UNM

Robert Wood Johnson Foundation | Center for Health Policy
at the University of New Mexico

December 1, 2011

To: Chair, Interim Legislative Health and Human Services Committee
Chair, Interim Legislative Behavioral Health Services Subcommittee
Chair, Interim Legislative Courts and Human Services Committee
Legislative Finance Committee
Legislative Council Service

Re: 50th Legislature, 1st Session, 2011, Senate Memorial 18 (SM 18)
Requesting the Robert Wood Johnson Foundation (RWJF) Center for Health Policy at the University of New Mexico (UNM) to reconvene a task force to continue the work of the Senate Memorial (SM) 33 (2010) Drug Policy Task Force and complete a statewide plan to alleviate the negative consequences associated with the use of alcohol and other drugs. SM 33 and SM 18 specify using the four-pillar approach (prevention, treatment, harm reduction, and law enforcement) to evaluate New Mexico's current approaches to drug policy and to develop strategies for effective change.

I am pleased to transmit the attached report of the SM 18 Drug Policy Task Force. The Task Force convened six times from June to November 2011.

Substance abuse disorders are highly prevalent, affect persons at all social levels, and exist in all parts of the state. The consequences are devastating. The cost in New Mexico in terms of disease, trauma, lives lost, families broken, property damaged, crime, incarceration, and lost productivity exceeds $2 billion annually. Priorities include long-term planning for program coordination and services that will require investment in human resources and facilities.

This report particularly emphasizes recommendations that can yield immediate and substantial results in terms of lives saved, improved quality of life, and reduced costs to the public. The recommendations are applicable for both the 2012 and 2013 legislative sessions as well as for consideration by state and other agencies.

Submitted by,

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A CALL TO ACTION

In November 2011, the Centers for Disease Control and Prevention (CDC) stated that the United States has a national epidemic of prescription opioid abuse that constituted a crisis in terms of consequences such as the rapidly escalating rates of deaths, hospital admissions, and emergency department visits from overdoses. New Mexico not only is a national leader in these categories for prescription opioids but also is among the national leaders in all statistics related to substance use disorders associated with alcohol and illicit and prescription drugs. **In New Mexico we have a substance abuse epidemic of monumental proportions.**

Taken together as described in this report, the dismal N.M. statistics, the increasing exceptionally high rates of death and other medical and social consequences of substance abuse, the associated costs, the shortage of treatment resources, and barriers to access highlight the inadequacies of the current commitment to prevention and harm reduction and the failure of effective treatment services to reach literally thousands of persons in New Mexico. **This is a statewide emergency that impacts all New Mexicans.**

While there are long-term issues with the necessary job of building an infrastructure and creating access to address the problems of alcohol and other drug addiction, **many steps that are proven to work, save lives, and be cost effective can and should be taken immediately to improve this situation**.

This Drug Policy Task Force report outlines numerous recommendations from Senate Memorial (SM) 33 and SM 18 potentially impacting all facets of N.M. society, some with the potential for almost immediate results and others for the long term. For example, the recommendations regarding the safer prescribing of opioids and the modernization of the Prescription Drug Monitoring Program (PDMP) may be expected to result in a reduction of unintentional deaths from overdose from opioids by at least a third in as little as three years. **The work of this Task Force culminating in this report is a CALL TO ACTION to the governor, our legislators, cabinet secretaries and their respective agencies, the medical and addiction treatment communities, and all other stakeholders and advocates to collaboratively and swiftly address these recommendations in order to improve the lives of thousands of New Mexicans and save many others affected by substance abuse.**

EXECUTIVE SUMMARY

In 2011, the N.M. Senate passed Senate Memorial 18, introduced by Senator Bernadette Sanchez, requesting that the Robert Wood Johnson Foundation (RWJF) Center for Health Policy at the University of New Mexico reconvene a task force to continue the work of the Senate Memorial 33 (2010) Drug Policy Task Force and complete a statewide plan to alleviate the negative consequences associated with the abuse of alcohol and other drugs. The two memorials direct the Task Force to use the "four-pillar approach" (prevention, treatment, harm reduction, and law enforcement) as a framework in evaluating New Mexico's current approaches to drug policy and in developing strategies for effective change.

The memorial recognizes the harm that alcohol and other drugs cause across New Mexico—the devastated lives, the overdoses, the burdens on families and institutions, and the enormous costs to the public. It also acknowledges the impact of alcohol and drugs on the criminal justice and corrections systems and how these systems, in turn, can sustain the problems associated with substance use and addictions.

The Problem and What the Data Show

The situation in New Mexico is alarming. New Mexico has been among those at the top in U.S. rankings in the misuse and abuse of alcohol and other drugs and in the numbers of people needing and not receiving treatment for substance use disorders. Rates are especially severe in the 12- to 17-year-old age group, where New Mexico ranks as the #1 state by far for unmet treatment needs for illicit and prescription drug abuse and third for unmet treatment needs for alcohol abuse.

While fatalities from DWI in New Mexico have fallen substantially in the past seven years, such that New Mexico is now ranked #25 nationally, New Mexico is still a national leader in those needing treatment for alcohol abuse and in deaths from alcohol-related chronic diseases.

New Mexico leads the United States in deaths from drug overdoses, now exceeding deaths from motor vehicle crashes. The Department of Health (DOH) estimates as many as 200,000 abusers of illicit or prescription drugs in New Mexico, with at least 25,000 of those being injection drug users, and the actual numbers may be considerably greater.

Within the category of drug overdose is the particular problem of prescription drugs, especially opioid pain medications. Unintentional overdose deaths from prescription opioid drugs nearly tripled from 2000 to 2009 and now exceed overdose deaths from heroin and cocaine combined. New Mexico is a leader in the nonmedical use of prescription opioids, especially in the 12- to 17-year-old group.

The annual costs in New Mexico for the associated medical disorders, trauma, physical property damage, and criminal and judicial expenses when combined with the losses in productivity are in the billions.

The statistics clearly demonstrate that our current investments to treat, to prevent, and to otherwise manage the issues of substance abuse and addiction have been insufficient and largely ineffective with respect to the magnitude of these problems.

Issues and Barriers that Underlie the Problem

A core concept underlying most of the recommendations in this report is that addiction—whether it is to alcohol, to an illicit drug, or to a prescription drug—is a chronic medical disease of the brain that is treatable. Dealing with addicted persons, whether in the community or during incarceration, requires application of this fundamental concept. Failure to do this means that the problem is likely to continue its ruinous course and allow the personal problems and social consequences to recur and recycle, often within the criminal justice system—all with continuing accumulation of social and financial cost.

There are cultural barriers in New Mexico that impede the effective application of this basic concept. One barrier is the misperception among many that alcohol abuse and some use of other drugs are normative behaviors, somewhat like a rite of passage, and that the risks, whatever they may be, are regrettable but not within reach of being addressed.

Another barrier is a pervasive view that society's response to criminal behavior associated with alcohol or with drug use should be punishment. The Task Force believes that, whether or not punishment is part of the consequence, it is in society's greater interest that all such persons should have access to treatment.

An additional barrier in our state is the lack of capacity in terms of human resources, programs, and facilities to manage persons with addiction—to say that we have as little as 50% of what is needed statewide is likely not an exaggeration. On top of this is the lack of access to addiction treatment. With an uninsured rate in New Mexico of 29% in nonelderly adults, and with no major insurers or Medicaid paying for residential treatment ("rehab") any longer, adequate and appropriate treatment for substance use disorders is out of the reach of many. Remedies to these problems are a long-term issue, and planning to address this must begin now.

A second core concept is the extraordinary cost-benefit of treatment. In 2009, the Substance Abuse and Mental Health Services Administration published an analysis that demonstrated that, on the average, each dollar invested in treating drug addiction yields a savings to the public of $12 in medical and criminal justice costs. The treatment of no other major chronic disease returns savings that come close to this extraordinary rate. While treating addictions may be expensive, not treating addictions is vastly more expensive.

A third core concept is the ongoing need for effective prevention. Primary prevention means taking steps that reduce or delay the number of persons who begin to engage in the harmful use of alcohol, particularly underage drinking; in the use of illicit drugs; and in the abuse of prescription drugs. Consequently, there are reductions in those sick with substance use disorders, criminal activities and other harms, burdens on the criminal

justice and corrections systems, and overall costs to the state and public. Primary prevention is a shared responsibility of the public health sector, health care providers, educators, families, and communities. The financial return for each dollar invested in prevention averages $18. Unfortunately, the state and municipalities have substantially disinvested in prevention programs, and the returns are difficult to measure during current political cycles.

The devastation and costs from the consequences of alcohol and other drug abuse along with the neglected reality that appropriate prioritization, funding, and interventions hold a promise for substantial mitigation in human suffering and cost savings make action imperative. Taken together, the woeful statistics and the severe lack of access and resources place New Mexico nationally at the top for severity and at the bottom for management of its drug and alcohol problem. The Task Force feels that this is a crisis that requires emergency action.

Summary of Findings and Recommendations
The principal recommendations of the Task Force are listed and briefly summarized here (with page numbers from the body of the report).

1. Need a central office, a comprehensive plan with public health goals, and much better coordination of programs and services (see page 22)
With planning to start immediately, the governor, with support of the legislature, should create a central, high-level office charged with developing and administering a comprehensive statewide addiction prevention, harm reduction, and treatment system, not unlike the statewide trauma system, for all persons with needs for such services. The office should house and manage all state programs that bear on the issue of substance use disorders, develop public health outcome goals, and strategically plan for an outcomes-oriented system of prevention and services. The office should promote, support, and coordinate with local programs and initiatives. The N.M. Behavioral Health Collaborative models the necessary interdepartmental structure.

2. Need for a comprehensive inventory and map of behavioral health and substance use disorder services (see page 24)
The extent of the present deficit of services related to behavioral health and substance abuse assessment and treatment is not clear. One prerequisite for planning is having a centralized, comprehensive inventory of providers and facilities that offer assessment and treatment. The Behavioral Health Services Division (BHSD) should take this on, perhaps utilizing and adapting the services directory offered by the Aging and Long-Term Services Department (ALTSD).

3. Prevention of alcohol use and abuse—deploying proven, cost-saving strategies (see page 26)
The #1 proven, cost-effective way of immediately reducing underage consumption and the consequences of alcohol misuse and abuse is to raise the alcohol excise tax. The Task Force makes this recommendation fully aware of political opposition to taxes and of inevitable opposition from an alcohol industry lobby that has established its influence

within the legislature. The tax will not eliminate the problems of alcohol misuse and abuse, but the impact will be real and move outcomes in the right direction. This recommendation is strongly supported by the Centers for Disease Control and Prevention. The rationale and evidence of effectiveness are compelling. In addition to savings, a modest excise tax increase can raise tens of millions of dollars annually to restore and add to funding needed for prevention and treatment. Recent funding cuts have gutted the state's modest community-based prevention programs—programs that have been proven effective and highly cost saving and are based on recommendations from the federal Substance Abuse and Mental Health Services Administration. It is important that funding for these at least be restored. Finally, the Task Force supports local social host liability ordinances as another strategy for curtailing underage drinking.

4. Prescription pain medications—controlling the opioid glut, misuse, and illicit use (see page 31)

Prescribed opioids, drugs used for pain relief and to suppress cough, can be highly addictive and are being abused in epidemic proportions. They are the most common gateway drug to precede heroin use, especially in youth. Prescription opioids (e.g., oxycodone, Percocet®, hydrocodone, Vicodin®) are abundantly available as a result of overprescribing by health care providers and because of underutilization of pills that are legally prescribed but not consumed at the time by the patient and then remain unsecured and accessible. Also, prescriptions for opioids and other drugs of abuse are obtained by individuals who have an addiction or by individuals seeking drugs for diversion into illegal street sales. "Doctor shopping," feigning pain, and using counterfeit prescriptions are examples of strategies these individual may use. The rapid rise of unintentional overdose deaths from these drugs has paralleled the rapid surge in supply through increased prescribing and availability. Actions are urgently needed to educate patients about the dangers of these drugs and to limit the amounts of drug that can be prescribed, while doing this in a manner that does not deny access to needed medication for pain control. Also needed is an information system that will allow any prescriber or pharmacist to immediately know a patient's up-to-date history of prescriptions for opioids and other controlled substances. The Prescription Drug Monitoring Program developed and run by the Board of Pharmacy needs to be supported and upgraded to have this capacity so that it can proactively identify doctor shoppers and those clinicians who may be inappropriately prescribing opioids or other controlled substances. Finally, the existence and purpose of the PDMP must be well publicized as a deterrent.

5. Harm reduction—reducing risks for those who cannot escape addiction (see page 39)

Although New Mexico has been a national leader in harm reduction, steps are needed to greatly expand its availability. This can be achieved with support for greater public awareness and training, including education and promotion of New Mexico's Good Samaritan Law. This act encourages the notification of emergency services when there is an overdose. Narcan® is an easily administered and safe drug that can reverse the effects of opioids such as heroin and prescription pain medications in order to stop a potentially lethal overdose. Its distribution and availability need to be widely increased. Also needed are the reduction of the age 18 limit and an overall expansion of the syringe exchange

program, the restoration of funding and staffing of the DOH's Harm Reduction Program, and a study of additional ways in which injection drug use can be made safer until the user can get into effective treatment.

6. Treatment of substance abuse disorders—making it effective and available (see page 44)

A large proportion of people with substance use disorders simply do not have access to needed treatment. For those with access, other barriers often render the care insufficient and therefore ineffective, making the situation desperate and even life-threatening. This is especially the case for adolescents for whom there are no significant centers for detoxification and residential treatment. Recommendations include expanding the number of treatment centers, including three small regional residential treatment facilities for adolescents on an emergency basis, reestablishing insurance coverage for residential treatment, and supporting long-term intensive aftercare. Barriers are created by a lack of enforcement of existing state and federal laws mandating that the treatment of mental illness (including addiction) have parity with the treatment of other medical diseases. Insurance policies all too frequently limit substance use disorder coverage, and some publicly supported clinics and provider systems fail to offer or ensure referral to addiction services. These issues are urgent and should be rectified.

7. Medication-assisted treatment (MAT)—making MAT available for those who can benefit when they need it (see page 48)

MAT is opioid replacement treatment with the prescription drug buprenorphine (the opioid in Suboxone®) or methadone. MAT allows persons with opioid addiction to control the craving and enables their return to orderly and productive lives. Timely access to MAT can be lifesaving, especially if the alternative is continuation or uncontrolled use of illegal drugs. Some patients respond better to one of these replacement drugs than the other. MAT is profoundly underutilized in New Mexico. Among the barriers is insurance. New Mexico is one of the shrinking minority of states in which Medicaid does not cover methadone treatment. Medicaid coverage should be instituted immediately as it was recently for buprenorphine. It will be of particular importance in 2014 when health care reform creates new access to Medicaid fully funded by the federal government for many adults with substance use disorders. In addition, solutions are needed to remedy the insufficient numbers of physicians trained and certified to prescribe buprenorphine and willing to accept patients for treatment. Cumbersome requirements for preauthorization and reauthorization need to be removed. Some publicly supported clinics and provider systems fail to offer MAT or ensure referral for access to this important and sometimes lifesaving treatment. Most of these issues can be addressed through changes in regulatory policies. Finally, MAT for persons with opioid addiction can be beneficial if utilized during incarceration and in anticipation of release to prevent both the return to illegal drug use and crime and the exceedingly high rate of overdose after reentry. These potential MAT roles have been piloted successfully, and their usage should be expanded.

8. Involvement of primary care—making it a part of an integrated system of behavioral health services (see page 54)

The numbers and distribution of behavioral health specialists and other providers are inadequate to meet the vast unmet need in New Mexico for mental health services and the management of substance use disorders. The system of channeling the financing for such services through the behavioral health carve-out largely cuts nonbehavioral health care providers out of reimbursement for such services. Nevertheless, many persons with mental health problems including substance use disorders present themselves to primary care providers and choose to receive their care in such settings. The carve-out needs to be adapted into a hybrid system that integrates primary care with behavioral care (and still can ensure that needed behavioral health budgets are protected). The emerging health care home provides a model where an integrated system of care can flourish. Many patients can receive appropriate mental health care coordinated with other medical services through their primary care providers, who are reimbursed to do so. Patients with more complex psychiatric or substance use problems still need to be seen with mental health specialty consultation.

9. Sentencing—an opportunity to address substance use disorders rather than perpetuate them (see page 57)

A large proportion of persons being jailed have committed crimes tied to alcohol or drug use or related to obtaining resources for drugs. Sentencing should be conducted with the realization that these people need treatment. Alternatives to incarceration that include sound treatment programs or treatment as a component of incarceration should be considered as preferred options in many cases. Additionally, judicial districts should develop technical violations programs to expedite the handling of minor probation and parole violations and expand options such as drug courts. The passage of a uniform collateral consequences act would help facilitate reintegration following incarceration.

10. Prison and parole—important opportunities for addressing addiction (see page 60)

Ninety-five percent of prisoners in N.M. prisons return to their communities, which are often environments conducive to drug relapse and criminal recidivism without adequate support for successful reentry, potentially creating a substantial burden on a local community's public health and public safety systems. In one study, 87% of prisoners in New Mexico were identified as having some sort of substance abuse disorder. Overwhelming evidence supports the advantages of identifying persons entering prison who have substance abuse disorders and providing addiction services during incarceration and later during parole. Managing these disorders during and after incarceration substantially helps the prospects for reintegration and is associated with reduced rates of substance use, criminal recidivism, and reincarceration. An important part of this includes ensuring that those who are released have access to medical care. One recommendation is for the Human Services Department (HSD) to take proactive steps to ensure that eligible persons are immediately enrolled in Medicaid upon release from prison. The N.M. Corrections Department has itself articulated a blueprint for restoring effective addiction services during incarceration, bridging services during reentry, and ramping up services for those on probation and parole. Supporting this plan

begins with the restoration of funding that has recently been substantially cut from these cost-saving programs.

11. County detention centers—coping safely with abusers of alcohol and drugs (see page 68)

The N.M. jail census extends far beyond the national norms in terms of numbers of persons in its county detention centers. A large proportion is in for alcohol- and drug-related arrests. Detention centers' deficient capacity to offer treatment for acute detoxification creates medical risks. A current survey will likely confirm varying capacities to identify and manage prisoners with substance use disorders. Access to mental health and medical treatment during incarceration is essential. Release without arranging for medication-assisted treatment coverage or for follow-up substance use disorder treatment invites a return to drug-associated behaviors (with a high potential for overdose) and to criminal recidivism. Recommendations include sentencing reforms such as alternatives for treatment in lieu of incarceration, MAT, and postrelease social services and medical follow-up. The Task Force notes that the Department of Health provides public health services in several detention centers and recommends that other DOH local public health offices that are positioned but insufficiently funded and staffed be provisioned to deliver these services.

12. Peer counseling—an underutilized resource (see page 71)

Persons who are in recovery from substance use disorders are uniquely suited to provide support and mentorship for addicts, especially in the criminal justice system. The Task Force supports the use of peer services whenever possible to provide and enhance services at prisons and county detention facilities, probation- and parole-related services, and community-based services generally.

SENATE MEMORIAL 18 DRUG POLICY TASK FORCE BACKGROUND AND HISTORY

Senate Memorial 18 was introduced by Senator Bernadette Sanchez and passed during the 50th Legislature (1st Session) in 2011. SM 18 requested that the Robert Wood Johnson Foundation Center for Health Policy at the University of New Mexico (UNM) reconvene a task force to continue the work of the Senate Memorial 33 (2010) Drug Policy Task Force and complete a statewide plan to alleviate the negative consequences associated with the use of alcohol and other drugs. SM 33 and SM 18 direct the Task Force to use the "four-pillar approach" (prevention, treatment, harm reduction, and law enforcement) for its scope in evaluating New Mexico's current approaches to drug policy and to develop strategies for effective change.

The SM 18 Task Force was convened and chaired by Dr. William Wiese from the Robert Wood Johnson Center at UNM. Membership as specified in the memorial was solicited via communication with agency leadership. In instances where leadership did not respond, the chair attempted to fill out the Task Force with either members from the preceding SM 33 Task Force or others from similar backgrounds or areas of expertise or experience. The designated membership was joined by invited technical advisers and reviewers, and by others who requested participation.

The Task Force met monthly from June to November 2011 in open meetings in Santa Fe. Background papers were prepared by ad hoc subcommittee members and by staff. Draft findings and recommendations were distributed for comment to all participants. Recommendations were developed through consensus of Task Force membership and amended as appropriate after circulation of minutes.

A preliminary report was presented to the Legislative Interim Behavioral Health Subcommittee in Las Cruces on August 19, 2011. The present report constitutes the final findings and recommendations of the Task Force.

A copy of Senate Memorial 18 is in Appendix A.

A listing of Task Force members and other participants is provided in Appendix B.

Agendas and minutes of the SM 18 Task Force meetings are available on the website of the Robert Wood Johnson Center for Health Policy at UNM: http://healthpolicy.unm.edu.

INTRODUCTION

New Mexico has been among those at the top in U.S. rankings in the misuse and abuse of alcohol and illicit drugs and in the numbers of people needing and not receiving treatment for substance use disorders.[1] Rates are especially severe in the 12- to 17-year-old age group, where New Mexico is the #1 state, by far, for unmet treatment needs for illicit drugs and third for unmet treatment needs for alcohol abuse.

While fatalities from DWI have been falling in the past seven years, New Mexico still leads the nation in this category. New Mexico leads in deaths from alcohol-related chronic diseases.

New Mexico leads the United States in deaths from overdose of illicit drugs, with such deaths now exceeding deaths from motor vehicle crashes. The Department of Health estimates 200,000 users of illicit drugs in New Mexico, and the actual number may be considerably greater.

Additionally, the misuse and abuse of prescription drugs, especially opioid pain medications, have reached epidemic proportions. Unintentional overdose deaths from prescription opioid drugs nearly tripled during 2000–2009 in New Mexico and the United States and exceed overdose deaths from heroin and cocaine combined.[2]

These statistics reflect lives being wasted, education going uncompleted, jobs lost, families broken, and death coming early. The annual expenditures in New Mexico for the associated medical disorders, trauma, physical property damage, and criminal and judicial costs when combined with the losses in productivity are in the billions.[3]

The SM 18 Drug Policy Task Force was established to make recommendations on how problems reflected in these grim statistics should be approached in terms of policy. Cutting across the issues are important general findings that apply to New Mexico and that have framed the approaches used by the Task Force to focus its consideration and

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[1] Substance Abuse and Mental Health Services Administration. *State Estimates of Substance Use and Mental Disorders from the 2008–2009 National Surveys on Drug Use and Health.* NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

[2] New Mexico Department of Health. *New Mexico Substance Abuse Epidemiology Profile*, 2011. Available at: http://nmhealth.org/ERD/SubstanceAbuse/2011%20New%20Mexico%20Substance%20Abuse%20Epidemiology%20Profile.pdf. Accessed December 11, 2011.

[3] New Mexico Department of Health. *The Economic Cost of Alcohol Abuse in New Mexico: 2007*, 2011. Available at: http://www.health.state.nm.us/ERD/HealthData/SubstanceAbuse/The%20Economic%20Cost%20 of%20Alcohol%20Abuse%20in%20New%20Mexico,%202007.pdf. Accessed December 11, 2011.

prioritize specific findings and recommendations. These are well documented in the research literature and include the following:

Addiction is a chronic brain disease that affects behavior and is treatable.[4]
Over the past two decades and particularly in the past 10 years, scientists have identified the neurological basis for how addictive substances in susceptible persons lead to craving and behaviors and choices over which the person no longer has control. Susceptibility is influenced genetically.

The co-occurrence of a mental health disease in persons with addiction disorders is common, with estimates of 60% and higher, and contributes to both susceptibility to addiction and its sustainability.

Framing the addiction as a chronic disease is an essential element for successfully addressing the human tragedies and costs associated with substance use disorders.

Stigma has contributed to deprioritization and underinvestment in addressing the needs of persons with addiction disorders.
There is a pervasive belief that addiction is simply a matter of choice despite evidence that this disease disables an individual's ability to make appropriate choices. Popular contempt for the addict is reinforced by the often-alienating aspects of behaviors associated with addiction. These have led to widely prevalent attitudes that addiction should be punished and that those with addictions do not deserve treatment. Too often, there has been general acceptance and toleration of halfhearted public programs to address the issues—programs that are implemented with indifference and apathy, underfunded, and inadequately scaled even to begin to meet the magnitude of the need. There has been toleration of policies that in some instances have been outright discriminatory against persons with mental illness or substance use disorders. Federal and state laws to ensure parity for behavioral health care have been ignored and have gone without enforcement.

Addiction treatment and prevention are highly cost-effective.
According to conservative estimates from a recent study in California, every $1 invested in addiction treatment programs yields a return of about $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.[5] In other studies, for every $1 spent on

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[4] National Institute on Drug Abuse (NIDA). *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide.* NIH Publication No. 06-5316, July 2006.

[5] Ettner S, Huang D, Evans E, et al. Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? *Health Serv Res.* 2006;41:192–213.

treatment, $4.87 on health care costs[6] and $7 on crime costs[7] were shown to be avoided. Additionally, major savings to the individual and to society stem from fewer interpersonal conflicts, greater workplace productivity, and fewer drug-related accidents, including overdoses and deaths.

The cost-effectiveness of prevention is even greater. Studies demonstrate a return from properly conducted school-based preventive programs at 18 to 1. Programs targeted at high-risk individuals or early users have returned savings at 30 to 1.[8] State budgetary issues in New Mexico in 2011 resulted in sharp cutbacks in preventive services that are proven effective and most certainly could more than pay for themselves in savings.

Treatment for substance use disorders is vastly underfunded in New Mexico.
Public funding is needed to address the public health consequences of substance use disorders and to provide safety-net treatment services principally for lower-income groups. The levels of funding cover only a small fraction of the persons with needs in these target groups. Furthermore, in recent years, state appropriations for such services have declined, service operations have been reduced, facilities and infrastructure have been withdrawn from service, and staffing for services in state prisons has been cut back.

Medicaid and most commercial health plans have cut benefits and the scope of services for substance use disorders. Allowed services are often insufficient or do not include services that may be essential for adequate and appropriate care. Examples in New Mexico include the elimination of coverage for residential treatment and aftercare.

The passage of state and federal laws to ensure parity in insurance coverage of mental health and substance abuse problems has raised hope for improvement of this state of affairs, although the results of these are yet to be seen. (See Appendix G, section on mental health parity.)

Medication-assisted treatment of addiction is grossly underutilized in N.M. communities and detention facilities.
Opioid replacement therapy (for example, with methadone or buprenorphine) is a proven and cost-effective component of treatment that is often useful and can be lifesaving. Steps to address the barriers that contribute to the limited deployment of MAT are covered in the recommendations of this report.

