

Addressing Substance Use Disorders

Summary

Drug overdose and alcohol-related deaths in New Mexico reached all-time highs in 2020, even though the state has tripled spending on substance use treatment since 2014. A 2019 LFC *Health Note* on substance use disorders found access to treatment had expanded significantly along with spending, and the state has since built on that progress by bringing new behavioral health services into Medicaid coverage, including residential treatment for substance use, peer support, and more. Inclusion in the Medicaid benefit package promises to stabilize service availability and improve its quality.

The Health Note: *The 2019 report found Medicaid expansion helped the state to nearly double spending on substance use treatment and to expand access to medication-assisted treatment. But the report noted critical gaps in the system remained. Alcohol was New Mexico's predominant problem, but received less policy attention than opioids and effective medications for alcohol dependence were chronically underused. Implementation of new Medicaid-eligible substance use services was behind schedule, and the report found that pervasive stigma prevented the state from effectively addressing substance use, creating ambivalence where action was needed.*

The COVID-19 pandemic may have contributed to the number of avoidable deaths in 2020 and limited further expansion of treatment. Still, that the most severe consequences of substance use disorders continue to worsen despite increased access to services indicates treatment is an essential but incomplete solution. The state must also improve its prevention and early intervention programs, particularly those that can address the complex, underlying causes of substance abuse, including poverty and childhood trauma.

Additionally, little progress has been made to close one of the most glaring gaps in the treatment system—the criminal justice system. Insufficient access to effective treatment in jails and prisons and to evidence-based diversion programs help to perpetuate cycles of substance abuse and incarceration.

Progress Reports foster accountability by assessing the implementation status of previous program evaluation reports, recommendations and need for further changes.



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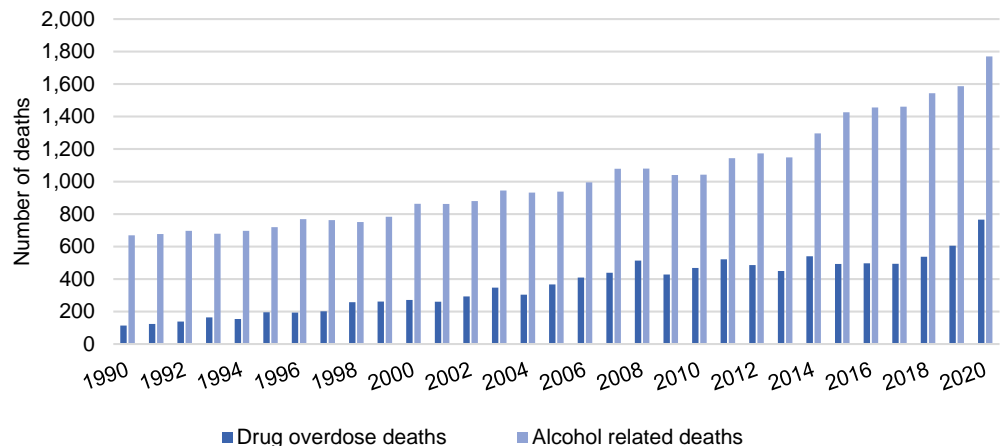


Drug and alcohol-related deaths reached all-time highs in 2020

New Mexico has long had some of the highest death rates from alcohol and drugs in the country and the problem continues to worsen. Since 1990, drug overdose deaths have increased by 572 percent and alcohol-related deaths have increased by 165 percent, with more than 43 thousand New Mexicans dying from those causes over the 30-year period. The deaths in a single year reached their highest point yet in 2020, with 1,770 alcohol-related deaths and 766 overdose deaths.

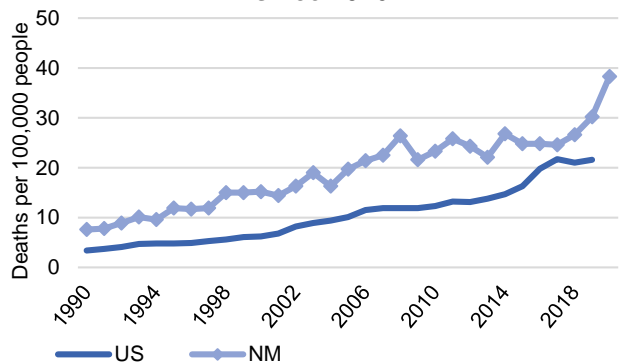
Consistent with the rise in absolute numbers, death rates related to substance abuse increased sharply over the last few years. In 2016, the state's alcohol-related death rate was 66 per 100,000 people, nearly double the national rate of 34 per 100,000 people. By 2020, New Mexico's alcohol-related death rate rose another 34 percent to 88.5 deaths per 100,000 people. Similarly, from 2016 to 2020, the state's drug overdose death rate increased by 54 percent. In 2019, the last year for which federal data is available, New Mexico's overdose death rate was 40 percent higher than the national rate.

Chart 1. Over 43 Thousand New Mexicans Have Died of a Drug Overdose or Alcohol-Related Cause Since 1990



Source: DOH

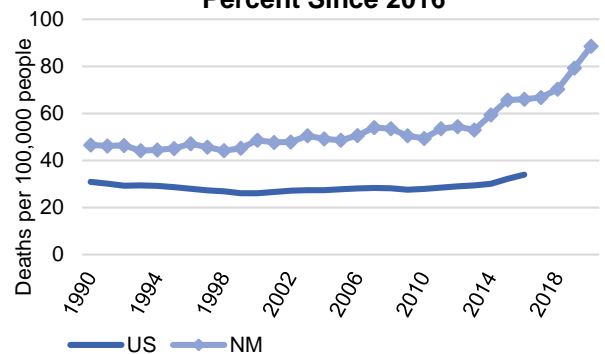
Chart 2. New Mexico's Drug Overdose Death Rate Increased by 54 percent since 2016



Note: Provisional 2020 state data

Source: DOH, CDC

Chart 3. New Mexico's Alcohol-Related Death Rate Increased by 34 Percent Since 2016



