MINUTES
of the
FOURTH MEETING
of the
COURTS, CORRECTIONS AND JUSTICE COMMITTEE

October 27-28, 2016
Room 307, State Capitol
Santa Fe

The fourth meeting of the Courts, Corrections and Justice Committee (CCJ) was a joint meeting with the Legislative Health and Human Services Committee (LHHS), which was called to order by Senator Gerald Ortiz y Pino, chair, LHHS, on October 27, 2016 at 9:28 a.m. in Room 307 of the State Capitol in Santa Fe.

Present
Sen. Richard C. Martinez, Co-Chair
Rep. Eliseo Lee Alcon
Rep. Gail Chasey
Sen. Linda M. Lopez
Rep. Georgene Louis (10/28)
Rep. Antonio Maestas
Sen. Cisco McSorley

Absent
Rep. Zachary J. Cook, Co-Chair
Sen. Joseph Cervantes
Rep. Jim Dines
Rep. Rick Little
Rep. Andy Nunez
Rep. William "Bill" R. Rehm
Sen. Sander Rue
Sen. Lisa Torraco

Advisory Members
Sen. Craig W. Brandt
Sen. Bill B. O'Neill
Sen. John Pinto
Rep. Patricio Ruiloba
Sen. Mimi Stewart
Rep. Christine Trujillo (10/27)

Sen. Jacob R. Candelaria
Rep. Brian Egolf
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Rep. Paul A. Pacheco
Sen. William H. Payne
Rep. Patricia Roybal Caballero
Sen. Michael S. Sanchez
Sen. Peter Wirth

Guest Legislator
Rep. Dennis J. Roch (10/28)

(Attendance dates are noted for members not present for the entire meeting.)

Staff
Monica Ewing, Staff Attorney, Legislative Council Service (LCS)
Celia Ludi, Staff Attorney, LCS
Peter Kovnat, Staff Attorney, LCS
Diego Jimenez, Research Assistant, LCS

Guests
The guest list is in the meeting file.

Handouts
Handouts and other written testimony are in the meeting file and are located on the New Mexico Legislature website (www.nmlegis.gov). Please see handouts for more presentation details.

Thursday, October 27

Welcome and Introductions
Legislators from the LHHS and the CCJ and staff introduced themselves.

Corrections Health Care: Report of the Corrections Health Care Task Force; Federal Prison Rape Elimination Act of 2013 (PREA)
Maria Martinez Sanchez, staff attorney, American Civil Liberties Union-New Mexico (ACLU-NM), told the committees that the ACLU-NM receives 70 complaints from New Mexico prisoners each month and that 10% to 20% of those complaints are regarding failures of the prison health system. Ms. Martinez Sanchez said the complaints include neglect in diabetes, cancer and hepatitis C care; untreated broken bones, hernias and kidney stones; dental neglect; and psychiatric medications not being provided.

Ms. Martinez Sanchez stated that she sees a pattern of neglect that violates the Eighth Amendment to the United States Constitution's prohibition on cruel and unusual punishment. She said that the State of New Mexico jails a lot of people but then fails to care for them. In addition, Ms. Martinez Sanchez said that preventative care would save the state money and that the state is opening itself up to liability in its substandard medical care of inmates.

To close, Ms. Martinez Sanchez said that the ACLU-NM wants to be included in the task force created pursuant to Senate Memorial 132 (2015). Without a prisoner health advocate, she said, the task force would be incomplete.

Jody Neal-Post, attorney at law, discussed the difficulties some of her clients faced in receiving health care while incarcerated. There were challenges with missed appointments, shackling on limbs despite a medical prohibition and failure to finalize recommended medical parole by the Parole Board. Ms. Neal-Post highlighted the fact that despite attempts by the Corrections Department (NMCD) to secure an inmate's medical parole, the Parole Board would

not grant it. She urged the committees and the task force to change the statutory guidelines for parole boards to ameliorate the problem. Ms. Neal-Post said that the state faces unnecessary exposure to liability based on a failure to provide adequate health care to inmates. She said that when inmate health care is more compassionate and humane, it is also cheaper. She said that she wants to see the task force continue and to have inmates participate on the task force, as everyone wants to be part of their own health care.

Matthew Coyte, Coyte Law, P.C., said that he gets about 20 inmate requests for help per week. He said that from a legal standpoint, these are difficult cases to win because there is a required showing of deliberate indifference of the prison as a health care provider. As long as the prison doctor gives the inmate Ibuprofen or Tylenol, the prison is immunized from lawsuits. Of course, cases can still be filed alleging negligence and malpractice against the doctor, but those cases are almost never filed. He said that he understands that the prisons are in a difficult situation, too. A lack of funding has led to understaffing, which only aggravates the situation.

Mr. Coyte said that the new contract for inmate health care prioritizes fiscal responsibility over medical care, as evidenced by there being limited medical oversight over the contract, but significant financial oversight.

