

## Substance Use Disorder Treatment and Outcomes in New Mexico

### AT A GLANCE

New Mexico has long had some of the highest rates of alcohol and drug abuse in the country, and the problem is getting worse. Since 2001, the combined rates of alcohol and drug related deaths in New Mexico rose by more than 60 percent. In 2018, 2,081 New Mexicans died due to alcohol or drug addiction, more than any previous year. In some counties such as McKinley, one in four deaths among working age adults is due to alcohol. Between 1990 and 2018, the state death toll was over 38 thousand, and by 2018 deaths due to substance abuse accounted for 11 percent of all deaths. Counting deaths is the standard way of estimating the scope of the problem, but we know many thousands more people, along with their children, families and communities, struggle with substance use on a daily basis. The problem is multi-generational and driven by complex underlying issues, such as poverty and trauma. In addition to the human toll, the social and economic costs rise every year: healthcare, domestic violence, child abuse, loss of productivity, incarceration and crime.

In 2018, the New Mexico Human Services Department spent over \$117 million in state and Medicaid funds to provide services to people with a substance use disorder (SUD) diagnosis – nearly double the \$62 million the state spent in 2014. In addition the state received over \$29 million in federal substance abuse grants. This brief will review the many ways this funding has improved access to critical SUD services. Medicaid expansion has brought more people into the behavioral healthcare system than ever before, and non-Medicaid SUD services have seen higher utilization as well. The state's harm reduction effort targeting drug overdoses through the widespread availability and use of naloxone, a life-saving drug that reverses opioid overdoses, has been very successful.

The counties have been active in addressing SUD as well, and this brief will explore important developments in three counties with high rates or numbers of substance-related deaths and injuries that have recently received an influx of public funds to target the problem. Over the last five years, the state has funneled \$5 million into Behavioral Health Investment Zones in McKinley and Rio Arriba counties, whose drug and alcohol-related death rates lead the state. Bernalillo county has collected over \$89 million through its behavioral health tax initiative. In all three counties the money has helped to build service capacity and to kick-start community-based initiatives targeting high-risk populations. But the strategy has also highlighted the slow nature of progress on these issues.

Despite these gains, there are still critical gaps in the system that merit focused attention. Treatment and funding for alcohol dependence, the deadliest SUD in New Mexico, does not meet the scale of the problem, and though effective medications exist for alcohol, as for opioids, they are chronically underutilized. Evidence-based treatments are largely absent in New Mexico's jails despite high rates of substance abuse in the incarcerated population. Similarly, hospital emergency departments are a potentially key intervention point, but nearly half of hospitals in New Mexico do not even stock the drugs used for medication assisted treatment in their pharmacies, and the state has an overall shortage of providers who are able and willing to prescribe these drugs.

Effectively addressing substance abuse is difficult, in part, because it requires overcoming pervasive stigma. A wide body of research shows that SUD are best understood and treated as chronic illnesses. Yet too often they are instead viewed as symptoms of moral failure. Stigma can prevent people from seeking help and providers from offering it, and it can dissuade the public and policymakers from pursuing bold solutions. Framing SUD as a moral failing does not allow us to make the critical connections between the disease and its origins in social determinants like poverty and childhood trauma, and creates ambivalence when action is needed. New Mexico will not get ahead of this crisis until we replace stigma with informed understanding and respond to SUD as the public health crisis it is.

**Health Notes** are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.



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### Major New Mexico Substance Use Disorder Policy Milestones

2000	Federal Drug Addiction Treatment Act opens the door for using buprenorphine for medication-assisted treatment.
2001	Good Samaritan legislation protects people who administer an opioid antagonist (naloxone).
2004	Interagency Behavioral Health Collaborative created.
2005	Prescription Monitoring Program created; expanded in 2012, and strengthened in 2016 and 2017.
2007	911 Good Samaritan legislation protects people who seek medical attention for someone experiencing a drug overdose. First in the nation.
2014	Centennial Care and Medicaid expansion bring behavioral health coverage – with some SUD-related services – to 250,000 more New Mexicans.
2014	Bernalillo County votes to impose new behavioral health initiative tax.
2015	Legislature appropriates funding to create behavioral health investment zones in McKinley County and Rio Arriba County.
2016	Legislation authorizes a standing order for naloxone, which means people do not need an individual prescription to legally use or administer the medication. Also creates overdose prevention and education programs who can receive naloxone from DOH for distribution.
2017	Opioid Overdose Education legislation mandates naloxone education and distribution by federally-certified opioid treatment centers and local and state law enforcement agencies, and tasks state and county jails with providing inmates with naloxone and training in how to use it upon their release.
2019	Centennial Care 2.0 adds new behavioral health services to the state’s Medicaid benefit, including some for SUD, through new 1115 demonstration waiver authority.
2019	Legislation amends the Pain Relief Act to require that healthcare providers educate all patients receiving a new prescription for opioid pain medication about the dangers of overdose and offer all these patients a prescription for naloxone.

This brief will begin with an introduction to substance use disorder (SUD) — how it affects the brain, what the trends and costs are for New Mexico, and how SUD impacts children, adults and families. The report will then turn to a discussion of evidence-based ways to treat SUD and how access to those treatments has improved over the last five years. The last section of the brief will delve in some detail into county-level efforts to address SUD in Bernalillo, McKinley and Rio Arriba counties. The brief concludes with a summary of what appears to be working in New Mexico today, what approaches or policies appear to hold promise, and where the state’s greatest remaining challenges lie.

## Introduction to the issue

For years, society viewed alcoholism and drug addiction as reflections of personal failure — a result of poor choices, weak character and a stubborn unwillingness to change. This moralistic view of addiction stigmatized people struggling with substance use. It was evident in the language used to describe them — junkie, crackhead, drunk — and abstinence-based approaches to treatment that emphasized admission of one’s character flaws as a necessary precursor to recovery.

Today, though stigma persists, the moral model of addiction has been supplemented by an extensive body of research on the effects of substance use on the brain. The research suggests that substance use disorder (SUD) is better viewed as a deadly but treatable chronic illness, not unlike diabetes or asthma. As an addiction specialist and psychiatrist who recently conducted an opioid training and research institute hosted by the New Mexico Attorney General’s Office put it: “Addiction is a brain disease whose visible symptoms are behaviors.”

Drugs and alcohol affect the brain’s reward center, stress response and executive function. When we ingest an addictive substance, it stimulates the same part of the brain that food and sex do, producing dopamine, a key chemical in the brain that transmits feelings of pleasure. Yet the effect of drugs is especially potent: whereas eating and sex both increase dopamine concentrations, cocaine has about twice the impact and methamphetamines increase dopamine levels by as much as five times more than these other pleasurable activities. When the brain’s reward circuits are stimulated, they not only produce feelings of euphoria, but also create memories. Scientists believe dopamine plays a direct role in rewiring the brain to encourage the repetition of pleasurable behavior, or habit formation.

The cruel irony is that, with repeated drug use over time, the positive effect diminishes and the negative effects associated with withdrawal increase. The brain begins to produce fewer receptors for the pleasure chemicals, making it impossible to recreate the first high even while taking drugs more frequently and in higher doses. At the same time, activity kicks up in the region responsible for fear. The absence of the drug or even a waning high triggers a stress response. Using again temporarily calms the feeling of fear, but it never again produces the same euphoria. This helps explain why some substance users say they no longer use to get high but to “get well.” Finally, neuroscientists have also found that substance misuse impairs the prefrontal cortex, making users less rational and more impulsive, and contributing to behaviors that foster stigma, such as stealing, secrecy, and missing work or personal obligations while seeking out substances.

These changes to brain circuitry persist even after a person discontinues use of the

This report is based on the Human Services Department’s Medicaid and non-Medicaid costs and utilization.

The two Department of Health facilities that provide SUD treatment—Turquoise Lodge Hospital (TLH) and the New Mexico Rehabilitation Center (NMRC) —serve a population that is largely eligible for Medicaid and are able to bill much of their costs to Medicaid.

This report also does not include an analysis of behavioral healthcare for the state’s justice-involved population. The LFC plans to complete a program evaluation on that topic in 2020.

Substance use disorder (SUD) is best understood as a potentially deadly but treatable chronic illness, not unlike diabetes or asthma.



problematic substance. But exactly how the brain recovers, and how long it takes, is not well understood. According to a major 2016 report on addiction from the U.S. Surgeon General, “little is known about the factors that facilitate or inhibit long-term recovery from substance use disorders or how the brain changes over the course of recovery.”

Medication-assisted treatment, or MAT, combines psychosocial counseling with U.S. Food and Drug Administration (FDA) approved medications – methadone, naltrexone or buprenorphine – and has been demonstrated to be safer and more effective than either psychotherapy or medication alone.

The neurological insights we do have suggest promising avenues for treatment and reinforce the necessity of approaches like medication-assisted treatment that act on the brain and are proven to work – when ‘work’ is understood to mean learning to live with and manage the illness, rather than die from it. Medication-assisted treatment, or MAT, combines psychosocial counseling with U.S. Food and Drug Administration (FDA) approved medications – methadone, naltrexone or buprenorphine – and has been demonstrated to be safer and more effective than either psychotherapy or medication alone. Even so, the stigma associated with addiction has not disappeared and remains a significant obstacle to broadening access to effective treatment. Despite the evidence base for MAT for opioid dependence, for instance, doctors must undergo special training and receive a license from the Drug Enforcement Agency to prescribe these drugs. Numerous doctors interviewed for this report indicated that stigma within the medical community prevents their colleagues from obtaining these licenses or utilizing them fully, and that stigma can make the leadership of health systems hesitant to implement comprehensive addiction programs for fear of becoming a magnet for ‘those patients.’ Though it is widely known that people with SUD frequently spend time in jail, only two county jails in New Mexico make MAT available to their inmates. One warden interviewed by LFC staff indicated that while his jail offered group therapy for substance abuse, its medical program did not offer MAT because the provider was philosophically opposed to treating addiction with drugs.

According to the National Survey on Drug Use and Health (NSDUH), nearly one in ten New Mexican adults – and one in six young adults between 18 and 25 years – have an SUD.

While research on the biological basis of addiction provides compelling evidence for treating it as a medical condition, an effective policy response must also consider the other factors that contribute to the development of the illness. After all, not everyone who takes a pain pill or drinks a beer will develop a substance use disorder. One’s risk of substance use progressing to misuse is influenced by genetics, age, other mental health issues, and social and environmental factors including childhood trauma. Some of these risk factors are particularly relevant to New Mexico. Stress and trauma in childhood in the form of abuse, neglect, poverty, and parental substance abuse or mental illness heighten one’s risk of developing an SUD later in life, for instance. It is thus likely no coincidence that New Mexico has the second highest poverty rate in the nation, one of the highest rates of childhood trauma, *and* high death rates from drugs and alcohol.

The fact that substance abuse is, in many cases, a symptom of complex underlying issues makes it a problem that demands a multi-pronged solution involving multiple levels of government, health providers, the criminal justice system, and community organizations. The population in need must be identified and connected to services every time they touch the system. Touchpoints and interventions include primary care physicians doing screenings, brief interventions and referrals to treatment (SBIRT); emergency department doctors initiating MAT; addiction consults in hospital inpatient units; social support plans for all infants born exposed to substances and their families; community-based law enforcement programs that divert low-level offenders from jail to treatment; and MAT programs in county jails and state prisons. Models for each of these approaches exist within New Mexico communities today, but in most cases they are the exception not the rule.

**New Mexico’s high prevalence of substance use disorder costs the state billions and led to over two thousand deaths in 2018.**

According to the National Survey on Drug Use and Health (NSDUH), nearly one in ten New Mexican adults – and one in six young adults between 18 and 25 years – have an SUD. For many people, substance abuse begins young: almost 10 percent of young New Mexicans between 12 and 17 years reported having consumed alcohol in the previous month, 6 percent reported binge drinking (defined as four or more drinks at a single setting for woman and five or more for men), and possibly most concerning, only 45 percent thought drinking five or more drinks once or twice a week posed a serious risk. Fewer than half of adult respondents perceived heavy drinking as risky.

The estimated lifetime cost of an illicit drug use disorder in New Mexico is \$245 thousand whereas the cost of an alcohol use disorder is \$154 thousand.

The cost of SUD is substantial. The CDC estimated the cost of excessive alcohol use alone in New Mexico in 2010 was \$2.2 billion. National research suggests that SUDs can lead to a number of costly outcomes including chronic disease, higher health care costs, property loss, and lost productivity. For a number of years the LFC has worked in partnership with the Pew-MacArthur Results First Initiative to examine evidence-based policymaking using tools including cost-benefit analysis and assigning value to outcomes such as SUD. Based on this approach, the estimated lifetime cost of an illicit drug use disorder in New Mexico is \$245 thousand whereas the cost of an alcohol use disorder is \$154 thousand. Given the prevalence of substance use disorder in New Mexico, the potential cost to the state and to those suffering from these disorders is substantial.

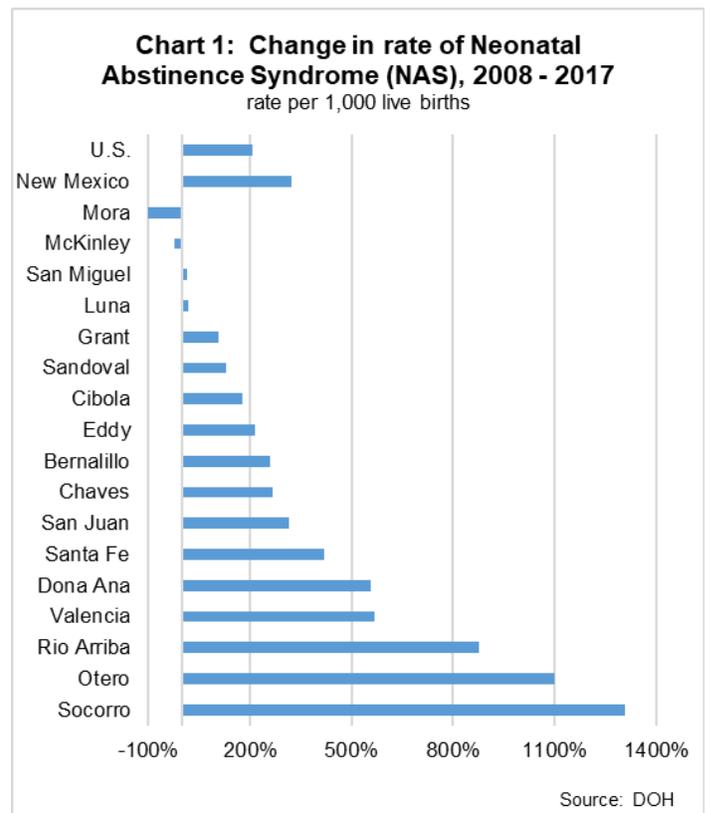
**The state’s poor performance on most key social determinants of health contributes to the prevalence of substance use disorder and the gravity of its outcomes.**

Although there may be biological and genetic predictors of SUD, social determinants can have an impact also, and play a particularly significant role when considered in the multigenerational context of the state’s challenges. New Mexico’s overall poverty rate was 19 percent in 2017, significantly higher than the national rate of 13 percent. Over one in four New Mexican children under five were living in poverty in 2017, compared to one in five nationally. Other early social determinants include whether a baby is born healthy and whether she suffers childhood traumas.

***The impact of substance abuse begins before birth.***

An increasing number of babies are being born in New Mexico with neonatal abstinence syndrome (NAS). NAS and neonatal opioid withdrawal syndrome (NOWS) occur when a pregnant woman uses drugs and her baby is born dependent on those drugs. The drugs involved may be illicit or prescribed: key MAT drugs methadone and buprenorphine can be the source of dependence in NAS cases, and buprenorphine has also been shown to help reduce NAS symptoms in infants. NAS babies are more likely to have low birthweights and respiratory conditions, among other complications, adding to the challenges – and the costs – of caring for mother and child.

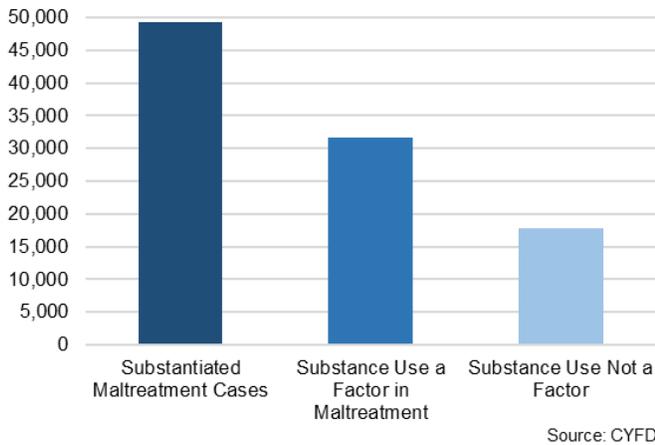
The increase in NAS births is a national issue; between 2008 and 2014 (the most recent year for complete data), the



rate of NAS in the country rose from just under three NAS cases per 1,000 live births to eight cases, a nearly 200 percent increase. Between 2008 and 2017, the rate in New Mexico increased from slightly over three NAS cases per 1,000 births to 14 cases, or 324 percent.

Fully understanding the dynamic at work with NAS in New Mexico is beyond the scope of this brief, but more – and better – data would be useful for program administrators and policymakers alike. The Department of Health (DOH) currently collects data only for the broader NAS category, and has pointed out the need for more training around early diagnosis of NAS and a standardized case definition for NAS to improve the accuracy of its estimates and help the state develop more robust health policy in this area.

**Chart 2: Substance Use and Child Maltreatment, 2014-2018**



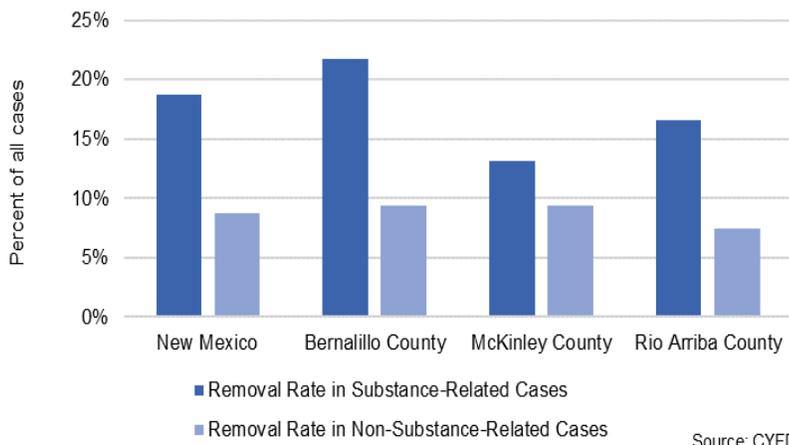
**Substance use disorder has a debilitating effect on families and long-lasting consequences for New Mexico’s children.**

Substance use disorder (SUD) plays a significant role in some of New Mexico’s most troubling and persistent social issues, such as child maltreatment. Investigators with the Children Youth and Families Department (CYFD) substantiated over 49 thousand of the 166.6 thousand allegations of child maltreatment the agency received from 2014 to 2018, meaning they found credible evidence of abuse or neglect. Abuse of alcohol, drugs or both was a factor in 64 percent of the substantiated cases.

Substance abuse also significantly increases the likelihood that child victims of maltreatment will be removed from their homes and placed in foster care. In substantiated cases of maltreatment involving substances, CYFD removed children from their homes at a rate more than twice as high as cases that did not involve substances.

Most of the cases CYFD opens for foster care are due to neglect, and because SUD can affect an adult’s ability to safely parent, it is a common cause of neglect findings, according to Protective Services officials. The risk appears particularly high in a child’s first year of life. CYFD substantiated 5.3 thousand cases of abuse or neglect of children less than one year old where an SUD was involved from 2014 to 2018, more than double the number of cases for any other age group. Cases in which substance abuse was not a factor did not show the same pattern.

**Chart 3: Removal Rate of Child Victims of Maltreatment, 2014 - 2018**



When SUD contributes to a child’s removal from the home, timely access to treatment – either inpatient or outpatient – is critical to eventually reuniting them with their families. However, Protective Services officials report

that parents and their case managers often encounter waiting lists. Wait times and the cyclical nature of SUDs, in which relapse is common, can make it more difficult to achieve reunification within 12 months. Of three thousand children who exited foster care from 2015 to 2019 and whose cases did not involve substances, 55 percent were reunited with their families and 30 percent were adopted. A lower percentage of the 2.3 thousand children who exited foster care and whose cases did involve an SUD were reunited with their families and a higher percentage were adopted – 47 percent and 42 percent, respectively.