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[6] Hartz DP, Meek P, Piotrowski NA, et al. A cost-effectiveness and cost-benefit analysis of contingency contracting-enhanced methadone detoxification. *Am J Drug Alcohol Abuse.* 1999;25:207–218.

[7] NIDA. *Principles of Drug Addiction Treatment.* NIH Publication No. 09-4180, August 2009.

[8] Miller T, Hendrie D. *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis*. DHHS Publication No. 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.

Effective treatment is out of reach for most New Mexicans who need it.
Treatments that are proven effective for persons with substance use disorders are presently out of reach for the majority of New Mexicans who need them. Reasons include the very high rates of uninsurance and underinsurance in nonelderly adults, the paucity of benefits for substance use disorders in most insurance plans, and the lack of treatment resources relative to the enormous scope of the problem. The numbers of persons needing but unable to obtain services are in the tens of thousands.

Persons with addictions who have been incarcerated account for a major portion of the costs and social consequences of alcohol and other drug use.
In 2002 the N.M. Department of Corrections reported that 87% of prisoners have some kind of problem with drugs or alcohol. Ninety-five percent of people incarcerated in New Mexico will return to their home communities. If the addictions and other health issues cannot be addressed during incarceration, persons will take these issues back to their communities, which are often conducive to the perpetuation of the cycle of addiction/crime/incarceration.

The numbers and distribution of behavioral health service providers are insufficient in N.M. communities and in the prison system.
The extent of the human resource deficit to provide basic behavioral health services in the state is not clear, but to estimate the current deficit to be at 50% or greater would not be an irresponsible assumption. The deficiencies in rural communities are of particular concern. For substance use disorders, the numbers and distribution of providers, services, and facilities are even worse.

Fragmentation of state programs continues to frustrate local planners.
While the coordination of behavioral health services for children, young adults, and adults is the goal and responsibility of the Behavioral Health Purchasing Collaborative and local collaboratives, programs still reach the community level via separate agencies. Fragmentation creates confusion and diminishes effectiveness. The needs of these programs vary across regions of the state, require local and regional specificity, and demand meaningful community involvement.

Leadership is key.
The campaign in New Mexico that started in 2004 and dramatically reduced underage drinking and lowered alcohol-related traffic fatalities was multidimensional and highlights the importance of the governor's active involvement, including wide visibility in the media and leadership in creating interagency cooperation, building public awareness and support, and pushing through the necessary enabling legislation.

This report provides a summary of the findings and recommendations of the SM 18 Drug Policy Task Force. The recommendations in this report mainly focus on the near-term, with actions that state agencies and community groups should be considering now and actions that the legislature should consider during its 2012 and 2013 sessions.

POPULATIONS NEEDING SPECIFIC ATTENTION

Youth:

The prevalence of alcohol and other drug use self-reported by middle and high school students in New Mexico is among the highest in the United States. Youth who use drug and alcohol in New Mexico are more likely to use at a younger age than anywhere in the nation. Youth who use drugs are far more likely to have problems as adults with drug addiction. While there has been some reduction of alcohol use in recent years, illicit drug use has been climbing,[9] and the heroin death rate among youth has risen sharply.[10] While still only accounting for a small percentage of the total burden of opiate mortality, the issue of heroin usage in youths is an important part of the broader spectrum of addiction in New Mexico.

Detoxification beds for adolescents and developmentally appropriate substance abuse and trauma treatment programs, as well as intensive outpatient programs, for adolescents and young adults are insufficient or lacking in most New Mexico communities including Albuquerque. SM 56 (2011) mandated a separate task force (Treatment of Opioid Addiction Among Adolescents) that is reporting with recommendations regarding this issue.

Systems of care that address the needs of adolescents and young adults (18–25) entering the adult treatment and adult justice systems need to be developed to intentionally include the developmental stages of youth, the treatment of trauma, physical health treatment, and other behavioral health needs.

Women and girls:

> Up to 92% of incarcerated girls have experienced one or more forms of physical, sexual, and emotional abuse before entering the juvenile justice system. More than 45% have been beaten or burned at least once; 40% have been raped; 32% have current or past sexually transmitted diseases; and 32% have chronic health problems. Girls exposed to violence on an ongoing basis are prone to self-abusive behavior, depression, mental illness, drug use, and suicide.

Despite ample data that men and women substance abusers differ, substance abuse treatment has traditionally been developed with male substance users in mind. Prison programs developed for men have historically been imposed on women, and the women

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[9] Green D. Highlights from the 2009 New Mexico High School Youth Risk and Resiliency Survey. *New Mexico Epidemiology.* 2010;2010(7). Available at: http://nmhealth.org/ERD/HealthData/yrrs.shtml

[10] Shah NG, Lathrop SL, Reichard RR, Landen MG. Unintentional drug overdose death trends in New Mexico, USA, 1990–2005: combinations of heroin, cocaine, prescription opioids and alcohol. *Addiction.* 2008;103(1):126–136.

were then blamed when the programs were ineffective. Only recently have programs begun to offer gender-sensitive and gender-specific treatment for women. These treatment programs have been shown to be more effective for women than traditional treatment programs.

The New Mexico population of girls in the juvenile justice system continues to grow. Best practice substance abuse and physical needs treatment and evidence-based trauma treatment are lacking for this population of at-risk and high-risk girls in New Mexico.

Increasingly, the services provided to women by the N.M. Corrections Department are reflecting differences in the experiences and needs of women prisoners, but much more work is required. Though there are guidelines available to assist states in the development of gender-specific treatment standards, at the time of the Task Force's review, New Mexico had yet to develop or implement standards for gender-sensitive treatment.

Additionally, a large number of children born in New Mexico to substance-using women are referred to the Children, Youth, and Families Department (CYFD) without other evidence of potential for child abuse or neglect. N.M. law does not define substance use in pregnancy as child abuse, nor does federal law require reporting of all substance-exposed infants. Not only do these referrals increase the workload of already burdened CYFD caseworkers, they create great fear among substance-using pregnant women that can be a deterrent to seeking prenatal care.

In 2009 the SM 19 Task Force developed a comprehensive state plan for improving policies and systems relating to substance abuse in pregnancy. Specifically, the plan calls for reducing unnecessary referrals to CYFD and increasing home visitation; increasing access to quality substance abuse treatment, prenatal care, and family planning for women; increasing access to supportive services; increasing treatment over incarceration for nonviolent drug-related crimes; changing attitudes about substance use; and increasing research and data collection.[11]

The SM 33 Drug Policy Task Force highlighted areas that needed particular attention, some of which have been assigned to new task forces in 2011:

- Develop and implement gender-sensitive treatment standards and rules for New Mexico. (House Memorial [HM] 13 [2011], Gender-Specific Treatment Standards: HSD Behavioral Health Services, was charged with convening a work group to create gender-specific treatment standards and rules for women and girls seeking treatment for substance abuse disorders.)
- Create alternatives to incarceration for drug offenses and more gender-sensitive probation and parole policies for pregnant women and women with young children. (HM 21 [2011], Juvenile Justice Gender Responsive Services, the

[11] New Mexico Governor's Women's Health Office. *Assess and Improve Access to Substance Abuse Treatment and Prenatal Care for Pregnant Women with Substance Abuse Problems: Final Report*, November 2010.

Juvenile Justice Advisory Committee's gender subcommittee, was charged with convening a task force to implement the recommendations previously developed for a sustainable plan for a continuum of gender-responsive services and programs for girls in the juvenile justice system.)

- In hospitals, enact and enforce treatment standards that encourage substance-abusing women who are pregnant to get prenatal and postnatal care. (HM 14 [2011], Substance Abuse and Prenatal Care, the Health Sciences Center at UNM, was charged with implementing the recommendations of the Pregnant and Drug Using Women's Task Force.)

Other recommendations needing implementation from the SM 33 report include the following:

- Develop a New Mexico state–owned centralized referral system for women seeking substance abuse treatment in New Mexico.
- Increase access to case management for substance-abusing women and their families by requiring assessment of case management needs and referral to core service agencies.
- Refer substance-exposed infants to home visitation programs rather than to child protection.
- Enact legislation requiring all substance abuse facilities to screen patients for family planning services and provide such services or make appropriate referrals.
- Enact legislation requiring all publicly funded addiction services that provide treatment for women to provide services to women who are pregnant.
- Encourage the use of medication assisted treatment (MAT) for all women, including pregnant women, unless medically contraindicated.

Persons over 50 years:
Older adults face a rising problem of alcohol abuse, prescription drug misuse and abuse, and illicit drug use.[12,13] The Substance Abuse and Mental Health Services Administration projects a doubling of the number of people with alcohol and other substance use (notably prescription drug abuse problems) in persons over age 50 by the year 2020. More older people are hospitalized for alcohol-related problems—for example, falls with injury or death and medication mismanagement, as well as alcohol-related diseases—than for heart disease.

An interagency team drawn from the Aging and Long-Term Services Department (ALTSD) and BHSD is concerned about fall-related deaths in older adults and the likely

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[12] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *The DAWN Report: Drug-Related Emergency Department Visits Involving Pharmaceutical Misuse and Abuse by Older Adults*. Rockville, MD. November 25, 2010.

[13] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *The DAWN Report: Emergency Department Visits Involving Illicit Drug Use by Older Adults: 2008*. Rockville, MD. September 9, 2010.

association with alcohol and other drug abuse and is exploring evidence-based prevention strategies in primary care settings to screen and provide early intervention for older adults who are identified as being at risk. Such screening and intervention is a new covered service that has just been added by Medicare under the Affordable Care Act (ACA).[14]

An important opportunity in New Mexico will come with improving the integration of primary care and behavioral health services. According to the ALTSD representative on the Task Force, a large majority of older persons prefer to receive management of behavioral health issues from primary care providers than from a behavioral health specialist. Integrating behavioral health treatment with primary medical care has been shown to be effective for older adults. Better integration along with building overall capacity to handle behavioral health issues in health care settings will be important steps.

[14] U.S. Department of Health and Human Services. *The Affordable Care Act's New Rules on Preventive Care and You*. July 14, 2010. Available at http://www.healthcare.gov/news/factsheets/2010/07/preventive-care-and-you.html

FINDINGS AND RECOMMENDATIONS OF THE TASK FORCE

1. COORDINATION OF SERVICES PROVIDED BY MULTIPLE STATE AGENCIES

Findings:
Prevention and treatment programs related to alcohol and drug use disorders and addictions are scattered across an estimated 40 agencies. State agencies include many departments: Human Services; Health; Corrections; Children, Youth, and Families; Aging and Long-Term Services; Public Education; Transportation; Public Safety; and Finance and Administration.

The interagency Behavioral Health Purchasing Collaborative partially addresses the multidepartmental fragmentation of behavioral health services. The collaborative, however, with its focus particularly on the financing of patient services, leaves many programs separated and scattered and working with various degrees of independence.

Municipal and county initiatives promoted or led by local behavioral health collaboratives, county health councils, and county DWI councils are limited in their connection with state initiatives and are largely disconnected with one another regarding planning, advocacy, and program coordination.

The effects of understaffing and underfunding are apparent. Gaps in services are the norm, with essential components simply unavailable for many who are in need. An additional issue is that many agencies tasked to address behavioral health deprioritize or simply overlook addiction.

Consolidation and coordination of effort regarding substance use disorders and addictions will be necessary to formulate, organize, and administer a strategic plan. Meaningful public health goals need to be set, resources carefully allocated, and programs monitored and evaluated. The areas of responsibility span prevention, all phases of treatment and a continuum of care, incorporation of public health and environmental strategies, public education, professional education, criminal justice, and corrections. With a goal that services follow the needs of the client or patient, there needs to be a seamless integration across state and community programs, programs targeting different age groups, and programs for incarcerated persons that includes bridging social and medical services upon community reentry from incarceration.

No one agency in the state is presently structured or authorized to take this on.

Recommendation for the Legislature and the Governor:
With planning to start immediately, create a central, high-level alcohol and drug abuse administration office charged with developing and administering a comprehensive statewide addiction prevention and treatment system for all person with needs, consolidating existing services. This office would preferably be its own state department but could also be a division of either the DOH or the HSD.

The office should

a. Establish the position of State Alcohol and Drug Abuse Director, which would preferably be a cabinet-level position or report directly to the cabinet secretary of the DOH or HSD and participate as a member of the National Association of State Alcohol and Drug Abuse Directors;
b. Create a full-time state opioid treatment authority that would work within this department and report to the director;
c. House and manage existing programs that bear on the issue of substance use and co-occurring mental disorders;
d. Develop statewide public health outcome goals and strategically plan for an outcomes-oriented system of prevention, harm reduction, and treatment services;
e. Receive and manage the funding for the system, allocating resources for partner agency-specific services including those in correctional institutions;
f. Have an independent board of advisers that will have representation from within state departments and local government, advocacy organizations, addiction and behavioral health treatment providers, insurers, consumers, and other relevant stakeholders;
g. Facilitate and promote the shift of the conceptual axis of service from agency-specific programs to community-responsive services and client-responsive solutions;
h. Promote and coordinate with locally based initiatives and services based in the private sector;
i. Ensure that the opportunities within health care reform are fully exploited to arrange for public financing for prevention, harm reduction, and treatment services and that other resources are available for persons without adequate insurance;
j. Ensure that addiction services are appropriately connected to the broad systems addressing behavioral health, medical/surgical health care, and public health.

2. INVENTORY AND MAPPING THE STATE'S CAPACITY FOR BEHAVIORAL HEALTH ASSESSMENT AND TREATMENT

Findings:
The extent of the present deficit of services related to behavioral health assessment and treatment is not clear, but to place the numbers at 50% of need or less would not be an irresponsible assumption. Computing the need and addressing this deficit represent a long-term issue, but one that is urgent for purposes of planning.

There is at present no centralized, comprehensive inventory of providers and facilities that offer behavioral health assessment and treatment. Information is scattered across multiple agencies and organizations, and its availability is fragmented and inefficiently available to planners and the public.[15]

The Behavioral Health Planning Council's Adult and Substance Abuse subcommittees along with the Behavioral Health Services Division are compiling a directory of adult behavioral health services, including addiction treatment services, gathering the data from the local collaboratives. Mounting this directory in the N.M. Social Services Resource Directory (SSRD) managed by the Aging and Long-Term Services Department has been discussed as a possibility. SSRD is regularly updated, able to link sites with mapping functions, and able to link such a directory for adult services with youth services. ALTSD has agreed to expand its taxonomy and service providers for adult behavioral health services for a pilot program planned for Catron County. Statewide expansion would require additional positions and funding to support the verification and maintenance of the database. The SSRD is funded until the end of state fiscal year 2013.

Recommendations for the Behavioral Health Services Division and Behavioral Health Planning Council in Conjunction with the Aging and Long-Term Services Department:

1. Pending a favorable evaluation of the pilot run (Catron County), and with an appropriate funding plan, the directory of adult behavioral health services should be completed and loaded into ALTSD's SSRD for public Internet access. The directory should be expanded to include or connect with children's services and facilities. The directory should include physicians certified for opioid replacement therapy (e.g., buprenorphine). Additional information sources (for example, the directories assembled by the N.M. Sentencing Commission, tribes, and various localities and agencies) should be scanned for inclusion in the directory.
2. The directory should be adapted to serve as a statewide inventory of services and be linked to other appropriate state websites. Estimates should be developed utilizing this directory regarding the state's overall capacity to provide behavioral

[15] An example of a model comprehensive resource directory is the Maryland Community Service Locator affiliated with the Maryland Alcohol and Drug Administration. Available at: http://www.mdcsl.org/advantagecallback.asp?template=map_search

health services including alcohol and drug addiction services relative to statewide needs. Gaps in the availability of services and facilities should be calculated and incorporated into a planning process.

3. PRIMARY PREVENTION OF ALCOHOL MISUSE AND ABUSE

Findings:
According to a telephone survey of adults in New Mexico, 4.4% "drink heavily," and 11.1% engage in "binge drinking"[16]—numbers reported for the United States are slightly higher.[17] The N.M. figures are likely substantial underestimates due to known socioeconomic study biases.

While the U.S. death rate secondary to alcohol-related chronic disease (e.g., liver disease and others) declined 15% from 1990 to 2007, the rate in New Mexico remained stable and high. As a result, New Mexico's rate went from being 1.6 times the U.S. rate in early 1992 to being 2.2 times the U.S. rate in 2007.[18]

Alcohol consumption is a major contributor to the three leading causes of death among young people: motor vehicle accidents, suicide, and homicide. In New Mexico, at least 132,000 people age 12 and older need treatment for alcohol use but are not receiving it.[19]

The priority for prevention must be the younger age groups. New Mexico leads the country in numbers of children who start drinking before age 13 and is higher than most states in the prevalence of students who drink regularly and who are binge drinkers.

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[16] Centers for Disease Control and Prevention (CDC) definitions:

- *Heavy drinking*: more than two drinks per day on average in men and more than one drink per day in women
- *Binge drinking*: five or more drinks during a single occasion for men and four or more drinks during a single occasion for women.

[17] New Mexico Department of Health. *New Mexico Substance Abuse Epidemiology Profile*, 2011. Available at: http://www.health.state.nm.us/erd/SubstanceAbuse/2011%20New%20Mexico%20Substance%20Abuse%20Epidemiology%20Profile.pdf. Accessed December 11, 2011.

[18] Roeber J, New Mexico Department of Health, Substance Abuse Epidemiology Program, direct correspondence.

[19] U.S. Department of Health and Human Services. *State Estimates of Substance Use and Mental Disorders from the 2008–2009 National Surveys on Drug Use and Health*, 2011. Available at: http://store.samhsa.gov/shin/content//SMA11-4641/SMA11-4641.pdf. Accessed December 11, 2011.

Table 1. Survey of N.M. Students (Youth Risk and Resiliency Survey), Grades 9–12, 2009

Survey Question	N.M. Prevalence	State Rank	Comment
Current drinker	41%	14	80% of alcohol use occurs at home
Binge drinking	25%	11	Accounts for 90% of alcohol consumption in 12- to20-year-olds
First alcohol before age 13	29%	1	Persons initiating before age 14 are six times as likely to become dependent

Source: CDC, Youth Risk and Resiliency Survey for New Mexico, 2009. See New Mexico Department of Health, *Youth Risk and Resiliency Survey: 2009 High School Alcohol Report*, 2010. Available at: http://www.youthrisk.org/pdf/2009/YRRS-2009-Presentation.pdf, accessed December 11, 2011.

On the positive side, the rates for N.M. students shown above represent substantial decreases over the six years since 2003.

Also, New Mexico has greatly improved its rate for drunk-driving fatalities, dropping from #1 to #25 in 2009—a decline of 32% since 1999.[20] This encouraging statistic is attributable to a high-profile, multifaceted statewide campaign against drunk driving.

Economics of Alcohol Use

In 2007, the costs to the N.M. public attributable to alcohol use for health care, property damage, criminal justice, incarceration, and social expenses exceeded $800 million. The additional costs in terms of lost economic productivity exceeded $2 billion, bringing the total to $2.8 billion. Taken together that amounts to $1,400 for every person in the state.[21] Additionally, the costs of underage drinking in New Mexico are the third highest per capita in the United States, a total of $259 million just for health and work loss costs in 2009.[22]

These costs, which are absorbed jointly by the public and state-funded programs, dwarf the annual revenues obtained from the excise tax on alcohol ($40 million).

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[20] Mothers Against Drunk Driving website. Available at: http://www.madd.org/drunk-driving/campaign/state-stats/. Accessed December 11, 2011.

[21] New Mexico Department of Health. *The Economic Cost of Alcohol Abuse in New Mexico: 2007*, 2011. Available at: http://www.health.state.nm.us/ERD/HealthData/SubstanceAbuse/The%20Economic%20Cost%20of%20Alcohol%20Abuse%20in%20New%20Mexico,%202007.pdf. Accessed December 11, 2011.

[22] Pacific Institute for Research and Evaluation. *Underage Drinking in New Mexico—The Facts, 2009*. Available at: http://www.udetc.org/factsheets/NM.pdf. Accessed December 11, 2011.

Prevention

The problems of preventing misuse or abuse of alcohol in adults and underage drinking can be divided into two general approaches: individual/direct prevention services ("demand reduction") and environmental approaches ("supply approaches").

Current budgetary realities in New Mexico, including a crippling 61% loss of funding in the last year for the Office of Substance Abuse Prevention (OSAP) of the Human Services Department,[23] require having to focus on environmental strategies that are clearly cost-effective. In particular, the Task Force strongly supports interventions to prevent or delay initiation or early use of alcohol and other substances through school-based, family-based, and community-based prevention services. Delaying the initiation of first alcohol use is a proven strategy for reducing alcohol abuse by minors and reducing the later development of alcohol and other drug dependence.

Other evidence-based environmental approaches to reduce alcohol abuse recommended by the CDC's Task Force on Community Preventive Services include the following:[24]

- Maintain dram shop liability (supply).
- Maintain limits on hours of sales of alcohol (supply).
- Regulate alcohol outlet density (supply).
- Enhance enforcement of laws prohibiting alcohol sales to minors (supply).
- Increase alcohol excise taxes (demand).

Alcohol abuse is a central issue in terms of the burdens and problems it creates in connection with all phases of criminal behavior. Any preventive approaches to reducing excessive drinking (particularly binge drinking) would have an impact on alcohol-related crime levels.

Alcohol Excise Tax Increase

Along with the CDC, the Institute of Medicine includes raising excise taxes among its recommended approaches to reducing underage drinking.[25] Because it is proven effective and can raise needed revenue to better address unfunded programs to prevent and treat

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[23] New Mexico Behavioral Health Services Division, Human Services Department. *Office of Substance Abuse Prevention/Alcohol, Tobacco and Other Drug Abuse Fact Sheet.* Available at: http://www.hsd.state.nm.us/pdf/LegislativeSession/2011/Prevention%201-12-11.pdf. Accessed December 11, 2011.

[24] CDC. *Guide to Community Preventive Services. Preventing Excessive Alcohol Consumption.* Available at: http://www.thecommunityguide.org/alcohol/index.html. Accessed December 11, 2011.

[25] National Research Council and Institute of Medicine. *Reducing Underage Drinking: A Collective Responsibility, a Report Brief*, September 2003. Available at: http://www.iom.edu/~/media/Files/Report%20Files/2003/Reducing-Underage-Drinking-A-Collective-Responsibility/ReducingUnderageDrinking.pdf. Accessed December 11, 2011.

addiction, the Task Force recommends raising the excise tax on alcohol. Appendix C provides detail on the rationale and the evidence that supports raising the alcohol excise tax.

An alcohol excise tax increase has been demonstrated to do the following:[26]

- Decrease alcohol-impaired driving and alcohol-related crashes
- Decrease alcohol-related medical conditions
- Decrease all-cause alcohol-related mortality and specifically mortality from motor vehicle crashes and liver cirrhosis
- Decrease the spread of sexually transmitted diseases
- Decrease the rate of severe violence toward children
- Decrease alcohol dependence rates
- Decrease hospital admissions
- Decrease the rates of certain crimes
- Decrease the number of suicides in males

These translate into significant savings in addition to annual tax revenue of $40 million–$80 million.[27]

National polls indicate strong public support for raising alcohol excise taxes.[28]

Social Host Ordinances

The high proportion of drinking done at home by youth points to the importance of other strategies such as targeting the social liability of property owners and parents.[29] Penalties are typically escalating for repeat offenses. Currently, a number of municipalities in New Mexico have social host ordinances that reportedly are widely supported by law enforcement and are being studied by the state for effectiveness: Farmington, Santa Fe, Espanola, and Moriarty.

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[26] Elder RW, Lawrence B, Ferguson A, et al. The effectiveness of tax policy interventions for reducing excessive alcohol consumption and related harms. *Am J Prev Med.* 2010;38(2):217–229.

[27] New Mexico State Legislature. *House Bill 23, Liquor Excise Tax Distribution to Schools, Legislative Education Study Committee Bill Analysis*. Available at: http://www.nmlegis.gov/Sessions/11%20Regular/LESCAnalysis/HB0023.pdf. Accessed December 11, 2011.

[28] Harwood EM, Wagenaar AC, Bernat DH. *Youth Access to Alcohol Survey, Summary Report*, December 2002. Available at: http://www.epi.umn.edu/alcohol/pubopin/2002_REPORT.PDF. Accessed December 11, 2011.

[29] Imm P, Chinman M, Wandersman A, Rosenbloom D, Guckenburg S, Leis R. *Preventing Underage Drinking: Using Getting to Outcomes™ with the SAMHSA Strategic Prevention Framework to Achieve Results*. Santa Monica, CA: RAND Corporation, 2007. Available at: http://www.rand.org/pubs/technical_reports/TR403. Accessed December 11, 2011.

Screening and Treatment

For persons with alcohol use disorders, treatment can be effective, even lifesaving, and is indicated. Near-term opportunities exist for public funding of behavioral health care in primary care settings through provisions of the Affordable Care Act.

Evidence supports the importance and usefulness of screening, brief intervention, and referral for treatment (SBIRT) in preventing alcoholism or reducing its negative consequences. Medicaid could help by enabling the use of Medicaid billing codes for SBIRT services.

Recommendations for the Legislature and Local Governments:

1. Implement an alcohol excise tax increase as either—or preferably both—a state and local option.

    a. A state alcohol tax has the advantage of impacting greater numbers of persons and generating a large funding source for vastly greater substance abuse prevention and substance use disorder treatment services in the state.
    b. A local option has the advantage of targeting the revenues toward alcohol and other drug prevention programs, as has been demonstrated in McKinley County.

2. Create legislation to provide for social host liability associated with underage drinking. In the absence of state legislation, local ordinances are encouraged.

Recommendations for the Legislature:

1. Restore funding to the Office of Substance Abuse Prevention from the state's general fund that was lost in the past two years for alcohol prevention providers.
2. Provide funding for full staffing of the Department of Public Safety Special Investigations Division to improve the enforcement of state liquor laws and to increase training in communities and businesses and develop strong ties with alcohol distributors based on the community policing model.

Recommendations for the Department of Health and the Human Services Department/Medical Assistance Division:

1. The BHSD should increase OSAP staff to improve its ability to restore grant funding and support prevention providers.
2. Restore funding to the state's county health councils (DOH) and local collaboratives (HSD) for the prevention of alcohol misuse.
3. Medicaid should cover billing codes to providers for screening, brief intervention, and referral for treatment.