Wendy Price, Psy.D., chief, Behavioral Health Bureau, NMCD, told the committees that she led the task force created pursuant to Senate Memorial 132 and went over the various issues discussed by the task force. The top maladies faced by inmates are hepatitis C, HIV and psychological disorders. She said that there are challenges to care, but that inmates are educated as to how they can request treatment.

Jillian Shane, PREA coordinator, NMCD, stated that 11 adult prisons and two community jails in the state all passed the PREA audit.

Steve Jenison, M.D., said that he oversaw HIV treatment in all New Mexico prisons, which meant visiting each facility at least every three months and having a state public health nurse involved to ensure continuity of care for each patient.

Questions from members of the committees and the ensuing discussion focused on hepatitis C treatment, including Section 340B of the federal Public Health Service Act discounted drug pricing eligibility; medical oversight at the NMCD; the task force; and the new contract between the NMCD and Centurion.

Members and presenters agreed that hepatitis C treatment under the University of New Mexico's (UNM's) Project ECHO program has been very effective. In the last year, there were 65 to 70 inmates treated for hepatitis C, which represents a big jump. While this may seem like a low number, with 58% of the state's inmates having hepatitis C, most states only treat about 1% of their inmates with hepatitis C. The biggest hurdle to treatment is the high cost, which is $90,000 to deliver a 12-week course of hepatitis C treatment to one person. Under the deeply

discounted pharmaceutical pricing available pursuant to Section 340B, the cost would be half that.

Alex Sanchez, deputy secretary, NMCD, said that 340B eligibility has a number of requirements, and the state fails to qualify, but it is written into the contract with Centurion that vendors will still seek it. A member mentioned a federally funded health provider in Albuquerque that would qualify for 340B pricing and said that the NMCD should partner with the provider. According to information received by another legislator, 340B pricing was actually discontinued at the recommendation of an NMCD medical director who no longer works for the state. That medical director sought pharmaceutical savings through the NMCD's contract with Corizon Correctional Healthcare.

A legislator asked how the NMCD decides who are among the 1% of inmates who are treated for hepatitis C. Deputy Secretary Sanchez said that the NMCD has a process for assessing whether an inmate would compromise treatment with intravenous needle usage or if the inmate has another condition that would have an impact on the viability of the treatment. When selecting an inmate for treatment, the NMCD contacts Project ECHO. Deputy Secretary Sanchez said that, though not all patients receive this expensive course of medicine, all patients receive, at a minimum, the care that an indigent patient would receive on the outside. A legislator said that Project ECHO is a "game changer", but the state cannot expect the same level of delivery if it is underfunded.

Regarding medical oversight of those incarcerated at NMCD facilities, Deputy Secretary Sanchez said that there is a medical director, Dr. Boynton, and Health Services Director Angela Martinez, who is in change of the auditing and medical care. Upon questioning, Deputy Secretary Sanchez stated that Dr. Boynton is not employed by the NMCD but is in fact the Centurion medical director. There is no medical director employed by the NMCD. Some legislators expressed concern that the health services director for the NMCD is not a medical professional as has occurred in the past.

Discussing the Corrections Health Care Task Force, members asked if the right people were on the task force and if there were an opportunity for members and nonmembers to be heard. Legislators voiced concerns when Dr. Price explained that, though it was being finalized for awhile, a draft report of the task force's findings was only sent out the day before for members of the task force to review. A legislator said that it is difficult to assess the task force's work when information is provided at the last minute.

Ms. Martinez Sanchez said that the ACLU-NM got a late invitation to join the task force, and after being assured that the director of the ACLU-NM could call in to participate in the meeting, the videoconferencing technology was a consistent obstacle to his ability to join in. Deputy Secretary Sanchez alleged that the director of the ACLU-NM attended four out of the five task force meetings.

In response to a question, Deputy Secretary Sanchez said that among the task force's recommendations, there is no recommendation that the task force continue. Legislators requested copies of those recommendations, that the task force continue its work and that it include more advocacy groups. Members said that a reason for the task force to continue is that it provides ongoing progress reports to the legislature.

Regarding the contract with Centurion, which went into effect on June 1, 2016, Deputy Secretary Sanchez said that there are actually two contracts, one for $41 million for health care and one not to exceed $11 million for pharmaceuticals. She said that the company does recruit within the state for staff and that, for the most part, the staff will remain the same. The improvement, she said, will happen in the required performance measures. A live dashboard is the centerpiece of that and is the key to real-time assessment.

Deputy Secretary Sanchez said that the dashboard will provide, on request, a real-time update on inmate information. Deputy Secretary Sanchez said that officers do not enter information into the dashboard; it is the vendor's responsibility. Members of the committees expressed concern that requested care by the inmates is not being provided and asked that the dashboard reflect that in an effort to improve care.

To close, a legislator suggested that the NMCD seek offset funding from the Indian Health Service to the extent that the NMCD provides health care to Native American inmates.