**Children in New Mexico experience childhood trauma at one of the highest rates in the nation.**

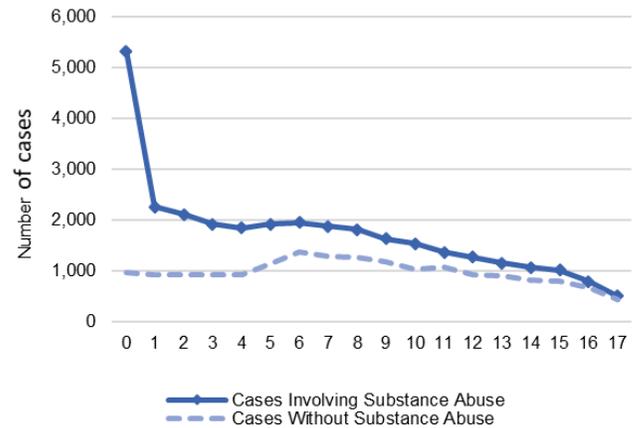
Abuse, neglect and substance abuse in the home all qualify as “adverse childhood experiences” (ACEs) – a categorization of sources of stress and trauma that have been determined to impact a child’s health and wellbeing for years to come. Childhood experiences play a crucial role in brain development and traumatic life events can have profound negative impacts. ACEs have been linked to numerous poor health outcomes including substance misuse in adulthood. Some researchers have linked ACEs to up to two-thirds of drug use problems. The CDC believes prevention of ACEs could reduce heavy drinking by up to 24 percent. Studies have found that children who experience four or more ACEs are at significantly higher risk of developing SUDs as adults. Based on the 2017-2018 National Survey of Children’s Health, in New Mexico, 27 percent of children have experienced two or more ACEs, compared to 19 percent of children nationwide. Indeed, among the 220 youth who were incarcerated in New Mexico in 2011, 86 percent had experienced four or more ACEs, according to a 2016 study by University of New Mexico researchers. Substance abuse in the home was among the most common ACE, with 80 percent having experienced it. A still greater number – 96 percent – struggled with SUDs themselves.

All of this points to the importance of early intervention and prevention in breaking the multi-generational cycle of substance abuse and trauma that plagues New Mexico. The Plan of Safe Care bill passed by the Legislature in 2019 presents an opportunity for the state to step-up its efforts on this front by identifying more families in need of intervention and connecting them to necessary services. The new law requires hospitals to notify CYFD anytime a baby is born exposed to substances. CYFD is then responsible for creating a plan of care for the child but can do so without opening a formal abuse or neglect case against the parent. Along these lines, the Abuse and Neglect Multilevel Response System bill passed by the Legislature in 2019 creates the framework for an additional access point for families who encounter CYFD, through reports of abuse or neglect, to receive assessment of need and connection to services.

**Between 1990 and 2018, over 38 thousand New Mexicans died as a result of a drug overdose or an alcohol-related condition.**

In adulthood, an SUD can impact physical and mental health, productivity (as evidenced by cost estimates above), and ultimately may lead to death. Over the last 30 years, nearly 10 thousand of the deaths in New Mexico were due to drug overdose,

**Chart 4: Victim Age in Substantiated Maltreatment Cases**

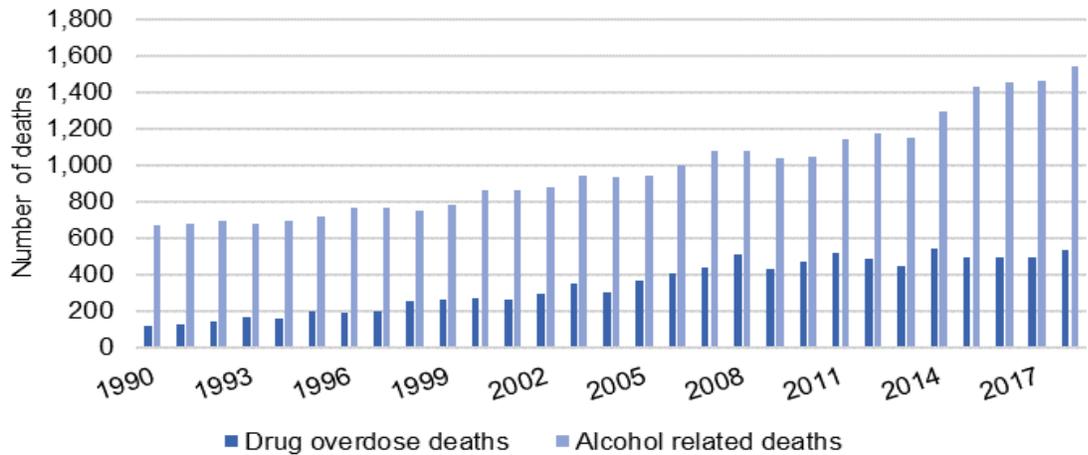


Source: CYFD

In 2018, SUD deaths accounted for 11 percent of all deaths in the state.

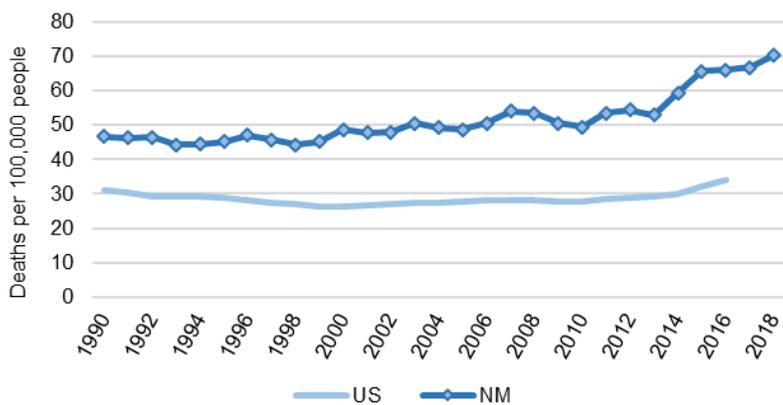
and over 28 thousand were alcohol-related. By 2018, these combined causes accounted for 11 percent of all deaths in the state. Using rates per 100,000 people is the standard of comparison for all causes of death, but rates can sometimes disguise the human cost of the epidemic of substance abuse deaths in New Mexico.

**Chart 5: Alcohol-Related Deaths Outnumber Drug Overdose Deaths, But Overdose Deaths Have Increased at a Faster Rate**



Source: DOH IBIS

**Chart 6: New Mexico's Alcohol Related Death Rate Shows Rapid Increase Since 2014**



Note: final federal data for 2017 and 2018 are not yet available. Source: DOH IBIS

**New Mexico's rate of alcohol-related deaths has been over 50 percent higher than the national average since at least 1990, rising 43 percent from 669 deaths in 1990 to 1,544 in 2018.** New Mexico has ranked in the top three among states for alcohol-related deaths since 1981, and according to DOH, has had the highest alcohol-related death rate of any state since 1997. Alcohol-related deaths as a share of all deaths in the state rose from 6 percent in 1999 to 8 percent in 2018.

Not all alcohol-related deaths are the result of substance use disorder, but alcohol use disorder (AUD) deaths cannot be readily separated from the broader category. For some alcohol-related deaths, alcohol is essentially the only cause of death – alcoholic liver disease and alcohol abuse have historically made up well over half of these in New Mexico. Other deaths are only partially attributed to alcohol,

using a standard formula developed by the Centers for Disease Control (CDC). Further, some alcohol-related deaths are due to chronic diseases that develop over years, while others can happen in an instant. In 2018, alcohol-related deaths involving chronic illnesses, primarily chronic liver disease, made up about 54 percent of the total. Leading causes for the 46 percent of deaths attributed to accident or injury were non-alcohol poisoning, motor vehicle accidents falls, and suicide.

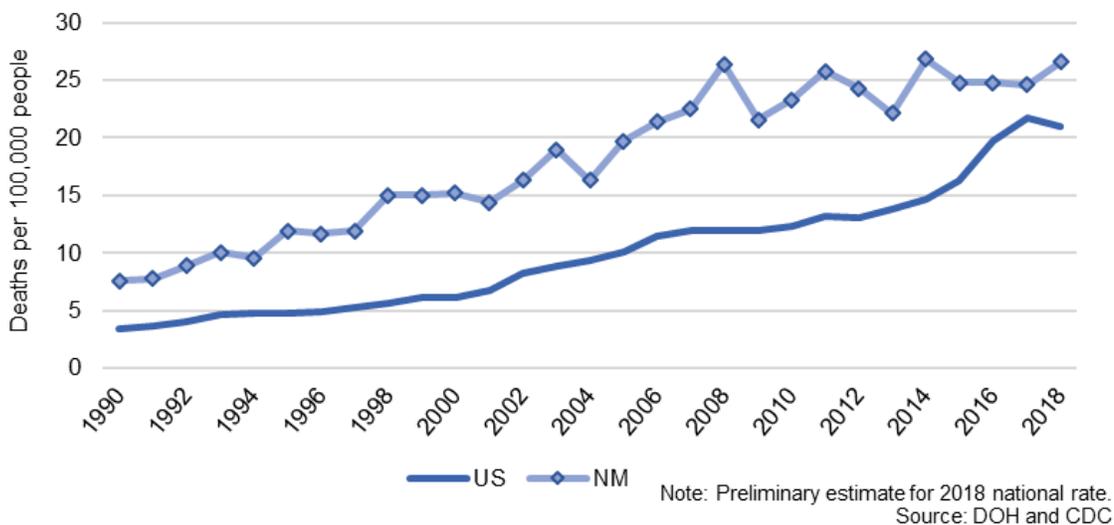
This problem is both widespread and long-standing. Some New Mexico counties have been harder hit by alcohol-related deaths than others, but none have been unaffected: between 1999 and 2018, 28 counties experienced alcohol-related death rates of 50 per 100,000 people or more. For the last 20 years, McKinley County and Rio Arriba County have alternated first and second for the highest rates, and both have been well above 100 since 2006. Cibola, San Juan, San Miguel and Socorro counties have all had persistently high alcohol-related deaths; other counties like Grant, Guadalupe and Mora have experienced more sporadic rates, over 100 in some years, fewer than 40 in others. [Appendix C has a full list of rates for all counties.]

According to a recent CDC study, over half the Americans who abused prescription opioids between 2010 and 2014 were also regularly engaging in binge drinking.

Numerous providers treating New Mexicans for opioid abuse who were interviewed for this brief reported their patients rarely combine alcohol and drugs. Yet according to a recent CDC study, over half the Americans who abused prescription opioids between 2010 and 2014 were also regularly engaging in binge drinking. Combining the two can lead to a much higher risk of overdose or death; greater awareness of this danger, and better screening of all SUD patients for co-occurring alcohol and drug use, could be part of the solution to New Mexico’s high death rates.

**Drug overdose deaths in New Mexico more than tripled between 1990 and 2018 and are substantially higher than the national trend.** For many of the years between 1990 and 2017, New Mexico’s drug overdose death rate – the number of overdose deaths per 100,000 people – was over twice as high as the national rate. Though the gap has narrowed, the change is not due to a decline in New Mexico drug deaths, but rather to the increase in drug related deaths across the nation. In 2017, New Mexico’s death rate was 24.6, very slightly lower than the 2016 rate. But in 2018, the rate increased again, by 8 percent to 26.6 deaths per 100,000 people. Preliminary CDC data indicates drug overdose deaths nationally declined in 2018 by about 3 percent.

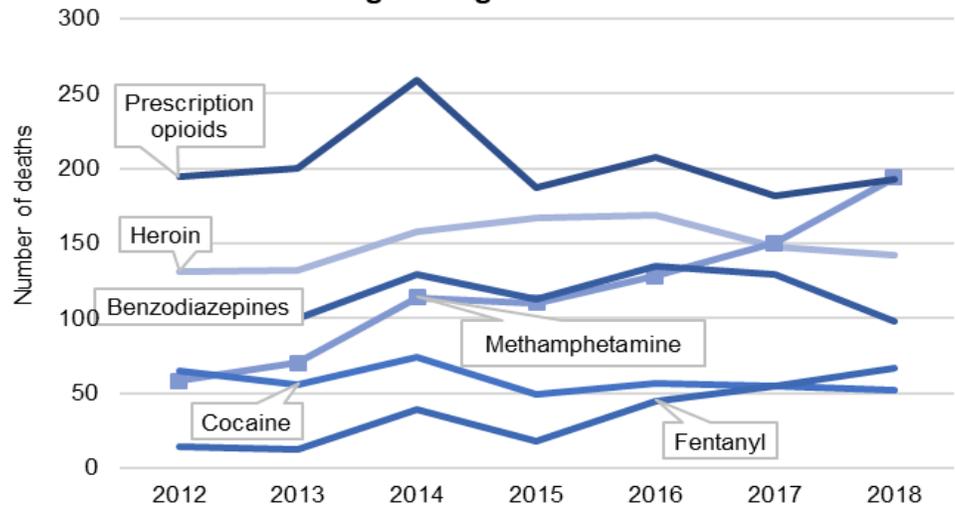
**Chart 7: New Mexico Rate of Drug Overdose Deaths Historically Higher Than National Rate**



**Understanding which drugs are driving New Mexico’s overdose deaths is key to developing effective policies to combat the problem.** Much of the national discussion about SUD – like most of the federal grant funding to address the problem – is focused around prescription opioids. But in the context of a national epidemic of drug overdose deaths, New Mexico has a long, unique and complicated experience.

From 2012 through 2017, New Mexico had more overdose deaths involving prescription opioids and benzodiazepines than illegal drugs, but overdose deaths due to illegal drugs surpassed prescription drug deaths in 2017. Drug overdose deaths are often due to a combination of substances. Opioids, for example, whether heroin, fentanyl or prescription, are made more deadly by the addition of benzodiazepines because the sedatives generally slow down a person’s breathing. Alcohol can have the same effect. The *Rio Grande Sun* does an annual in-depth review of medical examiner reports for drug overdose deaths in Rio Arriba County. For 2018, only eight of the 26 deaths the paper reviewed identified a single drug: four cases of acute heroin toxicity,

**Chart 8: Prescription Opioid Deaths Peaked in 2014; Deaths from Illegal Drugs Continue to Increase**



Source: DOH

**Table 1: Overdose Deaths: Prescription Opioids (non-fentanyl)**

Date	Total Deaths	Rate per 100,000 People
2012	195	9.8
2013	200	9.6
2014	259	12.7
2015	187	9.3
2016	208	10.2
2017	182	8.9
2018	193	9.2

Source: DOH

and two each for cocaine and methamphetamines. The other deaths were due to various combinations of opioids, benzodiazepines, and alcohol; at least seven involved what were likely prescribed drugs for MAT – methadone, Suboxone and buprenorphine. In Department of Health (DOH) data, each drug overdose death is attributed to each of the drugs identified in the victim’s body at the time of death, so although the following discussion is useful to identify trends, the reality is not quite as crisp as it may appear.

**Prescription opioids, excluding fentanyl, caused or contributed to 193 drug overdose deaths in New Mexico in 2018, 36 percent of 537 total drug overdose deaths.** Much of the national debate on SUD has been focused on the terrible toll prescription opioids have taken on communities around the country. The *Washington Post*’s recent in-depth analysis of data from the federal Drug Enforcement Agency (DEA) found

about 76 billion prescription opioid pills were distributed across the nation between 2006 and 2012. In the hardest-hit states – West Virginia, Kentucky, South Carolina and Tennessee – some counties received the equivalent of over 100 or even 200 pills per person per year.

New Mexico has not escaped the epidemic. According to the *Post*, over 522 million prescription opioid pills came to New Mexico between 2006 and 2012. Over 200 million were distributed in Bernalillo County alone, or enough for 44 pills per person per year. Other counties had even higher rates: Sierra County led the state with 73 pills per person, Lincoln, De Baca and Grant counties each received 50 or 51 pills per person, and Valencia, Colfax, Eddy and Rio Arriba counties each absorbed the equivalent of 46 or 47 pills per person. In 2014, the year prescription opioid overdose deaths appear to have peaked in New Mexico, all of these counties except De Baca and Valencia had drug overdose death rates higher than the statewide average of 26.8 – and they were each still among the highest in the state for 2018.

In the years since the timeframe of the *Post*'s analysis, prescription opioids in New Mexico appear to have come under somewhat better control. The New Mexico Prescription Monitoring Program (PMP) is an on-line data repository that prescribers and pharmacies can use to monitor the drug utilization patterns of patients and – most importantly – identify when appropriate use appears to be tending towards abuse. The PMP was created in 2005, expanded in 2012, and then in 2016 and 2017, additional legislation strengthened the requirements that prescribers and pharmacists check the PMP before writing or dispensing any new controlled substance prescription, and then again periodically as prescriptions are renewed. Physicians and other prescribers can check the PMP before issuing a new prescription to see if their patient has filled similar prescriptions recently from another provider, pharmacies can check to see if a patient is attempting to refill a prescription early or in multiple locations, and state licensing boards can review prescribing practices of their licensed providers.

***The prescription monitoring program has clearly helped rein in overprescribing of prescription opioids in New Mexico.*** Data show a 20 percent decline in the number of opioid prescriptions between 2016 and 2019, and a 55 percent reduction in the number of individuals able to fill prescriptions with multiple prescribers and/or at multiple pharmacies. However, the PMP remains underutilized by prescribers – in the first quarter of 2019, only 46 percent of prescribers requested a report for at least a quarter of their patients for whom a report was appropriate.

Given the notable decreases achieved when a minority of prescribers use the PMP, more consistent use of this important resource should lead to even greater reductions in prescription opioid abuse and deaths. Recent research found that when PMPs are poorly implemented, or implemented in isolation from a full array of opioid use disorder (OUD) services, they have a limited effect on overdose deaths and may in some cases be a factor in increasing heroin deaths as people are no longer able to obtain their prescription opioids. Features that make for more effective PMPs include: mandatory registration and use by all providers who prescribe controlled substances, mandatory review when writing new or continuing prescriptions, frequent data updates, and authorization for non-prescribing providers to view PMP data on their patients. Further, implementation of a PMP needs to be done as part of a broader set of public policies that address OUD, such as broader access to MAT, so that patients do not just shift to heroin or other illicit drugs.

New Mexico has not escaped the prescription opioid epidemic. According to the *Washington Post*, over 522 million prescription pain pills came to New Mexico between 2006 and 2012.

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DOH reports there were 2,164 drug overdose reversals using naloxone in 2018.

Opioid overdose deaths have been targeted by two other major policy initiatives. Using primarily federal grant dollars, the Behavioral Health Services Division (BHSD) of the Human Services Department (HSD) developed the New Mexico Opioid Hub, a hub-and-spoke evidence-based model of collaboration between board-certified addiction specialists and primary care providers. The goal has been to expand access to MAT through education about, and support for, best practices in the field. Later sections of this report delve into more detail about the relative success of efforts to expand MAT around the state.

**Another major policy initiative has been to encourage wide-spread use of naloxone, the opioid overdose reversal drug, commonly sold under the brand name Narcan.** The cornerstone of the state’s harm reduction efforts, use of naloxone in New Mexico grew steadily but slowly until legislation in 2016 authorized DOH to issue a standing order for pharmacies to dispense naloxone kits to anyone using opioids or in a position to assist someone using opioids, whether or not the opioid was obtained legally. The same legislation included protections for ‘good Samaritans,’ empowering more people to feel safe taking action in the face of an overdose. DOH issued the first standing order in 2017, and the program grew by leaps and bounds in 2018. BHSD and DOH have been responsible for distribution and training, and the policy was advanced by introduction of an inexpensive, easy-to-use nasal spray that has all but replaced the injectable version. Medicaid billing data shows fewer than 100 patients received naloxone in 2014, rising to over five thousand in 2018. DOH reports the number of reported drug overdose reversals using naloxone increased by 144 percent just between the first and last quarters of 2018, from 376 to 919.

**Prescription benzodiazepines caused or contributed to 98 drug overdose deaths in New Mexico in 2018, 18 percent of 537 total drug overdose deaths.** Benzodiazepines are primarily prescribed as tranquilizers, and they function essentially by slowing down a person’s nervous system. Benzodiazepines are widely available and commonly abused, and are particularly dangerous when taken in combination with alcohol or other drugs because they can impair an individual’s ability to breathe. Benzodiazepines have not received nearly the attention that opioids have, but one major national study found a 67 percent increase in the number of adults who filled a script for benzodiazepines between 1996 and 2013, and a stunning 400 percent increase in the rate of overdose deaths caused or related to prescription benzodiazepines.

**Table 2: Overdose Deaths: Prescription Benzodiazepines**

Date	Total Deaths	Rate per 100,000 People
2012	100	5.1
2013	100	4.7
2014	129	6.3
2015	113	5.8
2016	135	6.6
2017	129	6.5
2018	98	4.8

Source: DOH

One key factor is the correlation between opioids and benzodiazepines. Nationally, opioid prescribing increased rapidly during this time frame, opioids and benzodiazepines are commonly prescribed for the same patients, and, between 1996 and 2013, about 75 percent of overdose deaths attributed to benzodiazepines also involved prescription opioids. The rapid increase in deaths related to benzodiazepines began to slow in 2010, approximately the same time as national attention focused on prescription opioids began to show some positive effects.