Note: Federal data unavailable after 2016; provisional 2020 state data

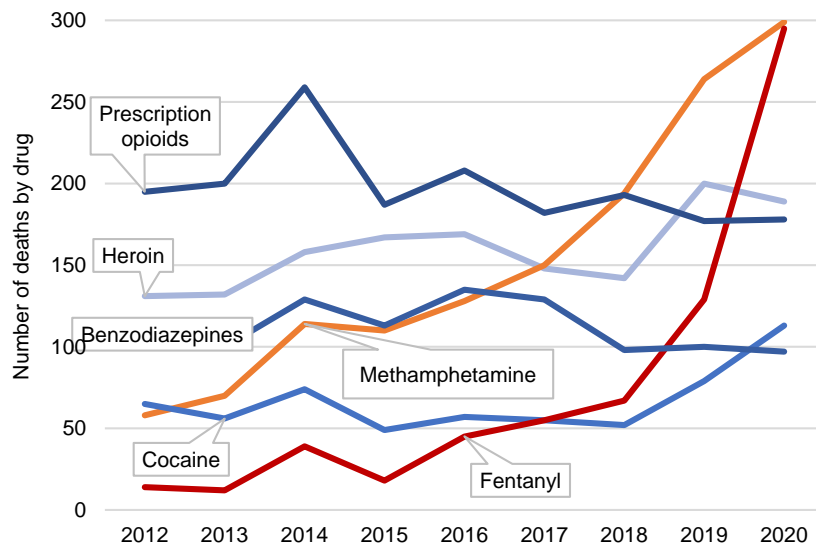
Source: DOH, CDC

Fentanyl and methamphetamine have surpassed heroin and prescription opioids as the leading causes of overdose deaths, contributing to 78 percent of those deaths in New Mexico in 2020.

COVID-19 may have contributed to the spike in drug and alcohol deaths in the state in 2020. Provisional data released by the Centers for Disease Control this summer showed that drug overdose deaths rose by 30 percent nationwide in 2020, and a recent working paper from the National Bureau of Economic Research found evidence that “deaths of despair”—avoidable tragedies such as suicide and drug overdose—increased by at least 10 percent relative to pre-pandemic levels.

In New Mexico, the nature of the drug epidemic is also shifting in significant ways. Fentanyl and methamphetamine have surpassed heroin and prescription opioids as the leading causes of overdose deaths. According to harm reduction staff at the Department of Health and law enforcement interviewed in 2019 by LFC staff, fentanyl and methamphetamine are cheaper and more widely available as street drugs and fentanyl is increasingly mixed with other drugs. Combined, fentanyl and methamphetamine contributed to 78 percent of drug overdose deaths in the state in 2020.

Chart 4. Fentanyl and Methamphetamine are Driving the Increase in Overdose Deaths in New Mexico



Source: DOH

Fentanyl is an opioid used in medical settings for treating severe pain. It is similar to morphine but 50 to 100 times more potent. Department of Health (DOH) clinical and harm reduction staff report seeing increasing numbers of clients who are using methamphetamine in combination with fentanyl, with methamphetamine used to counteract the sedative effects of fentanyl. Providers interviewed by LFC staff also said these drugs can make treatment more challenging, with medications like Suboxone and other forms of buprenorphine less effective for patients with a high tolerance for fentanyl. Treatment options for methamphetamine, meanwhile, are limited. There are no approved medications and it is unknown how widely available the evidence-based behavioral therapies are in New Mexico.

A leading harm reduction strategy for fentanyl overdose is illegal in New Mexico. Fentanyl test strips are an increasingly common and evidence-based

strategy for reducing the risk of overdose death among substance users who may unknowingly take fentanyl because it is cut into other drugs. Studies of harm reduction programs elsewhere in the country have found a positive result on a test strip leads to changes in behavior that reduce overdose risk. Those changes might include using less of the drug, using it more slowly, not using the batch at all, using with other people, or using with the life-saving opioid overdose reversal drug Narcan/naloxone on hand.

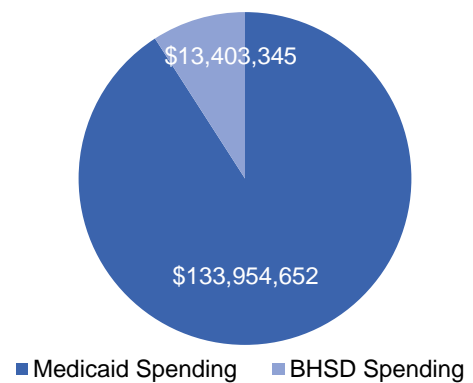
Currently, New Mexico’s Harm Reduction Act and Controlled Substances Act limit DOH’s ability to respond to changes in overdose risk with new harm reduction strategies. The legal framework for harm reduction in New Mexico was developed only to address intravenous drug use, and the laws do not allow DOH to distribute fentanyl test strips, which are considered drug paraphernalia. Rather, the department’s harm reduction program is only shielded from criminal liability for the exchange or possession of items necessary for safe consumption of intravenous drugs – in other words, new syringes. Senate Bill 255, which died during the 2021 session, would have amended the Harm Reduction Act to expand the purpose of DOH’s harm reduction program to include preventing drug overdose deaths from nonintravenous drugs, amended the act’s criminal liability protections to include possession and exchange of items necessary for safe consumption of controlled substances that are injected, smoked, *or* inhaled, and amended the Controlled Substance Act’s provision prohibiting possession of paraphernalia to exclude supplies provided by the harm reduction program. The changes necessary to enable distribution of fentanyl test strips, and to more generally allow DOH to pursue harm reduction strategies to address emerging risks, should be reconsidered by the Legislature.

The state tripled spending on substance abuse treatment from 2014 to 2020 and increased service delivery by 85 percent

Despite progress, services still likely fall short of the need.

In 2020, the New Mexico Human Services Department (HSD) spent at least \$147 million in state and Medicaid funds to provide core treatment services to people with a substance use disorder—more than triple the \$45.6 million it spent in 2014. The number of services delivered to people with substance use disorders increased by 85 percent over the same period, with at least 60,720 patients receiving some kind of treatment through Medicaid or services paid for directly by the Behavioral Health Services Division (BHSD) in 2020. Services paid by BHSD are funded with federal grants and state general funds, but the overall increase in spending was primarily driven by Medicaid, with Medicaid spending on core substance use services increasing by 255 percent from 2014 to 2020, or \$101.8 million.