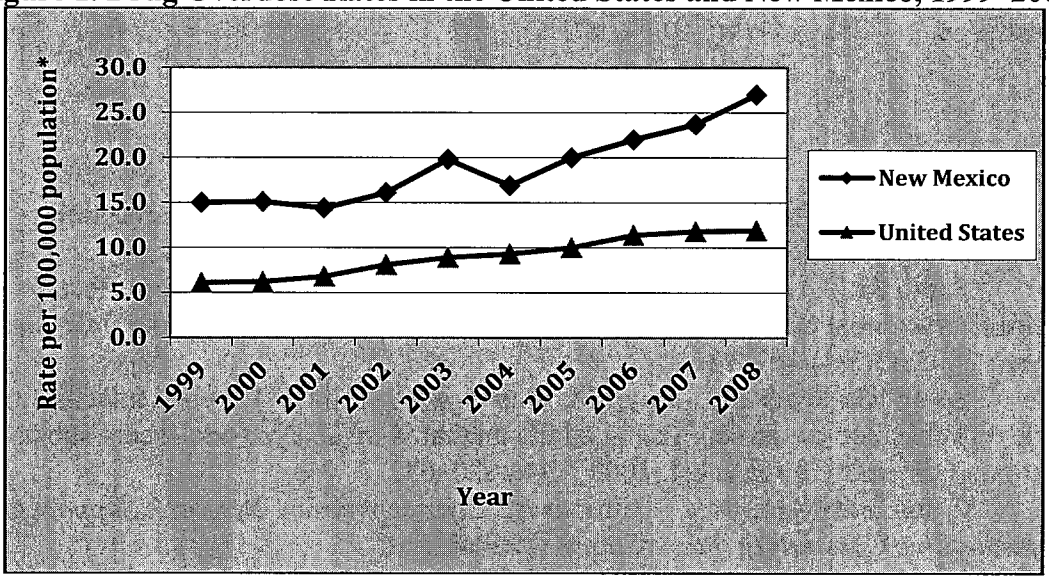
4. PREVENTION OF ILLICIT DRUG ABUSE AND PRESCRIPTION DRUG MISUSE

Findings:

Magnitude of the Problem

The consequences of the problem of illicit drug abuse and prescription drug misuse include the drug overdose death rate in New Mexico, which is the highest in the United States (and has been nine of the last ten years)[30]—more than double the U.S. rate, and the gap has been expanding (Figure 1). New Mexico also has the highest rate of overdose associated with illicit drugs and the second highest overdose rates associated with all prescription drugs and prescription opioids.[31] Moreover, among youth New Mexico has the highest national rate of illicit and prescription drug abuse[32] and is in the top five for drug use in all measured categories including prescription opioids.[33] The high rates of illicit and prescription drug use, the extreme rates of mortality, and the great cost are documented in detail in Appendix D, Characteristics of Drug Use and Deaths in New Mexico.

Figure 1. Drug Overdose Rates in the United States and New Mexico, 1999–2008



*Deaths per 100,000 population, age-adjusted to the 2000 standard U.S. population.

[30] CDC, National Center for Health Statistics. Underlying causes of death from the CDC WONDER online database, released 2011. Available at: http://cdc.wonder.gov. Accessed December 16, 2011.

[31] Ibid.

[32] Substance Abuse and Mental Health Services Administration. *State Estimates of Substance Use and Mental Disorders from the 2008–2009 National Surveys on Drug Use and Health.* NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

[33] Eaton DK, Kann L, Kinchen S, et al. Youth risk behavior surveillance—United States, 2009. *MMWR Surveill Summ.* 2010(June 4);59(SS-5).

Primary Prevention

School-based,[34] community-based,[35] and family-based[36] prevention programs have been demonstrated in a large number of studies to reduce initiation of drug use or delay the transition to more intense drug use.[37] Additional positive outcomes have included better retention in school and a reduction in criminal justice consequences.[38] Early initiation of alcohol or other drug use is one of the strongest predictors of adult substance use disorders.[39] A delay in the age of initiation of alcohol or drug use can make the difference between a teen just experimenting with alcohol or other drugs and becoming addicted.[40] When drug use initiation occurs at a later age, better school performance, life-coping skills, and more effective peer and family resources are often present.

The primary prevention of illicit drug abuse in the school and community settings has a very high benefit-cost ratio, with an average savings of $18 and greater for every dollar spent.[41]

The Task Force notes that drug prevention efforts in New Mexico have become reduced as the result of divesting resources in communities and N.M. middle and high schools. For example, funding for alcohol and other drug prevention through the Office of Substance Abuse Prevention of the N.M. Human Services Department is down by 61% in the last year.

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[34] Tobler NS, Stratton HH. Effectiveness of school-based drug prevention programs: a meta-analysis of the research. *J Prim Prev.* 1997;18:71–128.

[35] Spoth RL, Greenberg MT. Toward a comprehensive strategy for effective practitioner–scientist partnerships and larger-scale community benefits. *Am J Community Psychol.* 2005;35(3/4):107–126.

[36] Spoth RL, Trudeau L, Guyll M, Shin C, Redmond C. Universal intervention effects on substance use among young adults mediated by delayed adolescent substance initiation. *J Consult Clin Psychol.* 2009;77(4):620–632.

[37] Community Anti-drug Coalitions of America website. *Research Support for Comprehensive Community Interventions*. Available at: http://www.cadca.org/files/resources/ResearchSupport-4-ComprehensiveInterventions-09-2011.pdf. Accessed December 26, 2011.

[38] Ibid.

[39] Grant BF. The impact of a family history of alcoholism on the relationship between age at onset of alcohol use and DSM-IV alcohol dependence: results of the National Longitudinal Alcohol Epidemiologic Survey. *Alcohol Health Res World.* 1998;22:144–147.

[40] Grant BF, Dawson DA. Age at onset of alcohol use and its association with *DSM-IV* alcohol abuse and dependence: results from the National Longitudinal Alcohol Epidemiologic Survey. *J Subst Abuse.* 1997;9:103–110.

[41] Miller T, Hendrie D. *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis*. DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.

The primary prevention of drug abuse occurs not only as a result of programs supported by governmental spending and grants but also very successfully through the work of grassroots and local organizations like the Heroin Awareness Committee. Founded in Albuquerque in 2010, the Heroin Awareness Committee has been effective in creating awareness and educating in the schools and the community about the realities and negative consequences in New Mexico of heroin and other opioid drugs.

With alcohol use as an antecedent of subsequent drug abuse disorders, the successful prevention of underage drinking should be a part of the strategy for the primary prevention of drug abuse disorders. (See section 3, Primary Prevention of Alcohol Misuse and Abuse, and Appendix C in this report.)

Preventing Deaths from Prescription Opioids and Other Controlled Substances

Within the general category of unintentional deaths from drug overdoses, deaths from prescription opioid pain relievers[42] have tripled in the United States and New Mexico[43] over the 10-year period 1999–2008, now exceeding deaths from heroin and cocaine combined, and account for more deaths than automobile crashes. New Mexico is among the national leaders with its rate of unintentional deaths due to overdoses of prescription drugs.[44]

The CDC has identified two groups of opioid users at high risk for overdose: doctor shoppers (four different prescribers and four different pharmacies in one year) and those taking high-dose opioids (>100 mg morphine equivalents), each accounting for about 10% of patients prescribed opioids, but each also accounting for 40% of prescription opioid overdoses. The other 80% of patients prescribed low to moderate doses of opioids account for 20% of overdose deaths.[45] The rise in overdose deaths from opioid pain relievers strongly correlates with the amount of these substances prescribed, and the amount prescribed has been massively excessive—with enough sold to medicate every American adult with a typical dose of 5 mg of hydrocodone every four hours for one month.[46]

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[42] Examples of opioid pain relievers include morphine, oxycodone (OxyContin®, Percocet), hydrocodone (Vicodin), methadone, codeine, hydromorphone (Dilaudid®), oxymorphone (Opana®), and fentanyl.

[43] New Mexico Department of Health. *New Mexico Substance Abuse Epidemiology Profile*, 2011. Available at: http://nmhealth.org/ERD/SubstanceAbuse/2011%20New%20Mexico%20Substance%20Abuse%20Epidemiology%20Profile.pdf. Accessed December 11, 2011.

[44] CDC. Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. *MMWR*. 2011(November 1);60:1487–1492.

[45] CDC. CDC grand rounds: prescription drug overdoses—a U.S. epidemic. *MMWR*. 2012(January 13);61(1).

[46] Ibid.

The following strategies are described in greater detail in Appendix E, Reducing the Supply of and Preventing Overdose Deaths from Prescription Opioids, with respect to need, rationale, and documentation of effectiveness:

a. Prescriber education: The legislative House Memorial 77 (2011) Prescription Drug Abuse and Overdose Task Force has recommended that all potential opioid pain medicine prescribers undergo mandatory education regarding noncancer pain management that would likely include safe opioid use and prescribing.
b. Informed consent for patients: Also of importance in impacting prescription drug abuse and misuse is adequate patient education.[47] Nothing will guarantee education of the patient about opioids by the practitioner more than a requirement for informed consent, which will help patients and parents or guardians of patients become more responsible in the use, storage, and disposal of opioid medications, in addition to there being a discussion of the risks, benefits, and alternatives to opioid use, which is already mandated by N.M. law for all prescribed treatments. This will have a high impact considering that access to unused portions of leftover medications has been reported by far as the greatest source for diversion among youth[48] and adults.[49] Informed consent for opioid medications is currently a statute in 13 states[50] and is recommended by the Federation of State Medical Boards of the United States.[51]
c. Restricting the amount of opioid medication prescribed: Limiting the amounts dispensed for the management of cough and acute pain (i.e., to those without cancer or chronic pain) is another available strategy, not just because it may limit the amount that could be abused or misused but also in light of findings that the amount of prescribed opioid for acute or chronic pain is directly related to the risk of fatal overdose.[52,53] Another study has demonstrated that two-thirds of

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[47] Manchikanti L. National drug control policy and prescription drug abuse: facts and fallacies. *Pain Physician.* 2007;10:399–424.

[48] Inciardi JA, Surratt HL, Kurtz SP, Cicero TJ. Mechanisms of prescription drug diversion among drug-involved club- and street-based populations. *Pain Med.* 2007;8(2):171–183.

[49] Substance Abuse and Mental Health Services Administration. *Results from the 2009 National Survey on Drug Use and Health: Vol. I. Summary of National Findings.* NSDUH Series H-38A, HHS Publication No. (SMA) 10-4856. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2010.

[50] Medscape. *State-by-State Opioid Prescribing Policies*. Available at: http://www.medscape.com/resource/opioid/opioid-policies. Accessed December 27, 2011.

[51] Federation of State Medical Boards of the United States. *Model Policy for the Use of Controlled Substances for the Treatment of Pain*, 2004. Available at: http://www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf. Accessed December 27, 2011.

[52] Bohnert ASB, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA.* 2011;305(13):1315–1321.

postoperative patients had significant amounts of leftover medications after recovering, and 91% of those patients kept the medication at home without disposing of it.[54] Currently 10 states have set opioid prescribing limits at a 30- to 34-day supply, but none are more stringent.[55] Recently, CDC Director Dr. Thomas Frieden suggested that opioid prescriptions be limited to a three-day supply when not being used for cancer or chronic pain.[56] Overprescribing of opioids by dentists has become an area of particular concern.[57]

d. Barriers to tampering or forging prescriptions: Two methods that can reduce or eliminate tampering and forging of prescriptions of controlled substances are electronic prescribing (e-prescribing) and tamper-resistant or triplicate prescription forms.
e. Prescription drug monitoring programs: New Mexico is one of 42 states that has a functional PDMP (six others are in the process of creating one),[58] an electronic registry of prescriptions filled for controlled substances that may be accessed by or may automatically send reports to (in some states) prescribers, pharmacies, professional licensing boards, and law enforcement agencies. In New Mexico, the development of the PDMP has been undertaken by the Board of Pharmacy using only limited resources and staffing. The PDMP in New Mexico is neither mandated to require participation by all prescribers of controlled substances nor funded to collect information and make it available to users in a timely manner, undertake systematic surveillance, generate timely reports, or achieve its potential as an agency for actively detecting misuse of controlled substances. A PDMP should be able to

- curtail prescription fraud and doctor shopping,
- help prescribers have up-to-date information about their patients' medications to inform future prescribing,
- identify pharmacists and prescribers who are diverting medications,

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[53] Moore PA, Nahouraii HS, Zovko JG, Wisniewski SR. Dental therapeutic practice patterns in the U.S. II. Analgesics, corticosteroids, and antibiotics. *Gen Dent.* 2006;54(3):201–207.

[54] Bates C, Laciak R, Southwick A, Bishoff J. Overprescription of postoperative narcotics: a look at postoperative pain medication delivery, consumption and disposal in a urological practice. *J Urol.* 2011;185:551–555.

[55] Medscape. *State-by-State Opioid Prescribing Policies*. Available at: http://www.medscape.com/resource/opioid/opioid-policies. Accessed December 27, 2011.

[56] CDC. Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. *MMWR.* 2011(November 1);60:1487–1492.

[57] This discussion does not pertain to oral surgeons who annually perform third molar ("wisdom teeth") extractions and other major surgeries of the mouth and jaws.

[58] Alliance of States with Prescription Monitoring Programs. *Status of State Prescription Monitoring Programs Table.* Available at: http://www.pmpalliance.org/pdf/pmpstatustable2011.pdf. Accessed December 26, 2011.

- identify prescribers and clinics where there is potential overprescribing or misprescribing,
- inform public health and law enforcement to identify regions where excessive drug prescribing is occurring that may be at increased risk for consequences such as overdose and drug-related crime where increased public health and enforcement efforts can be aimed.

f. Prescription take-back programs: Take-back programs exist nationally in many municipalities, but any that involve the disposing of unused controlled drugs have by law always involved the Drug Enforcement Administration (DEA) or its designate local law enforcement agency. An even better solution of a permanent drop box available at any time for prescription drugs is beginning to show up in communities. The DEA is in the process of implementing laws to increase the availability of these methods that will reduce the stockpiles of unused prescription pain medications that sit in home medicine cabinets and reduce unsafe disposal into the environment.

Recommendations for the Legislature, the Human Services Department, the Department of Health, and the Board of Pharmacy:

1. Support current evidence-based primary preventive approaches to reduce illicit drug use and misuse of prescription drugs through school-based, community-based, and family-based programs. Prevention beginning with sixth graders should be emphasized. These efforts should be extended to higher education campuses. These approaches will build on the Institute of Medicine framework and the strategic prevention framework developed by the Substance Abuse and Mental Health Services Administration.

    a. Specifically, restore funding from the state's general fund that was lost this past year for substance use prevention providers through the Office of Substance Abuse Prevention (OSAP/BHSD/HSD).
    b. Increase the OSAP staff to improve their ability to procure grant funding and to support prevention providers in this process.

2. Support the HM 77 Prescription Drug Abuse and Overdose Task Force recommendations, which include mandatory prescriber education in pain management including the safe use and prescribing of opioid medications and mandatory prescriber requisition of a PDMP report for patients prescribed a one-month or more supply of opioid pain medication.
3. Pass legislation to protect children and adults from the overprescribing and misuse of opioid pain medications, to include

    a. Informed consent to be obtained by practitioners from all patients discussing the risks, benefits, and alternatives for opioids upon prescribing opioid pain medication and in the case of minors, from a parent or legal guardian (emancipated minors can sign their own consent);

b. A patient education pamphlet template to be available on the DOH website for prescribers to use and distribute to patients;
c. Limits on the amount of opioid medication prescribed based on whether the indication is for cough or for pain that is acute, chronic, cancer-related or in a hospice patient, and if the prescriber is a dentist (excluding oral surgery). Pharmacists are to be responsible for enforcing these limits when the prescriptions are filled and to fill opioid prescriptions only to the legal limit when the practitioner has overprescribed;
d. All prescriptions for opioid pain medication to have the indication written;
e. A parent or legal guardian to be present when a prescription for opioid pain medication for a minor is dropped off and the medication is picked up at the pharmacy;
f. No refills to be allowed on prescriptions written for opioids;
g. The appropriate licensing boards to enforce these provisions, and the Prescription Drug Monitoring Program to be utilized to help ensure compliance.

4. Pass legislation pertaining to the Board of Pharmacy and the Prescription Drug Monitoring Program to include

a. Funds in the amounts of $500,000 for the first year and $400,000 in years thereafter (adjusted for inflation), to be appropriated to the Board of Pharmacy or made available by permitting board access to annual fees collected by the board from prescribers of controlled substances;
b. Board to develop and implement systems whereby pharmacies report within 24 hours (with a long-term goal of real-time reporting) to the PDMP prescriptions that have been filled for controlled substances in order that the information is immediately available to prescribers;
c. Board to hire an epidemiologist to determine parameters for patterns of inappropriate prescribing by specialty, diagnosis, geographic area, and other demographic variables and from these establish definitions of outliers for the purpose of investigation by the board and subsequent notification of the proper licensing board and/or law enforcement when appropriate;
d. Board to develop automated surveillance for the identification of practitioners or pharmacists who may be diverting medications or overprescribing or misprescribing;
e. Board to develop parameters to identify patients whose patterns of prescriptions (multiple prescribers and/or pharmacies) suggest that they are "doctor shoppers" with the intent to obtain controlled substances for either misuse or diversion for sale or abuse and send alerts or reports to providers, pharmacies, and law enforcement where appropriate;
f. PDMP to have the capacity of interstate exchange of prescribing information with PDMPs of all bordering states;
g. Board to encourage prescribers in methadone maintenance treatment programs, the Veterans Administration, and the Indian Health Service to

utilize the PDMP and encourage reporting of prescribing controlled substances from these entities;

h. Board to inform state and local public health authorities by identifying geographic areas where disparate controlled substance prescribing is occurring;
i. Board to make adjustments and upgrades to the software and hardware of the PDMP system as indicated;
j. Board to create a Web-based course for controlled substance prescribers to instruct providers on utilization of the PDMP and on safe opioid prescribing practices;
k. Board to automatically register in the PDMP all providers who are issued a license by the board to prescribe or dispense controlled substances;
l. Board to provide an education campaign to inform the public about the existence of the PDMP as a deterrent against prescription drug diversion.

5. Reduce or eliminate tampering and forgery of prescriptions for controlled substances by

   a. Funding to the Board of Pharmacy for rapid implementation of e-prescribing in this state for controlled substances;
   b. A board-enacted regulation to require the use of tamper-resistant prescription forms for all controlled substances.

6. Controlled substance take-back programs and permanent prescription drug drop boxes should be implemented widely under the direction of the Board of Pharmacy, Department of Public Safety, and DOH when the DEA has set final guidelines for implementation.

5. HARM REDUCTION

Findings:
New Mexico has been among the top three U.S. states for drug-induced deaths since 1989 and currently has the highest rate of unintentional drug overdoses.[59] Prescription drugs (mostly opioids) have been associated with 49% of overdose deaths and the direct cause of 40%; heroin is associated with 36%.[60] New Mexico is second highest in the United States for overdoses associated with both prescription opioids and all prescription drugs and is first in the United States for overdose deaths associated with illicit drugs.[61]

While disproportionately affecting Hispanics, the demography of drug deaths includes all races and spans all parts of the state; median age is 43.7 years.

Based on reports of hospital overdose admission, the DOH estimated that in 2006 there were 24,000 adult injection drug users in New Mexico. This estimate is likely an underestimate, and state officials have recently given estimates as high as 50,000 injection drug users. Additionally, on the 2009 Youth Risk and Resiliency Survey, 3.2% of high school students reported heroin use during the past 30 days.[62]

For the 14 years since the passage of the Harm Reduction Act, New Mexico has been a national leader in providing harm reduction services. The DOH manages statewide reporting systems for drug overdose, syringe exchange programs, and overdose prevention through resuscitation training and distribution of the opioid antagonist naloxone (Narcan). Narcan is administered as a nasal spray to reverse the effects of heroin and of opioid prescription pain medications. Narcan can be administered by a family member or friend, and this should be done on-site as emergency first aid. There have been over 3,000 reported overdose reversals in 10 years in New Mexico, one of the highest per capita numbers of overdose reversals in the nation.

The very high rate of unintentional drug overdose despite the large number of reported overdose reversals with Narcan demonstrates significant gaps and ultimately the low penetration of harm reduction efforts in New Mexico.

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[59] CDC. Vital signs: overdoses of prescription opioid pain relievers—United State, 1999–2008. *MMWR.* 2011(November 4);60:1487–1492.

[60] New Mexico Department of Health. *New Mexico Substance Abuse Epidemiology Profile*, 2011. Available at: http://www.health.state.nm.us/erd/SubstanceAbuse/2011%20New%20Mexico%20Substance%20Abuse%20Epidemiology%20Profile.pdf. Accessed December 11, 2011.

[61] CDC, National Center for Health Statistics. Underlying causes of death from the CDC WONDER online database, released 2011. Available at: http://cdc.wonder.gov. Accessed December 16, 2011.

[62] New Mexico Department of Health. *New Mexico Substance Abuse Epidemiology Profile*, 2011. Available at: http://www.health.state.nm.us/erd/SubstanceAbuse/2011%20New%20Mexico%20Substance%20Abuse%20Epidemiology%20Profile.pdf. Accessed December 11, 2011.

Multiple issues stand in the way of the more widespread distribution and use of Narcan. There is no training for nursing and/or medical staff that focuses solely on overdose prevention and Narcan use and distribution. Currently, all clinical staff who wish to dispense Narcan are required to attend the entire one-day harm reduction course, which focuses mostly on syringe exchange. (Narcan training by itself can generally take less than one hour.) Medical practitioners actively prescribing Narcan are too few and work out of only a few of the local public health offices and clinics. They are often unavailable even at DOH facilities, at syringe exchange sites, or during outreach off-site.

Narcan availability is appropriate for the households of patients on chronic prescription opioids for pain management, of persons who are or have a history of using illicit opiates or abusing prescription pain medications, and of persons on opioid replacement therapy. Narcan is seldom prescribed, however, perhaps because of a lack of overdose awareness by prescribers. With lack of prescribing, many pharmacies do not stock it, nor do they have staff certified to train patients in its use.

Increasing the availability and use of Narcan is strongly supported by the Task Force. Narcan has little risk for side effects and no significant potential for abuse. It should be offered over the counter in pharmacies. Currently, the Food and Drug Administration (FDA) regulates dispensing of Narcan by prescription, and consequently, for it to be made available over the counter, approval would have to occur by change at a national level or possibly through an FDA waiver. Pharmacists should be trained to educate persons on how to administer it.

The 911 Good Samaritan Law provides limited immunity from drug possession charges when a drug-related overdose victim or a witness to an overdose seeks medical assistance. This law's effectiveness has been hampered for several reasons—it does not protect probationers and parolees, people with other offenses including drug trafficking charges, and those with outstanding warrants. Furthermore, education and outreach have been very limited by a lack of state funding such that even many law enforcement officials are unaware of it.[63]

Syringe exchange programs (SEPs) are associated with reduced incidence of HIV among intravenous drug users and are cost-effective in settings where prevalent HIV is transmitted by intravenous drug use.[64,65] SEPs are a mainstay of prevention strategies against hepatitis C, HIV, and other blood-borne infections and complications arising from needle sharing. SEPs also generate referrals to drug treatment programs. Because SEPs operate on a one-for-one basis (one new syringe for each used syringe, which is

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[63] Drug Policy Alliance, New Mexico. Available at: http://www.drugpolicy.org/new-mexico/laws. Accessed December 13, 2011.

[64] Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. *JAMA.* 2008;300:520–529.

[65] Belani HK, Muennig PA. Cost-effectiveness of needle and syringe exchange for prevention of HIV in New York City. *J HIV AIDS Soc Serv.* 2008;7:229–240.

returned), the problem of dirty syringes being found in parks, alleys, and so on has greatly decreased since the start of state-funded SEPs.

An important limitation is a DOH regulation that excludes teens under 18 years from participation in SEPs. Other issues include funding reductions in the SEP and the vacancy in the position of Harm Reduction Program Director.

One emerging and novel approach that may have a role in helping meet these needs with additional benefits is medically supervised injection sites. Medically supervised injection facilities are controlled settings where people can inject drugs without concerns about law enforcement; have an overdose reversed; and receive health care information, counseling, and referrals to social services and drug treatment. Supervised injection facilities first emerged in the United Kingdom and the Netherlands in the late 1970s and early 1980s.[66] Approximately 65 supervised injection facilities currently operate in eight countries worldwide.[67] North America's only supervised injection facility is in Vancouver, British Columbia.[68]

A significant and growing body of evidence indicates that supervised injection facilities can be effective in reducing the harms associated with injection drug use and in improving the health and well-being of both drug users and their surrounding communities without creating new problems. To date, 28 studies on the impact of supervised injection facilities have been published in peer-reviewed medical journals. These studies indicate that supervised injection sites

> are associated with reductions in needle and syringe sharing, overdoses, public injecting, the number of publicly discarded syringes; and with increased uptake of detoxification and addiction treatment, and have not led to increases in drug-related crime or rates of relapse among former drug users.[69]

Opioid replacement therapy with buprenorphine (Suboxone) or methadone is also considered a form of harm reduction for many people addicted to opioids and is covered as a separate topic in the Medication-Assisted Treatment section of this report.

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[66] Strathdee S, Pollini R. Editorial. A 21st-century Lazarus: the role of safer injection sites in harm reduction and recovery. *Addiction.* 2007;102:848–849.

[67] Letter. Let's have a debate about heroin rooms. *Bristol Evening Post*, May 24, 2006.

[68] Ibid.

[69] Maher L. Editorial. Supervised injecting facilities: how much evidence is enough? *Drug Alcohol Rev.* 2007;26:351–353.

Recommendations for the Legislature, the Department of Health, the Human Services Department/Medical Assistance Division, and the Board of Pharmacy:

1. Protect the DOH Harm Reduction Program from any budget cuts.
2. Encourage pharmacists and greater numbers of medical staff to be trained in the nasal administration of Narcan by reducing the training requirements for teaching this technique. This can be accomplished by creating a separate two-hour training session for overdose prevention and Narcan use and distribution aside from the current one-day DOH harm reduction training certification program.
3. Establish as a standard of care that patients who are at an increased risk for overdose who receive prescription opioid medication also receive a prescription for nasal Narcan and instructions for how to use it. Populations at higher risk include

    a. Persons on opioid replacement therapy using buprenorphine or methadone;
    b. Patients prescribed opiates long-term (≥one month) for pain;
    c. Patients with a history of a substance use disorder, active or in recovery;
    d. Elderly patients;
    e. Patients on other psychoactive medications that may be synergistic with opioids;
    f. Households with children when opioids are used.