Corrections Medicaid Enrollment and Suspension

Kari Armijo, deputy director, Medical Assistance Division, Human Services Department (HSD), discussed how the HSD is rolling out its program to ensure that Medicaid-eligible inmates have timely access to post-release health care (see handout). Deputy Director Armijo highlighted the impact of information technology and regulatory changes, the counties and agencies currently participating and the pilot program between the Bernalillo County Metropolitan Detention Center (MDC) and Molina Healthcare.

Deputy Director Armijo said that the HSD is working with more counties than are identified in the handout, but those not mentioned are still a work in progress. She said that there are still some delays with the daily sharing of information, but the process is automated. Another benefit is that over one-half of the inmates are actively engaged in their post-release health care coordination, and this drives down recidivism.

Jerry Roark, director, Adult Prison Division, NMCD, said that the NMCD has started signing up inmates for Medicaid 60 days before their release and have reached a 90% sign-up rate.

Gabriel Nims, special projects coordinator, MDC, said that the MDC accounts for the lion's share of the county budget, some $75 million to $80 million a year, and it is realized how important it is to be fiscally responsible and good custodians of that money.

Mr. Nims said that the MDC used to have a passive enrollment system, according to which the MDC waited until a Medicaid-eligible inmate requested it and even then it would hold the inmate's application for Medicaid until that person's release date. Now, MDC staff is approaching those inmates who qualify, helping them to fill out the application and then sending the applications for processing earlier. In response to a question, Mr. Nims said that inmates can still refuse to enroll, but that is rare. Mr. Nims said that the first 72 hours after release is the most important for recidivism, so any delay in continuity of health care can have an impact.

Currently, the Medicaid enrollment pilot project is ongoing only with Molina Healthcare, one of the four Medicaid managed care organizations (MCOs), but other MCOs are watching closely. In fact, the MDC/Molina Project is generating interest by Seattle-King County officials in the State of Washington.

Mr. Nims closed by discussing a proposed reentry resource center, which would include a rest area if an inmate is released at night. The center would be staffed with case managers to connect newly released inmates to available social services. He said that these efforts improve the system and have a positive financial impact.

Solitary Confinement and Custodial Segregation

Mr. Coyte said that whatever one calls it — administrative segregation, administrative housing, protective custody, solitary confinement — these are a lot of names to explain a deprivation of meaningful human contact, where a person is kept in a room for 23 hours a day on weekdays and 24 hours on weekends. Mr. Coyte said that while solitary confinement is banned in many states and New Mexico has paid out million-dollar judgments to people wrongly held in solitary, the state has not passed laws to stop solitary confinement.

Mr. Coyte highlighted the fact that inmates with a mental health diagnosis are not officially allowed to be in solitary confinement, but they should be in an alternative placement area. Despite that, he said, in New Mexico, those inmates are still being put in solitary confinement.

Stuart Grassian, M.D., appearing via videoconferencing, told members that restricted environmental stimulation is toxic to anyone and that inadequate exposure to stimulation, internal or external, results in stupor. Dr. Grassian discussed the history of solitary confinement, from an innovative criminal justice incarceration technique to significant limitation of its use because it was long ago found not to foster reform and to seriously and detrimentally impact prisoners' mental well-being. In fact, he said, the toxic effect has been known for so long, it is absurd that it is still in use.

Dr. Grassian said the arguments in support of solitary confinement are based on prisoners making rational decisions about how to act to avoid solitary confinement, but this situation rarely plays out where the decisions made by the inmate that resulted in solitary confinement are rationally made. This is especially pernicious in light of the fact that 75% of prison beds are

occupied by people whose initial offense can be tied to mental illness. A member agreed and said that inmates with traumatic brain injury often have diminished impulse control, which could cause the exact behavior that lands a person in solitary confinement.

Dr. Grassian said that inmates with impaired cognitive ability do terribly in solitary confinement. He said that the worst thing for people with posttraumatic stress disorder is to put them in a situation that they cannot control, and that is what solitary confinement is all about.

A legislator asked if inmates in solitary confinement can receive visitors and why the 23 hours of confinement is de rigueur. Mr. Coyte said that visitation rights depend on the facility and on the level of the prisoner. The 23-hour rule, according to Mr. Coyte, comes from a dictum in a legal case where the judge wrote, "Well, at least they should get an hour a day outside". Now, for whatever reason, that has been incorporated into the solitary confinement practice of many prisons and jails.

To illustrate the deleterious effects of solitary confinement, he cited the example of a once-healthy young man who was picked up for traffic tickets, placed in solitary confinement and came out with a severe mental illness. While held in solitary confinement, the young man was kept naked and forced to defecate in a hole in the floor.

A 54-year-old woman had severe postpartum depression in her twenties, according to Mr. Coyte. She later became severely mentally ill after being held by Valencia County in solitary confinement, where she had to sleep near a hole in a damp floor. For posttraumatic stress disorder and other complaints, she was awarded a $1.6 million settlement with Valencia County.