New Mexico’s PMP also tracks prescribing patterns for benzodiazepines; from 2015 to 2019, data show an 18 percent decline in the number of patients receiving prescriptions for benzodiazepines, a 24 percent reduction in the number of patients receiving high doses, and – possibly most important – a 40 percent decline in patients with concurrent opioid and benzodiazepine prescriptions. However, the PMP appears to be even more underutilized by benzodiazepine prescribers than opioid prescribers: in the first quarter of 2019, prescribers requested routine

reports for 75 percent of chronic opioid patients, but only 52 percent of chronic benzodiazepine patients.

**Fentanyl and its analogues caused or contributed to 67 drug overdose deaths in New Mexico in 2018, 12 percent of 537 total drug overdose deaths.** While still a small portion of total drug overdose deaths, fentanyl deaths in New Mexico increased by over 370 percent from 2012 to 2018; nationally, fentanyl-related deaths skyrocketed by over 980 percent, from about 2.6 thousand to over 28.4 thousand. Tracking fentanyl deaths is complicated by the fact that while the drug is an effective and widely-used prescription pain reliever, recent years have seen a surge of illegally manufactured fentanyl. Nationwide, overdose deaths involving fentanyl are increasing faster than prescribing rates, and new illicit fentanyl analogues, or look-alike drugs, keep being developed.

Illicit fentanyl is most commonly used as an inexpensive additive to other drugs, like heroin, that has the effect of making those drugs both more potent, and therefore more addictive, and more deadly. Users are frequently unaware there is fentanyl mixed with their usual drug, and the additional unexpected potency has led to a rapid increase in drug overdose deaths involving fentanyl. While at least some fentanyl overdose deaths in New Mexico are related to prescription fentanyl, these factors indicate the increase in fentanyl related deaths in New Mexico is likely driven by illegal forms of the drug. Closer attention to fentanyl prescribing in New Mexico, whether through better use of the PMP or other methods, could help the state get a better grasp on the scope of this problem and possible solutions.

**Table 3: Overdose Deaths: Fentanyl and Analogues**

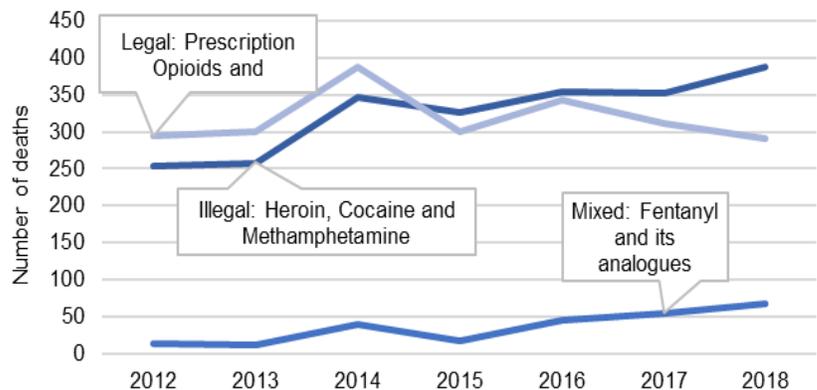
Date	Total Deaths	Rate per 100,000 People
2012	14	0.7
2013	12	0.6
2014	39	1.9
2015	18	0.9
2016	45	2.3
2017	55	2.8
2018	67	3.4

Source: DOH

**As overdose death rates related to prescription drugs have stabilized or dropped, overdose deaths due to illegal drugs have risen.** National studies have found that prior to the 1990s, most people who abused opioids started with illegal heroin – but by the 2000s, 75 percent of people who abused opioids began with prescription pain pills. New Mexico had a problem with heroin long before the 1990s, but there can be little question that the state’s drug epidemic was made worse by the addition of prescription opioids.

The persistence of high overdose death rates even as the prescription pill supply began to dwindle reveals a key complicating aspect of New Mexico’s drug epidemic: many people who struggle with drug addiction will shift from one drug to another depending on availability, price, and need. Some people who become addicted to prescription pain pills will turn to illegal drugs like heroin when they are no longer able to obtain prescription medication or simply because it is cheaper. Some people will be drawn to methamphetamine when a cheap new supply appears in the state, some heroin users will shift entirely to fentanyl when they become accustomed to it, and some people will mix whatever drugs they can find and afford on a given day.

**Chart 9: Overdose Deaths Related to Prescription Drugs are Trending Downward, but Deaths Attributed to Other Drugs are Rising**



Note: One death may involve multiple drugs and be counted more than once. Source: DOH

**Table 4: Overdose Deaths: Heroin**

Date	Total Deaths	Rate per 100,000 People
2012	131	6.5
2013	132	6.9
2014	158	8.0
2015	167	8.6
2016	169	8.4
2017	148	7.5
2018	142	7.2

Source: DOH

**Heroin overdose death rates increased by 29 percent between 2012 and 2016, and then slowed, causing or contributing to 142 drug overdose deaths in New Mexico in 2018.** Heroin overdoses made up 26 percent of 537 total drug overdose deaths that year. The rapid rise in this trend occurred between 2013 and 2014, when the prescription opioid problem was most acute and, at the same time, the first wave of illegal fentanyl appears to have arrived in the state.

State policies regarding expansion of MAT and naloxone distribution almost certainly contributed to the 16 percent drop in heroin related deaths between 2016 and 2018. According to DOH, there were 2,164 overdose reversals using naloxone in 2018.

**Methamphetamine continues to be one of the deadliest illegal drugs in New Mexico, causing or contributing to 194 drug overdose deaths in New Mexico in 2018, 36 percent of 537 total drug overdose deaths.**

According to the Albuquerque Police Department (APD), methamphetamine dominated its drug seizures in 2018 and the first half of 2019. APD made 755 methamphetamine seizures in 2018, representing 29 percent of its total drug seizures for the year. Marijuana was the next most frequently seized drug with 654 seizures or 25 percent of the total, followed by heroin with 603 seizures or 22 percent. So far, seizures in 2019 have broken down at similar rates, with methamphetamine again the most common at 30 percent of seizures, followed by marijuana at 23 percent and heroin at 22 percent.

**Table 5: Overdose Deaths: Methamphetamine**

Date	Total Deaths	Rate per 100,000 People
2012	58	3.0
2013	70	3.6
2014	114	5.8
2015	110	5.6
2016	128	6.6
2017	150	7.7
2018	194	9.9

Source: DOH

During research for this brief, LFC staff heard anecdotal reports about a rise in methamphetamine use from behavioral health providers around the state. APD narcotics officers say the trend is driven by drug cartels entering the methamphetamine market, which has effectively professionalized production, largely eliminated do-it-yourself labs, and made the drug cheaper and more available. Detectives say they've seen the price of methamphetamine drop precipitously, an indication of an increasing supply. In Albuquerque, methamphetamine seems to be more associated with violent crime than other drugs, according to the detectives, possibly due to its behavioral effects, which include paranoia and delusion.

A 2018 LFC report on the Bernalillo Criminal Justice System also found a significant surge in methamphetamine use citing a threefold increase in related emergency department visits from 2010 to 2016. In their response to the report, the Albuquerque Policy Department and the City of Albuquerque acknowledged the surge and tied it to the increase in violent crime in the city.

Methamphetamine addiction is more difficult to treat than opioid dependence because there are no medications that help users abstain and recover. That leaves behavioral therapies as the primary treatment option. Approaches like cognitive behavioral therapy (CBT) have been shown to reduce methamphetamine use, but their impact on long-term sobriety is unclear. In addition, because CBT is just one treatment modality used by therapists and counselors, and not a stand-alone category of treatment, how much it is being used and whether there are barriers to access cannot be tracked through Medicaid data.

## Understanding the basic structure of New Mexico's Behavioral Health System

In the context of these persistent and sometimes overwhelming behavioral health challenges, the state has taken a number of approaches to organize public agencies and resources to get better outcomes. In 2004, after the state's first comprehensive analysis of behavioral health needs and gaps identified critical problems with system fragmentation and lack of access and accountability, the Legislature created the Interagency Behavioral Health Purchasing Collaborative (Collaborative) to coordinate and streamline the scattered behavioral health services provided by an array of state agencies. Behavioral health was 'carved out' of Medicaid and other programs and into the domain of the Collaborative, and a single managed care entity administered provider contracting, coordination and payment.

Ten years later, in 2014, this picture changed dramatically with Medicaid expansion and the implementation of the state's Centennial Care Medicaid waiver program. The Centennial Care program reintegrated physical and behavioral healthcare through Medicaid managed care, and expansion allowed over 250 thousand New Mexican adults to access health insurance for the first time. Under Centennial Care, Medicaid continued to offer extensive behavioral healthcare coverage for children and the disabled, and extended outpatient and community based behavioral healthcare to eligible adults. Adult behavioral health services were mostly in the form of individual and group therapies and coverage for appropriate prescription drugs, with limited short-term hospital stays for stabilization of acute crisis situations.

The Collaborative has continued in its role as payer of last resort for medically or clinically necessary services to clients who are not Medicaid eligible or who do not have another form of health insurance, or for services that are not covered by Medicaid. For example, while Medicaid covers behavioral health residential treatment for children, the Behavioral Health Services Division (BHSD) of the Human Services Department (HSD) has covered adult residential SUD treatment. The BHSD administers the programs, providers and funding for these services using a combination of state general funds and major federal block grants like the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The Collaborative's coordinating role across state agencies also continued, although over the years some state agencies ceased participating as frequently, or even at all.

During roughly the same time as these expansions of services occurred, the state's behavioral health provider network was rocked by a series of disruptions that began with the 2013 HSD audit and suspension of 15 providers and continued through 2015 and 2016 when several of the Arizona providers brought in to replace them left the state. There are signs that the network has begun to stabilize, just as there is strong evidence of a renewed effort under the new administration to revitalize the Collaborative, as evidenced by the development of the first coordinated cross-agency behavioral health budget in several years.

Centennial Care 2.0 (CC 2.0), the Medicaid waiver renewal program that began in 2019, added new behavioral health services for both adult and child populations and offers the promise of a stronger behavioral health continuum at all levels. Of particular note for the SUD population, CC 2.0 added adult residential treatment to the benefit package, as well as longer allowable stays for inpatient hospital treatment and new

There are signs that the behavioral health network has begun to stabilize, just as there is strong evidence of a renewed effort under the new administration to revitalize the Behavioral Health Collaborative.



Persistently high rates of drug and alcohol-related deaths are clear markers that SUD needs in the state far eclipse services.

The most important questions about access are not related to distance or providers per capita. The critical questions are whether you are able to find a provider of the type of service you need, and that provider is accepting new patients, and your insurance, and has a wait time short enough to get the help you need when you need it. These are the aspects of access that New Mexico does not have clear information on.

crisis stabilization services. As of the date of this report, however, few of these services are available to Medicaid recipients yet due to difficulties and delays in implementation, a situation that will be discussed in detail later in this brief.

In addition to behavioral health services provided or covered at the state level, county and even local governments are also involved in the effort to improve New Mexico's behavioral health outcomes. This brief focuses on three counties that have made significant efforts – Bernalillo, McKinley and Rio Arriba – but that is not to suggest that other counties are not also devoting attention and resources to the problem.

**One other key aspect of the state's behavioral health system is the lack of definitive information about the gap between needs and services.** Persistently high rates of drug and alcohol-related deaths are clear markers that SUD needs in the state far eclipse services. Despite nearly doubling state spending on SUD services between 2014 and 2018, despite all of the information to follow in this report detailing how many more people are getting more services today than ever before, we have no precise way to determine just how much unmet need still exists. Previous LFC reports have cited this as a continuing issue potentially affecting service delivery. The Department of Health (DOH) is planning to complete a new gap analysis later this year that could shed more light on the issue.

There are two primary measures of network sufficiency, both of which indicate the state's goal of enough providers and enough services is still far away. The Medicaid program requires its managed care organizations (MCOs) to maintain provider networks adequate to meet the needs of their members, and MCO contracts establish specific geographic access standards for 22 behavioral health provider types. An MCO is determined to be in contractual compliance when 90 percent of its members in a given county live within 30 miles of a provider for urban counties, 60 miles for rural counties, and 90 miles for frontier counties. Previous LFC reports have found significant shortcomings for numerous types of behavioral health providers, particularly in rural counties.

Another way of measuring provider sufficiency is the approach taken by the New Mexico Health Care Workforce Committee, which calculates providers per capita to determine whether New Mexico counties meet national benchmarks. This is the same approach used in the recent report from the U.S. Office of Inspector General about the shortage of behavioral health providers in the state. The fine work done by the workforce committee sheds more light on the provider network in New Mexico than ever before, but even the committee acknowledges that its use of per capita markers is not a true measure of whether our healthcare workforce is sufficient or accessible.

More important than whether there is a provider within a reasonable distance of your home or whether the number of providers per capita appears sufficient, however, is whether you are able to find a provider of the type of service you need, and that provider is accepting new patients, and your insurance, and has a wait time short enough to get the help you need when you need it. There is also no current method for measuring workforce capacity in the context of local behavioral health need. For example, communities or counties with elevated rates of overdose deaths may have an even greater need for access to substance use treatment and providers. These are the aspects of access that New Mexico does not have clear information on.

## Prevention, intervention and treatment options

There is no true ‘cure’ for SUD, but there are prevention, intervention and treatment options that are evidence-based and have well-documented positive impacts.

Prevention/Early Intervention. The state is expanding its focus on prevention, with early childhood initiatives like expanded home visiting, the spread of programs like the PAX good behavior game that helps children develop resiliency and self-regulation, and the creation of the new department for early childhood. Additionally, the state increased at-risk funding for public schools by \$113 million for evidence-based social, emotional, or academic interventions. There is good evidence that these initiatives are likely to provide positive outcomes in the future, but it will be years before we can measure results.

- A 2014 LFC Results First report on programs to reduce child maltreatment discussed the need for an additional access point for families in crisis. In 2019 Governor Lujan-Grisham signed HB376, creating a framework for families coming into contact with CYFD to be assessed for needs and connected to services.
- Additionally, LFC reports consistently cite the potential impact of early childhood evidence-based programs such as home visiting (e.g. Nurse Family Partnership) and parental training (e.g. SafeCare) as a preventative tool that could reduce childhood trauma and provide needed resources for families, potentially preventing long-term poor outcomes such as an SUD.
- DOH cites CDC guidance on prevention for alcohol use including regulation of alcohol outlet density, increasing alcohol taxes, maintaining limits on days and hours of sale, enhanced enforcement of laws prohibiting sales to minors, and clinical best practices such as Screening and Brief Intervention (SBIRT) for alcohol use and abuse.

New Mexico has become a national leader in harm reduction efforts. The tremendous growth in distribution and training for naloxone, the overdose reversal drug, has made the state a stand-out in the national fight against opioid deaths.

Intervention. New Mexico has become a national leader in harm reduction efforts. Harm reduction policies are aimed at meeting people with SUD where they are, with strategies to reduce the negative consequences of their substance abuse and make them safer. Health education, syringe exchanges and safe injection sites are all harm reduction strategies, as is the distribution of naloxone, the overdose reversal drug. The DOH has run a needle exchange program since shortly after passage of the Harm Reduction Act of 1997, but it is the tremendous growth in distribution and training for naloxone that has made the state a stand-out in the national fight against opioid deaths. The Legislature has passed law after law expanding access to naloxone and protecting those who use it from civil liability, and the BHSD and the DOH have done significant work getting this life-saving drug into the hands of people in all walks of life – providers, pharmacists, first responders, family members, and patients receiving a prescription for an opioid pain medication.

Treatment. The LFC has published extensive cost benefit analyses regarding what works in behavioral health and SUD. Detailed analysis on program effectiveness and cost benefit are available in previous LFC reports. A general summary of this work is included below.

- A 2017 LFC Results First report on children’s behavioral health found that strengthening the state’s evidence-based community services would lead to better outcomes and less reliance on more costly acute (and residential) care over time. The report called for better data to diagnose need and matching service and

provider access to that need, along with implementation of evidence-based programming at the community level.

- Similarly, a 2014 LFC Results First report on adult behavioral health found that the existing behavioral health system had significant gaps in services, and encouraged an investment zone approach later pursued by the state through Behavioral Health Investment Zone grants, which used epidemiological data to target additional funding for evidence-based services. The report also cited existing evidence-based services that were available on a limited scale including medication-assisted treatment (MAT), assertive community therapy, peer support, and intensive outpatient treatment. Note that analysis shows peer support models (including 12-step models) tend to be cheaper than other evidence-based approaches, but likely less effective with lower likelihoods of being cost-beneficial.
- A number of LFC reports on the criminal justice involved population also cite the need for evidence-based services at a number of access points in the criminal justice system including while incarcerated and upon reentry to the community. Many programs effective in these contexts are similar to those effective with the general population.

### **Access to behavioral health services focused on substance use disorder expanded dramatically in New Mexico between 2014 and 2018.**

In 2018, the Human Services Department (HSD) spent over \$117 million in state and Medicaid funds to provide services to people with a substance use disorder (SUD) diagnosis, and there is evidence that Medicaid expansion and other initiatives have improved access to treatment. Medicaid spending on just the medication part of medication-assisted treatment (MAT) – prescription drugs that are highly effective in treating opioid and alcohol dependence – increased by 176 percent between 2014 and 2018, from \$8 million to \$22 million. The number of people receiving these drugs increased by 269 percent, from fewer than five thousand to over 17 thousand. Spending on the array of associated outpatient services for people with an SUD diagnosis increased by 78 percent, from \$50 million to \$89 million. The BHSD increased its spending on residential treatment from \$5.2 million to \$13.9 million, and served 1,050 more patients in 2018 than in 2014.

MAT combines psychosocial counseling with FDA-approved medications – methadone, naltrexone or buprenorphine – and has been demonstrated to be safer and more effective than either psychotherapy or medication alone, primarily because research shows it doubles the odds a person will be able to avoid relapse and stay in recovery for at least a year, and the more time without relapse the better.

**Medication-assisted treatment is the standard of care for substance use disorder.** According to the federal Substance Abuse and Mental Health Administration (SAMHSA), MAT is widely accepted to be the standard of treatment for opioid use disorder and can be very effective for alcohol use disorder as well, although there is less agreement about how best to treat other SUDs. MAT combines psychosocial counseling with FDA-approved medications – methadone, naltrexone or buprenorphine – and has been demonstrated to be safer and more effective than either psychotherapy or medication alone, primarily because research shows it doubles the odds a person will be able to avoid relapse and stay in recovery for at least a year, and the more time without relapse the better. In New Mexico, Medicaid covers an array of evidence-based therapies and counseling that are the foundation of effective MAT, as well as all three MAT medications.

**Access to some evidence-based therapies has improved, while access to others has declined.** Best practice for MAT requires a therapeutic component as well as supportive medications, and of course, SUD patients who may not be taking any of the MAT medications may nonetheless benefit from therapy. Some therapies

are distinct billable services and so can be tracked through Medicaid and non-Medicaid claims data. LFC reports on child and adult behavioral health have recommended the state invest more in several evidence-based therapies: intensive outpatient program services (IOP), a multi-faceted approach to discharge planning, therapy and education for individuals with substance abuse or co-occurring disorders; assertive community treatment (ACT), an integrated intensive community mental health approach; multisystemic therapy (MST), an intensive family-focused treatment for children; and motivational interviewing, a short-term counseling approach used to help people who are ambivalent become engaged and prepared to enter treatment.

Over the last five years, access to IOP has improved. According to Medicaid and BHSD claims data, in 2014, the state spent \$3 million to provide IOP to about 1,400 clients (Medicaid and non-Medicaid) with SUD diagnoses; by 2018, spending on IOP had more than tripled to \$10.6 million to provide services to over 2,300 clients. Access to ACT has also improved slightly, although overall numbers remain quite low. In 2014, the state spent \$99 thousand to provide ACT to 11 patients, rising to \$120 thousand for 28 clients in 2018. On the other hand, access to MST, which has always been limited in New Mexico, has worsened over the last five years, dropping from 63 patients in 2014 to just 20 in 2018.

Other therapies, like cognitive behavioral therapy (CBT) and motivational interviewing, are better understood as modalities and may be used within the more general category of individual or group psychotherapy; these we cannot measure without reaching into patient medical records. Claims data show that in 2014, about 23 thousand Medicaid and non-Medicaid clients with an SUD diagnosis received some form of therapy at a cost of \$13.6 million; by 2018 about 32 thousand patients received therapy at a cost of \$27.8 million.