4. Establish and fund a pilot program through Project ECHO at UNM to help expand access to Narcan through prescription. The pilot project would provide training and educational materials on Narcan to pharmacists at a retail pharmacy or pharmacies that agreed to stock Narcan. Project ECHO would also educate physicians about overdose prevention and prescribing Narcan for their patients receiving long-term opiate pain medication or on opioid replacement therapy.
5. Amend N.M. Administrative Code §7.32.7, the regulation regarding the administration of opioid antagonists, to allow standing orders for DOH nurses, both staff and contract, to distribute Narcan. Standing orders for nurses to dispense medications are common practice at departments of health around the nation and will allow the efficient distribution of Narcan in areas and clinics where physicians are unavailable to prescribe Narcan.
6. Have the chair of the SM 18 Task Force write a letter representing the Task Force to the N.M. congressional delegation requesting that they support changes by the Food and Drug Administration to allow Narcan to be available over the counter in lieu of being a prescribed medication.
7. Support funding to expand outreach and education regarding the 911 Good Samaritan Law.
8. Increase funds for and expand syringe and needle exchange programs in settings where drug use and needle sharing are prevalent, including outreach and referrals to drug treatment services.
9. Develop policies and procedures to address the needs of intravenous drug users below the age of 18 years. This could, in part, be accomplished by amending N.M. Administrative Code §7.4.6, the N.M. Harm Reduction Act, to allow

syringe exchange services to be provided to IV drug users under age 18 without parental consent.

10. Create a memorial for a task force or study to evaluate how to expand harm reduction services including overdose prevention and syringe exchange in New Mexico and to study emerging and novel approaches to harm reduction such as medically supervised injection facilities.

6. TREATMENT OF SUBSTANCE USE DISORDERS

Findings:
As noted in the introduction of this report, addiction is a treatable chronic brain disease. While treatment can be complex and challenging, and is not curative, it can allow a person to manage the disease and return to a productive life.

Treatments that are proven effective for persons with substance use disorders are out of reach for the majority of New Mexicans because of a severe shortage of resources, lack of access due to uninsurance or underinsurance, and the frequent lack of benefits for appropriate treatment in commercial insurance plans and Medicaid.

The "treatment gap" in New Mexico is massive. New Mexico is a leader in dependence on or abuse of alcohol, illicit drugs, or both and in the numbers of people needing but not receiving treatment. It is especially severe in the 12- to 17-year-old group. Table 2 shows the results of a national survey on alcohol and drug dependence and unmet treatment needs for the United States and New Mexico.[70]

Table 2. Alcohol and Illicit Drug Dependence or Abuse and Unmet Treatment Needs for the United States and New Mexico, 2008–2009

Diagnosis or Treatment Category	12+ Years Old			12–17 Years Old		
	U.S. (%)	N.M. (%)	State Rank	U.S. (%)	N.M. (%)	State Rank
Alcohol dependence or abuse in past year	7.4	8.7	5	4.7	6.7	3
Illicit drug dependence or abuse in past year	3.5	4.2	3	1.9	2.5	2
Alcohol or illicit drug dependence or abuse in past year	8.9	10.3	6	7.3	10.4	2
Needing but not receiving treatment for alcohol use in past year	7.0	8.2	4	4.5	6.3	3
Needing but not receiving treatment for illicit drug use in past year	2.5	2.9	7	4.2	5.7	1

Note: Illicit drugs include nonmedical use of prescription drugs.
Source: From the Substance Abuse and Mental Health Services Administration, *State Estimates of Substance Use and Mental Disorders from the 2008–2009 National Surveys on Drug Use and Health.*

[70] Substance Abuse and Mental Health Services Administration. *State Estimates of Substance Use and Mental Disorders from the 2008–2009 National Surveys on Drug Use and Health.* NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

Based on these estimates, the current unmet need for treatment in New Mexico for illicit drugs is 37,000–58,000 for those 12 years and older and 7,400–12,400 for the subgroup aged 12–17 years. Notably, these are substantial underestimates due to many groups with substance use disorders not being included in this household survey. Nevertheless, these statistics are consistent with a severe need for treatment centers and access to treatment for all ages in New Mexico and also in accordance with the complete lack of detoxification and residential treatment facilities for adolescents in the state.

Treating addiction is very challenging and difficult, with essential components largely unavailable in New Mexico. Drug abuse and addiction have many complicating dimensions, including high rates of co-occurring mental disorders in excess of 60% and relatively high rates of associated health problems such as HIV, hepatitis C, and cirrhosis of the liver. The most effective treatment programs typically incorporate multiple components, each directed to a particular aspect of the illness and its consequences. Addiction treatment must not only help the individual stop using drugs and maintain a drug-free lifestyle but lead to recovery by helping the individual achieve productive functioning in the family, at work, and in society. Most patients require long-term or repeated episodes of treatment to achieve the ultimate goal of sustained abstinence and recovery of their lives.[71]

Multiple issues not related to the disease create substantial challenges for persons with these disorders to get well. Co-occurring mental illnesses often go undiagnosed and untreated due to a lack of experienced treatment providers and/or access to them, and the frequent insufficient length of treatment is a major cause of treatment failure. There has been a substantial decline in available treatment services and facilities in New Mexico associated with the withdrawal of most insurance coverage (including Medicaid) for some components of care such as residential treatment that are essential for the successful treatment of many with chronic drug use disorders. Local, state, and federal funding, typically responsible for a large portion of drug treatment in most states, has seen vast cuts recently. Furthermore, there is no detoxification or residential treatment available in the state for adolescents.

These issues will become substantially exacerbated in 2014, when proportionally great numbers of people with substance use disorders will become eligible for treatment coverage through Medicaid and state insurance exchanges in accordance with provisions of the Affordable Care Act. For additional information, Appendix F covers in more detail the most pressing issues that are contributing to the failure in New Mexico of treatment of drug use disorders to do more than just touch the surface of the problem.

Appendix G addresses the lack of adherence to existing N.M. and federal laws in place that are supposed to ensure the provision of mental health care (including addiction services) equal in scope and depth with other medical health care, as well as potential solutions to contest the lack of enforcement of these laws.

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[71] NIDA. *Principles of Drug Addiction Treatment.* NIH Publication No. 09-4180, August 2009.

As noted, N.M. commercial insurance carriers and Medicaid have been allowed to pull away from covering comprehensive treatment of this disease, unlike other chronic diseases, presumably to reduce costs. People with substance use disorders are targets of convenience due to a lack of effective advocacy. As noted in the introduction, this divestment in treatment is a poor investment in the long term, however, because research has shown that every dollar invested in effective treatment yields a return of about $7 in reduced drug-related costs for crime, criminal justice activities, and theft. When the avoided costs related to other health care for the complications and consequences of drug use are included, the savings are estimated to exceed costs of treatment by a ratio of 12 to 1.

Recommendations for the Executive Branch Including the Human Services Department, the Department of Health, the Legislature, and the Public Regulatory Commission:

1. The Executive Branch should develop a comprehensive plan for building sufficient nonprofit treatment centers (adolescent and adult) and ensuring an adequate supply of appropriately remunerated addiction treatment providers. The plan should utilize the core service agencies and other community-based resources. A centralized referral service available 24/7 such as that described in Senate Memorial 56 will be necessary.
2. As an immediate measure, expand services at Turquoise Lodge in Albuquerque to at least 80 beds (from the current 34) so that it may also offer residential treatment ("rehab") and other long-term recovery services in addition to the intensive inpatient and detoxification services that it is limited to offering now.
3. As an immediate measure and as a pilot program, create at least three temporary 10-bed regional treatment centers (e.g., Farmington/Espanola, Albuquerque, Las Cruces) for adolescents for drug detoxification and residential treatment. These will anticipate the complete implementation of the SM 56 blueprint for adolescent substance abuse treatment that is scheduled over the next 5–10 years.
4. Pass a legislative memorial for a study to evaluate parity of resources, access, and treatment between physical illnesses and mental health and substance use disorders in the state. This would include an evaluation of the implementation and enforcement of the (federal) Domenici/Wellstone Mental Health Parity and Addiction Equity Act (MHPAEA), including the scope of benefits and an evaluation of the enforcement of N.M. Statute (ST) §59A-23-6 (parity for treatment of alcohol dependence), and recommendations for new legislation.
5. The Public Regulatory Commission should enforce NM ST §59A-23-6, Alcohol Dependency Coverage.
6. The legislature should amend NM ST §59A-23-6 to say "necessary care and treatment of ~~alcohol~~ *substance* dependency," in order to include drug dependency coverage as well as alcohol.
7. Pass a legislative memorial for a study to evaluate the cost of substance use disorders to the state on an annual basis, both direct and indirect costs, and to

evaluate the benefit-to-cost savings affected through current treatment and prevention services in New Mexico.

8. Provide as a Medicaid benefit support for patients with substance use disorders needing (1) residential treatment when less intense treatment modalities are ineffective and the addiction specialist the patient has consulted with has recommended this and (2) intensive long-term aftercare also when recommended. Such patients would include those on opioid replacement therapy who desire to detoxify to a state of abstinence from opioids. This will be in accordance with provisions of the MHPAEA. Such treatment would be covered at out-of-state facilities when in-state facilities are not available.
9. Any insurance policy offered through the state insurance exchange(s) created in accordance with the ACA should offer the comprehensive addiction treatment services as outlined in Appendix G.
10. Legislation should be enacted to require state entities to use self-insured health insurance plans only if they provide substance use disorder treatment.
11. Addiction prevention, intervention, and treatment needs of the state should be addressed as a priority issue for the state Office of Health Care Reform, as a priority public health issue in the N.M. DOH Strategic Plan, and as a strategic priority of the N.M. Behavioral Health Collaborative.
12. Capital and operational funding to meet the comprehensive addiction prevention, intervention, and treatment needs of the state should be provided by general funds; insurers; an increase in the alcohol excise tax or a special alcohol sales tax; grants; and state, county, and municipal bond issues.

7. MEDICATION-ASSISTED TREATMENT

Findings:
Medication-assisted treatment with opioid replacement therapy with either methadone or buprenorphine is an established way of restoring persons with opioid addiction to stable and productive lives. Although it is primarily administered to injection opioid users, MAT also benefits prescription opioid abusers and those on long-term opioid therapy for noncancer chronic pain who are otherwise unable to detoxify from their medication. For the latter group, buprenorphine is often the only viable exit strategy off of the opioids.

Patients stabilized on adequate, sustained dosages of methadone or buprenorphine regain appropriate social functioning—as evidenced by improved family and other social relationships, improved parenting, increased employment, reduced crime and violence associated with the street drug culture, and reduced harms associated with their exposure to HIV and hepatitis by stopping or decreasing injection drug use and drug-related high-risk sexual behavior. Patients stabilized on these medications also tend to engage more readily in counseling and other behavioral interventions essential to recovery and rehabilitation.[72]

Methadone is itself an opioid drug but has a substantially reduced euphoric effect compared with opioids of abuse, and because it stays in the body and on the receptors for a prolonged period of time it tends to inhibit the effect of other opioids that are abused (e.g., heroin, prescription oxycodone). It also reduces cravings for other opioids and reduces the overdose rate from injected opioids.[73] Methadone is distributed in federally licensed clinics where clients receive their treatment once a day directly observed by clinic staff, guaranteeing documented compliance. Methadone also is prescribed on an outpatient basis, but only for chronic pain.

Buprenorphine has opioid properties but completely blocks the effects of other opioids, reducing or eliminating cravings for opioids of abuse. It is typically taken under the tongue one to two times a day on a nonobserved outpatient basis with prescriptions given by providers (typically primary care physicians) who have undergone a specialized eight-hour training course and have received a waiver from the Drug Enforcement Administration to write prescriptions for it. It comes in two formulations. One is combined with an opioid antagonist, naltrexone (Suboxone), with the latter component deactivated when taken under the tongue and having no effect on the buprenorphine, but it will cause opioid withdrawal when injected and to a lesser extent when snorted—thus it is a form to help reduce abuse of the drug. The other formulation is pure buprenorphine (Subutex®), which is only indicated for use in pregnant patients. Another feature of

[72] NIDA. *Principles of Drug Addiction Treatment*. NIH Publication No. 09-4180, April 2009.
[73] Ibid.

buprenorphine is that it reaches a maximum effect in the body with escalating doses, making overdose purely from buprenorphine very unlikely.[74]

When comparing maintenance programs with methadone and buprenorphine in a large array of studies, the two medications have been demonstrated to be relatively equal for just about all outcomes. However, it is not possible to predict which patients will do better on either methadone or buprenorphine. Consequently, therapy must be individualized, and patients who are not successful with one therapy should if at all possible be offered a trial with the other, since untreated opioid addiction is associated with such a high level of morbidity and mortality.

Addiction treatment and total medical costs are comparable for patients managed on buprenorphine and methadone.[75]

In New Mexico, buprenorphine is currently covered by most insurers including Medicaid. In contrast, methadone maintenance therapy (MMT) is not covered. The federal clinics that manage MMT are not publicly funded, and most patients pay out-of-pocket costs that average $330 monthly in Albuquerque.[76]

New Mexico currently has approximately 2,500–3,000 patients on MMT, including U.S. military veterans. As of 2008, at least 36 other states covered methadone through their Medicaid programs,[77] including large states with significant heroin addiction problems such as New York and California.

The Department of Defense announced that it was reversing a decades-old policy of not providing MMT to its patients insured under TRICARE, stating that

> this prohibition of maintenance treatment of substance dependence utilizing a specific category of psychoactive agent is outdated and fails to recognize the accumulated medical evidence supporting certain maintenance programs as one component of the continuum of care necessary for the effective treatment of substance dependence.[78]

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[74] Kraus ML, Alford DL, Kotz MM, et al. Statement of the American Society of Addiction Medicine consensus panel on the use of buprenorphine in office-based treatment of opioid addiction. *J Addict Med.* 2011;5:254–263.

[75] Barnett PG. Comparison of costs and utilization among buprenorphine and methadone patients. *Addiction.* 2009;104:982–992.

[76] Dr. Bruce Trigg, MAT specialist in Albuquerque, personal communication.

[77] Rinaldo D. *50-State Table: Medicaid Financing of Medication-Assisted Treatment for Opiate Addiction.* National Conference of State Legislatures website. Available at: http://www.ncsl.org/default.aspx?tabid=14144. Accessed January 9, 2012.

[78] Department of Defense, Office of the Secretary. TRICARE; removal of the prohibition to use addictive drugs in the maintenance treatment of substance dependence in TRICARE beneficiaries. *Fed Regist.* 2011(December 29);76(250). Available at:

Medicaid coverage of MMT resulted in reducing felony arrests in Oregon and Washington.[79]

A frequently asked question is, Why not just switch from methadone to buprenorphine if only the latter is covered by Medicaid? Patients on high doses of methadone have to be detoxified to a relatively low dose before they are eligible to transition to buprenorphine therapy. Methadone has a very long half-life compared with most opioids—a prolonged detoxification from methadone to buprenorphine can result in substantial destabilization of methadone patients, putting them at high risk for relapse and even overdose.

The costs of MAT for both methadone and buprenorphine have been proven to be overwhelmingly offset by the cost savings in terms of the reduced medical complications of addiction (hospitalizations and medical care), related criminal behavior, criminal justice proceedings, subsequent incarceration, and social costs and in terms of restored families and economic productivity.[80] As for cost-benefit ratio savings, methadone returns on average at least $4 for every dollar invested in treatment just with respect to reductions in crime and incarceration.[81]

Despite the well-documented clinical and cost-effectiveness of MAT and relatively low risks for harm, abuse, and diversion, barriers in funding and the supply of providers have limited the use of MAT in New Mexico.

Treatment with MAT is remarkably inadequate considering that the state estimates that there are 25,000–50,000 injection opioid users in New Mexico. Insufficient numbers of physicians are trained and certified to prescribe or dispense buprenorphine. Of those who are certified, many do not use this in practice. Numerous factors have discouraged participation, including the failure to reimburse providers who care for their patients in the context of medical care (as opposed to behavioral health care), the need to obtain and then frequently renew onerous prior authorizations, and low reimbursements for clinical services that often take extra time and staff to address the many needs of these patients. Additionally, methadone clinics are only available in Albuquerque, Santa Fe, Espanola, and Belen.

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http://www.gpo.gov/fdsys/pkg/FR-2011-12-29/html/2011-33106.htm. Accessed December 30, 2011.

[79] Deck D, Wiitala W, McFarland B, et al. Medicaid coverage, methadone maintenance, and felony arrests: outcomes of opiate treatment in two states. *J Addict Dis.* 2009;28:89–102.

[80] Connock M, Juarez-Garcia A, Jowett S, et al. Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation. *Health Technol Assess.* 2007;11:1–171, iii–iv.

[81] Harwood HJ, Hubbard RL, Collin JJ, Rachal JV. The costs of crime and the benefits of drug abuse treatment: a cost-benefit analysis using TOPS data. In: *Compulsory Treatment of Drug Abuse: Research and Clinical Practice* (NIDA Research Monograph Series). Rockville, MD: DHHS, 1988.

It currently can take months or longer to get an appointment for starting on buprenorphine treatment, even for insured patients, jeopardizing the lives of heroin addicts who are ready to begin MAT, and the costs place therapy out of the reach of most uninsured or those with insurance unresponsive to buprenorphine.

Persons with histories of opioid addiction who become incarcerated are at very high risk for relapse into opioid use after release and for criminal recidivism.[82] These risks are partially mitigated by appropriate treatment services during incarceration. Risks are further mitigated by linking the person to MAT services upon release, which is seldom done. MAT is proven effective in preventing relapse and recidivism.[83] Given prior to release, MAT can be an effective strategy. With the statewide distribution of local public health offices, the Department of Health can serve a potentially useful role in assisting with creating services to bridge linkages into community services. This has been demonstrated in Bernalillo and Dona Ana counties, and broader use should be implemented.

The rapidly rising number of deaths among heroin-using youths in Albuquerque and elsewhere across the state is a grim testament to the current situation. These tragic deaths stand as only one aspect of a broader situation. Persons from all walks of life are in need, often urgent, for MAT and other treatment services that are proven effective and are not receiving them. At nearly every level, our systems of care have failed. Multiple barriers stand in the way, supported by narrow policies, reluctant bureaucracies, unwilling payers of health care services, competing priorities, and other points of resistance. Additionally, MAT is limited in youths by regulation—FDA approval is age ≥18 for methadone and ≥16 for buprenorphine, although use of off-label buprenorphine in those younger than 16 could be done legally, as is done in some other states.

Recommendations for the Behavioral Health Collaborative and Member Agencies, the Medical Assistance Division, the Department of Health, and the Legislature:

1. The Medical Assistance Division (MAD) should expand Medicaid coverage to include methadone opioid replacement therapy.
2. Take steps to increase the number of actively prescribing buprenorphine providers (given the anticipated large increase of adult clients eligible for MAT) and improve client access:

    a. MAD should require that Salud! managed care organizations ensure the availability of physicians who are certified and willing to treat patients with buprenorphine.
    b. MAD should ensure that any buprenorphine provider regardless of network

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[82] For example, a study requested by Senate Joint Memorial 28 from 2001 of women with a history of opiate addiction showed that 73% returned to prison within 36 months of release.

[83] NIDA. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*. NIH Publication No. 06-5316, July 2006.

affiliation manage patients and be reimbursed if a particular Salud! managed care organization has a regional provider shortage to meet the network's needs.

c. The DOH should require all public health regions to establish and maintain or arrange for buprenorphine programs for the uninsured, based on local needs.
d. The DOH and/or the legislature should develop incentives for state-supported community health clinics and programs to provide MAT in their service menus for substance use disorders.
e. Create incentive reimbursement processes whereby providers with capitated arrangements with the MAD can still be reimbursed for providing MAT services.
f. Restore funding from the DOH for Project ECHO at the University of New Mexico to support MAT programs and providers and to continue to train physicians for the certification needed to prescribe buprenorphine.
g. The BHSD should provide funding and support for the Project ECHO substance abuse community health worker program.
h. The BHSD should amend and revise the current federal Access to Recovery grant to include vouchers for both methadone and buprenorphine treatment.
i. The MAD should study the current utilization of buprenorphine by Medicaid clients for feedback to improve the program and to determine opportunities for expansion of the use of MAT.
j. Require the providers of long-term high-dose opioid therapy for pain to be buprenorphine providers.

3. Expand buprenorphine MAT and associated treatment services in Medicaid and in DOH clinics to adolescents <16 years old when deemed clinically indicated.
4. The BHSD should create an online statewide service directory of buprenorphine providers currently accepting new patients for MAT (see section 2, Inventory and Mapping the State's Capacity for Behavioral Health Assessment and Treatment).

Recommendations for Communities, Health Councils, Local Collaboratives, and Hospital Residency and Continuing Education Programs:

1. Place substance use disorder services including MAT on priority lists for all health councils and local collaboratives.
2. Utilize and support funding for Project ECHO to offer technical assistance and support to local drug courts concerning MAT.
3. Include addiction treatment and buprenorphine training and certification in all primary care and psychiatry training programs and have such training available through continuing medical education on an ongoing basis.

Recommendations for County Detention Facilities, the N.M. Corrections Department, and the Administrative Office of the Courts:

1. Work with local DOH offices in each public health region to provide buprenorphine induction for persons before release or within 24 hours after

release from prisons and detention facilities and to plan immediate seamless referrals to buprenorphine providers for continuing treatment.

2. Develop formal discharge planning to include counseling, referrals, and dispensing and training in the use of naloxone (Narcan) prior to release from prisons and county detention centers for persons who have a history of opioid addiction to reduce their high risk of overdose after their release.
3. Provide education and training to the N.M. Corrections Department (NMCD) probation and parole officers to facilitate referrals of persons in community custody for MAT.
4. Have drug courts allow the use of methadone in addition to buprenorphine.
5. Where available county detention facilities should allow persons enrolled in local methadone maintenance programs to continue to receive methadone during incarceration, either via delivery from a local clinic or through a contract with an independent contractor, as is done in the Bernalillo County Metropolitan Detention Center.

Recommendation for the Legislature:
Increase funding to avail the entire continuum of addiction treatment, including long-term residential treatment, for those on maintenance MAT who are ready to go through detoxification from buprenorphine and methadone.

8. INTEGRATION OF BEHAVIORAL HEALTH SERVICES WITH PRIMARY CARE

Findings:

Following the recommendations of the 2002 report *Behavioral Health Needs and Gaps in New Mexico*,[84] the Behavioral Health Collaborative was formed to oversee the administration and public funding of children, youth, and adult behavioral health services. The intended outcome was to carve behavioral health services out from other medical care. The unintended consequence, however, has been to limit compensation from public payment sources for behavioral health services rendered in non–behavioral health sites, including primary care. At least a quarter of primary care visits involve a behavioral health or substance use issue.

There is insufficient capacity in the formal behavioral health system to deliver the needed services. Because of its numbers and geographic distribution, the further engagement of primary care in managing aspects of behavioral health and addiction medicine should be developed and encouraged beyond the services currently under the collaborative. Many primary care providers presently provide frontline clinical services for persons with addictions and other behavioral health problems.

Under the Affordable Care Act, New Mexico is to be given financial incentives to coordinate treatment for substance use disorders with other chronic diseases by creating "health homes," with the option to amend Medicaid plans to incorporate health homes for substance use disorders. Health homes are designed to increase collaboration among medical and behavioral health treatment providers and to provide reimbursement to providers for coordinating care for patients. Currently, the Behavioral Health Services Division of the Human Services Department is in the process of establishing New Mexico's first Medicaid health homes, including housing them in some core service agencies.

Many older adults have chronic medical conditions for which they are receiving regular services from primary care and other specialty providers. Taken together, the high rate in this population of substance use disorders and other behavioral health conditions such as depression, the preference of many for receiving behavioral health care from primary care providers, and the shortage of addiction treatment providers and resources in New Mexico all support the rationale for behavioral health services being provided by and supported in primary care settings whenever feasible. Additionally, under the provisions of the ACA, approximately 300,000 will be newly insured in 2014 through Medicaid and the state health insurance exchange, exacerbating the shortage of specialty care for addiction and other behavioral health diagnoses.

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[84] *Behavioral Health Needs and Gaps in New Mexico*, 2002. Available at: http://www.hsd.state.nm.us/mad/pdf_files/Reports/BHGapanalysis.pdf

Screening, Brief Intervention, and Referral to Treatment

SBIRT is an established technique that can be applied in primary care and other settings to identify both adults and youth with or at risk for substance use disorders. Used along with motivational interviewing techniques and referral to treatment, this approach has been shown to

- decrease the frequency and severity of drug and alcohol use,
- reduce the risk of trauma, and
- increase the percentage of patients who enter specialized substance abuse treatment.[85]

For older adults with addictions as well as other behavioral health problems, SBIRT is only one of several evidence-based practices. Most evidence-based and best practice models are collaborative models.

Recommendations for the Human Services Department; the Children, Youth, and Families Department; the Behavioral Health Collaborative; the Medical Assistance Division; and the Health Sciences Center:

1. Replace the behavioral health "carve-out" with either a hybrid or a "carve-in" integrated model that will permit the support of primary care practitioners in providing addiction and other behavioral health services. Set targets/goals and pathways for integrated primary care and behavioral health services.
2. Broadly institute health homes, beginning with demonstration projects and later expanding beyond Medicaid, in order to include primary care in a continuum of care for patients as they move between medical and behavioral health care providers, and when possible utilize the health home (including the core service agencies) as a location for the provision of behavioral health and addiction services.
3. Primary care providers should be appropriately reimbursed when they treat and bill Medicaid and commercial insurers for visits for addiction and for common mental health problems such as depression and anxiety.
4. Strengthen educational programs for practicing primary care clinicians and students of health care to improve assessment and treatment skills for addiction.
5. Promote broader implementation of screening and brief intervention for alcohol and other substance use problems. These steps could include the following:

    a. Enabling the use of Medicaid billing codes for SBIRT services in a variety of provider settings including primary care,
    b. Promoting broader SBIRT training for N.M. health professionals.

[85] Screening, brief intervention, and referral to treatment. *Co-Occurring Disorders Research and Resources Monthly Review* 2008;3(8). Available at: http://www.samhsa.gov

6. Provide education and outreach to health and social service providers to improve the recognition, assessment, and collaborative models of treatment of behavioral health problems in the elder population, particularly for substance abuse and depression and other co-occurring conditions.

9. SENTENCING AND COLLATERAL CONSEQUENCES

Findings:

Treatment Instead of Incarceration
In general, treatment of substance abuse in lieu of incarceration should be considered as a means of diverting offenders from jail beds to treatment beds while addressing the offenders' struggle with substance abuse. The limited menu of community-based treatment programs, especially in rural parts of New Mexico, is a challenge in some counties but not one that should deter considering this option where the capacity in the community exists and the offender is deemed to be of little risk to others not being incarcerated.

Diversion from incarceration to treatment can apply prior to booking, prior to sentencing, or postsentencing.