Mr. Coyte described the case of a man who was held in Carlsbad in a tiny cell, naked, where he had to endure lights left on 24 hours a day and sleep by a drain into which he was forced to push his feces, which would later bubble up through the drain. He was kept in cold temperatures, with no water with which to wash. He was never released for exercise. "Why do we do this?", Mr. Coyte asked. There needs to be a law that bans these practices, he stated. In 1998, West Virgina banned solitary confinement for juveniles. Mr. Coyte stated that he is currently suing Curry County for use of solitary confinement on juveniles there.

In response to a question about tests that show the different effects of solitary confinement and additional punishment, i.e., leaving the lights on for 24 hours or removing all furniture or the inmate's clothes from the room or the inmate's clothes, Steve Allen, director of public policy, ACLU-NM, said that most prisons and jails do not collect good data on whom they put in solitary, so no such tests exist. The little data that are collected, Mr. Allen said, are not useful for comparison because each facility collects different information. In the past, house and senate bills were introduced in New Mexico that would have required prisons and jails to collect information on solitary confinement in a uniform way. Those bills did not pass. Colorado, he explained, took a data-driven approach and requires uniform data collection. This has resulted in a drastic decrease in the use of solitary confinement. During their 2017 legislative sessions,

Idaho, Maine and Texas are going to consider laws using a data-driven approach to solitary confinement.

Mr. Allen said that other research has shown that there is no good reason for the use of solitary confinement on minors, the mentally ill or anyone for more than 15 days. He said that Colorado is the national leader in improving techniques for the use of solitary confinement.

Grace Philips, general counsel, New Mexico Association of Counties, said that there are correctional facilities in 27 of the 33 counties in the state and far fewer facilities for juvenile inmates, which means that juvenile offenders are often incarcerated farther from home. She stated that New Mexico has a much higher incarceration rate than do other states. One-third of those incarcerated in county jails are in for failure to comply reasons, including probation violations, parole violations and warrants. Housing of probation violators alone cost counties $35.8 million in fiscal year 2016. County jails also hold many people who live with mental illness. On average, 2,557 inmates a day in New Mexico county jails have a diagnosed serious mental illness.

Ms. Philips said that when the legislature seeks harsher criminal penalties, especially in times of financial hardship, longer sentences mean a bigger cost to the taxpayer. She also said that jails and prisons are de facto mental health hospitals and posited that there are more people in jail taking psychotropic medicine than there are in mental health facilities and more county detention staff than clinicians treating the mentally ill.

To close, Ms. Philips said that in her experience, families do not typically bond out the mentally ill, as those families often use the jail as a safe way to remove a person from the home.

Pablo Sedillo, director, Public Safety Department, Santa Fe County, highlighted the county's efforts to handle the mentally ill. All of the county's public safety officers and first responders have crisis management training and know crisis-intervention techniques. Also, Santa Fe County has two reentry specialists and is looking for a third.

Mr. Sedillo reiterated what Ms. Philips said regarding the families of the mentally ill. He said that the families of those with mental illness are often happy when the mentally ill person is held in a detention center. Mr. Sedillo explained that, nevertheless, jails are not hospitals. While they do their best to care for mentally ill inmates, it is not the same as a hospital setting. County jails do not have trauma areas, for example, as a hospital would.

Michael Ferstl, assistant director of operations, Bernalillo County Youth Services Center, said that he is the former head of the United States Marshals Service for New Mexico, and as such, he is very familiar with the state's correctional facilities. He said that New Mexico has well-run jails and that the solitary confinement lawsuits stem from staff failures and not department policy. He said that as a corrections professional, he sees through a lens of prisoner

days. He warned against taking these lawsuits out of context and said that five lawsuits arising out of 47 million prisoner days is not a high number at all.

Mr. Ferstl said that the Bernalillo County Youth Services Center does not utilize solitary confinement, as that term is defined. In fact, he thinks that the segregation policy his facility uses is worthy of being a national model. Mr. Ferstl said that he is wary of any blanket legislation regarding solitary confinement because he fears that it will hamper the efforts of corrections officers.

When asked about how long juveniles are kept in isolation at the Bernalillo County Youth Services Center, Darren James, case manager, Bernalillo County Youth Services Center, discussed some case studies and said that when inmates relapse, they might be in isolation more than a few weeks.

Mr. Roark said that New Mexico's adult facilities use the American Correctional Association's definition of restrictive housing, which includes 22 hours of cell time a day. He said that despite all efforts to curb it, there will always be illegal activity in prisons, be it trafficking, gambling or something else. That activity will spur outbursts of violence, which will, in turn, require the separation of inmates. A legislator said that perhaps that is the case, but that there is a difference between segregation and segregation with additional punishment.

A large number of beds are going unused at the Department of Health's (DOH's) New Mexico Behavioral Health Institute at Las Vegas (BHI), according to one legislator. Why, the legislator asked, is the DOH turning people away from treatment at the BHI? The legislator requested that the LHHS follow up with testimony from the DOH on the BHI's accessibility for seriously mentally ill New Mexicans.