Another evidence-based facet of the SUD continuum of care is screening, brief intervention and referral to treatment (SBIRT). SBIRT is, just as its name implies, a screening and referral tool that could be used by virtually all primary care providers to identify problematic alcohol or drug use, depression, or trauma, and then refer a patient for additional treatment if appropriate. The service was originally available in New Mexico from 2004 through 2008 and an independent evaluation showed improved outcomes for participants, including a 58 percent decline in use of alcohol or illegal drugs. Due to a loss in federal funding there was limited implementation from 2008 until 2013, when the service became available in the state again under a five year, \$10 million federal grant. During those five years of activity, BHSD reports SBIRT screenings were conducted with over 44 thousand people, about half of whom were determined to need some level of follow-up intervention or treatment. The program had a follow-up rate of 52 percent; this group reportedly saw improvements in the areas of abstinence from alcohol or illegal drugs, and higher rates of employment and social connectedness. As of January 1, 2019, SBIRT is included in Centennial Care 2.0 (CC 2.0) but roll-out to the full Medicaid population remains slow. Current issues with implementation under CC 2.0 are discussed in a later section of this brief.

One indicator that New Mexico still has a long way to go to get ahead of the SUD epidemic: there were at least 60 thousand people with identified SUD diagnoses in the data sets the LFC received from HSD and BHSD. That means on average, HSD-spent about \$1,900 per person; if MAT drugs are removed from the calculation, the average drops to about \$1,100 dollars per person that was spent on direct services. That amount is clearly far lower than the true cost of meaningful care, and is an indi-

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intensive outpatient program services (IOP), a multi-faceted approach to discharge planning, therapy and education for individuals with substance abuse or co-occurring disorders;

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multisystemic therapy (MST), an intensive family-focused treatment for children; and

motivational interviewing, a short-term counseling approach used to help people who are ambivalent become engaged and prepared to enter treatment.

In 2018, the state spent an average of about \$1,100 per person with an SUD diagnosis on direct services (not including pharmaceutical costs). That amount is clearly far lower than the true cost of meaningful care

cator that while more people are accessing services, most of them are touching the system just long enough to get an assessment or evaluation or perhaps a few visits with a provider, and then encountering some barrier that prevents full engagement in treatment. Barriers to full engagement in SUD treatment include not enough providers, long wait times, transportation difficulties, and stigma. All SUD treatment relies heavily on individual motivation, but until New Mexico can build a system strong enough to fully engage as many people as possible, we will not be able to reverse the deadly trends we see today.

**Medicaid spending for medication-assisted treatment drugs more than doubled between 2014 and 2018, from \$8 million to \$22 million, as the number of people accessing these drugs rose from five thousand to more than 17 thousand, or 245 percent.** The increase is driven by expanded access to and utilization of key MAT

drugs buprenorphine and Suboxone; spending on these two medications alone increased from \$7.8 million in 2014 to \$19.7 million in 2018, and the number of patients grew from about 3,800 to 7,700.

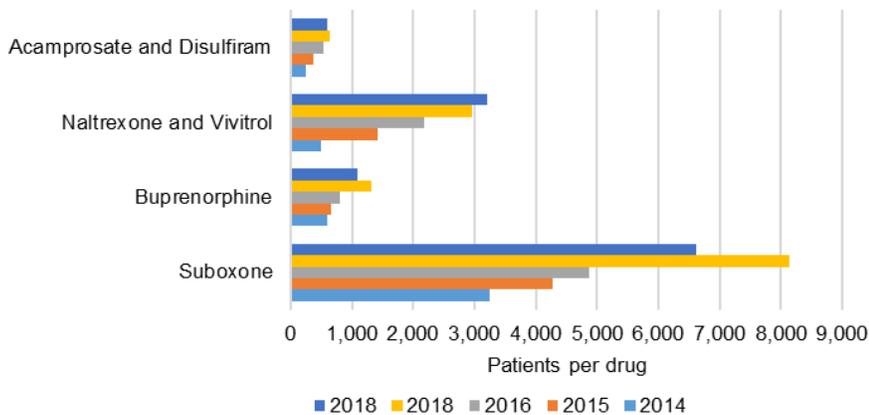
The MAT drugs naltrexone and Vivitrol can be used to treat either opioid use disorder (OUD) or alcohol use disorder (AUD). Both show positive growth over the last five years, although Medicaid prescription claims data does not include patient diagnosis so it is not possible to separate the two uses here. On the other hand, acamprosate and disulfiram are two drugs used exclusively for AUD – the number of people prescribed these drugs more than doubled between 2014 and

2018, but still remained fewer than 600 people. Given the much higher rate of AUD compared to OUD in New Mexico, MAT for alcohol dependence is clearly dramatically underutilized.

Unlike other MAT medications, methadone drug costs are billed together with administration charges, so for Medicaid clients, the expanded access to methadone appears in Medicaid claims data rather than prescription data. Between 2014 and 2018, the number of Medicaid clients who made use of methadone services more than doubled, from just under three thousand to seven thousand people. Spending on the service rose from \$11 million to over \$25 million.

**BHSD has also increased its spending on methadone administration, nearly doubling between 2017 and 2018.** One key role BHSD plays is to cover services for people who are not eligible for Medicaid. That group includes at least some services for individuals who are incarcerated, and BHSD saw its spending on methadone administration jump from under \$800 thousand to over \$1.5 million between 2017 and 2018 largely due to increased services for inmates at the Bernalillo County Metropolitan Detention Center (MDC). Changes at MDC are discussed in more detail in the Bernalillo County section below.

**Chart 10: Statewide, MAT Drugs for Opioid Treatment Much More Widely Prescribed than Drugs for Alcohol Treatment**



Source: LFC analysis of Medicaid data

According to the American Society of Addiction Medicine, the standard of care for SUD is to have all MAT medications available so that patients and their providers are able to select the medication that works best for each individual.

**Despite these improvements, access to medication-assisted treatment remains limited.**

The growth in utilization summarized above has taken place despite several important barriers: the state’s shortage of providers approved to administer methadone or buprenorphine, the administrative burdens faced by those who want to become approved, and the persistent shadow of stigma that keeps some individuals who would benefit from MAT from seeking help and some providers from offering it.

Federal restrictions on prescribers limit the delivery of medication-assisted treatment in New Mexico and nationwide. The federal bar is steepest for methadone providers, referred to as opioid treatment programs (OTPs). Because methadone is classified by the U.S. Drug Enforcement Administration as a schedule II drug, with a high potential for abuse, methadone providers must be federally accredited as an OTP and follow rigorous federal treatment standards. Methadone must be administered and observed by a provider, which means that clients have to come to the clinic every day, although compliant long-term clients are generally allowed to take some doses at home.

As a result of the high federal standards and the operational costs of hands-on delivery of the medication, there are only 16 OTPs currently operating in New Mexico, most of which are in Albuquerque with very limited access anywhere else in the state. As of the last quarter of 2018, the Medicaid MCOs reported 12 counties where their members had no access to methadone within a reasonable distance from their homes, and another seven counties where fewer than 50 percent of their members had access, leaving a total of over 164 thousand Medicaid recipients with limited or no reasonable access to methadone. At the end of 2018, no MCO had a methadone clinic in network in McKinley County, and there was only one methadone clinic in any MCO network in Rio Arriba County. There are some positive signs that this situation may improve: according to BHSD, there are several new applications for methadone providers pending, and HSD included a 29.5 percent increase in the rate for methadone administration in the October 2019 rate increases.

**Buprenorphine providers must also seek federal authorization.** Buprenorphine, delivered either by itself or combined with naloxone (Suboxone), is a prescription medication that is highly effective in treating opioid dependence. Buprenorphine activates opioid receptors in the brain, decreasing or eliminating symptoms of withdrawal from heroin or prescription pills like oxycontin. Unlike those drugs, buprenorphine is only a partial opiate agonist, meaning it has a limited ability to flood the brain’s receptors and is thus far less likely to produce the euphoria that breeds problematic opioid addiction.

Though buprenorphine was approved by the Food and Drug Administration in 2002, a federal law passed two years earlier – the Drug Addiction Treatment Act – required physicians to obtain a special waiver from the Drug Enforcement Agency to prescribe it. Though much more is now known about the safety and efficacy of the drug, the law is still in place, primarily due to fears it will be diverted for illicit use. To obtain the so-called “X waiver,” doctors have to attend an 8-hour training, and nurses and physician assistants must attend 24 hours of training. They must then submit an application, agree to open their records to the DEA, and demonstrate capacity to refer patients to behavioral therapy. In their first year of licensure, providers may treat no more than 30 patients at a time, and after that, no more than 100. Physicians with certain qualifications may be allowed to start at 100 patients, and after one year, they can apply to increase their limit to 275. Buprenorphine is widely viewed as a critical tool to stemming the opioid overdose crisis, yet none of the same rules apply to the prescription opioids that fueled the crisis in the first place.

Federal restrictions on prescribers limit the delivery of medication-assisted treatment in New Mexico and nationwide.

There are only 16 opioid treatment programs currently operating in New Mexico, most of which are in Albuquerque with very limited access anywhere else in the state.



The X waiver is a practical hurdle to expanding access to MAT, and according to medical providers interviewed by LFC staff, it reinforces stigma among clinicians against patients struggling with addiction. A handful of New Mexico physicians, agencies and public officials are active in efforts to eliminate the X waiver so that any clinician with prescribing privileges could prescribe buprenorphine. They believe this is key to making MAT for opioid use disorders a mainstream practice in primary care and hospital-based medicine. In May 2019, U.S. Rep. Paul Tonko, a Democrat from New York, introduced H.R. 2482 in the House, a bi-partisan bill to eliminate the unusual restrictions on buprenorphine prescribing. Rep. Ben Ray Lujan is a co-sponsor.

**While the number of buprenorphine providers in New Mexico has grown in recent years, more are needed.**

LFC analysis of Medicaid pharmaceutical data found 12.6 thousand people received buprenorphine prescriptions in 2018, more than double the number from 2014. There were 507 buprenorphine prescribers in the Medicaid data set in 2018, a 65 percent increase since 2014. That increase is a solid sign of improved access to much-needed OUD services, but there are also indications that more providers are needed. Only 37 percent, or 186 providers, treated at least 10 patients during the year, and only 30 treated 100 or more patients. The other 290 providers, 57 percent, treated fewer than 10 patients, and 153 treated only a single patient. Given that the initial year of a buprenorphine waiver allows the provider to treat up to 30 patients at any time, these very low numbers indicate a significant need for continued training and outreach. In one example of the negative effect of stigma and administrative burden, an FQHC clinic in one location reported to LFC staff that it had finally accomplished the goal of having all of its providers obtain waivers and begin prescribing buprenorphine; but at a different location of the same clinic, not a single provider is willing to prescribe buprenorphine.

Who is an “active” prescriber?

There were 507 buprenorphine prescribers active in the state in 2018.

- 30 treated 100 or more patients
- 186, or 37 percent, treated at least 10 patients
- 290, or 57 percent, treated fewer than 10 patients
- 153 of those treated only a single patient.

These very low numbers indicate significant need for continued training and outreach.

The three Medicaid managed care organizations (MCOs) reported between 210 and 257 providers with buprenorphine waivers in their networks; some providers are enrolled with multiple MCOs, so the total number is likely smaller. It is not clear why the MCOs report fewer waived prescribers than the 507 who appear in Medicaid prescribing data. Even if all of these providers were actively offering MAT to SUD clients, the MCOs still reported over 19 thousand members with few or zero buprenorphine providers within a reasonable distance from their homes, including three thousand in McKinley County where one MCO had no waived providers in its network at all. As noted above, the Medicaid prescribing data show that few certified providers are actually actively prescribing, so gaps in the MCO networks for this service almost certainly underrepresent how few Medicaid recipients have access to buprenorphine.

**Many New Mexico hospitals are missing the opportunity to improve outcomes with medication-assisted treatment. Nearly half do not even stock the necessary drugs in their pharmacies.**

Opioid related visits to hospital emergency departments (EDs) have increased in New Mexico, rising by 60 percent from 2012 to 2018. Patients with opioid use disorders present in the ED in times of crisis, such as after an overdose, but also for medical issues commonly associated with substance use, like abscesses or withdrawal. These patients often are not accessing regular medical care with a primary care physician, and frequent visitors to the ED are at higher risk of dying of subsequent overdoses.

There is evidence that initiating MAT in the ED could shift these odds. A randomized clinical trial published in the *Journal of the American Medical Association* in 2015

tested the efficacy of three approaches to treating opioid-dependent patients in the ED. Screening combined with brief intervention, buprenorphine induction in the ED, and referral to primary care proved far more successful at engaging patients in treatment than screening and referrals alone, or screening, brief intervention and referrals. Seventy-eight percent of patients in the group that received buprenorphine in the ED were still engaged in treatment after 30 days, compared to 37 to 45 percent in the other two groups. Research shows treatment with buprenorphine or methadone after a non-fatal overdose significantly reduces subsequent risk of overdose death.

Emergency departments – and hospitals more generally – are thus a key intervention point. Yet they currently represent a significant gap in the medical system’s delivery of MAT. UNM medical researchers surveyed all general and acute care hospitals in the state this year to determine how many formularies included buprenorphine. This was a simple way to determine which hospitals offered some level of MAT because without the drug in the hospital, doctors would not even have the option to offer the treatment. The researchers found 45 percent of New Mexico’s hospitals did not stock buprenorphine, and 10 counties do not have a hospital that carries the medication.

In a separate survey of its members that the New Mexico Hospital Association conducted for the LFC, only two of 13 respondents – Union County General Hospital and Presbyterian Healthcare Services – reported having a MAT program in the ED. Union County also offered the treatment in its inpatient units, while Presbyterian offers it in some but not all of its hospitals. One additional hospital without an ED – Kindred – reported offering MAT to inpatients.

Interviews LFC staff conducted with doctors in hospitals that do stock the necessary drugs suggest that, even in these settings, delivery of MAT is uneven and often dependent on the motivation of individual providers. The survey responses, while not a definitive accounting of the availability of MAT in New Mexico hospitals, similarly speak to the lack of systematic approaches to treatment delivery in hospitals. UNMH responded that they had no MAT program in their EDs or inpatient units, for instance, but LFC staff interviewed individual providers within the system who do induce patients in the hospital. Some of these providers are advocating for funding to build-out addiction consult teams within UNMH, but noted leadership has been reluctant to add full-time employees for this purpose.

Doctors reported several common barriers to expanding treatment in their hospitals, including the DEA waiver required to prescribe buprenorphine, confusion about the regulations, a general lack of training and comfort-level with treating SUDs, a shortage of community providers to refer patients to for ongoing treatment, and a lack of staff capacity within the hospital to make those referrals effectively.

***Presbyterian is developing a model system for medication-assisted treatment in its EDs and inpatient units, starting with its hospitals in Espanola and Santa Fe.*** An emergency physician addiction specialist and a peer recovery coach form the core of an addiction medicine consult team for the inpatient units of both hospitals. When hospitalized patients are referred to them, the doctor provides a medical assessment and care – including MAT for both alcohol and opioid use disorders – while the peer recovery coach evaluates the patient’s level of interest in treatment and connects them to the appropriate services after discharge. In addition to buprenorphine providers, each ED is staffed with a navigator dedicated to connecting patients to ongoing treatment. The hospitals have relationships with providers in

Research shows treatment with buprenorphine or methadone after a non-fatal drug overdose significantly reduces subsequent risk of overdose death.

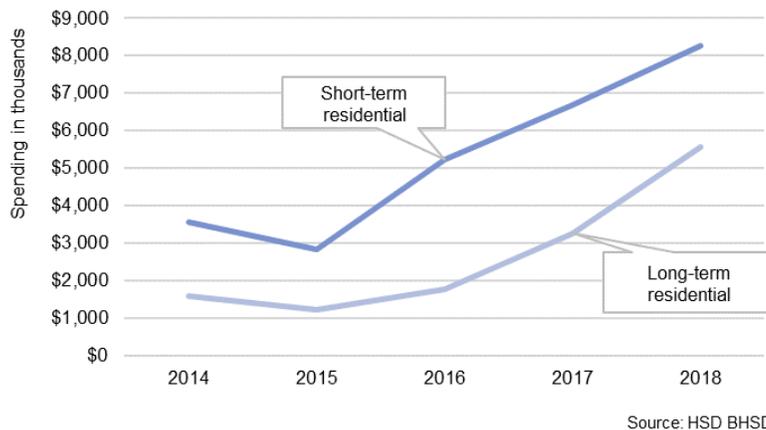
Emergency departments and hospitals are thus a key intervention point. Yet they currently represent a significant gap in the medical system’s delivery of MAT.

the community to facilitate those connections, and in Espanola, the hospital’s own outpatient clinic is staffed with multiple buprenorphine providers and offers both scheduled appointments and walk-in hours. The clinic thus serves as a safety net for patients for whom the hospital has trouble scheduling timely follow-up appointments with outside providers. In addition, the doctor provides phone and in-person support to other providers who are new to treating SUDs, a key part of reducing stigma against these patients within the medical community and encouraging mainstream adoption of MAT.

**For individuals with substance use disorders, residential treatment centers are the highest level of care short of hospitalization.**

According to research gathered by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), evidence-based outpatient SUD detoxification and treatment can be very effective for many people, but for others a residential setting may provide stability and community lacking elsewhere and ultimately prove more effective than outpatient treatment alone. Residential treatment may be particularly useful for vulnerable populations like pregnant women or homeless individuals, who benefit most from wrap-around type services.

**Chart 11: Access to Residential Treatment has Increased**



The BHSD spent over \$16.7 million in non-Medicaid funds on SUD services in 2018, mostly on the residential services Medicaid did not cover. According to BHC data, the two largest components of its SUD spending every year between 2014 and 2018 were short term residential treatment and long term residential treatment. During this time frame, the number of short term residential patients increased from fewer than 800 people to nearly 1,400 – or 75 percent – and spending increased by 131 percent, from \$3.6 million to \$8.3 million. The second largest spend, long term residential treatment, saw patients more than double, from 300 in 2014 to 750 in 2018, while spending increased by 250 percent, from \$1.6 million to \$5.6 million.

**Centennial Care 2.0 includes several new behavioral health services, but implementation of some has been slow.**

The new Centennial Care 2.0 (CC 2.0) waiver includes an array of new services directed to the SUD population, as well as other new behavioral health services likely to benefit people with SUD. These services became effective on January 1, 2019, and are included here as indications of what the future holds for ongoing efforts to address the state’s SUD and behavioral health challenges.

- Crisis stabilization services and crisis triage centers (CTCs) will offer critical care to the entire population of people seeking behavioral healthcare, not just those with SUD. However, at this time only one provider is offering crisis stabilization and only two other CTCs are engaged in the implementation process. HSD reports it is doing outreach and education to encourage more providers.
- Peer support services are also now covered by Medicaid; HSD reports there are currently 43 certified peer support workers (CPSW) and the department is running frequent trainings and certification exams to try to increase that number.

- Screening, brief intervention and referral to treatment (SBIRT) is, just as its name implies, a screening and referral tool that could be used by virtually all primary care providers to identify problematic alcohol or drug use or mental illness, and then refer a patient for additional treatment if appropriate. SBIRT was available in New Mexico between 2004 and 2008, and again between 2013 and 2018 under a federal grant; CC 2.0 moves SBIRT into the more stable status of a Medicaid covered service. Previous implementation of SBIRT in New Mexico showed improved outcomes for participants including reduced alcohol and illegal drug use, fewer arrests, increased employment and education, better health outcomes and more stable housing. Access to this service, too, has been limited, however; primary care providers who want to be certified to provide the state-approved model must go through training, and there is only one entity currently contracted with BHSD to provide that training. Providers have also reported difficulties with the Medicaid certification process. According to BHSD’s SBIRT implementation plan, the goal is to conduct training for providers at over 300 clinics across the state, but as of the end of September, 2019, only nine (3 percent) have completed training and been certified to conduct SBIRT.

Screening, brief intervention and referral to treatment (SBIRT) is, just as its name implies, a screening and referral tool that can be used by virtually all primary care providers to identify problematic alcohol or drug use or mental illness, and then refer a patient for additional treatment if appropriate.

Three SUD-specific services are also included in CC 2.0. In 2018, the federal Centers for Medicare and Medicaid Services (CMS) relaxed its limitations on inpatient care provided at an institute of mental disease (IMD) - psychiatric hospitals or psychiatric units of general hospitals—and allowed states to provide coverage for up to 30 days for SUD patients only. HSD built this extension into CC 2.0. Partial hospitalization is a concentrated form of outpatient psychiatric care where the patient may spend up to 20 hours a week at the hospital receiving therapeutic services. These programs can be expensive, and for various reasons appear to have fallen out of use around the state. CC 2.0 expanded the service to adult patients with SUD in addition to mental health issues and included a 29.5 percent increase in the October 1, 2019 reimbursement rate increases, which may help reinvigorate this important step in the continuum of care.