Drug courts are an example of the last—a sentencing option. Studies have found that unrestricted drug treatment assistance for all at-risk arrestee offenders would prevent recidivism, promote public safety, and be cost-effective.[86] Drug court goals match the findings of this study and are an excellent means for treating large numbers of at-risk individuals in a formal and systematic program.

In 2010 there were 24 drug courts in N.M. counties. Typically, drug offenders are placed in drug court by an order of the judge. Drug court programs provide continuous and intense judicial oversight, treatment, mandatory drug testing, immediate sanctions, and incentives. Most drug court clients are not likely to go to prison for their charges, but indirectly participation in drug court may keep the offender from being rearrested and potentially going to prison. The requirement for treatment and the intensity of oversight may be variable. The interim report of the SM 33 Drug Policy Task Force had specific recommendations regarding New Mexico's drug courts.

As an alternative model, Hawaii's HOPE Probation program is based on probation and a strategy of swift, predictable, and immediate sanctions for probationers violating conditions, usually resulting in a brief period in jail. Evaluation indicates that the program is successful at reducing drug use and crime, even among difficult populations such as methamphetamine abusers and domestic violence offenders.[87]

Treatment During Incarceration
In San Juan County judges sentencing a person convicted of DWI can offer the county's Detention, Treatment, and Aftercare Program—a 28-day period in jail with an up-to-date

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[86] Bhati AS, Roman JK, Chalfin A. *To Treat or Not to Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders*. Washington, DC: Justice Policy Center, the Urban Institute, April 2008.

[87] Hawaii State Judiciary's HOPE Probation Program. Available at: http://www.hopeprobation.org/

alcohol treatment program. Successful completion of treatment results in release from jail. It has proven itself effective, demonstrating lowered rates of DWI recidivism both compared with persons jailed but not in the program and compared with persons arrested but not jailed. Simply letting an offender off without consideration may invite a higher rate of recurrent offense than when the alternative is incarceration in combination with a treatment program.[88] The program receives some of its funding through the county's DWI grant from the state. A related program provides for methamphetamine (and other drug) treatment.

Prebooking Diversion

A prebooking diversion program is the Law Enforcement Assisted Diversion program currently being piloted in Seattle. This gives frontline police officers the power to divert an arrested person involved with drug possession or low-level use into intensive, community-based intervention, bypassing the judicial process and jail altogether.

Technical Violations Program

Regarding violations of probation, currently the rules of procedure in New Mexico allow a judicial district to create a technical violations program. Under this program, if a probation offender provides a positive urinalysis for controlled substances or evidence of other technical violations, he or she would be allowed to waive all due process rights to contest the allegation and serve an automatic short period of incarceration (usually between three and five days). This avoids the common situation whereby probationers may spend weeks and sometimes months in jail awaiting a hearing on a parole violation, even when the probationer wants to admit to the allegation. In 2011, the legislature enacted House Bill 469 directing (requiring) each judicial district to create a technical violations program. The governor, stating that the option already exists and is sufficient, vetoed this bill.

Uniform Collateral Consequences of Conviction Act

The SM 33 Task Force supported the concept of a uniform collateral consequences act, under which an individual charged with a crime would be informed at arraignment of collateral consequences affecting employment, education, housing, public benefits, and occupational licensing. At the time of sentencing, the individual could petition the sentencing judge for an order of limited relief from one or more of the collateral consequences. The individual could also petition the parole board at any time after sentencing for relief from a specific collateral consequence. If relief is granted, it would assist rehabilitated drug offenders to engage in gainful employment, obtain school loans, or receive other benefits necessary for successful reentry into the community. This bill also passed both the House and Senate in 2011 but was vetoed.

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[88] Kunitz SJ, Woodall WG, Zhao H, Wheeler DR, Lillis R, Rogers E. Rearrest rates after incarceration for DWI: a comparative study in a southwestern U.S. county. *Am J Public Health.* 2002;92(11):1826–1831.

Recommendations for the Legislature and Counties:

1. Sentencing rules need to be examined and modified for reducing the burdens on county jails created by incarceration for minor drug offenses, excessive holding times, and having county detention facilities be responsible for drug-related probation and parole violations.
2. Counties should consider any of several alternatives to incarceration, such as treatment either instead of incarceration (drug courts), during incarceration (San Juan County Detention, Treatment, and Aftercare Program), or prebooking (Seattle's Law Enforcement Assisted Diversion program), and the legislature should provide incentives for planning, pilot programs, and evaluation.
3. Judicial districts should establish technical violations programs whereby persons with a technical violation of parole or probation can be processed in an expedited fashion.
4. Enact a uniform collateral consequences act whereby an individual being sentenced could petition the sentencing judge for an order of limited relief from one or more of the consequences that otherwise restrict later access to housing and employment and other limitations creating barriers to reintegration into society.

10. MANAGEMENT OF PRISONERS AND PAROLEES WITH SUBSTANCE USE DISORDERS

Findings:

Prisoners' Legal Right to Addiction Treatment

With extensive research providing incontrovertible evidence that addiction is a medical disorder of the brain and has a strong genetic component, withholding addiction treatment will likely eventually prove unconstitutional. Withholding treatment for addictions as a category may be viewed as a violation of the Americans with Disabilities Act and the Rehabilitation Act and risks violating the U.S. Constitution's Eighth Amendment prohibition on cruel and unusual punishment.[89] See Appendix H for further discussion.

Substance Use Disorders in U.S. and N.M. Prisons

Approximately 87% of N.M. prisoners have some kind of substance use disorder; this is well above the national average of 65%–70%.[90] Rates of co-occurring mental disorders, especially those related to adult and childhood trauma, are very high in this population nationally.[91]

The high percentage of prisoners with substance use disorders is exacerbated by the large number of nonviolent drug offenders incarcerated instead of receiving treatment in the community. In January 2011, 39% of the 6,637 N.M. Corrections Department inmates were serving sentences for direct drug and/or alcohol crimes (e.g., possession, DWI, trafficking, vehicular homicide when DWI, etc.), with an estimated annual cost of $107 million. The additional number serving time for crimes committed because of impaired judgment due to drug use or to get money for drugs is unknown but likely significant.

Managing addictive disorders during and after incarceration substantially helps the prospects for reintegration and is associated with reduced rates of both substance use and criminal recidivism, as well as a reduced overall number of prisoners. The average annual cost per inmate in N.M. prisons in 2009 was $41,000. Addiction treatment is cost-saving when recidivism is reduced. Without treatment, half of prisoners return to incarceration within two years; with treatment this number is reduced to 35%.[92] Nationally, one out of

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[89] Legal Action Center. *Legality of Denying Access to Medication Assisted Treatment in the Criminal Justice System*, December 1, 2011. Available at: http://www.lac.org/doc_library/lac/publications/MAT_Report_FINAL_12-1-2011.pdf. Accessed December 11, 2011.

[90] Hand tabulation of all intake interviews at the Corrections Department over a one-year period, 2001–2002, cited in *Behavioral Health Needs and Gaps in New Mexico, the Technical Assistance Collaborative, Inc., Final Report*, July 2002, p. 64.

[91] Chandler RK, Fletcher BW, Volkow ND. Treating drug abuse and addiction in the criminal justice system. *JAMA*. 2009;301:183–190.

[92] Welsh WN. *Evaluation of Prison Based Drug Treatment in Pennsylvania: A Research Collaboration Between the Pennsylvania Department of Corrections and the*

four individuals released returns to prison within three years just for a technical violation such as testing positive for drug use.[93]

Treatment of Substance Use Disorders in Prison

The treatment for substance use disorders in N.M. prisons generally consists of living in a therapeutic community (TC) or receiving outpatient (OP) treatment. There is also a peer education program, and Alcoholics Anonymous and Narcotics Anonymous meetings are brought into correctional facilities. TCs have been well demonstrated to reduce recidivism (by 25%–30%) and to also contribute to prison safety and security.[94] Both minor and major disciplinary infractions are vastly reduced among NMCD TC inmates (major: TC 0.2% vs. non-TC 10.8%; minor: 0.6% TC vs. non-TC 14.1%), and there are significantly fewer positive drug screens among TC participants.

The NMCD Addiction Services operates TCs in 11 prisons, with a combined capacity of 768 beds (11.6% of all NMCD beds). There are 350 OP slots, for an annual capacity of 700. Despite the high rate of substance abuse, the treatment capacity of 1,468 provides for only 26% of the estimated 5,650 inmates annually with a substance use disorder under ideal conditions of full clinical staffing. Addiction Services was substantially affected by the 11% NMCD budget decrease over the past four years. In January 2011 there was a 30% clinical staffing vacancy rate and consequently, a clinical staffing ratio for inmates in treatment of only 1 to 29. When considering all inmates with substance use disorders, the ratio of clinical staffing to inmates drops to 1 to 113.

TCs are losing their effectiveness not just because of clinical staff deficiencies and poor funding but also because of a frequent transition of inmates because of classification transfers and a lack of opioid replacement therapy. OP treatment is so poorly funded and staffed that it has essentially become just drug education in some facilities.

Medication-assisted treatment with buprenorphine or methadone is currently not available to inmates in the NMCD. This is consistent with the situation nationally, in which there have only been trials of methadone begun prior to release—in each of these cases, prerelease methadone accompanied with counseling was associated was less postrelease heroin use, overdose, and criminal activity.[95] Methadone, which costs about $4,000 per year, has been shown to save money postincarceration. For example, an Australian study showed that a prison methadone program paid for itself when prisoners

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Center for Public Policy at Temple University: Final Report, 2002. Available at: http://www.ncjrs.gov/pdffiles1/nij/grants/197058.pdf. Accessed December 11, 2011.

[93] Langan PA, Levin DJ. *Recidivism of Prisoners Released in 1994*. Department of Justice Publication NCJ 193427. Washington, DC: Office of Justice Programs, Bureau of Justice Statistics, 2002.

[94] De Leon G. Therapeutic communities: is there an essential model? In: De Leon G, ed. *Community as Method: Therapeutic Communities for Special Populations and Special Settings*. Westport, CT: Praeger, 1997:3–18.

[95] Chandler RK, Fletcher BW, Volkow ND. Treating drug abuse and addiction in the criminal justice system. *JAMA*. 2009;301:183–190.

leaving the system avoided just 20 days of incarceration.[96] The Vermont Office of Alcohol and Drug Abuse Programs found that for each dollar spent on methadone treatment, $12–$14 would be saved in health and social costs, namely, in crime reduction, health care costs, and increased employment.[97] The potential exists in the NMCD for prerelease MAT to be initiated with buprenorphine or methadone linked to close follow-up care, but as in almost all state and federal prison systems, this approach has not been adopted.[98]

Barriers to Inmates Obtaining Substance Use Disorder Treatment After Release

There is a critical lack of funding for treatment services for parolees and probationers without insurance or with special needs. Budget cuts have also been substantial in the Probation and Parole Division in the past several years, significantly impacting those with substance use disorders. Likewise, there is poor continuity between prison medical staff and community health providers.

On release from prison, addicted persons experience multiple challenges to their sobriety through various stressors that increase their risk of relapse to drug use: the stigma of being labeled an ex-offender, a lack of finances and health coverage, the need for housing and employment, stresses in reunification with family, multiple requirements for criminal justice supervision, and often returning to a neighborhood that is rich with drug triggers.[99,100]

Ninety-five percent of prisoners return to their community.[101] Releasing individuals with untreated substance use disorders can create a substantial burden on a local community's public health and public safety systems.

The postrelease period also presents extraordinary health risks—in the first two weeks after release, former inmates are 129 times more likely to die from a drug overdose and

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[96] Warren E, Viney R. *An Economic Evaluation of the Prison Methadone Program in New South Wales. Centre for Health Economic Research and Evaluation*, January 2004. Human Rights Watch, 2009.

[97] Boucher R. *The Case for Methadone Maintenance Treatment in Prisons*. Available at: http://www.drugpolicy.org/docuploads/boucher_prison_methadone.pdf. Accessed December 11, 2011.

[98] Rich JD, Boutwell AE, Shield DC, et al. Attitudes and practices regarding the use of methadone in US state and federal prisons. *J Urban Health.* 2005;82(3):411–419.

[99] Field G. Continuity of offender treatment: from the institution to the community. In: Knight K, Farabee D, eds. *Treating Addicted Offenders: A Continuum of Effective Practices*. Kingston, NJ: Civic Research Institute, 2004:33-1–33-9.

[100] Shivy VA, Wu JJ, Moon AE, Mann SC, Holland JG, Eacho C. Ex-offenders reentering the workforce. *J Couns Psychol.* 2007;54(4):466–473.

[101] Nieto M. *Adult Parole and Probation in California.* Sacramento, CA: California Research Bureau, 2003. Available at: http://www.library.ca.gov/crb/03/09/03-009.pdf. Accessed December 11, 2011.

12 times more likely to die of any cause than non-inmates in their communities.[102] To mitigate these risks, prerelease MAT could be utilized in opioid addicts (with overdose prevention such as Narcan). Mechanisms for the bridging of addiction care with other health and social care needs will also be necessary. A pilot project currently planned for women prisoners being released is the three-stage, nine-month Critical Time Intervention, an evidence-based community reentry program.

Large numbers of inmates are uninsured after reentry to the community—in a recent study, after inmates were discharged from prison, 78% at two–three months and 68% at 8–10 months had no public or private health coverage.[103]

Inmates are not eligible for Medicaid during incarceration, so although not required by federal law, benefits in New Mexico are routinely terminated upon entry into prison. Supplemental Security Income (SSI) is suspended for the first 12 months of incarceration and then terminated. Social Security Disability Insurance (SSDI) is typically suspended after one month of incarceration, although SSDI benefits can continue to a spouse and children. Mechanisms in the NMCD to get prisoners enrolled in Medicaid, SSI, or SSDI before discharge are sparse or nonexistent, so most eligible prisoners leave without coverage from these sources. In general, release planning for health care is severely lacking.

Impact of Health Care Reform (the Affordable Care Act)

The ACA has provisions that allow for all nonelderly adults (18–64) with income <139% federal poverty level (FPL; 133% FPL plus a 5% income disregard) to be eligible for Medicaid beginning in 2014. Other uninsured adults will qualify for the state insurance exchange, with those at 139%–400% FPL income eligible for subsidies to pay for their insurance in the exchange.[104] Currently there are 180,000 New Mexican adults who are uninsured and have <139% FPL, including most inmates.[105]

More than $11 billion is being made available to federally qualified health centers where many inmates could receive care after reentry for both substance use and mental

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[102] Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—a high risk of death for inmates. *N Engl J Med.* 2007;356:157–165.

[103] Mallik-Kane K, Visher C. *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration.* Washington, DC: Urban Institute, 2008. Available at: http://www.urban.org/url.cfm?ID=411617. Accessed December 11, 2011.

[104] Kaiser Family Foundation. *Summary of New Health Reform Law.* Available at: http://www.kff.org/healthreform/upload/8061.pdf. Accessed December 11, 2011.

[105] Kaiser Family Foundation, statehealthfacts.org. Available at: http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=33&ind=779&sub=177. Accessed December 11, 2011.

disorders.[106] The establishment of health homes could facilitate such treatment through these facilities.

Prison Reform in New Mexico for Those with Substance Use Disorders

In 1997, under the guidance of a federally appointed expert addictions consultant, Dr. Michael Gendel, the NMCD developed a system of TCs to provide effective and efficient addiction services. Consequently, the Addiction Services Bureau worked with federal addiction technology transfer centers, universities, and researchers to expand addiction treatment availability to inmates and develop and implement evidence-based treatment strategies.

Following a 2007 audit of the Corrections Department by the Legislative Finance Committee over concerns that addiction treatment in the NMCD was still at best suboptimal, Addictions Services hired Dr. Gendel again to review its system of treatment services and make recommendations. His report includes the following observations:[107]

- TCs are the primary method of addiction treatment in many state prison systems, and studies have well demonstrated TCs to provide effective addiction treatment.
- TC effectiveness is well established in the literature, and reproving it is neither necessary nor useful.
- Inmate behavior usually improves during the course of treatment, so they are often reclassified and transferred to a lower-custody-level facility before completing treatment. This can negatively impact treatment outcomes.
- Recidivism by itself can be a poor measure of treatment effectiveness, given the large number of other factors and conditions that influence recidivism, not the least of which is the glaring scarcity of aftercare resources in New Mexico.
- Addictions staffing levels should at least be maintained and if possible increased.

As noted, budget cutbacks in the Corrections Department have had a crippling effect on staffing. At the end of 2011, the 30% vacancy rate for clinical service providers in the NMCD was associated with suspended outpatient services at two facilities and two TCs that had closed. Services at other facilities are just one resignation or retirement away from disappearing.

In approaching ongoing budget shortfalls, the NMCD will need to consider other possibilities that move beyond cutting staff and closing down programs. For example, Indiana is evaluating reduced and alternative sentencing to vastly cut costs.[108] Other states facing similar budgetary problems such as Michigan have reduced recidivism by

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[106] Kaiser Family Foundation. *Summary of New Health Reform Law*. Available at: http://www.kff.org/healthreform/upload/8061.pdf. Accessed December 11, 2011.

[107] Gendel M. *Psychiatric Consultation to New Mexico Department of Corrections and Addictions Services Bureau*, June 27, 2008.

[108] Indiana's answer to prison costs. *New York Times*, January 17, 2011. Available at: http://www.nytimes.com/2011/01/18/opinion/18tue2.html. Accessed January 19, 2011.

focusing energy and funds on reentry and parole, emphasizing substance abuse treatment, job training, and job placement, which has contributed to a 15% reduction in their prison population over four years. There are similar initiatives under way in New York and California.[109]

A review of evaluations of prison-based addiction treatment programs in Texas, Delaware, and California demonstrates their effectiveness in reducing rearrest and reincarceration and in increasing employment.[110] This particularly applies to TCs and to instances when treatment is linked with extensive aftercare.

Recommendations for the Legislature, N.M. Corrections Department, Sentencing Commission, Human Services Department, and Department of Health:

1. Prioritize a restoration of funding to the N.M. Corrections Department in the state budget (11% lost since 2008 on the adult prisons side alone), with an emphasis on appropriations for addiction treatment.
2. Restore funding and expand staffing levels for addiction treatment, including positions removed subsequent to the 2010 hiring freeze and restoration to full capacity of the therapeutic communities that are proven effective.
3. All corrections staff should be educated about addiction as a medical disorder and as a chronic brain disease, including how to recognize the signs of substance use disorders and what methods are employed in their treatment.
4. All inmates should have their constitutional right to appropriate medical treatment upheld, which includes adequate and appropriate treatment of substance use disorders and co-occurring mental health disorders.
5. Create mechanisms within the prison system to guarantee that all eligible inmates upon reentry are enrolled in Medicaid, SSI, and SSDI by the discharge date:

    a. The NMCD and HSD should collaborate during the prerelease period to ensure Medicaid enrollment of eligible prisoners.
    b. Medicaid should be suspended instead of terminated for those already enrolled upon incarceration, with presumption of enrollment upon release.
    c. Individuals exiting correctional facilities are a vulnerable and underserved population that the HSD should target for aggressive outreach and enrollment efforts for Medicaid in accordance with the provisions of the Affordable Care Act.

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[109] States help ex-inmates find jobs. *New York Times*, January 25, 2011. Available at: http://www.nytimes.com/2011/01/25/business/25offender.html?pagewanted=1&emc=eta 1. Accessed December 11, 2011.

[110] Welsh WN. *Evaluation of Prison Based Drug Treatment in Pennsylvania: A Research Collaboration Between the Pennsylvania Department of Corrections and the Center for Public Policy at Temple University, Final Report*, 2002. Available at: http://www.ncjrs.gov/pdffiles1/nij/grants/197058.pdf. Accessed December 11, 2011.

d. The HSD should utilize presumptive eligibility for Medicaid based on incarceration status or qualify prisoners for Medicaid using criminal justice system data.

6. Corrections staff involved in prisoner reentry should partner with DOH public health offices and federally qualified health centers to provide a seamless transition for the reentry health care, addiction treatment, and social needs of returning citizens. This includes evaluating and improving the processes of information-sharing between services bureaus, in-house caseworkers or classification officers, the Probation and Parole Division (PPD), and community services. The outcome should be a "warm handoff," where the referring party ensures a satisfactory linkage with subsequent providers resulting in timely scheduled appointments and established contact. The NMCD and DOH should be provided funds by the legislature to support this continuum of care.
7. Make a commitment to build a continuum of care from prison to community that is designed to engage a person and his or her family in a holistic and culturally appropriate manner around addiction treatment and reintegration. The funding of pilot projects such as Critical Time Intervention should be undertaken.
8. Expand addiction treatment services for uninsured and underinsured parolees and probationers to reduce recidivism. Moreover, overall substance abuse services for offenders should be enhanced throughout the state. Specifically,

    a. Prioritize the restoration of the budget in the PPD for addiction treatment that will allow for the men's and women's recovery academies to be used at full capacity again and to expand outpatient services for offenders in the community.
    b. Encourage and support Dismas House New Mexico to reopen a halfway house site for women.

9. Develop provisional policies for reentry medication-assisted therapy to be utilized by appropriately selected known opiate addicts by

    a. Requiring the NMCD medical vendor to ensure that all of its physicians are certified and prepared to prescribe buprenorphine (Suboxone);
    b. Providing prerelease buprenorphine MAT induction to appropriate inmates prior to parole, followed by a seamless transition to a buprenorphine provider and to addictions treatment in the community (this may be started with a select population as a pilot project);
    c. Requiring brief training for all prison staff (wardens, correctional officers, classification officers, etc.) and relevant PPD staff on buprenorphine and other MAT (such as methadone) to enhance understanding; and
    d. Making MAT training available to the parole board, Sentencing Commission, and drug court personnel.

10. Identify and treat all inmates with co-occurring mental health and substance use disorders as part of a comprehensive treatment program in order to improve drug relapse and criminal recidivism outcomes.
11. Begin utilization of the Reentry Drug Court Program (N.M. ST §31-21-27), provided there are clarified lines of authority, including authority to reincarcerate.
12. Establish a quality-of-care review system for community treatment provider agencies utilizing brief interviews to evaluate the experience of offenders and providers and to encourage a stronger collaboration between the NMCD and providers.
13. Establish adequate funding for PPD drug testing.
14. Provide drug-specific training for probation and parole officers with a concentration on individualized interventions and triage, according to best practices.
15. Provide for expert consultation and research support to review emerging best practices to maximize outcomes involving the concomitant use of therapeutic communities and outpatient treatment.
16. For offenders who recidivate, establish a process upon reincarceration to identify issues and problems with community adjustment—essentially a professional review process for "what went wrong."
17. Bring the prison health system under the facility licensing authority of the DOH.

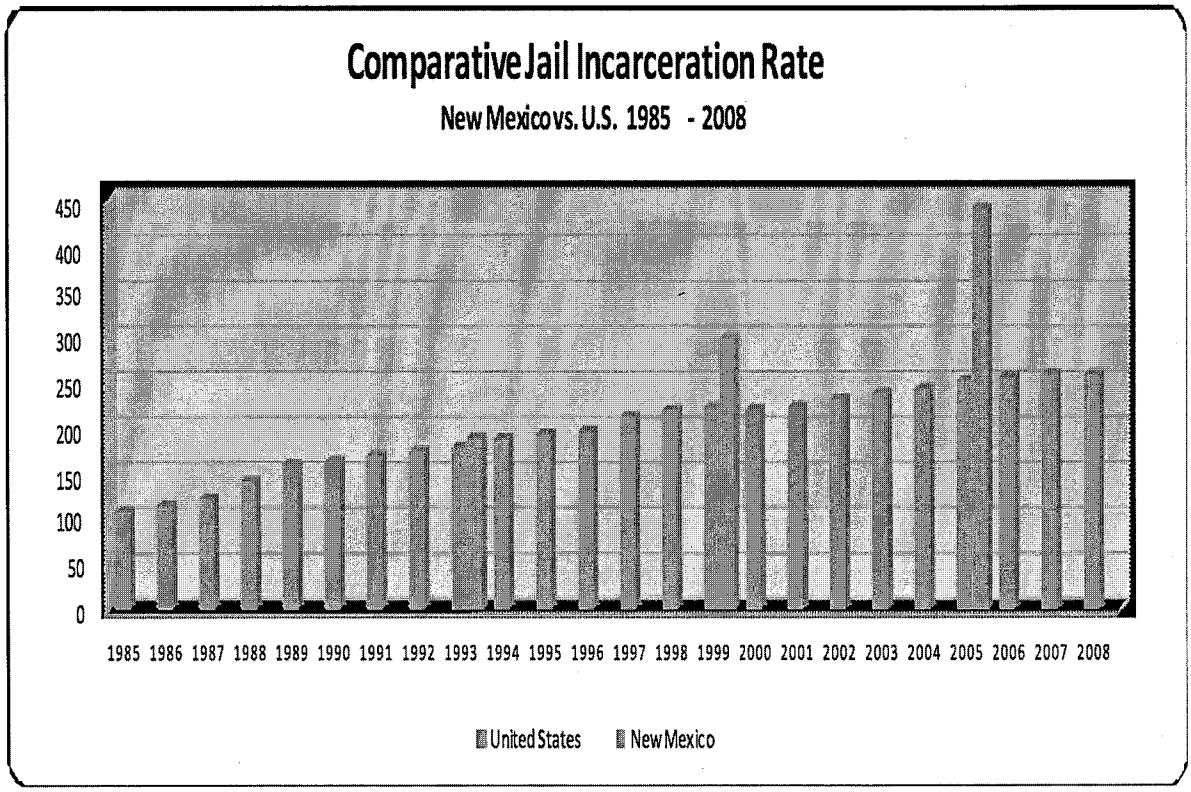
11. COUNTY DETENTION CENTERS AND FACILITIES

Findings:
Counties house the full range of criminal offenders, from the violent felon to the first-time misdemeanor offender. Some of the individuals housed in county detention facilities are not charged with any crime but are brought to the county facility for protective custody due to intoxication or mental health disorders. In some jurisdictions, the jail has become the community's principal option for managing behavioral health issues, including substance abuse disorders.

Overcrowding in the county jails is an increasing issue. While the N.M. Corrections Department is currently operating below its operational capacity, many county jails are overpopulated, requiring counties to rent beds in other counties or out of state. The reasons are multiple. As criminal justice resources are increasingly inadequate to manage the caseloads, arrestees spend longer and longer time in pretrial confinement. Inmates also wait for long periods to receive their judgment and sentence paperwork, delaying their transport to state facilities. A substantial proportion of inmates are in detention awaiting disposition for nonviolent, drug-related crimes. In addition, counties incur unreimbursed expenses housing parole and probation violators for the state.

The rates of incarceration in N.M. jails are rising much faster than in most other states. Figure 2 compares jail incarceration rates for New Mexico (red bars) with rates for the United States (blue bars) from 1985 to 2008.