A legislator said that there will be a bill introduced next session and that it is important that legislators learn from the NMCD and county corrections officials about jail management so that the language in the bill reflects the legislative intent. The legislator wants New Mexico to comply with international standards.

Finally, a legislator said that oversight of probation and parole needs to be taken from the NMCD and given to the judiciary, which is better prepared to provide objective administration.

Public Comment

Diana Crowson discussed her son, who spent almost two years in solitary confinement in Las Cruces. She said that she is aware of an inmate, not her son, who received only an Ibuprofen after suffering a stroke.

Ruth Hoffman, director, Lutheran Advocacy Ministry-New Mexico, read the following statement.

Mr. Chairman and Members of the Committee,
Our denomination, the Evangelical Lutheran Church in America, adopts social statements which are the underpinnings of our advocacy work. The following is a quote from our newest social statement on criminal justice: 'As people of reason, we accept differences in correctional philosophies, but as people of faith we reject dehumanization of the incarcerated through brutalizing means whether legal, psychological, sexual, emotional, racial, cultural, or spiritual.' With this underpinning, we oppose the use of solitary confinement for juveniles and the seriously mentally ill. We also urge that it be restricted for use with the general population of those incarcerated and that the use of solitary confinement be closely monitored and tracked.

Ms. Hoffman said that Mississippi has virtually eliminated solitary confinement, not because of a moral distaste for its use, but because it saves the state a lot of money.

Reverend Holly Beaumont stated that 80% of the job is just "showing up", and she was present to represent 300 faith leaders in support of limiting solitary confinement. (Please see letter provided in the handouts, Item (18), for the week's hearings.)

Leona Stuckey-Abbott spoke against the use of solitary confinement.

Recess

There being no further business before the committees, the meeting recessed at 5:25 p.m.

Friday, October 28

Welcome and Introductions

Senator Ortiz y Pino reconvened the meeting at 8:59 a.m. and the members and staff of both committees introduced themselves. He also mentioned that legislators and staff were invited by Robin Otten to tour supportive housing facilities at Lomas and Second in Albuquerque at 8:00 a.m. on Veterans Day, November 11.

Adverse Childhood Experiences in Juvenile Offenders in New Mexico and What We Can Do About It

Amir Chapel, research scientist, New Mexico Sentencing Commission (NMSC), discussed a newly released report about adverse childhood experiences (ACEs), with a focus on ACEs within the state's juvenile justice population. Mr. Chapel said that the study was undertaken in part to identify ways to target treatment for people who have experienced trauma. The report highlights and analyzes the results of several studies and includes a study of more than 26,000 randomly sampled adults nationwide and a study of 220 juvenile offenders in New Mexico. Mr. Chapel said that the field of ACEs is growing quickly. It started with health outcomes, is now being used with juvenile justice issues and will likely be used to assess a number of things in the near future.

The authors of the report looked at a number of factors or "ACEs". Those factors are emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, parental divorce or separation, family violence or domestic abuse, household substance abuse and household member incarceration. One hundred percent of female inmates and 93% of male inmates in New Mexico facilities surveyed were found to have experienced physical neglect, and 81% of inmates had experienced a diagnosable substance abuse or dependence issue. These were the most common correlates for probation violations. He informed the committees that the final report is available on the NMSC's website.

George Davis, M.D., director of psychiatry, Children, Youth and Families Department (CYFD), stated that the ACE study was "one of the greatest behavioral health studies ever done". He said that ACEs have long-term effects on people's physical, mental and emotional lives, but not every ACE has the same deleterious effect. In fact, ACEs work in concert with one another, and typically, four different ACEs is the number where studies show that they have an impact. Studies show that a person who has experienced four or more ACEs will live 20 years less than if the person had not had any ACEs.

Dr. Davis said that juvenile delinquents are created, not born, but intervention needs to happen early, long before the person commits a crime. ACE intervention has to rewire these children's brains. Dr. Davis said that while not all neglected children end up in trouble, 90% of those in the juvenile justice system in New Mexico experienced ACEs. Early childhood trauma is an attachment disturbance, which is an emotional disruption causing an inability to be calmed by adults. Sports, t'ai chi and any large-muscle activities that are multisensory; vocational skill-building; showing respect; animal therapies, such as equine and dog therapy; and using discharge planning in facilities are all methods that the CYFD employs at its facilities that can be helpful in counteracting the effects of ACEs.

A legislator said that prevention is the first step, and one of the challenges is getting home-visiting services to the right homes. The legislator said that experience shows that the people who sign up for home visiting are rarely the people who need it. There are good results with home visiting, but it is obvious that those who accept it are in families where the parents are more informed and more likely to accept and incorporate constructive criticism.

Dr. Davis said that the difficulty is not identifying those most in need of home visiting but to coerce those families into accepting the visits. This is especially the case where there is a need for ongoing visits. Solutions posed were tying cash assistance or Medicaid to home visits.