**Full implementation of one of the signature new SUD services of Centennial Care 2.0, accredited adult residential treatment centers, appears unlikely until at least early 2020.** Residential treatment programs for children are closely regulated and licensed by the Children, Youth and Families Department. During the years covered by this report, no such structure existed for adult residential treatment centers (RTCs). Historically, BHSD has not exercised oversight regarding the quality of adult RTC programs, including whether an RTC is using evidence-based therapies or tracking program outcomes. Recent reports out of California and Florida demonstrate what can go wrong when there is insufficient oversight of residential treatment facilities; both states have found significant issues with financial fraud and ineffective, low-quality services.

This situation is changing with CC 2.0, under which *accredited* adult residential treatment centers (AARTCs) will be eligible for Medicaid reimbursement. However, with Medicaid reimbursement comes greater oversight and higher standards for facilities and the programs they offer. Existing and new AARTCs will be required to be accredited with one of three national accrediting bodies: the Joint Commission (JC), the Council on Accreditation (COA), or the Commission on Accreditation of Rehabilitation Facilities (CARF). AARTCs will also be required to follow the American Society of Addiction Medicine (ASAM) level of care guidelines, and provide evidence-based SUD treatments, including MAT.

Under CC 2.0, accredited adult residential treatment centers (AARTCs) will be eligible for Medicaid reimbursement. However, with Medicaid reimbursement comes greater oversight and higher standards for facilities and the programs they offer. AARTCs are required to obtain national accreditation, to follow American Society of Addiction Medicine guidelines, and provide evidence-based therapies, including MAT.

Progress on implementing this service has also been slow. Would-be providers did not receive guidance from HSD until near the end of 2018, when the service was described in detail in HSD’s state plan amendment (SPA) and formal regulations to govern the AARTCs were promulgated; the public comment period has recently closed and the regulations may be in place by the end of the year. BHSD and HSD developed an application process for new providers – but the applications were not sent to interested providers until August 2019. At the same time, interest from the provider community has been muted; LFC staff have heard from providers that they are reluctant to add new services without a greater sense of clarity and support from the department; providers have referred to the 2013 behavioral health shake-up as the basis for a persistent mistrust between the provider community and HSD.

According to BHSD four programs have submitted applications so far – three of which have had contracts with BHSD, and one of which served only commercially insured clients until now. Two of those applicants are fairly far along in the certification process, but necessary work remains to be done at the departmental level. When the CC 2.0 waiver was written, the department initially planned to have national accreditation be the primary requirement for AARTCs, with no additional state-level regulation. In December, 2018, however, the Centers for Medicare and Medicaid (CMS) informed HSD that it also wanted the state to take an active oversight role. HSD spent several months assessing how to proceed, and then turned to the Department of Health’s Division of Health Improvement (DHI) for assistance. DHI is tasked with licensing of all health facilities in the state, and has an inspection process that includes a life safety inspection to ensure due diligence on the part of the state.

The first barrier the two departments ran into is the fact that DHI’s authorizing statute, the Public Health Act, does not include a license type that precisely fits an adult RTC, and DHI was unwilling to proceed without clear authorization. The departments spent some time first discussing a possible memorandum of understanding (MOU), whereby HSD would grant the necessary authority to DHI, and then considering whether a change to the statute would be necessary. At the time of this report, DOH’s attorneys appear to have concluded that the existing statute is written broadly enough to cover AARTCs, and DOH plans to begin working with HSD shortly to draft rules. Given the time necessary to draft and promulgate new regulations, it will be at least March or April 2020, at the very earliest, before DHI licensure can begin. In the meantime, BHSD is issuing temporary certifications and HSD reports it will begin using Medicaid dollars to pay for this new service once an AARTC has a temporary certification and has negotiated its provider-specific rate with the department.

## Efforts to address substance use disorder at the county level

While state-level policy will continue to play a critical role in increasing access to treatment for substance use disorder (SUD), local governments and community organizations are an important part of the solution, too. Here the brief turns to an in-depth discussion of three counties making significant efforts to address substance abuse: Bernalillo, Rio Arriba and McKinley. Each of these counties leads the state in one way or another: Bernalillo has the highest absolute number of substance-related deaths, McKinley and Rio Arriba have the first and second highest per capita rates of alcohol-related deaths, and Rio Arriba has the highest rate of drug overdose deaths.

All three counties also received significant public funding in recent years to reduce the negative consequences of SUD in their communities; these efforts are discussed in detail in the county sections that follow. Since 2015, Bernalillo County residents have paid a one-eighth percent gross receipts tax dedicated to behavioral health initiatives. In 2016, the Legislature appropriated \$1 million to HSD to establish Behavioral Health Investment Zones in counties with high death rates from drugs and alcohol. The BHSD subsequently designated two such zones in McKinley and Rio Arriba counties and awarded each a \$500,000 annual grant for five years. The initial legislation for the grants stated the funding was to be used to establish or expand evidence-based behavioral health services; by the time the BHSD rolled out application guidelines to the counties, the goals appeared a bit more flexible: to accelerate community-based efforts to improve behavioral health and treatment of SUDs. In response, each county developed its own specific goals and implementation strategies and BHSD reviewed, commented on, and ultimately approved their plans. The money has helped to build service capacity and to kick-start community-based initiatives targeting high-risk populations. But the strategy has also highlighted the slow nature of progress on these issues. While city officials and providers have succeeded in rebuilding depleted services in Gallup, for instance, alcohol-related death rates in the county have nonetheless continued to climb.

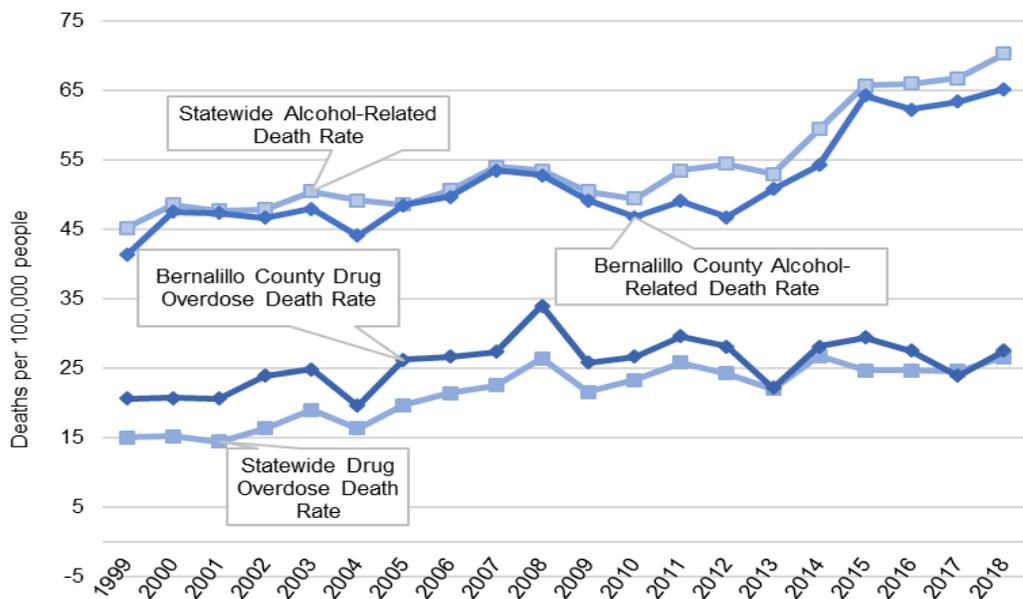
**The sheer size of Bernalillo County’s population means that the number of deaths there due to drug overdose and alcohol use lead the state.**

Between 1999 and 2018, 3,311 Bernalillo county residents died from drug overdoses – 40 percent of the drug overdose deaths in the state. Over the same period, 6,824 county residents died from alcohol-related causes – 31 percent of the total in the state. The Bernalillo county rate of alcohol-related deaths has tracked fairly close to the statewide average, rising from 41.3 per 100,000 deaths in 1999 to 65.2 in 2018. The drug overdose death rate exceeded the statewide average every year except 2017, rising from 20.6 per 100,000 deaths in 1999 to 27.5 in 2018. The human toll for the county is high, although the rates and proportions are in line with its status as home to about 32 percent of New Mexicans.

Bernalillo, McKinley and Rio Arriba Counties:

- lead the state in number or rate of substance abuse deaths;
- have received funding beyond traditional state funding for SUD issues;
- have seen expanded service availability and delivery;
- have SUD outcomes that remain high or have continued to worsen.

**Chart 12: Alcohol-Related and Drug Overdose Death Rates: Bernalillo County and Statewide**



Source: DOH IBIS



The goals of the Bernalillo County behavioral health initiative aim to add and expand services delivered in a coordinated and effective continuum of care across all stages of life and in all circumstances, including incarceration. The 1/8 of a cent gross receipts tax has raised approximately \$20 million per year since it was implemented in mid-2015.

**In 2014, Bernalillo county commissioners and county voters took decisive action to address the behavioral health issues in the county.** Motivated by several high-profile tragic police shootings of people with mental illness, voters approved a tax increase to fund major improvements to the county’s behavioral health network. The goals of the behavioral health initiative are far-reaching, and aim to add and expand services delivered in a coordinated and effective continuum of care across all stages of life and in all circumstances, including incarceration. The 1/8 of a percent gross receipts tax has raised approximately \$20 million per year since it was implemented in mid-2015.

The county oversees the Behavioral Health Initiative (BHI), but because of its commitment to collaboration between all stakeholders and determination to thoroughly vet all ideas, tangible progress was initially slow. Ideas and plans for new services are first reviewed by one of four subcommittees: crisis services, community supports, supportive housing, and prevention, intervention and harm reduction. Subcommittee ideas flow to a steering committee, then to the joint city-county Albuquerque Bernalillo County Government Commission (ABCGC), and lastly to the city council and county commission for final approval. The first projects were not approved until near the end of 2016. According to the county, by the end of FY19, the tax had brought in \$81.8 million, of which about \$14.8 million had been spent leaving a fund balance of \$67 million. The county reports \$52.8 million in nonrecurring expenses pending, which, minus a 20 percent reserve of \$4.5 million resulted in a remaining fund balance of \$9.7 million at the end of FY19. BHI programs are discussed in detail later in this section.

**Availability of Medicaid substance use disorder services has expanded in Bernalillo County.** Medicaid claims data show an increase in spending for SUD services in the county of about 88 percent, from \$9 million to \$17.6 million, with a corresponding 78 percent increase in the number of Medicaid clients accessing services – from 3,500 people to 6,300 people. In Bernalillo county, as in the rest of the state, most-used Medicaid services were intensive outpatient programs and methadone administration, bolstered by an array of assessments, treatment plans and therapies.

MAT drugs also show substantial improvement in utilization: in 2018, over 960 more people were prescribed buprenorphine than in 2014, and over 708 more were prescribed naltrexone. As is true statewide, there were smaller increases in the number of people receiving MAT drugs for alcohol use disorder – only approximately 170 Medicaid recipients in 2018, or 71 more people than in 2014. Over 23 hundred people were supplied with Narcan in 2018 – yet drug overdose deaths that year still climbed.

BHSD data show a 67 percent increase in the number of patients accessing non-Medicaid SUD services, driven largely by an increase from 398 patients receiving methadone in 2014 to over 960 patients in 2018. As discussed in more detail below, this jump is due almost entirely to expansion of the methadone program at the Metropolitan Detention Center. There were also significant increases in the number of patients accessing two other

<b>Table 6: Bernalillo County 2018</b>	<b>County</b>	<b>State</b>
Population	678,216	2,101,730
Poverty rate (2017)	14.6%	19%
Poverty rate for children under 18 (2017)	18.7%	25.9%
Families served by CYFD where SUD involved	40.1%	42.4%
Child abuse cases that are substantiated	27.6%	29.5%
Substantiated child abuse involving SUD	45.1%	46.0%
<i>SUD data by rate per 100,000 people</i>		
Alcohol-related deaths	65.2	70.3
Alcohol-related chronic liver disease deaths	21.3	25.6
Alcohol-related motor vehicle crash deaths	4.8	6.0
Drug overdose deaths	27.5	26.6

Source: DOH

non-Medicaid services, sub-acute detoxification and long term residential treatment, although almost all of the patients received these services from providers located in Santa Fe or Espanola.

**Bernalillo County has also been active in providing substance use disorder services.** The county, like the rest of the state, has a chronic shortage of behavioral health professionals, especially in the areas of children’s services and addiction medicine, working in an historically fragmented and uncoordinated system. The county’s Department of Behavioral Health Services (DBHS) runs four major programs out of its CARE Campus – an acronym for comprehensive assessment and recovery through excellence (the new name for the Metropolitan Assessment and Treatment Services (MATS) campus). These programs are funded primarily with liquor excise tax monies and have a combined annual budget of just over \$4 million:

- The public inebriate intervention program (PIIP), started by the county in 2013, is a 30 bed unit where inebriated individuals can walk in, be referred from UNMH, or brought in by police to divert people who might otherwise be taken to the UNMH emergency room or to MDC. The basic service is 23 hour, 59 minute stabilization and observation, but clients can receive case management and, if interested, continue in the detox program. Between 2014 and 2018, the number of visits to the PIIP increased by 50 percent, from about 5.6 thousand to over 8.4 thousand, although close to 80 percent of those people were re-admitted at least one time. Annual budget: \$154 thousand.
- The detox program is a short-term residential social detox program, with average stay of about four days. Initially run by the city, the county took over the detox program in 2007. County clients in the detox program received associated medical services through a contract between the county and the Department of Health’s Turquoise Lodge Hospital (TLH), which was located on the same campus. In mid-2019, TLH relocated and the county took over the facility and has continued running the detox unit in collaboration with UNMH, with plans to add MAT to the program. Between 2014 and 2018, over 9 thousand clients used the detox program, although the pace of intakes has slowed each year, from about 2.3 thousand clients in 2014 to just over 1.6 thousand clients in 2018. During that time, the number of clients reporting issues with alcohol has increased by about 20 percent; the number reporting issues with opiates has dropped by about 20 percent but the number reporting issues with methamphetamine has more than doubled – an indication of a potentially more complex patient mix. Annual budget: \$1.7 million.
- The supportive aftercare community (SAC) program, begun in 2009, is a short term residential program with average stays of between four and five months. The SAC program follows the community reinforcement approach, an evidence based practice of cognitive behavioral intervention for SUD, and offers a supportive environment, classes and coaching for clients coming out of detox or rehabilitation. The program has grown steadily since its inception from just 10 clients in 2014 to 67 clients in 2018; data collected by the county indicates the individuals who spend time in the SAC program have fewer subsequent visits to either the PIIP or the detox program, as well as fewer bookings into MDC. Annual budget: \$500 thousand.
- The addiction treatment program (ATP) is a four-week inpatient program that the DSAP runs in a segregated unit at MDC, where assessment, training and support are offered to DWI offenders and others referred by the courts. Started by the city, the county took over the ATP program in 2007. This program also uses the evidence-based community reinforcement approach. In 2014, the majority of clients reported alcohol addiction as their primary issue, with opiates second and metham-



The Department of Health's Turquoise Lodge Hospital (TLH) is the state's oldest publicly funded inpatient detox and rehabilitation hospital and offers three key stages of the SUD treatment continuum: inpatient detox and rehabilitation, and an intensive outpatient program. The TLH was co-located on the same campus as the county's MATS program from 2007 through mid-2019, during which time it had a contract with the county to provide medical assessments, treatment recommendations and medication dispensing to MATS clients. In June 2019, TLH ended its contract and moved to its new location on Gibson, where it has expanded in both bed size and programmatic offerings: for the first time, TLH is providing its inpatient clients full MAT services, and plans to add an addiction medicine clinic to offer those services on an outpatient basis. The hospital is also pursuing JCAHO accreditation and certification by Medicaid as an accredited adult residential treatment center. Cost to operate in FY18: \$6.8 million.

phedamine third; by 2018, the proportions had shifted as the number of individuals reporting methamphetamine addiction doubled. Annual budget: \$1.7 million.

In addition to the programs above, the county has a contract with UNMH to administer the Milagro residential program, a supportive aftercare program for pregnant and postpartum women that offers integrated behavioral and physical healthcare. The participating women receive SUD treatment services through UNMH's addiction and substance abuse program (ASAP) while living on the county's campus. The children may receive pediatric and behavioral healthcare through UNMH, as needed. In 2018 there were 13 clients, with an average length of stay of just under three months.

***The Behavioral Health Initiative has added numerous new sources of behavioral health services for county residents.*** Two BHI programs went live in 2017, another four in 2018, and two more in 2019, at a combined annual cost of \$10.2 million. Another eight projects with a total planned cost of over \$57 million in BHI funds are in various states of development, and several other large projects are in the earliest stages of planning and do not have costs attached yet. While planning and development occurred for all these programs, the BHI accumulated a fund balance of approximately \$9.7 million, and in September the Bernalillo County Commission announced plans to disburse \$3 million in the form of competitive grants directly to behavioral health providers in the county.

The BHI programs that are fully operational today involve dozens of community-based behavioral health providers who contract to provide the new and expanded services. In addition, the BHI has key partnerships with UNM hospital, the City of Albuquerque, and county and city law enforcement agencies, among others. In keeping with the goals of the BHI, the current and future projects focus on services for people of all ages and in all circumstances, from prevention and harm reduction through crisis response and community supports. DBHS reports that over the last two and a half years, as the different programs became operational, over 20 thousand individuals have come into contact with these various services.

Briefly, the eight BHI programs currently operating fall into four categories. BHI has collected basic utilization data for each service, but most are too new to have any meaningful outcome data yet.

- Crisis services include six mobile crisis teams specially focused on responding to 911 calls that involve individuals experiencing behavioral health crises. The teams pair a crisis intervention unit deputy with a master's level behavioral health clinician, and are a partnership between the county and the city; there are four with APD and two with BCSO. Between go-live in February 2018 and October 2018, mobile crisis team clinicians had 773 encounters (not all calls result in a clinical encounter), most commonly for people considering suicide. Few of these encounters ended up with an arrest, and most resulted in individuals either being taken to a provider of their choice for further assistance or having their issue de-escalated enough that they were able to remain safely in the community. Annual budget: \$1.5 million. Crisis services also include the Resource Reentry Center, discussed in detail below.
- Supportive housing services include community connections and youth transitional living. Community connections provides intensive case management services and housing subsidies to homeless or precariously housed individuals with mental illness or other disabilities who are frequent utilizers of the emergency room and/or

have become involved in the criminal justice system. The program began in 2017 and has grown steadily, doubling the number of vouchers provided and expanding case management contracts. Annual budget: \$2.7 million. Youth transitional living provides case management and transitional housing for at-risk youth who are precariously housed or homeless and who are not already being served by the Children, Youth and Families Department. Annual budget: \$800 thousand.

- Prevention, intervention and harm reduction services include one of the largest efforts in the state to address the challenge of adverse childhood experiences, or ACES. ACES have the potential to harm a child’s developing brain, and increase the possibility of negative health, educational and social outcomes. The county has contracted with seven providers to bring wrap-around services including prevention, early intervention, support and treatment, to at-risk children and their families; to date the program has served over 10 thousand clients, 58 percent of whom have had high ACE scores of 4 or more. Annual budget: \$2.9 million. The education and training program has provided a total of seven trainings for community organizations and others who serve people with behavioral health needs on topics such as motivational interviewing and trauma informed care. Annual budget: \$3 million.
- Community supports services include four peer support drop-in centers for youth and adults living with mental health and/or SUD. Annual budget: \$300 thousand. Peer case management uses peers as part of the case management teams currently operating through Centro Savila in the community and at the Westside shelter as well as through Crossroads for Women. Annual budget: \$620 thousand.

Prevention, intervention and harm reduction services include one of the largest efforts in the state to address the challenge of adverse childhood experiences, or ACES. The county has contracted with seven providers to bring wrap-around services for at-risk children and their families; to date the program has served over 10 thousand clients, 58 percent of whom have had high ACE scores of 4 or more

**Services for SUD have expanded at the Metropolitan Detention Center as well.**

The Metropolitan Detention Center (MDC) has offered inmates methadone maintenance – meaning if they arrive already using methadone, they can continue to receive their medication – since late 2005. Methadone in prisons was highly unusual in 2005, and unfortunately remains so today; as a 2013 study of the MDC’s methadone maintenance treatment (MMT) program noted, immediate (and often unsupported) detox is the standard of practice in prisons around the state and the country, while the medical standard of care is medication-assisted treatment (MAT). The MMT program combines methadone administration with cognitive behavioral therapy. In addition to the harm-reduction benefits for inmates while they are incarcerated, the study found post-release benefits as well: participants showed significantly lower rates of resuming substance abuse and much higher rates of remaining in treatment after release.

MDC’s methadone treatment program combines methadone administration with cognitive behavioral therapy. A 2013 study of the program found harm-reduction benefits for inmates while they are incarcerated, as well as post-release benefits of significantly lower rates of resuming substance abuse and much higher rates of remaining in treatment after release.