Figure 2. Jail Incarceration Rates, New Mexico and United States, 1985–2008



New Mexico puts more people in jail per capita than any other state. There are twice as many women in jail than the national average. Despite the large and growing number of individuals held in county jails, few definitive data exist regarding who is locked up, for what, and for how long. It is critical that such information be gathered in order to inform policy and decisions.

The N.M. Sentencing Commission is overseeing a study in seven N.M. counties that will provide current information on such things as demographics, types of offenses, and status of adjudication. The study will not particularly clarify health issues such as the need for detoxification. The analysis should be completed by late spring 2012.

There is no doubt that alcohol and drug use and addictions play a major role in the number of jail incarcerations. Issues include the front-end management of behavioral health issues, including the management of detoxification and withdrawal. Limited access to timely health care is an issue. For example, unmanaged withdrawal (detoxification), for example, from alcohol, opioids, or benzodiazepines (sedatives) can be physically extremely stressful and occasionally lethal. Medical monitoring of these prisoners is a basic but often unmet need. In fact, only seven of 32 county detention facilities have a medical protocol for the detoxification of inmates. The ability to offer opioid maintenance to the prisoner who has been on such a regimen is also important.

The ability to offer or arrange to make available medication-assisted treatment in anticipation of discharge currently exists only in a few settings such as Bernalillo County for a limited number of inmates. Inmates with health issues, including addiction, should be connected to follow-up clinical care and, when appropriate, prerelease access to MAT and Narcan. A concern is the lack of a mechanism for managing the hand off into the community. Such a connection will benefit in helping the returnee in terms of social connectivity, prevention of relapse, and reduction of recidivism. The DOH local public health offices are well distributed and potentially appropriate for assisting with this role. Even though these services have been implemented in Bernalillo County and Dona Ana County, most of the DOH public health offices are understaffed for this kind of role.

The House Joint Memorial 17 Task Force provided recommendations on how law enforcement agencies and detention centers should respond to people who have mental health disorders and reduce the numbers of such persons in incarceration. Ultimately the answer lies in better funding, improving the mental health system, and making available services that can provide needed assessment and treatment. The SM 18 Task Force strongly endorses the House Joint Memorial 17 conclusions and recommendations, noting that all of the recommendations have direct applicability to persons whose behavioral health problem is alcohol or other drug use or addiction. The basic insight is that incarceration is almost always a solution by default.

Recommendations for the Sentencing Commission:

1. Make recommendations based on the survey results to reduce or eliminate detention stays for alcohol- and other drug-related incarcerations and

recommendations to better provide local resources for the assessment and treatment of behavioral health and addiction problems.
2. Sentencing rules need to be examined and revised for reducing the burdens from incarceration for minor offenses, excessive holding times, and having county detention facilities be responsible for probation and parole violations.

Recommendation for the Legislature and County Detention Facilities:
Create regional adult and adolescent programs in Bernalillo and Dona Ana counties for the diversion of offenders with substance use disorders into treatment, modeled, for example, off the San Juan County DWI Detention/Treatment/Aftercare and Methamphetamine Pilot programs (as noted in section 9, Sentencing and Collateral Consequences). These treatment programs should be gender-specific.

Recommendations for the Department of Health and County Detention Facilities (also see recommendations from the MAT section of this report):

1. The DOH should plan for and move to develop a substantial oversight role to ensure appropriate clinical care for incarcerated persons. Unless otherwise provided, this should include creating protocols and standards of care and the use of DOH clinical staff in detention facilities in all counties where DOH clinics are located to bring clinical and other public health services. Services covered will include medically supervised detoxification, immunizations, disease screening, and health education. Target diseases include substance use and mental health disorders and acute and chronic diseases.
2. DOH offices in each public health region should provide buprenorphine induction for persons before release or within 24 hours after release from detention facilities and plan immediate seamless referrals to buprenorphine providers for continuing treatment.
3. Where feasible county detention facilities should allow persons enrolled in local methadone maintenance programs to continue to receive methadone during incarceration, either via delivery from a local clinic or through a contract with an independent contractor, as is done in the Bernalillo County Metropolitan Detention Center.
4. Develop formal discharge planning to include counseling, referrals, and dispensing and training in the use of naloxone (Narcan) prior to release from county detention centers for persons who have a history of opioid addiction to reduce their high risk of overdose after their release.

12. PEER-TO-PEER COUNSELING

Findings:
Persons who are in recovery from substance use disorders are uniquely suited to provide support and mentorship for addicts. They constitute a large and underutilized resource of volunteers for this role. These persons can be especially helpful in filling the large treatment gap previously outlined in this report in detention centers and prisons and for parolees and probationers. In many situations, the ability of someone incarcerated to communicate with peer counselors is limited and needs to be facilitated and encouraged.

Recommendation for the Behavioral Health Collaborative, N.M. Corrections Department, and Counties Regarding Incarcerated People:
Use peer services whenever possible to provide and enhance services: at prisons, county detention facilities, probation- and parole-related services, and community-based services generally.

APPENDIX A
SENATE MEMORIAL 18

50th Legislature—STATE OF NEW MEXICO—1st Session, 2011
INTRODUCED BY
Bernadette M. Sanchez

A MEMORIAL
REQUESTING THE UNIVERSITY OF NEW MEXICO'S ROBERT WOOD JOHNSON FOUNDATION CENTER FOR HEALTH POLICY TO CONTINUE THE WORK OF THE DRUG POLICY TASK FORCE IN ORDER TO COMPLETE ITS COMPREHENSIVE STATEWIDE STRATEGIC PLAN BASED ON THE FOUR PILLAR APPROACH.

WHEREAS, the forty-ninth legislature passed Senate Memorial 33 requesting the university of New Mexico's Robert Wood Johnson foundation center for health policy to create a drug policy task force to evaluate New Mexico's approach to alleviating the negative consequences associated with the use of alcohol and other drugs; and

WHEREAS, the drug policy task force met seven times between June and December of 2010, inviting designees appointed by the New Mexico legislative council; representatives from the office of the governor, the office of the lieutenant governor, the corrections department, the department of health, the children, youth and families department, the human services department, the public education department, the legislative finance committee, the DWI grant council, the aging and long-term services department, county detention facilities, the administrative office of the courts, the department of public safety, the interagency behavioral health purchasing collaborative, the behavioral health planning council, the university of New Mexico, the New Mexico association of counties, the drug policy alliance and the New Mexico women's justice project; two individuals with criminal drug convictions; and two individuals in recovery from substance abuse; and

WHEREAS, the drug policy task force utilized a four pillar approach to examine prevention, treatment, harm reduction and enforcement in order to develop strategies for effective change in New Mexico's drug policy; and

WHEREAS, the initial comprehensive statewide strategic plan that was developed by the task force includes a section on current approaches to drug policy, addressing the number and geography of people impacted and local and statewide assessments of services and needs; a section on prevention recommendations; and a section on treatment recommendations; and

WHEREAS, the drug policy task force was directed to compile a list of expenditures for prevention, treatment, harm reduction and enforcement and an assessment of the effectiveness of current programs, but the task force was unable to complete the process of gathering this data and information prior to the start of the first session of the fiftieth legislature; and

WHEREAS, the task force was directed to develop a list of evaluation measures to include the impact of drug abuse on youth, rates of drug overdose fatalities, rates of HIV/AIDS and hepatitis, access to treatment, the number of incarcerated, nonviolent drug

law offenders, access to alternatives to incarceration and racial disparities exacerbated by the criminal justice system, but the task force was unable to complete the process of gathering this data prior to the first session of the fiftieth legislature; and

WHEREAS, the drug policy task force presented its initial findings to the interim legislative health and human services committee, the interim courts, corrections and justice committee and the legislative finance committee;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE OF NEW MEXICO that the university of New Mexico's Robert Wood Johnson foundation center for health policy be requested to continue the work of the drug policy task force in order to complete its comprehensive statewide strategic plan based on the four pillar approach; and

BE IT FURTHER RESOLVED that the task force continue to evaluate New Mexico's approach to alleviating the negative consequences associated with the use of alcohol and other drugs; and

BE IT FURTHER RESOLVED that the task force present its final comprehensive statewide strategic plan, including conclusions and recommendations, to the interim legislative health and human services committee, the legislative finance committee and other appropriate interim legislative committees by November 2011; and

BE IT FURTHER RESOLVED that the strategic plan and all of its conclusions and recommendations be made available to other interested legislative committees, executive agencies and the public through publication on the center for health policy's web site; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the director of the Robert Wood Johnson foundation center for health policy and to each of the agencies and organizations named in this memorial as participants on the task force.

APPENDIX B
SENATE MEMORIAL 18 DRUG POLICY TASK FORCE MEMBERS AND PARTICIPANTS

Sponsor
Senator Bernadette Sanchez
District 26 (Bernalillo)

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Juvenile Justice Advisory Committee

Harris Silver, MD, Policy Analyst

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OptumHealth

Jaye Swoboda, MD, Physician

Catherine Torres, MD, Secretary
N.M. Department of Health

Bruce Trigg, MD, Addiction Specialist
N.M. Department of Health (retired)

Susie Trujillo
Gila Regional Medical Center

Jennifer Weiss, President
Heroin Awareness Committee

William Wiese, MD, MPH, Associate Director
Robert Wood Johnson Foundation Center for Health Policy at UNM
Task Force Chair

Rick Word, JD
Drug Policy Alliance

APPENDIX C
PRIMARY PREVENTION OF ALCOHOL MISUSE AND ABUSE

According to a telephone survey of adults in New Mexico, 4.4% "drink heavily," and 11.1% engage in "binge drinking"[111]—numbers reported for the United States are slightly higher.[112] The N.M. figures are likely substantial underestimates, because these results are from a survey that does not capture cell phone users or those without phones. New Mexico has one of the highest rates in the United States of adults who use a cell phone only. Cell phone–only users have twice the rate of binge drinking. New Mexico also has the highest rate of households without a phone, a situation also associated with elevated rates of heavy drinking and binge drinking.[113]

While the U.S. death rate secondary to alcohol-related chronic disease (e.g., liver disease and others) declined 15% from 1990 to 2007, the rate in New Mexico remained stable and high. As a result, New Mexico's rate went from being 1.6 times the U.S. rate in early 1992 to being 2.2 times the U.S. rate in 2007.[114]

Alcohol consumption is a major contributor to the three leading causes of death among young people: motor vehicle accidents, suicide, and homicide. In New Mexico, at least 132,000 people age 12 and older need treatment for alcohol use but are not receiving it.[115]

Alcohol abuse is a central issue in terms of the burdens and problems it creates in connection with all phases of criminal behavior. Any preventive approaches to reducing excessive drinking (particularly binge drinking) would have an impact on alcohol-related crime levels.

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[111] Centers for Disease Control and Prevention definitions:

- *Heavy drinking*: more than two drinks per day on average in men and more than one drink per day in women
- *Binge drinking*: five or more drinks during a single occasion for men and four or more drinks during a single occasion for women.

[112] New Mexico Department of Health. *New Mexico Substance Abuse Epidemiology Profile*, 2011. Available at: http://www.health.state.nm.us/erd/SubstanceAbuse/2011%20New%20Mexico%20Substance%20Abuse%20Epidemiology%20Profile.pdf. Accessed December 11, 2011.

[113] Blumberg SJ, Luke JV, Ganesh N, et al. Wireless substitution: state-level estimates from the National Health Interview Survey, January 2007–January 2010. *National Health Statistics Reports.* 2011(April 20);39.

[114] Roeber J, New Mexico Department of Health, Substance Abuse Epidemiology Program, direct correspondence.

[115] U.S. Department of Health and Human Services. *State Estimates of Substance Use and Mental Disorders from the 2008–2009 National Surveys on Drug Use and Health*, 2011. Available at: http://store.samhsa.gov/shin/content//SMA11-4641/SMA11-4641.pdf. Accessed December 11, 2011.

The priority for prevention must be the younger age groups. New Mexico leads the country in numbers of children who start drinking before age 13 and is higher than most states in the prevalence of students who drink regularly and who are binge drinkers. Persons who initiate drinking before age 21 are much more likely to abuse or become dependent on alcohol as adults than persons who initiate at a later age. Persons initiating before age 14 are more than six times as likely to become dependent.[116]

Table C.1. Survey of N.M. Students (Youth Risk and Resiliency Survey), Grades 9–12, 2009

Survey Question	N.M. Prevalence	State Rank	Comment
Current drinker	41%	14	80% of alcohol use occurs at home
Binge drinking	25%	11	Accounts for 90% of alcohol consumption in 12- to 20-year-olds
First alcohol before age 13	29%	1	Persons initiating before age 14 are six times as likely to become dependent

Source: Centers for Disease Control and Prevention (CDC), Youth Risk and Resiliency Survey for New Mexico, 2009. See New Mexico Department of Health, *Youth Risk and Resiliency Survey: 2009 High School Alcohol Report*, 2010. Available at: http://www.youthrisk.org/pdf/2009/YRRS-2009-Presentation.pdf, accessed December 11, 2011.

On the positive side, the rates for N.M. students shown above represent substantial decreases over the six years since 2003.

Also New Mexico has greatly improved its rate for drunk-driving fatalities, dropping from #1 to #25 in 2009—a decline of 32% since 1999.[117] This encouraging statistic is attributable to a high-profile, multifaceted statewide campaign against drunk driving.

Economics of Alcohol Use

In 2007, the alcohol-attributable costs in New Mexico totaled $2.8 billion, more than $1,400 for every person in the state (see Table C.2 below).[118] This represented an

[116] *2009 National Survey on Drug Use and Health: Detailed Tables*, 2010. Available at: http://oas.samhsa.gov/WebOnly.htm#NSDUHtabs. Accessed December 11, 2011.

[117] Mothers Against Drunk Driving website. Available at: http://www.madd.org/drunk-driving/campaign/state-stats/. Accessed December 11, 2011.

[118] New Mexico Department of Health. *The Economic Cost of Alcohol Abuse in New Mexico: 2007*, 2011. Available at: http://www.health.state.nm.us/ERD/HealthData/SubstanceAbuse/The%20Economic%20

increase of 11% from 2006, also associated with an 11% increase in alcohol-related deaths.

The costs of underage drinking in New Mexico are the third highest per capita in the United States, a total of $259 million just for health and work loss costs in 2009.[119]

Table C.2. Economic Costs of Alcohol Abuse in New Mexico, 2007

Cost Component	Costs (millions)	% of Total Cost
Health Care Costs		
Alcohol-related prevention and treatment services	$83	3
Medical consequences of alcohol consumption	$379	14
Subtotal	$462	17
Productivity Costs		
Lost future earnings due to premature deaths	$559	20
Lost earnings due to illness	$1,342	48
Lost earnings due to crime (incarcerations and victimization)	$118	4
Subtotal	$2,019	72
Other Social Costs		
Crimes—criminal justice and property damage	$84	3
Social welfare program administration	$8	0
Motor vehicle crashes and fires—property damage	$231	8
Subtotal	$323	11
Total Costs	**$2,804**	100

Source: N.M. Department of Health.

These costs, which are absorbed jointly by the public and by publicly funded programs, dwarf the annual revenues obtained from the excise tax on alcohol ($40 million).

Prevention

The problems of preventing misuse or abuse of alcohol in adults and underage drinking can be divided into two general approaches: individual/direct prevention services ("demand reduction") and environmental approaches ("supply approaches"). A crippling 61% loss of funding in the last year for the Office of Substance Abuse Prevention in the

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Cost%20of%20Alcohol%20Abuse%20in%20New%20Mexico,%202007.pdf. Accessed December 11, 2011.

[119] Pacific Institute for Research and Evaluation. *Underage Drinking in New Mexico—The Facts, 2009.* Available at: http://www.udetc.org/factsheets/NM.pdf. Accessed December 11, 2011.

N.M. Human Services Department[120] undermines the evidence-supported school-based, family-based, and community-based prevention services targeting youth and high-risk groups and individuals. Delaying the initiation of first alcohol use is a proven strategy for reducing alcohol abuse by minors and for the later development of alcohol and other drug dependence. The cuts reflect recent budgetary realities. These funds should be restored as soon as possible.

Environmental approaches create limits to access and supply, are able to reduce demand, and are achievable without the need for substantial state appropriations. Moreover, they can be demonstrably cost-effective.

The CDC's Task Force on Community Preventive Services recommends the following evidence-based, cost-effective alcohol abuse prevention strategies:[121]

- Maintain dram shop liability (supply).
- Maintain limits on hours of sales of alcohol (supply).
- Regulate alcohol outlet density (supply).
- Enhance enforcement of laws prohibiting alcohol sales to minors (supply).
- Increase alcohol excise taxes—primary recommendation of the task force (demand).

Alcohol Excise Tax Increase

Along with the CDC, the Institute of Medicine includes the raising of excise taxes among its recommended approaches to reducing underage drinking.[122]

In New Mexico, alcohol is taxed by volume, not based on price like a sales tax is. This tax has not been increased since 1993—thus, the effective rate of taxation has gone down substantially. The tax rate is currently $0.41/gallon of beer, $0.45/liter of wine, and $1.60/liter of spirits.[123] The annual amount of revenue from the N.M. alcohol excise tax is approximately $40 million, the majority of which has gone to the general fund.

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[120] New Mexico Behavioral Health Services Division, Human Services Department. *Office of Substance Abuse Prevention/Alcohol, Tobacco and Other Drug Abuse Fact Sheet.* Available at: http://www.hsd.state.nm.us/pdf/LegislativeSession/2011/Prevention%201-12-11.pdf. Accessed December 11, 2011.

[121] CDC. *Guide to Community Preventive Services. Preventing Excessive Alcohol Consumption.* Available at: http://www.thecommunityguide.org/alcohol/index.html. Accessed December 11, 2011.

[122] National Research Council and Institute of Medicine. *Reducing Underage Drinking: A Collective Responsibility, a Report Brief*, September 2003. Available at: http://www.iom.edu/~/media/Files/Report%20Files/2003/Reducing-Underage-Drinking-A-Collective-Responsibility/ReducingUnderageDrinking.pdf. Accessed December 11, 2011.

[123] Tax Foundation website. Available at: http://www.taxfoundation.org/news/show/245.html. Accessed December 11, 2011.

Furthermore, 41.5% of funds (approximately $16 million) are earmarked to the county DWI programs for prevention and treatment.[124] This revenue is far less than the costs to the state and the public of alcohol use ($2.8 billion as noted above).

One way to measure the impact of alcohol price on consumption is through price elasticity, defined as the expected percentage of change in consumption when the price increases by 1% (example: –0.50 means that consumption decreases by 0.5% with a 1% price increase).

Table C.3 shows the price elasticity for different alcohol types.

Table C.3. Average Price Elasticity by Consumption of Different Types of Alcohol in Adults

Alcohol Type Consumed	Average Price Elasticity	Number of Studies
Beer	–0.50	18
Wine	–0.64	22
Spirits	–0.79	21
All alcohol types	–0.77	11

Source: CDC, *Guide to Community Preventive Services. Preventing Excessive Alcohol Consumption.* Available at: http://www.thecommunityguide.org/alcohol/increasingtaxes.html, accessed December 11, 2011.

A 2010 bill analysis by the N.M. Taxation and Revenue Department projected that a statewide increase in the tax would generate approximately $78 million for an increase of $0.10 per alcoholic drink.[125]

Since a relatively small number of drinkers consume most of the alcohol, most people who drink alcohol, and those who do not drink, will not be particularly affected by an increase in the alcohol excise tax, while those who are heavy drinkers and/or binge drinkers are disproportionately affected. Youth are affected to a greater degree. There is strong evidence demonstrating that they are more price-sensitive.[126]

[124] New Mexico State Legislature. *House Bill 23, Liquor Excise Tax Distribution to Schools, Legislative Education Study Committee Bill Analysis.* Available at: http://www.nmlegis.gov/Sessions/11%20Regular/LESCAnalysis/HB0023.pdf. Accessed December 11, 2011.

[125] CDC. *Guide to Community Preventive Services. Preventing Excessive Alcohol Consumption.* Available at: http://www.thecommunityguide.org/alcohol/increasingtaxes.html. Accessed December 11, 2011.

[126] Ibid.

An alcohol excise tax increase has also been demonstrated by research to[127]

- Decrease alcohol-impaired driving and alcohol-related crashes
- Decrease alcohol-related medical conditions
- Decrease all-cause alcohol-related deaths and specifically deaths from motor vehicle crashes and liver cirrhosis
- Decrease the spread of sexually transmitted diseases
- Decrease the rate of severe violence toward children
- Decrease alcohol dependence rates
- Decrease hospital admissions
- Decrease the rates of certain crimes
- Decrease the number of suicides in males

These translate into significant savings in addition to the tax revenue.

National polls indicate public support for raising alcohol excise taxes. In one poll of 7,201 adults, 82% were in favor of a nickel-a-drink tax increase when funds were earmarked for addressing problems with alcohol use. Support dropped to 69% if the funds were used to provide tax relief.[128]

The alcohol industry has historically been the primary opposition to alcohol tax increases, channeling its opposition through advertising, lobbying, and donations. (The alcohol industry contributed $169,882 to N.M. state election campaigns for 2010.[129]) Recently, Maryland was able to enact a special sales tax on alcohol in the face of significant industry opposition.

Social Liability Ordinances

The high proportion of drinking done at home by youth points to the importance of other strategies such as targeting the social liability of property owners and parents.[130] Social host liability refers to the legal responsibility of adults who knowingly or unknowingly

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[127] Elder RW, Lawrence B, Ferguson A, et al. The effectiveness of tax policy interventions for reducing excessive alcohol consumption and related harms. *Am J Prev Med.* 2010;38(2):217–229.

[128] Harwood EM, Wagenaar AC, Bernat DH. *Youth Access to Alcohol Survey, Summary Report*, December 2002. Available at: http://www.epi.umn.edu/alcohol/pubopin/2002_REPORT.PDF. Accessed December 11, 2011.

[129] National Institute on Money in State Politics website. Available at: http://www.followthemoney.org/database/StateGlance/contributor_details.phtml?&i=57&s=NM&y=2010&summary=0&so=a&p=1#sorttable

[130] Imm P, Chinman M, Wandersman A, Rosenbloom D, Guckenburg S, Leis R. *Preventing Underage Drinking: Using Getting to Outcomes™ with the SAMHSA Strategic Prevention Framework to Achieve Results*. Santa Monica, CA: RAND Corporation, 2007. Available at: http://www.rand.org/pubs/technical_reports/TR403. Accessed December 11, 2011.

host underage drinking parties on property that they own, lease, or otherwise control. This is regardless of whether or not they provide the alcohol. The prospect of being held liable can act as a deterrent, provide incentives for hosts to be vigilant and prevent parties while away, hold youth accountable, reinforce a municipality's zero-tolerance policy, and act as a means for law enforcement to recover the costs of repeatedly responding to the same party site. Penalties are typically escalating for repeat offenses. Currently, a number of municipalities in New Mexico have social host ordinances that reportedly are widely supported by law enforcement and are being studied by the state for effectiveness: Farmington, Santa Fe, Espanola, and Moriarty.

Screening and Treatment

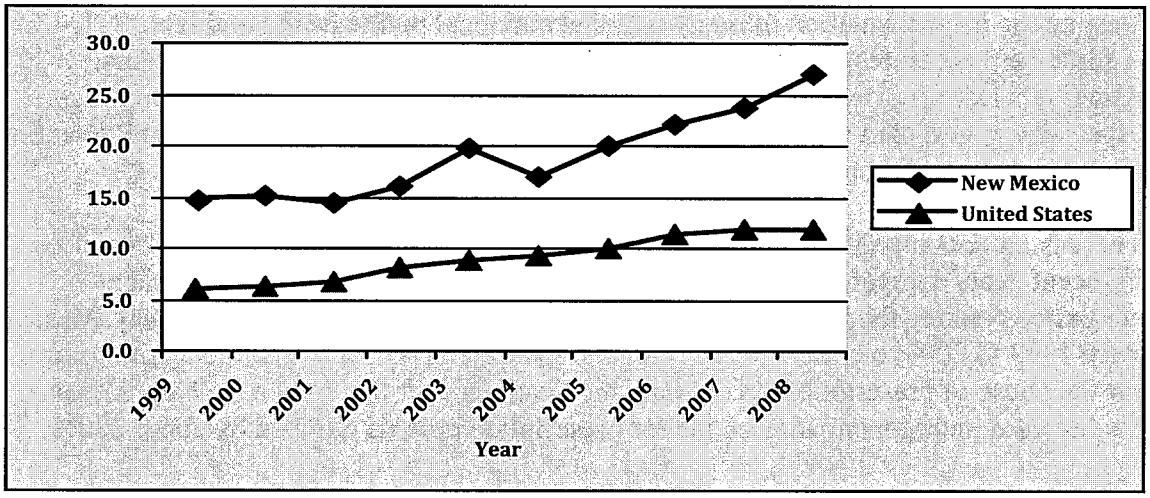
For persons with alcohol use disorders, treatment can be effective, even lifesaving, and is indicated. Several sections of this report deal with the long-term need for broadening the behavioral health care infrastructure. Near-term opportunities exist for public funding of behavioral health care in primary care settings through provisions of the Affordable Care Act. The report elsewhere describes the importance and usefulness of screening, brief intervention, and referral for treatment (SBIRT) in preventing alcoholism or reducing its negative consequences. Medicaid could help by enabling the use of Medicaid billing codes for SBIRT services. The University of New Mexico Health Sciences Center could assist by promoting SBIRT training for health professionals and taking steps to identify and recommend best practices for implementing SBIRT.

APPENDIX D
CHARACTERISTICS OF DRUG USE IN NEW MEXICO

Background and Overdoses

The drug overdose rate in New Mexico is the highest in the United States[131] (and has been nine of the last 10 years)—more than double the U.S. rate, and the gap has been expanding. New Mexico also has the highest rate of overdose associated with illicit drugs and the second highest overdose rates associated with all prescription drugs and prescription opioids (Figure D.1).[132]

Figure D.1. Drug Overdose Death Rates in the United States and New Mexico, 1999–2008



Note: Deaths per 100,000 population, age-adjusted to the 2000 standard U.S. population.

During 2005–2009 in New Mexico, 60% of unintentional drug overdose deaths were caused by illicit drugs, while 40% were caused primarily by prescription drugs. Within the general category of unintentional deaths from drug overdoses, deaths from prescription opioid pain relievers tripled in the United States and New Mexico[133] over the 10-year period 1999–2008. Also, the annual number of heroin overdose deaths in youths in New Mexico has risen sharply in the past two years.

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[131] Centers for Disease Control and Prevention (CDC). Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. *MMWR.* 2011(November 1);60:1487–1492.