A legislator asked whether marijuana legalization might contribute to ACEs. Dr. Davis stated that this would be part of a larger picture. Where there is substance abuse in the home, there may be ACEs.

The discussion focused on lifestyle tips for improving the home life of children in New Mexico. Topics discussed include helping young mothers, providing books and toys to help with

parenting, de-incentivizing divorce, providing cash assistance to single parents and treating substance abuse.

A member said that one way to break the familial incarceration cycle is to prevent recidivism by prohibiting a lack of criminal history to be used as a condition of employment. Another legal solution posed was to tie home visiting to early childhood development efforts so that it can be considered a medical home visit and be covered by Medicaid.

In response to a question about what types of probation violations are leading to incarceration, Mr. Chapel cited a report from a few years ago on what probation violations land people in jail. However, he said, a lack of uniformity in the data collection continues to be an obstacle. There are some uniform rules that are being implemented now that should help in the future.

A member mentioned Uniform Probation Code provisions that are being used in New Mexico and the need to teach parenting skills.

In closing, a legislator warned that, based on ACEs, there will be more women in the criminal justice system as more and more girls are being traumatized.

Sharpening Prescribing Practices for Pain Management

Michael Landen, M.D., state epidemiologist, DOH, told the committees that the prescription monitoring program is critical to sharpening the prescribing of pain medication to more effectively combat pain and not over-prescribe. (Please see handout under Item (20) for details and, on page 8, recommendations.) Dr. Landen cited a study that shows that the mortality rate among middle-aged White Americans is on the rise, in stark contradiction to comparable countries where the rate is going down. He attributed the difference to pain and pain medications. He said that more than one-half of the people who die of a prescription overdose have a prescription for the drug that caused it, but just under one-half do not. More than two-thirds of people who die of opioid overdose are on chronic opioid therapy.

Dr. Landen said that oversight, like that provided by the New Mexico Prescription Monitoring Program (PMP), if used effectively, can prevent overlapping prescriptions. However, there are still 3,000 to 6,000 patients in the state with overlapping prescriptions.

Discussing specific drugs, Dr. Landen said that hydrocodone was rescheduled in 2014, after which overdose deaths dropped precipitously. He also said that New Mexico is a leader in the use of Naloxone, an overdose medication.

Dr. Landen closed by saying that what is being done is not working, but work continues on the problem. For example, the chronic pain survey findings by the Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council will be implemented in 2017.

Joanna Katzman, M.D., M.S.P.H., director, UNM Pain Center; and director, UNM Project ECHO Chronic Pain and Headache Program, said that the UNM Pain Center saw 8,000 patients last year suffering from an array of maladies. She said that most heroin addicts started with prescribed opioids given to them by a friend or relative. An important way to address this and other issues is to train everyone that can prescribe how to and how not to prescribe opioids. Dr. Katzman said the need is to train everyone, not just doctors and osteopaths, but nurse practitioners, physician assistants, etc. Currently, a five-hour training is now required for doctors at all federal clinics.

Demetrius Chapman, M.P.H., M.S.N.; R.N., executive director, Board of Nursing, provided a primer of advanced practice registered nursing. There are four types of advanced practice registered nurses (APRNs), three of which are regulated by the Board of Nursing: C.N.P., C.R.N.A. and C.N.S. Certified nurse-midwives are regulated by the DOH. APRNs in New Mexico have prescriptive authority that does not require physician oversight, while neighboring states have more limits to the prescriptive authority of APRNs. All APRNs are registered nurses with a bachelor's degree in nursing and either a master's degree or doctorate in advanced nursing.

APRNs include:

1. C.N.P.— (certified nurse practitioner), who provides primary care in community and acute-care settings, of whom New Mexico has 1,794;
2. C.R.N.A. — (certified registered nurse anesthetist), who provides anesthesia care or pain management, of whom New Mexico has 425; and
3. C.N.S.— (clinical nurse specialist), who has different training than a C.N.P. in that the C.N.S. is are more specialized in one population, disease process or anatomical system, such as the cardiovascular system, of whom New Mexico has 130.

Mr. Chapman provided an overview of recent federal law impacting the nurses' prescriptive authority and related training and said that the Centers for Disease Control and Prevention guidelines for the prescribing of opioids for chronic pain are a nice synthesis of the current science that is available regarding the prescribing of opioids.

He said that the PMP has been a valuable tool for APRNs in determining treatment for patients with opioid prescriptions. Mr. Chapman discussed Suboxone and said that limited access and high need have resulted in a market on the street for the self-treatment of addiction. He said the limited number of patients that a certified Suboxone prescriber can treat also creates a barrier to care because there are not enough providers to meet the needs of opioid-addicted patients. The limit was 30 and is now 100, but that will still not be enough.

Ben Kesner, executive director, Board of Pharmacy (BOP), introduced Shelley Bagwell, director, PMP, BOP, and Sarah Trujillo, licensing manager, BOP. Ms. Bagwell went through the steps of the PMP. She said the program has been responsible for lowering the number of doctor shoppers. To increase use of the program, doctors and providers are required to have a PMP file.