Chart 5. Medicaid Funded 91 Percent of New Mexico's Core Substance Use Services in 2020



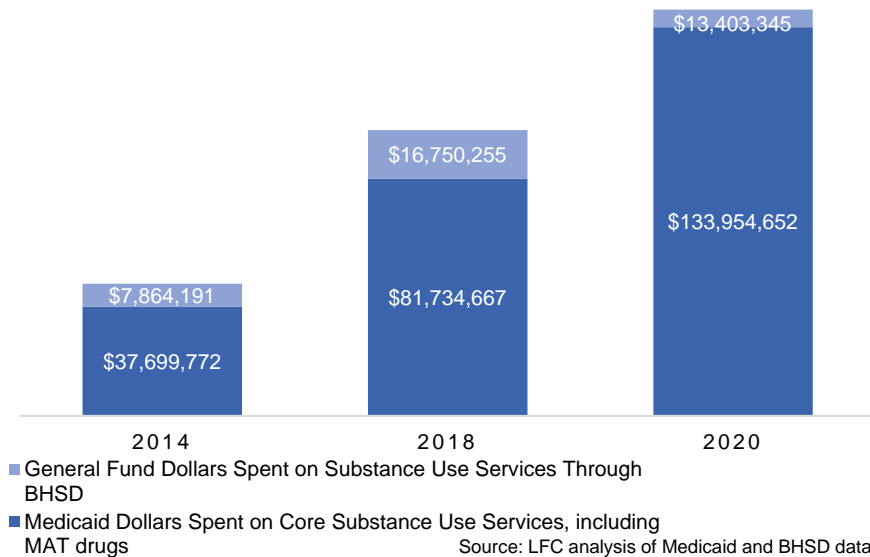
Source: LFC analysis

LFC also identified Medicaid spending on patients with substance use disorder diagnoses for general hospitalizations and other medical services. Since these

services did not appear consistently in the most recent Medicaid data provided by HSD and the prior dataset for the 2019 report, they were not included in the numbers on core services. That other spending totaled \$24.5 million in 2020 and \$13.9 million in 2014, bringing overall spending on patients with substance use disorder diagnoses to \$172 million in 2020 compared to \$59.5 million in 2014.

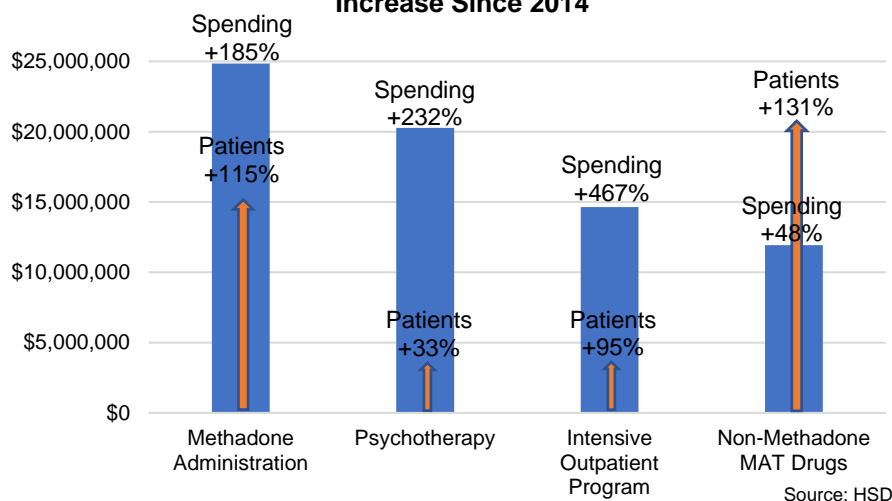
Additionally, it should be noted that the numbers in this report represent conservative estimates of service delivery because they do not capture patients without formal substance use disorder diagnoses who accessed treatment and they do not include physical health services. Starting in 2019, HSD began reporting quarterly to the Center for Medicare and Medicaid Services (CMS) on a variety of substance use disorder treatment metrics in order to track the efficacy of its expansion of Medicaid services over time. In the future, if this reporting is made available to the Legislature, 2019 could be used as the baseline against which to track the state’s progress on expanding access to treatment and the efficacy of its continuum of care.

Chart 6. New Mexico Tripled Spending on Core Substance Use Services, 2014-2020



The service categories driving most of the spending increase were methadone administration, psychotherapy, intensive outpatient programs, and medication-assisted treatment (MAT) drugs other than methadone. The number of patients served increased in each category, but at slower rates than spending for everything but MAT drugs, indicating rate increases played a large role in the overall spending increase.

Chart 7. Services Driving the Medicaid Spending Increase Since 2014

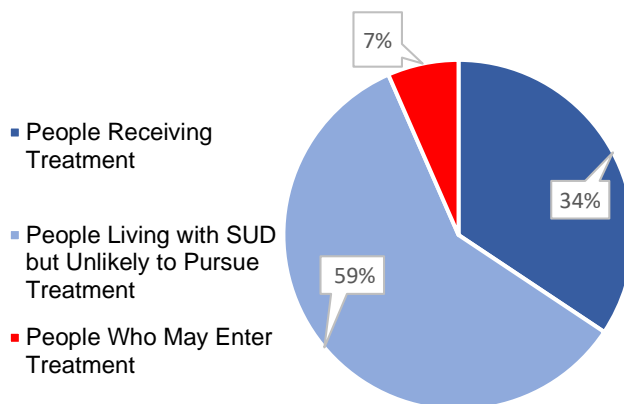


The disproportionate increase in spending on psychotherapy relative to the patients served may also indicate a shift in the types and lengths of services delivered, because LFC used it as a catchall for a number of different billing codes. The outsized increase in patients on MAT drugs relative to spending, meanwhile, represents cost savings due to the availability of generic versions of key drugs.