[132] CDC, National Center for Health Statistics. Underlying causes of death from the CDC WONDER online database, released 2011. Available at: http://cdc.wonder.gov. Accessed December 16, 2011.

[133] New Mexico Department of Health. *New Mexico Substance Abuse Epidemiology Profile*, 2011. Available at: http://nmhealth.org/ERD/SubstanceAbuse/2011%20New%20Mexico%20Substance%20Abuse%20Epidemiology%20Profile.pdf. Accessed December 11, 2011.

N.M. medical examiner data indicate that the most common drug types involved in overdose deaths (not mutually exclusive) are those listed in Table D.1.[134]

Table D.1. Percent of Deaths in New Mexico by Drug Type

Drug Type	%
Prescription opioid pain medications	49
Heroin	36
Cocaine	31
Benzodiazepines/muscle relaxants	29
Antidepressants	16

Prescription Drug Abuse and Misuse and Overprescribing

Despite the implementation of many national and local public health and law enforcement measures intended to reduce the misuse of prescription medications, America's fastest-growing drug problem is the nonmedical use of prescription drugs, especially opioid pain relievers. Recently the Centers for Disease Control and Prevention declared this a crisis and an epidemic.[135]

There is more compelling evidence that the abuse of prescription drugs has skyrocketed in recent years compared with the use of illicit drugs—substance abuse treatment admissions among those aged 12 and older in the United States remained nearly the same from 1999 to 2009, but there was a dramatic increase of 430% in treatment admissions for the abuse of prescription opioid pain medications over that period. In New Mexico, the increase in treatment admissions for prescription opioids climbed by about 230%.[136]

From 2004 to 2008 the U.S. rate of emergency department visits involving the misuse of prescription drugs more than doubled to 306,000. The majority of the nonmedical opioid-related visits were for oxycodone and hydrocodone, whose rates also more than doubled during 2004–2008. Similarly, during this five-year period the rate of emergency department visits involving benzodiazepines and other sedatives/hypnotics increased by 89%.[137]

While all classes of controlled prescription medications have the potential for abuse, opioid pain medications are particularly dangerous given their extremely addictive

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[134] Ibid.

[135] Office of National Drug Control Policy. *Epidemic: Responding to America's Prescription Drug Abuse Crisis*, 2011. Available at: http://www.whitehousedrugpolicy.gov/publications/pdf/rx_abuse_plan.pdf. Accessed December 16, 2011.

[136] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS): 1999–2009. State Admissions to Substance Abuse Treatment Services*. DASIS Series S-58, HHS Publication No. (SMA) 11-4663. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

[137] CDC. Emergency department visits involving nonmedical use of selected prescription drugs—United States—2004–2008. *MMWR*. 2011(June 18);59(23).

nature, high risk for overdose, and abundant supply. The increase in supply is clearly illustrated through data tracking the sale of the pain medication hydrocodone. According to the Centers for Disease Control and Prevention, between 1997 and 2007 there was a 627% increase in the national sales of hydrocodone products (including Vicodin® and Lortab®),[138] making it the most widely prescribed drug in the United States 2006–2010.[139] Opioid-related overdose deaths during that period had a parallel increase of 296% to 11,499 in the United States.[140] Overall, opioid prescribing by amount increased by 250% during 2000–2009,[141] while the number of prescriptions written for opioid pain relievers during that time increased by only 48%—although the prescriptions for high-dose extended release compounds such as OxyContin® (oxycodone) increased by 148%.[142] This indicates that not only has the number of prescriptions written increased but so has the potency of the medication prescribed and the amount of medication per prescription.

The primary reasons for this rapid growth in opioid prescribing remain unclear but are likely related to numerous factors. Diversion, defined as the attainment and/or use of prescription medications for other than their prescribed intention with or without a prescription, has proliferated rapidly along with novel methods to accomplish it. "Doctor shopping," when someone uses several providers and pharmacies to obtain medications simultaneously, has become commonplace.[143] In some states, high-profit "pill mills," where one or more providers in a clinic prescribe controlled substances in excess, have flourished,[144] although only sparse reports of these clinics have arisen in New Mexico. An associated factor is a larger quantity of patients with chronic pain medication needs with an aging population surviving longer; consequently, areas such as Florida with a

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[138] CDC. *Public Health Grand Round Presentation*, 2011. Available at: http://www.cdc.gov/about/grand-rounds/archives/2011/pdfs/PHGRRx17Feb2011.pdf. Accessed December 16, 2011.

[139] RxList. *Top 200 Drugs—U.S. Only*. Available at: http://www.rxlist.com/script/main/hp.asp. Accessed December 26, 2011.

[140] CDC. Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. *MMWR*. 2011(November 1);60:1487–1492.

[141] Ibid.

[142] Food and Drug Administration (FDA). Briefing materials presented at the Joint Meeting of the Anesthetic and Life Support Drugs Advisory Committee and the Drug Safety and Risk Management Advisory Committee, Adelphia, MD, July 22–23, 2010. Available at: http://www.fda.gov/downloads/AdvisoryCommittees/CommiteesMeetingsMaterials/AnestheticAnd%20Life%20SupportDrugsAdvisoryCommittee/UCM217510.pdf. Accessed December 26, 2011.

[143] Manchikanti L. National drug control policy and prescription drug abuse: facts and fallacies. *Pain Physician*. 2007;10:399–424.

[144] Alvarez L. Florida shutting "pill mill" clinics. *New York Times*, August 31, 2011. Available at: http://www.nytimes.com/2011/09/01/us/01drugs.html?pagewanted=all. Accessed December 16, 2011.

large prevalence of elders (and no Prescription Drug Monitoring Program) have had the highest frequency of pill mills.

There have been substantial advertising and promotion campaigns directed at both practitioners and patients by pharmaceutical companies to encourage the use of opioid pain medications, especially high-dose long-acting drugs and various other new formulations.[145] Many practitioners have been encouraged to more aggressively manage noncancer pain, facilitated in part by the incompletely evaluated "regulatory" standards for the screening and management of acute and postoperative pain from the Joint Commission on Accreditation of Healthcare Organizations that were driven by professional pain organizations and pain advocacy groups funded by pharmaceutical corporations.[146] This has led numerous states, hospitals, and clinics to create a patients' "bill of rights" that advocates for patients to have adequate relief of pain. Also, many disease-specific advocacy organizations may have been "too effective" in advocating for pain relief on behalf of their constituents.

Many practitioners likely overprescribe unconsciously based out of their concerns about undermedicating and the possible consequences of litigation or their compassion for their patients' fear of pain and increased demands for pain relief. However, practitioners may also overprescribe for the convenience of their practice and/or the patient, to avoid calls or visits for more pain medication, and to obviate the possible need for the patient to make another trip to the provider or pharmacy. Finally, patients may have a misperceived sense of legitimacy and safety about using these medications because they are prescribed by medical practitioners and distributed by pharmacists.

Thus, there is a significant ongoing ethical conflict between the obligations to adequately manage a patient's pain and to avoid facilitating the abuse of opioid pain medications—a complex issue without easy answers.

Drug Use in New Mexicans

In Table D.2 results from the National Survey on Drug Use and Health (NSDUH) averaged for 2008–2009 demonstrate that there are high rates of drug dependence or abuse and a strong unmet need for treatment for illicit and prescription drugs in New Mexico for both youth and adults.[147]

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[145] FDA. Briefing materials presented at the Joint Meeting of the Anesthetic and Life Support Drugs Advisory Committee and the Drug Safety and Risk Management Advisory Committee, Adelphia, MD, July 22–23, 2010. Available at: http://www.fda.gov/downloads/AdvisoryCommittees/CommiteesMeetingsMaterials/AnestheticAnd%20Life%20SupportDrugsAdvisoryCommittee/UCM217510.pdf. Accessed December 26, 2011.

[146] Volkow N, McLellan TA. Curtailing diversion and abuse of opioid analgesics without jeopardizing pain treatment. *JAMA.* 2011;305:1346–1347.

[147] Substance Abuse and Mental Health Services Administration. *State Estimates of Substance Use and Mental Disorders from the 2008–2009 National Surveys on Drug*

Table D.2. Results of the National Survey on Drug Use and Health for the United States and New Mexico for Illicit Drug Dependence and Abuse Diagnosis and Illicit Drug Use (2008–2009)

Diagnosis or Drug Use Category	12+ Years Old			12–17 Years Old		
	U.S. (%)	N.M. (%)	State Rank	U.S. (%)	N.M. (%)	State Rank
Illicit drug dependence or abuse diagnosis in past year	3.5	4.2	3	1.9	2.5	2
Needing but not receiving treatment for illicit drug use in past year	2.5	2.9	7	4.2	5.7	1
Illicit drug use in the past month	8.4	9.1	18	9.7	12.4	3
Illicit drug use in the past month other than marijuana	3.5	3.8	21	4.5	5.4	4
Nonmedical use of pain relievers in the past year	4.8	5.7	12	6.5	8.5	3

Note: Illicit drugs include marijuana/hashish, cocaine (including crack), methamphetamine, heroin, hallucinogens, inhalants, or prescription drugs used nonmedically.

For youth aged 12–17 years, New Mexico is statistically the national leader in all categories of illicit drug use and misuse of prescription pain relievers (opioids). This survey tends to underestimate for all categories of drug use, especially in youth, because it is a household survey where parents may be present during survey administration, but it likely gives good estimates relative to other states. The youth underestimation becomes clear when reviewing the results from the survey below (Table D.3), which has been validated to give reliable estimates that are significantly higher than those obtained from the NSDUH.

One age group that is often neglected for consideration in analyses is the 18- to 25-year-old group, who on the NSDUH had by far the greatest levels of illicit drug use in the past month including or not including marijuana nationally (20.4% and 8.1%, respectively), with N.M. rates close to the U.S. average in both categories. The nonmedical use of opioid pain relievers is also very high in this group at 11.9%.

For all age groups collectively in the NSDUH survey, the source of the opioid pain reliever for the most recent nonmedical use was from a friend or a relative 70% of the time (55% for free, 10% bought, 5% without asking), 18% obtained from one doctor (this

Use and Health. NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

answer does not rule out doctor shopping), and <5% bought from a drug dealer.[148] These data imply that a substantial portion of prescription opioids obtained for nonmedical use is acquired from unused portions in the household—this is especially true in youth.[149] The remainder of prescription drug diversion is typically by one or more of the following methods, especially in adults: doctor shopping, illegal Internet pharmacies, drug theft, prescription forgery, or illicit prescriptions by physicians.[150] These latter methods are particularly high in people with recent nonmedical use associated with true abuse or dependence on opioids. It should be noted that illegal Internet pharmacies sell prescription drugs of abuse at prices similar to those found on the street.

The prevalence of illicit drug use self-reported by middle and high school students in New Mexico is among the highest in the nation—and has been climbing (see Table D.3 below for high school rates) based on the national Youth Risk Behavior Survey[151] and its N.M. counterpart, the Youth Risk and Resiliency Survey.[152] These surveys are administered in schools and underestimate youth drug use rates nominally because of denial and/or stigma, because addicted youth have high rates of truancy and may not be present on the day of the survey and also have relatively high rates of dropout. Factors that were associated with a lower risk of alcohol or other drug or use on the N.M. Youth Risk and Resiliency Survey were caring and supportive relationships in the family, positive peer influence, high expectations in the community, caring and supportive relationships in the school, and behavioral boundaries in the school and involvement in school activities (all characteristics demonstrated in studies on prevention to reduce drug use in youth).[153]

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[148] Substance Abuse and Mental Health Services Administration. *Results from the 2009 National Survey on Drug Use and Health: Vol. I. Summary of National Findings*. NSDUH Series H-38A, HHS Publication No. (SMA) 10-4856. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2010.

[149] Manchikanti L. National drug control policy and prescription drug abuse: facts and fallacies. *Pain Physician.* 2007;10:399–424.

[150] Ibid.

[151] Eaton DK, Kann L, Kinchen S, et al. Youth risk behavior surveillance—United States, 2009. *MMWR Surveill Summ.* 2010(June 4);59(SS-5).

[152] New Mexico Department of Health. *New Mexico Substance Abuse Epidemiology Profile*, 2011. Available at: http://nmhealth.org/ERD/SubstanceAbuse/2a11%20New%20Mexico%20Substance%20Abuse%20Epidemiology%20Profile.pdf. Accessed December 11, 2011.

[153] Ibid.

Table D.3. High School Student Drug Use in the Past 30 Days or Ever (2009)

	Current Use (past 30 days)			Ever Use		
Drug	**U.S. (%)**	**N.M. (%)**	**State Rank**	**U.S. (%)**	**N.M. (%)**	**State Rank**
Marijuana	20.8	28.0	1	36.8	49.7	1
Prescription opioids misuse to get high	NA	14.3	NA	NA	NA	NA
Heroin	NA	3.2	NA	2.5	4.7	4
Ecstasy	NA	NA	NA	6.7	14.1	1
Cocaine	2.8	5.6	1	6.4	12.8	1
Methamphetamine	NA	3.9	NA	4.1	6.3	3

Note: NA = data not available for 2009.
Source: Youth Resiliency and Risk Survey (New Mexico) and Youth Resiliency and Behavior Survey (United States).

APPENDIX E
REDUCING THE SUPPLY OF AND PREVENTING OVERDOSE DEATHS FROM PRESCRIPTION OPIOIDS

New Mexico leads the nation with its rate of unintentional deaths due to overdoses of prescription drugs. Deaths attributed to opioid pain medications exceed those due to heroin. The rate of deaths from pain medications in New Mexico more than tripled from 2000 to 2009.[154]

Provider Education

The legislative House Memorial 77 Prescription Drug Abuse and Overdose Task Force has recommended that all potential opioid pain medicine prescribers undergo mandatory education regarding noncancer pain management that would likely include safe opioid use and prescribing. Several surveys have demonstrated that many physicians are poorly educated with respect to the proper use and appropriate prescribing of opioids, methods of diversion by patients, and pain management in general.[155,156,157] Provider education has been shown by research to be effective in reducing the misuse of prescribed opioids,[158] and it should also prepare practitioners to conduct an adequate informed consent to prescribe opioids. Of course, the greater deficit impacting prescription drug abuse and misuse is the lack of patient education.[159]

Patient and Parent/Guardian Education

Nothing will guarantee the education of the patient about opioids by the practitioner more than a requirement for informed consent in which the risks, benefits, and alternatives of prescription opioid use are discussed and documented. This will help patients and parents or guardians of patients to become more responsible for the use, storage, and disposal of

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[154] New Mexico Department of Health. *New Mexico Substance Abuse Epidemiology Profile*, 2011. Available at: http://nmhealth.org/ERD/SubstanceAbuse/2011%20New%20Mexico%20Substance%20Abuse%20Epidemiology%20Profile.pdf. Accessed December 11, 2011.

[155] Bollinger LC, Bush C, Califano JA, et al. *Under the Counter. The Diversion and Abuse of Controlled Prescription Drugs in the U.S. National Center on Addiction and Substance Abuse at Columbia University (CASA)*, July 2005.

[156] Bhamb B, Brown D, Hariharan J, Anderson J, Balousek S, Fleming MF. Survey of select practice behaviors by primary care physicians on the use of opioids for chronic pain. *Curr Med Res Opin.* 2006;22:1859–1865.

[157] Manchikanti L. National drug control policy and prescription drug abuse: facts and fallacies. *Pain Physician.* 2007;10:399–424.

[158] Marinopoulos SS, Dorman T, Ratanawongsa N, et al. *Effectiveness of Continuing Medical Education*. Evidence Report/Technology Assessment No. 149. (Prepared by the Johns Hopkins Evidence-Based Practice Center, under Contract No. 290-020018.) AHRQ Publication No. 07-E006. Rockville, MD: Agency for Healthcare Research and Quality, January 2007.

[159] Manchikanti L. National drug control policy and prescription drug abuse: facts and fallacies. *Pain Physician.* 2007;10:399–424.

opioid medications. This will have a high impact considering that access to unused portions of leftover medications has been reported as the greatest source for diversion among youth[160] and adults.[161] Informed consent for opioid medications is currently a statute in 13 states.[162] The Federation of State Medical Boards of the United States created a "model policy for the use of controlled substances for the treatment of pain" in 2004, and one of its key recommendations was for the prescriber of controlled substances for the management of pain to obtain informed consent.[163]

Prescribing Limits

Restricting the amount of opioid medication prescribed to those without cancer or chronic pain diagnoses makes good sense, not just because it may limit the amount that could be abused or misused by others or the patient but also in light of new findings that the dose of prescribed opioid for acute or chronic pain is directly related to the risk of fatal overdose.[164,165] Another recent study demonstrated that two-thirds of postoperative patients had significant amounts of leftover medications after recovering, and 91% of those patients kept the medication at home without disposing of it.[166] The authors conclude that postoperative narcotics are often overprescribed and patients retain the majority of leftover medication.

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[160] Inciardi JA, Surratt HL, Kurtz SP, Cicero TJ. Mechanisms of prescription drug diversion among drug-involved club- and street-based populations. *Pain Med.* 2007;8(2):171–183.

[161] Substance Abuse and Mental Health Services Administration. *Results from the 2009 National Survey on Drug Use and Health: Vol. I. Summary of National Findings*. NSDUH Series H-38A, HHS Publication No. (SMA) 10-4856. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2010.

[162] Medscape. *State-by-State Opioid Prescribing Policies*. Available at: http://www.medscape.com/resource/opioid/opioid-policies. Accessed December 27, 2011.

[163] Federation of State Medical Boards of the United States. *Model Policy for the Use of Controlled Substances for the Treatment of Pain*, 2004. Available at: http://www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf. Accessed December 27, 2011.

[164] Bohnert ASB, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA.* 2011;305(13):1315–1321.

[165] Moore PA, Nahouraii HS, Zovko JG, Wisniewski SR. Dental therapeutic practice patterns in the U.S. II. Analgesics, corticosteroids, and antibiotics. *Gen Dent.* 2006;54(3):201–207.

[166] Bates C, Laciak R, Southwick A, Bishoff J. Overprescription of postoperative narcotics: a look at postoperative pain medication delivery, consumption and disposal in a urological practice. *J Urol.* 2011;185:551–555.

Currently 10 states have set opioid prescribing limits at a 30- to 34-day supply, but none are more stringent.[167] Recently, Centers for Disease Control and Prevention Director Dr. Thomas Frieden suggested that opioid prescriptions be limited to a three-day supply when not being used for cancer or chronic pain.[168]

The overprescribing of opioids by dentists has become an area of particular concern; dentists are second only to family practitioners in the percentage of immediate-acting opioids (e.g., Vicodin®, Percocet®) prescribed, amounting to 12% of all opioid prescriptions.[169,170] Dentists are the leading prescribers of opioid medications to those aged 10–19 years, accounting for 31% of opioid prescriptions in that group.[171] Moreover, on average, dentists prescribe 20 pills per opioid prescription.[172]

Despite evidence that nonopioid anti-inflammatory medications are often sufficient to manage postoperative dental pain and have actually been shown to outperform opioids in most clinical trials of dental pain, dentists still often prescribe opioids simply because it is the treatment with which they have the most clinical experience and are most comfortable or because of a patient's fear of dental pain and expectations for an opioid to manage dental pain.[173]

A continuing education article in the *Journal of the American Dental Association* recently stated that good clinical practice would suggest that prescribing quantities expected to last more than a few days actually may be harmful, noting that prolonged severe pain after surgery most often is an indication of poor healing or infection and that an

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[167] Medscape. *State-by-State Opioid Prescribing Policies*. Available at: http://www.medscape.com/resource/opioid/opioid-policies. Accessed December 27, 2011.

[168] Centers for Disease Control and Prevention (CDC). Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. *MMWR.* 2011(November 1);60:1487–1492.

[169] IMS Health. National Prescription Audit Plus™. Year 1998 to 2002, excluding long-term care and mail-order channels, data extracted August 2003.

[170] Rigoni GC. *Drug Utilization for Immediate and Modified Release Opioids in the U.S.* Available at: http://www.fda.gov/OHRMS/DOCKETS/ac/03/slides/3978S1_05. Accessed December 26, 2011.

[171] Volkow N, McClellan TA, Cotto JH, Karithanom M, Weiss SRB. Characteristics of opioid prescriptions in 2009. *JAMA.* 2011;305:1299–1300.

[172] Moore PA, Nahouraii HS, Zovko JG, Wisniewski SR. Dental therapeutic practice patterns in the U.S. II. Analgesics, corticosteroids, and antibiotics. *Gen Dent.* 2006;54(3):201–207.

[173] Golubic S, Morre PA, Katz N, Kenna GA, Hersh EV. *Opioid Prescribing in Dentistry. DentalAegis.com Continuing Education Course and Literature Review.* Available at: http://cde.dentalaegis.com/courses/4516. Accessed December 26, 2011.

immediate visit to the practitioner's office may be a better course of action than continued consumption of pain medications.[174]

The association consequently recommended that nonopioid pain medications should be considered the first line of therapy for the routine management of acute postoperative dental-related pain based on the evidence.[175]

Reducing Prescription Forgery and Tampering

Two methods that can reduce or eliminate tampering and forging of prescriptions of controlled substances are electronic prescribing (e-prescribing) and tamper-resistant or triplicate prescription forms. E-prescribing is currently used by many practitioners in New Mexico for noncontrolled substances. On June 1, 2011, the Drug Enforcement Administration (DEA) passed regulations allowing for controlled substances to be e-prescribed, but it will take at least a year and much encouragement for pharmacies and providers to make the necessary updates to computer systems, and the system then has to be certified by an entity approved by the DEA before use.[176] Tamper-resistant or triplicate prescription forms have been required since the 1980s in many states (not New Mexico) for at least some of the most addictive drugs (e.g., oxycodone) and have been demonstrated to substantially reduce the number of prescriptions written for these drugs.[177] Currently in New Mexico, a large amount of controlled substance diversion can be easily performed with just one stolen prescription pad along with a provider's state and DEA registration numbers and a copy of his or her signature.

Prescription Drug Monitoring Programs

New Mexico is one of 42 states that has a functional Prescription Drug Monitoring Program (PDMP; six others are in the process of creating one),[178] an electronic registry of prescriptions filled for controlled substances that may be accessed by or may automatically send reports to (in some states) prescribers, pharmacies, professional licensing boards, and law enforcement agencies. In New Mexico, the PDMP is under the auspices of the Board of Pharmacy.

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[174] Denisco RD, Kenna GA, O'Neil MG, et al. Prevention of prescription opioid abuse: the role of the dentist. *J Am Dent Assoc.* 2011;142:800–810.

[175] Ibid.

[176] American Pharmacists Association website. *E-prescribing Now Permitted for Controlled Substances*. Available at: http://www.pharmacist.com/AM/Template.cfm?Section=Home2&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=23597. Accessed December 27, 2011.

[177] Paulozzi L. The other epidemic: prescription drug abuse in US. Ten prevention ideas from the states. Presented at the National Conference of State Legislatures "Injury Prevention Through the Life Cycle" meeting, Atlanta, GA, May 14, 2009. Available at: http://www.ncsl.org/portals/1/documents/health/Paulozzi509.pdf. Accessed December 27, 2011.

[178] Alliance of States with Prescription Monitoring Programs. *Status of State Prescription Monitoring Programs Table.* Available at: http://www.pmpalliance.org/pdf/pmpstatustable2011.pdf. Accessed December 26, 2011.

PDMPs have the potential to

- curtail prescription fraud and doctor shopping,
- help prescribers have better information about their patients' medications to inform future prescribing,
- identify pharmacists and prescribers who are diverting medications,
- identify prescribers and clinics where there is potential overprescribing or misprescribing,
- inform public health and law enforcement to identify regions where excessive drug prescribing is occurring that may be at increased risk for consequences such as overdose and drug-related crime where increased public health and enforcement efforts can be targeted.

Not only is preventing doctor shopping important for reducing the diversion of prescription drugs for personal misuse and distribution to others, but it is important for overdose prevention. In a recent article in the *Journal of the American Medical Association*, it was determined that almost one-quarter of overdose victims from prescription medications were doctor shoppers.[179] More recently, the Centers for Disease Control and Prevention estimated that doctor shoppers now account for 40% of prescription opioid overdoses.[180]

Communities often cluster with respect to doctor shopping and other forms of diversion. Knowledge of community prescribing practices obtained from PDMPs through the mapping of questionable prescribing rates (for example, in Massachusetts, as seen in Figure E.1) can help inform the prevention of future prescription drug problems by targeting prescription take-back programs, prescriber outreach and education, promotion of PDMP use, and drug prevention programs.[181]

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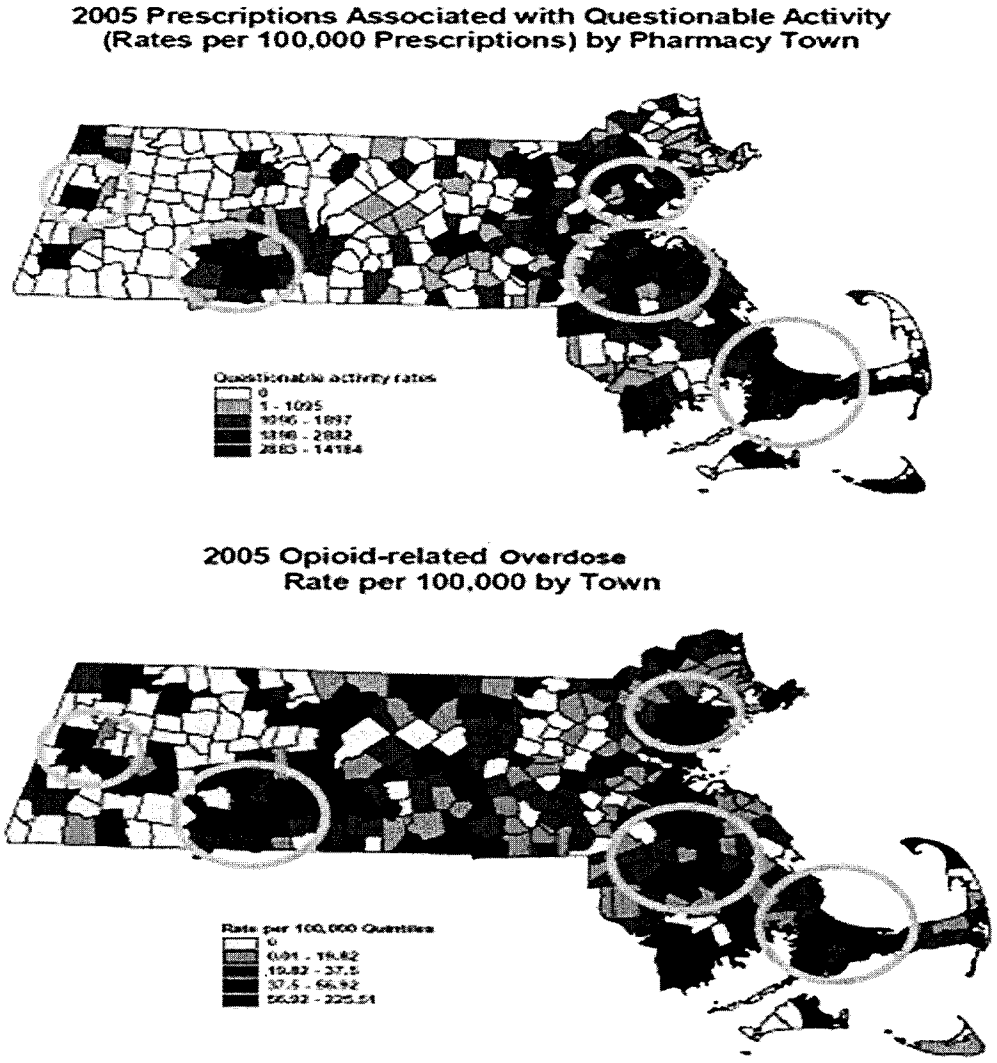
[179] Hall AJ, Logan JE, Toblin RL, et al. Patterns of abuse among unintentional pharmaceutical overdose fatalities. *JAMA.* 2008;300(22):2613–2620.