In 2018, MDC took another step forward and began offering methadone induction to inmates. Recovery Services of New Mexico is an opioid addiction treatment provider with five locations around the state, including one at MDC, where the company has the contract for the facility’s methadone program. When MDC decided to expand its program from just methadone maintenance to induction, Recovery Services’ claims grew from under 10 thousand in 2014 to nearly 69 thousand claims in 2018, with a corresponding increase in reimbursements from under \$800 thousand to over \$1.5 million. The cost of these services has been covered by non-Medicaid funds from BHSD, however LFC staff was unable to obtain patient counts for the MMT program and also unable to obtain an explanation of how BHSD initially accepted the role of paying for county inmates or why it has remained in that role even after implementation of the behavioral health tax initiative. The MDC is reportedly working to add other forms of MAT, including Suboxone, to the behavioral health services it provides inmates.



***The Resource Reentry Center (RRC) in Bernalillo County represents an effort to provide inmates being discharged from jail with transition planning and connection to services.*** Until the RRC opened, a van from MDC periodically pulled up to the corner of 4<sup>th</sup> Street and Roma Ave releasing about three quarters of MDC inmates during non-business hours (see LFC’s 2018 report on the Bernalillo County Criminal Justice System). There, former inmates faced a host of difficulties that potentially contributed to rapid recidivism: no transportation, no ability to make a phone call, no place to go or stay for the night, and the lure of potential drug or alcohol purchases nearby. Individuals with SUD who were receiving methadone while in MDC were also particularly vulnerable, often having no medical provider to continue treatment with and at significant risk of overdose if they returned to using street drugs.

Bernalillo County and the Behavioral Health Initiative determined to address this situation through a combination of enhanced pre-release transition planning and creation of the RRC, housed within the Bernalillo County Public Safety Center. There are seven UNMH-funded community service workers currently providing discharge planning from inside MDC – the hospital took over this service about a year ago after the pilot project to have Medicaid MCO Molina do in-jail care coordination came to an end. Now, inmates being discharged work with a transition planner prior to their release to identify what services they may need after release and what benefits they may be eligible for, and to provide referrals to appropriate providers as well as assistance with enrollment. However, not all inmates get the full benefit of transition planning, since many are released within 72 hours, but the planners try to work with the rapid release population as much as possible.

The RRC opened its doors on June 12, 2018. Twenty-four hours before an inmate is released, staff at the RRC receive an email alert, and then when the MDC van pulls out of the jail facility, the RRC gets a call saying they are on their way. Instead of stopping on the street corner, the MDC van now pulls into a secure fenced lot behind the building and individuals are released in such a way that they must walk into the RRC. They do not have to stay, and many do not. But if they do stay, there are sandwiches, snacks and coffee, restrooms, phones, computers, and comfortable places to sit and wait while their cell phones charge or they wait for a ride. The van still consistently drops people off during non-business hours, and the RRC allows anyone to stay in the facility through the night if they wish.

The RRC is staffed by community health workers (CHW) who offer case management services, helping newly released individuals actually make their healthcare appointments, or obtain referrals to a wide variety of services from housing to counseling to detox. CHWs at the RRC will arrange transportation and at times use their own cars to drive individuals where they need to go; they also personally escort people upstairs to pre-trial services, which, according to RRC administrators, has reportedly reduced the failure to report rate for the District Court by 35 percent. The offices at the RRC are also available for meetings with care coordinators from the Medicaid managed care organizations, and caseworkers from the Income Support Division of the Human Services Department have just completed a pilot “in-reach” project to screen people for food stamp eligibility.

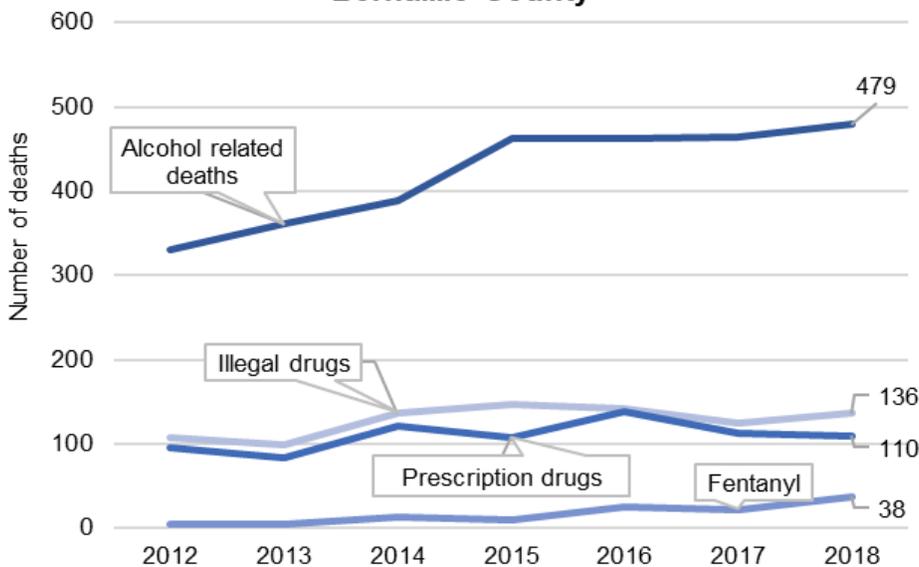
Between opening in June, 2018, and the end of July, 2019, over 20 thousand people passed through the RRC. In the first month of operation, only 50 percent of people stayed in the RRC long enough to access any services; by the end of July, 2019, that proportion had risen to 78 percent. Data collection about which services are used

most by RRC clients was inconsistent for most of the first year of operation. From available data, food, hygiene, phones and bus passes are the clear favorites, but referrals for housing and legal assistance appear to also be key.

The BHI’s stated goals for the RRC include increased engagement in community services, reduction of ER and hospitalization, improved health, reduced recidivism, and improved system coordination and efficiencies. There are some signs of progress towards these goals: in its first full year of operation, the RRC helped over 200 people with Medicaid and SNAP enrollment, made about 300 referrals to counseling and MAT services, distributed at least 70 Narcan kits, and made nearly 700 warm hand offs to pre-trial services. It is too soon to measure the impact of the RRC on recidivism or health outcomes; BHI and RRC leadership are aware of the keen interest in those measures and are working to collect and analyze relevant data.

***Bernalillo County is experiencing the worst of the statewide increase in deaths from methamphetamine and fentanyl, and despite all of the expanded access to services and new treatment options discussed above, the county’s alcohol and drug death rates both rose again in 2018.*** The persistence of the SUD crisis in the state’s largest county is in part a reflection of the chronic nature of SUD, and in part due to the in-process nature of much of the work of the BHI, where most programs have just recently gotten fully underway and many planned programs have not yet been implemented.

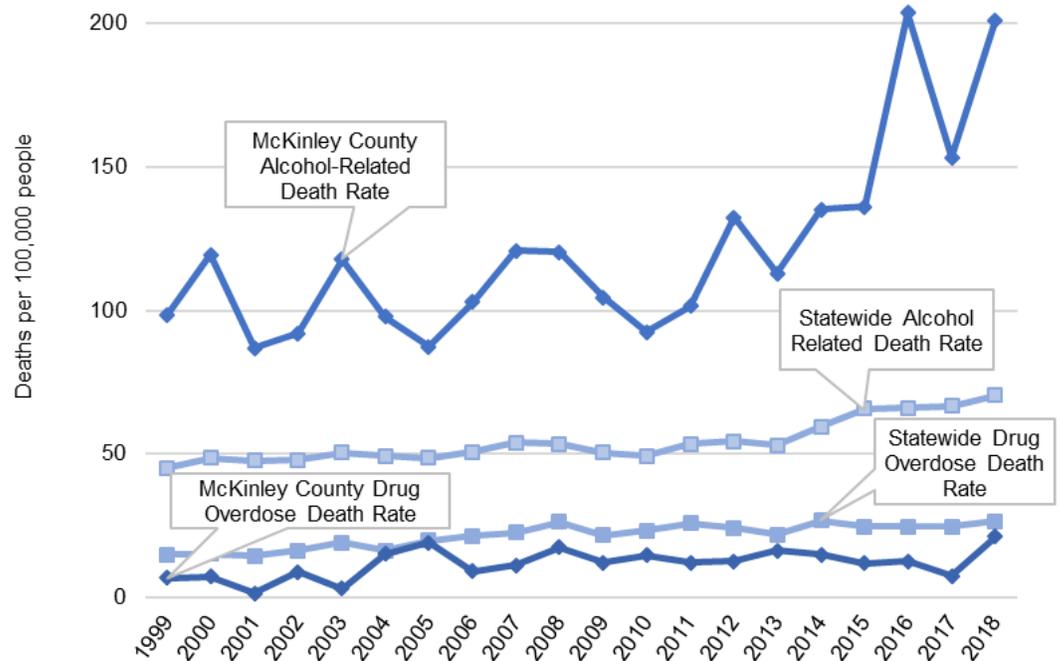
**Chart 13: Drug and Alcohol Related Deaths in Bernalillo County**



**A combination of local, state and federal funds have helped to stabilize and expand services in Gallup, but McKinley County’s alcohol-related death rate has nevertheless continued to rise.**

New Mexico’s alcohol-related death rate has led the nation for decades, and within the state, McKinley County’s alcohol-related death rate is consistently significantly higher than other counties. In 2000, it was 119 per 100,000 people, more than twice the state rate of 48.6; by 2018, the county’s rate was 201 per 100,000 people, nearly three times the state’s rate of 70.3. The majority of these deaths in McKinley County are linked to chronic conditions, such as liver disease, but the county has troublingly high rates of accidental deaths linked to alcohol, too, such as deaths from exposure in winter.

**Chart 14: Alcohol-Related and Drug Overdose Death Rates: McKinley County and Statewide**



Source: DOH IBIS

The county’s drug overdose death rate, on the other hand, has long trended below the statewide rate. It did tick up notably in 2018, however, from a ten-year low of 7.5 per 100,000 people to 21.1, the highest rate the county has ever seen. The increase was driven primarily by fentanyl and methamphetamine. Fentanyl was implicated in four overdose deaths in McKinley County in 2018 compared to one in the previous six years combined. In 2018, methamphetamine was implicated in double the number of deaths in any of the previous six years. While these numbers remain relatively small

and could be an anomaly, they are worth noting given the parallel increases in fentanyl and methamphetamine overdose deaths statewide.

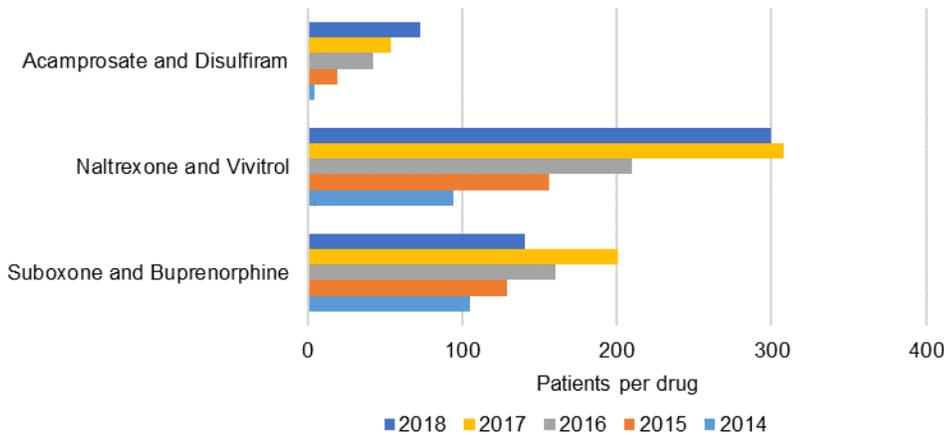
**Availability of substance use disorder services has improved in McKinley County, as it has elsewhere in the state, but the improvement is uneven.**

Access to MAT drugs has increased, according to Medicaid prescription data, with utilization of naltrexone and Vivitrol, its brand name equivalent, growing more than other MAT drugs from 2014 to 2018. Three hundred patients received naltrexone and Vivitrol in 2018 compared to 94 in 2014, a 219 percent increase. Naltrexone is used to treat both opioid and alcohol use disorders, and the prescription data does not separate its uses, so it is not possible to say whether treatment of alcohol or drug disorders drove the increase. Statewide, however, use of naltrexone and Vivitrol increased more steeply, by 555 percent from 2014 to 2018. Given that McKinley County’s alcohol-related death rate far exceeds the statewide rate, this may be an indication that the drugs are still underutilized here for treating alcohol dependence.

Table 7: McKinley County 2018	County	State
Population	71,243	2,101,730
Poverty rate (2017)	37.8%	19%
Poverty rate for children under 18 (2017)	45.9%	25.9%
Families served by CYFD where SUD involved	51.9%	42.4%
Child abuse cases that are substantiated	46.0%	29.5%
Substantiated child abuse involving SUD	58.1%	46.0%
<i>SUD data by rate per 100,000 people</i>		
Alcohol-related deaths	201.2	70.3
Alcohol-related chronic liver disease deaths	74.9	25.6
Alcohol-related motor vehicle crash deaths	15.5	6.0
Drug overdose deaths	21.1	26.6

Source: DOH

**Chart 15: Utilization of Naltrexone has Increased More than Other MAT Drugs in McKinley County**

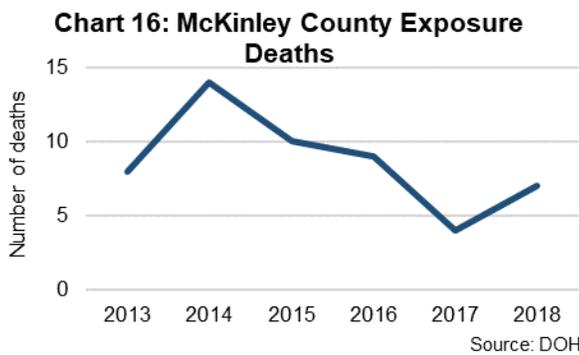


Source: LFC analysis of Medicaid data

Utilization of methadone and intensive outpatient treatment (IOP), meanwhile, remains extraordinarily low in McKinley. Medicaid data shows only 12 patients participating in IPO programs and 38 patients receiving methadone in 2018, although about two thousand patients accessed the wider array of assessment and therapy services.

**McKinley County’s alcohol problem – and the deaths associated with it – are concentrated in Gallup, in part due to the region’s unique cultural geography.** Gallup is the commercial hub of the county, and a border town for the Navajo reservation, where alcohol sales are prohibited. On the weekends, residents of the reservation and other rural towns come to Gallup to shop, access services, and according to many locals interviewed for this report, to have a good time. Some esti-

mates indicate that the city’s population can even double in size on the weekends. The city police increase the number of officers on shift on the weekend and the fire department sees its ambulance calls go up, with the need largely driven by alcohol use, according to officials from both departments. High densities of outlets for liquor sales are recognized as contributing to excessive drinking, while limiting their density is an evidence-based strategy for reducing it. Gallup has 34 full liquor licenses, which allow for package and on-site drink sales. Under New Mexico’s quota system, designed to limit liquor licenses based on population, a city Gallup’s size should have 11 full licenses.



Despite the severity and persistence of Gallup’s alcohol problem, the community has struggled to maintain basic services, such as detox, shelter, and residential treatment. Management of the Gallup Detox Center has changed repeatedly over the last 6 years: in 2013, management shifted from the Na’nizhoozhi Center Inc. (NCI), which had operated the center since the 1990s, to a city contract with the Navajo Nation that lasted until 2015, at which time the city took over operations and offered bare-bones detox before securing emergency federal funding to bring back NCI and to resume minimal shelter services in the fall of that year. During this volatile period, the city appears to have seen some rise in alcohol-related exposure deaths. The residential treatment program operated by Rehoboth McKinley Christian Health Care Services in Gallup also closed in 2014 due to financial difficulties, before reopening in the fall of 2015 under new leadership.

High densities of outlets for liquor sales are recognized as contributing to excessive drinking, while limiting their density is an evidence-based strategy for reducing it.

Gallup has 34 full liquor licenses, which allow for package and on-site drink sales. Under New Mexico’s quota system, designed to limit liquor licenses based on population, a city Gallup’s size should have 11 full licenses.

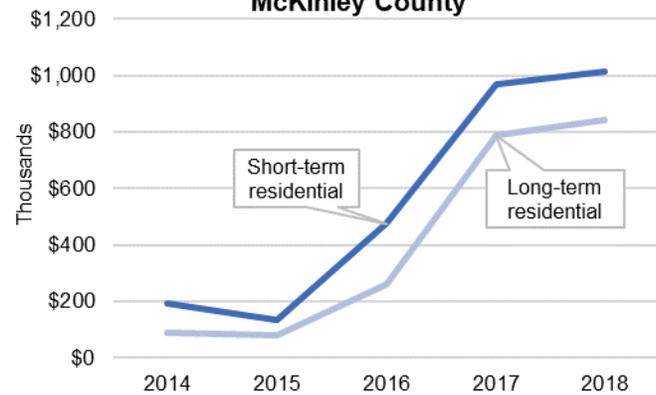
Since 2015, harm reduction services at the Gallup Detox Center and treatment through Rehoboth have stabilized and expanded considerably. Rehoboth has more than doubled its residential beds and expanded aftercare services to improve its clients’ success after leaving treatment. These changes are reflected in sharp increases in annual reimbursements from BHSD for residential treatment in McKinley County, from \$136.8 thousand for short-term residential in 2015 to \$1 million in 2018, and from \$81.5 thousand for long-term residential in 2015 to \$841.7 thousand in 2018.

**The state’s Behavioral Health Investment Zone grant has played a key role in building service capacity in Gallup.** The McKinley County Behavioral Health Investment Zone aimed to reduce alcohol-related injury and death. The BHIZ’s strategy, spearheaded by the city of Gallup, focused on both harm reduction and treatment. It included stabilizing and expanding social detox and shelter care, increasing the availability of counseling and case management services, increasing collaboration between providers, particularly Rehoboth and NCI, and increasing access to long-term residential treatment.

With its first year of funding, the city hired a manager to coordinate and implement the BHIZ plan and focused on shoring up services at NCI. The first year of BHIZ funding was released to the city in late FY16, which required the program to spend down the entire amount in a three or four months period. The city was able to use most of the funds for direct services at NCI, including counselors, behavioral health technicians and a detox manager; the remainder was used for miscellaneous items like building updates, office supplies and plumbing. Since the first year, the portion of the grant flowing to NCI has decreased, but the state money, along with funding from McKinley County’s local liquor excise tax, the city of Gallup general fund, and a new federal grant, have collectively facilitated a significant expansion of services at NCI.

In FY18, \$241 thousand of the BHIZ grant funded case management and individual and group counseling for NCI detox clients. Case managers and counselors target the top 200 utilizers of NCI each time they come in, as well as clients on a 72-hour hold. The hold is a form of protective custody that allows NCI to keep people for three days before releasing them, and it applies to clients who have utilized the facility more than twice within 30 days. Local funds amounting to \$835.5 thousand pay the salaries of management, nursing staff and behavioral health technicians at NCI, and fund the shelter and 72-hour hold program. The BHIZ has also funded training for NCI case managers, counselors and behavioral health technicians in evidence-based motivational interviewing, and weekly staff meetings to workshop cases. In FY19, the BHIZ reduced the state grant money funding core operations at NCI to \$141 thousand.

**Chart 17: State Spending on Residential Treatment Rose with Expanded Capacity in McKinley County**



Source: BHSD

In October 2017, Gallup leveraged these state and locally-funded programs to secure \$1.5 million in federal funds to further expand the detox center's services. Gallup has used the money to: keep its shelter open 24 hours a day and to add beds; to restart its First Step recovery program, which aims to recruit people into treatment with a commitment to only 15 days at a time; to expand case management and outpatient counseling capacity; to provide services for high-risk clients with complex medical needs; and to contract with the city police to transport clients from the hospital emergency room to NCI. Prior to the federal grant, only one-third of the building that houses that Gallup Detox Center was in use, according to city officials. The facility is now fully utilized. The federal grant expires in 2022.

The BHIZ also helped to rebuild Rehoboth's services since its reopening in 2015. Rehoboth's residential treatment program offers a 90-day program for up to 69 clients. The BHIZ does not fund its core services but rather staff positions designed to increase clients' success after treatment. These include a GED program for long-term residential clients and an aftercare counselor for Rehoboth's work program, which connects clients to employment opportunities in the community in the last phase of their residential stay. In FY19, Rehoboth received \$100 thousand of the BHIZ grant.

**Efforts by community leaders and providers, combined with an influx of public funds, have succeeded in significantly increasing substance use disorder services available in Gallup over the last five years.** But a lack of consistent and quality outcomes data makes it hard to judge the potential efficacy of the current service array or to determine what's working and what's still needed. Both NCI and Rehoboth were initially reluctant to participate in annual program evaluations for the BHIZ, which was a condition of the state grant. It took time to get the providers on board and to do data collection training for staff. Ongoing staff turnover in both organizations has also negatively impacted data collection.