Several policy changes have helped increase overall access to treatment. Medicaid expansion brought more people into the behavioral health system than ever before, and the state has increased funding for non-Medicaid services as well. Centennial Care 2.0 (CC 2.0), the Medicaid waiver renewal program that began in 2019, brought new behavioral health services into Medicaid coverage, offering the promise of a stronger continuum of care and a more stable funding landscape for providers. Of particular note for patients with substance use disorders, CC 2.0 added adult residential treatment to the benefit package, as well as longer allowable stays for inpatient hospital treatment, screening, brief intervention, and referrals to treatment, peer support, and crisis treatment services.

Despite increased access to treatment, an estimated 134 thousand New Mexicans are living with a substance use disorder and receiving no treatment. In January 2020, the New Mexico Department of Health (DOH) completed a gap analysis for substance use disorder treatment and estimated 134 thousand New Mexicans were in need of treatment but not receiving it. Based on estimates from the Office of the Surgeon General on the portion of people with substance use disorders who actually receive treatment, DOH estimated that roughly 10 percent of that population might actually enter treatment if it was accessible, or about 13,000 people. The department identified the largest treatment gap for alcohol disorders, with 73,178 people in need of treatment but not receiving it.

Chart 8. Over 100 Thousand New Mexicans Live with Untreated Substance Use Disorders



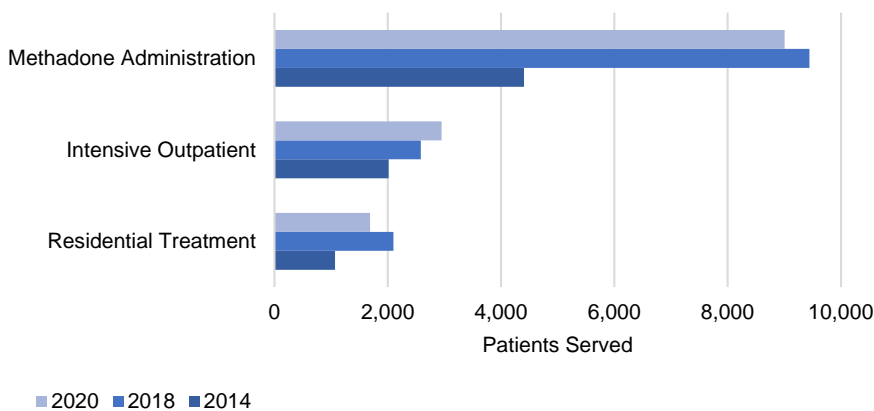
Source: DOH

Utilization of some key substance use treatments remained flat or declined in 2020. Substance use services became more difficult to administer during the COVID-19 pandemic. Residential treatment and methadone, a medication for opioid dependence, must be administered in person, and utilization of both declined in 2020 relative to 2018, when LFC last reported treatment data. The number of people accessing intensive outpatient (IOP) services, meanwhile, rose by 14 percent in 2020 compared to 2018. HSD authorized IOP to be delivered via telehealth during the COVID-19 public health emergency. Unlike residential treatment, IOP allows patients to undergo treatment while continuing to work, live with their families, and go about their daily lives. It includes frequent, intensive therapy and support, and may or may not provide medication-assisted treatment. While it is not clear exactly which

IOP models are most common in the state, IOP is one of several evidence-based therapies past LFC reports on adult and children’s behavioral health recommended the state invest in. Utilization has grown by about a third since 2014, but appears limited overall relative to the state’s substance use problem and may present an opportunity for further expanding access to treatment.

The use of at least one Medicaid-eligible, evidence-based behavioral therapy for substance use recommended in past reports remains

Chart 9. Utilization of Some Key Substance Use Services Was Flat or Declined from 2018 to 2020



Source: LFC analysis of Medicaid and BHSD data

extremely limited. Multisystemic therapy (MST), an intensive family-focused treatment for children, increased from 2018 to 2019 but declined in 2020, and the absolute numbers served were below 100 every year. In 2020, only 40 young people received MST. Access to MST providers is limited in much of the state. In the first quarter of 2021, Presbyterian was the only managed care organization (MCO) to meet network adequacy standards for MST and it only met the standard in urban areas. Network adequacy requires MCOs to ensure members have access to covered services within a reasonable driving distance. No MCO met adequacy standards for MST in rural and frontier areas of the state.

Another evidence-based facet of the substance use disorder continuum of care is screening, brief intervention, and referral to treatment (SBIRT). As its name implies, SBIRT is a screening and referral tool that could be used by virtually all primary care providers, hospitals, and in other human and social service settings to identify problematic substance use, depression or trauma, with referrals 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 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. The program had a follow-up rate of 52 percent; the patients receiving follow-up interventions reportedly saw improvements in abstinence from alcohol or illegal drugs, and higher rates of employment and social connectedness. Centennial Care 2.0 (CC 2.0) covers SBIRT, and in 2020, roughly 8,000 screenings were completed, representing just over 1 percent of the overall Medicaid population. Because SBIRT has the potential to be a universal screening tool, these numbers should be much higher.

Expanding SBIRT should remain a priority for the state, particularly when its current usage is considered against the Department of Health’s estimate that 134 thousand New Mexicans live with untreated substance use disorders. One other strategy for engaging people in treatment that merits consideration is the Community Reinforcement Approach to Family Training (CRAFT). The approach uses behavioral therapy to train family members or others close to a person struggling with addiction to not engage in behavior that reinforces substance use, to help their loved one enter treatment and support them in ways that reinforce recovery, and to protect themselves from stress, anxiety, and depression. Though the method was developed at the University of New Mexico, it is, curiously, not commonly practiced in the state. BHSB is currently funding a project to train and support providers in implementing CRAFT, though the project is behind schedule.

Table 1. Impact and Return on Investment of Select Substance Use Services, Pew Results First Initiative

Program	Demonstrated Impact	Benefit-Cost Ratio
SBIRT in emergency department	Reduces problematic alcohol use, drinking and driving, drug use, ED visits, and injuries	\$4.72
Intensive outpatient program, matrix model	Reduces drug use disorders	\$7.37
Community reinforcement approach with vouchers	Reduces drug use disorders	\$9.61
Peer support for substance abuse	Reduces drug use disorders	\$13.55
Motivational interviewing	Reduces alcohol, opioid, and other drug use disorders	\$33.73

Note: Results based on data from Washington State and its ROI model. While cost and utilization information specific to New Mexico is available for some of these services, it was not used due to uncertainties about consistency with the underlying assumptions of the Washington model.

