have people who are repetitively showing up in the back seat of your patrol

cars. I am interested in these people and not that I want them arrested. I am looking at this timeline.

Sgt. Sanchez: They don't have to be arrested for us to refer them. We don't have to arrest them and if we can get them treatment that is fine by us. The people I am running in to on a day-to-day basis are somehow missing this whole connection. The people I am chasing around aren't getting the services or are lying to me or you.

Mr. Boschelli: I bring that up because Albuquerque has the Coast program which works in that exact direction and in that manner of those problem individuals but they want to link them up to treatment. They visit them, they link them up to the Behavioral Health outpatient program; they put them on the radar screen. I have a client who was the #1 member of the SF Detention Center and the Emergency room who has been sober for 8 months for the first time in this person's life. This person talks about his current run in with local police departments in a positive way. The law enforcement police officers are seeing this individual and can tell how sober he/she is. Patient talks about this on a daily basis which is the design of the Coast Program from Albuquerque to reward positive behaviors. It is being done already, that framework is already designed and I see law enforcement officers practicing that behavior already.

Mr. Allena: I want to speak to a macro issue that I am hearing having consulted with the state of California on their initiative with the California Department of Corrections and Rehabilitation and also the University of California. They have put a lot of money into these issues like we are hearing right now on capacity building within the system. If you throw all of your resources at the offender that you are trying to get into the program, you don't build capacity with all these agencies sitting around the table. There is a piece on capacity building which the Chief has spoken to. I think there are many other topics we haven't touched on and maybe it is the work of the model work group. What we found across 63 counties that I worked in California is we had to basically bring stakeholders to the table and do the collaboration, do the trust building, do the sharing of data, and that was a critical piece for that programs success. But if we didn't put money in to building that type of capacity within all of these different stakeholders and all you did was throw money at agencies, it wasn't pre-booking diversion it was in this particular case, alternative….. What we found is it was good use of money to strengthen the local communities and I don't think we should lose sight of that. I think there are macro issues that are going to come up and it going to be a culture change for us. The change in the culture was every bit important of the agencies which is another issue that police officers don't want. So how do you help the street officers, check this policing model that we are introducing to them, what kind of capacity can they handle? There are a lot of capacity moving features. How do we process an offender though the system.

Ms. Ferlich: Question to build on that culture piece; how do you come to arrest these people? Are you looking for these people who are drunk or are doing drugs?

Deputy Johnson: Giving you our upfront and honest answer, no, we are not out looking for them. Right now our staffing levels are such that we cannot afford to. Our officers spend and overwhelming majority of their time in reactive response calls. They go from one call to a next. How we are getting these? Some are coming in from our bicycle officers that are patrolling downtown. Those are probably aside from overtime assignments, proactive patrol and majority coming in from the public, traffic stops, medical calls where we dispatch police with fire, probable cause is identified. We are not out patrolling river beds and looking for narcotics. Frankly, we do not have the time.

Ms. Ferlich: What do you see as a culture change for the officers?

Chief Johnson: For the young police officer out in the field they have to learn and recognize that arrest is a tool, not a job. That is a tool to achieve to serve the community, arrest is just a tool and sometime they lose sight of this. Change of culture is that there are other means to help people besides throwing them in jail. Often times they may be getting drugs in jail and coming out worse, it affects their lives for a long time or forever. It is important to expand their minds that there are other options available and for them to understanding that these people need help.

Mr. Sedillo: The county facility has emulated what law enforcement already do and that is practicing intervention techniques. That is identifying the individual upon stop or upon having any type of confrontation with them to identify that type of individual to find out if they have mental health problems, substance abuse problems. That is where culture change is very prominent here in Santa Fe because the SO does it, SFPD does it as well and Santa Fe County Detention Center is the first detention center in the state of New Mexico who has gone through crisis intervention techniques. When we get them in our facility, we need to identify those individuals and know how to talk to them and to identify them as having mental health problems. We have about 50% of individuals coming in to our facility who have mental health problems. We are doing a lot of triage within our facility. The Culture change has already been established and they are not just booking, they are identifying those individuals upon a call. I always see the Fire Department and Santa Fe County dealing with this and I have spoken to the Fire Chief to get that crisis intervention techniques for their EMS who respond to those calls within the county when they get to an individual who may not have all their senses together at that time. That culture change has been established and I know in talking to Police Chief Rael, Assistant Chief, Sheriff and Undersheriff, they have to go through that crisis intervention techniques annually.

Katherine: Is that after arrest?

Mr. Sedillo: No, this is prior to the arrest, when they get to the call that is the very first thing they have to establish to see what kind of individual they are going to be dealing with. That is what we do inside of the facility too when they bring them to

us. I think that culture change is now being established about identifying those kinds of individuals and how to deal with them.