There are some indications that harm reduction is having an effect, however. The volume of emergency medical calls to the Gallup Fire Department declined by 28 percent from 2014 to 2018, for instance. Emergency medical response accounts for 90 percent of the fire department's calls, and officials estimate half of those are alcohol-related.



Similarly, for the 2013 to 2018 period, alcohol-related exposure deaths peaked in 2014, the one full year the Gallup Detox Center did not offer shelter care. The number of exposure deaths dropped to four in 2017 before rising again in 2018 to seven, which was still just half the 2014 high. Demand for shelter service rose over this same period. The Gallup Detox Center had just over 26 thousand intakes in 2018, 1,400 more than 2017, due to 2,900 more shelter intakes than in 2017.

So far, the expanded service array at the detox center does not appear to be consistently resulting in referrals to treatment, however. In the first half of FY18, as part of its regular reporting to BHSD, the BHIZ reported 10 successful referrals to Rehoboth, eight to NCI's residential program, two to other residential programs, and 10 to outpatient treatment. In the second half of the year, it reported only two successful referrals to Rehoboth, zero to NCI, two to other residential treatment, and one to outpatient. In the first half of FY19, it reported two other residential referrals and none in the other categories. Additionally, of the clients NCI case managers and counselors engaged, 83 percent expressed no interest in treatment.

Gallup has successfully leveraged its BHIZ funding to secure an additional \$1.5 million in federal funds to further expand services.

Finally, while the city of Gallup has successfully stabilized NCI, it does not have a plan for directly replacing the BHIZ funds when the grant expires at the end of this fiscal year. Rehoboth is currently pursuing CARF accreditation in order to bill Medicaid for residential and outpatient treatment under the Centennial Care 2.0 waiver. To meet the requirements of the waiver, the facility will have to hire medical staff capable of starting clients on a MAT program during their stay. Rehoboth clients are currently able to maintain their MAT drugs while in treatment, but are not able to start any medications if they are not already on them.

***Alcohol-related death rates in McKinley County continue to rise.*** While more and better data would contribute to a clearer understanding of what's working in Gallup and what's not, the persistence of the problem is undoubtedly also a reflection of its complex underlying causes, including poverty and historical and intergenerational trauma. McKinley County has the highest poverty rate in the state: 38 percent of its population lived below the poverty line in 2017, compared to 19 percent in New Mexico as a whole and 13 percent in the U.S. Additionally, city officials noted a lack of funding for prevention as an ongoing challenge.

**Drug overdose deaths in Rio Arriba County have declined since hitting an all-time high in 2014, as access to medication-assisted treatment and overdose reversal drugs has expanded. But the alcohol-related death rate remains troublingly high.**

The opioid crisis hit Rio Arriba County earlier and more severely than the rest of the nation, and it was driven by heroin rather than prescription pills. In 1999, the rate of drug overdose deaths in Rio Arriba County was 50.2 per 100,000 people, more than triple the statewide rate and eight times the national rate. The gap is not quite as wide today – in 2017, the county's overdose death rate was four times the national rate – primarily due to the rapid increase in opioid-related deaths around the country.

Because the county's drug-related death rate is so high compared to the rest of the state and the nation, efforts to combat substance abuse have mainly targeted opioids. But alcohol is an even heavier burden on the community. The county's alcohol-related

death rate was 79 percent higher than its overdose death rate in 2018 and more than double the statewide alcohol-related death rate.

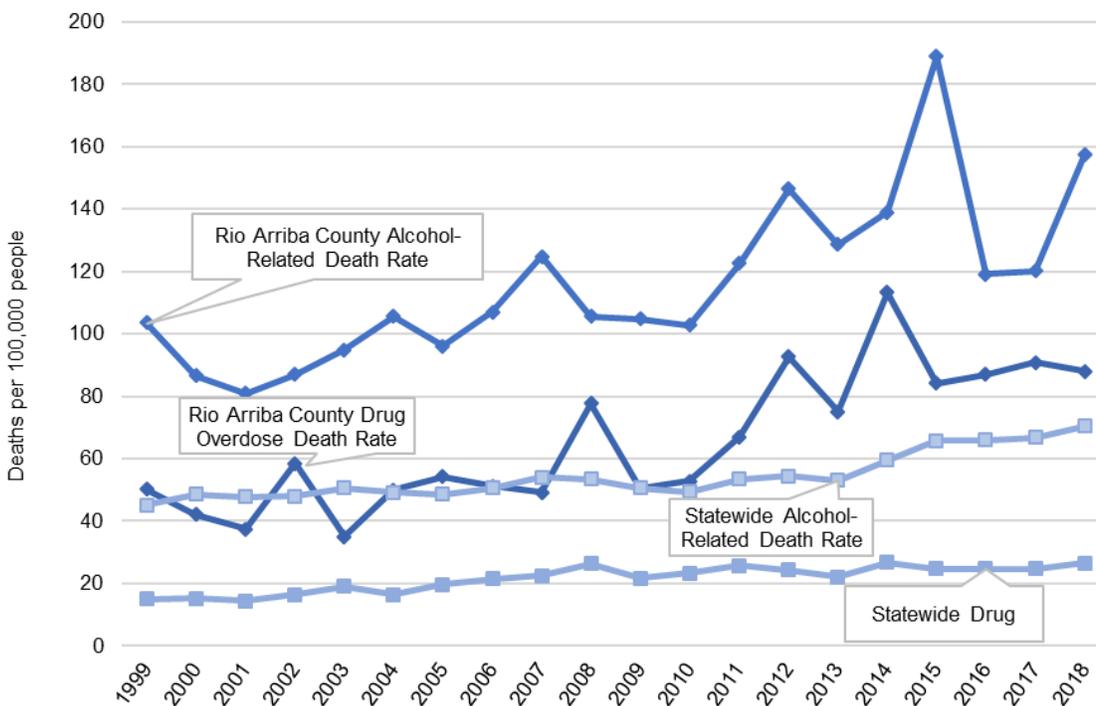
After reaching an all-time high in 2014, the drug overdose death rate in Rio Arriba County dropped significantly in 2015, and, with only small changes each year since then, may have stabilized. The number of deaths from prescription opioids and benzodiazepines also reached its peak in 2014 and has since declined. Today, deaths from illicit drugs outnumber those from prescription drugs. Similarly, after peaking in 2015, the rate of opioid-related emergency department visits has dropped three years in a row.

**In the midst of these trends, county residents have seen expanded access to treatment.** Medicaid expansion brought the same broad expansion of services to Rio Arriba county as to the rest of the state. The county focused its Behavioral Health Investment Zone funding largely on developing an integrated case management system that would help clients and their providers navigate among the new services and coordinate care to ensure the most effective treatment. According to Medicaid data, the number of people who received MAT for opioid use disorders in the form of the drugs buprenorphine or Suboxone rose by 83 percent from 2014 to 2018. The number of Medicaid clients receiving methadone treatment for opioid use disorders more than

Table 8: Rio Arriba County 2018	County	State
Population	39,118	2,101,730
Poverty rate (2017)	28.9%	19%
Poverty rate for children under 18 (2017)	32.6%	25.9%
Families served by CYFD where SUD involved	57.4%	42.4%
Child abuse cases that are substantiated	41.0%	29.5%
Substantiated child abuse involving SUD	56.4%	46.0%
<i>SUD data by rate per 100,000 people</i>		
Alcohol-related deaths	157.4	70.3
Alcohol-related chronic liver disease deaths	58.3	25.6
Alcohol-related motor vehicle crash deaths	14.3	6.0
Drug overdose deaths	88.1	26.6

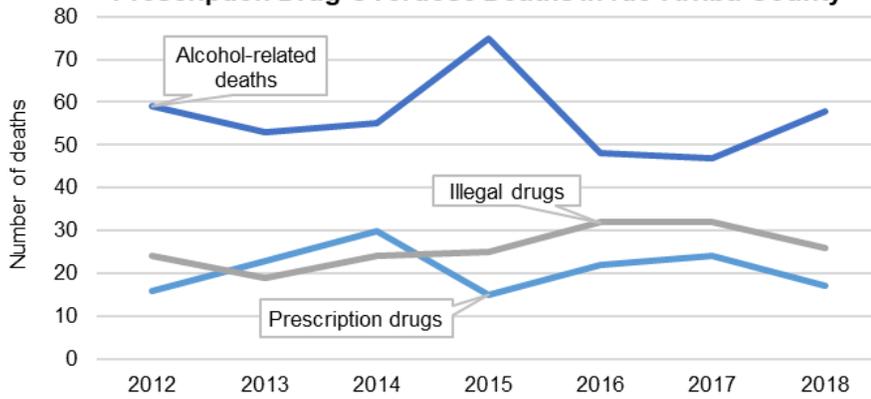
Source: DOH

**Chart 18: Alcohol-Related and Drug Overdose Death Rates: Rio Arriba County and Statewide**



Source: DOH IBIS

**Chart 19: Overdose Deaths from Illicit Drugs Outnumber Prescription Drug Overdose Deaths in Rio Arriba County**



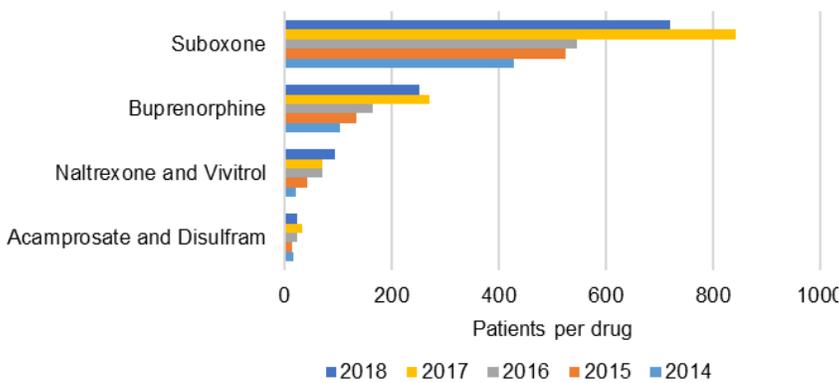
Source: DOH

doubled, from 310 in 2014 to 631 in 2018, while the number who received the overdose reversal drug naloxone rose by 737 percent. The number of people participating in intensive outpatient programs also doubled, from 47 to 91, while the number of people accessing short and long term residential treatment increased by 31 percent, from 83 in 2014 to 110 in 2018.

**Rio Arriba County's Behavioral Health Investment Zone sought to reduce the county's death and injury rates from opioids within the five-year term of the grant by developing a coordinated, county-wide treatment system.**

The effort included a short-term strategy to distribute the overdose reversal drug Narcan to high-risk populations, and a long-term strategy to develop a coordinated treatment, case management and referral system among providers, public entities and social service organizations. The Rio Arriba County Health and Human Services Department serves as the hub for this system, which includes approximately 20 participating organizations collectively known as the Opioid Use Reduction (OUR) Network.

**Chart 20: MAT Drugs for Alcohol Remain Underutilized in Rio Arriba County**



Source: LFC analysis of Medicaid data

The county has spent the majority of its BHIZ money on contractual services, a broad category covering about \$215 thousand annually for direct services, as well as funding Pathways software, Narcan kits, and meeting facilitation. From FY16 to FY19, the county spent 63 percent of its grant, or \$949 thousand, on these services.

Its other major spending focus was building the OUR Network. It hired a hub manager and four case managers within the county's Health and Human Services Department, including a re-entry specialist based in the county jail who connects inmates with SUDs with Medicaid coverage and treatment upon release. From FY16 to FY19, the county spent 32 percent of its grant, or \$485.3 thousand, on salaries, benefits and other costs associated with these positions.

Central to the network's strategy was the adoption of a health information technology (IT) system aligned with the core conceptual model of Pathways case management, which the county has been using for many years. Pathways facilitates care coordination between providers, tracks outcomes, and pays providers when certain milestones related to a patient's identified needs are reached. The model was developed in Ohio to coordinate the delivery of medical care with wraparound services to address social determinants of health, such as housing and food insecurity. It has proven effective at

addressing issues such as low birthweights in impoverished communities, but Rio Arriba County was the first entity to apply the system to SUDs.

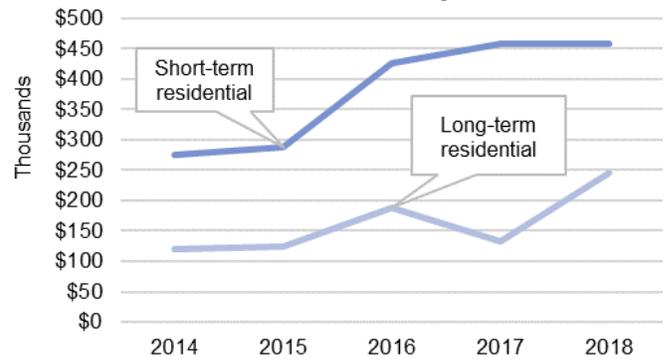
**The Pathways model is well-suited to treating substance use disorders in theory, but successfully implementing it in Rio Arriba County has proven difficult.** Pathways works by identifying a client’s health, economic and social needs and tracking their progress in meeting that need with a measureable outcome. Each need constitutes a “pathway,” and a client may be on multiple pathways at a time – one for behavioral health needs and another for securing housing, for instance. In 2017, the county adopted an IT system meant to support the referrals and sharing of provider data integral to the Pathways case management model. The IT system allows for centralized tracking of clients utilizing services from a variety of providers, and is supposed to produce data the hub can use to identify barriers or gaps in the system as well as outcomes and achievements.

The Pathways model of care is well-suited to the complex needs of patients with SUDs, but case managers in Rio Arriba County found the IT system the county chose did not allow them to track many of the services they provide, such as transportation, helping clients get identification, or securing a spot on a treatment wait list, nor did it capture the data needed to identify barriers their clients were experiencing. Thus, case managers continued to document much of their work with clients in case notes entered in the software, rather than using the predetermined fields in the system that would allow the hub to pull and analyze data on the system as a whole.

Inconsistent data entry and logistical delays in getting the IT system integrated with some providers’ existing medical records systems has prevented the county from fully implementing the outcomes-based payment aspect of the model. The county is confident the Pathways model is producing positive outcomes, but because of the shortcomings of the IT system there is little data to support this position. The county was recently invited to apply for a community opioid response evaluation grant from the Pew Charitable Trusts, which should lead to improved data collection and analysis.

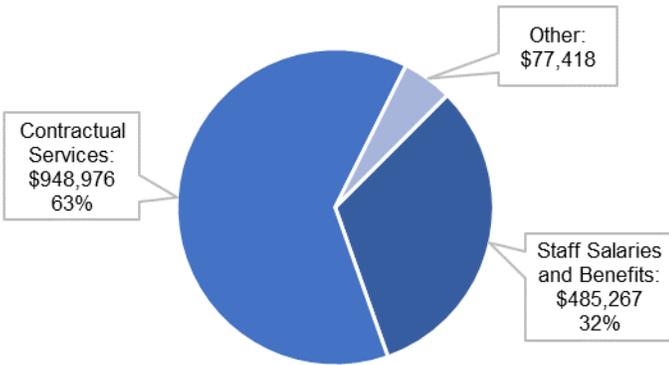
**Over the life of the grant, an increasing portion of the contract money has gone to medical and behavioral health service providers.** In addition to services, the contracts paid for staff from each agency to participate in trainings and meetings to develop and implement the Pathways system. Contracts also covered time for staff to participate in taskforces targeting specific issues and populations, such as jail diversion, detox, transitional living, pregnant women, and overdose prevention and outreach. The taskforces have been a key component of leveraging BHIZ funding, because their members have worked to identify issues, gather information and develop potential solutions that the county has been able to use to enhance programming and as the basis for several successful grant applications. The contracts were designed this way because the primary focus of the BHIZ was systems development rather than direct service provision.

**Chart 21: Utilization of Short-Term Residential Treatment Has Increased in Rio Arriba County**



Source: BHSD

**Chart 22: Rio Arriba County BHIZ Spending Categories, FY16 - FY19**



Source: Rio Arriba County

Three BHIZ-funded case management positions are located in the county Health and Human Services Department in Espanola, and one is based in the county jail in Tierra Amarilla. The county’s case managers have served 403 clients since they began using the Pathways software in November 2017. The BHIZ’s FY19 evaluation reported data for 210 active clients in the system. Case managers provide a variety of supports to their clients, from connecting them to residential and outpatient treatment, to assisting with securing housing, employment and legal assistance, to providing transportation to appointments. One of the BHIZ provider contracts funds an additional case manager through Las Cumbres Community Services, which works exclusively with pregnant women with SUD, and with parents of infants and toddlers, prioritizing those at risk of incarceration.

County officials report that case management within the jail has been particularly successful. A majority of the county’s clients have been incarcerated at some point, and officials see the re-entry work as an important step toward one of its central goals, reducing incarceration for issues related to substance abuse and increasing diversion to treatment instead. In FY18, the re-entry specialist successfully referred 50 inmates to treatment upon release compared to four the previous year. In FY19, the BHIZ expanded its efforts targeting the criminal justice system, splitting the cost of hiring a coordinator through the Health and Human Services Department with another grant to develop a law enforcement assisted diversion (LEAD) program. LEAD programs aim to connect low-level offenders to treatment instead of sending them to jail, breaking both the cycle of substance abuse and incarceration.

Among providers, Hoy Recovery has been the largest beneficiary of BHIZ money in Rio Arriba County. Located in Velarde, Hoy is a 48-bed adult residential treatment center, with eight beds set aside for social detox. The agency also operates an outpatient addiction treatment clinic in Espanola. Hoy obtained CARF accreditation in 2019 with training and financial support from BHSD. From FY17 to FY19, Hoy received a flat \$100 thousand annually from the BHIZ.

When the BHIZ was formed, Rio Arriba County did not have a detox facility, and a social detox center in Taos had recently closed. Hoy’s BHIZ contract supported the addition of detox to fill the gap in the county’s continuum of services. It also paid the salary of an intake coordinator to conduct assessments and intake for clients referred to Hoy through the OUR network.

However, OUR network case managers initially encountered difficulty getting their clients into Hoy. Hoy took clients on a first-come, first-served basis, and was not able to give clients from Rio Arriba County special priority due to BHSD requirements that they serve the entire state. The facility often had a wait list. According to BHSD claims data, Hoy served clients from 27 New Mexico counties in 2017 and 2018. In 2017, 20 percent of its detox and residential clients were from Rio Arriba County, and in 2018, 14 percent were county residents. It also frequently served clients from Santa Fe, Taos and Bernalillo counties.

Additionally, many of the clients Rio Arriba case managers tried to get into treatment were coming directly from jail and often had illicit substances in their systems, according to county staff. Because it took time to get detox up and running, and because

Hoy initially could not take people with benzodiazepines in their systems due to potential medical complications, clients did not always qualify for intake. In its 2018 semi-annual report to BHSD, the county reported that only two of 16 jail-based clients referred to Hoy were accepted. Clients who could not get into Hoy usually accessed treatment elsewhere, such as at Turquoise Lodge or Santa Fe Recovery, but those providers are not part of the OUR Network, which limited the county's capacity to track its clients' success. The county's referral rate to Hoy has since improved. In FY19, Hoy took seven of 12 successful referrals to residential treatment.

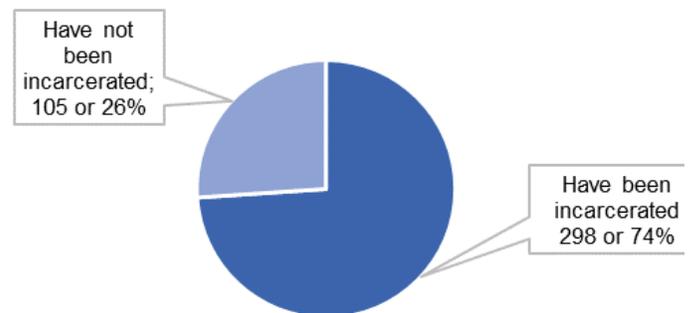
Still, this means that in practice, Hoy's BHIZ contract has provided general, flexible support for residential treatment in Rio Arriba County rather than direct services to county residents. Hoy provides short-term residential services of 30 days, as well as long-term-residential up to 90 days and transitional living beyond 90 days. According to Hoy staff, lower reimbursement rates for longer-term services do not cover the cost of those services and the agency uses the BHIZ money, small grants, and a \$150 admission fee it charges residential clients to cover the gap. The final year of Hoy's contract was changed from a flat fee to payment based on services delivered. The BHIZ implemented a similar contract change for Las Cumbres. It should also be noted that Hoy is among the residential facilities actively pursuing eligibility to bill Medicaid for its services. As of the publication of this report, the agency was working with BHSD to complete its application.

The BHIZ's evaluation firm recently created a supplemental data collection tool, alongside the Pathways system, in order to better understand the activities of case managers, barriers in the system, and client needs and outcomes. Though the data is limited and covers only one year, it provides some valuable insights and highlights the need for quality data to guide the development of effective treatment systems going forward.