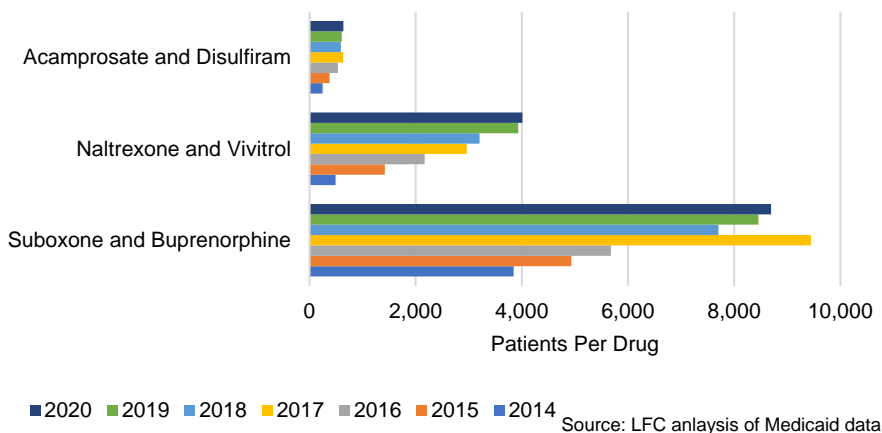
Source: Pew Results First model

Other evidence-based therapies for substance use, like cognitive behavioral therapy and motivational interviewing, are modalities that may be used in individual or group therapy but cannot be identified in Medicaid data because providers do not specifically bill for these services. However, claims data show that at least 19 thousand Medicaid patients with substance use disorder diagnoses received some form of therapy in 2020, a 13 percent increase from 2014.

The use of effective medications for alcohol dependence has increased but remains limited. Effective and federally-approved medications for alcohol use disorder exist just as for opioid use disorders, but LFC’s 2019 *Health Note* found the alcohol medications were chronically underutilized in New Mexico, particularly relative to the scale of the problem. That remains true today. Acamprosate and disulfiram are two medications used exclusively to treat alcohol use disorders. Though their use has increased since 2014, only 639 patients received these medications in 2020. The drugs naltrexone and Vivitrol, meanwhile, can be used to treat either opioid use disorder or alcohol use disorder. Both drugs continue to see positive growth and are more widely used than the alcohol-only medications, but the number of patients with prescriptions for naltrexone and Vivitrol was less than half the number with prescriptions for Suboxone and buprenorphine, which are used exclusively to

treat opioid use disorders. Medicaid prescription drug data does not include information on a patient’s diagnosis, making it impossible to separate the two uses for the dual-purpose medications. However, even if all the naltrexone and Vivitrol prescriptions were used to treat alcohol-use disorders—which is unlikely—their usage relative to the opioid drugs would still represent underutilization since alcohol-use disorders are far more common in the state.

Chart 10. Medications for Opioid Disorders Are More Widely Prescribed than for Alcohol Disorders



Significant treatment gaps exist in the criminal justice system and should be addressed. In New Mexico and nationwide, substance use is intimately connected to the criminal justice system. Substance use often results in incarceration and inadequate services within jails and prisons help to perpetuate substance use disorders and contribute to recidivism. According to the National Institute on Drug Abuse, as many as 85 percent of American prisoners have an active substance use disorder or were incarcerated for a crime involving drugs or drug use.

The number of inmates admitted to New Mexico’s prison system for drug possession increased by 18 percent over the last decade.

In New Mexico, the number of inmates admitted to the prison system for drug possession offenses increased by 18 percent over the last decade and the majority of inmates likely need treatment or support for substance use. A 2019 LFC analysis of data from the New Mexico Correction Department’s Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) risk/needs assessment found that treatment for substance use disorder was the most needed service for those on probation and parole, with over 70 percent rated as highly probable for needing substance abuse support. New Mexico’s three-year recidivism rate was 54 percent in FY19 and FY20, with substance abuse and parole revocations for technical violations driving the high rates of return to prison after release.

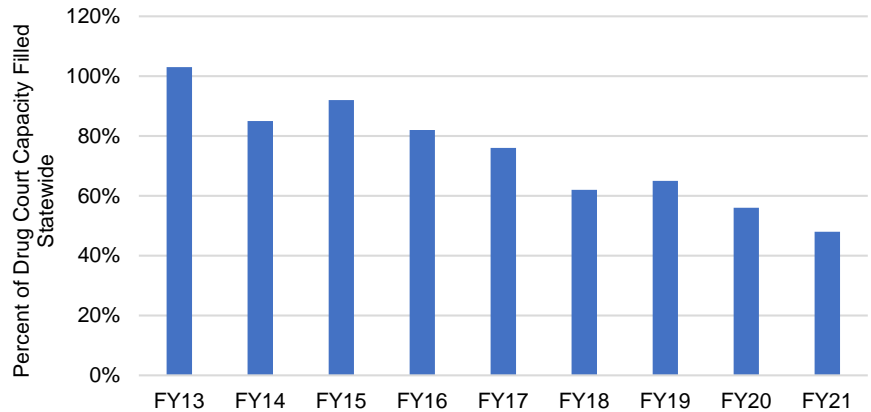
Reducing incarceration and recidivism linked to substance use requires effective diversion, access to evidence-based programming in prison, and re-entry services that facilitate access to treatment upon release. While such programs and services do exist in New Mexico, they are not necessarily widely available or used. For instance, drug court, an effective diversion program, has excess capacity and referrals by district attorneys declined 13 percent from FY19 to FY20. Statewide, drug courts operated at only 48 percent capacity in FY21 and they have not

been full since FY13. Law Enforcement Assisted Diversion (LEAD), a public safety program that allows police to divert people to mental health services rather than jailing them, has gained traction in some communities but is not universally used. The pilot phase of the program in Santa Fe found that LEAD clients had fewer arrests six months after referral and reported reduced heroin use and gains in securing permanent housing. BHSD is currently using state general funds and federal grants to support LEAD initiatives in seven counties and the city of Gallup.