[180] CDC. CDC grand rounds: prescription drug overdoses—a U.S. epidemic. *MMWR.* 2012(January 13);61(1).

[181] Brandeis University PMP Center of Excellence. *The Prescription Drug Abuse Epidemic and Prevention: How Prescription Monitoring Programs Can Help.* Webinar presented September 23, 2010. Available at: http://www.pmpexcellence.org/sites/all/pdfs/pmp_subst_abuse_prevent_web_09_23_10.pdf. Accessed December 16, 2011.

Figure E.1. Public Health Mapping from the Prescription Drug Monitoring Program for Questionable Prescribing Rates Associated with Overdoses in Massachusetts



Source: Brandeis University PMP Center of Excellence, *The Prescription Drug Abuse Epidemic and Prevention: How Prescription Monitoring Programs Can Help*, webinar presented September 23, 2010. Available at: http://www.pmpexcellence.org/sites/all/pdfs/pmp_subst_abuse_prevent_web_09_23_10.pdf, accessed December 16, 2011.

A national analysis of poison control center data found that in states with PDMPs, calls concerning intentional exposures to opioids (an indicator of opioid abuse or misuse) rose just 1.0% annually, compared with 7.9% in states without PDMPs.[182] A 2010 study

[182] Reifler LM, et al. Reduction over time in RADARS System poison center opioid misuse/abuse rates associated with prescription monitoring programs. American Public Health Association poster session 218163 RADARS® System, November 2010.

compared New York and Pennsylvania, two states similar demographically, both with PDMPs since the 1970s, and found a 60% higher accidental overdose death rate in Pennsylvania, attributed largely to the much greater funding and sophistication of the N.Y. PDMP, as well as the use of tamper-resistant prescription forms in New York.[183] PDMPs have also been well demonstrated through research to be associated with

- reduced overall rates of controlled substance diversion,
- reductions in doctor shopping,
- improved clinically appropriate prescribing,
- reduced prescription drug treatment admissions,
- reduced investigation times and costs for investigations of drug diversion,
- reduced costs of law enforcement and in drug court monitoring,
- improved results in targeting drug prevention efforts.[184]

The ideal PDMP has real-time reporting of prescription information from pharmacies that is immediately available to providers and pharmacists, although Oklahoma is the only state currently to do this. In reality, the majority of PDMPs nationally have delays between 24 hours and seven days for pharmacy reporting despite the existence of real-time reporting to insurers.[185] In New Mexico, reporting is supposed to occur every seven days from pharmacies but does not in at least one-quarter of cases according to the N.M. Board of Pharmacy. Most PDMPs report plans for real-time reporting in the next couple years. The most sophisticated PDMPs have also developed parameters by which they can identify outliers in questionable prescription activity, overprescribing, and misprescribing and have automated systems to flag these situations that allow proactive unsolicited reporting or alerts of these activities to the appropriate providers or agencies. Currently in New Mexico the vast majority of investigations of patients or providers begin retroactively with reports from providers, pharmacies, and the community, and there is no unsolicited identification and reporting of potential diversion by the PDMP. In other words, as opposed to prevention, we are currently getting after-the-fact investigations of

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Available at: http://rmpdc.org/Portals/23/Poster%20PC%20rates%20for%20PMP-LAOs%2015SEP10.pdf. Accessed December 28, 2011.

[183] Paulozzi LJ, Stier DJ. Prescription drug laws, drug overdoses, and drug sales in New York and Pennsylvania. *J Public Health Policy.* 2010;31:422–432.

[184] Brandeis University PMP Center of Excellence. *Briefing on PMP Effectiveness. Prescription Monitoring Programs: An Effective Tool in Curbing the Prescription Drug Abuse Epidemic*, February 2011. Available at: http://www.pmpexcellence.org/sites/all/pdfs/pmp_effectiveness_brief_a_2_24_11.pdf. Accessed December 28, 2011.

[185] Brandeis University PMP Center of Excellence. *The Prescription Drug Abuse Epidemic and Prevention: How Prescription Monitoring Programs Can Help.* Webinar presented September 23, 2010. Available at: http://www.pmpexcellence.org/sites/all/pdfs/pmp_subst_abuse_prevent_web_09_23_10.pdf. Accessed December 16, 2011.

diversion or inappropriate prescribing. There is strong evidence that PDMPs are much more effective when they are proactive instead of reactive.[186]

In 2003 the N.M. Board of Pharmacy received federal funding of $245,650 to develop its PDMP, which began in 2005. Since then the PDMP has received little funding or state financial support, to the point that it now has no full-time-equivalent employee dedicated to running it and no recurring funding. It has just received a $75,000 grant obtained through the N.M. Medical Review Association for software upgrades that will enable it to allow queries to be made by prescribers online, instead of the current system whereby requests are sent via e-mail or fax, with a turnover time of one–four business hours. The current delays reduce its potential effectiveness as a tool in emergency departments and urgent care centers.

Other issues include the fact that not all prescribers are registered with or utilize the PDMP because they are not required to—of 9,300 controlled substance providers in New Mexico, only about 400 are regular users. There is also no online course available to train people to access and understand the PDMP reports. The Brandeis PMP Center of Excellence reports that PDMPs require a minimum of $350,000 annually to efficiently manage a modern maximized PDMP and more in states that are larger and have greater issues with prescription diversion.[187] In order to obtain maximal efficiency and utilization of the N.M. PDMP, the modernizing of the PDMP and its functions will need to be prioritized through substantial funding appropriations.

Prescription Take-Back Programs

Take-back programs exist nationally in many municipalities, but any that involve the disposing of unused controlled drugs (e.g., opioid pain medications and sedatives) always involve the DEA or its designate local law enforcement agency. In 2010, President Obama signed into law the Secure and Responsible Drug Disposal Act, a bill to amend the Controlled Substances Act to provide for take-back disposal of controlled substances in certain instances and for other purposes. Despite this law, the DEA, with other governmental agencies, continues to work out the details of how to implement this in communities. As a result, currently any public disposal of controlled substances has to be done through the DEA or local law enforcement agencies. Another issue that is frequently brought up is who should pay for these programs—with many calls for funding by pharmaceutical companies.

A newer option being utilized in some communities is a permanent drop box for unused prescription drugs usually located at a law enforcement agency, with the advantage of

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[186] Manchikanti L. National drug control policy and prescription drug abuse: facts and fallacies. *Pain Physician.* 2007;10:399–424.

[187] Brandeis University PMP Center of Excellence. *The Prescription Drug Abuse Epidemic and Prevention: How Prescription Monitoring Programs Can Help.* Webinar presented September 23, 2010. Available at: http://www.pmpexcellence.org/sites/all/pdfs/pmp_subst_abuse_prevent_web_09_23_10.pdf. Accessed December 16, 2011.

prescription disposal at any time, reducing the amount of time during which unused portions remain in the home that is incurred while waiting for a take-back program day. The primary obstacle these programs have faced is accessing means for the disposal of the drugs in the drop box.

APPENDIX F
DRUG TREATMENT SERVICES IN NEW MEXICO

Treating addiction is challenging and difficult, with essential components largely unavailable in New Mexico.

Drug abuse and addiction have many complicating dimensions, including high rates of co-occurring mental disorders and associated health problems such as HIV, hepatitis C, and cirrhosis of the liver. Accordingly, and since alcohol and other drug addictions cause disruption to so many aspects of an individual's life, the most effective treatment programs typically incorporate multiple components, each directed to a particular aspect of the illness and its consequences. The severity of addiction and previous efforts to stop using drugs can also influence a treatment approach. Addiction treatment must not only help the individual stop using drugs and maintain a drug-free lifestyle but lead to recovery by helping the individual achieve productive functioning in the family, at work, and in society. Most patients require long-term or repeated episodes of treatment to achieve the ultimate goal of sustained abstinence and recovery of their lives.[188]

Research indicates that most addicted individuals need at least three months of intensive outpatient and/or residential treatment to significantly reduce or stop their drug use and that the best outcomes are associated with a longer duration and higher intensity of treatment.[189] As with other chronic illnesses, relapses can occur and are part of the disease and should signal a need for treatment to be reinstated, adjusted, or intensified. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.[190] This typically needs to be followed by a lifetime commitment to recovery work for sobriety to continue.

Mental illnesses occur frequently with substance use disorders and often go undiagnosed.

Substance use disorders themselves are a mental disorder because of the effect of the drug on the brain and the changes in brain chemistry and structure that are caused by long-term drug use. In addition, co-occurring mental disorders are present at least 60% of the time according to some estimates, and some who work in the addiction treatment field say that this percentage is much higher. Mental disorder diagnoses are often missed. Nevertheless, treatment for co-occurring disorders is paramount. Substance abuse or

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[188] National Institute on Drug Abuse (NIDA). *Principles of Drug Addiction Treatment*. NIH Publication No. 09-4180, August 2009.

[189] Hubbard RL, Craddock SG, Flynn PM, Anderson J, Etheridge RM. Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychol Addict Behav.* 1998;11(4):291–298.

[190] Simpson DD, Brown BS. Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychol Addict Behav.* 1998;11(4):294–307.

misuse may occur in order to relieve the untreated symptoms of a mental disorder. Research indicates that untreated mental disorders are a major cause of relapse.[191]

Comprehensive treatment for substance use disorders in New Mexico is generally unavailable or inaccessible.
The components for treatment that need to be developed or restored—and readily accessed by all people afflicted—to provide comprehensive evidence-based services according to need, severity of disease, and comorbidities are

a. Outpatient counseling
b. Intensive outpatient treatment
c. Halfway houses and sober living quarters
d. Residential treatment ("rehab")
e. Intensive inpatient management
f. Outpatient, residential, and inpatient detoxification services
g. Outpatient medication-assisted treatment and other harm reduction methods
h. Treatment for co-occurring mental disorders
i. Treatment for family members
j. Long-term and lifetime aftercare services, including ongoing substance abuse and mental health treatment and other health services and ancillary services that include employment, vocational, housing (including transitional), education, legal, health insurance, and peer-based services.[192]

Residential treatment ("rehab") is not available to most New Mexicans.
An important and dismaying finding for the Task Force was that all major New Mexican insurers and Medicaid are no longer providing benefits for residential treatment for substance use disorders, despite this service being an essential component in the continuum of addiction treatment and its coverage when necessary supported by the provisions in the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the state Alcohol Dependency Act (discussed below and in Appendix G).

Studies of different treatment approaches have found that residential treatment is effective and usually essential for individuals with a long history of addictive behavior, severe addictions, or criminal activity and anytime when other less intensive approaches have been ineffective.[193] Additionally, those with severe co-occurring mental disorders, medical complications of their addiction, polysubstance abuse, and intravenous drug use

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[191] NIDA. *Principles of Drug Addiction Treatment*. NIH Publication No. 09-4180, August 2009.

[192] Ibid.

[193] U.S. Department of Health and Human Services. *NIDA InfoFacts: Treatment Approaches for Drug Addiction*, August 2007. Available at: http://www.nida.nih.gov/infofacts/treatmeth.html. Accessed December 15, 2011.

typically require the structure, intensity, and change of environment that residential treatment affords, and sometimes long-term, to achieve and maintain sobriety.[194]

Residential treatment resources in New Mexico are limited.
Access to residential treatment in New Mexico is difficult not only because insurance generally no longer pays for it but because of the paucity of residential treatment beds in New Mexico. Many people who are able to undergo residential treatment often incur egregious out-of-pocket costs to go outside of New Mexico for these services.

In the 2009 National Survey of Substance Abuse Treatment Services, a survey done annually to determine the number of people in substance use disorder treatment on a single day, New Mexico had 4% of 15,315 clients in substance abuse treatment on March 30, 2009, in some type of residential treatment. These numbers include several treatment centers that have closed since the survey and many sober living and halfway houses that provide anything from just supervision and sobriety requirements to low-intensity residential treatment but not "rehab." The majority of others were in either "regular" outpatient treatment (61.9%), intensive outpatient treatment (11%), opioid replacement therapy programs for methadone maintenance (16.9%), or outpatient detoxification (5%) programs.[195]

Most beds for detoxification, residential, and intensive inpatient care are provided through federal, state, and local government services in New Mexico. Although it is beyond the scope of this report to provide a complete list of private and public residential and inpatient facilities in New Mexico, the largest providers in the state are the Veterans Administration, the Department of Health (DOH), and the N.M. Corrections Department. Private residential facilities in New Mexico are exceedingly scarce and have limited capacities.

The "hub" of DOH treatment is Turquoise Lodge in Albuquerque, which provides 34 beds for detoxification and intensive inpatient management services, prioritizing patients who are pregnant, those who are intravenous drug abusers, and those with complicating medical and mental disorders. Turquoise Lodge provides detoxification and medical stabilization but not residential treatment. Two other DOH facilities are Roswell Rehabilitation and Yucca Lodge, usually with a census of 5–10 persons with uncomplicated substance use disorders but often plagued by a lack of staffing. There is also the Metropolitan Assessment and Treatment Services facility in Albuquerque, which is only for detoxification. Notably, there are no facilities in Albuquerque for detoxification or treatment for those younger than 18 years old. In fact, there are no state government facilities that cater primarily to children with substance use disorders.

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[194] NIDA. *Principles of Drug Addiction Treatment*. NIH Publication No. 09-4180, August 2009.

[195] Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. *National Survey of Substance Abuse Treatment Services, New Mexico*, 2009. Available at: http://www.dasis.samhsa.gov/webt/state_data/NM09.pdf. Accessed December 15, 2011.

The Healthcare for the Homeless residential treatment facilities closed in 2011 due to expiration of grant funding. Also in 2011 Medicaid halted funding for the only residential treatment facility for pregnant women, Casita de Milagros. The N.M. Corrections Department has its recovery academies for men and women parolees, which have had a significant reduction in the number of beds due to recent funding cuts.

Taken together with the National Survey of Substance Abuse Treatment Services statistics and the lack of residential facilities, the Task Force estimates that <1% of people treated daily in New Mexico for substance use disorders are in residential treatment programs historically recognized as "rehab."

Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and, for some, can pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence and recovery. Thus, patients should be encouraged to continue drug treatment following detoxification.[196] This can include self-help and peer support groups such as Alcoholics Anonymous and Narcotics Anonymous, although this alone for aftercare is often not enough. Based on information provided by Task Force members and advisers, much of what is accomplished in N.M. treatment centers is detox and stabilization alone, without further treatment, often because of a lack of insurance authorization, no insurance coverage, and/or the treatment being unaffordable. Recommendations for further treatment are always made, but relatively few people gain access to the level of further treatment that is recommended.

Treatment parity for substance use disorders is needed.
Two laws currently have the potential to affect treatment parity between substance use disorders and other medical disorders: N.M. Statute §59A-23-6, Alcohol Dependency Coverage,[197] and the 2008 federal MHPAEA, sponsored by Senators Pete Domenici and Paul Wellstone.[198]

Alcohol Dependency Coverage is not being enforced, and the applicability of MHPAEA to the broad spectrum of treatments for mental illness and substance abuse disorders is disputed by insurance companies, resulting in denial of payments for needed comprehensive services.

The parity issue is described and discussed in Appendix G.

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[196] NIDA. *Principles of Drug Addiction Treatment.* NIH Publication No. 09-4180, August 2009.

[197] Justia US Law.com. Available at: http://law.justia.com/codes/new-mexico/2006/nmrc/jd_59a-23-6-14e19.html. Accessed December 15, 2011.

[198] Wellstone P, Domenici P. Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A. §1185a(a)(3)(A)(ii)(2009).

APPENDIX G
PARITY FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

A contentious issue in New Mexico has been the refusal of insurance plans to cover major elements of mental health and substance use disorder treatment that are broadly deemed as essential components in the continuum of care. (See Appendix F.) Among these are residential treatment of sufficient duration and step-down services, both viewed by experts in the field to be essential in the treatment of some patients. Proponents argue that compared with benefits for medical and surgical services, benefits for mental health services are being shortchanged. This is the issue of parity, and it has direct bearing on persons needing treatment for substance use diagnoses.

Two laws applicable in New Mexico have the potential to affect treatment parity: the N.M. Statute §59A-23-6, Alcohol Dependency Coverage,[199] and the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), sponsored by Senators Pete Domenici and Paul Wellstone.

Neither law is being enforced in New Mexico.

N.M. Statute §59A-23-6, Alcohol Dependency Coverage
This is a partial parity law that states:

> Each insurer that delivers or issues for delivery in [New Mexico] a group health insurance policy shall offer and make available benefits for the necessary care and treatment of alcohol dependency. Such benefits shall: (1) be subject to annual deductibles and coinsurance consistent with those imposed on other benefits within the same policy; (2) provide no less than thirty days necessary care and treatment in an alcohol dependency treatment center and thirty outpatient visits for alcohol dependency treatment; and (3) be offered for benefit periods of no more than one year and may be limited to a lifetime maximum of no less than two benefit periods. . . .
>
> . . . alcohol dependency treatment center: means a facility that provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a physician or meeting the quality standards of the Behavioral Health Services Division of the Human Services Department.

When asked about any knowledge of this statute, a high-level official from the Public Regulation Commission admitted to not being familiar with this law. No enforcement of this statute is known to exist currently.

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[199] Justia US Law.com. Available at: http://law.justia.com/codes/new-mexico/2006/nmrc/jd_59a-23-6-14e19.html. Accessed December 15, 2011.

Mental Health Parity and Addiction Equity Act of 2008

The Domenici/Wellstone law, MHPAEA, provides participants who already have benefits for mental health and substance use disorders (MH/SUD) with parity in limitations comparable to their medical/surgical coverage. MHPAEA may apply to large-group self-funded health plans and large-group fully insured health plans. It does not apply to individual and small-group plans (2–50 participants). Also, MHPAEA does not require large-group health plans and their health insurance issuers to include MH/SUD benefits in their benefits package if not already present.

MHPAEA states that a group health plan may not impose financial requirements (e.g., deductibles, copayments, and coinsurance) and annual or lifetime treatment or dollar limits (e.g., number of visits, maximum benefit amounts) on MH/SUD benefits that are less favorable or more restrictive than those imposed on medical/surgical benefits. If a group allows out-of-network medical/surgical benefits, it must do the same for MH/SUD benefits. Standards for medical necessity determinations must also be the same (e.g., preauthorizations for services should not be required for outpatient MH/SUD services if they are not required for outpatient medical/surgical services).[200] A provision of the law is that the health plans must pay for a similar range and scope of treatments for MH/SUD as compared with medical/surgical conditions.[201]

Insurance plans in New Mexico are not covering many essential and common MH/SUD treatments despite the MHPAEA, including residential treatment, providing the rationale that certain MH/SUD treatments have no "medical analogy," meaning that these treatments are not the same or are not comparable to any other medical/surgical treatment. Some plans have even come out stating that they have no legal obligation to pay for a similar range and scope of services for MH/SUD treatments based on their interpretation of the MHPAEA.[202]

The national Parity Implementation Coalition, comprising prominent organizations,[203] has been formed to help legally interpret and advocate for MHPAEA implementation. The coalition hired the legal firm Patton Boggs from Washington, DC, for interpretation of the law and for legal advice regarding how to advocate for implementation. In particular, Patton Boggs has argued that the MHPAEA requires large health plans to provide benefits for residential treatment and many other lower levels of care (e.g.,

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[200] Wellstone P, Domenici P. Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A. §1185a(a)(3)(A)(ii)(2009).

[201] Mental Health Parity Watch—Parity Implementation Coalition. *Frequently Asked Questions and Answers About MHPAEA Compliance*, November 2011. Available at: http://www.psych.org/Departments/HSF/Parity/Compliance-FAQs.aspx. Accessed December 15, 2011.

[202] Ibid.

[203] American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, Betty Ford Center, Faces and Voices of Recovery, Hazelden, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Council for Behavioral Healthcare, and Watershed Addiction Treatment Systems.

intensive outpatient treatment) and diagnostic services (e.g., psychological testing) that are presently routinely denied for coverage.[204] Without further federal guidance, which has been anticipated from the Obama administration, this interpretation will need to be upheld through legal action.

The Parity Implementation Coalition has filed about 150 complaints about possible violations (of the MHPAEA), according to Dr. Henry Harbin, a psychiatrist and adviser to the group. Some cases involve the denial of residential treatment for substance abuse or mental illnesses by plans offered by companies like Wal-Mart and Coca-Cola Bottling.[205] The first major case utilizing a California State parity law similar to the MHPAEA played out in court and was won when the U.S. Court of Appeals for the Ninth Circuit ruled in August 2011 that insurers in California must pay for residential treatment for eating disorders and other serious mental illnesses under the state's mental health parity law.[206]

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[204] Mental Health Parity Watch—Parity Implementation Coalition. *Frequently Asked Questions and Answers About MHPAEA Compliance*, November 2011. Available at: http://www.psych.org/Departments/HSF/Parity/Compliance-FAQs.aspx. Accessed December 15, 2011.

[205] Eating disorders a new front in insurance front. *New York Times*, October 14, 2011. Available at: http://www.nytimes.com/2011/10/14/business/ruling-offers-hope-to-eating-disorder-sufferers.html?_r=1&nl=todaysheadlines&emc=tha23. Accessed December 11, 2011.

[206] Ibid.

APPENDIX H
LEGAL RIGHT TO ADDICTION TREATMENT IN PRISON

According to Dr. Nora Volkow, director of the National Institute on Drug Abuse, and coauthors, "[A]ddiction remains a stigmatized disease not often regarded by the criminal justice system as a medical condition; as a consequence, treatment is not constitutionally guaranteed as is the treatment of other medical conditions."[207] Despite extensive research providing incontrovertible evidence that addiction is a medical disorder of the brain with a strong genetic component, there continues to be a disconnect between what is known and the treatment of addiction in the criminal justice system. As a consequence, about 80% of prisoners who could benefit from substance use disorder treatment do not receive it.[208]

Even though federal, state, and local governments are legally required to provide health care to inmates, there has historically been a debate about whether prisons and jails are required to provide treatment for substance use disorders.[209] Despite numerous court battles all the way to the Supreme Court, the only consensus seems to be that addiction treatment for incarcerated offenders is mandated only when there could be acute and life-threatening consequences of nontreatment.[210,211] However, a 2009 Human Rights Watch publication argues that recent advances in our understanding of addiction obligate us to revisit the issue of addiction as a medical illness that prisons are legally mandated to treat.[212] Moreover, a recent legal opinion by the Legal Action Center strongly asserts that denying addiction treatment to prison inmates, including medication-assisted treatment, violates the Americans with Disabilities Act and the Rehabilitation Act and risks violating the U.S. Constitution's Eighth Amendment prohibition on cruel and unusual punishment.[213]

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[207] Chandler RK, Fletcher BW, Volkow ND. Treating drug abuse and addiction in the criminal justice system. *JAMA.* 2009;301:183–190.

[208] Mumola CJ, Karberg JC. *Drug Use and Dependence, State and Federal Prisoners, 2004.* Department of Justice Publication NCJ 213530. Washington, DC: Office of Justice Programs, Bureau of Justice Statistics, 2006.

[209] McLearen AM, Ryba NL. Identifying severely mentally ill inmates: can small jails comply with detection standards? *J Offender Rehabil.* 2003;37(1):25–40.

[210] Cohen F. Captives' legal right to mental health care. *Law Psychol Rev.* 1993;17(Spring):1–39.

[211] Peter RH, Steinberg ML. Substance abuse treatment services in US prisons. In: Shewan D, Davies JB, eds. *Drug Use and Prisons: An International Perspective.* Amsterdam: Harwood Academic Publishers, 2000:89–116.

[212] Human Rights Watch. *Barred from Treatment: Punishment of Drug Users in New York State Prisons*, 2009. Available at: http://www.hrw.org/reports/2009/03/23/barred-treatment. Accessed December 11, 2011.

[213] Legal Action Center. *Legality of Denying Access to Medication Assisted Treatment in the Criminal Justice System*, December 1, 2011. Available at: http://www.lac.org/doc_library/lac/publications/MAT_Report_FINAL_12-1-2011.pdf. Accessed December 11, 2011.

Unfortunately, to have a sea change improvement in addiction treatment in the corrections system will likely require more legal action. Staff at the National Center on Addiction and Substance Abuse at Columbia University summarized this sad state of affairs:

> The courts have been one of the most successful catalysts of criminal justice reform in the U.S. The convergence of new findings in addiction science with the burgeoning inmates' rights movement has created an unprecedented opportunity to mobilize judicial power to intervene on behalf of inmates suffering from substance use disorders. Litigation or the threat of litigation can provide correctional authorities with a basis for demanding more resources and stimulate innovative ideas about treatment alternatives to incarceration that have proven effective even among chronic felons.[214]

[214] National Center on Addiction and Substance Abuse (CASA) at Columbia University, *Behind Bars II: Substance Abuse and America Prison Populations*. New York: CASA, February 2010. Available at http://www.scribd.com/doc/56446042/CASA-575-report2010behindbars2, accessed June 5, 2012.

NOTE AND DISCLAIMER

The content and recommendations of this report were assembled from drafts submitted by Drug Policy Task Force members and are in final form.

This version was copyedited, June 2012.

Recommendations are based on consensus developed at Task Force meetings.

The views expressed in this document are those of the Task Force and do not necessarily represent the Robert Wood Johnson Foundation Center for Health Policy, the University of New Mexico, or collaborating organizations or funders.

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This report and minutes of the Task Force meeting are available at
http://healthpolicy.unm.edu/about/Initiatives/SM18

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