According to county officials, the data yielded constructive information on clients' treatment preferences and showed promise for evaluating the efficacy of different approaches. Case managers made far more referrals to MAT in FY19 than to residential treatment, with 73 referrals to MAT and 18 to residential treatment. Case managers offered a few possible explanations for the pattern, which is driven by client interest: some clients have tried residential treatment in the past or know others who have tried it without success, it's easier to begin MAT quickly, and many clients don't want to go to detox, which they must do before they can be admitted to residential treatment but is not necessary to begin medication.

Referrals to treatment by county case managers were not always successful, either because the client was not able to connect with services or because the client was unable to remain in treatment. Of the 73 clients referred to MAT by county case managers, 82 percent succeeded in getting at least an initial appointment with a provider, 67 percent of referrals to residential treatment were accepted into treatment, and 47 percent were compliant with MAT treatment program for three or more months. Forty-one percent of clients referred to residential treatment were compliant. The data sets are quite small and should be interpreted cautiously, but more robust data in the same vein would be highly valuable.

**Chart 23: Rio Arriba County Case Management Clients Who Have Been Incarcerated**



Source: Rio Arriba County



Rio Arriba County was awarded a three-year, \$1 million federal grant to improve interventions for opioid use disorders and build on the work of its BHIZ. The county plans to use the grant to expand its case management capacity and delivery of MAT, and establish a residential treatment facility specifically for clients diverted from the county jail.

***Rio Arriba County successfully leveraged the state BHIZ funding into a federal grant to expand its efforts to address the negative consequences of substance abuse.***

In August 2019, Rio Arriba County was awarded a three-year, \$1 million grant from the federal Health Resources and Services Administration (HRSA) to improve interventions for opioid use disorders and build on the work of its state-funded BHIZ. The county plans to use the grant to expand its case management capacity and delivery of MAT, with an eye toward establishing a residential treatment facility specifically for clients diverted from the county jail. The network of providers, referral pathways and local care coordination that has been the central project of its BHIZ was critical in establishing the infrastructure that qualified it for the HRSA grant, according to county officials. El Centro Family Health, which operates primary care clinics throughout northern New Mexico – including an Espanola clinic co-located with the Rio Arriba County Health and Human Services Department – also received \$1 million in the same round of HRSA awards. El Centro will use the grant to expand MAT across its clinical network, with the goal of 90 percent of prescribers offering the service to patients. The county does not, however, have a plan for directly replacing the BHIZ funds when the grant expires at the end of this fiscal year.

***Stabilization in the rate of drug deaths is a sign of progress, while high alcohol-related deaths are concerning.***

The drop in the 2018 drug death rate in Rio Arriba County and its relative stabilization is reason for guarded optimism given the context: a national opioid crisis and a county that has struggled under the burden of substance abuse for decades. The significant increase in alcohol-related deaths, however, remains troubling, not least because so few of the BHIZ efforts focused on alcohol dependence. The county’s current focus on systems change, and in particular on interventions in its criminal justice system, are promising but still in their very early stages.

## Conclusion

New Mexico has made important strides over the last five years to address the terrible human, social and economic costs of SUD in the state. But SUD is a chronic, persistent disease which takes many different forms and responds to different treatments for different people, which means the public policies that the state adopts to respond to it must be just as varied – and just as persistent.

### What’s working in the state today?

Two major public policies are working for New Mexico: Medicaid expansion and the wide-spread distribution and use of naloxone. Since 2014, Medicaid expansion allowed thousands of people suffering from SUD to access behavioral health services that were never before available to them. Even the people who have accessed non-Medicaid services like residential treatment are a reflection of Medicaid expansion – most receive the majority of their other healthcare services, including important MAT medications, through Medicaid, where they have the experience of successfully managing the healthcare system for the first time.

The importance of naloxone for New Mexico cannot be understated. The Legislature has passed law after law expanding access to naloxone and protecting those who use

it from civil liability, and the Behavioral Health Services Division and the Department of Health have done significant work getting this life-saving drug into the hands of people in all walks of life – providers, pharmacists, first responders, family members, and nearly everyone receiving a prescription for an opioid pain medication. Naloxone is powerful past its immediate use as an overdose reversal drug – it empowers the people who administer it to a friend or family member in crisis, it helps defeat the stigma around SUD, and research shows those whose lives it saves are more likely to seek treatment afterwards.

The Prescription Monitoring Program has also proven to be an effective tool for reducing inappropriate prescribing of opioids and benzodiazepines, although more consistent use of this important resource should lead to even greater reductions in prescription drug abuse and deaths.

### **What are some promising avenues for further progress?**

This brief identified several areas where the state is poised to move forward, if only we take advantage of the opportunities in front of us. There are many touchpoints in the healthcare system that hold the possibility of recognizing and addressing SUD. Emergency departments are at the epicenter of the SUD crisis, as people experiencing drug overdose, alcohol poisoning, painful withdrawal, or any of the other potential acute conditions related to SUD come through their doors in moments of stress and vulnerability. Primary care providers are at the other end of the healthcare spectrum, interacting with their patients at generally calmer moments when concerns and questions can be addressed. At both these points – and no doubt many in between – there are immediate, evidence-based SUD interventions that any practitioner could administer. No person should pass through the emergency department – or the hospital – without at least a brief behavioral health screening, and no SUD patient should leave the hospital or emergency department without being offered an appropriate medication and referral to treatment. Similarly, every primary care practitioner should be able and willing to conduct SBIRT with every patient and offer MAT to those who need it. Yet only a handful of our state’s hospitals are taking advantage of the outsized role they could be playing, and only a fraction of our healthcare providers are certified to offer either SBIRT or MAT.

Another potential touchpoint comes for some individuals when they interact with the justice system. Bernalillo County’s Metropolitan Detention Center (MDC) is leading the way for jails around the state with an innovative approach to providing MAT for inmates, showing it can grow its program as new opportunities arise, and changing from a release protocol where released inmates were dropped on a street corner in the small hours of the night to having them exit through a reentry center dedicated to re-connecting them to resources they need to stay alive, be healthy and avoid a quick return to incarceration. The MDC model may not be a one-size-fits-all solution for smaller counties: the San Miguel County Detention Center has developed its own MAT and reentry model. But most other county jails in New Mexico still bring newly-incarcerated people with SUD into custody and leave them to go through grueling and sometimes life-threatening detox on their own with little medical assistance, no treatment, and no chance of coming to meaningful grips with the chronic disease that very likely was responsible for bringing them to the attention of law enforcement to begin with. Prisons, emergency rooms, and family physicians may not seem like they have that much in common – but each of them offers the chance to touch and redirect.

#### What’s working?

Medicaid expansion

Harm reduction and  
Narcan

Prescription monitoring  
program

There are many touchpoints in the healthcare system that hold the possibility of recognizing and addressing SUD. This brief has highlighted three of these:

Emergency departments and hospitals should conduct at least a brief behavioral health screening for all patients, and all SUD patients should be offered appropriate medication and referral to treatment.

Every primary care practitioner should be able and willing to conduct SBIRT with every patient and offer MAT to those who need it.

Individuals who interact with the justice system should receive SBIRT assessments and a behavioral health standard of care that includes full MAT services for those who need them.

There are also promising changes happening to the Medicaid program itself. Centennial Care 2.0 offers new and important services to patients and new sources of stable funding for providers. The Human Services Department (HSD) has made great strides raising reimbursement rates for healthcare providers, with the goal of expanding services as more providers become willing to accept Medicaid rates and care for Medicaid patients. As of October 1, 2019, HSD increased rates for the top 40 most used behavioral health services by an average 27 percent; the rates for methadone administration, IOP, ACT and MST were all raised by 29.5 percent. However, as of the date of this brief, most providers had not yet received any increase to their rates because of the time required to reprogram payment systems. We should be able to see if the goal of the rate increases is met by looking again at the number of providers accepting Medicaid in another year.

Other system-level changes are occurring at the county level. The Legislature funded the two behavioral health investment zones, established in McKinley and Rio Arriba counties, in 2015, the same year Bernalillo County enacted its behavioral health tax initiative. This brief has investigated in some detail how each of these counties has used to its new funds to build capacity and administrative infrastructure, and to some extent expand service delivery, with more expansion and new services promised for the future. There is no point attempting a direct comparison of progress made by a large and well-resourced county like Bernalillo to that of much poorer and hard-pressed county like McKinley; the point here is that each county has made progress from its own unique starting point and each is planning the ways it can continue building its behavioral health system.

Also in the ‘promising’ category is the current reinvigoration of the Behavioral Health Collaborative. The Collaborative is a tremendous opportunity to coordinate the resources, experience and expertise of multiple state agencies into a truly collaborative approach to addressing the behavioral health challenges of New Mexico. Current Collaborative leadership has established four goals and divided responsibility for them among the five largest agencies; the Human Services Department is to address stabilization and expansion of the behavioral health workforce, the Children, Youth and Families Department is charged with expanding community based mental health services for children, the Department of Health (DOH) will be responsible for addressing the SUD crisis, and the Corrections Department will work to provide effective behavioral health services for justice-involved individuals.

The agencies of the Collaborative will be presenting a joint behavioral health budget proposal to the Legislature this year for the first time in several years; initial versions of that \$35 million request show 28 initiatives including plans by DOH to expand MAT, create an alcohol prevention office and increase availability of crisis triage and stabilization services.

### **What are our greatest remaining challenges?**

Remaining challenges are significant. New Mexico has had the highest alcohol related death rate of any state since 1997, and the rate increased again in 2018. DOH has noted that the state has not implemented most recommended prevention strategies for excessive alcohol use. A 2019 DOH report recommends implementing effective prevention strategies including increased alcohol taxes, regulation of alcohol outlet density, screening, brief intervention and referral to treat-

ment (SBIRT), and limiting alcohol sales. Drug overdose death rates had a small increase in 2018, although DOH reports that New Mexico has made progress on some types of drugs (for example, New Mexico has implemented all of six key National Safety Council policies on opioid prevention). Surges in newer drugs such as methamphetamine and fentanyl, however, have posed new challenges to the treatment community. Continued focus on evidence-based strategies for prevention, intervention, and treatment will be key in moving the needle.

Although progress has been made through Medicaid expansion and individual county efforts, progress is often slow, system infrastructure in some communities is somewhat fragile, and overall state outcomes have not improved. Medicaid and non-Medicaid spending appears to have increased by a large amount, but most of that is driven by Medicaid expansion and the addition of over 250,000 new people to the Medicaid rolls. On average in 2018, each person with an SUD diagnosis received only about \$1,100 in direct services, an amount that likely indicates not enough assistance to make a meaningful difference. Until outcomes improve, excessive and unwarranted use of alcohol and illicit or illegal drugs will continue to take significant tolls on the New Mexico economy, the behavioral health and health care system, and New Mexico families.

Finally, everywhere LFC staff working on this brief went, every person LFC staff spoke with, talked about the stigma associated with SUD and the multiple ways in which that stigma keeps us from moving forward. Many people still perceive SUD, whether alcohol, illegal drugs or legal prescription drugs, as an individual moral failing. Thinking of SUD this way stops people from seeking the help they need, stops providers from offering appropriate evidence-based treatment, and stops people from understanding that SUD recovery is not linear and that the relapses that characterize the process are not failings. Framing SUD as a moral failing does not allow us to make the critical connections between the disease and its origins in social determinants like poverty and childhood trauma, and creates ambivalence when action is needed. We now have decades of research to inform us about the nature of the disease and promising ways to treat it, both through medication and therapies. Continued monitoring, along with concerted efforts to address these issues through strategic prevention, intervention and treatment with evidence-based programs and practices will be necessary to improve outcomes for New Mexico families.

## Appendix A: Data Sources and Acknowledgements

### Major cost and utilization of services data sources used for this Health Note:

#### Human Services Department

- Medicaid managed care encounter data, 2014 – 2018
- Medicaid fee for service claims data, 2014 – 2018
- Medicaid prescription drug claims data, 2014 – 2018

#### Behavioral Health Services Division

- Non-Medicaid behavioral health claims data
- OptumHealth of New Mexico 2014 – 2016
- Falling Colors 2017 – 2018
- BHIZ documents

#### Children, Youth and Families Department

- Ad hoc data requests related to services provided to children and families

#### Department of Health

- On-line Indicator-based Information System for Public Health (IBIS)
- Numerous ad hoc requests of the Epidemiology and Response Division for more detailed data
- DOH facilities for financial and utilization data

### Assistance and information from the counties came primarily from:

- Bernalillo County Department of Behavioral Health Services: Katrina Hotrum-Lopez, Margarita Chavez, Charlie Verploegh, Pam Acosta, and others.
- City of Gallup: Maryann Ustick, Debra Martinez, Fire Chief Eric Babcock, and others.
- Rio Arriba County Department of Health and Human Services: Lauren Reichelt, Amber Leichtle, Hannah Smith, Alicia Aguilar, and others.

**Lastly, our acknowledgment and deep appreciation for all of the providers and advocates working on the front lines of the SUD crisis who took time to meet with LFC staff to inform and educate us.**

## Appendix B: Medication-Assisted Treatment Drugs

None of these medications is a cure for substance use disorder, and standard of practice for each of them stresses they should be used as part of a comprehensive therapeutic approach. Each of them in some way limits the positive experience of the substance, essentially buying a person time to remain sober and in treatment long enough to address the underlying causes of their disorder and change their behavior patterns. Best practices for all of these medications indicate a person should be maintained on them for months or even years, depending on their individual experience with SUD and their recovery process. It frequently takes someone who has been chronically abusing drugs or alcohol several months to re-establish some form of stability in their life, and only then can they begin to focus on recovery. Note: the drugs listed here are FDA approved for treatment of substance use disorder. An array of other drugs may be used as off-label treatment, often for the symptoms of withdrawal.

### Medications for opioid use disorder

**Methadone** is an opioid agonist, which means that it acts by attaching to the opioid receptors in the brain, leaving no room for other opioids. Its effects are mild – it eases pain but with much less of the euphoria associated with heroin or other prescription pain killers like oxycodone – and users are able to function in their daily lives without cravings to ‘get high’ and without going through withdrawal. A person does not have to be in withdrawal from other opioids to begin taking methadone. Methadone is a daily medication, and patients must generally come to the clinic every day to take their dose under clinical supervision, making diversion difficult (after prolonged successful compliance with treatment some patients are able to take some doses home). Because methadone is classified by the DEA as a schedule II drug, with a high potential for abuse, methadone providers must be accredited through SAMHSA as an opioid treatment program and follow rigorous federal treatment standards. It has been used to treat opioid addiction since 1947 and is widely considered to be safe and effective when administered and taken correctly.

**Buprenorphine** is a partial opioid agonist, which means that it, too, attaches to the receptors in the brain and blocks other opioids, but its pain killing and euphoria effects are weaker than methadone. The effects of buprenorphine also level off at a moderate dose, so even if a person takes more the effects will not increase, which discourages misuse. Buprenorphine requires medically monitored induction because timing is important: a person must already be at least 12 to 24 hours into withdrawal from other opioids because if buprenorphine is started too soon it can trigger abrupt, painful withdrawal. Buprenorphine comes in several forms – pills, film, monthly extended release injection and six month subcutaneous implants. Buprenorphine is classified by the DEA as a schedule III drug, with a moderate to low potential for dependence, but prescribers are still required to complete specialized training and be certified through SAMHSA. **Subutex** is a brand name for buprenorphine.

**Suboxone** is the brand name for combined buprenorphine and **naloxone**, the medication that blocks opioid receptors and stops overdoses. The buprenorphine provides some pain relief while the naloxone blocks any opioid-related euphoria and discourages misuse. Suboxone comes as a film or a pill, both meant to be dissolved under the tongue. If the Suboxone pill is taken correctly, the buprenorphine works as it is supposed to, but if a person crushes the tablets to inject the drug, the naloxone kicks in and can trigger abrupt and painful withdrawal. Like the buprenorphine it contains, Suboxone is classified by the DEA as a schedule III drug, and prescribers are required to complete specialized training and be certified through SAMHSA.

**Naltrexone** is an opioid antagonist, meaning that it blocks, rather than binds to, the brain’s opioid receptors. It has no pain reducing or euphoric effects of its own, and if a person takes an opioid while on naltrexone the drug blocks the expected effects; even though it provides no ‘high’ of its own, naltrexone has been shown to reduce drug cravings and has little risk of diversion or misuse. Because naltrexone completely blocks the opioid action, a person must have completed initial withdrawal from any opioids, usually seven to 10 days before starting naloxone to avoid going into immediate with-

drawal. Naltrexone is available as a once a day pill or as a monthly extended release injection; the injection is sold under the brand name **Vivitrol**. Providers are not required to have any special training or certification before prescribing naltrexone.

**Naloxone** is an opioid antagonist that reverses an opioid overdose. It is drawn to the brain's opioid receptors more strongly than heroin or other opioids, and when administered to someone who is having an overdose it removes the opioid from the receptors for a short while. That reverses the overdose and allows the person to resume breathing normally. Depending on the amount of opioids the person has taken, more than one dose may be necessary. Naloxone has no effect on someone who does not have opioids in their system and it has no other positive effect on the brain, so there is no potential for diversion or misuse. Naloxone is also sold under the brand name Narcan.

### **Medications for alcohol use disorder**

**Disulfiram** works by changing the way the body metabolizes alcohol and creating an aversive reaction. It breaks the alcohol down into the same toxic chemical that causes hangovers, and then blocks the body from breaking it down further, so that a person keeps feeling sick for a prolonged period of time. Because of the way it interacts with even a small amount of alcohol, disulfiram cannot be started until at least 12 hours after a person has consumed alcohol. **Antabuse** is the brand name for disulfiram.

**Acamprosate** acts in the brain to block the positive feelings of being intoxicated and over time helps to re-stabilize brain chemicals that were damaged by years of alcohol abuse. Research indicates it is most useful as supportive therapy for people who have already stopped drinking. It does not mitigate any of the negative effects of alcohol withdrawal and so people should not start this medication until five to eight days after they stop drinking. Acamprosate comes in a pill that is taken two or three times per day. **Campral** is the brand name for acamprosate.

**Naltrexone** can also be used for alcohol dependency, where it blocks the positive feeling of being intoxicated and reduces cravings for alcohol. Without an incentive for relapse, some people are able to stay sober and in treatment for longer periods of time, increasing the potential for recovery. Naltrexone is available as a once a day pill or as a monthly extended release injection; the injection is sold under the brand name **Vivitrol**.

**Benzodiazepines** are anti-anxiety medications that affect the same receptors in the brain that alcohol does. That allows the body to withdraw from alcohol without feeling the full negative effects, and lessens symptoms of alcohol withdrawal like hallucinations or seizures. Because this class of drugs is highly addictive, benzodiazepines are used only until the most severe symptoms of withdrawal pass.

## Appendix C: 2018 SUD death rates for all counties

	Alcohol-related deaths	Alcohol-related death rate per 100,000 people	Drug overdose deaths	Drug overdose death rate per 100,000 people	Population
<b>Statewide</b>	<b>1,544</b>	<b>70.3</b>	<b>537</b>	<b>26.6</b>	<b>2,101,730</b>
Bernalillo County	479	65.2	191	27.5	678,216
Catron County	**	**	**	**	3,518
Chaves County	48	69.5	12	18.7	64,811
Cibola County	24	86.6	6	24.2	27,103
Colfax County	9	67.9	5	43	12,147
Curry County	22	48.4	9	23.9	50,028
De Baca County	**	**	0	0	1,805
Dona Ana County	94	42.3	33	17.5	217,401
Eddy County	49	83.1	21	36.4	58,162
Grant County	18	62.1	8	28.7	27,628
Guadalupe County	**	**	0	0	4,381
Harding County	**	**	0	0	698
Hidalgo County	**	**	**	**	4,315
Lea County	39	58.3	14	20.7	70,832
Lincoln County	15	54.7	5	27	19,548
Los Alamos County	7	36.4	3	12.4	18,809
Luna County	13	50.7	8	38.8	24,635
McKinley County	136	201.2	14	21.1	71,243
Mora County	**	**	**	**	4,505
Otero County	42	62	12	18.7	66,887
Quay County	9	90	1	6.8	8,368
Rio Arriba County	58	157.4	31	88.1	39,118
Roosevelt County	7	44.8	0	0	19,356
Sandoval County	92	61.4	33	22.6	145,153
San Juan County	135	108	21	18.2	128,046
San Miguel County	23	69.9	10	33.8	28,030
Santa Fe County	93	56.6	40	29.9	149,813
Sierra County	9	75.2	8	108.1	11,119
Socorro County	16	94.3	5	26.3	17,108
Taos County	29	82.3	10	37.3	32,907
Torrance County	11	63.5	6	39.3	15,811
Union County	**	**	0	0	4,163
Valencia County	51	62.2	26	37.3	76,064

\*\* Some counties are excluded because number is too small for publication.  
Source: DOH IBIS