Similarly, while NMCD does offer evidence-based programming in many of its facilities, it is unclear if those programs are available to all inmates who need them and how effective they are in practice. The department has made progress in screening inmates to determine need for treatment. NMCD officials recently reported to the Legislature that 94 percent of inmates had received COMPAS assessments, up from just 4 percent in 2019, and according to the department, assessments are one of the tools used to place inmates in programming. LFC has not yet received details on the number of inmates in need of treatment or the number that annually complete treatment programs, however. Additionally, medications specifically designed to treat addiction—one of the most effective approaches to treatment and the current standard of care for opioid disorders—are not currently available to most inmates in state custody. The exception is pregnant women who were on MAT prior to their incarceration.

A pilot program currently under development in the department would change that. The pilot will identify inmates for initiation of medication-assisted treatment just prior to release. Initially, the program will be small by design and is likely to be offered in a single facility. NMCD is exploring offering a shot of Vivitrol, which is effective for 30 days and is authorized to treat both opioid and alcohol use disorders, though the details of the pilot program have not been finalized. NMCD would eventually aim to expand the program to additional facilities and should also consider expanding its scope in order to ensure the standard of care is delivered to all inmates with substance use disorders. Doing so would require a system including screenings, access to MAT while in custody, and re-entry services that effectively support ongoing recovery.

Chart 11. The State's Drug Courts Were Less Than Half Full in FY21



Source: AOC (active participants on June 30 of each year)

According to BHSD, only two detention centers in the state currently offer jail-based MAT programs, in Bernalillo and San Juan counties.

The agency is supporting five additional detention centers in building jail-based MAT services in McKinley, Lincoln, Roosevelt, Socorro, and Rio Arriba counties.

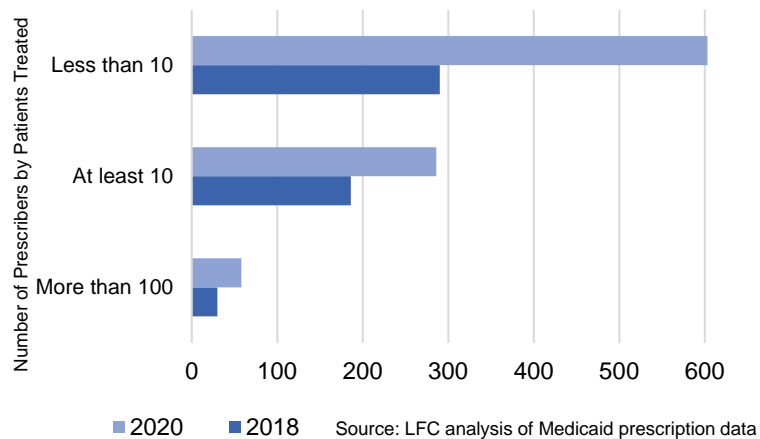
The state expanded access to medication-assisted treatment and stood-up new Medicaid services

8,700 patients received buprenorphine through Medicaid to treat opioid dependence in 2020—a 126 percent increase since 2014.

Access to medication-assisted treatment for opioid use disorders has more than doubled since 2014. New Mexico has made significant strides in improving access to proven medications for treating opioid dependence. LFC identified nearly 8,700 patients who received Suboxone and other forms of buprenorphine through Medicaid in 2020—126 percent more than received the drugs in 2014. These medications are the standard of care for opioid disorders and their use with psychosocial counseling has been shown to be safer and more effective than counseling alone.

The number of providers writing prescriptions for buprenorphine has also increased just in the last few years. In 2018, LFC identified 506 active prescribers in the state. In 2020, the number rose to 947, an 87 percent increase. However, a large proportion of these providers treated less than 10 patients, just as was true in 2018, indicating the need for continued training and outreach to reduce stigma around these medications and help providers feel more comfortable using them.

Chart 12. Most Providers Prescribing Buprenorphine Treat Fewer than 10 Patients

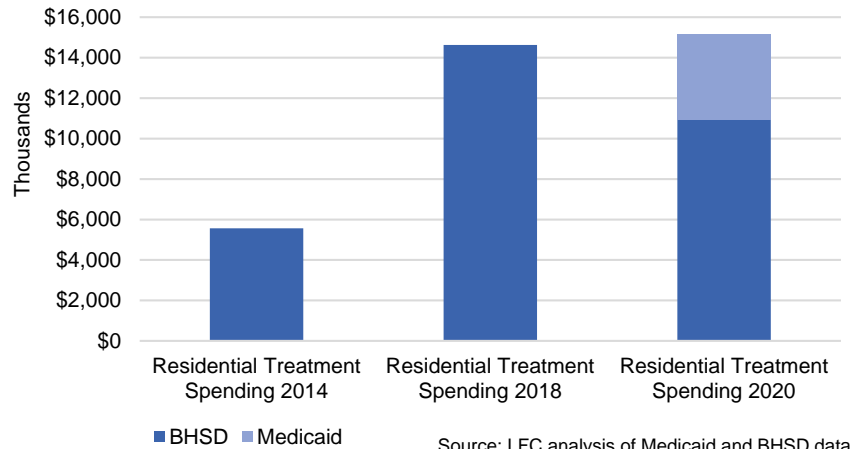


The state also more than doubled access to Narcan/naloxone, a life-saving harm reduction drug that reverses opioid overdoses. Medicaid pharmacy data shows 14,185 patients obtained Narcan/naloxone in 2020 compared to 5,709 just two years prior, in 2018. Several factors help explain the jump, including a 2020 letter of direction from HSD to the managed care organizations to remove prior authorization requirements from most MAT drugs and Narcan/naloxone, and a policy change enacted by the Legislature in 2019 requiring health care practitioners prescribing opioids for pain for more than five days to co-prescribe an opioid antagonist, like Narcan/naloxone.