To better gauge their own work, providers will now be able to stay informed on where they rank in the state and among similar specialists regarding prescribing medications.

Ms. Trujillo told the committees that there are 13 types of prescribing licenses that the BOP issues. She stated in response to a staff request that there are currently 950 custodial drug permits issued to boarding homes statewide.

Ralph McClish, executive director, New Mexico Osteopathic Medical Association, told the committees that the Board of Osteopathic Medicine is currently changing its rules partly to address opioid prescribing. He stated that opioids are physically and mentally addictive and that the public needs to know that. He stressed that patient education is a critical aspect of this discussion that is often ignored. He expressed his support for the use of abuse-deterrent opioids. "We had a small dip in opioid deaths" when there was more public messaging about the dangers of opioid use, he asserted. With less outreach and education, the numbers have again worsened.

Sondra Frank, J.D., executive director, New Mexico Medical Board, told the committees that until now, there has been a structural problem linking the PMP to the appropriate doctor. When someone enters data into the PMP but does not reference the right doctor, the doctor does not receive credit, and then it looks in the system as if the doctor was noncompliant or as if the doctor was not using the system enough or at all. When that happens, the doctor can end up on the high-risk prescriber list. Last year, there were 56 complaints filed about providers. Some of the confusion, Ms. Frank said, is that for some reason, cancer and hospice physicians thought they were exempt from the PMP, but they are not. Anyone with dispensing power, except veterinarians, must use the PMP. If a doctor needs retraining in pain medication prescribing, the New Mexico Medical Board sends the doctor to the Center for Personalized Education for Physicians in Denver. Ms. Frank said that New Mexico Medical Board investigations can be triggered by PMP irregularities.

In response to a question about why oxycodone use is so prevalent, Dr. Landen said that, often, oxycodone is the most appropriate thing to prescribe for pain. Dr. Landen said that among those people who die from opioids, 85% are dealing with chronic, not acute, pain.

When asked if there is a danger of overdose if the drugs are used as prescribed, Dr. Katzman said that in her opinion and in her experience, for the people who are taking their opioids responsibly, the risk of death is low.

A member forwarded the idea of using medical marijuana as an alternative to opioids. Mr. McClish said that there is a lack of cannabis training for doctors. He said that doctors want to prescribe cannabis, but they do not know how to go about it.

In response to the question of whether there is a problem mixing opioids and cannabis, several presenters explained that it is hard to know how to parse out what drug is having what effect and that there are many issues with cannabis, including the various legal issues. While the

evidence for the benefits of cannabis for chronic pain is strong anecdotally, the evidence-based research is sparse because it is banned. In fact, a legislator said, cannabis research is a big reason to legalize. The possibilities for application seem very broad, and it can be paid for by diverting regulatory fees for cannabis to medical research.

A legislator expressed disappointment with the fact that there is little funding for training while providers attempt to treat pain appropriately. The legislator said that there is an unfunded mandate to train clinicians to treat pain adequately while not getting patients addicted.

Non-Pharmaceutical Treatment for Chronic Non-Cancer Pain

Michael Pridham, D.C.-A.P.C., N.R.C.M.E., member, executive board, New Mexico Chiropractic Association, explained the role of chiropractic treatment in the attempt to deal with the opioid epidemic. He said that a big challenge to these efforts is that in New Mexico, Medicaid does not reimburse providers for chiropractic treatment for opioid addiction, but there are 27 states that do. Dr. Pridham said that a patient's pharmaceutical costs are 85% lower when the patient seeks chiropractic treatment first.

Juliette Mulgrew, N.D., M.S.A.Y., vice president, New Mexico Association of Naturopathic Physicians, said that pain is a personalized experience. People with the same malady will experience different levels of pain and require differentiated treatment. Ms. Mulgrew said that pain is a symptom, not a diagnosis. In fact, many people who come to seek naturopathic pain treatment are already using opioids. She said that there is a six-month wait to get into a pain clinic, so other therapies are important and need recognition and support.

In response to a question, Dr. Pridham told the committees that the veterans' hospital in Albuquerque covers chiropractic treatment if the patient gets a referral from the patient's primary care physician to a qualifying chiropractor.

When asked what the legislature can do to help, Dr. Pridham said that chiropractors are legally prohibited from telling patients to stop using opioids and that it would be helpful to be able to do so if appropriate. He told the committees that some chiropractors would be seeking to change their scope of practice to permit this.

Medication-Assisted Treatment

Lindsay LaSalle, senior staff attorney, Drug Policy Alliance, said that New Mexico has been innovative and is credited with a lot of firsts in drug treatment and drug policy.

Eugenia Oviedo-Joekes, associate professor, School of Population and Public Health, University of British Columbia (UBC), discussed a study with Dilaudid that she published in *Psychology Today*. She said that by providing clean drugs, clean needles and a safe place to inject and having a person around in case of an overdose, deaths and the spread of disease went down. The study included more than 200,000 injections, and there were only 27 overdoses that required Narcan. Also notable in her work, she said, were better familial relationships for the

addicts and significant savings in emergency room treatment costs and criminal justice costs because of an 80% retention rate in treatment.