Ms. Ferlich: Percentage of the time that you find drugs on someone? Is it an automatic arrest?

Chief Byford: It depends on the amount and the type of drug because there are some things that are an automatic arrest. Weed is going to be much less, so it all depends.

Katherine: Anything other than weed?

Deputy Johnson: Anything other than marijuana they are going to get charged for it.

Chair: Statistics – We need to remember that these are the number of arrests not the number of interactions or encounters. We get that question a lot when we talk about this model. How many people are we talking about? Again, this is just with the Santa Fe Police Department.

Erica Garcia, Operations Manager, Espanola, Taos and Chimayo: State Police – As a State Agency we always use discretion. If that Officer believes that the individual needs to be incarcerated we will recommend that. If we start dictating that they will, than we have taken that Officers discretion away from them. It is important that the Officer know that we believe in their discretion. I don't recommend that. Going back to the original question from earlier; the amount of time that we are going to take to seek assistance for the detainee could take a bit longer. Let me back track a little bit more, the time it takes to for us to deal with the prisoner is anywhere from 2 1/12 to 6 ½ - 8 hours depending on if we have to transport them to Las Vegas because Santa Fe County Detention center cannot take them. To answer your question in regards to incarceration, the contact time that we have with them – 2 ½ hours to 8 ½ hours and sometimes 10-15 hours. If you delegate an officer to watch a prisoner because he/she may need the assistance, it depends on our location, time varies according to location. As you noted earlier, the exchange needle program in Espanola, Rio Arriba county together with the Department of Health take in anywhere from 40,000 to 80,000 needles exchanged monthly. So where do you succeed. My recommendation is getting them the help, keep the needle exchange program. The last thing I want to do, if they want my Officers to protect and arrest, is to put them in a situation where they can be contaminated with HIV or hepatitis. Yes, I encourage the LEAD program. State Police is dealing with 4 counties and more time. It was noted that there are 57 Officers in that area.

Deputy Johnson: Reported Offenses – 1 year July 1, 2011 to June 30, 2012
Crimes reported to dispatch; these are inputted in to the CAD system.
Narcotic Violation – 1
Control Substance - 4

Possession of Controlled Substance – 158
Possession of Marijuana > 8 oz. – 4
Possession of Marijuana < 8 oz. – 101
Trafficking a controlled substance – 10
Distribution of controlled substance – 9
Possession of drug paraphernalia – 184

Those are just what the officers wrote a report on where that was the primary offense.

Arrests in the same time frame.
4 – Opium, Cocaine, Heroin
5 – Sales of marijuana
4 – Sales of synthetic manufactured drugs
74 - Possession of Opium, Cocaine, Heroin
118 – Possession of Marijuana or Hashish
39 – Possession of synthetic manufactured drugs
1 – Possession of other non-narcotic barbiturates
Total: 245

This is what is reported in the CAD so these numbers are difficult to say they are 100% accurate because in some of these cases where we have reported, there are crimes that are reported as second or third charges that don't show up here. The numbers are actually higher than these as the numbers reflect the primary charges.

Municipal Judge: Are these only arrest numbers?

Deputy Chief: I can't answer that as this was provided to me specifically to arrests. I would suspect that there are misdemeanor charges, these are just arrests.

Cathy: Are these the primary charges? What are the secondary charges?

Deputy Chief: The primary charge that is reported which is the highest charge; it is really difficult to drill down in to our records management system which is archaic. The key thing to take away from here is the problem is greater than these statistics and it is hard to extract that data from our archaic system.

Laura: Could we pull a file and list out the charges for those 100 arrests which would be a percentage to find out what percentage are drug related.

Chair: Eligibility criteria needs to happen first, if someone is arrested for domestic violence or heroin, if we first ask that question and ask the eligibility worker to find out who is eligible.

Sheriff: Individuals who we deal with are on multiple things, alcohol, cocaine, mostly multiple drugs on board.

Sheila: Do we need to identify the drug itself, the problem is there.

Sheriff: You may have an individual burglarizing a home but it could be a DUI.

Chair: We will provide this to the Eligibility/Treatment group and then ask what reliable data they need.

d. What is the meaningful data that we need?

The Chair would like all groups to meet in December. Next full meeting is December 10th from 1- 5 pm.

Work Groups:
Model
Legal Eligibility
Funding Cost Analysis
Treatment Service Group
Steering Committee

We can help find space, and organize those meetings should assistance be needed. I will connect with each of the group contacts with guiding questions.

F. Old Business

a. Core Values/Principles: What do we want to accomplish? What are the measurable objectives?