Four residential treatment providers with eight locations around the state are now billing Medicaid rather than BHSD for services. Standing up a Medicaid program for residential substance use disorder treatment proved a complicated and lengthy process. Though the service technically became Medicaid-eligible on January 1, 2019, providers had to become accredited, and go through a state licensure and rate-setting process before they could actually

transition to billing Medicaid. In November of 2019, when LFC published its *Health Note* on treatment for substance use disorders, no provider had successfully completed that process. In July 2020, a year and a half after the CC 2.0 waiver went into effect, the first Medicaid-eligible residential provider came online, and since then three more providers have transitioned most billing to Medicaid. One more provider—the residential treatment program at Rehoboth McKinley Hospital in Gallup—completed the approval process but shutdown just a month later. Several more providers are going through the approval process now. In calendar year 2020, just over \$4 million in billing for residential treatment shifted to Medicaid. A much larger portion should be paid by Medicaid in 2021.

Chart 13. Roughly \$4 Million in Residential Treatment Billing Shifted to Medicaid in 2020



Residential treatment centers offer the highest level of care for individuals with substance use disorders short of hospitalization. Providers’ transition to Medicaid should help solidify service availability at this acute end of the continuum of care while also improving service quality. To become accredited as a residential treatment center, for instance, providers must offer medication-assisted treatment (MAT). 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. Research shows it doubles the odds a person will be able to avoid a relapse and stay in recovery for at least a year. MAT is the standard of care for substance use disorders for which medications are available and its use is consistent with a wide body of research demonstrating that substance use disorders are best understood and treated as chronic diseases affecting the brain. Provision of MAT within residential treatment was not common in New Mexico until recently, however, nor was it required for the state to reimburse providers for their services. Such changes are welcome and needed, though it should also be noted that the state does not have data on the efficacy of residential treatment programs nor a mechanism for collecting that data from providers.

Residential Treatment Providers Currently Billing Medicaid:

- Santa Fe Recovery, multiple locations in Santa Fe and Gallup
- Four Winds Recovery, Farmington
- Hoy Recovery, Velarde
- Shadow Mountain, Taos and Rio Rancho

Two crisis triage centers have opened and are billing Medicaid while a third is open but not billing Medicaid. Crisis triage centers are another new CC 2.0 service that may cater to patients with substance use disorders and are just opening their doors. The services offered at the centers will include emergency triage, evaluation, and admission, withdrawal management, peer support, brief intervention, counselling, medication, and service navigation and referrals. The centers are intended to provide easy access to service whenever it’s needed, to divert people from hospital emergency departments and the justice system during behavioral crises, and to facilitate access to services. The open centers accepting Medicaid are in Santa Fe and Las Cruces.

The third center that is open is in Albuquerque, but it is not currently billing Medicaid. A fourth center, in Grant County, opened during the public health emergency but is currently closed due to a shortage of staff and clients.

Utilization of two Medicaid-eligible services that provide social support and life skills development for people with substance use disorders increased in 2020. Comprehensive Community Support Services promotes recovery through interventions to develop skills for independent functioning. Providers develop a treatment plan for each individual focusing on five functional domains— independent living, education and learning, working, socializing, and recreation— identify assets and barriers to recovery, and coordinate needed services. A total of 2,423 Medicaid recipients received these services in 2020, up from 1,578 in 2019, at a cost of \$4.3 million. Peer support—where people who have been through recovery provide practical and emotional support to those in it—also grew and is newly Medicaid-eligible under CC 2.0. In 2020, 1,246 Medicaid recipients received peer support, up from 757 in 2019, at a cost of \$452 thousand.

The state must sustain and improve prevention and early intervention programs

LFC’s 2019 *Health Note* noted the slow nature of progress in addressing substance abuse. 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.

The central findings of this progress report—that deaths continue to rise even as treatment expands—demonstrate that while adequate access to treatment is essential, treatment is only one part of the solution to the state’s substance use problem. The state must also make a focused effort to provide services and interventions to at-risk populations in order to prevent substance use disorders from developing or progressing to a level of acuity requiring treatment.

Substance use disorder has a debilitating effect on families and long-lasting consequences for New Mexico’s children. Substance use disorders play a significant role in some of New Mexico’s most troubling and persistent social issues, such as child maltreatment. LFC’s 2019 *Health Note* found that investigators with the Children Youth and Families Department (CYFD) substantiated over 49 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.

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

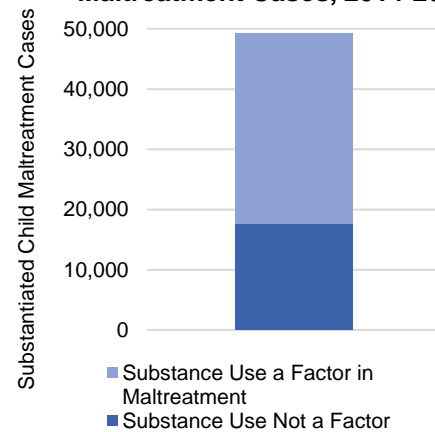
and traumatic life events can have profound negative impacts. ACEs have been linked to numerous poor health outcomes including substance misuse in adulthood. Some researchers have linked ACEs to up to two-thirds of drug use problems, and studies have found that children who experience four or more ACEs are at significantly higher risk of developing substance use disorders as adults. Unfortunately, children in New Mexico experience childhood trauma at one of the highest rates in the nation. 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.

ACEs are preventable and successful prevention could make a big difference. The Centers for Disease Control (CDC) believes prevention of ACEs could reduce heavy drinking by up to 24 percent. CDC recommends prevention strategies that strengthen economic supports to families, ensure a strong start for children, teach parenting and relationship skills, as well as treatment to reduce short- and long-term harms. These strategies could include early childhood and family support programs the state already invests in that are not specific to substance use, including childcare assistance, home visiting, the Family Infant Toddler child development program, the Women, Infants, and Children nutrition program, and virtually any income support program. Recurring funding has increased significantly for these early childhood programs. In FY22, the Legislature appropriated nearly \$380 million to early childhood programming, a 188 percent increase since FY12. However, past LFC reports have found that some programs are undersubscribed, suggesting that agencies must improve marketing and implementation for the state to realize the long-term benefits these programs promise.