Miriam Suzanne Komaromy, M.D., associate director, ECHO Institute; and associate professor of medicine, UNM, said that using technology allows front-line providers to access information via telemedicine. Dr. Komaromy said that the case-based treatment supported by the web-based database allows providers the ability to share best practices and to reduce disparities in the provision of health care. She said that opioid addiction is the most common disorder seen and that three-fourths of the physicians changed their treatment after working with the ECHO program. Dr. Komaromy said that the institute just got a grant from the United States Department of Health and Human Services' Health Resources and Services Administration to launch six opioid use disorder programs.

Andrew Hsi, M.D., principal investigator, FOCUS Programs at the Center for Developmental and Disability, UNM Health Sciences Center; principal investigator, Reflejos Familiares Project; professor of family and community medicine, discussed neonatal opioid withdrawal syndrome (NOWS) and said that since data started being collected, New Mexico is high on the list of NOWS per capita. He said that long-term outcomes of those who suffer NOWS are hard to predict. Dr. Hsi said that UNM pediatric clinics have become a significant provider, with about 120 families with young children receiving treatment, including a growing number of fathers. "We care for a very challenged population", he stated in response to a question about whether the adolescent wing at Turquoise Lodge is needed to provide detox services to adolescents. He spoke of administrative barriers that make it harder to serve people who desperately need assistance. He urged that health care administration be informed by medical expertise and not by "administrative fiat".

Dr. Komaromy stated that Turquoise Lodge is very important for reaching "highly at-risk" people. She also informed the committees that UNM was starting a post-detention clinic on an outpatient basis for children released from juvenile facilities. She stated that UNM would send case managers to homes to ensure compliance, and if there were issues at home, UNM would send a caregiver to help.

Responding to a legislator's question, Professor Oviedo-Joekes said that the use of opioid-assisted treatment is patient by patient and that treatment is meant to reach patients as they are and to go from there. Professor Oviedo-Joekes said that just starting this treatment is not a magic elixir that will put the patient back into the workforce right away. The treatment discussed in her study is for the very poor, very addicted and not socially competent people who must come to the clinic three times a day.

Professor Oviedo-Joekes said that treatment varies country by country. In some places, clinics will allow the patient to take home a maintenance dose, which is rare, but that in her clinic, if anything is sent home with the patient, it would be methadone, which is much less popular than heroin. In fact, for the addict, Professor Oviedo-Joekes explained, opioids go from

being a street drug to being a medication, and this provides the person with a great sense of pride. While the patients go to the clinic in Vancouver, British Columbia, for the medication, the staff is there to care for them as patients and provide them with an entire suite of social services. Another benefit to these clinics, Professor Oviedo-Joekes said, is that when heroin is offered for free at the clinic, the black market for heroin is undercut.

When asked about treatment for alcohol abuse and dependence, Professor Oviedo-Joekes stated that UBC has a small pilot project group in Vancouver that makes its own alcohol for consumption as a community. The project is showing that alcohol consumption is diminishing through the community work.

A legislator expressed frustration at the fact that the state is closing juvenile detoxification facilities, and the medical director of one facility does not believe in medical detoxification. Dr. Hsi said that the decision of whether or not to provide inpatient detoxification should be a medical one for the particular patient and not done by administrative fiat. Ms. LaSalle said that most people do not require inpatient detoxification, but facilities should prioritize treatment for the sickest rather than exclude those very patients.

Economic Burden of Prescription Opioid Abuse

Alan White, Ph.D. in economics, UBC; M. Litt. in economics and mathematics, and B.A. in economics and mathematics, University of Dublin, Trinity College; managing principal, Analysis Group, Inc., provided the members with a map of the United States showing the prevalence of prescription opioid abuse by zip code that indicates that large swathes of New Mexico are in the top 10%. He said that the medical cost associated with an opioid abuser is $20,000 above the average person. The total burden on the United States is $50 billion a year, he stated. That figure includes only diagnosed prescription opioid use, Dr. White explained, so it is likely a very low estimate. There are also associated costs that this estimate ignores, such as missed days of work, for example.

Dr. White mentioned two initiatives that may reduce opioid abuse and curb its costs. First is the use of tamper-resistant pills so that users cannot alter them to smoke or snort the drug. Second is interpreting claims data to identify patients at risk for abuse before treatment begins.

A legislator questioned the figure previously cited as a cost to the criminal justice system and said it is much more costly.

In response to a question by a member, Dr. White said that an opioid will typically be 20% of the cost of its equivalent abuse-deterrent opioid.

Public Comment

Nat Dean, disability advocate, said that at Express Scripts, the difference in price between an opioid and its equivalent abuse-deterrent opioid is $15.00 versus $90.00.

There being no further business before the committees, the meeting adjourned at 5:25 p.m.