G. Sub-Committee Assignments
None

H. Next Meeting December 10, 2012 – 1 pm – 5 pm (Model Development)
None

I. Adjournment
The attendees broke out in to group sessions. Documentation was ceased and the Chair allowed the Stenographer to stop recording and to be excused. (5:45 pm)

Signature Page:

Emily Kaltenbach, Chair

Fran Lucero, Stenographer

LEAD Task Force Members:

Name	Signature	Email Address
Alfred Perez		
Bennett Baur		
Bill Dimas		
Cathy Ansheles	Cathy Ansheles	cathy@nmcdla.org
David Coss	not appointed member - excused	
Emily Kaltenbach	Emily K	
Eric Garcia	Eric F. Garcia	eric.garcia1@STATE.NM.US
George L. Ortiz		
Jayde Archuleta		
Jeneen Lujan	Jeneen Lujan	jglujan2@gmail.com
Jerome Sanchez	Jerome Sanchez	jmsanchez@santafenm.gov
Jessica Dimas		jessdimas@gmail.com
Kate Ferlic		~~egat~~ ferlic law.com kate@ ~~egat~~ ferlic law.com
Kathy Armijo Etre		- excused
Ken Johnson	K. J.	KJohnson@SantaFeCounty.org
Krishna Picard	K Picard	Khpicard@Santafenm.gov
Laura Brown	Laura Brown, MD	lbnewmexico@gmail.com
Marcela Diaz	Marcela R	Marcela@RT66.com

Maria Jose Rodriguez Cadiz mjrodcadiz@findsolace.org

Michael Delgado

Milagro Castillo

Pablo Sedillo, III PSedillo@SantaFeCounty.org

Patti Bushee – excused

Rachel O'Connor rocanor@strivety.org

Raye Byford raye.byford@tesuque-tribalpolice.com

Raymond Chavez

Shelia Lewis SHELAIN-SANTAFE@GMAIL.COM

Spence Pacheco

Stephen Branch

Steve Kopelman skopelman@nmcounties.org

Thom Allena thomalna3@aol.com

William Johnson wjohnson@santafenm.gov

Yolanda Briscoe ybriscoe@sfrecovery.org

SKY Gray sky@santafemc.org

Mary

GUESTS	Organization	Email
Mark Boschelli	Presbyterian Medical Services	mark_boschelli@pmsnet.org
Richard DeMella	City of SF	rndemella@santafeNM.gov
Brian Byrnes	Santa Fe Community Foundation	BBYRNES@santafecf.org

SANTA FE
Recovery Center
THE PATH TO RECOVERY

Yolanda Basoco Briscoe, M.Ed., PsyD.
Executive Director/Clinical Psychologist

Sylvia Barela, MBA
Chief Operations Officer

4100 Lucia Lane
Santa Fe, NM 87507

PHONE: 505-471-4985
FAX: 505-471-6084

www.sfrecovery.org

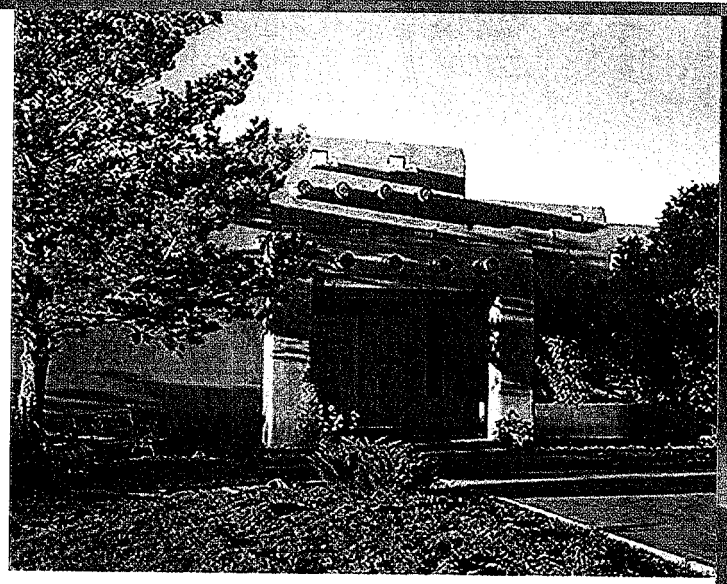
SANTA FE
Recovery Center
THE PATH TO RECOVERY

The Santa Fe Recovery Center is a CARF accredited program that provides evidence based services in the treatment of chemical dependency in residential and outpatient settings in both English and Spanish. We have a psychiatrist on staff as well as two registered nurses, a licensed psychologist, social worker, and mental heath and addiction counselors.