Recent implementation of the Comprehensive Addiction Recovery Act provides an opportunity to provide targeted early intervention services to especially high-risk children. The Plan of Safe Care bill passed by the Legislature in 2019 in response to the requirements of the federal Comprehensive Addiction Recovery Act (CARA) requires hospitals to develop plans of care for families when babies are born with exposure to substances. CYFD and DOH are notified whenever a plan of care is created and work with care coordinators at managed care organizations or other health insurers to implement the plans. The plans identify appropriate services for families and make referrals to programs, including 12-step programs, childcare, domestic violence services, home visiting, housing and financial assistance, infant mental health, medication-assisted treatment, counseling, and more. The law is intended to promote a supportive rather than a punitive approach to new mothers struggling with substance use. As a result, neonatal exposure to substances no longer automatically leads to the filing of an abuse or neglect report with CYFD. In the past, hospitals automatically made such reports without offering referrals to service for the newborn or caregivers.

In 2020, the program’s first full year, 1,105 plans of care were created, 34 percent of which were for babies exposed to methamphetamine and 19 percent

Chart 14. Substance Use Factored Into 64 Percent of Child Maltreatment Cases, 2014-2018



Source: CYFD

In FY22, the Legislature appropriated nearly \$380 million to early childhood programs, many of which can contribute to substance abuse prevention.

Top Services CARA Families Were Referred To:

1. Early intervention
2. Home visiting
3. Mental health counseling
4. Parenting group
5. WIC

Top Services CARA Families Declined:

1. 12-step recovery program
2. Childcare
3. Smoking cessation
4. Children's medical services
5. Domestic violence services

Most Common Resources Requested by CARA Families in Care Coordination:

1. Housing assistance
2. Financial assistance

for opioids. DOH and CYFD noted several challenges with early implementation, including:

- Uneven implementation by hospitals, though training of hospital staff by state agencies is ongoing.
- Uneven quality of safe care plans, at least partly due to variability in who is writing the plans since some hospitals do not have social workers in labor and delivery.
- Lack of universal screening for substance use in prenatal care or in labor and delivery units.
- Mothers not understanding the purpose of their plan of safe care and sometimes being unaware a plan was created for them.
- For some families, having to work with care coordinators in order to access services is a barrier due to the time involved to complete required screenings before being able to access services.

DOH staff noted that universal screening for substance use during pregnancy and at delivery should be a priority. If universal screening occurred, it could provide opportunities for intervention before infants suffer greater consequences of exposure to substances, and it could allow medical and service providers to identify more families in need of services.

No performance measures currently exist on infant safety, entry into substance use treatment, or other services utilized as a results of plans of safe care, and though DOH staff are collecting data in order to evaluate the program, they do not currently have the ability to measure these key short- and long-term outcomes. The department could work with the Legislature to identify opportunities to meaningfully track the efficacy of the policy and create related performance measures.

The state has an opportunity to leverage Medicaid to further expand evidence-based home visiting with federal dollars. Two evidence-based home visiting models currently in use in New Mexico—Nurse Family Partnership and Parents as Teachers—are Medicaid-eligible services, so long as providers are approved to bill Medicaid and have contracts with the MCOs. The state has been piloting the Medicaid home visiting program since 2019, but utilization remains low because only two providers participate. In 2020, the University of New Mexico Center of Development and Disability served 63 families in Bernalillo County with Nurse Family Partnership home visiting, and 56 families with Parents as Teachers, while ENMRSH served 32 families with Parents as Teachers in Curry and Roosevelt counties. In total, 151 families were served with Medicaid home visiting, while 5,746 families were served with state-funded programs in FY20.

BHSD uses federal grants to fund multiple substance use prevention programs around the state and could work with LFC to enhance performance reporting on prevention. BHSD's Office of Substance Abuse Prevention administers seven federal grants to provide infrastructure, funding, and support to prevention providers around the state in selecting and implementing policies, programs, and practices proven to be effective in substance abuse prevention. The agency's prevention office is the state's largest purchaser and distributor of Narcan/naloxone, the opioid overdose reversal drug. Among its activities, the office uses the Substance Abuse

Prevention and Treatment Block Grant to fund 15 countywide projects and three tribal projects. Each project does community surveys to assess needs, creates a strategic plan, and evaluates the impact of its activities each year. The programs are staffed by certified prevention specialists who must have 2,000 hours of prevention-related work experience and 120 hours of prevention-specific education to be credentialed, and complete 40 hours of continuing education every two years. The office also funds the training and administration of the PAX Good Behavior Game in public and tribal schools. In FY21, it served over 29,000 students at a cost of \$1.1 million. PAX is an evidence-based tool for building self-regulation skills among youth, and it has been shown to reduce substance use, depression, suicidal ideation, and disruptive behavior. The program has a benefit-cost ratio greater than \$20: \$1, according to the Pew Results First Initiative.

The 2020 General Appropriation Act required the Human Services Department to begin reporting quarterly performance of the PAX program, as measured by the game's spleem instrument, which measures the game's effect on behavior. However, HSD has yet to submit this reporting. Additionally, this is the only performance reporting currently required of the prevention programs.

Next Steps

The following steps should be considered to address important issues identified in this Progress Report:

The Legislature should consider:

Amending state statute to allow the Department of Health's harm reduction program to distribute fentanyl test strips to reduce the risk of overdose death from one of two leading sources.

The Department of Health, Human Services Department and collaborating agencies should consider:

Exploring opportunities for focused expansion of access to treatment, prioritizing need and what works. Opportunities may include intensive outpatient programs, increased use of medication-assisted treatment for all substance use disorders for which it is available, and universal use of SBIRT. The Department of Health can assist in identifying treatments most in need of expansion through its planned biennial updates to the gap analysis it completed in 2020. While the first gap analysis made broad recommendations that the state focus on expanding access to treatment where services are most needed and most lacking, future analyses could identify specific communities where needs are greatest and treatment most lacking, and which services would best address the need in those areas.

Identifying and removing barriers to service access for families for whom plans of care are created due to neonatal exposure to substance use.

Continuing efforts within the Department of Health to identify tools and any needed policy changes to implement universal screening for substance use during pregnancy and at delivery.

HSD, CYFD, and the Early Childhood Education and Care Department should consider continuing targeted expansion of evidence-based prevention programs, including home visiting, and improve performance reporting to the Legislature on these programs.

The Department of Corrections should consider:

Moving aggressively to stand-up its pilot program for medication-assisted treatment in state prisons, expanding the program, and otherwise ensuring adequate access to services inside its facilities and post-release.