Care Philosophy

Santa Fe Recovery Center brings years of collective experience in helping individuals struggling with the devastating affects of addiction. High quality treatment is provided in a compassionate and caring environment.

- Client centered and self-directed treatment
- Capitalizes on the strengths and resilience of clients, families, and communities
- Encourages personal responsibility for sustained health, wellness, and recovery
- Contact with client continues after acute stage of treatment
- Recovery support services are extended to family members



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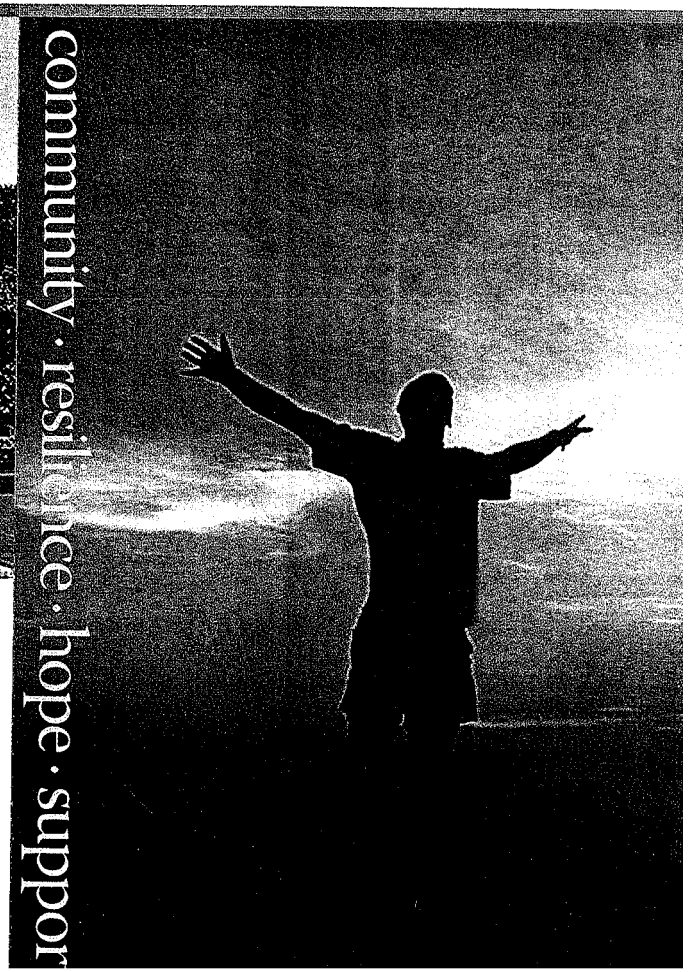


Our Mission

The Santa Fe Recovery Center works with individuals to sustain resilient lifelong recovery from alcoholism, addictions and related mental illness. We provide culturally relevant evidence-based treatment and education in partnership with other community organizations.

Our Values

We operate with integrity and treat each client with compassion and respect in a safe, nurturing environment.

Residential Program

- 3-7 Day Detox
- Up to 30 Days of Residential Treatment
- 12 Step Model
- Community Reinforcement Approach
- Cognitive Behavioral Therapies
- Motivational Interviewing
- Family Workshops
- Yoga
- Acupuncture
- Spirituality

care

Outpatient Program

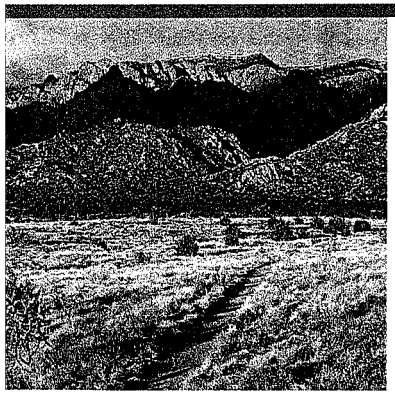
- Intensive Outpatient
- Regular Outpatient
- 12 Step Model
- Matrix Model
- Focus on Lifestyle Change
- Training on Relapse Prevention
- Cognitive Behavioral Therapies
- Motivational Interviewing
- Family Involvement
- Locations in Santa Fe and Española

Admissions

For information regarding admissions, please call (505) 471-4985. We offer a free screening to assess for appropriate level of care.

For our Española outpatient program, please call (505) 747-8302

We accept most private insurance including Aetna, Blue Cross Blue Shield, Cigna, Lovelace, Presbyterian, and United Behavioral Health. Payment may be submitted by check, cash, or major credit card. Our billing department offers support with payment options.



"Santa Fe Recovery Center was a great place for me to come and get sober and learn tools to stay sober. The staff was amazing in creating a warm and caring atmosphere that allowed me to focus on my recovery." – MARY M.

compassion